**Tayside NHS Board**

A meeting of Tayside NHS Board will be held on **Thursday 23 February 2017** in the **Board Room**, **Level 10, Ninewells Hospital** at **9:30am.** Apologies/enquiries to Donna Howey, DD 01382 740760, extension 40760 or e-mail donna.howey@nhs.net

**AGENDA**

Matters on which discussion is expected are included in Part A of the agenda. Part B is for other matters for approval or reporting. At the beginning of the meeting the Chairman will give members the opportunity to identify items in Part B on which they would wish to comment or ask questions.

Members should declare at the beginning of the meeting, or during the meeting if it becomes appropriate to do so, any financial or any other material interest they may have in any matter which is to be discussed by the Board. In cases of doubt, further advice may be obtained from the Board Secretary.

**Following approval by the Board, items indicated as reserved business are to be discussed in closed session by the Board and the appropriate officers (at the invitation of the Chair). Reserved business will be considered under the relevant FOISA exemption.**

| | | Lead Officer | Report No |
|---|---|---|---|
| **1.** | **Apologies** | | |
| **2.** | **Chairman's Welcome and update**<br>To note that the Patient Safety Team has been invited to attend lunch with the Board and give a poster presentation | **Mr S Hay** | **verbal report** |
| **3.** | **Chief Executive's Update** | **Ms L McLay** | **verbal report** |
| **4.** | **Minutes** | | |
| | **Minute of meeting of 1 December 2016** | **Mr S Hay** | **attached** |
| **5.** | **Action Points Update** | **Ms L McLay** | **verbal report** |
| **6.** | **Other matters arising** | **Mr S Hay** | **attached** |
| **7.** | **Committee Chairs' Assurance Reports** | | |
| | **Audit Committee** | **Mr S Hay** | **verbal report** |
| | **Clinical and Care Governance** | **Mrs A Rogers** | **BOARD19/2017** |
| | **Finance and Resources** | **Mr D Cross** | **BOARD31/2017** |
| | **Universities Strategic Liaison** | **Dr A Cowie** | **BOARD27/2017** |

**PART A Matters on which discussion is expected**

| | | | |
|---|---|---|---|
| **8.** | **Corporate Financial Report for period ended 31 December 2016** | **Mr L Bedford** | **BOARD18/2017** |
| **9.** | **Tayside Oral Health Equity Strategy – update** | **Dr D Walker/Dr D Richards** | **BOARD11/2017** |
| **10.** | **Board Assurance Framework (BAF)** | **Ms M Dunning** | **BOARD20/2017** |
| **11.** | **Strategic Risks reported to the Board** | | |
| | **Waiting times and RTT targets** | **Ms L Wiggin** | **BOARD12/2017** |
| | **Infection management** | **Mrs G Costello** | **BOARD13/2017** |
| | **Health equity** | **Dr D Walker** | **BOARD14/2017** |
| | **Capacity and flow** | **Ms L Wiggin** | **BOARD15/2017** |
| | **NHS Tayside estate infrastructure** | **Ms L Wiggin** | **BOARD16/2017** |
| | **Development of primary care services** | **Ms V Irons** | **BOARD17/2017** |

**PART B Other matters for note, information, reading**

| | | | |
|---|---|---|---|
| **12.** | **Health Promoting Health Service monitoring report and feedback** | **Dr D Walker** | **BOARD01/2017** |
| **13.** | **HAI control in Tayside for November and December 2016** | **Prof A Russell** | **BOARD02/2017** |
| **14.** | **Performance report** | **Ms L Wiggin** | **BOARD03/2017** |
| **15.** | **Organ and Tissue Donation and Transplantation – A Consultation on Increasing Numbers of Successful Donations** | | **BOARD04/2017** |
| **16.** | **North of Scotland Planning Group Annual Report** | | **BOARD05/2017** |
| **17.** | **Scottish Patient Safety Programme in Mental Health Report** | **Prof A Russell** | **BOARD10/2017** |
| **18.** | **Schedule of meetings 2017/18** | **Ms M Dunning** | **BOARD06/2017** |
| **19.** | **Appointment of new Non Executive Member to Committees** | **Ms M Dunning** | **BOARD07/2017** |
| **20.** | **NHS Tayside Code of Corporate Governance updates** | **Ms M Dunning** | **BOARD08/2017** |
| **21.** | **NHS Tayside Annual Report** | **Ms M Dunning** | **BOARD09/2017** |
| **22.** | **Record of Attendance** | **Ms M Dunning** | **attached** |

**23. Minutes**

| | |
|---|---|
| **Staff Governance Committee 27 September 2016** | **Mr M Hussain** |
| **Universities Strategic Liaison Committee 1 November 2016** | **Dr A Cowie** |
| **Clinical and Care Governance Committee 10 November 2016** | **Mrs A Rogers** |
| **Finance and Resources Committee 17 November 2016** | **Mr D Cross** |

**Awaiting Committee Approval**

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|---|---|
| **Finance and Resources Committee 19 January 2017** | **Mr D Cross** |

**RESERVED BUSINESS**

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| **24.** | **Reserved Minute of meeting of 1 December 2016** | **Mr S Hay** | **attached** |
| **25.** | **Reserved action points update** | **Ms McLay** | **attached** |

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|---|---|---|---|
| **26.** | **Committee Chairs' Assurance Reports** | | |
| | **Remuneration Committee** | **Mr D Cross** | **BOARD30/2017** |
| | **Transformation Programme Board** | **Mr S Hay** | **BOARD22/2017** |
| | **Area Clinical Forum** | **Dr A Cowie** | **BOARD28/2017** |
| | **Finance and Resources Committee** | **Mr D Cross** | **BOARD32/2017** |
| | **PART A Matters on which discussion is expected** | | |
| **27.** | **Staffing Issue** | **Mr G Doherty** | **BOARD25/2017 BOARD26/2017** |
| **28.** | **NHS Scotland Pharmaceutical 'Specials' Service – Full Business Case Addendum** | **Mr L Bedford** | **BOARD24/2017** |
| **29.** | **Property Disposal Land and Buildings - 4 Dudhope Terrace, Dundee** | **Mrs J Bodie** | **BOARD20/2017** |
| **30.** | **Property Disposal Land and Buildings – Orleans Clinic** | **Mr L Bedford** | **BOARD21/2017** |
| **31.** | **Property Disposal Land and Buildings – 14/16 Rosemount Road, Arbroath** | **Mr L Bedford** | **BOARD23/2017** |
| **32.** | **One Year Plan 2017/18** | **Ms L McLay** | **verbal report** |
| **33.** | **Strategic Five Year Plan** | **Ms L McLay** | **verbal report** |
| **34.** | **Mental Health Improvement Programme : General Adult Psychiatry In Patient Services Update** | **Prof A Russell** | **verbal report** |
| | **PART B Other matters for note, information, reading** | | |
| **35.** | **Data Breach** | **Ms M Dunning** | **BOARD29/2017** |
| **36.** | **Reserved Minutes** | | |
| | **Clinical and Care Governance Committee 10 November 2016** | | **Mrs A Rogers** |
| | **Finance and Resources Committee 17 November 2016** | | **Mr D Cross** |
| | **Transformation Programme Board 23 November 2016** | | **Mr S Hay** |
| | **East of Scotland Research Ethics Service REC 1 9 December 2016** | | |
| | **Transformation Programme Board 21 December 2016** | | **Mr S Hay** |
| | **Awaiting Committee Approval** | | |
| | **Area Clinical Forum 20 October 2016** | | **Dr A Cowie** |
| | **Remuneration Committee 13 December 2016** | | **Mr D Cross** |
| | **Area Clinical Forum 15 December 2016** | | **Dr A Cowie** |
| | **Finance and Resources Committee 19 January 2017** | | **Mr D Cross** |
| **37.** | **Date of next meeting** | | |
| | **Thursday 16 March 2017 after the Finance and Resources Committee , Board Room, Kings Cross** | | |

**Prof J Connell**
**Chair**

**February 2017**

# Minute NHS Tayside

**TAYSIDE NHS BOARD**

Minute of the above meeting held at 9:30am on Thursday 1 December 2016 in the Board Room, Level 10, Ninewells Hospital and Medical School, Dundee

**Present**

**Non Executive Members**

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| Dr A Cowie | Non Executive Member, Tayside NHS Board |
| 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 ( to item 7.2 ) |
| 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 (from item 3) |
| Councillor G Middleton | Non Executive Member, Tayside NHS Board |
| Mr H Robertson | Non Executive Member, Tayside NHS Board |
| Mrs A Rogers | Non Executive Member, Tayside NHS Board |
| Mrs S Tunstall-James | Non Executive Member, Tayside NHS Board |
| **Executive Members** | |
| Mrs G Costello | Nurse Director |
| Ms L McLay | Chief Executive |
| Professor A Russell | Medical Director |
| **Apologies** | |
| Professor M Smith | Non Executive Member, Tayside NHS Board |
| Dr D Walker | Director of Public Health, NHS Tayside |
| **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 |
| Ms M Dunning | Board Secretary |
| Mr T Gaskin | Chief Internal Auditor |
| Miss D Howey | Head of Committee Administration |
| **By Invitation** | |
| Mrs S Chima | Diversity and Inclusion Manager ( for item 8.4 ) |
| Mr D Cunningham | Chief Executive, The Archie Foundation ( for item 7.1 ) |
| Ms K Fowlie | Project Lead, Children's Theatre (for item 7.1 ) |
| Dr G Main | Consultant Radiologist/Associate Medical Director ( for item 7.2) |
| Dr G Phillips | Lead Infection Control Doctor ( for item |
| Dr M Watts | Associate Medical Director - Primary Care (for item 7.2 ) |
| Ms L Wiggin | Chief Operating Officer ( for items 7.1and 8.3 ) |

**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 to the Board meeting, He advised that lunch would be available in the promenade area on Level 7 at 12:30pm. Nominees and attendees for the Cullen Awards had been invited to attend the lunch with the Board.

The Cullen Awards were to be held in the Gannochy Lecture Theatre and Board Members were invited and encouraged to attend.

Board Members were also invited along to the Ninewells Gift Shop (Tayside Health Fund), on the concourse, to help celebrate their two year anniversary.

Other items that the Chairman highlighted were:

- A recent visited to Highland Perthshire – Aberfeldy and Pitlochry with Mrs Dunion. These were both excellent examples of co –production and models for future ways of working. Board Members were encouraged to visit both areas
- The Cabinet Secretary for Health and Well being had recently opened the Leaf Room at the Community Garden in Ninewells Hospital. The Leaf Room was a focus and hub for a number of patient, staff and school groups. The Chairman thanked Dr Drew Walker, Director of Public Health and Mrs Mary Colvin, Senior Health Improvement Practitioner for their work in getting the Leaf Room established
- With the Chief Executive, the Chairman had recently attended a national Senior Leadership Forum. This had covered a variety of issues and the Cabinet Secretary for Health and Well being was to make a statement to the Scottish Parliament before the new year on transforming the NHS in Scotland
- A meeting had been held with local MSPs on 18 November 2016. The main topic of discussion had been Shaping Surgical Services as considered by the Board on 27 October 2016
- There had been a successful Board Development Session on 24 November 2016 and a North of Scotland Planning Group event on regional working on 30 November 2016

**The Board noted the Chairman's update**

Councillor Lynn arrived

**3. CHIEF EXECUTIVE'S UPDATE**

The Chief Executive highlighted:

- The mid-year review letter had been received from the Scottish Government Health and Social Care Directorate on 30 November 2016. The key highlights were the financial position and the requirement to achieve a £46.7 million target and the associated risk control mechanisms that had to be in place. Prescribing, workforce and delayed discharges were also highlighted. The scale of the challenge was recognised and there was monthly reporting to the Scottish Government on the

prescribing and supplementary staffing spend

- The Safe and Reliable Results Handling project was progressing well. This had been introduced in thirteen areas of Specialist Services and had resulted in the switch off of paper results processes, improving the quality and safety of patient care

**The Board noted the Chief Executive's update**

**4. DECLARATION OF INTERESTS**

No interests were declared.

**5. MINUTE OF PREVIOUS MEETING**

**5.1 Minute of Meeting of Tayside NHS Board held on 27 October 2016**

The Minute of the Meeting of Tayside NHS Board held on 27 October 2016 was approved subject to the undernoted amendment:

Page 75, **6.2 Clinical and Care Governance Committee (BOARD102/2016),** first sentence to read, " The assurance update submitted by Mrs Rogers, Chair of the Clinical and Care Governance Committee was noted"

With this amendment recorded, the Minute of the meeting of Tayside NHS Board held on 27 October 2016 was approved on the motion of Mrs S Tunstall-James and seconded by Mrs J Golden.

**5.2 Action Points Update**

It was noted that the one action point was an item for discussion on the agenda.

**The Board noted the Action Points Update**

**5.3 Any Other Matters Arising**

There were no other matters arising.

**6. COMMITTEES – ASSURANCE REPORTS FROM CHAIRS**

**6.1 Clinical and Care Governance Committee**

Mrs Rogers, Chair of the Clinical and Care Governance Committee gave a verbal assurance update in respect of the Clinical and Care Governance Committee.

She highlighted that at the last meeting of the Clinical and Care Governance Committee on 10 November 2016, the eight strategic risks reported to the Committee had been considered. There had been no change in the risk rating of the Delivery of Care to Older People strategic risk, the risk rating for the Maternity Services strategic risk had increased and an improvement plan was in place and was to come to the next meeting of the Clinical and Care Governance Committee. The rating for the PRI/Patient Flow strategic risk had also increased and Managed 2c practices was a new strategic risk. Progress with the HSE Improvement Plan in relation to the Mental Health strategic risk was also discussed at each meeting of the Clinical and Care Governance Committee.

A number of policies had come for endorsement to the meeting of the Clinical and Care Governance Committee on 10 November 2016 and Mrs Rogers highlighted

the Non Medical Prescribing Policy in particular. It was noted that other staff being able to prescribe medication would increase capacity.

Other items of note were the Scottish Public Service Ombudsman Report, the Public Health Performance Management Framework and the Section 23 Agreement.

**The Board noted the verbal assurance report given by Mrs Rogers**

**6.2 Finance and Resources Committee**

Mr D Cross, Chair of the Finance and Resources Committee gave a verbal assurance update in respect of the Finance and Resources Committee.

He advised that the Finance and Resources Committee had been held on 17 November 2016. The main focus of the meeting had been the financial position. He noted that the financial position continued to worsen and for the month of October there was an overspend of £1.2 million. If this continued at this rate each month; there was a likelihood the unbalanced Local Delivery Plan figure of £11.6 million would be breached at the year end.

It was vital that the unbalanced Local Delivery Plan figure was not exceeded. The accelerated proposals discussed at the Board meeting on 27 October 2016 and the efficiency programme were designed to assist with this.

Consideration had been given to the strategic risks that reported to the Finance and Resources Committee. This now included consideration of the underlying operational risks in relation to revenue and capital.

It was noted that there had been a joint Finance and Resources and Staff Governance Committees meeting held on 18 November 2016. This had been a productive meeting and a joint piece of work in respect of workforce plans aligned to the emerging financial position had been commissioned.

The Board Development Session on strategic and financial planning on 24 November 2016 was also noted as productive.

**The Board noted the verbal assurance report given by Mr Cross**

**6.3 Universities Strategic Liaison Committee**

Dr A Cowie, Chair of the Universities Strategic Liaison Committee gave a verbal assurance update in respect of the Universities Strategic Liaison Committee.

He advised that the Committee was still trying to find its role and there was an ongoing update to its remit.

The Chairman noted that it was felt that the Academic Health Science Partnership (AHSP) had superseded the role of the Universities Strategic Liaison Committee; however, the Universities Strategic Liaison Committee was a statutory requirement as Tayside was a teaching Board area. The aim in the longer term, was that the Academic Health Science Partnership Governance Board would act as the Universities Strategic Liaison Committee.

**The Board noted the verbal report given by Dr A Cowie**

The Chairman advised that although not an agenda item, Mr Hussain, Chair of the Staff Governance Committee had requested that he give an update to the Board.

**6.4 Staff Governance Committee**

Mr Hussain advised that he had updated the Board at the Board meeting in October with a full written update of the meeting of the Staff Governance Committee held on 27 September 2016.

He wished to advise the Board that he had recently received the staff sickness absence results from across NHS Scotland. He advised that amongst their peer boards, NHS Tayside was currently the best performing Board in relation to staff absence. Mr Hussain asked the Board to acknowledge this area of good performance.

There were, however, areas in breach that Mr Hussain wished to bring to the Board's attention. These were the Perth and Kinross IJB (increase in staff sickness absence since September 2016) and the Operations Directorate (running at a higher rate for a number of years), Operations had improved this figure in the past but the current figure of 6%+ was unsustainable and the Board had to take serious notice of this area. He also highlighted three job family areas that were at very high figures, two were in the Nursing and Midwifery Directorate, Learning Disabilities and Maternity with an absence rate of 8%+ and the other area was Support Services at just over 7% (this area covered a wide range of posts and work areas so a deeper look was needed). He also highlighted that two of the three areas highlighted have had cultural challenges noted in the recent past.

The Chairman thanked Mr Hussain for his update and asked the Director of Human Resources and OD and the Employee Director for their views.

The Director of Human Resources and OD advised that this was to come to the meeting of the Staff Governance Committee on 13 December 2016 for further discussion. It was noted that in respect of overall attendance reporting, there was a steady, downward trajectory. There were complex and long term issues in the areas that had been highlighted.

The Employee Director advised that steps had been taken in partnership to assist with the management of sickness absence in Support Services. This would be reported at the Staff Governance Committee on 13 December 2016. Further detailed work was to be taken forward as part of this assurance process.

There was discussion around what was actually meant by the culture of the organisation. It was noted that this included the micro cultures within teams. This related to the Future Assurance Reporting item that was discussed at the Board meeting on 27 October 2016.

**The Board noted the verbal update provided by Mr Hussain and the update from the Director of Human Resources and OD and the Employee Director**

**7. STRATEGIC ISSUES**

**7.1 NHS Tayside/ARCHIE Collaboration – Update on Children's Theatre Suite Project (BOARD132/2016)**

The Chief Operating Officer gave a background to the project and the fundraising efforts to date then introduced Ms Kay Fowlie, the Project Lead and Mr David Cunningham, the Chief Executive of the Archie Foundation.

Ms Fowlie gave an overview of the project to create a fit for purpose, state of the art, 21st century Children's Theatre Suite in Ninewells Hospital to replace the current inadequate facilities.

It was noted that there was £4 million capital funding available from NHS Tayside. The Archie Foundation was fundraising for an additional £2 million to support this project.

Ms Fowlie outlined the governance and approval processes. It was noted that the Initial Agreement had been approved and work was now proceeding on the Outline Business Case. A key element of this was the appointment of the design team and it was noted that Ritchie, Dagen and Allen Ltd. had been appointed.

It was noted that there would be detailed workshops as part of the Outline Business Case process. This included benefits realisation and site scoring as well as the selection of a preferred site. There were regular Project Board meetings chaired by Mr Stephen Hay, Vice Chair of the Board, on schedule progress and approvals.

Ms Fowlie advised that an artist's impression of the design of the facility was to be produced at an early stage.

Congratulations and thanks were expressed to the Archie Foundation on the success of the "Oor Wullie Bucket Trail" in not only raising funds for the Children's Theatre Suite project, but in bringing local families together on walks, taking photographs etc. It was stressed that this community was not exclusive to Dundee but was across the whole of Tayside.

Mr Cunningham advised that the Archie Foundation was very pleased to be involved with fundraising for this worthwhile project and noted there would be close involvement with the design team.

He highlighted that the "Oor Wullie Bucket Trail", had been a major national event that had covered not just Dundee but that it had the greatest impact on Dundee. It was noted that the fundraising had reached the halfway mark and there was a confidence in delivering the £2 million target. All was on track and the project was going well.

It was noted that a key part of the interview process with the prospective design teams had been the involvement of children/young people in the proposed design. There would be preliminary workshops with children and families. This would cover children of all ages as the facility would be for children aged from 0 to 16 years.

Mr Hay as chair of the Project Board commended the work undertaken by Ms Wiggin and Ms Fowlie. He noted that this was a complex project to deliver and there were a number of contingent projects around it that had to be in place for the project's success.

The Chairman on behalf of the Board thanked all involved with the project.

**The Board:**

- **Noted the progress of the children's theatre suite project and the Scottish Government's approval of the Initial Agreement**
- **Noted the progress of the fundraising campaign by the ARCHIE Foundation**
- **Congratulated the ARCHIE Foundation on the enormous success of the "Oor Wullie Bucket Trail" both in terms of fundraising for the children's theatre suite and in terms of bringing the community of**

## 7.2 NHS Tayside Medicines Management Proposals (BOARD133/2016)

The Director of Pharmacy was in attendance for this report along with Dr M Watts, Associate Medical Director - Primary Care and Dr G Main, Consultant Radiologist/Associate Medical Director.

The Director of Pharmacy gave a presentation on the safe, clinically effective and cost effective use of medicines. She outlined the explained variation, unexplained variation , the focus on positive patient outcomes and concluded by outlining the further work to be done in relation to a formulary review, lidocaine plasters, pregabalin, rosuvastatin and quality prescribing visits along with the communication with communities and patients.

Dr Watts outlined the approach to be undertaken in accelerating the pace of change whilst maintaining a focus on quality and safe care whilst addressing the issues of waste, variation and harm.

It was noted that primary care in NHS Tayside was an early adopter of the new GMS contract and in particular the management of chronic disease. There were a large number of areas in NHS Tayside that showed a demonstrable difference in chronic disease prevalence. An example given was atrial fibrillation; in Tayside there was a 15% higher prevalence in Tayside compared to the national average however; Tayside had a lower death from cardiovascular disease related to stoke rate than the rest of Scotland. Internationally, NHS Tayside was at the forefront of managing and treating Hepatitis C and liver disease; with the aim of eradicating Hepatitis C in the population in the next five years. It was noted that NHS Tayside had the lowest referral rate for liver transplants to the national transplant team.

Dr Watts was clear that some high prescribing costs were producing really good outcomes for patients. It was highlighted that from the better use of data, that in comparison to NHS Lothian, the cost per treated patient for diabetes was lower in NHS Tayside by £13 and for inhaled steroids the cost per treated patient for asthma and COPD, were £9.35 lower.

However, there were areas where there was unexplained variation and external validation had been undertaken by NHS Lanarkshire. Areas highlighted were the high prescribing rates in Tayside for pregabalin and lidocaine plasters where a whole systems pathway approach would be required to understand and address this.

The Director of Pharmacy drew the Board's attention to appendix 3 of the report. This outlined the supporting governance structures and reporting arrangements to the Clinical Quality Forum and the Clinical and Care Governance Committee.

It was noted that there would be a focussed formulary review, as well as quality prescribing visits along with social media campaigns targeting repeat prescriptions and medicine waste.

Dr Main outlined that this was a whole systems issue and he explained how the prescribing management group enabled and supported staff in making changes to their prescribing habits. He stressed the importance of using quality improvement methodology in this process.

It was noted that there were large amounts of high quality granular data available to assist general practice with reviewing and changing their prescribing practice.

The Director of Pharmacy advised that NHS National Services Scotland was also providing support through data analysts in addition to support from NHS Ayrshire and Arran and NHS Fife.

The Chairman noted that the Board had requested this report at its meeting on 27 October 2016 and he thanked the Director of Pharmacy and the rest of the team for bringing the paper forward.

During discussion the following points were noted:

- There needed to be robust data mapping of the 8 chapters of the British National Formulary; there would be work done on the first and second choice drug and if it was cost effective and clinically effective as well as ensuring formulary compliance
- The prescribing management group had a 3 to 5 year plan and there was a month by month focus on the plan. In relation to GP clusters, these had only been in place for a few months and there would be engagement with the cluster leads. In respect of horizon scanning, the Scottish Medicines Consortium's recommendations were robust and considered in the budget setting process
- The formulary was advisory and not mandatory in primary care
- There was a query if the use of warfarin could be phased out. It was noted that the new anti coagulants were not suitable for all patients, so there would still be a need for warfarin and the associated support mechanisms
- The present NRAC allocation formula did not take account of prevalence of disease
- Areas of unwanted variation had been highlighted and there was a requirement for the Local Delivery Plan figures to be met in this financial year
- The higher differences in prescribing in Angus were noted. Currently there was not a simple explanation for this. There was good engagement with the practices concerned and the next tranche of data would provide more information
- It was felt that the current system was a barrier to making changes; in the case of lidocaine plasters, there needed to be a review of the chronic pain pathway to provide alternative opportunities for patients
- A small number of GP practices had been unable to participate in the review work due to capacity issues and further work would help to support them to do so
- The minor ailments programme had little impact on the total prescribing budget. Community pharmacists would be involved where they could in improving cost effectiveness e.g. pack sizes
- There was a need for good health economic analysis to understand the quality and anticipated savings that could be made with this review work. It was acknowledged that this was a complex piece of work. It was noted that health economic information had a 5 to 10 year time frame
- It was highlighted that there was no opportunity to recall resources top-sliced from budgets for national services, such as liver transplants, that were not used
- Concern was expressed that the recommendation in respect of the prescribing of pregabalin might not be met as its use was driven by secondary care. This illustrated the need for a whole system approach to driving change

Councillor Doogan left the meeting.

**The Board:**

- **Supported the development of the Tayside Prescribing Management Group as a strategic means to support clinically led whole system quality oriented cost effective prescribing change**
- **Supported the five focussed programmes (listed below) to address the current financial gap in prescribing expenditure:**
  - **Deliver the quality prescribing visits scheduled across 15 practices with a view to releasing £100,000 by March 2017**
  - **Review the use of rosuvastatin within Tayside and ensure formulary compliance by December 2016 releasing £200,000 by March 2017**
  - **Review and reduce the use of lidocaine plasters within Tayside by December 2016 releasing £200,000 by March 2017**
  - **Review and reduce the use of pregabalin in Tayside and embed prescribing management guidance as part of a refreshed pain management pathway releasing £100,000 through implementation by March 2017**
  - **Complete a review of local formulary compliance by December 2016, with the implementation of a refreshed and combined NHS Tayside/Fife formulary releasing £1 million by March 2017**
  - **Support the financial savings forecast of £5 million (FYE) through these and current initiatives, with £1.6 million to be delivered through the accelerated initiatives by March 2016/17**
- **Agreed to the review of the 6 national therapeutic indicators where we are ranked lowest in Scotland and seek to address unwanted variation**

## 8. GOVERNANCE ISSUES

### 8.1 HAI Control in Tayside for September and October 2016 (BOARD135/2016)

Dr Phillips was in attendance and spoke to this report. She advised that there was no major difference to the report that had been presented to the Board on 27 October 2016. There was a slightly better performance in respect of *Staph aureus* bacteraemias (SAB) over the second 6 months, the target for *C Difficile* was just about on target and as yet there had not been any flu or norovirus issues.

There was discussion in respect of community acquired SAB infections and how NHS Tayside compared across the rest of Scotland. Dr Phillips advised that in comparison with other teaching Board areas, Tayside was not an outlier however, it was a variable situation.

**The Board:**

- **Noted Report BOARD135/2016 for information**

**8.2 Corporate Financial Report for Period Ended 31 October 2016 (BOARD136/2016)**

The Director of Finance spoke to this report. He advised that at the end of October, the overspend was £8.9 million, an increase of £1.2 million at the end of September 2016. It was highlighted that if this pattern of spend did not change then the Local Delivery Plan would be breached.

It was noted that actions in relation to prescribing had been outlined in the earlier discussion of the NHS Tayside Medicines Management Proposals. The nursing workforce proposals would be discussed later in the agenda.

The Director of Finance advised that the £8.9 million figure reflected the proportionate release of the Board's contingency, the benefit of the non added value capital and the actions to contain spend. This covered £6.8 million of the unbalanced Local Delivery Plan and there was in excess of £2 million shortfall against the efficiency savings.

There was an increase in the trajectory on employed staff in the month to reflect principally the impact of the commencement of recruitment to nurse and midwifery vacancies through the appointment of the newly qualified practitioners. Employed staff within the month had increased with 80 new practitioners. Given the induction and orientation period of 2-3 weeks an element of double running costs due to supplementary costs had been incurred with a similar impact in November expected.

It was highlighted that all workforce supplementary costs were higher than in the same period in the last year with medical agency costs continuing to increase. External non contract nursing agency costs were however 14% lower than the same period last year.

In respect of prescribing there was an overspend of £3.4 million at the end of October, there was a £3.9 million overspend in FHS medicines and £0.5 million underspend in secondary care.

It was noted that primary care prescribing remained above the national average cost per head of weighted patient at 8.5% and the financial assessment of this was close to £7 million. This included both warranted and unwarranted variation as highlighted in an earlier Board paper. It was noted that December sees an increase in costs of over 10% from the monthly norms that is not recovered in future months. National messages and local social media campaigns were being used to highlight medicines waste to the public.

It was noted that the use of biosimilar medicines had increased deriving an expected year end benefit of close to £1.2m. The 2 particular medicines identified in the report showed a higher level of switching than the average across Scotland.

The efficiency savings from the various workstreams were outlined on page 15 of the report; there was a £2.8 million shortfall. Further action was required in relation to prescribing and the nursing agency spend. These were the cornerstones in delivering a significant reduction in spend in the final four months of the financial year, however, all spend needed to be contained.

During discussion the following points were noted:

- The message that all spend had to be contained was reinforced as the Local Delivery Plan position had to be met
- A query was raised in respect of the non-compliant training grade rotas. The reasons for this were outlined by the Medical Director – Operational Unit. It was noted that with breached rotas there were banding

supplements to be paid and this included treble pay
- The forecast of £39.4 million efficiency savings was queried and what the current position was in relation to this target. It was noted that the forecast outturn paper presented in October was still relevant and there had been no further movement. Further actions were needed to have a recurring impact and the work to be undertaken in respect of prescribing could have a further impact of £5 million recurring

**The Board:**

- **Noted the current position and supported the actions being taken to contain spend**

**8.3 Performance Report (BOARD138/2016)**

The Chief Operating Officer and the Medical Director – Operational Unit were in attendance for this report.

The Chief Operating Officer advised that in respect of Access to Treatment, there had been positive performance in Accident and Emergency four hour waits, Child and Adolescent Mental Health Services (CAMHS), Drug and Alcohol and IVF services.

Treatment Time Guarantee (TTG), at the end of September 2016, was ahead of the trajectory submitted in the LDP by seven patients. However the position had deteriorated over October 2016 due to a number of service challenges.

These were noted as :

- Ophthalmology – the IVT (Intravitreal injection) procedure room was no longer able to accommodate the volume of activity which had displaced cataract operations from theatre. This had resulted in 52 patients not being seen within their TTG. A plan has been agreed with the service, however, it would be March 2017 before the backlog was addressed
- Gynaecology – 36 above trajectory due to long term consultant vacancies with one consultant locum available to provide cover. An advert was currently out to attract applicants to the posts with a closing date of 18 December 2016
- Plastic Surgery - 19 above trajectory due to increased demand and surgeon sickness absence which have impacted on performance
- Vascular Surgery – 15 above trajectory due to consultant absence
- An emerging risk in relation to orthopaedics was highlighted resulting from sickness absence rates reducing workforce capacity

In respect of out patients, NHS Tayside had not achieved the standard for outpatient waits and was currently 1430 above the LDP trajectory. Particular challenges within dermatology, gastroenterology and general surgery were contributing to current performance
It was noted :

- Dermatology – had a referral rate substantially greater that the seasonal trend. Weekend clinics had started in October and would continue through December to assist in reducing the backlog
- Gastroenterology – the consultant vacancy was now filled and the post would help to stabilise the position. Support was being sought to address the backlog with a bid to the Scottish Government Patient Access Team
- General Surgery – had planned to provide additionality however this had not been feasible

- Respiratory Medicine – additional clinics had commenced in October 2016 and these were planned to run until March 2017
- Vascular Surgery – a technician had been appointed which had resulted in an improving position in the last quarter

DMMI, it was noted that NHS Tayside had an improving position in colonoscopy with a plan in place over the remaining quarter.

An improvement was required in 18 weeks performance as a result of the above.

Cancer 31 and 62 day waits were also below standard. The breast cancer pathway and dates for surgery were challenging due to increasing demand. There had been 61 referrals on the pathway in May and 74 in June in comparison to the monthly average of 34 for previous months. The October performance for 62 days was 90% and for 31 days was 75%. A similar performance was predicted for November, however, it was anticipated the position would improve by January 2017.

In respect of delayed discharges, there had been a deteriorating position over September and October. November was showing an improved position given the significant work undertaken by teams to support the improvements.

The external review of the Feedback service had been received by the Nurse Director and the Chief Operating Officer. A proposed improvement plan to address the review's recommendations was being progressed.

Dr Cook advised that there had been little change in respect of his reporting areas of the performance report since the Board meeting in October.

During discussion the following points were noted:

- The doubling of the breast cancer referrals was queried. Dr Cook advised that there had been a consultant radiologist on long term sick leave but the vans had continued to screen women and there had been a delay in reading the films (7 to 8 weeks). As the screening backlog was cleared over a relatively short period and the women assessed it creates a one off increase in the number of breast cancers detected. This had coincided with a surgeon on sick leave which had led to further delays in treatment. All mammograms have now been reported and women assessed and the backlog had been eliminated
- The potential for up to a quarter of the readmissions at Perth Royal Infirmary to be avoidable was highlighted. It was noted that these were generally short term readmissions covering cardiology, respiratory and mental health conditions. Better links between primary and secondary care and the development of an assessment area in Perth gave the potential for these to be reduced
- Thanks were extended to the CAMHS team for sustaining their performance

**The Board:**

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

**8.4 Section 23 Legal Agreement between Tayside NHS Board and the Equalities and Human Rights Commission (BOARD139/2016)**

The Board Secretary gave an introduction to this report and advised that Mrs Chima was in attendance to answer any questions. It was noted that this had been given detailed consideration at the recent meeting of the Clinical and Care

Governance Committee.

Mrs Rogers noted the considerable amount of work that had been undertaken and queried how it could be sustained over time. Mrs Chima advised that the improvements put in place would continue to be monitored over the next few years and there would still be reporting through the current governance structures.
The Nurse Director highlighted that there was an outstanding piece of work to be undertaken in respect of mapping all the associated work to allow the organisation to be clear how this would in the future be reported through the governance structures.

**The Board:**

- **Noted the content of this report and the work progressed by NHS Tayside to meet its legal obligations and compliance with the requirements of the Section 23 Legal Agreement**
- **Agreed that the aims and requirements of the Section 23 Agreement had been met**

**9. FOR INFORMATION**

**9.1 Maternity and Child Quality Improvement Collaborative (MCQIC) (BOARD140/2016)**

Report BOARD140/2016 was noted for information.

**9.2 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.**

**10. MINUTES**

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

**10.1 Minute of Reserved Business of Tayside NHS Board held on 27 October 2016**

The Minute of the Reserved Business of Tayside NHS Board held on 27 October 2016 was approved.

**10.2 Reserved Action Points Update**

The Reserved Action Points Update was noted.

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

**11. COMMITTEES – ASSURANCE REPORTS FROM CHAIRS**

**11.1 Transformation Programme Board**

The Board noted the update given by the Chairman.

**11.2 Area Clinical Forum**

The Board noted the update given by the Chair of the Area Clinical Forum.

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

**12. Staffing Issue (BOARD142/2016)**

The Board noted this report and the update given by the Director of Human Resources and OD.

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

**13. Property Disposal – Land and Buildings at Longcroft Clinic, Dundee (BOARD144/2016)**

The Director of Finance presented this report.

**The Board approved the recommendations in Report BOARD144/2016**

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

**14. Property Disposal – Land at Former Douglas Clinic, Dundee (BOARD145/2016)**

The Director of Finance spoke to this report.

**The Board approved the recommendations in Report BOARD145/2016**

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

**15. Property Disposal – Land and Buildings at 4 Dudhope Terrace, Dundee (BOARD143/2016)**

The Director of Finance presented this report.

**The Board approved the recommendations in Report BOARD143/2016**

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

**16. Chairman/Chief Executive Update**

The Board noted the verbal update given by the Chairman and Chief Executive on the arrangements for the Public Audit and Post- legislative Scrutiny Committee meeting to be held in Dundee on 15 December 2016.

**The Board noted the verbal update**

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

**17. Contingency Plan for Sustaining Mental Health Services during Transition**

The Medical Director gave a verbal update.

**The Board noted the verbal update**

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

**18. Governance and Risk Plan for Safe Quality Patient Care (BOARD134/2016)**

The Nurse Director presented this paper and the Board agreed the recommendations in the report.

**The Board agreed the recommendations in Report BOARD 134/2016**

**19. For Information**

**Minutes of Meetings of Standing Committees**

**Approved as a correct record**

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

**19.1 East Of Scotland Research Ethics Service REC 1 – 21 October 2016**

The Minute was noted.

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

**19.2 Transformation Programme Board – 19 October 2016**

The Minute was noted.

**20. Date of Next Meeting**

The next meeting of Tayside NHS Board will be held on Thursday 23 February 2017 2016 at 9:30am in the Board Room, Level 10, Ninewells Hospital and Medical School

**Actions Points Update** **NHS Tayside**

**Tayside NHS Board – 23 February 2017**

| | Meeting | Minute Reference | Heading | Action Point | Responsibility | Status |
|---|---|---|---|---|---|---|

No action points for this meeting

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

**Item 7**

**BOARD19/2017**
**Tayside NHS Board**
**23 February 2017**

**COMMITTEE CHAIR'S ASSURANCE REPORT**

**Clinical and Care Governance Committee - OPEN AND RESERVED BUSINESS**

**Thursday 10 November 2016**

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

**Update on Risks**

**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 discussed by the Clinical Quality Forum (CQF) on 12/09/16. It was noted that completion of documentation to demonstrate quality of care continues to be a challenge. There was a short discussion on the quality of care for older people within the Health and Social Care Partnerships. Complexities of patient discharge and detail in relation to readmission rates would be included in future reports.

**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, and was discussed by the Clinical Quality Forum (CQF) on 12/0916. Regarding gaps in assurance, Ms Napier confirmed that staffing levels had been reduced within the Clinical Governance and Risk team but there was still resource within the area that could be drawn on.

**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. |

This risk was discussed by the Clinical Quality Forum (CQF) on 12/09/16. The Committee noted that the risk manager was now Ms Joan Wilson, Chief Nurse – Children and Families following the retirement of Ms Kay Fowlie, and that the report at the next meeting would provide more contemporary information in relation to this risk.

**395 Mental Health Services**

Owner – Andrew Russell
Change to the owner

Red Risk
Increase in the scoring of this risk

This risk was discussed by the Clinical Quality Forum (CQF) on 12/09/16. The update was provided in Reserved Business. The committee noted the report and were content with the level of assurance that the risks were being actively mitigated and managed or controlled. The committee noted that a report would go to the Finance and Resources Committee in January 2017 outlining the cost of the replacement windows for Mental Health Service areas.

**121 Person Centredness**

Owner – Gillian Costello
No change to the owner

Yellow Risk
No change to the scoring of this risk

This risk was discussed by the Clinical Quality Forum (CQF) on 12/09/16. There were no comments relating to this assurance report and 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 item was discussed in Reserved Business. There was discussion about the current challenges associated with: Angus maternity services and Community Midwifery Units, recruitment of midwives amid concerns about the availability of qualified midwives, and environmental issues. The committee asked that the Improvement Plan come to the next meeting.

**302 PRI Patient Flow**

Owner – Alan Cook
No change to the owner

Amber Risk
A change to the scoring of this risk

This risk was discussed by the Clinical Quality Forum (CQF) on 12/09/16. There was a short discussion on actions taken in PRI regarding the number of delayed discharge patients. At any given time there were likely to be between 10 - 14 patients experiencing delayed discharge in the wards in PRI; this did not affect the elective surgery workload. However, recently there has been as many as 34 patients experiencing delayed discharge in PRI. At this level the PRI hospital site was compromised, the patient flow was significantly affected and consideration was given to diverting patients.
There was a discussion on the shortage of Community and Social Care Nursing staff. Recruitment and retention of social care staff was a challenge despite funding being available, in some areas external organisations were being encouraged to provide care in rural areas, as providing care in rural areas was more complex. The Medical Director advised that an alternative approach to the winter plan would be developed and that he would be meeting with the Chief Officers and the Chief Operating Officer for Acute Services to progress this. The Medical Director described the actions taken by the Medical Director, Operational Unit when it

was not appropriate for patients affected by delayed discharge to remain in acute beds during the recent period of high demand for these beds. Patients were transferred to a more appropriate healthcare setting pending their discharge from hospital care.

**414 Managed/2C Practices (CCGC/2016/66)**

This risk was discussed by the Clinical Quality Forum (CQF) on 12 September 2016. The Committee acknowledged the considerable progress and team work to achieve a satisfactory outcome in Brechin GP practice and discussed new ways of working within GP practices including a triage model operating in Blairgowrie, the provision of a triage service for doctors by NHS 24 and Advanced Nurse Practitioners (ANPs) undertaking a number of duties. There was discussion about training, recruitment and retention of Advanced Nurse Practitioners.

**Delegated Decisions taken by the Committee**

The Committee:

- Requested that another Board Development Session on strategic risk and risk appetite be organised.
- Asked that the addition in the Risk Report template of a section on emerging issues be considered
- Requested a report on patient feedback collection across NHS Tayside for a future CCGC meeting
- Acknowledged the progress, achievement and challenges of each of the MCQIC programmes and encouraged another application to the Board of Trustees for funding for the seconded Patient Safety Champion post
- Noted progress with the Statutory Specific Duties Action Plan 2013-2017, that NHST Board had met its legal obligations in relation to Equality and Diversity
- Approved the Equality and Diversity Workplan March 2016 - March 2017 and agreed that the Section 23 report should be submitted to NHST Board on 1 December 2016. It was noted that the Section 23 Agreement Governance and Leadership Team no longer required to meet as all obligations had been fulfilled
- Approved the Revised Clinical Quality Forum Terms of Reference and Workplan 2016/17
- Noted that the Health Improvement Scotland (HIS) Care of Older People in Acute Care Unannounced Inspection: Improvement Action Plan Update was a positive report, with much progress to date, agreed the proposed model of scrutiny and improvement at multidisciplinary team level and reporting mechanisms, and noted that areas identified for improvement were being progressed and that there were good governance arrangements in place.
- Adopted the Non-Medical Prescribing Policy. There was much discussion about the importance of the training, support and regulation of non-medical prescribers in different settings and the positive impact this expanded practice makes to patient care.
- Requested that the Nurse Director conveyed their thanks to the Child Protection Team and all involved in Child Protection. The Committee requested that the reference to a ‘named person’ in the improvement plan was changed to ‘responsible person’.

- Approved the Spiritual Healthcare Committee Annual Report 2015/16, Terms of Reference and Work plan and also the Spiritual Healthcare Department Annual Report 2015/16

- Requested that the Maternity Services Improvement Plan come to the next CCGC meeting

- Requested that the Nurse and Medical Directors progress the Scottish Public Services Ombudsman report (currently discussed in reserved business) being made available in the Open Business section of the meeting in future.

- Approved the Public Health Performance Management Framework. The framework would now be incorporated into the performance review process. The Committee discussed the importance of gaining an understanding of the impact of Public Health advice on commissioning plans. It was noted that the Health Equity Strategy would be central to the commissioning plans.

**Any Other Major Issues to highlight to the Board**

- The Committee supported the implementation of a sustainable improvement plan for Blood Transfusion services across NHS Tayside, acknowledging that while there was a compelling case for the introduction of wristband barcode technology for cost and patient safety reasons, the introduction of barcoded technology was not on a prioritised list at present for NHS Tayside and encouraged the development of a business case and cost benefit analysis to support this.

**Mrs A Rogers**
**Chairman**
**Clinical and Care Governance Committee**

**February 2017**

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

**Item 7**

**BOARD31/2017**
**Tayside NHS Board**
**23 February 2017**

**COMMITTEE CHAIR'S ASSURANCE REPORT**
**FINANCE & RESOURCES COMMITTEE - OPEN BUSINESS 19 JANUARY, 2017**

## 1. PERFORMANCE AGAINST WORKPLAN

At the meeting held on 19 January, 2017, the Committee took the opportunity to review its workplan and received assurance from members that it covered the required areas of business. The Committee considered the Capital and Corporate Financial reports for the period ended 30 November, 2016. It also reviewed contract decisions taken under delegated authority and where competitive tendering procedures had been waived and concurred with the decisions taken. The Committee reviewed the strategic risks allocated to it and received an assurance report on the implementation of TrakCare.

The following matters are highlighted for the attention of the Board:-

- The Board's Capital Resource Limit for 2016/17 is £12.397 million, which includes £0.466 million of capital grants. A breakeven position is forecast for the year. The non-added value element of funding to support the capital plan has reduced from £2.0 million to £1.0 million and forecasted gross capital expenditure for the year is £17.642 million. It was noted that the current national contract for telephony services was due to end in November 2017. It had been anticipated that the replacement would be carried out as a full managed service contract and, therefore, a revenue solution, however tender returns have indicated equipment will be excluded from the managed service contract. This means an element of the replacement will need to be funded from capital.

- The revenue position reported as at 30 November, 2016, was an overspend of £9.981 million. This is within the submitted LDP figure of £11.7 million but above trajectory for the eight month period. It was reported that individual directors were holding meetings in January regarding the specific actions required in all areas to achieve further traction in the remaining months of 2016/17. The Committee agreed it was important to ensure the change in behaviours, improvements and cost efficiencies were carried over into 2017/18, and it would apply scrutiny in the early months of next financial year to ensure this was the case.

- The Committee received an update on implementation of TrakCare. It was noted that whilst overall progress of the programme had slipped, remedial actions had been identified to prioritise activities. It was emphasised, however, that the programme was entering a critical stage in determining whether it would achieve the planned go-live date, or whether this should be deferred. The Committee received assurance that implementation would only take place if a safe go-live position was established.

## 2. UPDATE ON RISKS

There are three strategic risks which fall under the scrutiny of the Finance and Resources Committee. There was no movement in the evaluation of these risks since the position was last reported to the Committee. It is important, however, 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 remains at 16 (high) against an inherent risk score of 20. This 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 Committee did not consider this risk at its meeting on 19 January, however 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).

The Committee recognised there was unlikely to be much change in the evaluation of these risks for some time. It was agreed, therefore, that the Committee would receive details of the operational risks that underpin the strategic risk, and that these would be scrutinised to gain assurance that work was continuing to mitigate these risks.

## 3. DELEGATED DECISIONS TAKEN BY THE COMMITTEE

No delegated decisions were taken at the meeting on 19 January, 2017.

## 4. ANY OTHER MAJOR ISSUES TO HIGHLIGHT TO THE BOARD

The Committee discussed the lack of progress around the Bridge of Earn Surgery project, and it was agreed there was a need for clarity around the Board's intentions for Bridge of Earn and also for the Carse of Gowrie. The Chief Executive agreed to facilitate discussions with the Chairman and the Perth and Kinross Health and Social Care Partnership Chief Officer on this, and submit a report to a future Board meeting.

## 5. HORIZON SCANNING

The Committee will receive the draft NHS Tayside Financial Framework 2017/18 – 2021/22 and the draft Strategic Capital Plan 2017/18 – 2021/22 at its next meeting on 16 February, 2017.

**Doug Cross**
**Finance and Resources Committee Chairman**
**February 2017**

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

**Item 7**

**BOARD27/2016**
**Tayside NHS Board**
**23 February 2017**

**COMMITTEE CHAIR'S ASSURANCE REPORT**

**UNIVERSITY STRATEGIC LIAISON COMMITTEE – OPEN BUSINESS**

**1 November 2016**

**Performance against workplan**
The workplan is rather nebulous at present, with much of the strategic coordination between University and Health Board very sensibly moving to the Academic Health Science Partnership (AHSP).
It is an opportunity for those that attend to update each other on current events, but action on these discussions occurs via other routes.

**Update on Risks**
Given alternative routes for decision making and strategic planning, attendance may suffer, limiting the opportunity for discussion.
This may also mean missing out on the views of universities not engaged with the AHSP

**Delegated Decisions taken by the Committee**
N/A

**Any Other Major Issues to highlight to the Board**
The AHSP is developing well, with NHS Fife coming on board.
Workforce issues remain a national problem, with nursing quota allocations not finalised at the time of the meeting.
There was discussion about surgical robotics training, and the financial and workforce implications of Tayside not having access to a surgical robot.

**Dr Andrew Cowie**
**University Strategic Liaison Committee Chairman**

**February 2017**

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

**Item 8**

**BOARD18/2017**
**Tayside NHS Board**
**23 February 2017**

# CORPORATE FINANCIAL REPORT FOR PERIOD ENDED 31 DECEMBER 2016

## 1. PURPOSE

The purpose of this report is to advise the Board of the financial position of NHS Tayside as at 31 December, 2016.

## 2. RECOMMENDATION

Board Members are requested to note the current position and support the actions being taken to contain spend.

## 3. EXECUTIVE SUMMARY

This report is set in the context of the unbalanced 2016/17 Local Delivery Plan (LDP) submitted to Scottish Government Health & Social Care Directorate (SGHSCD) in May 2016.

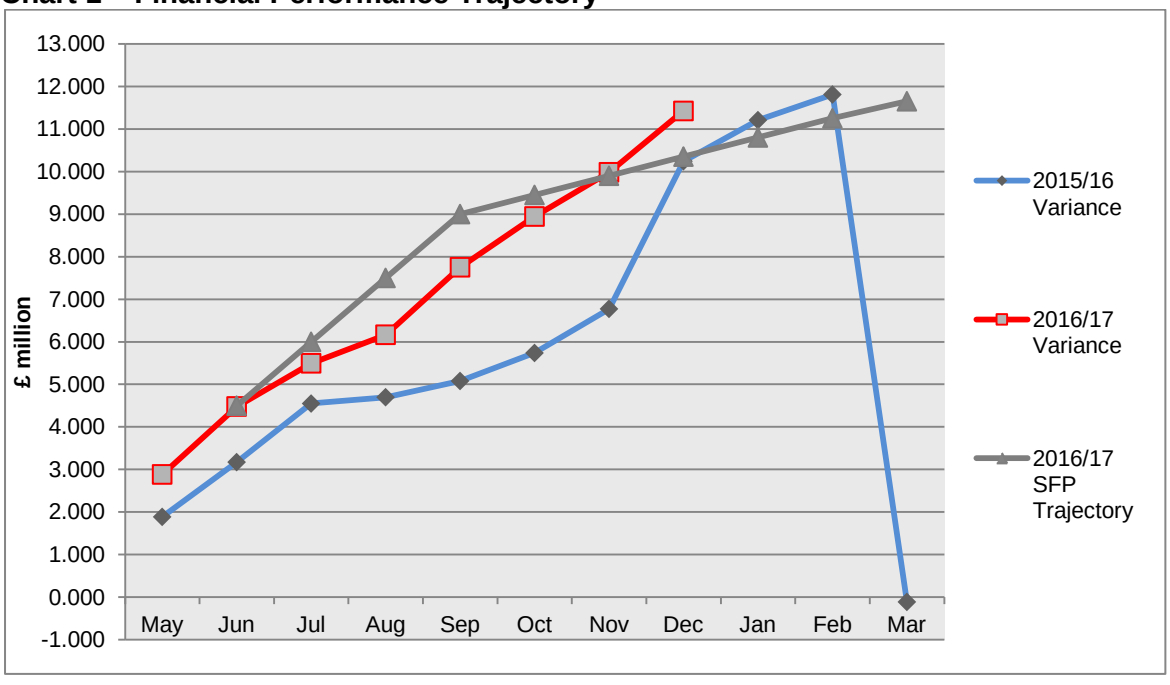
The LDP identified a potential deficit of £11.65 million in 2016/17, recognising both unidentified savings and an element of high risk savings proposals.

### 3.1 Financial Performance for the period to 31 December, 2016

NHS Tayside is reporting an overspend of £11.422 million for the nine months to 31 December, 2016, (last month £9.981 million).

Chart 1 below measures performance to date against the unbalanced LDP trajectory and the previous year's position:-

**Chart 1 – Financial Performance Trajectory**




At this stage, the gap between performance and trajectory is close to £1.1 million.

Further significant risks and challenges remain for 2016/17. A current assessment of the forecast outturn identifies a risk of up to £2.0 million in relation to delivering a position consistent with the LDP deficit.

The Workstream Programme is focused on a range of accelerated actions to reduce the gap in the current year.

In addition to the Workstream Programme, all services and departments are actively engaged in the drive to reduce costs in the final three months of the year.

The financial position is summarised below.

**Table 1 - Operating Cost for the period to 31 December, 2016**

| | Annual Plan | Plan to Date | Actual to Date | Over/ Under(-) |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| **Core Operational Unit** | | | | |
| Access Group | 72,123 | 54,388 | 53,242 | -1,146 |
| Medicine Group | 119,082 | 90,616 | 94,321 | 3,705 |
| Specialist Services Group | 69,650 | 52,488 | 54,126 | 1,638 |
| Surgery and Theatres Group | 89,134 | 67,686 | 70,404 | 2,718 |
| Regional Mental Health Services | 6,253 | 4,951 | 4,857 | -94 |
| Tayside Communities | 12,795 | 9,432 | 9,428 | -4 |
| Facilities & Operational Services | 74,417 | 55,573 | 54,895 | -678 |
| OU Committed Earmarks | 7,688 | 3,041 | 0 | -3,041 |
| **Total Core Operational Unit** | **451,142** | **338,175** | **341,273** | **3,098** |
| | | | | |
| **Integrated Joint Boards** | | | | |
| Angus | 104,294 | 77,114 | 78,684 | 1,570 |
| Dundee | 154,598 | 113,400 | 116,300 | 2,900 |
| Perth & Kinross | 124,011 | 90,932 | 92,924 | 1,992 |
| **Total Integrated Joint Boards** | **382,903** | **281,446** | **287,908** | **6,462** |
| | | | | |
| **Board/OU Corporate** | | | | |
| Area Wide Corporate Services | 46,126 | 31,958 | 31,712 | -246 |
| Operational Unit Corporate Services | 12,326 | 12,447 | 12,126 | -321 |
| Other Healthcare Services | 21,824 | 16,456 | 17,666 | 1,210 |
| Income | -17,839 | -13,292 | -13,081 | 211 |
| Income from Other Boards & NES ACT | -62,856 | -47,140 | -47,506 | -366 |
| Depreciation | 21,045 | 16,166 | 16,166 | 0 |
| Profit (-)/Loss on disposal of Assets | -2,500 | -107 | -107 | 0 |
| Board Committed Earmarks | 2,789 | -3,624 | 0 | 3,624 |
| Board Reserves | 3,000 | 2,250 | 0 | -2,250 |
| **Total Board Corporate** | **23,915** | **15,114** | **16,976** | **1,862** |
| **Net Operating Cost for NHS Tayside** | **857,960** | **634,735** | **646,157** | **11,422** |

### 3.2 Key Issues to Note

- The results to December recognise a full nine months of the £11.65 million gap identified within the unbalanced LDP submission to SGHSCD. This totals £8.738 million, with £4.364 million recognised in the IJBs and the balance of £4.374 million identified in the mainstream accounts.
- The meeting of Tayside NHS Board on 27 October, 2016, approved the non recurring release of the £3.0 million Board Contingency on a proportionate basis to recognise the range of cost pressures evident across the system. The sum released to date totals £2.25 million.
- 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 nine month period, efficiency savings delivery is £4.557 million behind trajectory.

- The three Integrated Joint Board (IJB) proposals on efficiency savings were considered by each of the governing Boards in June 2016.
- The IJBs have intimated their intention to invoke 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 31 December, 2016, of £11.422 million by subjective heading is provided in Table 2 below.

**Table 2 – Subjective Analysis for the period ended 31 December, 2016**

| | Annual Plan | Plan to Date | Actual to Date | Over/ Under(-) |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| Pay | 518,102 | 394,038 | 396,171 | 2,133 |
| Prescribing | 136,641 | 103,594 | 108,809 | 5,215 |
| Other Non Pay | 169,872 | 115,963 | 117,820 | 1,857 |
| FHS- Unified & Non Discretionary | 115,331 | 86,765 | 86,398 | -367 |
| Resource Transfer & Voluntary Sector | 21,455 | 15,865 | 15,839 | -26 |
| Other Healthcare Services | 24,938 | 18,501 | 19,314 | 813 |
| Depreciation & Profit/Loss on Asset Disposal | 18,545 | 16,059 | 16,059 | 0 |
| Income | -148,393 | -113,493 | -114,253 | -760 |
| Service efficiencies yet to be identified | -10,756 | -4,224 | 0 | 4,224 |
| Committed earmarks | 9,225 | -583 | 0 | 583 |
| Reserves | 3,000 | 2,250 | 0 | -2,250 |
| **Total** | **857,960** | **634,735** | **646,157** | **11,422** |

The three elements of Pay, Prescribing and Other Non-Pay are considered in more detail below.

### 3.4 Pay Costs and Workforce

The overspend on Pay for the nine-month period is £2.133 million.

The analysis of pay costs 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 | 126,385 | 95,702 | 96,644 | 942 |
| Nursing | 202,810 | 156,047 | 159,660 | 3,613 |
| Health Science Services | 21,512 | 15,851 | 15,653 | -198 |
| Allied Health Professionals | 35,682 | 27,112 | 26,681 | -431 |
| Other Therapeutic | 19,228 | 14,316 | 13,913 | -403 |
| Medical & Dental Support | 5,274 | 4,368 | 4,155 | -213 |
| Administrative Services | 63,676 | 47,829 | 46,153 | -1,676 |
| Senior Managers | 5,980 | 4,501 | 3,880 | -621 |
| Support Services | 37,248 | 28,173 | 28,203 | 30 |
| Personal and Social Care | 1,558 | 1,194 | 1,229 | 35 |
| Vacancy Factor | -1,251 | -1,055 | 0 | 1,055 |
| **Total** | **518,102** | **394,038** | **396,171** | **2,133** |

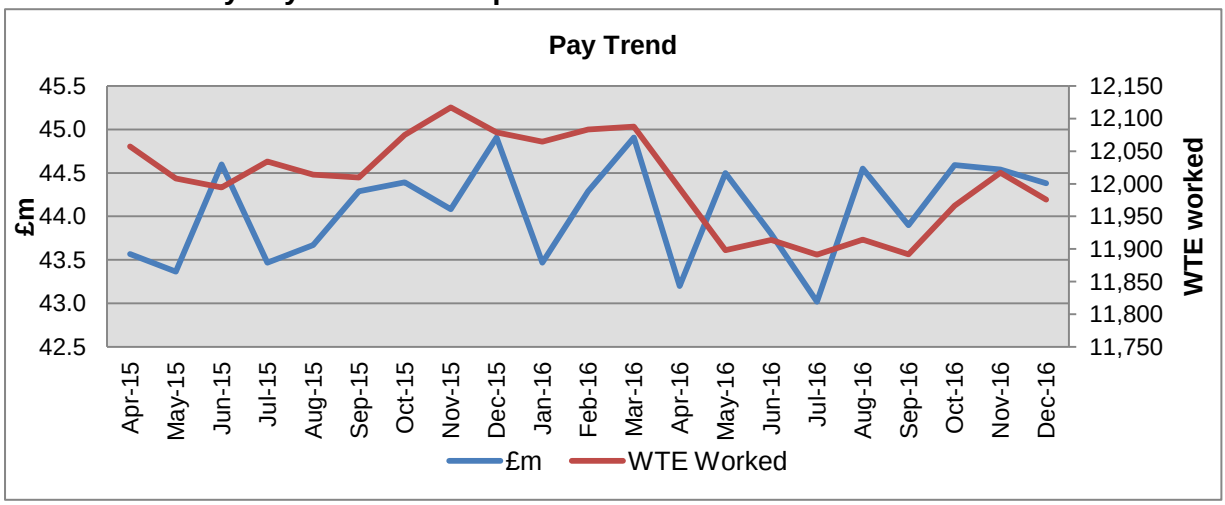
A number of pay issues were dealt with through the legacy aspect of the NHS Tayside Financial Framework 2016/17. This, together with the implementation of efficiency measures, has contained the level of overspend on pay in comparison with previous years – the current overspend of £2.133 million (0.5%) compares with an overspend of £8.815 million (2.3%) for the same period last financial year.

In terms of cost, the Financial Framework anticipated an increase in expenditure of 3% in 2016/17, reflecting inflationary pay uplifts and an increase in national insurance rates. Expenditure to date of £396.2 million represents an increase of 2.1% from the previous year, indicating a reduction in the underlying rate of spend of 0.9% when compared with the 3% anticipated increase. This 0.9% equates to £3.4 million.

**Monthly Pay Costs and WTE**

Chart 2 presents the monthly trend in pay costs and whole time equivalent (WTE) worked from the start of last financial year.

**Chart 2 - Monthly Pay Cost Trend April 2015 – December 2016**




A clear downward trend in WTE worked contributes to the reduction in underlying rate of spend noted above.

Numbers have fallen by 110 wte since March 2016, an improvement from the figure of 87 wte reported the previous month. Nursing & Midwifery (-65 wte) and Admin & Clerical/ Senior Managers (-58 wte) continue to be the main contributors to the decrease since March.

While the overall trend is downwards, the figures in Table 4 below confirm an increase in WTE worked figures towards the end of the calendar year. This reflects the engagement of close to 200 Newly Qualified Practitioners (NQPs), intended to manage areas of clinical risk and reduce reliance on supplementary staffing.

**Table 4 – Monthly Profile**

| | £m | | | | WTE Worked | | |
|---|---|---|---|---|---|---|---|
| **Staff Group** | **Apr-Oct** | **Nov-16** | **Dec-16** | | **Apr-Oct** | **Nov-16** | **Dec-16** |
| Medical & Dental | 74.44 | 10.79 | 10.69 | | 1,177.5 | 1,196.7 | 1,194.9 |
| Nursing & Midwifery | 124.22 | 18.13 | 17.69 | | 5,302.8 | 5,367.5 | 5,333.6 |
| Healthcare Sciences | 11.92 | 1.77 | 1.79 | | 487.5 | 501.2 | 496.9 |
| Allied Health Professionals | 20.8 | 2.96 | 2.95 | | 858.1 | 866.5 | 866.3 |
| Other Therapeutic | 10.81 | 1.56 | 1.56 | | 402.7 | 406.3 | 412.3 |
| Medical & Dental Support | 3.3 | 0.48 | 0.48 | | 170.7 | 175.4 | 177.7 |
| Admin & Clerical | 35.76 | 5.14 | 5.15 | | 1,984.0 | 1,972.2 | 1,978.8 |
| Senior Managers | 3.09 | 0.43 | 0.43 | | 72.3 | 69.9 | 68.9 |
| Support Services | 22 | 3.14 | 3.51 | | 1,432.3 | 1,428.2 | 1,412.9 |
| Personal and Social Care | 0.98 | 0.14 | 0.13 | | 33.3 | 31.4 | 31.3 |
| **Total** | **307.32** | **44.54** | **44.38** | | **11,921.1** | **12,015.3** | **11,973.6** |

**Supplementary Costs**

A comparison of supplementary costs with the previous year is presented in Table 5 on page 5. Supplementary Costs in graphical format are provided at Appendix 1 of the report.

**Table 5 – Supplementary Costs**

| Supplementary Costs | Cumulative April – December | | |
|---|---|---|---|
| | 2015/16 | 2016/17 | Inc/(Dec) |
| | £000s | £000s | £000s |
| Excess Part Time Hours | 2,670 | 2,411 | (259) |
| Overtime | 2,373 | 2,491 | 118 |
| Bank | 3,518 | 4,026 | 508 |
| Agency Costs | 7,064 | 7,076 | 12 |
| **Total** | **15,625** | **16,003** | **378** |

In overall terms, costs are up by £378k (2.4%) from the previous year.

The increase in Bank costs reflects more extensive use of the Nurse Bank, with the aim of reducing premium costs associated with agency and overtime.

Agency costs appear relatively static, but the headline figure masks significant movements in both Nursing and Medical agency costs.

Nursing agency costs are £3.3 million for the period to date, down by £747k (19%) from last financial year, but still reflecting an average of close to 40 WTE engaged at the premium agency rate over the nine months. Costs reduced significantly in the month of November following the appointment of NQPs – this level of reduced cost has continued in December.

Medical agency costs, also at £3.3 million, are up by 41% on the previous year. This is predominantly within 'hard to fill' specialty areas.

**Other Factors**

A number of other factors impact on pay costs. These include:-

- **Delayed Discharges** - the number of bed days lost to delayed discharges in excess of 14 days is 20,875 for the period to December 2016, covering both Integrated Joint Board delegated services and the Core Operational Unit of the Board. This represents 76 beds, the equivalent of three wards.

  At a notional cost of £150 per day, the resource impact in the first nine months is estimated at £3.1 million.

- **National Performance Targets** - the need to create and/or maintain theatre and ward capacity to meet waiting times guarantees adds to costs. To date, SGHSCD have allocated £2.5 million non-recurring funding for waiting times, which contributes towards a total of £5.0 million additional resource committed (pay and non-pay costs).

- **Surge Beds** - 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 £0.7 million to the position.

- **Medical Rotas -** The cost of non compliant Medical Training Grade rotas adds £0.7 million to the position to date. A number of further rotas are at risk - the potential exposure in the current year is up to £1.4 million.

  The Operational Unit Medical Director has established a group involving relevant clinicians and managers and representation from Scottish Government to address the ongoing issue of rota compliance.

**Workforce Efficiencies**

A range of actions are in place to ensure the effective deployment of staffing resource. Current initiatives include:-

- roll out of eRostering;
- development of standardised shift patterns;
- review of Nurse bank operational arrangements;
- implementation of a direct engagement model for Medical Agency Locums, and
- provision of timeous data for ward areas.

The Workforce and Care Assurance workstream, set up as part of the Board's Transformation Programme, is currently forecasting the over-achievement of efficiency savings targets by up to £2.5 million for the Core Operational Unit.

The achievement of savings in 2016/17 reflects the embedding of 'business as usual' activities and the tackling of areas of variation. Looking forward, the scale of efficiency challenge facing the Board dictates the need for wider transformational change through the range of programmes in place as part of the Board's Clinical Strategy.

## 3.5 Prescribing

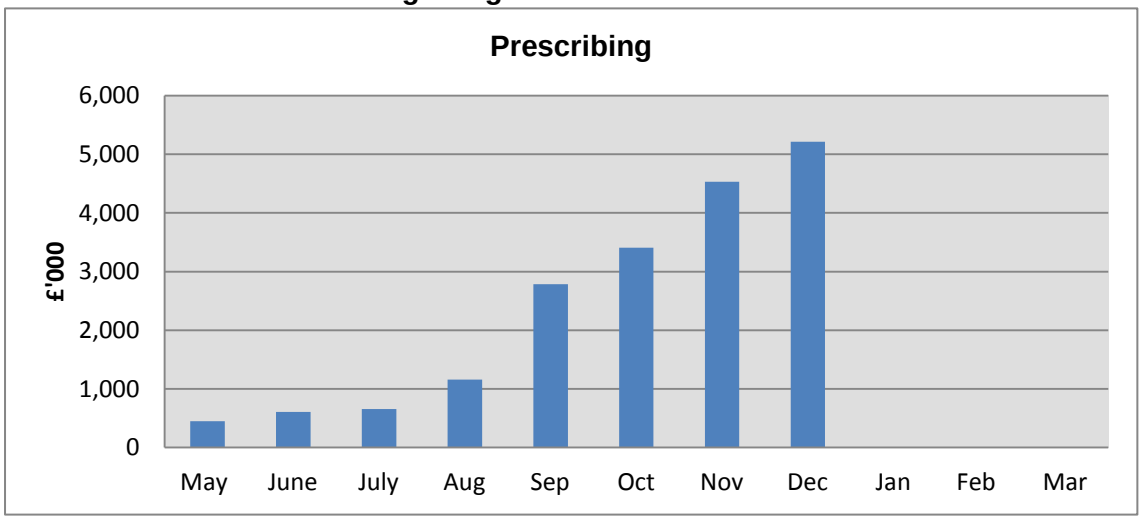
The prescribing overspend for the nine-month period is £5.215 million. Table 6 summarises the position:-

**Table 6 – Prescribing Costs**

| | Annual Plan | Plan to Date | Actual to Date | Over/ Under(-) |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| FHS-Angus IJB | 20,816 | 15,780 | 17,857 | 2,077 |
| FHS-Dundee IJB | 33,198 | 25,160 | 26,953 | 1,793 |
| FHS Perth & Kinross IJB | 26,127 | 19,797 | 21,352 | 1,555 |
| Hospital & Community | 56,500 | 42,857 | 42,647 | -210 |
| **Total** | **136,641** | **103,594** | **108,809** | **5,215** |

Chart 3 plots the trend in budget variance to date:-

**Chart 3 – Trend in Prescribing Budget Variance**




**FHS Prescribing**

The FHS Prescribing overspend of £5.425 million reflects growth in items (£1.138 million), an increase in prices (£1.499 million), and a shortfall in delivery of efficiency savings targets.

The NHS Tayside Financial Framework 2016/17 set an efficiency savings target of £4.5 million for FHS Prescribing, consistent with the 5.5% target applied across NHS Tayside, and noting Tayside's variance from Scottish average costs.

The unbalanced LDP submission to SGHSCD in May 2016 subsequently recognised that £2.0 million of the FHS Prescribing efficiency savings target was unlikely to be delivered in the current year.

Against a revised target of £2.5 million, the current efficiency programme identifies initiatives to the value of £1.3 million for 2016/17.

NHS Tayside's variance from Scottish average costs is increasing – cost per weighted patient has increased by 4.5% locally for the seven months to October 2016, compared with a Scotland-wide increase of 3.3% for the same period. This level of growth increases the gap to the Scottish average to 9.2% (last year 8.0%).

**Chart 4 – Variation in Cost per Weighted Patient**

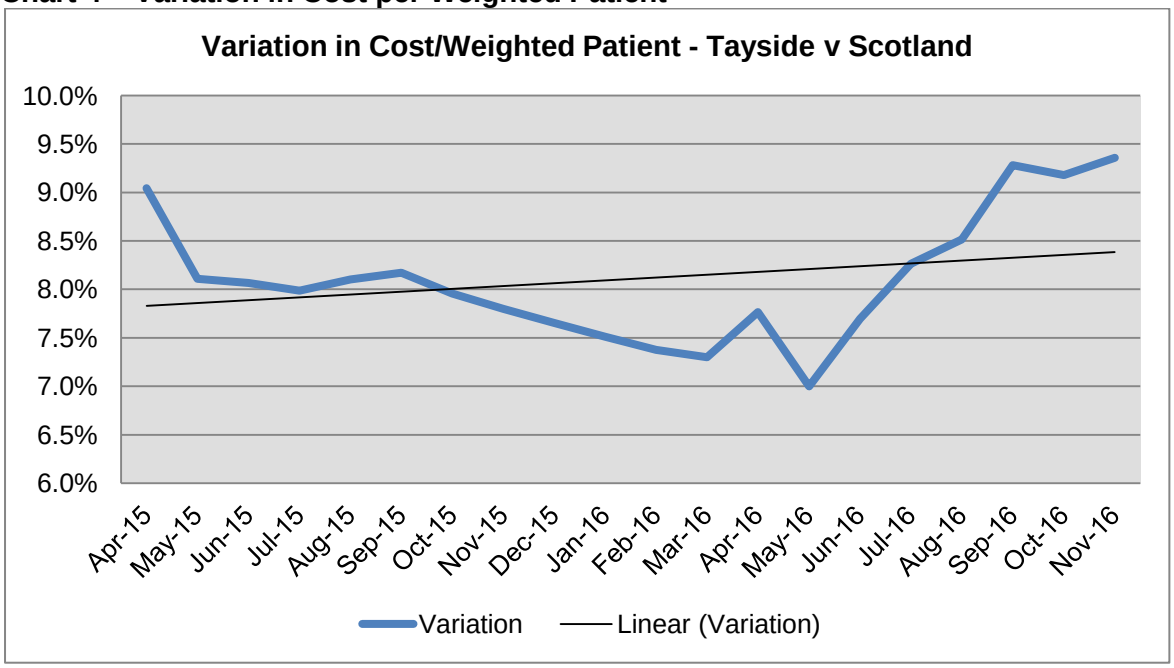



Chart 4 highlights the increase in the gap between Tayside costs and the Scottish average for the period from April 2015. The cost of this variation is currently close to £7.0 million per annum. This figure is in line with the projected overspend for 2016/17, demonstrating a clear link between the level of variation and budget overspend.

Key stakeholders continue to work collaboratively to tackle variation through the work of the Prescribing Management Group (PMG), supported by local Prescribing Forums within the IJBs. A range of accelerated initiatives are in the process of implementation

**Secondary Care Prescribing**

Hospital & Community medicine spend is contained within resources available. The current underspend assists the overall prescribing position but, with underlying expenditure patterns showing a sustained level of growth, this benefit is unlikely to continue.

The switch to biosimilar medicines is progressing in Tayside - 93% biosimilar switch from infliximab (Scottish average 74%); 36% switch to biosimilar from etarnercept (Scottish average 40%).

**New Medicines Fund**

The level of SGHSCD funding allocated to Tayside through the New Medicines Fund is anticipated to be lower than the planning assumption included within NHS Tayside's Financial Framework 2016/17, which was based on national advice at the time. The risk is assessed as close to £1.4 million. A firm position will be known later in February.

**Prescribing Efficiencies**

A Prescribing Management Group (PMG) is operational at a Tayside level comprising clinical, financial and managerial input from Clinical Groups and IJBs, and supported by corporate Pharmacy and Finance colleagues. The PMG is also supported by prescribing/medicines forums within each of the Partnerships and 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.

For 2016/17, the focus on variation is reflected in the development of programmes within five key priority areas - quality prescribing visits (initially targeting practices at greatest variance to prescribing spend); projects aimed at specific drugs, rosuvastatin, lidocaine plaster, pregabalin, and review of the drugs formulary.

The full year effect of this programme will benefit the 2017/18 position.

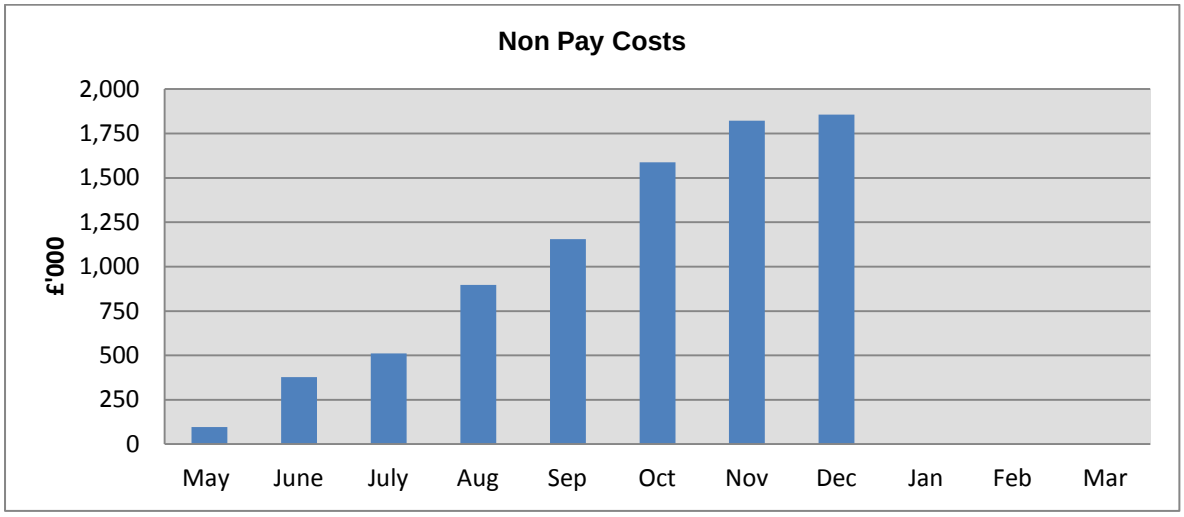
In addition, a number of medicines are expected to come off patent in 2017/18, the most significant of which is Pregabalin. A "windfall" saving of up to £2.4 million is expected in 2017/18, with a full year effect of £6.0 million. These figures are consistent with other Boards' planning assumptions.

## 3.6 Non Pay Costs

**Table 7 – Non Pay Costs**

| Non Pay | Annual Plan | Plan to Date | Actual to Date | Over/ Under(-) |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| Clinical Supplies | 57,435 | 43,527 | 45,387 | 1,860 |
| Energy Costs | 10,615 | 7,257 | 7,143 | -114 |
| Other Supplies & Services | 101,822 | 65,179 | 65,290 | 111 |
| **Total** | **169,872** | **115,963** | **117,820** | **1,857** |

**Chart 5**




Demand pressures continue to impact on the level of clinical supplies costs. Examples include diagnostic consumables, an increase in acute medical admissions, and rising referrals for cardiac investigation.

The energy position reflects benefits from the national pricing scheme.

The Workstream Programme relating to Procurement ensures that the required standard of products is procured at the most economically advantageous price. This workstream is on track to deliver the 2016/17 efficiency savings target in full.

The focus of the Facilities and Estates workstream will also derive benefit within non pay costs.

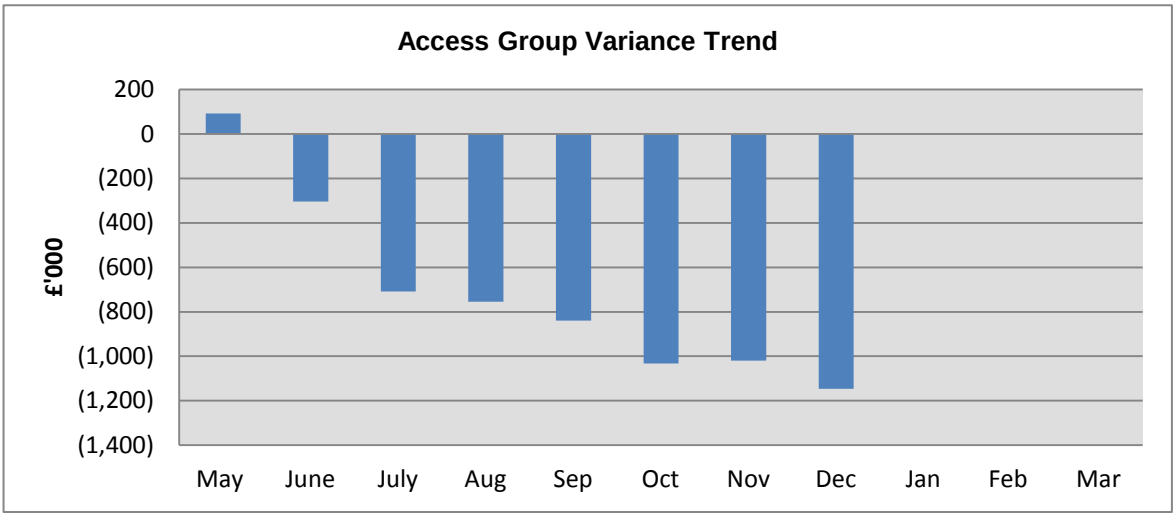
## 3.6 Group Summary

### Access Group

**Table 8 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Access Management Team | 0.495 | 0.371 | 0.357 | -0.014 |
| Diagnostics | 39.743 | 30.056 | 29.965 | -0.091 |
| H.A.I. | 1.126 | 0.849 | 0.830 | -0.020 |
| Hosted Services | 10.718 | 8.074 | 7.962 | -0.112 |
| Dental | 8.652 | 6.493 | 5.759 | -0.734 |
| Pharmacy | 11.389 | 8.545 | 8.369 | -0.176 |
| **Total** | **72.123** | **54.388** | **53.242** | **-1.146** |

**Chart 6**



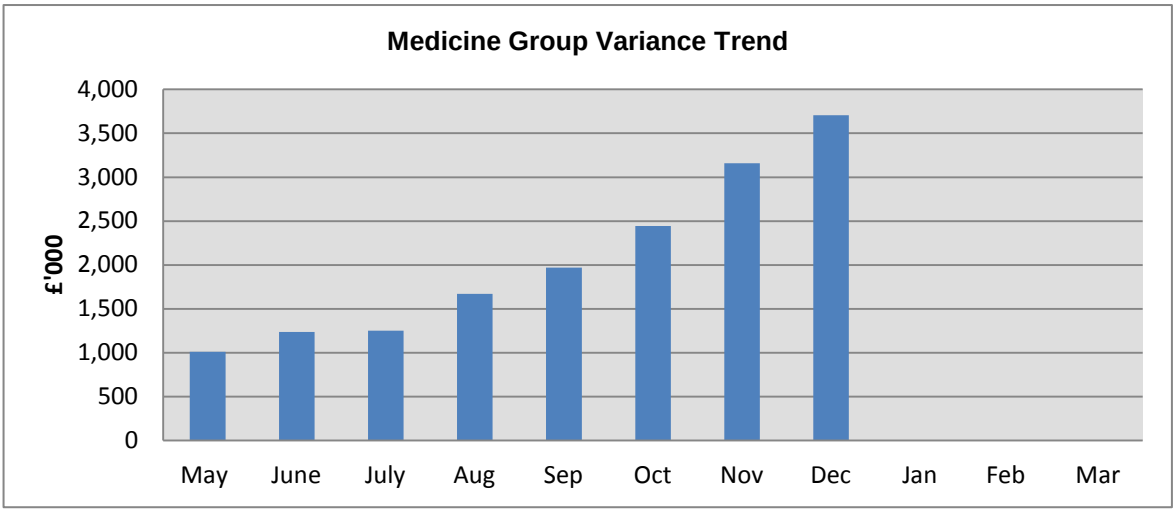

- The position within Access is supported through staff turnover and vacancies.
- Within the position the costs associated with maintaining waiting times during the MRI scanner replacement have been managed.
- Similarly, a new Advanced Nurse Practitioner model within Stracathro Regional Treatment Centre is being managed within existing funding.
- The iFit medical records tracking system has been implemented, where reduced staffing levels have offset the initial procurement costs and savings have now been delivered. The staffing model will now deliver recurring savings as anticipated.

### Medicine Group

**Table 9 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Planned Care | 40.213 | 31.328 | 33.949 | 2.621 |
| Urgent Care | 31.012 | 23.370 | 24.673 | 1.303 |
| Women & Children Services | 47.589 | 35.731 | 35.543 | -0.188 |
| Medicine Other | 0.268 | 0.187 | 0.156 | -0.031 |
| **Total** | **119.082** | **90.616** | **94.321** | **3.705** |

**Chart 7**



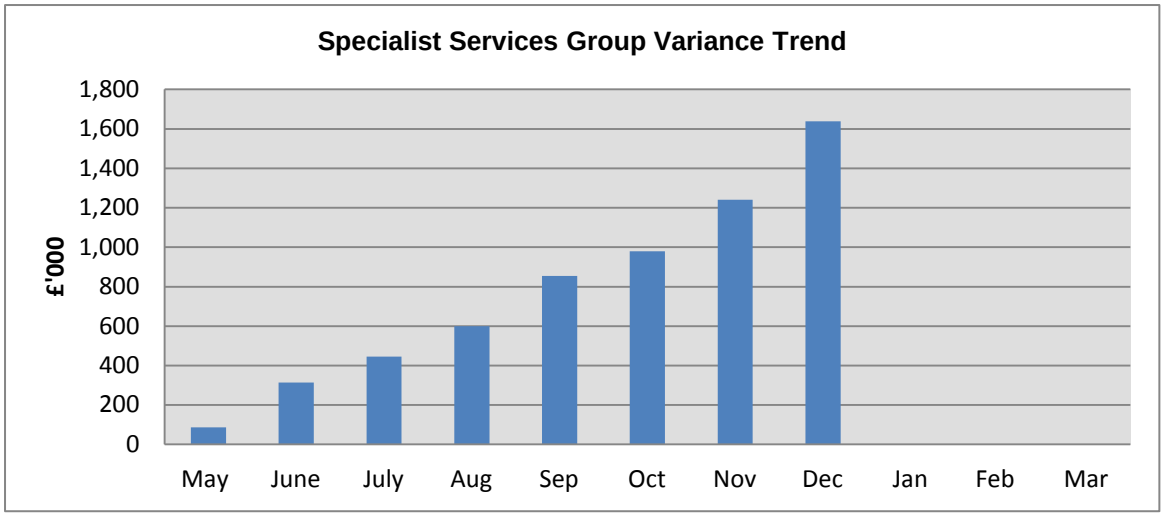

- Since April the service has continued to staff the acute surge beds across the medicine floor, and is reporting an overspend of £0.7 million at the end of December.
- Absence levels overall within the Group for the year to date are identified as 4.62%, although inevitably a small number of individual areas are reporting considerably higher levels. Higher absence, together with vacancies, continues to drive a level of supplementary and agency costs. Agency costs show an increase of £103k in comparison with the same period last year and remain significant at close to £2.2 million for the nine-month period. This equates to an average of 30 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 £0.2 million.
- eRostering 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.
- Non pay costs within the Acute Medical Unit are up by £90k to date, reflecting increased patient numbers.
- Cardiac Services has seen a 30% increase in patient referrals from 2011 to 2015 resulting in an increase in the cath lab consumable spend of £220k to date.

**Specialist Services**

**Table 10 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Specialist Services | 45.512 | 34.130 | 35.184 | 1.053 |
| Oncology, Haematology & Renal | 23.606 | 17.958 | 18.538 | 0.580 |
| Specialist Services Other | 0.533 | 0.400 | 0.404 | 0.005 |
| **Total** | **69.650** | **52.488** | **54.126** | **1.638** |

**Chart 8**



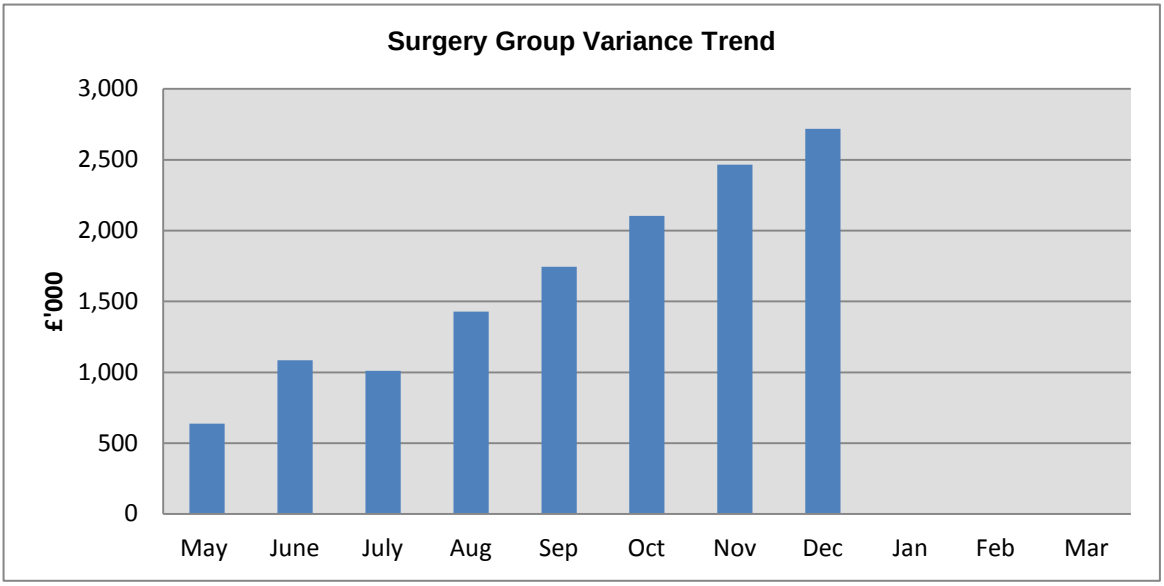

- A proleptic appointment within Ophthalmology contributes to the financial position of the Group.
- The impact of posts previously supported through other funding mechanisms continues.
- Specialist Services wards have now all been rolled out onto the eRostering system.
- Supplementary costs continue at a relatively low level for the Group which, at £594k to date, is £133k below the previous year level.
- Increased patient numbers, particularly within Oncology and Neurology, are adding to prescribing costs.
- The impact of new drug regimes can be significant within this Group and continues to be closely monitored.

**Surgery**

**Table 11 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| General Surgery | 28.960 | 21.878 | 23.266 | 1.388 |
| Orthopaedics | 21.907 | 16.539 | 16.220 | -0.319 |
| Theatres and Critical Care | 37.611 | 28.795 | 30.648 | 1.853 |
| Surgery Other | 0.656 | 0.474 | 0.271 | -0.204 |
| **Total** | **89.134** | **67.686** | **70.404** | **2.718** |

**Chart 9**



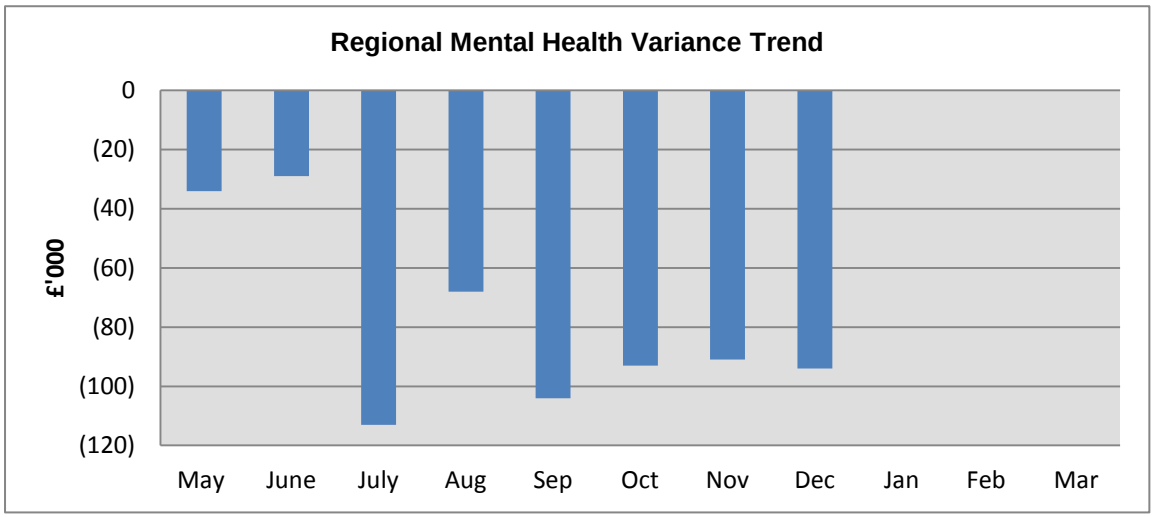
- Non compliant medical training grade rotas contribute to the position shown. Approximately £329k additional cost has been incurred to date.
- Nursing vacancies and absence levels have led to significant supplementary costs. In December the Group has maintained a reduced level of supplementary costs from the recent intake of Newly Qualified Practitioners.
- Supplementary costs are close to £2.8 million, however, this is a £338k reduction from the previous year's 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 £109k to the costs of the Group, with additional beds re-opened in the month of October.
- 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 evidence of costs reductions through the elimination of waste and increased efficiency across the wards.

**Regional Mental Health**

**Table 12 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Forensic Services | 5.255 | 3.944 | 3.573 | -0.372 |
| Other Services | 1.169 | 1.139 | 1.284 | 0.145 |
| Centrally Managed Budget | -0.171 | -0.132 | 0.000 | 0.132 |
| **Total** | **6.253** | **4.951** | **4.857** | **-0.094** |

**Chart 10**



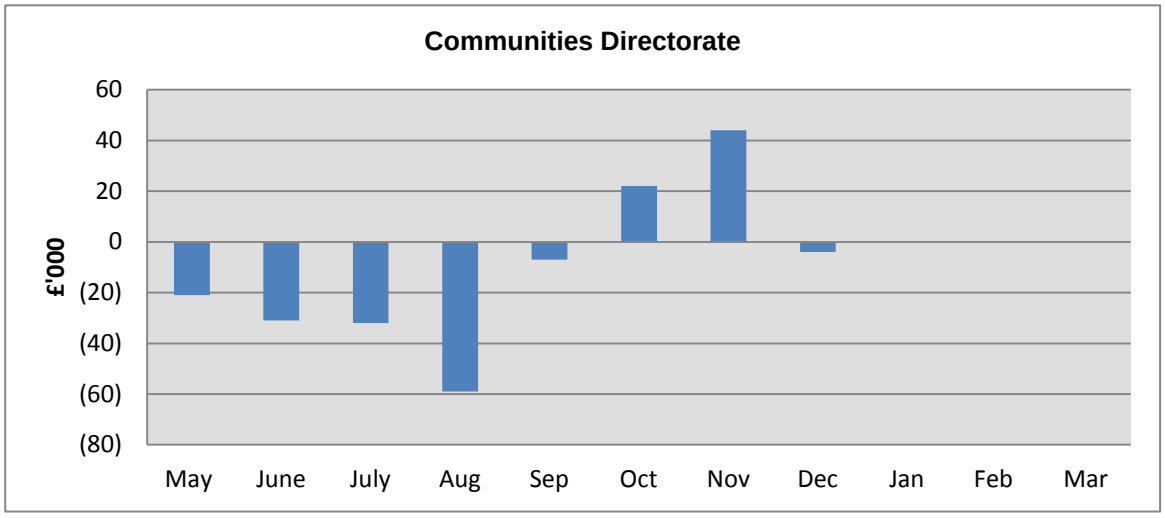

- Agency cover totalling £455k has been incurred in the nine-month period, principally in relation to training grade medical staff and the challenges that have been highlighted in levels of staffing. The first quarter incurred over half of these costs.
- Supplementary costs (excluding Agency) are relatively small for this group at £285k which includes £191k incurred in relation to overtime. The premium impact of overtime equates to £66k.
- Forensic Medium Secure unit continues to benefit from income received in respect of several patients being treated from areas outwith the consortium, however this is deemed non-recurring income.
- Medical Training Grades continues to incur additional costs as a result of a non compliant rota.

## Tayside Communities

**Table 13 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Children & Young People | 11.912 | 9.678 | 9.473 | -0.205 |
| Primary Care | 0.112 | 0.037 | -0.045 | -0.082 |
| Primary & Community Reserves | 0.771 | -0.283 | 0.000 | 0.283 |
| **Total** | **12.795** | **9.432** | **9.428** | **-0.004** |

**Chart 11**



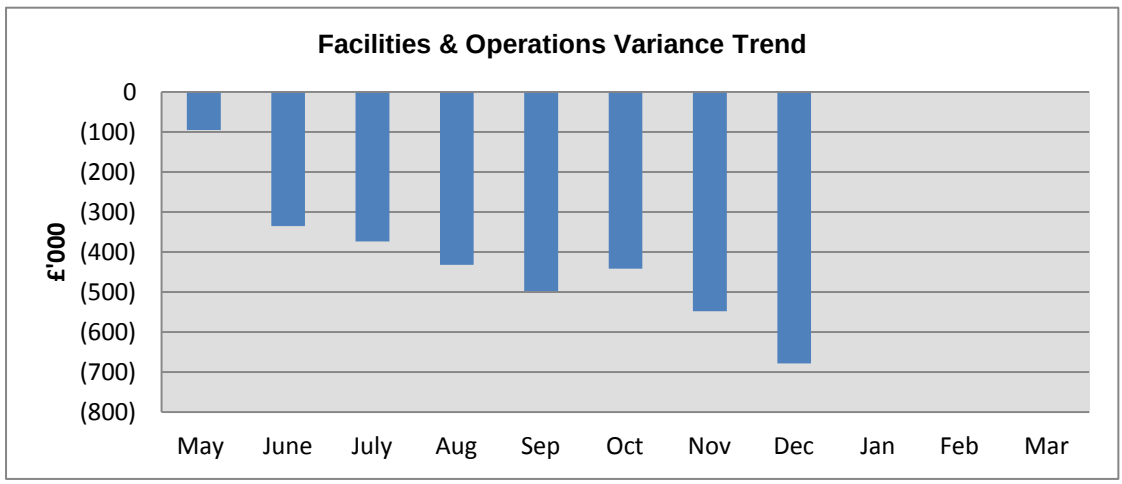

- Supplementary costs are minimal for this area.
- Vaccine costs remain within the identified financial budgetary limit.
- Child and Family Services are underspending due to difficulty in recruiting trained Health Visitors, which has led to the temporary covering of a large element of the savings target on a non-recurring basis.

## Facilities & Operations

**Table 14 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Property | 40.066 | 29.712 | 29.027 | -0.684 |
| Site Support Services | 29.628 | 22.393 | 22.398 | 0.005 |
| Procurement | 1.196 | 0.889 | 0.864 | -0.025 |
| Production Unit | 2.413 | 1.942 | 2.024 | 0.082 |
| Tayside Pharmaceuticals | -0.157 | -0.391 | -0.416 | -0.025 |
| General Management | 1.272 | 1.028 | 0.999 | -0.030 |
| **Total** | **74.417** | **55.573** | **54.895** | **-0.678** |

**Chart 12**



- 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 circa £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 £167k.

**Integrated Joint Boards (IJBs)**

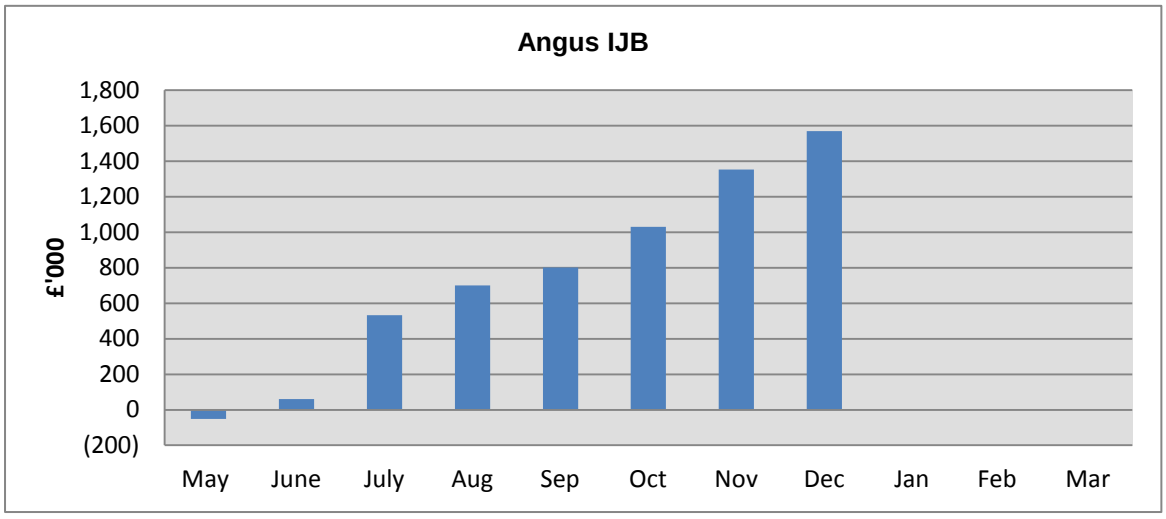
The positions identified for the three IJBs reflect the cross charging for services presently hosted within each of the bodies. A standard split is in place across each of the three bodies. This sees a sharing of any reported over/underspend for each Hosted function.

**Angus IJB**

**Table 15 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Core Revenue - Pay & Supplies | 49.738 | 35.892 | 35.522 | -0.370 |
| Core Revenue - FHS Prescribing | 20.818 | 15.780 | 17.858 | 2.078 |
| Core Revenue - Hosted Services | 5.812 | 4.455 | 4.389 | -0.066 |
| General Medical Services | 16.445 | 12.353 | 12.312 | -0.041 |
| FHS Cash Ltd & Non Cash Ltd | 11.481 | 8.634 | 8.603 | -0.031 |
| **Total** | **104.294** | **77.114** | **78.684** | **1.570** |

**Chart 13**



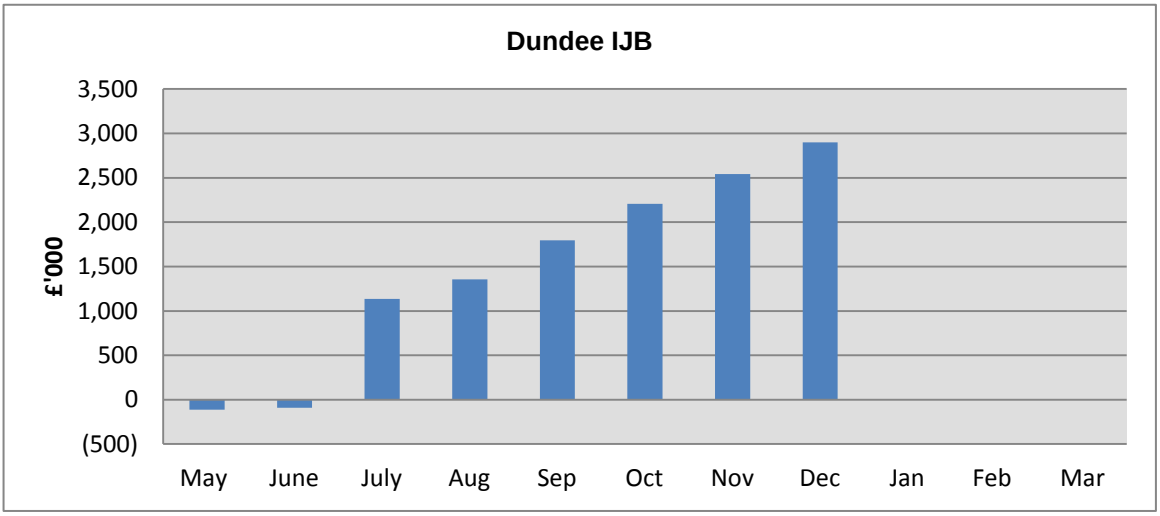

- Angus IJB considered the devolved budget and range of proposed savings measures and work programmes at its meeting on 29 June, 2016.
- A risk around the delivery of the devolved GP Prescribing Budget has been reported.
- PMG has been established at a Tayside level comprising clinical, financial and managerial input from Clinical Groups and IJBs, and supported by corporate Pharmacy and Finance colleagues. 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 16 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Core Revenue - Pay & Supplies | 71.903 | 51.180 | 51.350 | 0.170 |
| Core Revenue - FHS Prescribing | 33.196 | 25.160 | 26.952 | 1.792 |
| Core Revenue - Hosted Services | 4.632 | 3.362 | 4.420 | 1.058 |
| General Medical Services | 24.668 | 18.530 | 18.468 | -0.062 |
| FHS Cash Ltd & Non Cash Ltd | 20.199 | 15.168 | 15.110 | -0.058 |
| **Total** | **154.598** | **113.400** | **116.300** | **2.900** |

**Chart 14**



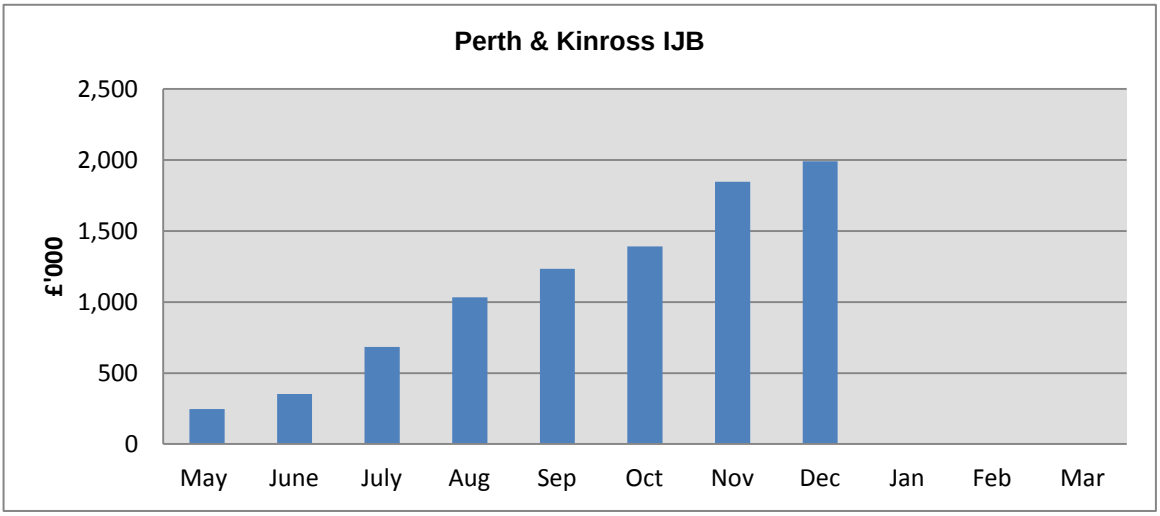

- Dundee IJB considered the devolved budget and range of proposed savings measures and work programmes at its meeting on 28 June, 2016.
- A risk around the delivery of the devolved GP Prescribing Budget has been reported with the stated intention of invoking the risk sharing agreement.
- The due diligence 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.
- High supplementary staff costs, particularly in Royal Victoria Hospitals wards, continue to be monitored, with work ongoing to address this, including service review and redesign.

## Perth & Kinross IJB

**Table 17 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Core Revenue - Pay & Supplies | 72.691 | 52.157 | 53.674 | 1.517 |
| Core Revenue - FHS Prescribing | 26.128 | 19.797 | 21.352 | 1.555 |
| Core Revenue - Hosted Services | -10.444 | -7.817 | -8.809 | -0.992 |
| General Medical Services | 22.138 | 16.629 | 16.574 | -0.055 |
| FHS Cash Ltd & Non Cash Ltd | 13.498 | 10.166 | 10.133 | -0.033 |
| **Total** | **124.011** | **90.932** | **92.924** | **1.992** |

**Chart 15**



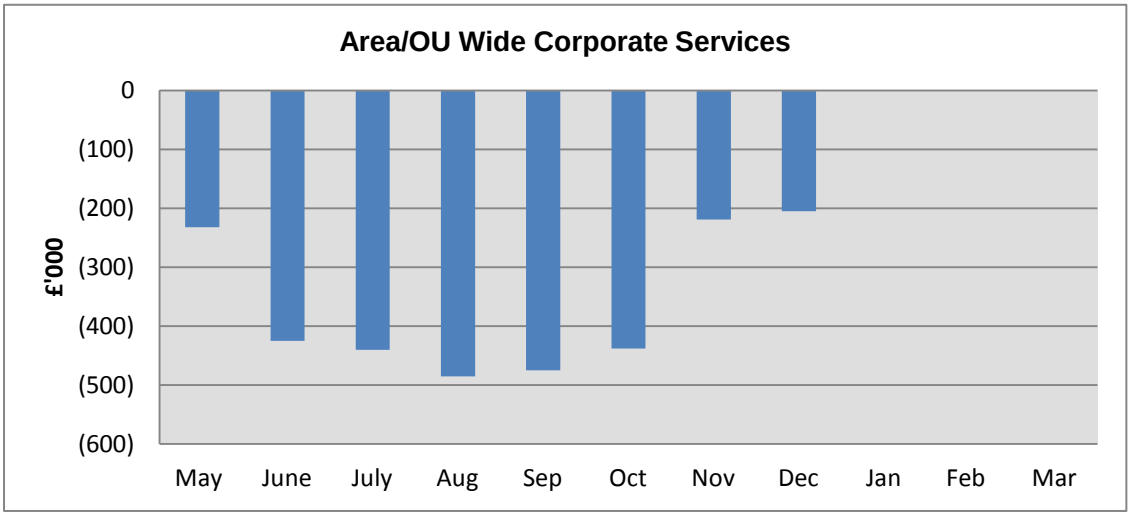

- Perth & Kinross IJB considered the devolved budget and the work undertaken by the Chief Finance Officer and wider partnership team to develop a robust financial recovery plan.
- In a similar vein to the other IJBs, noted the risk around the delivery of the devolved GP Prescribing budget.
- In addition, 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 18 – Operating Costs for the period to 31 December, 2016**

| Service | Annual Budget £m | Budget to 31.12.16 £m | Actual to 31.12.16 £m | Variance £m |
|---|---|---|---|---|
| Public Health/Health Promotion | 5.363 | 3.799 | 3.734 | -0.065 |
| Drug and Alcohol Teams | 1.662 | 1.298 | 1.298 | 0.000 |
| Medical Education | 0.265 | 0.199 | 0.193 | -0.006 |
| Finance | 8.233 | 6.213 | 6.013 | -0.200 |
| eHealth | 14.246 | 11.505 | 12.056 | 0.551 |
| Human Resources | 5.419 | 4.087 | 4.072 | -0.015 |
| Pharmacy | 0.329 | 0.216 | 0.221 | 0.005 |
| Board Corporate | 5.698 | 3.960 | 3.901 | -0.059 |
| Corporate Earmarks | 2.242 | -0.635 | -1.094 | -0.459 |
| Corporate Medical & Nursing | 5.563 | 4.274 | 3.946 | -0.328 |
| Other Corporate | 6.763 | 8.173 | 8.180 | 0.007 |
| North of Scotland Planning Group | 2.669 | 1.316 | 1.680 | 0.364 |
| **Total** | **58.452** | **44.405** | **44.200** | **-0.205** |

**Chart 16**




- WTE Worked has fallen by 18 wte since the start of the financial year.

## 3.7 Efficiency Savings

In submitting an unbalanced LDP 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 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 current position against the workstream programme is depicted below, together with the position of the IJBs in order to provide a NHS Tayside perspective.

**Table 19 – Efficiency Savings**

| Workstream/Intitiative | Annual Plan | Revised 2016/17 Plan LDP Submission | Plan to Dec (excl IJB) | Achieved to Dec | Unachieved Savings to Dec |
|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| Service Redesign | 2,000 | 1,300 | 65 | 0 | 65 |
| Facilities & Estates | 2,000 | 2,000 | 1,351 | 1,007 | 344 |
| Better Buying & Procurement | 1,750 | 1,750 | 1,214 | 1,191 | 23 |
| Workforce | 17,000 | 14,900 | 8,381 | 7,081 | 1,300 |
| Realistic Medicine | 10,050 | 7,250 | 2,898 | 1,956 | 942 |
| Operational Efficiencies | 1,000 | 1,000 | 582 | 769 | -187 |
| Repatriation | 1,500 | 1,500 | 938 | 0 | 938 |
| Alcohol & Drugs | 600 | 300 | 225 | 0 | 225 |
| Corporate | 12,000 | 12,250 | 10,224 | 10,050 | 174 |
| National Initiatives | 10,500 | 0 | 0 | 0 | 0 |
| Asset Disposal Proceeds | 0 | 4,500 | 107 | 107 | 0 |
| **Total Workstreams** | **58,400** | **46,750** | **25,985** | **22,161** | **3,824** |
| | | | **Plan to Dec IJB** | **Achieved to Dec** | **Unachieved Savings to Dec** |
| Integrated Joint Boards | | | 4,240 | 3,507 | 733 |
| **Total Efficiencies** | **58,400** | **46,750** | **30,225** | **25,668** | **4,557** |
| | | | | | |
| **Shortfall Against Original Plan Per LDP Submission** | | **11,650** | | | |

A shortfall of £4.557 million is identified against the planned efficiency target to date, with notable variances from plan within Rostering, FHS Prescribing, and Repatriation.

The current programme is forecast to deliver £44.75 million in 2016/17, which is £2.0 million short of the target of £46.75 million identified through the unbalanced LDP. It is estimated that £22.2 million (50%) of this will be delivered on a recurring basis.

Table 20 below summarises the forecast position.

**Table 20 - Forecast Efficiency Savings Delivery 2016/17**

| Workstream/Initiative | Recurring | Non Recurring | Total 2016/17 |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Service Redesign | 0 | 0 | 0 |
| Facilities & Estates | 1,400 | 500 | 1,900 |
| Better Buying & Procurement | 1,600 | 0 | 1,600 |
| Workforce | 11,050 | 2,600 | 13,650 |
| Realistic Medicine | 3,050 | 0 | 3,050 |
| Operational Efficiencies | 700 | 800 | 1,500 |
| Repatriation | 300 | | 300 |
| Alcohol & Drugs | 0 | 200 | 200 |
| Corporate | 0 | 14,750 | 14,750 |
| National Initiatives | 0 | 0 | 0 |
| Asset Disposal Proceeds | 0 | 2,500 | 2,500 |
| **Total Workstreams** | **18,100** | **21,350** | **39,450** |
| | | | |
| Integrated Joint Boards | 4,100 | 1,200 | 5,300 |
| **Total Efficiencies** | **22,200** | **22,250** | **44,750** |

The figures include a range of accelerated initiatives within Workforce, Realistic Medicine, Operational Efficiencies, and Corporate headings. The Board considered the programme in respect of Nursing & Midwifery Staffing and Medicines Management at its meeting on 1 December, 2016.

Given the potential shortfall of £2.0 million, a range of further initiatives are under consideration to close the gap by year end.

Consultation with SGHSCD colleagues is ongoing.

The impact of initiatives implemented is not solely on 2016/17. The Financial Framework set out a target of 40% of efficiency savings to be delivered on a recurring basis. The identified recurring savings total of £22.2 million from Table 21 represents 38% of the overall efficiency target of £58.4 million, so current performance is marginally below stated planning assumptions.

The progress of the workstreams is monitored though the Transformation Programme Board.

### 3.8 Board Committed Earmarks

During the course of any financial year, the Board receives a number of SGHSCD financial allocations which are in addition to the baseline revenue allocation confirmed at the start of the year.

However, 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.

This means that allocations received in 2016/17 may not be expended until the following financial year. This slippage on committed earmarks, also referred to as deferred

expenditure, is planned for through the annual budgeting process. The annual budget therefore includes two specific elements:-

**i.** A deferred expenditure target, which is a planned level of slippage on committed earmarks received during the course of the year or on allocations remaining from previous years - the target for 2016/17 is £23.5 million, and

**ii.** A level of funding to meet, or effectively reinstate funding for, deferred expenditure carried forward from a previous year - funding provided for 2016/17 to meet 2015/16 deferred expenditure is £22.5 million.

Both of these elements are considered in the main through management of Board reserves and allocations.

In closing 2015/16, deferred spend was £3.2 million greater than planned due to late notification of slippage. This creates a financial pressure in 2016/17 that is managed through both a review of deferred spend brought forward and board reserves. The full amount has been identified.

In relation to the deferred spend target of £23.5 million for 2016/17, the main risk to delivery of this target remains 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. Essentially, the Board has lost a degree of flexibility in the management of funds, as a number of high-value allocations are passing straight through to IJBs.

Chief Finance Officers are engaged in discussion to manage the position in the current year. Steps are also being taken to manage Board reserves and earmarks in a robust fashion to meet the target, without compromising the use of funds for intended purposes.

At this stage the level of risk against the deferred spend target is assessed at £2.0 million.

### 3.9 Forecast Outturn

Tayside NHS Board considered the Forecast Outturn at its meeting on 27 October, 2016. 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.

The current risk is £2.0 million.

In recognising this, the Board has responded through the development of further efficiency proposals. Assessments on the Forecast Outturn at an individual Group/Service Area level inform the overall corporate assessment, recognising the current spend patterns and those initiatives that are presently in place.

### 3.10 Board Contingency

The financial plan approved by the Board provided a total contingency for 2016/17 of £4.3 million. Of this resource, £1.3 million is set aside to respond to environmental issues, leaving a general contingency of £3.0 million.

At this stage of the year, a £2.25 million proportionate share of the general contingency has been released to offset a range of cost pressures, including the cost of surge beds remaining open; the additional costs of “hard to recruit to” medical posts, and non compliant medical rotas. This reflects the agreement of Tayside NHS Board at its meeting on 27 October, 2016.

### 3.11 Reconciliation to Approved Financial Plan

A reconciliation of anticipated resources per the approved financial plan to the updated position at 31 December, 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 31 December, 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 | 4,479 | | | 4,479 |
| Revision to Non-discretionary | | | 80 | 80 |
| Revision to Non Core | | 1,408 | | 1,408 |
| **Total Resources at 31 December, 2016** | **781,900** | **33,338** | **42,722** | **857,960** |

### 3.12 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 3.7. 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 31 December, 2016, were submitted to SGHSCD on 20 January, 2017.

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

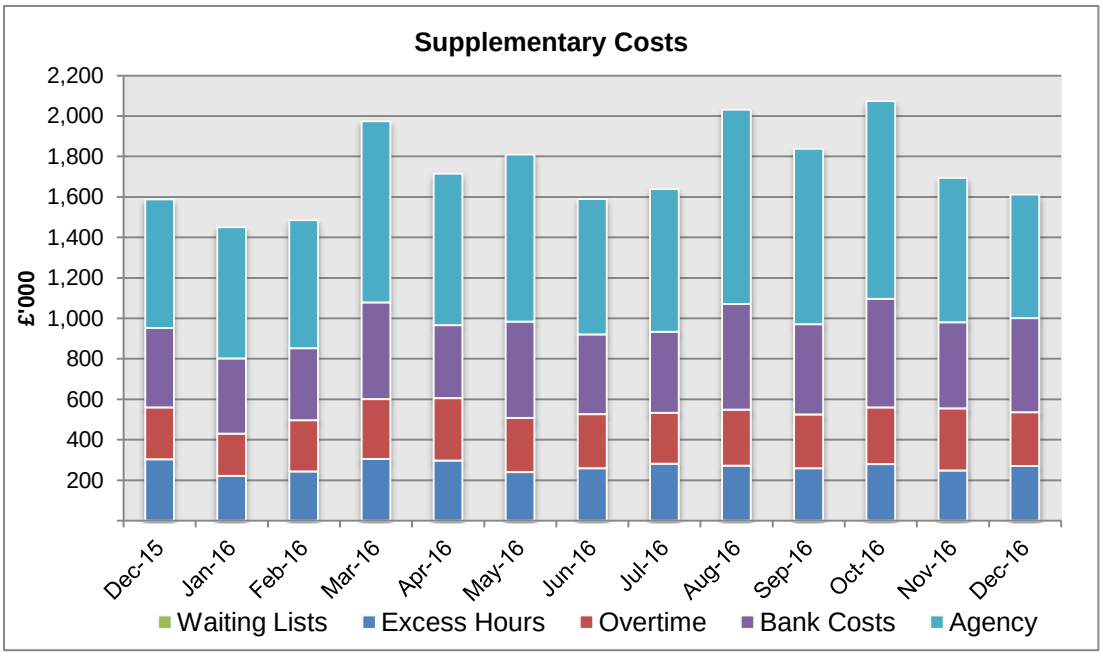
Contributes to the delivery of care and services across a range of environments in NHS Tayside. As part of the engagement programme highlighted above, a wider dialogue with both patients staff and public will be initiated.

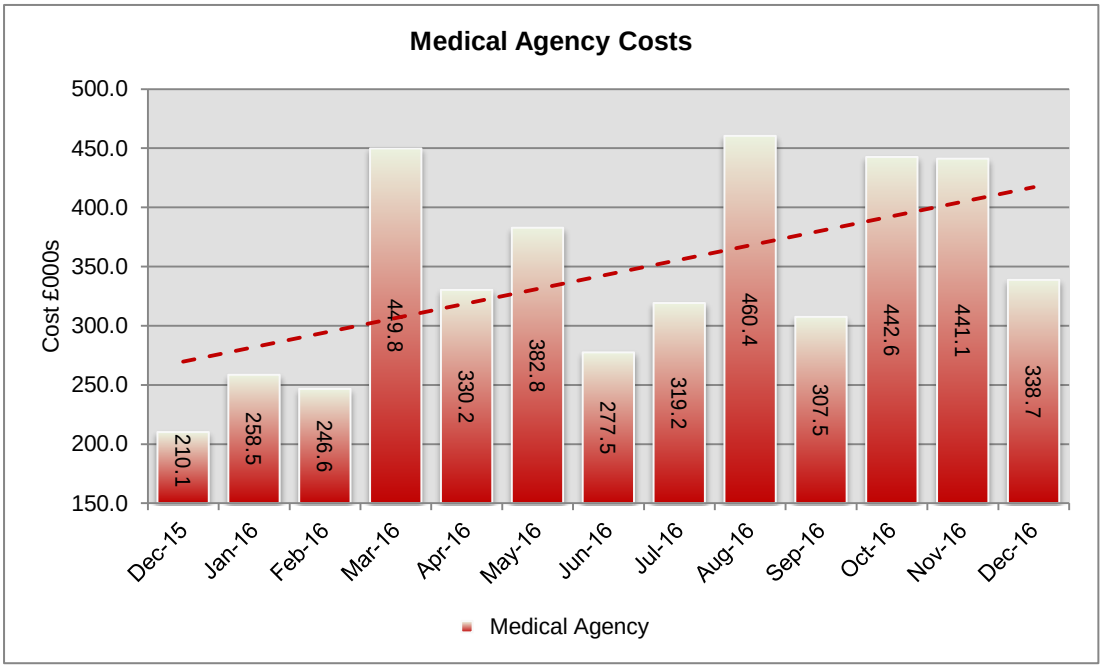
**Mr S Lyall**
**Head of Finance**

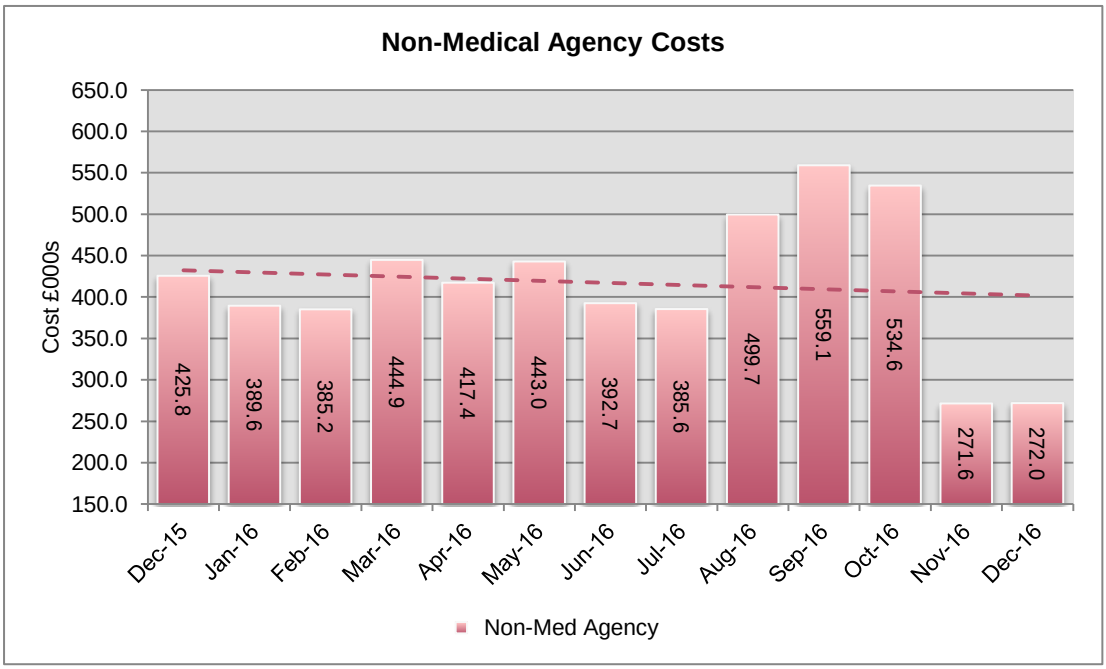
**Ms L McLay**
**Chief Executive**

**Mr L Bedford**
**Director of Finance**

**February 2017**


Supplementary Costs
£'000
2,200
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-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
210.1
258.5
246.6
449.8
330.2
382.8
277.5
319.2
460.4
307.5
442.6
441.1
338.7
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-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
425.8
389.6
385.2
444.9
417.4
443.0
392.7
385.6
499.7
559.1
534.6
271.6
272.0
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-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 £2m | 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 £1.0m | 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 £3.0m | 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.<br>Real-time RAG status reporting developed to ensure effective deployment of overall Nursing resource.<br>Centralised Rostering Bureau.<br>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 £0.3m | Framework for delivery supported through workstream programme. |
| Enhancements During Leave – backdated payments may exceed the amount accrued through 2015/16 accounts. | Medium | Up to £0.5m | Ongoing monitoring and review. |
| SGHSCD anticipated funding allocations may be less than anticipated through financial plans. | High | Up to £1.4m | Potential exposure around New Medicines Fund. |
| Environmental control risk (Mental Health) – cost of property upgrades exceeds contingency. | High | Up to £1.0m | Costs to be incurred in 2017/18. |
| Funding sources assumed within the 2016/17 efficiency plan not available (Non DEL, NPDO refinancing). | High | Up to £1.0m | DEL Funding confirmed through SGHSCD allocation, and is in line with planning assumptions. Other risks remain. |
| Costs incurred following approval of new medicines nationally are not contained within the overall prescribing uplift. | High | Up to £0.5m | 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. | High | Up to £2.0m | Re-routing of funds through IJBs presents risk. |
| Inability to mitigate costs in line with reductions in anticipated central funding allocations, including Outcomes Framework and Alcohol & Drugs funding. | Medium | c£0.2m | Implications recognised 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 £0.2m | Slippage in implementation often results in a non-recurring saving. |
| Price inflation may be higher than the planned level of 1.5%. | Medium | 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. |

**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. |
| 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. |

**Item 9**

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

**BOARD11/2017**
**Tayside NHS Board**
**23 February 2017**

# TAYSIDE ORAL HEALTH EQUITY STRATEGY – UPDATE

## 1. SITUATION AND BACKGROUND

The Tayside Oral Health Equity strategy was approved by the Health Board at its meeting in February 2016. Since the publication of the Tayside Oral Health Equity Strategy the Scottish Government has undertaken a consultation exercise on Scotland's Oral Health Plan. A core element of the consultation document was to focus on prevention and reduction of inequality highlighting potential changes to primary care dental service. The consultation closed in December 2016 with around 400 responses. A response to the consultation is expected in the latter half of 2017 and the Health and Social Care delivery plan suggest that this will be, *'a comprehensive approach to modernise dentistry and improve the oral health of the population through a prevention and early intervention approach'.* The government response to the consultation is likely to have a significant impact on the future delivery of oral health services in Scotland.

## 2. ASSESSMENT

Steady progress is being made on implementing the strategy. Appendix A provides an update of activity and key data items related to the main aims of the strategy:-

- To improve the oral health and reduce oral health inequalities of the population of Tayside
- To work with partner agencies to develop public policy and practice that supports oral health promoting behaviours
- To co-produce improved oral health, particularly with deprived populations, using an asset-based approach
- To enable adequate and equitable access for the whole population of Tayside to primary and secondary NHS dental services by targeting improved provision in deprived areas population profile
- To develop the quality, effectiveness and efficiency of dental services in order to improve dental and oral health in Tayside.

## 3. RECOMMENDATIONS

The Health Board should note progress in the implementation of the Tayside Oral Health Equity strategy.

## 4. REPORT SIGN OFF

**Dr D Richards**
**Consultant in Dental Public Health**

**Ms L McLay**
**Chief Executive**

**Dr D Walker**
**Director of Public Health**

**February 2017**

**Appendix A.**

## Update of activity and key data items related to the main aims of the Tayside Oral Health Equity Strategy

### Aim: - To improve the oral health and reduce oral health inequalities of the population of Tayside

A number of key programmes are already in place to help meet this aim.

**Childsmile Programme**
The Childsmile programme ( www.child-smile.org) provides a mix of universal and targeted elements and is the key method of delivering prevention to children in Tayside. There are four elements to the programme

- *Core programme* - This involves the provision of an oral health pack via the health visitor network, with further packs going to those aged one to three years in areas of high dental risk. There is 100% coverage of the target with additional supplies to high risk children. Just over 39,000 packs are distributed annually as part of the core and practice programmes.

- *Childsmile Practice* - Links families with young children to dental practices from a young age utilising Public Health Nurses or Health Visitor networks and Dental Health Support Workers. The aim is to encourage dental attendance and provide early preventive care. 73% of local practices are actively participating.

- *Childsmile Nursery* - Provides supervised tooth-brushing to all nursery schools, both private and Local Authority. In addition a twice-yearly application of fluoride varnish is provided in targeted nurseries (most deprived SIMD quintile). Currently 27.2% nurseries are targeted in the varnish programme.
- *Childsmile School* - Provides supervised tooth-brushing and fluoride varnishing programmes in targeted primary schools (most deprived SIMD quintile). Currently 30.8% schools are targeted in the varnish programme.

In addition to the Childsmile programme a number of other chlld focussed projects are underway:-

**Oral Health Education for schools**
Work is ongoing to develop a leave behind resource for nursery and primary school teachers to use with 3 different age groups. This will be a long term ongoing project to ensure that it is kept current.

**Protecting Teeth at Three**
We are supporting the University of Glasgow with research which is ongoing in nurseries as a Randomised Control Trial for Fluoride Varnish for 3 year olds.

**BBaRTS: Healthy Teeth Programme**
We are supporting the University of London with research around promoting parents reading to children and incorporated messages that support parents to develop healthy eating habits for their children and to brush their child's teeth at bedtime.

**Priority Group work**

Work is underway implementing programmes for dependant older people, those with special care needs and people experiencing homelessness, in line with the 2012 National Oral Health Improvement Strategy for priority groups.

***Older People –*** The local Oral Health Improvement team (OHIT) continue to support and roll out the Tayside Oral Health Award. Forty-six Care Homes have now achieved the award, with a further 49 working towards achieving this.

***Gypsy travellers -***
Advice, education and treatment are provided to this client group as required with the mobile unit attending varying sites across Tayside.

***Homelessness –*** NHS Tayside was actively involved in the Smile4life project led by Prof Ruth Freeman and her team at Dundee Dental School. The Smile4life Guide for Trainers (Freeman et al., 2012) developed to support professionals working within the homelessness sector in terms of oral health promotion is being used locally. The University and Shelter facilitated a joint Health and Social Care event was to encourage better communication and interaction between key partners and services from the Third Sector, NHS Boards, University, Scottish Government and Local Authorities. The focus was on how to better support people faced with homelessness or experiencing homelessness and how, through touch points with either health, housing or other support services, a more integrated approach could be achieved which would lead to a more stable outcome for the client. A report of the event is available (http://dentistry.dundee.ac.uk/scottish- oral-health-improvement-homelessness-programme-smile4life). Dr Andrea Rodriguez, Senior Research Fellow sits on the Dundee Council Health and Homelessness Group and is a key link for oral health issues in the Housing Options and Homelessness Support Plan (2016-2021). NHS Tayside Public Dental Services provides regular dental services to the homeless from a mobile clinic to improve access for this group.

***Prisoners -*** The Oral Health Improvement team continues to work in partnership with prison staff to delivery oral health promotion in prisons. They work closely with the Crossreach visitors centre and a range of agencies to provide resources and oral health information to the prisoners and their families. The Mouth Matters resource, the development of which was led by Prof Ruth Freeman is currently in use locally. In conjunction with the Oral Health Improvement (OHI) Team and the Scottish Prison Service (SPS), Professor Freeman's team are developing a Mouth Matters Mentoring Programme for people in HMP Perth. This team are also piloting an innovative health coaching programme for prisoners at Perth Prison which has included input from the OHI Team, SPS and Third Sector Organisations. After the successful completion of the first cohort a second cohort is underway and formal evaluation if the programme is being progressed.

Susan Carson, Academic Specialty Registrar in Dental Public Health has been working in close partnership with staff from the schools of medicine and nursing at Dundee University as part of a NHS Education for Scotland funded project which aims to understand, communicate and deal with social inequalities in undergraduate training. Staff from NHS Tayside, SPS and third sector organisations were also involved in the initiative which saw prisoners from HMP Castle Huntley participate in simulated patient exercises for students. The sessions were designed to developing a critical understanding of problems; communication skills; capacity to understand situations and deal with vulnerable groups; and being improve ability to identify stigmatising practices and tackle them.

The above initiative also saw volunteers from Dundee International Women's Centre participating in sessions which enabled students to understand situations where communication may be difficult and build capacity to deal with vulnerable groups.

The Childsmile programme and priority group work is funding through the oral health element of the preventive bundle. This is monitored by the Chief Dental Officer' office. Funding has been reduced during the current financial year but efficiencies within the programmes have enabled existing delivery levels to be maintained. However, further reductions will have an impact on Health Board delivered programmes.

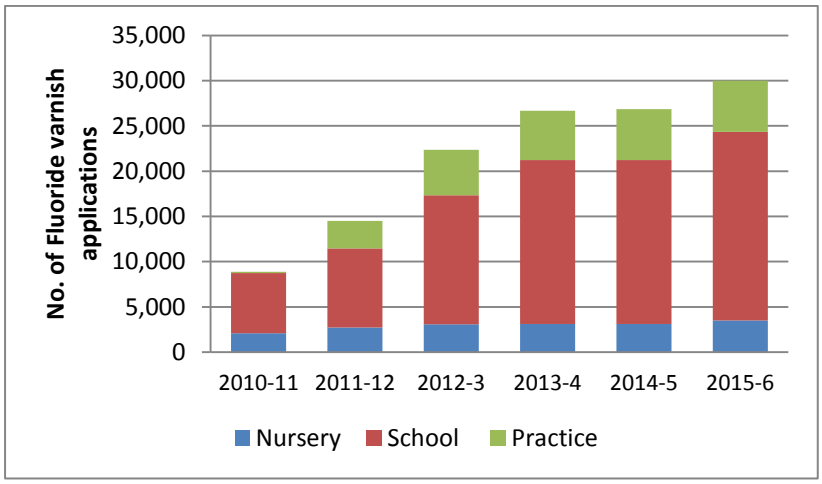
## Adult Oral Health

Within the scoping phase of the Tayside Oral Health Strategy a number of 'gaps' in the availability of adult dental data were highlighted. During 2016 a Scottish adult dental health survey (SAOHS) was undertaken piloting data collection using primary care dentists using a novel online collection tool. The steering group included Susan Carson and Derek Richards with several local primary care practices collecting data. The report is due to be launched in 24th February 2017 and will help inform future planning.

## Changes in key oral health indicators

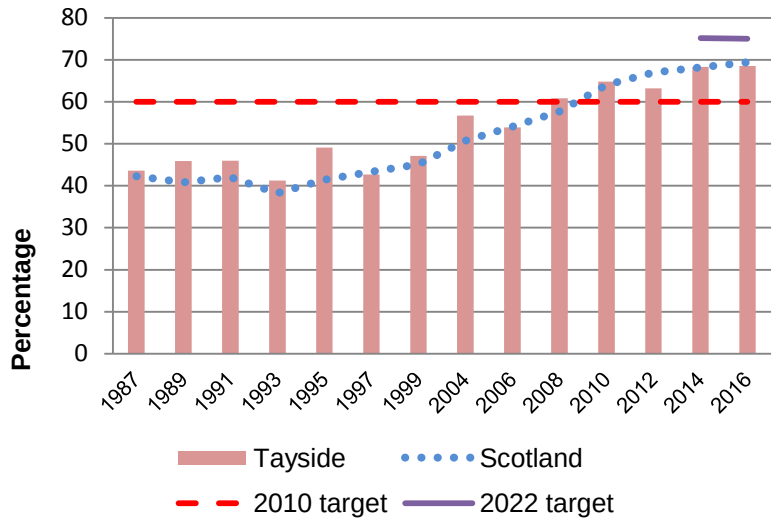
The following data provides an update of key elements of oral health activity since the launch of the oral health equity strategy.

### Annual number of Fluoride Varnish Applications (FVAs) provided in NHS Tayside 2011-2016




Fluoride varnish applications (FVAs) in Schools increased in the past 12 months. Application in Nurseries and High-Street Practices are stable.
Further increases in FVAs will require increase in practice based activity.

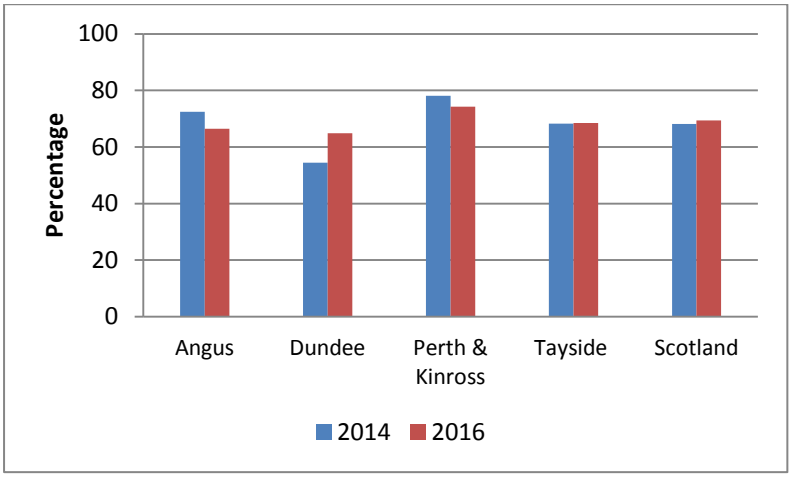
**Changes in the proportion of P1 children in Scotland & Tayside with no obvious decay 1987- 2016**




A further small improvement was seen in the percentage of P1 pupils to 68.5% with 'no obvious decay' in 2016.

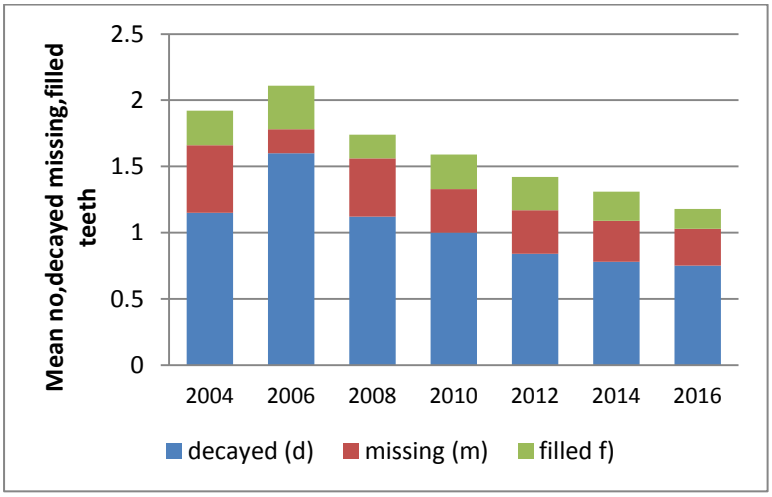
The national target for 2022 of 75% requires a 2.2% improvement for each of the next 2 years which will be a challenge.

**Changes in the proportion of P1 children Tayside H&SCP with No Obvious decay 2014-2016**



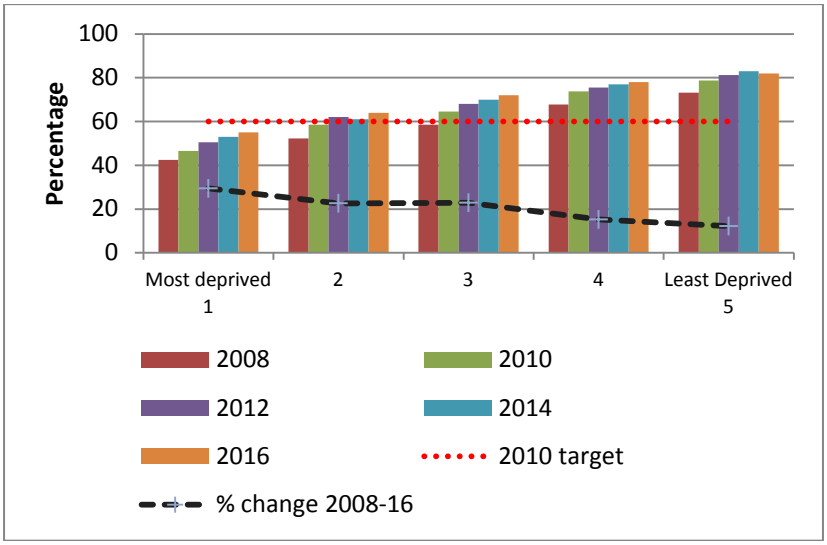

Local data for the past 2 years suggests an improvement in Dundee which a majority of the Childsmile activity is focussed. Small decreases in Angus and Perth and Kinross are within data confidence intervals. But continuing monitoring is required.

**Mean number of decayed, missing and filled teeth in P1children in Tayside 2004-2016**



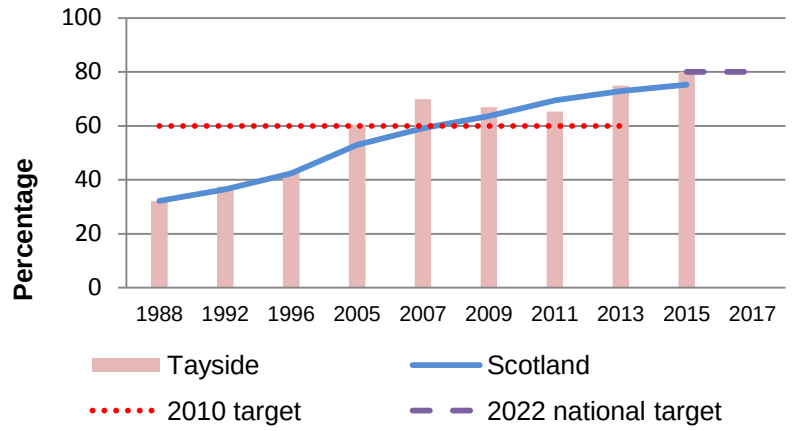

The average number of decayed missing and filled primary teeth (dmft) continues to fall (improve) as the number of children with no obvious decay increases. However, this means that those with disease have an average dmft of 3.71.

**Proportion of Scottish P1 children with no obvious decay experience by Scottish Index of Multiple Deprivation quintile; 2008-16**




By 2016 across Scotland only P1 children in the most deprived group (SIMD 1) have not yet met the 2010 national target of 60% free of obvious disease. A larger gradient exists with those in the least deprive SIMD although the target Childsmile Programme has seen a larger percentage improvement in children in SIMD 1.

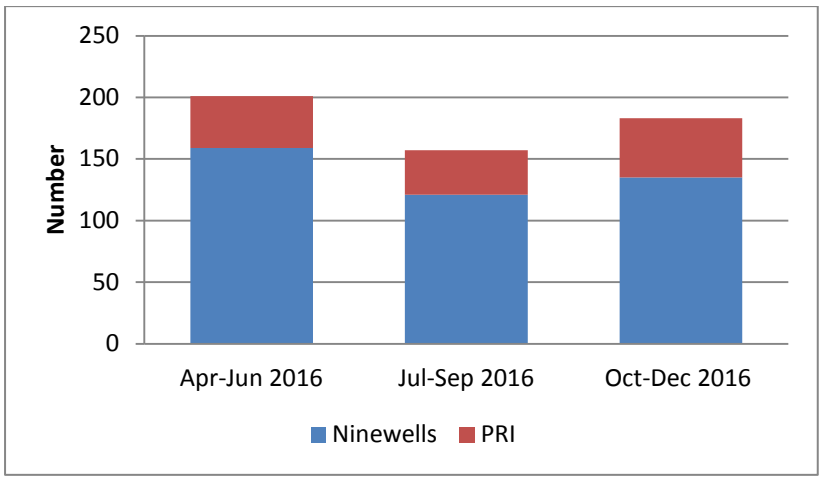
**Changes in the proportion of P7 children in Scotland & Tayside with no obvious decay 1988- 2015**




The 2022 national target for 'no obvious decay' in P7 children is 80%. This was achieved in Tayside in 2015.

A more challenging target of 88% with 'no obvious decay' is the revised local target.

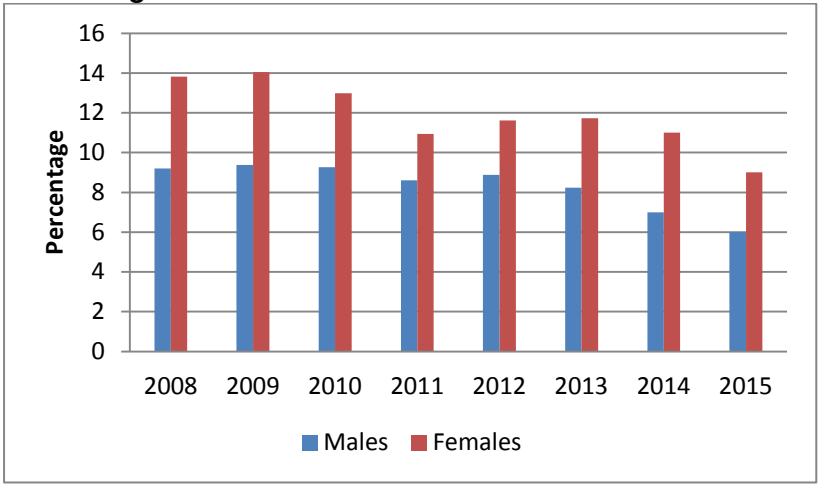
**Number of child General Anaesthetic cases in NHS Tayside 2016**




In the decade from 2001 to 2011 data from ISD demonstrated that child general anaesthetics in Tayside fell from around 1400 to around 700 per annum.

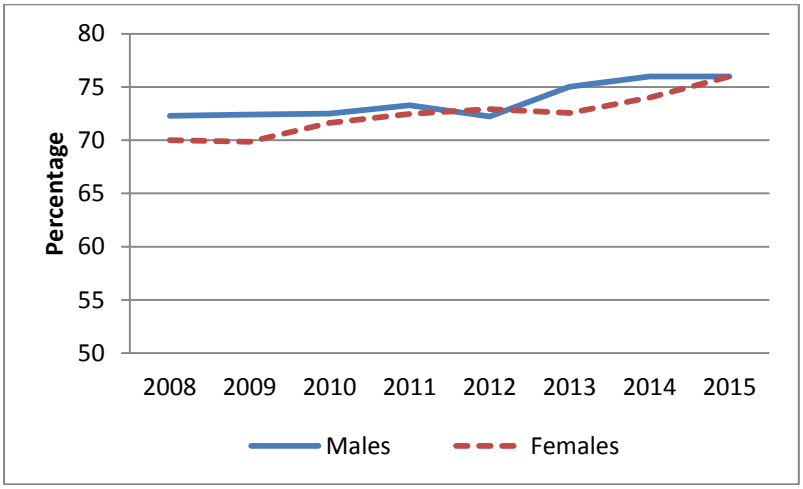
Since April 2016 we have been collecting local data quarterly for monitoring.

**Percentage of Scottish adults with no natural teeth 2008-2015**




This data from the Scottish Health Survey suggests an improving picture with fewer adults having no natural teeth with a smaller proportion of females having no natural teeth. This can be compared with data from the pilot Scottish Adult oral health survey in due course.

**Percentage of Scottish adults with 20 or more natural teeth 2008-2015**




People with 20 or more natural teeth are considered to have a functional dentition.

The proportion of Scottish men and women with more than 20 natural teeth had risen to 76% by 2015.

**Aim: - To work with partner agencies to develop public policy and practice that supports oral health promoting behaviours. Targeting those in the more deprived populations to reduce the gap between those in the most and least deprived SIMD quintiles.**

Currently the Public Dental Services Childsmile activity is supported by good working relationship with Education Departments, Health visitors and local high street dental practitioners. Work with adult priority groups including those experiencing homelessness and people in prison is enhanced by collaboration with the Dental Public Health Research Unit at the Dental School and other university colleagues, the Scottish Prison Service and a wide range of third sector organisations. Provision oral health improvement support to care homes has been facilitated by the development of the Tayside Oral Health Care Award and support for care home management teams and staff.

The Oral Health Educators have a varied timetable for delivering oral health training sessions which are adapted to multiagency target audiences across Tayside to include NHS Health Care Assistants induction, carers working with Dysphasic patients, care at home staff, Palliative Care Nurses, Health care staff within the prison, Universities of Dundee and Abertay nursing students (general and mental health), patients and carers within the learning disability facilities.

Initial discussions are taking place with the Dental School on new oral health improvements activities and community engagement activity Linking with Professor Peter Mossey and Dr Sucharita Nanjappa.

**Aim: - To co-produce improved oral health particularly of the deprived populations using an asset-based approach.**

This area is still in the early discussion stages and required further development. We hope to build on the DAPER project (https://dentistry.dundee.ac.uk/daper-research-programme) which produced is an evidence-based communication tool (CHATTERBOX) co-designed by parents in areas of high social deprivation in NHS Tayside and NHS Highland in collaboration the Dental Health Services Unit and the Duncan of Jordanstone College of Art and Design, University of Dundee

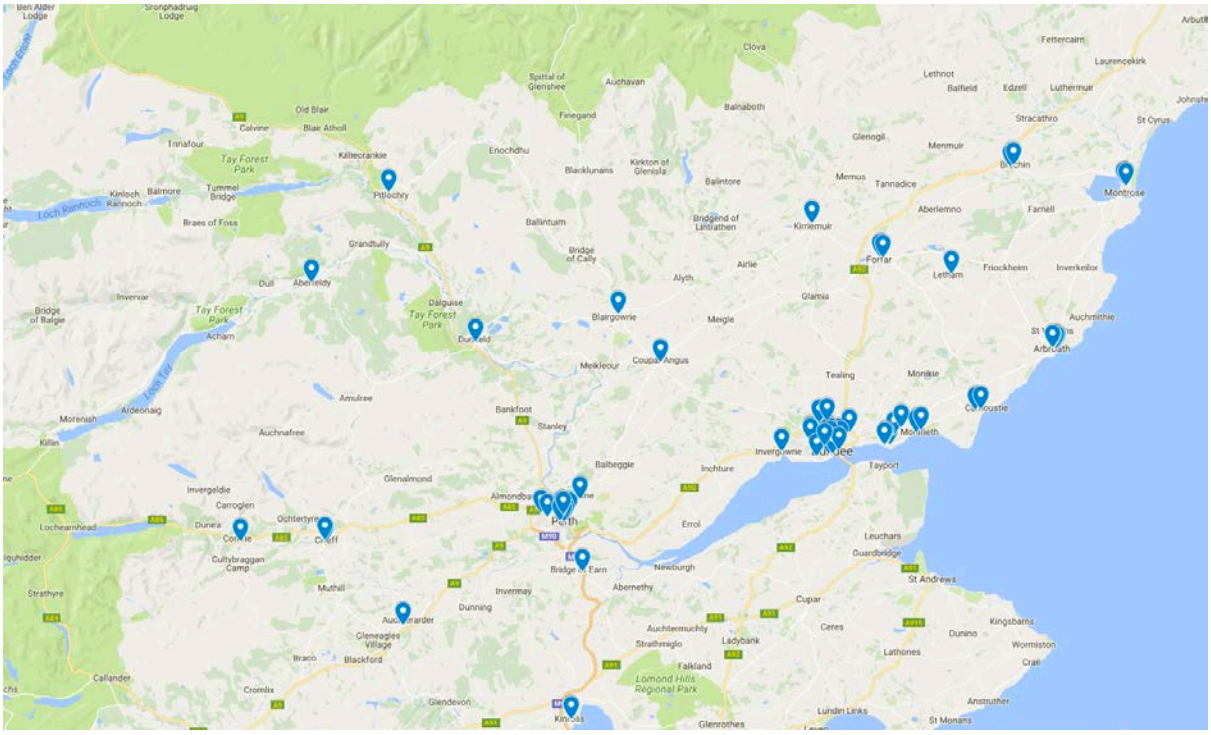
**Aim: - To enable adequate and equitable access for the whole population of Tayside to primary and secondary NHS dental services by targeting improved provision in deprived areas population profile**

The 2005 National Dental Action Plan set a dentist patient population ratio of 1:1750 and the data shows that Across Tayside this target has been met. Overall dentists and practice numbers are stable Although, one practice in Angus has closed and number of new premises have opened in Dundee. Registration and participation rates are also stable.

**Distribution of Primary Care dentists and high street practices in Tayside January 2016**

| | **Angus** | **Dundee** | **Perth & Kinross** | **Tayside** |
|---|---|---|---|---|
| Population | 116,900 | 148,210 | 149,930 | 415,040 |
| Dental Practices | 16 | 36 | 26 | 78 |
| Dentists | 51 | 108 | 91 | 250 |
| Dentist/Patient population ratio | 1:2292 | 1:1372 | 1:1648 | 1:1660 |

**Map of general Dental Practitioners in NHS Tayside**




**Aim: - To develop the quality, effectiveness and efficiency of dental services in order to improve dental and oral health in Tayside.**

All NHS dental practices are subject to a 3-yearly practice inspection undertaken by the Health Board's following a nationally agreed document. Dentists are also required to undertake 15 hours of clinical audit in a 3-year cycle and compliance is monitored. The Scottish Dental Clinical Effectiveness Programme (SDCEP) is based at the Dundee Dental Education Centre and has recently obtained NICE accreditation. Guidance developed by SDCEP is widely dissemination and supported by educational activities, nationally, locally and with linked audit activity.

To complement the data collection component of the SAOHS an integral quality improvement project was developed by a member of the NHS Tayside Dental Public Health team in collaboration with the Scottish Dental Practice Research Network and the wider SAOHS team. A number of General Dental Practitioners in Tayside participated in this quality improvement project which aimed to enable them to plan improvements in their practice in relation to two of the six quality dimensions (Scottish Government, 2010):
1. Providing effective services which are based on scientific knowledge.
2. Providing equitable care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.

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

**BOARD20/2017**
**Tayside NHS Board**
**23 February 2017**

# BOARD ASSURANCE FRAMEWORK (BAF)

## 1. PURPOSE OF THE REPORT

The purpose of this report is to present the Board Assurance Framework as at February 2017.

## 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 Managed/2C Practice; Mental Health; Maternity Services; Workforce Optimisation and PRI/Patient Flow Strategic Risks
- Acknowledge the work undertaken in respect of risk appetite and key performance indicators
- Approve the proposal in respect of the reduction in frequency of reporting the Board Assurance Framework to Tayside NHS Board
- 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 27 October 2016, it has been discussed at two meetings of the Strategic Risk Management Group (SRMG) on 24 November 2016 and 2 February 2017. At these meetings the risk owners provided exception reports in relation to each of the strategic risks facing NHS Tayside.

Progress has been made in relation to the following Strategic Risks:

Managed/2C Practices – This risk has now been Downgraded from a 20 (5x4 Red) to 16 (4x4 Amber) as a result of a successful recruitment strategy, 2/3 2c practices now have a full complement of GP staff.

Mental Health – This risk has been reviewed and the current risk score increased from 16 (4x4 Amber) to 20 (5x4 Red)

Maternity Services - This risk has also been reviewed and the current risk score increased from 12 (3x4 Amber) to 16 (4x4 Amber) and planned risk exposure changed from 12 (3x4) to 9 (3x3)

Workforce Optimisation – This risk has been updated and the current risk score increased from 16 (4x4 Amber) to 20 (5x4 Red)

PRI/Patient Flow - This risk has also been updated and the current risk score increased from 16 (4x4 Amber) to 20 (5x4 Red)

During the process of horizon scanning two new risks in respect of General Medical Council (GMC) Visit to NHS Tayside and Health and Social Care Partnership (HSCP) Governance and Assurance were raised.

Assurances were provided that robust operational arrangements were being progressed in respect of the GMC Visit and that these were being monitored through Performance Review.

With regard to HSCP Governance and Assurance it was noted that it had been agreed at a meeting of the Finance and Resources Committee that there was a requirement for a high level meeting to take place. As a result an initial meeting took place on 12 January 2017. A further meeting of the Chief Officers, Board Secretary and Internal Audit will now be scheduled with a view to developing/scoping out recommendations before being submitted to the larger group for approval. This will provide a framework for Year End Governance Arrangements and inform further work to be progressed in relation to risk registers ensuring risks are appropriately aligned and managed.

In summary, it was agreed that no strategic risks are required to address these at the current time.

The Board Assurance Framework as at February 2017 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.

Risk Appetite

Following liaison with other NHS Boards, a shortlife working group, consisting of Board Secretary, Risk Manager, Head of Committee Administration along with Internal Audit and Doug Cross, Non Executive Member, input into the development of the revised risk appetite

statement for NHS Tayside. This was agreed by the Strategic Risk Management Group on 2 February 2017. The next steps will be to seek approval from the Audit Committee on 16 March 2017 and thereafter incorporate details into the Risk Management Strategy and implement arrangement s to carry out a review of the statement on an annual basis.

Ongoing Work

Draft Key Performance Indicator headings have now been agreed in conjunction with the shortlife working group described above. Work continues to be undertaken to fully develop these. It is envisaged that these will be presented to the April meeting of the Strategic Risk Management Group and the Audit Committee thereafter.

Work is also ongoing in relation to improvements to the Assurance Template, the Committee Chairs Report template and the accompanying guidance for each of these

Board Assurance Framework/Strategic Risk Profile Reporting Arrangements

It was recognised in Internal Audit Report T13B/16 (Follow Up of T13B/14 – Risk Maturity) which was published on 12 November 2015 that a substantial amount of work had been undertaken since the issue of the original risk maturity report on 29 May 2014.

Since then further work to embed risk management systems and processes has concluded. This includes increased and more robust strategic and operational risk reporting arrangements, the introduction of horizon scanning as a standing agenda item at the SRMG, the development of an additional assurance reporting template and the review and further development of risk appetite. As a result, discussion and consultation has taken place with the Board Secretary and colleagues from Internal Audit and the following alterations are now proposed:

| BAF Current Reporting Cycle | | BAF Proposed Reporting Cycle | |
|---|---|---|---|
| SRMG | Quarterly with Horizon Scanning as Standing Agenda Item | SRMG | No changes |
| TNHSB | 4 times per annum | TNHSB | Biannually. Assurance will also be received through:<br>• Committee Chairs Assurance Reports<br>• Minutes and committee report from Audit Committee which has delegated authority for Risk Management. |
| Audit | Biannually as part of the Risk Management Mid and Annual Reports with continued assurance through regular receipt of minutes from SRMG | Audit | No changes |
| Standing Cttees | Reports on individual strategic risks by Risk Owner/Manager a minimum of 4 times per annum (including an update on progress in relation to linked operational risks) | Standing Cttees | No changes |

## 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**

**February 2017**

# NHS TAYSIDE RISK RATINGS – STRATEGIC RISK PROFILE

**Appendix A**

| | Datix Ref | Risk Title | Lead Director/ Risk Owner | Inherent Risk Exposure | 1 Oct 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Oct 2013 | Feb 2014 | April 2014 | Dec 2014 | April 2015 | Oct 2015 | Feb 2016 | June 2016 | Oct 2016 | Feb 2017 | | |
| **Tayside NHS Board: Chair – John Connell/Lead Officer – Lesley McLay** | | | | | | | | | | | | | | | | |
| 1 | 26 | Waiting Times and RTT Targets | Chief Operating Officer | 25 (5x5) Very High | 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 | 15 (5x3) High | → |
| 2 | 14 | Infection Management | Medical and Nurse Directors | 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 | 20 (5x4) Very High | 16 (4x4) High | → |
| 3 | 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 | 12 (3x4) High | → |
| 4 | 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 | 20 (5x4) Very High | → |
| 5 | 312 | NHS Tayside Estate Infrastructure Condition | Chief Operating Officer | 20 (5x4) Very High | - | - | - | - | - | - | 20 (5x4) Very High | 16 (4x4) High | 16 (4x4) High | 16 (4x4) High | 6 (2x3) Medium | → |
| 6 | 353 | Sustainable Primary Care Services | Chief Officer, Angus HSCP | 20 (5x4) Very High | - | - | - | - | - | - | 12 (4x3) High | 12 (4x3) High | 12 (4x3) High | 9 (3x3) Medium | 9 (3x3) Medium | ↓ |
| **Finance and Resources Committee: Chair – Doug Cross/Lead Officer – Lindsay Bedford** | | | | | | | | | | | | | | | | |
| 7 | 36 | Strategic Financial Plan 2015/16 – 2019/20 | Director of Finance | 25 (5x5) Very 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 | 25 (5x5) Very High | → |
| 8 | 37 | Impact of Reduction in Capital Resources | Director of Finance | 20 (5x4) Very 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 | 16 (4x4) High | 16 (4x4) High | → |
| 9 | 38 | Information Governance Risk | Board Secretary | 25 (5x5) Very High | 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 | 12 (4x3) High | 9 (3x3) Medium | → |

| | Datix Ref | Risk Title | Lead Director/ Risk Owner | Inherent Risk Exposure | 1 Oct 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Oct 2013 | Feb 2014 | April 2014 | Dec 2014 | April 2015 | Oct 2015 | Feb 2016 | June 2016 | Oct 2016 | Feb 2017 | | |
| 10 | 415 | Implementation of Trackcare | Director of e-Health | 20 (5x4) Very High | - | - | - | - | - | - | - | - | 12 (4x3) High | 12 (4x3) High | 8 (4x2) Medium | → |
| **Staff Governance Committee: Chair – Munwar Hussain /Lead Officer – George Doherty** | | | | | | | | | | | | | | | | |
| 11 | 95 | Medical Workforce | Director of Human Resources | 25 (5x5) Very High | 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 | 20 (5x4) Very High | 9 (3x3) Medium | → |
| 12 | 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 | 16 (4x4) High | 20 (5x4) Very High | 9 (3x3) Medium | ↑ |
| 13 | 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 | 20 (5x4) Very High | 16 (4x4) High | → |
| **Clinical and Care Governance Committee: Chair – Alison Rogers /Lead Officer – Gillian Costello/Andrew Russell** | | | | | | | | | | | | | | | | |
| 14 | 16 | Clinical Governance | Medical and Nurse Directors | 25 (5x5) Very 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 | 16 (4x4) High | 9 (3x3) Medium | ↑ |
| 15 | 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 | 12 (3x4) High | 9 (3x3) Medium | → |
| 16 | 22 | Health Protection of Children and Young People | Nurse Director | 25 (5x5) Very 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 | 9 (3x3) Medium | ↓ |
| 17 | 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 | 12 (3x4) High | 9 (3x3) Medium | → |
| 18 | 395 | Mental Health Services – Sustainability of Safe and Effective Services | Chief Officer, P&K HSCP | 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 | 20 (5x4) Very High | 12 (4x3) High | ↑ |

| | Datix Ref | Risk Title | Lead Director/ Risk Owner | Inherent Risk Exposure | 1 Oct 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Oct 2013 | Feb 2014 | April 2014 | Dec 2014 | April 2015 | Oct 2015 | Feb 2016 | June 2016 | Oct 2016 | Feb 2017 | | |
| 19 | 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 | 16 (4x4) High | 9 (3x3) Medium | ↑ |
| 20 | 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 | 20 (5x4) Very High | 12 (3x4) High | ↑ |
| 21 | 414 | Managed/2c Practices | Medical Director | 25 (5x5) Very High | - | - | - | - | - | - | - | - | 20 (5x4) Very High | 16 (4x4) 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<br>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 | Access Directorate |
| Clin. Group/Dept | Strategic Portfolio |
| Title | Waiting Times and RTT Targets |
| Description | Failure to deliver on the key national targets for waiting times and RTT targets |
| Owner<br>The Owner of the risk is the person who has overall corporate responsibility | Wiggin, Lorna - Director of Acute Services |
| Manager<br>The Manager of the risk is the person who manages it on the owner's behalf | Smith, Lynn - Interim General Manager, Access, Directorate, NW |
| Last updated | Sarah Lowry 02/01/2017 22:40:53 |

## 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 1013 patients waiting over 12 weeks as at the end of November 2016. This performance was 83 greater than the trajectory for

November.
Diagnostic performance stabilized over recent months with 153 patients waiting over 6 weeks as at the end of November 2016, this placed us 84 patients behind trajectory.
Following improvements in Outpatient performance up to the end of March 2016, performance has deteriorated with 5036 patients waiting over 12 weeks as at the end of November 2016. Whilst behind trajectory, the November position demonstrates an improvement performance over the past 3 months.
In October performance against the 31 and 62 day cancer waits was below the national standard.

**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 | 31/03/2016 | 09/10/2015 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | have been reached as 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 | 30/04/2016 | 13/10/2016 | High Priority |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 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). | | | |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 14 |
| Type of Risk<br>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.<br>•NHST cannot provide assurance that there will be consistent compliance with all national and local requirements at all times.<br>•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.<br>• 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<br>• Adverse reports from external agencies e.g. HSE, HPS, HIS, etc. will have a negative reputational impact |
| Owner<br>The Owner of the risk is the person who has overall corporate responsibility | Costello, Gillian - Nurse Director |
| Manager<br>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 12/01/2017 12:10:43 |

## 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 | 31/03/2016 | 24/03/2016 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | HEI HAI Improvement Action Plans following publication of each inspection are included within HAI Board report. | | | |
| 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 | 12/01/2017 | |
| 4643 | Mrs Dawn Weir | | Risk Register | Six month risk review | | 11/07/2017 | | |

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Hilary Walker

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 201 |
| Type of Risk<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Walker, Dr Drew - Director of Public Health |
| Manager<br>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 Register | Locality Single Outcome Agreements | All three locality Single 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. | 31/03/2016 | 01/04/2016 | High 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 |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 313 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Agencies working together and with communities to im<br>prove services and health outcomes<br>Improve patient experience of our services<br>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:<br><br>- unsatisfactory patient experience<br>- an increase in delayed discharges<br>- patients being boarded<br>- closure of neighbouring health boards and vice versa<br>- elective cancellations<br><br>leading to damage to organisational reputation. |
| Owner<br>The Owner of the risk is the person who has overall corporate responsibility | McLay, Lesley - Chief Executive |
| Manager<br>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 | 19/05/2016 | 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 |
| 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 |
| 3335 | Lorna Wiggin | Hilary Walker | Risk Register | OOH support | Consider revised models for OOH professional and management support over seven days. | 31/03/2017 | | High Priority |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 312 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Building capacity and capability to achieve sustainable change<br>Deliver on the priority areas in our clinical strategy including achieving HEAT targets<br>Improve quality of care in all health settings<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Wiggin, Lorna - Director of Acute Services |
| Manager<br>The Manager of the risk is the person who manages it on the owner's behalf | Anderson, Mark - Head of Property NHST |
| Last updated | Lesley Wilson 30/12/2016 11:24:59 |

## 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 |
| INT | Draft IA being developed in collaboration with SG re major investment need to address electrical infrastructure. Draft to be issued yo SG for comment prior to end Dec 2016 |

**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 | 30/04/2016 | 29/02/2016 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | similar via EAMS. | | | |
| 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 |
| 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 | 16/12/2016 | 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 | 16/12/2016 | Medium Priority |
| 3696 | Mark Anderson | Hilary Walker | Risk Register | 24 week maintenance | Surgical Directorate to review downtime to allow for planned 24 week maintenance programme and programme to be developed. | 30/12/2016 | 16/12/2016 | High Priority |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 353 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Agencies working together and with communities to improve services and health outcomes<br>Deliver on the priority areas in our clinical strategy including achieving HEAT targets<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Irons, Vicky - HSCI Chief Officer Angus, St Margarets House, Forfar |
| Manager<br>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 | Jillian Galloway 13/01/2017 14:30:53 |

## 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): Possible - may occur occasionally

Rating (current): 9

Risk level (current): MED

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 |
| Sustainability Framework developed to support identifying GP practices in difficulty early |
| Out of Hours and Health and Social Care Partnerships have completed winter plans as part of Winter Preparedness 16/17 |
| GP Practices running dedicated flu clinics including at weekends to ensure access and uptake of the vaccination |

**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 | | 31/03/2016 | 11/04/2016 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Development of OOHs Workforce Plan | | | |
| 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 | | | | | 31/08/2016 | 07/09/2016 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Hilary Walker | Risk Register | IJB Performance Review | Develop Performance Review Framework for each Integrated Joint Board | | | 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 Services (FMS) and Prisoner Healthcare (PHC) | 31/10/2016 | 01/12/2016 | Medium Priority |
| 3956 | Gail Smith | Hilary Walker | Risk Register | Risk Profile | Review Risk Profile for Angus Integrated Joint Board | 31/10/2016 | 28/11/2016 | Medium Priority |
| 3436 | Jillian Galloway | 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 | 30/11/2016 | 13/01/2017 | Medium Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | governance for Primary Care within NHS Tayside structures of assurance | | | |
| 3950 | Michelle Watts | Hilary Walker | Risk Register | GP Workforce Plan | Develop a detailed GP Workforce Plan | 30/12/2016 | | High Priority |
| 3955 | Michelle Watts | Hilary Walker | Risk Register | Implementation Plan | Develop and Deliver Implementation Plan for Primary Care Strategic Framework | 31/03/2017 | | Medium Priority |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 36 |
| Type of Risk<br>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 | As a result of an inability to show progress from the current financial position to achieving a state of financial balance, there is a risk that NHS Tayside will fail to deliver the Strategic Financial Plan (SFP). This would place the delivery of national and local plans in jeopardy and would result in a breach of the statutory financial obligations of the Board. |
| Owner<br>The Owner of the risk is the person who has overall corporate responsibility | McLay, Lesley - Chief Executive |
| Manager<br>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 12/01/2017 14:16:03 |

## 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): 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 and this inherent score reflects the currernt significant financial challenges the Board faces and the required timescale for returning to financial balance.

**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 an unbalanced LDP submitted 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 Valuing 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 |
| Collaboration with NHS Fife & NHS Ayrshire & Arran and National Support organisations to identify further efficiency measures |

**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 |
| INT | Monthly reporting to Transfortmation Programme Board |
| INT | Monthly meetings held with Chairs and Lead Officers of the Finance and Resources and Staff Governance Committees to discuss cross cutting issues and to develop a co-ordinated approach to issues of mutual interest |

**Gaps in Assurances**
**What additional assurances should we seek?**

| Source | Value |
|---|---|
| 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 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 | 30/09/2015 | 06/10/2015 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | profiles can be benchmarked against peer organisations | | | |
| 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 | 17/11/2016 | |
| 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 |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 37 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Building capacity and capability to achieve sustainable change<br>Making the best use of resources and achieving financial balance<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | McLay, Lesley - Chief Executive |
| Manager<br>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 12/01/2017 14:18:27 |

## Inherent Risk Exposure Rating

Inherent Risk Exposure Rating
Assessment of the risk without any controls in place.

Consequence (initial): Major (Category 1)

Likelihood (initial): 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 The Board submitted the Local Delivery Plan to Scottish Government Health Social Care Department in May 2016. 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. Discussions with Scottish Government Health Social Care Department Capital Unit will continue regarding | 31/03/2016 | 30/06/2015 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | 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 |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 38 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Agencies working together and with communities to improve services and health outcomes<br>Deliver on the priority areas in our clinical strategy including achieving HEAT targets<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Dunning, Margaret - Board Secretary, Ninewells |
| Manager<br>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 08/02/2017 16:20:54 |

## 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 |
|---|
| Following completion of the Information Security Policy Maturity Assessment, an Information Security Policy Framework Improvement and Action Plan has been developed for Information Governance and eHealth to progress. Actions have been delegated to key/named individuals with regular reviews of progress. |
| The Information Security Policy Maturity Assessment has been documented. The work required to complete the elements that are outstanding will be documented within an Information Security Improvement Plan and a |

working group will be set up to take responsibility for devising/delivering the requirements of the Information Security Policy Framework.

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 February 2017 - An Information Security Policy Framework Improvement and Action Plan has been developed for Information Governance and eHealth to progress. Actions have been delegated to key/named individuals and progress will be reviewed on a monthly basis.

October 2016 - The Information Security Policy Maturity Assessment has been documented. The work required to complete the elements that are outstanding will be documented within an Information Security Improvement Plan and a working group will be set up to take responsibility for devising/delivering the requirements of the Information Security Policy Framework.

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

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.

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 415 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Building capacity and capability to achieve sustainabl<br>e change<br>Improve quality of care in all health settings<br>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.<br><br>Implementation will require complex service configuration and data transfer operations to occur in conjunction with changes to operational service processes. |
| Owner<br>The Owner of the risk is the person who has overall corporate responsibility | Bodie, Jenny - Director of eHealth |
| Manager<br>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 09/02/2017 08:33:01 |

## 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 introduction 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.

The original go live plan is postponed and re-planning is underway providing an opportunity to adopt learning into the Programme

**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. |
| Go Live Planning - Table Top Exercise complete - Tuesday 20/12/2017 |
| Go/No Go List Created and Managed - January 2017 |

**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 | AG1 | 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 | 01/11/2016 | High Priority |
| 4057 | Jenny Bodie | | Risk Register | Three month risk review | Supplier Management Meeting Project Stage Reports Risk Log Review | 15/11/2016 | 08/02/2017 | Medium Priority |
| 4055 | AG1 | Hilary Walker | Risk Register | Adoption (October 2016 - February 2017) | • Service 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 | 28/02/2017 | | Medium Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Data Migration Verification | | | |
| 4056 | AG1 | 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 |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 95 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Deliver on the priority areas in our clinical strategy in cluding 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<br>The Owner of the risk is the person who has overall corporate responsibility | Doherty, George - Director of Human Resources |
| Manager<br>The Manager of the risk is the person who manages it on the owner's behalf | Mudie, Jennifer - Associate Director of HR - Resourci ng |
| Last updated | Ian Davidson 18/01/2017 15:10:29 |

## 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 met the June 2016 deadline.

Redesign in respect of medical workforce is beginning to be evidenced.

The Report on Shaping Surgical Services was approved at the Board and is progressing to Formal Consultation. When implemented, it is anticipated that this new service delivery model will remodel the medical workforce.

In August 2016, NHS Tayside attracted trainees to the majority of training places, however there are 6 ST vacancies and 2 FY1 vacancies to still be filled.

Progress around the redesign of Mental Health service provision is also at Formal Consultation stage.

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 | George Doherty | | 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 | Dr Philip McLoughlin | 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 | 31/03/2016 | | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | specifically in relation to redesign of medical workforce | | | |
| 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 | 02/11/2016 | |
| 2959 | Michelle Watts | Jennifer Mudie | Risk Register | Local Workforce Plans | Local Workforce Plans specifically in relation to redesign of medical workforce | 30/12/2016 | 18/01/2017 | High Priority |
| 4411 | Jennifer Mudie | | Risk Register | Three month risk review | | 31/01/2017 | | |
| 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 |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 58 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Building capacity and capability to achieve sustainable change<br>Deliver on the priority areas in our clinical strategy including achieving HEAT targets<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Doherty, George - Director of Human Resources |
| Manager<br>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 02/11/2016 11:45:34 |

## 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): 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 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 As at October 2016, actual wte is sitting at 11778.6 as oppoosed to the Projected wte at 11817.5. However, nursing numbers are currently 150 wte short of the projected number. This contributes to the higher supplementary staffing costs.

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 2 for 2016/17 was 4.64% which was 0.07% lower than in the same period in 2015/16. Long term absence at 2.19% in September 2016 is slightly lower than September 2015(2.35%) by 0.16%. Short term absence at 2.61% in September 2016 is higher than September 2015 (2.45%) by 0.17%.

The administration and clerical job family which includes senior managers which was projected to reduce 100 wte is currently 89.6 wte over the projected number.

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.

A Recruitment authorisation performance Group now meets each Monday to have an overview of the impact of the criteria driven recruitment process.

**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 information and the Clinical | 31/03/2016 | 11/08/2016 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | 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 | 02/11/2016 | |
| 4413 | Jennifer Mudie | | Risk Register | Three month risk review | | 31/01/2017 | | |
| 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 |

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Hilary Walker

# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 280 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives<br>ng achieving HEAT targets | Deliver on the priority areas in our clinical strategy includi |

## 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.<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Costello, Gillian - Nurse Director |
| Manager<br>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 03/02/2017 16:48:36 |

## 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. 211 recruited which is a further 20% increase on previous year (figure includes 21 Midwives) |
| Weekly workforce huddle with Heads of Nurse/Nurse Managers to provide support to reduce reliance on supplementary staffing |
| External review of nurse bank |

**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.

Engagement with both local Universities has commencedfor 2017 recruitment programme.

eRostering implementation progressing as per project plan, Safe Care implementation now commenced.

Recruitment of 2016 Nursing Graduates Commenced April 2016. To date (Sept 2016) 211 NQPs have been recruted to substantive posts. Induction programme completed to support transition from University Student to NMC Registered Nurse/Midwife working for NHS tayside.

Supplementary staffing requests now monitored weekly to provide support to Heads of Nursing/Nurse managers to reduce reliance on supplementary staffing.

**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 year renewal/ravalidation dates | Develop a system to ensure 3 year renewal/ravalidation dates are recorded and monitored | 30/09/2015 | 30/09/2015 | High Priority |
| 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 | 30/09/2016 | 04/07/2016 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Tayside as an employer | | | |
| 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 with the Scottish Government Revalidation Programme Board maintained; First staff Group partipating in revlaidation have successfully achieved revalidation during April 2016. | 31/10/2016 | 04/07/2016 | High Priority |
| 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 | 05/12/2016 | Medium Priority |
| 3415 | Eileen McKenna | Eileen McKenna | Risk Register | Familiarisation Workshops | Programme of Familiarisation workshops scheduled from November 2015 - December 2016 | 30/12/2016 | 05/12/2016 | 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 | 05/12/2016 | High Priority |
| 3417 | Eileen McKenna | Eileen McKenna | Risk Register | Education for confirmenrs | Education programme to support staff who are identified as confirmenrs to meet | 30/12/2016 | 03/02/2017 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | the requirements of the role | | | |
| 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 | 05/12/2016 | Medium Priority |
| 2711 | Jenny Bodie | Eileen McKenna | Risk Register | Implementation of e Rostering | Implementation of eRostering for Nursing & Midwifery | 30/12/2016 | 03/02/2017 | 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 | 05/12/2016 | Low Priority |
| 4531 | Eileen McKenna | Eileen McKenna | Risk Register | Weekly workforce Huddles | Weekly workforce huddles with Associate Nurse Director< Heads of Nursing/Nurse Managers implemented to provide scruitiny and support to reduce reliance on supplementary staffing | 30/12/2016 | 03/02/2017 | High 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 and capability of effective workforce planning and use of the nursing and midwifery resource. Plan to run revised module January 2017 | 31/01/2017 | 03/02/2017 | Medium Priority |
| 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 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 4738 | Eileen McKenna | | Risk Register | Three month risk review | | 04/05/2017 | | |
| 4737 | Eileen McKenna | Eileen McKenna | Risk Register | Nurse Bank Review | Implement recommendations from NHS tayside Nurse Bank Review | 31/05/2017 | | Medium 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 |
| 4740 | Eileen McKenna | Eileen McKenna | Risk Register | NQP Recruitment | To maximise the recruitment of nurses graduating from both local universities in 2017. | 31/10/2017 | | High Priority |
| 4736 | Eileen McKenna | Eileen McKenna | Risk Register | Supplemenetary Staffing | Daily monitoring of bank and agency requests and fill rate | 30/12/2017 | | High Priority |
| 4739 | Jenny Bodie | Eileen McKenna | Risk Register | Implementation of eRostering to improve rostering efficiency | eRostering to be implemented across NHS Tayside, implementation plan to be updated to reflect current position and ongoing plan. | 28/02/2018 | | High Priority |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 16 |
| Type of Risk<br>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 and care settings unexpected adverse events may occur which would result in harm or deterioration to patients. |
| Owner<br>The Owner of the risk is the person who has overall corporate responsibility | Russell, Andrew - Medical Director |
| Manager<br>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 07/02/2017 16:47:04 |

## 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 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 - review in progress |
| 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- review in progress |
| 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. |
| Partipatory Learning session at CQF to share learning and improvement |

**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 |
| INT | Internal Audit report Grade "B" on Patient Safety - January 2017 |

**Gaps in Assurances**
**What additional assurances should we seek?**

| Source | Value |
|---|---|
| INT | Additional measures required within GDET to capture measurement across all Patient Safety Programmes |
| INT | As highlighted above, formal KPI reporting to the Clinical and Care Governance Committee is under development. |

| | |
|---|---|
| INT | 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. |
| INT | 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) |
| INT | Performance review process to be spead to Board functions and HSCPs |
| INT | Performance reveiw meetings have not spread to IJBs therefore there reamins an assurance gap around safe, effective and person centred evidence for assurance |
| INT | Framework for IJBs re Care and Clinical Governance Strategy around R1/R2/R3 groups not fully implemented |

**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.

Next steps for improvement is to refresh the CG Strategy to include Vincent Framework, IJB governance re Clinical Care and Professional Assurance

**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 Governance | 26/05/2016 | 20/05/2016 | Medium Priority |
| 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 | | | CQF | | 30/09/2016 | 18/08/2016 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Hilary Walker | Risk Register | | Review Clinical Quality Forum Terms of Reference to take in new performance review system | | | Low Priority |
| 4010 | Arlene Napier | | Risk Register | Three month risk review | Risk reviewed 25/9/16 CG stratgey review is underway, agrement to be reache re links with the Framework for Clinical Care and Professional Governace document to be agreed at CRM meeting in Novemeber | 03/11/2016 | 27/10/2016 | High 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 | 05/12/2016 | 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 | 31/01/2017 | 07/12/2016 | Medium Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Internal Audit Report on Clinical Audit Half Days. | | | |
| 4569 | Arlene Napier | | Risk Register | Three month risk review | | 07/03/2017 | | |
| 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 commenced by November 2016. Include formal KPI reporting to the Clinical and Care Governance Committee | 31/03/2017 | | Medium Priority |
| 4764 | Arlene Napier | Arlene Napier | Risk Register | IJB Performance reviews implemented | 3xIJBs to create a culture of accountability around clinical and care governance, to provide assurances that safe, effective and person centred care is being delivered in all services | 13/12/2017 | | Medium Priority |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 121 |
| Type of Risk<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Costello, Gillian - Nurse Director |
| Manager<br>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 03/02/2017 16:08:27 |

## 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 The 2016 Scottish Care Experience Survey Programme In Patient Survey reported that 93% of NHS Tayside patients rated their care and treatment during their hospital stay as excellent or good, a statistically significant positive difference compared with the Scottish average of 90%. Results for Tayside in 2012 and 2014 are 87% and 91% respectively. For all the overarching key questions, bar one, that indicate 'overall experience' NHS Tayside performed above the Scottish average. The question that falls below the Scottish average is in relation to care or support services after leaving hospital (Question 64).

**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 | 31/12/2015 | 19/01/2016 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | the evidence based 8 Nursing KPI's. | | | |
| 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 | |
| 2862 | Eileen McKenna | LWILSO | Risk Register | Methodology and Measures | Engagement nationally and locally to agree methodology and measures | 31/03/2016 | 22/04/2016 | High Priority |
| 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 |
| 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 | 03/02/2017 | Medium Priority |
| 2721 | Alison Moss | 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 | 03/02/2017 | 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 | 03/02/2017 | High Priority |
| 4013 | Eileen McKenna | | Risk Register | Three month risk review | | 03/11/2016 | 03/02/2017 | |
| 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 | 03/02/2017 | Medium Priority |
| 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 • | 28/02/2017 | | Medium Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | 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 | | | |
| 4728 | Alison Moss | Eileen McKenna | Risk Register | Implementation of Complaints Review 90 day improvement plan | 90 day improvement plan implemted with a focus of engaging and training staff to provided knowledge and skills to promote early resolution of complaints. | 31/03/2017 | | High Priority |
| 4734 | Eileen McKenna | | Risk Register | Three month risk review | | 04/05/2017 | | |
| 4733 | Eileen McKenna | Eileen McKenna | Risk Register | Practice Development School | The curriculum for the practice development school 'Fostering a Culture of Effectiveness Through Practice Development' has been developed by the international consortium IPDC (International Practice Development Collaborative). The five-day course is uniquley offered with NHS Tayside by IPDC approved facilitators. This programme is designed for health care professionals who are responsible for developing, implementing or researching practice development strategies | 30/09/2017 | | Medium Priority |

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|---|---|---|---|---|---|---|---|---|
| | | | | | with an aim of promoting person centred care through developing person centred cultures. | | | |
| 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 patients experience are actively listened and responded to. | 30/09/2017 | | Medium Priority |
| 4735 | Eileen McKenna | Eileen McKenna | Risk Register | Communication training | Delivery of SAGE and THYME® communication training to support all staff in health and social care to effectively support people who are in emotional distress. | 30/12/2017 | | Medium Priority |
| 4731 | Arlene Napier | Eileen McKenna | Risk Register | Engagement with Deaf and Hard of Hearing Community | Following a number of issues raised by the deaf and hard of hearing community the Health and Deaf Action Group was established to drive improvements in partnership with local community. | 31/12/2017 | | High Priority |
| 4729 | Eileen McKenna | Eileen McKenna | Risk Register | Care Assurance Framework | National Excellence in Care Programme is being led by CNO Directorate to work with NHS Scotland Boards to define and implement a national approach to Care | 28/02/2018 | | Medium Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Assurance. NHS tayside activley engaging in this programme. | | | |
| 4730 | Eileen McKenna | Eileen McKenna | Risk Register | Test Right time Patient Feedback | As part of the national person centred programme, NHS Tayside currently testing a right time patient feedback methodology using volunteers to undertake post discharge telephone interviews. | 28/02/2018 | | Medium Priority |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 22 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Get the early years right for every child<br>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.<br>Update 01/11/2016<br>Since this risk was initiated, focus has began to shift more towards children, young people and families through the work of the Children, Young People and Families Board and associated workstreams. NHS Tayside is also better progressed in fulfilling it's statutory duties under the Children and Young People (Scotland) Act 2014.<br>Update 06/01/2017<br>The NHS Tayside Children, Young People and Families Board is now established within associated workstreams.<br>Priority mapping has taken place to support NHS Tayside in agreeing key priorities across multiple agenda's.<br>The number of Health Visitors/Named Persons has increased considerably which will support NHS Tayside in fulfilling it's statutory duties under the Children and Young People (Scotland) Act 2014. In addition there is refreshed focus on the GIRFEC agenda and a plan is operational to ensure completion of outstanding work. |
| Owner<br>The Owner of the risk is the person who has overall corporate responsibility | Costello, Gillian - Nurse Director |
| Manager<br>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 25/01/2017 08:50:27 |

## 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): Possible - may occur occasionally

Rating (current): 9

Risk level (current): MED

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 collaborative, 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 receive 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.
Update 06/01/2017
The current and adjusted score reflects the progress made within the organisation in terms of the establishment of the Children, Young People and Families Board and the increased capacity within the Named Person Service. The GIRFEC agenda is well progressed and there is refreshed focus on the Integrated Children's Planning agenda.

**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.
Update 06/01/2017
There is now greater emphasis on services for children, young people and families and assurances on future plans going 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 |
| --- |
| 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. Update 01/11/2016 - Leadership changes have had an impact on representation on these groups. The current position is that the NHS Tayside Interim Lead for Children's Services represents the organisation on all 3 groups in addition to a local Operational Manager. Plans are in place for a member of the Nursing Directorate to also contribute to the work of these groups. Update 06/01/2017 - NHS Tayside representation is in place on the 3 Integrated Children's Services Planning Groups. There is also executive level representation on the 3 area Chief Officer Groups. |
| 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. Update 01/11/2016 - It is currently unclear regarding the tests of change in NHS Tayside that have been scaled up and sustained. Further information is required in this context. Update 06/01/2017 - Further information has been sought to determine the current state position with the work of the Early Years Collaborative in each locality area. |
| Child Protection Executive Group - An NHS Tayside Child Protection Executive Group, chaired by the Nurse Director provides assurace to the Board around all matters relating to Child Protection, ensuring continuous improvement in processes and procedures, addressing workforce training 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. Update 06/01/2017 - CPEG is well established and operates both a group workplan and quality assurance arrangements which report via the Clinical Quality Forum. |
| 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 third sector and Government. NHS Tayside is represented by the Child Health Commissioner. Chief Executive of Dundee City Council, has recently been appointed to the Chair and opportunity is being taken to review the workplan. Update 01/11/2016 - This group is no longer in operation. A refreshed arrangement encompassing a wider remit is currently being considered by Multiagency Children's Partnerships across the region. Update 06/01/2017 - The Tayside multiagency GIRFEC Group is no longer operational. Groups exist in each local area and health is represented via operational services and the Nursing Directorate. |
| 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. Update 01/11/2016 - This group is now chaired by the Cheif Nurse. A stocktake is ongoing regarding work outstanding to ensure NHS Tayside is in a strengthened position regarding GIRFEC Policy and implementation of the aforementioned legislation. Update 06/01/2017 - Fiollowing a stocktake of the work of the NHS Tayside GIRFEC Group, a refreshed workplan is in place and on track. |
| 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. Update 06/01/2017 - This area of work is no longer part of this risk and is required to be considered by NHS Tayside Public Health. |

| |
|---|
| 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. Update 01/11/2016 - The Children, Young People and Families Board are currently considering the outcomes from an internal review of LAC along with their role as a corporate parent. When the Board's position on this agenda is agreed, the current NHS Tayside LAC Group may require to be refocussed. Updated 06/01/2017 - A review of LAC and Corporate Parenting has been considered by NHS Tayside Children, Young People and Families Board. An improvement plan is now in place. |
| 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. Update 01/11/2016 - The workplan related to the Transforming Agenda and CEL 13 is set to complete by the Spring of 2017. Update 06/01/2017 - The workplan related to this agenda is now well progressed and nearing completion. |
| 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. Update 06/01/2017 - This Board is now established with Terms of Reference and a meetings timeline. |

**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. Update 06/01/2017 - There are reporting arrangements for all groups highlighted in this risk. |
| | Joint Inspections of Children's Services are 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). Update 06/01/2017 - There are reporting arrangements for all groups highlighted in this risk. |
| SHA | Progress in implementing the Children & Young People Act (Scotland) 2014 is improving. Update 06/01/2017 - The implementation of the Children and Young People (Scotland) Act 2014 is progressed as appropriate to the stage of implementation in Scotland. |

**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 Tayside 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.
Update 06/01/2017
The Children,Young People and Families Board is now better established, has agreed Terms of Reference and meets monthly.

**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 | | | | | 16/10/2015 | 19/10/2015 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Risk Register | One month risk review | New one month risk review set | | | 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 | 09/08/2016 | 27/09/2016 | High Priority |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 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. | | | |
| 4396 | Joan Wilson | | Risk Register | Three month risk review | The Children, Young People and Families Board are currently considering strengthened governance arrangements to provide assurance that improvements arising from Inspections and other significant reviews are progressed within an agreed timeframe. | 30/01/2017 | 11/01/2017 | Medium Priority |
| 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 | 27/02/2017 | | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | 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 | | | |
| 4630 | Joan Wilson | | Risk Register | Three month risk review | This risk has been fully updated which provides a rationale for the current and reduced rating. The Children, Young People and Families Board is now well established with clear terms of reference and meets monthly. All aspects of this risk have been reviewed and refreshed to reflect the increased focus on this Agenda highlighting an improving picture. | 06/04/2017 | | Medium Priority |

**Notifications**

| Recipient Name | Recipient E-mail | Date/Time | Contact ID | Telephone Number | Job title |
|---|---|---|---|---|---|
| **No notification e-mails sent** | | | | | |

**Email and Feedback (Other Datix Users)**

**Recipients**

**Message**

| Message history | | | |
|---|---|---|---|
| **Date/Time** | **Sender** | **Recipient** | **Body of Message** |
| **No messages** | | | |

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Hilary Walker

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 15 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Building capacity and capability to achieve sustainable change<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Costello, Gillian - Nurse Director |
| Manager<br>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 04/01/2017 09:53:05 |

## 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/Frailty 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 update December 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 December 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 16-weeks uodated completed and sent to HIS. Associate Medical Director OP to present improvement plan to Clinical and Care Governance Committee on 10th November 2016. Update December 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 December 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. Agreement to extend the work of this national group agreed until March 2017. Update before March 2017. |
| Performance & Assurance - Implementation of Medicines Safety and HIS Standard 6 Pharmaceutical Care - Including polypharmacy work in the community, use of antipsychotics in care homes (awaiting natinal work on Commitment 13 of the Scottish Government Dementia Startegy) 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. Evaluation of the ECS model for the whole of South Angus (South East and South West localities), population of 55,000 is underway and presentation agreed at National conference in Edinburgh at the end of November 2016. |

**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 Care in Acute Settings inspections. Currently working on an Improvement Plan following HIS unnanounced inspection to older people's care in Ninewells during 7-9 June 2016. Tobe presented at the Clinical and Care Governance Committee on 10th November 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. For multidisciplianary teams in acute hospitals, the ownership of scrutiny and improvemnt plans will belong to each of the Clincial Teams under the leadership of the Heads of Nursing. |

**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 | 28/12/2012 | 19/11/2014 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Age Liaison Service to patients admitted to Ninewells Hospital. | | | |
| 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 people's health care in Tayside. | 31/12/2015 | 24/12/2015 | High Priority |
| 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 | 31/12/2015 | 24/12/2015 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | will take place as appropriate | | | |
| 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 | 27/10/2016 | |
| 2999 | Cesar Rodriguez | LWILSO | Risk Register | Spread of the Locality Model | The Locality Model Steering Group is was working on the spread of the model in the three areas of Tayside and on an evaluation framework. Now each of the HSCPs areas in Tayside report regularly to the Older People Clinical Board. | 04/08/2017 | | High Priority |
| 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 | 04/08/2017 | | High Priority |
| 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. Current focus on the improvement action plan following HIS unnanounced inspection in the care of older people in Niewells hospital in June 2016. | 04/08/2017 | | High Priority |

**Notifications**

| Recipient Name | Recipient E-mail | Date/Time | Contact ID | Telephone Number | Job title |
|---|---|---|---|---|---|
| No notification e-mails sent | | | | | |

**Email and Feedback (Other Datix Users)**

**Recipients**

**Message**

| Message history | | | |
|---|---|---|---|
| **Date/Time** | **Sender** | **Recipient** | **Body of Message** |
| 07/01/2016 16:30:15 | Walker, Hilary | e.myers@nhs.net | This is a feedback message from Hilary Walker. The Risk reference is 15. The feedback is: Have had a telephone conversation with Cesar a nd he has asked me to email you so you can have a look at this risk. Any problems, please give me a ring and I will arrange for you to be g iven a copy by other means. Cesar will call you tomorrow morning. Ple ase go to http://fernie.tnhs.tayside.scot.nhs.uk/datix/live/index.php?a ction=risk&recordid=15 to view it. |
| 08/11/2012 13:52:11 | Rodriguez, Cesar | McGuire, M argaret | This is a feedback message from Cesar Rodriguez. The Risk reference is 15. The feedback is: Hi Philip, this is my first attempt at the Datix re gister in Mags"" absence (will catch up with her on return from holida ys). Would you mind having a look to see if I""m on the right track? A s you can see, I have updated the "Current Controls" section with the update from Mags. I have populated three "Proposed Controls" with a couple of connected "Actions". As I will be in Glasgow tomorrow at th e Patient Safety event, I am happy to work during the week-end on th is prior to the Audit Committee meeting on 15th November. Thanks, C esar Please go to http://fernie.tnhs.tayside.scot.nhs.uk/datix/live/inde x.php?action=risk&recordid=15 to view it. |
| 08/11/2012 13:52:11 | Rodriguez, Cesar | philip.wilde@nhs.net | This is a feedback message from Cesar Rodriguez. The Risk reference is 15. The feedback is: Hi Philip, this is my first attempt at the Datix re gister in Mags"" absence (will catch up with her on return from holida ys). Would you mind having a look to see if I""m on the right track? A s you can see, I have updated the "Current Controls" section with the update from Mags. I have populated three "Proposed Controls" with a couple of connected "Actions". As I will be in Glasgow tomorrow at th e Patient Safety event, I am happy to work during the week-end on th is prior to the Audit Committee meeting on 15th November. Thanks, C esar Please go to http://fernie.tnhs.tayside.scot.nhs.uk/datix/live/inde x.php?action=risk&recordid=15 to view it. |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 395 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Improve mental health and mental health services<br>Improve patient experience of our services |

## Risk Ownership

| | |
|---|---|
| Directorate/H&SCP | Mental Health Directorate |
| Clin. Group/Dept<br>r Only) | Tayside Mental Health Services (Use for Risk Registe |
| Title | Mental Health Services - Sustainability of Safe and Effective Services across Tayside |
| Description | As a result of primarily workforce challenges and secondary, delegation and hosting arrangements across 3 IJBS and NHST for Mental Health & Learning Disability services, sustainable delivery of services are at risk and fragmentation and variation in service planning and provision may occur, which will impact on:<br>1. Provision and delivery of sustainable 'whole system' high quality safe, effective care and treatment within financial framework.<br>2. Need for clear mechanisms for reporting and monitoring of accountability, assurance, governance and continuous quality improvement for clinical care and professional practice standards<br>3. Availability of required medical and nursing workforce to deliver sustainable safe and effective services for population of Tayside 24/7 |
| Owner<br>The Owner of the risk is the person who has overall corporate responsibility | Russell, Andrew - Medical Director |
| Manager<br>The Manager of the risk is the person who manages it on the owner's behalf | Packham, Robert - Chief Officer |
| Last updated | Karen Ozden 23/11/2016 12:41:41 |

## 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): Almost certain - could occur frequently

Rating (current): 20

Risk level (current): VHIGH

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 It is not anticipated that there will ever be a time when this risk is completely mitigated, however a reasonable position would be to reduce the risk from major to moderate by having a rationalised service delivery model that will have fewer service delivery sites and will require fewer medical staff to cover rotas.
Having robust and related mechanisms for performance and quality reporting across the 3 IJB service areas and NHS Tayside will reduce the risk of fragmentation and variation in standards of care and service planning.

**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 AMD and Head of In-pt Services P&K IJB through temporary use of Locum psychiatrists. 45 NQPs appointed to nursing vacancies Sep-Nov 2016. Attempts to recruit to Medical vacancies continue until such time as Medical workforce plan is reviewed in line with awaited outcome of service redesign and transformation programme |

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 from P&K to also be provided from 1 single locality (Dundee) 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 was presented to NHST Board in August 2016. The Initial Agreement for a decision on the outcome of the option appraisal process will be presented to the 3 Integrated Joint Boards and NHS Tayside Board and relevant committees for a strategic decision in early in 2017.

**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 | Operational contingency plan agreed and can be implemented at short notice when needed |
| EXT | In response to Medical workforce challenges and impact on trainees experience of placement in Mental Health Services NHS Tayside, Deanery visit outcome was that Trainees would not be removed at this stage as a result of Feedback, but further improvements required before next visit early 2017. Improvement plan under development |
| INT | R3 Mental Health (including GAP, CAMHS, Secure Care, Substance Misuse) & Learning Disability Care & professional Governance Group formed and frameworks being developed regarding assurance around quality and standards of care. Reporting arrangements and relationship to R2 Groups in each IJB will be established. |

**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 | Paper to Board in respect of Mental health Service Redesign and Transformation Programme deffered until March 2017 from December 2016 |

**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 Contingency plan for Medical Workforce shortages developed and approved by NHS Tayside Board end Oct 2016 and P&K IJB early November 2016. Requirement to implement the contingency plan is highly likely (Feb 2017 - there will be only 18.6 trainees allocated to 32 places across Tayside therefore OOHs rota will need to operate from 1 locality).
Initial Agreement for Mental Health Service Redesign and Transformation Programme progressing.
First meeting of R3 Group held end October 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 |
|---|---|---|---|---|---|---|---|---|
| 3866 | Grace Gilling | Hilary Walker | Risk Register | Improvement Programme | Deliver on Ward Improvement Support Programme for Moredun | 30/06/2016 | 08/08/2016 | High Priority |
| 3870 | KROBER | | Risk Register | One month risk review | | 16/07/2016 | 08/08/2016 | |
| 3868 | KROBER | 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 | RPACKH | | Risk Register | One month risk review | A contingency planning paper was presented to the NHS Board on Thursday 27th October 2016. The verbal record of the action note from that meeting states "It was agreed that the contingency plan would come into operation if required and would be used at the discretion of senior clinicians in the service. If used it will be reviewed at 3 months. The revised timetable was noted with the aim that the process be expedited | 28/09/2016 | 28/10/2016 | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | if possible. Final approval for the timetable rests with P&K IJB." A revised version of the same paper will be presented to the Perth and Kinross Integration Joint Board for approval on Friday 4th November 2016. | | | |
| 3869 | KROBER | 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 | 23/11/2016 | High Priority |
| 3865 | KROBER | Hilary Walker | Risk Register | Procurement Process | Procurement process for replacement beds, windows and electronic door top alarms across estate. | 31/12/2016 | 23/11/2016 | Medium Priority |
| 4508 | Andrew Russell | KROBER | Risk Register | Establishment of robust Performance and Governance review mechanism for all MH&LD services | NHS Tayside require a robust mechanism for ensuring MH&LD servivces are performing to a high standard across the arrangement of service delegations, hosting and retained services. Chief Officers of IJBs and Chief Operating Officer of NHS Tayside in partnership with Medical | 20/01/2017 | | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Director and Professional Leads to agree mechanism for performance monitoring and assurance. | | | |
| 4509 | RPACKH | | Risk Register | Three month risk review | | 21/02/2017 | | |
| 3867 | KROBER | Hilary Walker | Risk Register | HSE Action Plan | Fully Implement HSE Action Plan | 28/02/2017 | 23/11/2016 | High Priority |

**Notifications**

| Recipient Name | Recipient E-mail | Date/Time | Contact ID | Telephone Number | Job title |
|---|---|---|---|---|---|
| **No notification e-mails sent** | | | | | |

**Email and Feedback (Other Datix Users)**

**Recipients**

**Message**

| Message history | | | |
|---|---|---|---|
| **Date/Time** | **Sender** | **Recipient** | **Body of Message** |
| **No messages** | | | |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 144 |
| Type of Risk<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Costello, Gillian - Nurse Director |
| Manager<br>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 01/02/2017 12:24:04 |

## 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 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.

4/1/17
Clarity is required with regard to the Angus CMU situation.
The medical rota and job planning needs urgent action.
Continuous recruitment of midwives.
Organisational culture works continue but is challenging.
Parity between professions is required where there are individuals practice issues.
Practice to evidence based guidance is required to reduce variation which is known to increase harm.

1/2/2017 medical obsteric rota will be launched in April 2017, continued lack of consultant cover in some areas,MDT attendance at risk management improved previous 3 weeks

**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.

21/12/16 planned score amended to reflect service once all mitigating actions are in place

**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 |
| INT | Compliance with K2 modules in some groups very poor |
| INT | medical obstetric rotas and job plans remain not finalised therefore risk remains |
| INT | Gaps identifird in ultrasound service over Christmas and New Year . short notice notification of abscence medical annual leave, midwife sonographer sickness |

**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 |
| 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 | 01/02/2017 | High Priority |
| 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 , | 23/07/2015 | 27/08/2015 | Medium Priority |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 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 with implementation of the Growth Assessment Protocol , escalated to ND. Mitigation- is not to implement yet but prepare to implement. Medical obstetric rota. | | | |
| 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 |
| 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 |
| 2687 | Carol Goodman | Carol Goodman | Risk Register | Six month risk review | | 23/02/2016 | 01/09/2016 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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 |
| 4121 | Justine Craig | | Risk Register | One month risk review | strategic risks reviewed and updated | 01/10/2016 | 30/08/2016 | High Priority |
| 4617 | Justine Craig | Justine Craig | Risk Register | Midwives compliance with K2 | Reports run managerial action taken | 04/01/2017 | | High Priority |
| 4618 | Antony Nicoll | Justine Craig | Risk Register | Finalise Job Plans and Rotas for obstetrics Gynaecology | ongoing since 2013 | 04/01/2017 | | High Priority |
| 4619 | Justine Craig | Justine Craig | Risk Register | Clinical Governance meetings and Structure | Encourage multidisciplinary attendance as a priority will improve when rotas and Job plans are assigned | 04/01/2017 | | High Priority |
| 4615 | Justine Craig | | Risk Register | One month risk review | | 20/01/2017 | | |
| 4614 | Justine Craig | | Risk Register | One month risk review | | 03/02/2017 | | |
| 4616 | Antony Nicoll | Justine Craig | Risk Register | K2 Compliance obstetric staff | poor compliance trainess and consultants who deliver obstetric care | 28/04/2017 | | High Priority |
| 3383 | Justine Craig | Justine Craig | Risk Register | Implementation of Maternity TRAK care | Plan to implement Maternity IT system and unify electronic approach. Concern that it will not integrate with EMIS and other IT systems relevent to Maternity | 08/05/2017 | | High Priority |
| 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 | 31/08/2017 | | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | this will be an ongoing process for every new/updated or amended guideline | | | |
| 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. | 30/12/2017 | | 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. | 30/12/2017 | | 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. | 30/12/2017 | | High Priority |
| 2871 | Justine Craig | LWILSO | Risk Register | LAER/SCEA learning | Embed process to disseminate learning from LAER and SCEAs | 30/12/2017 | | High Priority |
| 2872 | Justine Craig | LWILSO | Risk Register | I.T. System | Review of IT System as this impacts on flow, capacity and | 30/12/2017 | | High Priority |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | discharge. Working with the Business hub to ensure we are utilizing IT to its fullest potential for clinical care, audit and service planning. | | | |
| 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 that maternity emergency theatre is being used for el procedures- audit to commence | 30/12/2017 | | High Priority |

**Notifications**

| Recipient Name | Recipient E-mail | Date/Time | Contact ID | Telephone Number | Job title |
|---|---|---|---|---|---|
| **No notification e-mails sent** | | | | | |

**Email and Feedback (Other Datix Users)**

**Recipients**

**Message**

| Message history | | | |
|---|---|---|---|
| **Date/Time** | **Sender** | **Recipient** | **Body of Message** |
| **No messages** | | | |

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# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 302 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Agencies working together and with communities to improve services and health outcomes<br>Deliver on the priority areas in our clinical strategy including achieving HEAT targets<br>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:<br><br>Not have access to the right care, in the right place, at the right time<br><br>Experience harm from waits for a bed<br>Be cancelled for elective procedures<br><br>Experience harm and delay through being treated and cared for outwith specialty<br><br>Be diverted to Ninewells Hospital when bed capacity is exhausted<br><br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Cook, Alan - Consultant Radiologist (Associate Medical Director) |
| Manager<br>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 26/01/2017 13:58:03 |

## Inherent Risk Exposure Rating

Inherent Risk Exposure Rating
Assessment of the risk without any controls in place.

Consequence (initial): Extreme (Category 1)

Likelihood (initial): 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 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 bed 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.

21 October 2016 - During the last week there was requirement to divert patients from PRI to Ninewells and close to surgical and orthopaedic emergency admissions. Elective surgical admissions were cancelled (add patients affected). The number of patients waiting for a bed increased. This situation arose because of the dramatic increase in the number of patients experiencing a delayed discharge rising to 39 patients delayed on the PRI site at one point of the week. In the short term despite close working between health and social care partnership members there is unlikely to be an improvement in the numbers of patients experiencing a delayed discharge, and the significant risk of having to divert patients and cancel elective activity remain. Therefore, the risk exposure rating has been reassessed and raised to 20.

7 December 2016 - There had been a reduction in the number of patients experiencing a delayed discharge from 39 patients in October 2016 to 28 patients during week ending 11 December 2016. This resulted in patients in inappropriate locations (boarding). The risk exposure rating therefore remained at 20.

26.01.17 - A review of the December 2016 data as reported to CCGC for it's meeting on 9 Feburary 2016 confirmes a slight reduction in the risk score for the indicators measured. However system resilience has been impacted on by nursing vacancies and use of supplementary staff, a high number of patients exeriencing a delayed discharge resulting in patients boarding and waiting for a bed. The number of patients with a delayed discharge had increased to 19 on Monday 9 January, coinciding with spikes in the number of medical admissions resulting in a full divert of unscheduled activity from PRI to Ninewells on the night of 9 January 2017 extending to 10 January 2017. This actions was implemented following multidisciplinary assessment of the risk and the divert was the mitigation action. Over the next few days concerted joint effort was taken to create capacity for unscheduled admissions to resume at PRI. This risk exposure rating therefore remains at 20.

**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 outputs of nursing workforce tools Target recruitment 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 | 09/01/2017 | Medium Priority |

**Notifications**

| Recipient Name | Recipient E-mail | Date/Time | Contact ID | Telephone Number | Job title |
|---|---|---|---|---|---|
| **No notification e-mails sent** | | | | | |

**Email and Feedback (Other Datix Users)**

**Recipients**

**Message**

| Message history | | | |
|---|---|---|---|
| **Date/Time** | **Sender** | **Recipient** | **Body of Message** |
| **No messages** | | | |

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Hilary Walker

Datix

# Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

## Risk Description

| | |
|---|---|
| RISK ID | 414 |
| Type of Risk<br>Only Directors may add Strategic Risks | Strategic Risk |
| Principal objectives | Building capacity and capability to achieve sustainabl<br>e change<br>Improve patient experience of our services<br>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<br>The Owner of the risk is the person who has overall corporate responsibility | Russell, Andrew - Medical Director |
| Manager<br>The Manager of the risk is the person who manages it on the owner's behalf | Watts, Michelle - Associate Medical Director - Primar<br>y Care Verifier for NHS Tayside |
| Last updated | Michelle Watts 05/01/2017 17:43:15 |

## 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 Situation has improved, due to successful recruitment. 2/3 practices now have full complement of GP's.

**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 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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 |
| 4031 | Sue Mackie | Hilary Walker | Risk Register | Risk Assessments | Practice Risk Assessments to be carried out. | 30/09/2016 | 07/10/2016 | Medium 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 |
| 4621 | Michelle Watts | Michelle Watts | Risk Register | complete GP recruitment to Brechin | further 1.0 WTE required to bring practice back towards stability. | 28/04/2017 | | High Priority |
| 4622 | Michelle Watts | | Risk Register | Six month risk review | | 04/07/2017 | | |
| 4620 | Michelle Watts | | Risk Register | Six month risk review | continue to work locally with practices and across other boards at both regional and national level to ensure good exchange of data, and support comprehensive recruitment and retention strategy. good success with returners scheme (NES) with 3 successful returners, 4 career start pots recruited, development of a national standard GP salaried contract progressing. | 04/07/2017 | | High Priority |

**Notifications**

| Recipient Name | Recipient E-mail | Date/Time | Contact ID | Telephone Number | Job title |
|---|---|---|---|---|---|
| Watts, Michelle | michelle.watts@nhs.net | 11/08/2016 10:48:12 | 290 | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Associate Medical Director - Primary Care Verifier for NHS Tayside |

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**Message**

| **Message history** | | | |
|---|---|---|---|
| **Date/Time** | **Sender** | **Recipient** | **Body of Message** |
| **No messages** | | | |

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

**Item 11**

**BOARD12/2017**
**Tayside NHS Board**
**23 February 2017**

**STRATEGIC RISK**
**WAITING TIMES AND REFERRAL TO TREAT (RTT) TARGETS**

## 1. STRATEGIC RISK

Waiting times for treatment in Scotland are a key priority for all NHS Boards. As a minimum 90% of patients accessing acute secondary care services can now expect to be treated within 18 weeks from the receipt of their referral to the start of their treatment. This is underpinned by standards for the maximum length of wait for a first outpatient appointment and also for an inpatient or day case appointment for admission. The Patient Rights (Scotland) Act 2011 enshrines in law that, once a patient has been diagnosed as requiring inpatient or day case treatment, and has agreed to that treatment, that patient's treatment must start within 12 weeks of the treatment having been agreed with the Health Board.

The current waiting time standards are

- 12 week Treatment Time Guarantee
- 12 weeks for new outpatient appointments
- 6 weeks for the eight key diagnostic tests and investigations
- 18 weeks Referral to Treatment for 90% of patients
- 95% of patient referred with an urgent suspicion of cancer will be treated within 62 days of their referral
- 95% of patients diagnosed with cancer will be treated within 31 days of their diagnosis

### Treatment Time Guarantee (TTG) – Waiting Time Legal Right

The Treatment Time Guarantee (TTG) requires all eligible patients to have an individual maximum wait of no more than 84 days for inpatient / day case treatment. NHS Tayside must ensure that all patients receive a reasonable offer of treatment which is set out in the National Waiting Times Guidance and NHS Tayside's Access and Waiting Times Guidance Policies. All patients who are not offered reasonable offer of treatment within 84 days from agreeing this with their clinician receive a letter indicating the reason for the breach.

## 2. CURRENT PERFORMANCE

### TTG

The number of patients within NHS Tayside that have breached their personal TTG, and were still waiting to be admitted at the end of November 2016 was 1013. The trajectory submitted through our Local Delivery Plan (LDP) was to have 930 patients waiting over 84 days as at the end of November 2016, therefore performance is currently 83 adrift of plan.

Funding has been aligned to interventions across orthopaedics, general surgery, urology, plastic surgery, ENT, gynaecology, neurosurgery and vascular surgery in order to support service delivery.

This includes additional in house activity, a see and treat contract with Golden Jubilee National Hospital for orthopaedic foot and ankle patients and the outsourcing of some activity for general surgery and gynaecology.

Orthopaedics is the speciality with the greatest volume of patients waiting over 84 days and whilst interventions planned for the year have been implemented, unplanned absence of a number of key staff has further impacted on waiting times for patients.

There was also an unforeseen deterioration in ophthalmology performance that led to an increase in waits due to the need to relocate Intravitreal (IVT) injections from a procedure room to theatre, displacing cataract procedures. This change resulted in 58 patients waiting greater than 84 days. The service has subsequently put in place mitigating actions and has reduced the current queue to 26 patients waiting over 84 days.

**New Outpatient Waiting Times**

The number of new outpatients waiting over 12 weeks at the end of November 2016 was 5036. Current performance is currently 1,778 adrift from the trajectory submitted through the LDP. Whilst behind trajectory, the November position demonstrates an improved performance over the past three months.

The specialities that are currently contributing to this deviation from our forecast position are:

Gynaecology, 630 more than planned. The speciality has struggled with vacancies and unplanned absences impacting on capacity. This has meant there has been limited ability to deliver additional in house activity as was planned at the start of 2016-17 leading to a continued growth in the number of patients waiting over 12 weeks. Additional funding has been received from Scottish Government to allow NHS Tayside to contract with the independent sector to see 300 patients during January to March 2017.

Gastroenterology, 431 more than planned. A new consultant commenced with the speciality in August and has successfully supported stabilisation of the current waits over 12 weeks. Funding has been received from Scottish Government to allow NHS Tayside to contract with the independent sector to see 500 patients during January to March 2017 which would support a significant reduction in the current queue.

General Surgery, 406 more than planned. The speciality were unable to deliver additional activity in house as planned at the start of 2016-17 leading to an increase in the number of patients having to wait over 12 weeks. Funding has been received from Scottish Government to allow NHS Tayside to contract with the independent sector to see 240 patients which would support a significant reduction in the current queue.

**Diagnostic 8 key tests waits > 6 weeks**

The number waiting over six weeks for diagnostic tests at the end of November 2016 was 153, an improvement on the position at the end of April 2016 when there were 417 patients waiting more than six weeks. Whilst positive improvement has been shown throughout the year, this position places NHS Tayside 84 patients

behind the trajectory submitted through the LDP. This is largely due to waits for colonoscopy which whilst improved, have not reduced to 0 over six weeks as had been forecast. Additional activity is still scheduled to take place throughout January to March 2017 and it is anticipated that the position at the end of March will be 88 patients waiting over 6 weeks as originally forecast.

**Cancer Waiting Times**

In October 2016 both the 31 and 62 day standards were not met. The two sites that consistently breached both the 62 and 31 day pathway in October 2016 were urology and breast.

Challenges remain with the urology pathway due to having a single handed consultant for laparoscopic prostatectomy The service is therefore relying on the support of two locum consultants and sessions from a retired consultant to support service delivery.

Breast has experienced delays associated with staff sickness absence in breast surgery and radiology and associated whole patient pathway demand fluctuations. The service has now returned to surgeon and radiologist complement, and is anticipating performance to improve towards January 2017

**18 weeks Referral to Treatment**

In October 2016, 84.4% of patients were treated within 18 weeks of referral. 18 week performance is intrinsically linked to TTG and OP performance, therefore further improvements are not anticipated until such time that there is evidence of sustained improvements in TTG and OP performance.

**3. Performance Monitoring and Service Planning**

Directorate service planning meetings have taken place during November and December 2016. These meetings have focused on monitoring performance against standards and future service planning and delivery based on predicted activity, workforce availability and profiles for 2017/18.

Services are identifying what service improvements, including efficiency and productivity activities, will be undertaken to ensure the best and most appropriate use of resources to meet service demand.

Regular meetings are ongoing with services through the revised governance structure and framework that was implemented earlier this year. These meetings enable regular review of progress against service plans and performance against trajectory. They also allow for any variance from plan to be identified early and suitable mitigating actions to be identified.

Regular meetings continue with the Access Support Team and Cancer Delivery Team at Scottish Government.

## 4. CONCLUSION

The Current Risk Exposure Rating remains unchanged, as the overall performance position has not changed, and capacity shortfalls have been identified across a range of specialities, this gives a current risk Level of High (15).

A new quarterly review date has been added.

## 5. REPORT SIGN OFF

**Ms L Wiggin**
**Chief Operating Officer**

**Ms L McLay**
**Chief Executive**

**Dr A Cook**
**Medical Director, Operational Unit**

**February 2017**

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

**BOARD13/2017**
**Tayside NHS Board**
**23 February 2017**

# STRATEGIC RISK INFECTION MANAGEMENT

## 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 | January 2017 |

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 attached DATIX report. These principally reflect the current mechanisms and actions that are being taken by the Infection Control and Management Team within NHS Tayside. The Infection Control and Management Annual Work Plan for 2017-18 has been aligned to the national Scottish Antimicrobial Resistance and Healthcare Associated Infection (SARHAI) Delivery Plan.

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 and 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**

**Ms L McLay**
**General Manager**

**Mrs G Costello**
**Nurse Director**
**HAI Executive Lead**

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

**Item 11**

**BOARD14/2017**
**Tayside NHS Board**
**23 February 2017**

## STRATEGIC RISK – HEALTH EQUITY

### 1. STRATEGIC RISK

In 2010 Tayside NHS 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 |

The Board is 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 and are being reported regularly to the IJB Boards.

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 Board 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 the Dundee Partnership Fairness Commission Action Plan 2017- 2020
- Tayside NHS 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.
- Public health colleagues have been participating in the development of a health equity strategy in Perth and Kinross IJB. The final draft will have been

reviewed by the end of January 2017. Public Health are supporting the production of the final version.

- Following Ms McLay's attendance at a senior officer meeting it was agreed to hold a 'Leadership in Action' event within Public Health on 10 January 2017. This session showcased four significant pieces of service transformation work that had achieved their objectives by successfully utilising the principles of service improvement methodology, co-production, advocacy, data interpretation and distributed leadership to achieve the outcomes of improving local population health by establishing evidence based initiatives, maximising efficiency and promoting health equity.
- Routine meeting dates for the 2017 Health equity Governance Board will be issued by the Director of Public Health.

## 5. CONCLUSION

The actions contained within the Internal Audit Action Plan are now complete and will be 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. This diagram is being used as the assessment tool to identify future gaps against as it directs plans towards the themes of; 'undo', 'prevent', 'mitigate'. Following the 'Leadership in Action' session within Public Health the directorate are currently mapping the seven strands of the Transformation Programme and will use the diagram to aid an assessment of where a public health approach can support service improvement and identify health equity improvement opportunities.

Discussions are being held with NHS Tayside's transformation programme lead officer regarding how the public health staff can input into and support the outcomes of the programme.

## 7. REPORT SIGN OFF

**Dr D Walker**
**Director of Public Health**

**Ms L McLay**
**Chief Executive**

**February 2017**

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

**Item 11**

**BOARD15/2017**
**Tayside NHS Board**
**23 February 2017**

**STRATEGIC RISK**
**CAPACITY AND FLOW**

## 1. STRATEGIC RISK

NHS Tayside's Board Assurance framework has a corporate risk related to Perth Royal Infirmary. This risk is that there is insufficient resilience at Perth Royal Infirmary to cope with fluctuations in unscheduled demand and the level of delayed discharge. There is a risk therefore patients will:

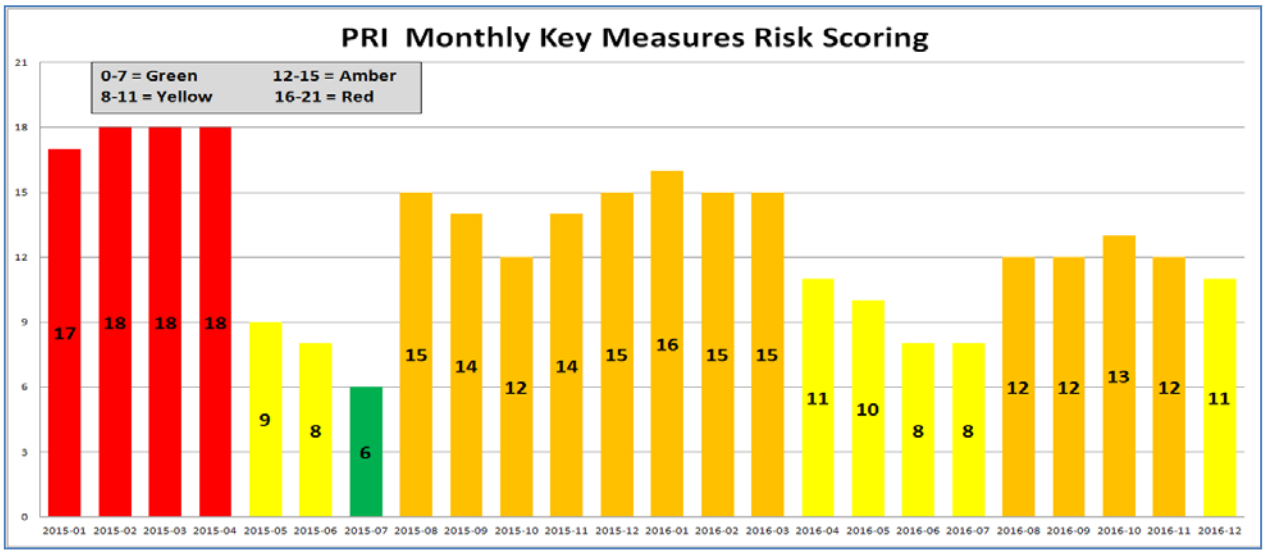
- Not have access to the right care, in the right place, at the right time
- Experience harm from waits for a bed
- Be cancelled for elective procedures
- Experience harm and delay through being treated and cared for out with specialty
- Be diverted to Ninewells Hospital when bed capacity is exhausted.

This could result in reputational damage to the organisation as a result of being unable to fulfil its commitments to patients, organisational objectives and achieve its HEAT targets and standards.

An agreed set of key measures are reported to monitor this risk and the impact of the mitigating actions. A scoring system has been developed for the key measures to enable an overall risk score to be presented. The measures and the risk score are used to inform the risk stratification score. This was presented and endorsed at the Clinical and Care Governance Committee on 12 May 2016.

## 2. CURRENT PERFORMANCE & REPORT DETAIL

The scoring is based on a scale of 0 to 3 for each measure: 0 represents the most positive position and 3 represent the highest risk level. The scoring system has been applied to 7 indicators, giving a total possible score of 21. In December 2016 the score across all the metrics is 11(Yellow).




**Measure 1 - A&E: Number of 4 hour breaches and percentage performance**

Over the past 24 months compliance with the 4 hour standard within A&E at Perth Royal Infirmary has been positive with the 95% target always being met. In the past 3 months (Oct-Dec 2016) there have been **108** patients who had to wait longer than 4 hours, compared to **83** who breached over the same period in 2015. The scoring agreed for this measure is as follows: <90% = 3 points, 90-94.99% = 2 points, 95-97.9% = 1 point, ≥98% = 0 points, which would mean that the **December score achieved is 1.**

**Measure 2 - Number of waits for a bed experienced each month**

From November 2014 to July 2016 there had been a steady fall in the number of patients having to wait on a trolley or in a chair before their admission to a bed following transfer from A&E. From July to December 2016 the number of patients started to increase again, with a drop only in the month of November 2016. In the past 3 months (Oct-Dec 2016) there have been **166** patients who had to wait on a trolley or in a chair compared to **158** patients over the same period in 2015. The scoring agreed for this measure is as follows: ≥41 = 3 points, 21-40 = 2 points, 1-20= 1 point, 0 = 0 points, which would mean that the **December score achieved is 3.**

**Measure 3 - Bed Occupancy**

There is evidence of seasonal variation in bed occupancy rates at Perth Royal Infirmary over the past 24 months. In the past 3 months (Oct-Dec 2016) there has been an occupancy rate of 74%, 69% and 61% compared to 84%, 90% and 88% during the same period in 2015. The scoring agreed for this measure is as follows: >90% = 3 points, 86-90% = 2 points, 81-85% = 1 point, ≤80% = 0 points, which would mean that the **December score achieved is 0.**

NB - The current measure focuses on occupancy at midnight and work is underway to review identify if monitoring occupancy at either midday or 4pm may be a more appropriate measure for identifying any risks within the system.

**Measure 4a - Patients in Inappropriate Locations – Boarding Bed Days in the Month**

There is evidence of some seasonal variation in the average number of bed days lost per month due to boarding over the past 24 months. Surgical boarding is very low with medical boarding more prevalent as a result of challenges meeting the medical demand. This peaked in March 2015 followed by a significant decline in May 2015. From May 2015 through February 2016 the numbers showed an upward trend, decreasing steadily over the last 5 months from February to June 2016 before increasing again each month from July to October 2016 (24 days). Numbers then decreased in November and again in December (16 Days). The scoring agreed for this measure is

as follows: ≥30 = 3 points, 16-30 = 2 points, 1- 15 = 1 point, 0 = 0 points, which would mean that the **December score achieved is 2.**

**Measure 4b - Patients in Inappropriate Locations – Delayed Discharges: No. of patients and bed days lost. Medicine Directorate and Surgical Directorate**

Patients experiencing a delayed discharge remain one of the main factors impacting on capacity and flow within Perth Royal Infirmary. From a 24 month low in June 2015, the number of individual patients delayed and the number of bed days lost to delays has continued to increase. In the past 3 months (Oct-Dec 2016) the average number of patients experiencing a delay each month was 52 compared to 43 over the same period in 2015, and the number of bed days lost in the past 3 months was 1100 (equivalent of 12.0 beds) a decrease of 193 bed days from 1293 (equivalent of 14.1 beds) in the same period in 2015. The scoring agreed for this measure is as follows: ≥23 Patients = 3 points, 11-23 Patients = 2 points, ≤10 Patients = 1 point, 0 Patients = 0 points, which would mean that the **December score achieved is 3.**

**Measure 4C - Patients in Inappropriate Locations – Stroke patients not in the stroke ward within 24 hours**

The number of stroke patients who had stays outwith the stroke ward, therefore spending time within a potentially inappropriate location for one or more days. It should be noted that there may be occasions where it would not have been appropriate to transfer a patient to the stroke ward i.e. if they were clinically unstable. In the past 3 months (Oct-Dec 2016) 8 patients spent time outwith the stroke ward compared to 14 over the same period in 2015. At present, no scoring has been identified for this measure.

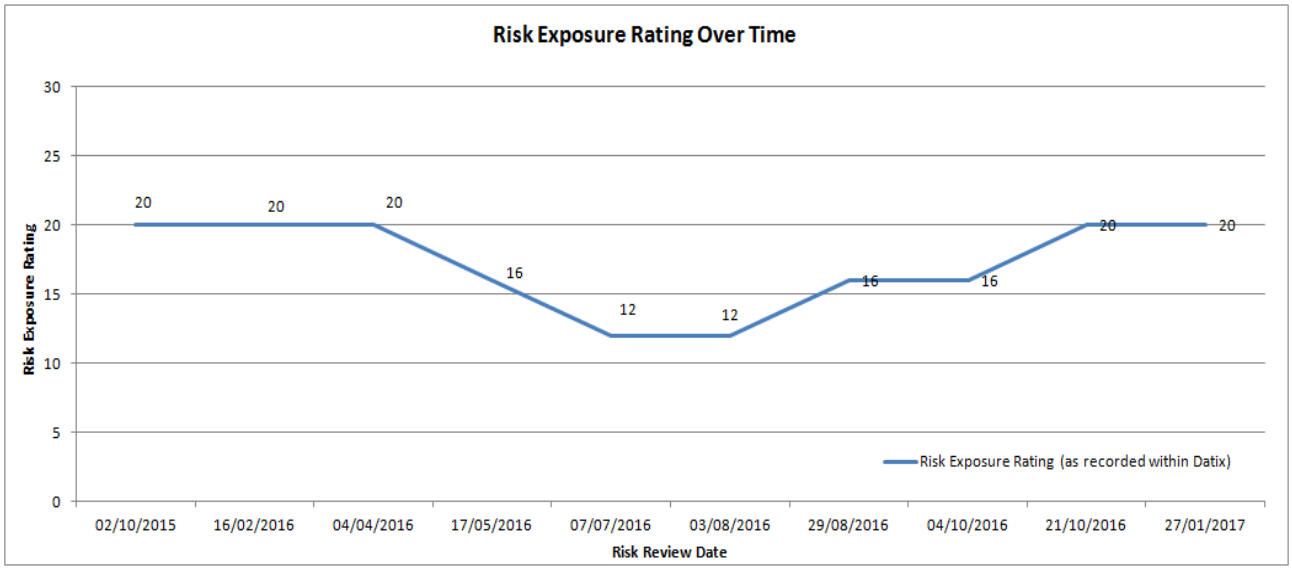
**Measure 5 - Elective Cancellations due to Bed Pressures**

The number of elective cancellations due to bed pressures has seen significant improvement since collection of this data formally began in January 2015, although there was an increase in both October and November 2016. In the past 3 months (Oct-Dec 2016) there were 37 cancellations due to bed pressures compared to 55 over the same period in 2015. December 2015 had 38 cancellations compared to only 1 in December 2016. The scoring agreed for this measure is as follows: ≥9 = 3 points, 5-8 = 2 points, 1-4 = 1 point, 0 = 0 points, which would mean that the **December score achieved is 1.**

**Measure 6 - Nursing Bank and Agency Usage**

Nursing bank and agency usage data is currently available from December 2014 onwards. The information available shows variation in the overall number of WTEs accessed via agency and bank. In the past 3 months (Oct-Dec 2016) there were 146.7 WTE weeks accessed via bank and agency compared to 146.2 WTE weeks over the same period in 2015. The scoring agreed for this measure is as follows: ≥72wte = 3 points, 71-48wte = 2 points, 47-24wte = 1 point, 23-0wte = 0 points, which would mean that the **December score achieved is 1.**

The risk exposure rating as recorded within Datix is provided in the graph below. This is based on the risk score from the above measures and local intelligence of the resilience on the PRI site.




## 3. ASSURANCE

The leadership teams at PRI and the Perth and Kinross Health and Social Care partnership continue to work collectively to assess the daily risk and proactively take action to mitigate this where possible.

### Assessment of Overall Risk Rating

Although the risk score from the key measured reduced from 12 in November to 11 in December, other factors have influenced the overall risk rating that has been recorded within DATIX for the strategic risk. In December 2016 although there had been a reduction in the number of patients experiencing a delayed discharge compared to the October 2016 position, this continues to impact on the level of patients boarding and patients waiting for a bed.

An additional factor affecting resilience of the PRI site is the high number of Registered Nurse vacancies and maternity leave in some wards, mainly Tay Ward, Stroke Ward, and 2 medical wards, Wards 3 and 6. The high number of vacancies exists despite the recruitment of 24 Newly Qualified Registered Nurse Practitioners to the site in November.

It is expected that there will be a continued risk that there is insufficient resilience at Perth Royal Infirmary to cope with fluctuations in unscheduled demand and patients experiencing a delayed discharge. The introduction of the Discharge Hub Model with a Senior Nurse Team Lead seeks to mitigate this risk along with ongoing review of Care at Home Services, Capacity & Flow Improvements.

The risk exposure rating therefore remained at 20.

## 5. CONCLUSION

The Board is asked to note the performance against the key measures and current risk exposure rating score.

## 6. REPORT SIGN OFF

**Ms L Wiggin**
**Chief Operating Officer**

**Ms L McLay**
**Chief Executive**

**Dr A Cook**
**Medical Director, Operational Unit**

**February 2017**

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

**BOARD16/2017**
**Tayside NHS Board**
**23 February 2017**

**STRATEGIC RISK**
**NHS TAYSIDE ESTATE INFRASTRUCTURE**

## 1. STRATEGIC RISK

NHS Tayside Estate infrastructure condition.

## 2. 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) to address infrastructure needs.

Given the age and design of the existing estate infrastructure, NHS Tayside must ensure appropriate consideration is given to the ongoing investment need to facilitate the effective delivery of not only the existing key facilities but also give due consideration to its ability to accommodate future demand, site expansion and service change.

Following a meeting held on Thursday 4 August 2016 between the Scottish Government (Alan Morrison and Yvonne Summers), Scottish Futures Trust (Colin Proctor) and Health Facilities Scotland (John Connelly) in relation to NHS Tayside's Initial Agreement paper detailing the investment need for electrical infrastructure on the Ninewells site, there has been several discussions with HFS and the Senior Technical Officer within the Property Department to agree a preferred design option that complies with current SHTM06, provides assurances that there will be resilience in relation to service delivery and business continuity and within timescales that reduce the risk likelihood.

The development of the Initial Agreement is ongoing with an updated draft version being submitted to HFS for consultations in January 2017. A design option appraisal was carried out and identified a preferred design option for Zone 1 (Polyclinic) that has been agreed by HFS Principle Engineer because it provides the agreed benefits and it allows for future proofing and resilience. The design strategy adopted for this preferred design will be similar for the majority of the blocks elsewhere on the Ninewells site. The Initial Agreement has been updated to reflect these recent discussions.

An external cost advisor has updated the high level budget cost to reflect the associated works required for the preferred design option for Zone 1 (Polyclinic). High level indicative budget cost for Zones 2 – 11 have also been included in the draft Initial Agreement.

In addition to the design options there has been dialogue with HFS to set up a meeting in January 2017 to progress the development of a site Masterplan for Ninewells Hospital. A site Masterplan development group will be set up and will include representations from NHS Tayside, HFS, SFT and the Scottish Government to establish a strategic vision for services on the Ninewells site. The outcome of this Masterplan will be summarised into the Initial

Agreement to ensure NHS Tayside can provide assurance to the Scottish Government that there will be resilience in relation to service delivery and business continuity.

Further to approval of the Initial Agreement, an Outline Business Case and Full Business Case will also be required to be developed and submitted through NHS Tayside governance approval routes and CIG for final approval.

## 3. ASSURANCE

- Update reports to each meeting of Capital Scrutiny Group in relation to either project status or emerging demands
- Infrastructure Recommendation paper to Directors
- Infrastructure Recommendation paper to F&R Committee - 15 October 2015
- Infrastructure recommendation to Tayside NHS Board - 25 February 2016
- Demands into Capital Investment programme and property and asset management strategy (PAMS) document
- Head of Property attends each meeting of Finance and Resources Committee

## 4. REPORT DETAIL

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.

## 5. CONCLUSION

The revised draft Initial Agreement has been updated to reflect the ongoing discussion with NHS Tayside Technical Officers and HFS Principle Engineer. The revised draft Initial Agreement will be sent to HFS (John Connelly) in January 2017 to allow consultations with HFS colleagues on the preferred technical design option.

In the meantime work on the Masterplan will continue to ensure NHS Tayside can meet the Scottish Governments expectations. This will involve working closely with HFS, SFT and Scottish Government over the coming months to ensure a strategic Masterplan can be developed for Ninewells Hospital.

A date has been scheduled for the Masterplan development group and once NHS Tayside receives feedback from HFS on the draft Initial Agreement and preferred technical design option, a further update will be provided.

## 6. REPORT SIGN OFF

**Mr M Anderson**
**Head of Property**

**Ms L McLay**
**Chief Executive**

**Ms L Wiggin**
**Chief Operating Officer**

**February 2017**

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

**Item 11**

**BOARD17/2017**
**Tayside NHS Board**
**23 February 2017**

**STRATEGIC RISK**
**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 | Dec 2016 |
|---|---|---|---|---|---|---|---|
| 353 | Sustainable Primary Care Services | Chief Officer Angus HSCP | 20<br>(5x4)<br>Very High | 12<br>(4x3)<br>High | 12<br>(4x3)<br>High | 12<br>(4x3)<br>High | 9<br>(3x3)<br>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

A number of posts have been successfully recruited to including career start posts to support practices and OOH. There are also a number of national working groups ongoing which Tayside are heavily involved in. 2c practices and OOH are now stabilising, and we plan to continue to build on this over the coming 12 months.

There remains a risk that other practices may still run into difficulties- this is being proactively monitored and managed using the Sustainability Framework

## 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 implemented as part of the Angus Health and Social Care Partnership who host Primary Care
- 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 continue to be discussed and agreed via the newly established Tayside Primary Care Strategic Development and Transformation Board.

## 7. REPORT SIGN OFF

**Mrs V Irons**
**Chief Officer**
**Angus Health & Social Care Partnership**

**Ms L McLay**
**Chief Executive**

**February 2017**

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

**Item 12**

**BOARD01 /2017**
**Tayside NHS Board**
**23 February 2017**

**CMO (2015) 19 LETTER - HEALTH PROMOTING HEALTH SERVICE (HPHS): ACTION IN SECONDARY CARE SETTINGS**

**Year 1 2015/16 Reporting and Feedback from NHS Health Scotland**

## 1. SITUATION AND BACKGROUND

The previous action required for HPHS was directed through two Chief Executive Letters (2008 and 2012) and significant change has been achieved over time, e.g. implementation of the Healthy Living Award +, the introduction of smoke-free grounds and commitment to healthier food and retail outlets in hospitals.

The ethos of HPHS is that *'every healthcare contact is a health improvement opportunity'* - although this applies to patients and visitors, the promotion of staff health and wellbeing is equally central to the HPHS vision.

The first CMO Letter for HPHS was issued to Chief Executives in October 2015 and details the key responsibility for promoting health and wellbeing within the hospital setting. HPHS applies to all acute, mental health, maternity, paediatric and community hospitals. Clinicians, managers, estates, human resources, finance and procurement colleagues all have leadership roles with respect to HPHS.

The CMO Letter asks Chief Executives to support the continued implementation from 2015 to 2018 of HPHS, and to ensure that there are clear lines of responsibility and accountability for its delivery and that their Health Board is kept informed of progress.

Nationally, HPHS is guided by a Ministerial Group (Professor John Connell and Dr Drew Walker are the Board Chairperson and Director of Public Health representatives on this group), a Lead Officers' Network (NHS Tayside is represented by Lesley Marley, Directorate Manager, Public Health) and the HPHS Champions' Group comprising a non-Executive Board Member from each Territorial Health Board in Scotland (Munwar Hussain represents NHS Tayside). Locally the work is led by an operational steering group, chaired by Lesley Marley.

## 2. ASSESMENT

NHS Tayside's HPHS Report for 2015/16 (Appendix A), based on the national monitoring framework, was submitted as required in September 2016. The monitoring framework comprises actions around:

Strategic Actions
Smoking
Alcohol
Maternity
Food and Health
Staff Health and Wellbeing
Reproductive Health
Physical Activity and Active Travel
Managed Clinical Networks
Inequalities and person-centred care
Mental Health

The Feedback Letter and Report from NHS Health Scotland (Appendices B, C) were issued 23 January 2017. A summary follows:

The positive impact that NHS Tayside HPHS Ministerial Group representatives have had in supporting and embedding the HPHS ethos at a strategic level locally is recognised; role of the HPHS Champion is also important.

Specific achievements in 2015/16 noted in the Feedback Report include:

- The comprehensive approach taken across tobacco actions; including communication on smoke-free grounds, support and training for staff which has led to an increase in capacity to deliver smoking cessation on wards and the number of pathways in place to support stop smoking services.

- The quality improvement work being undertaken in relation to breastfeeding.

- The positive impact that food and health measures have had; including the influence on environmental developments such as the proposed concourse redesign at Ninewells and the continuation of the 100% healthy drinks initiative Drinks4Health.

- The greenspace and active travel work taken forward in NHS Tayside is noted as an example of good practice the learning from which should be applied across all sites.

We need to sustain and deepen our commitment to HPHS, and continue to drive forward actions in three key areas: staff health and wellbeing; a health promoting environment where healthier choices are the norm; and person-centred care with a focus on addressing inequalities.

In 2016/17 the Feedback Report encourages NHS Tayside to:

- Work with the local Integration Joint Boards to raise awareness of HPHS and embed it within local plans.

- Build-in the measurement of impact of HPHS within relevant strategic, or commissioning and implementation plans.

- Continue to work to achieve the Healthcare Retail Standards (HRS) – it is noted that progress is impeded where longstanding contracts are in place, but note the positive impact that the target date of achieving HRS compliance is having on negotiations.

- Collect data for a range of measures indicators, including staff wellbeing indicators and not just sickness absence rates.

- Measure and analyse staff uptake of physical activity programmes; in particular the uptake by staff grouping to identify those utilising the activities to help inform targeted interventions.

## 3. RECOMMENDATIONS

The Health Board is asked to note progress in the implementation of CMO (2015) 19 Letter HPHS.

## 4. REPORT SIGN OFF

**Dr D Walker**
**Director of Public Health**

**Ms L McLay**
**Chief Executive**

**February 2017**

# HPHS Reporting Template: CMO (2015) 19 letter

**All annual report evidence submissions should report on actions undertaken between April1st 2015 - March 31st 2016.**

**Required submission details:**

| | |
|---|---|
| **NHS Board** | **NHS Tayside** |
| **Submission Date** | **30 September 2016** |
| **HPHS Lead** | **Lesley Marley, Directorate Manager Public Health** |
| **Contact email address** | **lesley.marley@nhs.net** |
| | |
| List all hospital sites represented within the submission (specified by site category) | |
| Acute | Ninewells Hospital, Dundee<br>Perth Royal Infirmary (PRI)<br>Stracathro, Brechin |
| Community | Dundee Dental Hospital<br>Royal Victoria Hospital, Dundee<br>Whitehills, Forfar<br>Arbroath infirmary<br>Brechin Infirmary<br>Montrose Infirmary<br>Crieff Community Hospital<br>Blairgowrie Community Hospital<br>Aberfeldy Community Hospital<br>Pitlochry Community Hospital<br>St Margaret's Community Hospital, Auchterarder |
| Maternity | Acute Maternity Unit Ninewells.<br>Community Midwife-led Maternity units in Ninewells, PRI, Arbroath Infirmary and Montrose Infirmary. |
| Paediatric | As part of Ninewells Hospital Dundee |
| Mental health | Murray Royal Hospital, Perth |
| | |
| Hospital sites not included in this reporting (specify category as above) and brief rationale | All our hospital sites are represented in some capacity i.e. all are covered under the NHS Smoking Policy; many are registered with Healthy Working Lives participation, some are required to attain HLA+ , some sites have vending that must comply. |

**Summary questions**

1. Describe what **went well** in the delivery of HPHS in 2015/16 and provide examples:

The CMO Letter was a catalyst to enhanced interest in HPHS; had it been another CEL it would have not provided such traction. The day it arrived within the CE's office it was issued by them to relevant Directors to seek their 'sign-up' and acknowledgement of their required actions. This had not, to my knowledge, happened in the past with the previous two CELs.

All areas required for HPHS monitoring have achieved progress as per targets set as reflected in the individual sections that follow.

The NHS Tayside HPHS Steering Group, which is an operational level group, has worked well together to continue a network approach. The topic leads all provided their monitoring data on time and the new Word format of the document has been more user-friendly. We have increased our membership (which for many years has been predominately Directorate Public Health colleagues) to include Allied Health Professional (AHP) colleagues and we benefitted from a very 'hands-on' HPHS Champion, Penny Campbell, who attended our meetings and motivated the work of the Group.

Penny, for the majority in 2015/16 was instrumental in enhancing the profile of HPHS in Tayside with the Chairman and Tayside.NHS Board. Through this enhanced engagement at a strategic level I was able to capitalise on conversations to which previously I had not been party. In December 2015 I was able to ensure HPHS and Public Health's influence to the work that was underway (without our involvement) to refurbish the concourse at Ninewells. I facilitated the formation of a multi-disciplinary group, chaired by the Director of public Health that now guides our colleagues in Property in their dealings with contractors. We are now assured that HPHS requirements will be embedded in any future contracts with service providers i.e. catering/retrial standards/person-centred approaches.

With helpful input from our Director of Public Health, in December 2015 we were given a unit on Ninewells concourse to house an Advice Centre to provide welfare/benefit advice and other person-centred help e.g. volunteering/carers' advice. This will open in late 2016 and will be multiagency operated and funded. It will be a pilot with a view to offering the same model in Perth Royal Infirmary in the future.

2. Describe **barriers to progressing** the delivery of HPHS in 2015/16 and describe how you have, or plan to overcome them:

The late issue in October 2015 of the monitoring framework was an inhibitor, but as many colleagues have been with the HPHS programme since 2008 we were able to overcome any apathy and motivate at least a 'business as usual' approach until all was clear.

In June 2015 HPHS lost a 20 hour Band 6 HPHS Development Worker post to efficiency savings. We have overcome this, in part, by ensuring only action notes are taken from Steering Group meetings and I have been able to distribute some tasks to other colleagues in the Directorate of Public Health i.e. the HPHS Small Grant Scheme administration.

We began to work with the commercial café owner on the concourse at Ninewells to ensure their understanding of the HCRS. The 2017 deadline for compliance has been both a catalyst and barrier as progress can creep along March 2017 looms.

3. Describe how you have **built on activity** reported in previous years.

The HPHS monitoring since 2012 has allowed us to chart progress and implement improvement plans where required. It has ensured that the HPHS actions are embedded in the objectives of topic/settings and in particular it has allowed us traction around creating a person-centred, health promoting environment both inside our hospitals and in the wider green-space. Each year we strive to surpass previous progress and spread the ethos as wide as is possible.

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Section A: Strategic Actions

Section B: Smoking

Section C: Alcohol

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Section E: Food and Health

Section F: Staff Health and Wellbeing

Section G: Reproductive Health

Section H: Physical Activity and Active Travel

Section I: Managed Clinical Networks - NEW

Section J: Inequalities and person-centred care - NEW

Section K: Mental Health - NEW

Section L: Innovative and Emerging Practice

Appendix A**:** Add any additional contributors for each section

**Strategic Actions:** Lead contributor

| | |
|---|---|
| Name | **Lesley Marley** |
| Job Title | **Directorate Manager, Directorate of Public Health** |

| **Section A: Strategic Actions** | | | | |
|---|---|---|---|---|
| **Action 1** | Chief Executives are asked to delegate responsibility for implementation to the appropriate committee and governance structures and to provide a report to the Board on progress.<br>• This should account for new health and social care integration structures.<br>• Role of Facilities Managers and HR Directors should be integrated into HPHS delivery. | | | |
| **A.** Named executive lead for delivery of the actions within this letter and their role. | CMO Letter was circulated in October 2015 to the following by the CE's office for their action:<br>Andrew Russell, Medical Director<br>Gillian Costello, Director of Nursing<br>Drew Walker, Director of Public Health<br>Ken Armstrong, Director of Operations<br>Vicky Irons, Chief Officer, Angus Integration Joint Board (IJB)<br>David Lynch, Chief Officer, Dundee IJB<br>Rob Packham, Chief Officer, Perth and Kinross IJB | | | |
| **B**. Description of plans or developments with Health and Social Care Integration Boards | Director of Public Health sits on all three of our IJBs. There was no explicit overall HPHS plan for 2015/16; 2016/17 will see its spread.<br><br>Tayside's Tobacco Plan went through the three local authorities and IJB's. Local authorities are reviewing their policies in line with the guidance sent out from COSLA and there is a willingness to align it to the NHS Tayside's Smoking Policy. | | | |
| **C.** Named Health Facilities Lead(s) to support measures for vending, catering and the provision of green space developed to enable physical activity | (Interim) Mark Anderson, Head of Property, in the absence of Mark Scholes, Head of Site/ Support Services(NHS Tayside). | | | |
| **Action 2** | The attainment of generic health behaviour training, including inequalities training.<br>Please ensure any duplicate reporting on staff training in relation to specific evidence requirements for physical activity and mental health are referenced within the submission. | | | |
| | Name of module or course | Course description & method of delivery | professional role | Number and proportion |
| **A.** Hospital-based staff completing | Health Behaviour Change | Two and a half day face-to-face | Nursing<br>Support staff<br>Physiotherapists | 9<br>5<br>11 |

| | | | | |
|---|---|---|---|---|
| health behaviour training, including training on inequalities | Introductory | | Occupational Therapist<br>Dietitians<br>Clinical Services Manager<br>Health Promotion Officer<br>Speech & Language Therapist<br>Chaplain | 1<br>3<br>1<br>1<br>1<br>1 |
| | Health Behaviour Change Level 2 Course, extending knowledge and skills in relation to helping people change. | Two and a half day face-to-face | Nursing<br>Dietitian<br>AHP Support Worker | 2<br>1<br>1 |

| | |
|---|---|
| **Action 3** | Clinical and medical leadership |
| **A.** Description of clinical and medical leadership responsible for delivery of health improvement in a specific clinical area (include successes & challenges) | Professor John Connell, Chairman Tayside NHS Board, Professor Andrew Russell, Medical Director NHS Tayside, Dr Drew Walker, Director of Public Health, NHS Tayside and Professor Annie Anderson, Professor in Dietetics, University of Dundee are all members of HPHS Ministerial Group and contribute to embedding the HPHS ethos at a strategic/Board level along with giving local leadership to HPHS. This has been very helpful allowing us to operationalise effectively.<br><br>In addition, in 2015/16 HPHS benefited from the input of Dr Rod Mountain, ENT Consultant and Healthcare Design and Innovation Lead within the Academic Health Science Partnership in Tayside (AHSP). He has championed to create opportunities for patient engagement in the design and development of a redesigned concourse for Ninewells. He has encourage a patient centred approach through a design-lead approach with Duncan of Jordanstone College of Art and Design whose students will inform the development of a patient engagement hub at Ninewells. He, along with Professor Annie Anderson, Joyce Thompson Dietetic Consultant in Public Health Nutrition and Dr Drew Walker, has challenged the current nutritional quality of services offered on the concourse and in our canteens. Healthy food, exercise options and a more creative approach to creating wellness is their aim. |
| **B.** Evidence of sustained health improvement practice by clinicians | Quality improvement activities are an essential part of the consultant appraisal documentation and are discussed in appraisal meeting between Appraiser and Appraisee. Evidence is documented on the Form 4 and submitted to the Appraisal Lead and Medical Director, NHS Tayside. Across NHS Tayside many hospital |

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| | consultants support progression of HPHS work e.g. pre-assessment clinic staff work around smoking cessation and physical activity Brief Intervention/Brief Advice. Given their leadership role in the NHS it is our vision that all medical consultants embed the HPHS ethos in their work. We shall work towards this goal by engaging further in relevant clinical fora, improving communication and inputting to their CPD activities. |
| **Action 4** (NEW) | Assessment of impact of HPHS CEL (1) 2012 and CMO letter, and forward planning |
| **A.** Evidence of the impact of strategic actions, including assessment of impact across person-centred care, staff health and wellbeing and hospital environment. | The HPHS Steering Group membership has been instrumental since 2012 (actually, 2008) in ensuring the targets in the monitoring have been reached and where data have not been available, work-arounds or new collection systems have been created to ensure compliance. We have ensured that the relevant topic lead has been supported to be able to embed the HPHS work within their portfolios; moving annually with the expanded expectation of the monitoring framework. HPHS outcomes sit within relevant service improvement plans and are part of the Directorate of Public Health's performance framework 2015/16. After a gap in 2015 (due to committee changes), 2015/16's HPHS report will go to the Board 17 February 2017. |
| **B**. Briefly describe the intended / unintended consequences of the programme | An unintended consequence was that the introduction of a CMO Letter as opposed to previous CELs stimulated interest and understanding of the HPHS agenda across relevant strategic officers in NHS Tayside. Without a CEL or CMO Letter the journey towards a health promotion hospital would have been very much slower. |
| **C**. Briefly describe a forward plan for sustaining implementation of HPHS and inequalities focus in hospital settings | The HPHS Steering Group will be instrumental in taking forward the agenda in 2016/17.<br><br>The NHS Tayside Health Equity Strategy Governance group will be a vehicle to embed inequality focused work in the hospital setting. This group is chaired by our CE.<br><br>2016 will see the introduction of an Advice Centre at Ninewells to provide welfare/benefits advice.<br><br>Face-to-face training on poverty awareness will be rolled-out to staff in NHS Tayside. It is planned to include an appropriate question in the Nurse Documentation to help assess a patients' financial stability.<br><br>Work on health literacy will be progressed. |

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| **D.** Briefly describe plans to include HPHS in recent changes for health and social care integration | Our Director of Public Health sits on all three of our IJBs and 2016/17 will see HPHS embedded in its plans. All 3 Chief Officers were made aware in October 2015 of their lead role for HPHS in their IJB |

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section A: Strategic Actions**. Exception submitted:<br>[Limit each entry to 200 words] |
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| **2A** | **NHS Tayside Workforce Plan does not break down staff to the categories used by attendees registering on the course, so a meaningful proportion is not able to be calculated.** |

**Smoking:** Lead contributor

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| Name | **Margaret Winton** |
| Job Title | **Tobacco Control Manager, Directorate of Public Health** |

| **Section B: Smoking** | |
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| **Action 5**<br>Section B Smoking Guidance.docx | All smokers, on admission to hospital, are supported to manage their smoking, offered NRT, and encouraged to quit. Boards are asked to focus efforts on targeting specific settings including: respiratory, vascular, cardiac, diabetes, mental health, maternity and cancer. |
| **A (i)** Name of system used to record the smoking status for each patient | Nursing admission documentation (Multidisciplinary Record of Care Core Data Set) and is a manual process. |
| Provide the role of the person who records the smoking status for each patient. | Ward nursing staff and student nurses contribute to clerking in patients and recording of smoking status within Nursing Core Data set. |
| **A (ii)** Provide the number of smokers supported with NRT while in hospital | **940 = number of smokers who received NRT in hospital.**<br>Due to transient patients and readmissions a breakdown to specific settings is difficult to calculate. NRT prescriptions and breakdown recorded below. |
| If the above number is not known, note the number of prescriptions issued for NRT products | **1128 prescriptions of NRT given within hospitals**<br>Respiratory – 81<br>Vascular – 58<br>Cardiac - 152<br>Diabetes – not known due to recording systems<br>MH - 70<br>Maternity – 3<br>Cancer - 44 |
| **A (iii)** Provide the number of quit dates set in hospital. | **345 patients with quit attempts following hospital admission**<br>Respiratory – 33<br>Vascular –15<br>Cardiac - 54<br>Diabetes – not known due to recording systems<br>MH - 13<br>Maternity – 55<br>Cancer – 7 |
| If possible, provide this figure as a proportion of all smokers recorded in a hospital setting. | Total number of smokers admitted to hospital unknown due to manual recording systems. Providing this figure would be very labour/time intensive. |
| If the quit date is set for when the smoker returns home, indicate how they will be | If patient wishes to continue or start quit then discharge letter given to patient to |

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| supported once they are home. | take to their chosen community pharmacy for enrolment in stop smoking support. Some patients supported through specialist nurses i.e. stroke liaison and cardiac rehab or primary care teams such as health visitors. |
| **B.** Evidence of referral pathways to support smoking cessation pathways in the targeted settings | |
| List pathways in place or being developed. Include setting, targeting and if aligned to a Managed Clinical Network | Universal nursing pathway in place in all target areas except mental health.<br><br>Smoker's Inpatient Pathway – across all NHS Tayside inpatient areas<br><br>Nicotine Replacement Prescribing Guidance – used alongside Smoker's Inpatient pathway across all NHS Tayside inpatient areas.<br><br>Smokers' Outpatient Pathway – across all NHS Tayside outpatient/clinic areas<br><br>Mental Health Pathway in development.<br><br>Give It Up For Baby pathway (maternity) in antenatal clinics across NHS Tayside<br><br>Smoking part of Diabetes and Respiratory MCNs but pathways not aligned due to MCNs covering primary care and secondary care. Pathways are secondary care only.<br><br>Smokers' Inpatient Pathway aligned to Integrated Care Pathway "Non ST-Segment Elevation Acute Coronary Syndromes ICP" in place in Coronary Care Units, Ninewells and PRI. |
| Note if an opt-out scheme is in operation and if the approach is integrated with primary care | All pathways and processes are built on an opt-out approach. |
| How has pathway(s) impacted on patient-centred care through referral and uptake of support | The patient centred care is delivered through our whole workforce therefore it is ward/nurse led. |
| **Action 6** | Maintenance of a comprehensive organisational tobacco policy and alignment with partners on shared sites. |
| **A (i)** Description of progress on tobacco policies relating to shared sites. | Tayside Tobacco Plan is in the process of going through Local Authorities and IJBs. Local authorities are in the process of reviewing their policies in line with the guidance sent out from COSLA and there is a willingness to align it to the NHS Tayside's smoking policy. |
| **A (ii)** How is the NHS Smoke-free grounds policy communicated | The policy is communicated to staff through internal newsletters, web site and pay slips. New staff will be informed on smoking policy as part of application process and at interview. Managers also encouraged to discus policy with staff and Policy to Practice training |

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| to staff, patients and visitors? | reinforces this.<br>Patients are informed on smoke free through letter confirming their referral to the hospital, patient information leaflets, and discussion at Pre-Assessment and on admission as per inpatient pathway.<br>Visitors are informed through local media and also signage and public announcement system. Health information points and most clinical areas providing patient information display policy leaflets. |
| **A (iii)**<br>Description of implementation and assessment of adherence to smoke-free NHS grounds. | Training offered on a regular basis:<br>'What's My Role' addresses the legislation and staff roles and responsibilities.<br><br>'Policy to Practice' focuses on how to implement our No Smoking Policy (NSP) and negotiate barriers. Both are aimed at clinical and managerial colleagues.<br><br>'Mental Health Smoke Free' training to encourage staff within mental health to take responsibility for their staff who smoke and patients to follow pathways to promote adherence of policy.<br><br>'Very Brief Advice', DVD from National Centre for Smoking Cessation Training, is being rolled out across the acute sector ensuring a core level of training to a wide variety of staff. The objective is to build the capacity, especially at a ward level, to engage and support smokers to abstain while in our care.<br><br>All sessions address smoke free grounds and use various resources including trigger videos to prompt discussion about how to communicate and approach smokers on grounds.<br><br>These learning outcomes are also provided in training delivered to Dundee University medical and nursing students (all 2nd year nursing students, 1st year medical students and 3rd year oncology elective students).<br><br>Dundee City Council inspects Ninewells hospital grounds and as part of their enforcement remit has issued Fixed Penalty Notices to those found smoking in areas that contravene smoking in enclosed areas legislation and littering offences.<br><br>Working with senior managers, public health and human resources complaints regarding staff breaches of the NSP. Have a specific managers' pathway.<br><br>Communication of complaints regarding smoking on hospital grounds are shared through meetings between public health leads and senior hospital staff. |
| **Action 7** (NEW) | Provide a narrative on your assessment on the impact of smoking actions since their introduction in 2012. Frame your narrative to reflect impact on patient-centred care, staff health and wellbeing and the hospital environment. |

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| **7** | Patient Centred Care - Progress made in<br>Targeted Settings & Pathways.<br><br>The Hospital Smoke Free Service has changed the way it operates and is still in a process of transition. We have moved from providing a direct cessation service to patients on wards to building the capacity of clinical staff and wider to implement the No Smoking Policy. The focus is on a collaborative approach which is driven by ward staff adhering to tailored 'in' and 'out' patient pathways that compliment their core duties. Pathways provide stepped guidance for staff in prescribing pharmacotherapy to support smokers to abstain during their hospital stay. This approach adds value to their patients in ensuring a care plan that is focused on delivering the best health outcomes.<br><br>The NSP adopts an 'opt out' approach that requires clinical staff and managers to directly support smokers. The Hospital Smoke Free Service visit wards and provide a range of bespoke learning opportunities to support colleagues in engaging with smokers. The content includes Very Brief Advice videos to prompt discussion about engaging with smokers. There are excellent examples of no smoking practice across our hospitals but there are areas where smoking is seen as a patient lifestyle choice and there is an assumption that engaging in cessation can threaten nurse patient relationships. Our 'Policy to Practice' training addresses these assumptions in more detail and includes smoke free grounds. This supports the need for closer integration between clinical and health perspectives.<br><br>Underpinning our educational approach is the collecting of data on NRT prescribing on a ward by ward basis. This information helps identify those wards that are being proactive in supporting patients to abstain during their stay and those where more support is needed. The data has provided evidence that there is a lack of knowledge of the secondary NRT option, the inhalator, and this may be why it is under prescribed. Our training has been adapted to address this. The prescribing data and information obtained during ward visits, including training provision, is recorded. This quantitative and qualitative data will enable us to measure change over a specific time period and inform ongoing NSP practice.<br><br>Learning.<br>As this is a period of transition there remains much work to be done to secure greater involvement. Changing attitudes and building capacity will take time. While we are seeing a reduction in smoking across Scotland many of those coming into hospital with smoking related illness, are from areas of deprivation. This gives us the opportunity to address one of the factors of health inequalities. Some of these smokers have been smoking for many years and both staff and smoker may find it difficult to negotiate abstinence. We have evidenced a reduction in ward prescribing NRT but as more staff members become involved in engaging with patients who smoke this will change. This will be more effective long term than 1.5 WTE being responsible for contacting all smokers in NHS Tayside acute sector.<br><br>Staff Wellbeing & Hospital Environment: Supporting SC for staff.<br>Staff are adhering to the smoke free grounds but there remains work to be done with managers to continue to support and promote the |

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| | policy. Numbers for staff drop-in has reduced over the last year. The use of e cigarettes and access to any community pharmacy for stop smoking are factors that may have influenced this.<br><br>Against this backdrop of change we have been able to increase the take up of NCSCT's Very Brief Advice and bespoke sessions. We have had requests for further learning after colleagues have attended our Policy to Practice training: this is evaluating well and a wide range of clinical staff and managers are attending. We are beginning to see more health promoting activities |

Input your narrative on the page below. Refer to the guidance for associated themes and observe the word count of 500 words / 1 page:

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section B: Smoking**. Exception submitted:<br>[Limit each entry to 200 words] |
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| **A(ii) and A(iii)** | **Unable to elicit prescribing data for 'Diabetes' due to there not being any specific inpatient wards for diabetic patients. Ongoing quits for this patient group are also not provided as unable to identify patients with diabetes for the same reason given above.**<br><br>**Manual records held within Diabetes outpatient areas and no prescribing data recorded for outpatients also means no data is able to be provided for this specific setting breakdown.**<br><br>**The only data that can be provided by Diabetes MCN is that 83.5% of Tayside diabetic patients have had their smoking status recorded with 2015/2016 period, down by 1% on previous year.** |

**Alcohol:** Lead contributor

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|---|---|
| Name | **Neil Fraser** (now retired) |
| Job Title | **Strategy and Performance Manager, NHS Tayside** |

| **Section C: Alcohol** | |
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| **Action 8** (NEW) | Provide narrative on your assessment of the impact of alcohol actions, since their introduction in 2012.<br><br>Frame your narrative to reflect impact on patient-centred care and if appropriate, also the impact on staff health and wellbeing and the hospital environment. |

ABI activity is captured by the Business Unit and submitted to ISD. In the light of the impending retiral of Neil Fraser, the Sustaining Alcohol Screening Brief Interventions Sub Group was formed in 2015/16; the group membership includes the three Alcohol and Drug Partnerships (ADPs), Director of Public Health, Tayside Council on Alcohol (TCA), health improvement lead for workplace health, health intelligence and learning and development colleagues.

As stated in NHS Tayside Local Delivery Plan (LDP) 2015/16, substance misuse disproportionately affects the most vulnerable and socio-economically deprived in our community. *Changing Scotland's Relationship with Alcohol: Framework for Action* focuses upon reducing alcohol consumption. *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* highlights the importance of a recovery focused approach.

NHS Tayside has a direct involvement in the redesign of substance misuse services to create a greater focus on whole families and support for recovery in the Angus local communities and to address new ways of working to deliver the 'Support and Connect' Project - a recovery directed system - within the Dundee communities**.** Various areas are allocated as "priority" by the LDP - these include Primary Care (including Keep Well and Healthy Living Initiatives), Sexual Health, A&E and MIUs, admissions to Acute Hospitals and Maternity.

A lot of effort has been put into supporting Maternity to deliver ABIs. There were initial successes during the Angus pilot, but the senior midwife who acted as a Champion moved on. Staff confirm that screening and ABIs are being undertaken, but not recorded and therefore, no data/evidence is available. Midwives have noted that the ABI guidance lists questions relating to pre-pregnancy alcohol consumption rather than during pregnancy.

Work is progressing across agencies in Perth and Kinross to support the development of a recovery focussed model of care. NHS Tayside is actively supporting the future development of mutual aid groups within this locality. Extra clinic time (which was established in January 2013) continues. NHS Tayside is meeting the LDP access standard and continues to work towards maintaining this.

Ongoing measurement of the LDP Standard to ensure that no clients wait more than 3 weeks to appropriate drug or alcohol treatment.

FOCUS FOR 2016/17

Continue delivery of ABIs in the priority areas of Primary Care, A&E and Antenatal Services and embed training to deliver ABIs.

Apply learning from community pharmacy delivery of ABIs so that provision for people in deprived areas is tailored to need and effectiveness of delivery.

Given that NHS Health Scotland will no longer provide training (Training for Trainers) specifically for screening and ABIs – NHS Tayside will develop their own trainers. Two NHS Tayside staff from the Directorate of Public Health will work with colleagues within TCA to progress this. Co-ordination and delivery of this core function (training on delivery of Screening and ABIs) will lie with the NHS Tayside training and development department. A timetable will be developed to prepare the group to take over this training over the next 12 months.

The ADP representatives have offered their support for these processes and agreed that analysing the data helps identify priorities instead of just meeting standards.

The Director of Public Health will be the Consultant covering the addiction and substance misuse remit for the foreseeable future – this will include responsibility for submission of the LDP data.

| Action (provide number and any assigned letter) | **Section C: Alcohol**. Exception submitted: [Limit each entry to 200 words] |
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**Maternity:** Lead contributor

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| Name | **Janet Dalzell** |
| Job Title | **Infant Nutrition Coordinator, Directorate of Public Health** |

| **Section D: Maternity** | |
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| **Action 9**<br>Section D Maternity Guidance.docx | UNICEF UK Baby Friendly Initiative accreditation |
| **A.** Mechanism or plans for monitoring of WHO Code compliance (local monitoring details, informing staff & managing breaches) | Compliance with the International Code of Marketing of Breast milk Substitutes is an integral component of NHS Tayside Infant Feeding policy. Staff in all areas of the Maternity Service are aware of the need for constant observation for materials that do not comply with the WHO code and will seek clarification from the Infant Feeding Advisor as required.<br>In addition, and as part of regular Baby Friendly Audits, areas are inspected to ensure code compliance.<br>Any breaches would be discussed with the Infant Nutrition Co-ordinator with appropriate steps taken to ensure non-compliant materials are removed with the source contacted to terminate any further distribution of supplies.<br>NHS Tayside Infant Formula Information Group (IFIG) is responsible for overall monitoring across community nursing and general practice. |
| **Action 10** | Pathways are in place to support continued breastfeeding when infants or mothers are admitted to hospital settings, **out with** the maternity unit |
| **A** Initiatives supporting breastfeeding in wider settings**,** including:<br>**(i)** ensuring that procedures and drugs have as little impact on breastfeeding as possible<br>**(ii)** how staff enable mothers in acute settings to express and store milk<br>**(iii)** how staff enable mothers in acute settings to have their infants in their room | **(i)** The Infant Feeding Advisor is notified and asked for advice/support when a breastfeeding mother/baby is admitted to hospital. Breast pump equipment can be provided to enable breast milk to be expressed prior to specific procedures/investigations taking place. In addition, all medications can be discussed/considered with additional advice sought as required via electronic drug information sources or pharmacy drug information service etc.<br>**(ii)** Breast pump equipment is portable and can be taken to wherever it is required. A dedicated breastmilk fridge is available both within the Postnatal ward and the Neonatal Unit and in addition freezer storage facilities are available in the Neonatal Unit. Expressed milk requiring storage can be kept within either of these locations.<br>**(iii)** Wherever possible, a mother who is breastfeeding her baby would be cared for within a single room having her baby with her. Each situation requires to be risk assessed considering the potential risks/benefits for both mother and baby. An adult family member may also be encouraged to stay in order to provide care for the baby whilst the mother is ill. |
| **B.** Evidence of systems supporting expression of breast milk (e.g. policies, | NHS Tayside Maternity Service has a pump loan arrangement in place with Medela. There are 51 Medela Symphony Breast Pumps in use across both Hospital and Community Services. Where required, mothers have ready access to a breast pump |

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| breast pump loan schemes, expressing logs) for preterm and sick babies and for mothers encountering feeding problems | within the hospital and mothers who experience challenges at home can also be supplied with an efficient breast pump on a short term loan basis.<br><br>Mothers with a baby in the Neonatal Unit are also supplied with a breast pump for use at home whilst their baby is still within the Unit. Additional Medela Pumps are being purchased within the Neonatal Unit to enable mothers to more easily express milk at their baby's cotside. Mothers are provided with a log to record all milk expressions. |
| **Action 11** | Identify common causes and work towards reducing breastfeeding attrition rates |
| **A.** Provide evidence of the analysis of local attrition rates, common causes and actions taken | ISD supply quarterly data which is analysed for attrition rates. Investment in additional breastfeeding support workers in Dundee where initiation and continuation rates are lowest has demonstrated lower cessation.<br><br>Nationally as well as locally there has been a significant increase in the numbers of mothers choosing to mix breast and bottle feeding.<br><br>There is a focus of attention on supplementation across Tayside, with Maternity Services using the UNICEF audit and assessment tool on supplementation to monitor rates. Results are fed back to staff with action plans to address issues highlighted.<br><br>Additional support for initiation of breastfeeding in hospital is provided by volunteers and in community by paid breastfeeding support workers.<br><br>The number of Breastfeeding groups has increased across Tayside along with online support systems e.g. local mother/baby Facebook groups.<br><br>There is a breastfeeding clinic available for mothers with more complex challenges. |
| **B (i)** Provide a description of quality improvement methodologies being applied to support the maintenance of breastfeeding during **birth to hospital discharge** | Development of : Antenatal Preterm Bundle<br>Snuggle bundle<br><br>Utilising the Institute for Healthcare Improvement methodology 'The Breakthrough Series' collaborative model for achieving breakthrough involvement, PDSA cycles the snuggle bundle and the ante natal bundles evolved.<br><br>The Snuggle Bundle is a safety bundle that aims to reduce the unnecessary separation of mums and babies by missed risk factors such as hypothermia, hypoglycaemia and/or infection.<br>It comprises of 3 main elements.<br>1: All babies' temperature is maintained.<br>2: Uninterrupted skin to skin<br>3: Risk assessed.<br>Not only does this safety bundle attempt to reduce physical and emotional hardships experienced with mother and infant |

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| | separation, it also incorporates global values and recommendations set out by UNICEF in offering all babies skin to skin.<br><br>It encompasses patient safety measures targeted in Maternity and children's quality improvement collaborative's (Mcqic) Neonatal measurement plan (UDP2): The at risk infant being cared for using appropriate care pathway. As well as the Mcqic Maternity Care measure plan (MB01): Newborn babies who are normothermic at point of leaving the birth area.<br><br>Our quality improvement work around this bundle has gained national recognition. A delegate from NHS Tayside was asked to present this quality improvement initiative at the Mother Midwife Baby Conference In London in February of this year. Similarly it gained a poster presentation place at the NHS Scotland event of June of this year as well as being presented at the WHO CC 2016 Global Secretariat in Glasgow July.<br><br>We also secured a place in the innovative pilot project being run by NES and funded by the Health Foundation called the 'always event' project. This aims to improve the quality of everyday patient experiences of healthcare and social care through an innovative person centred approach.<br><br>This is particularly relevant within PRI and the day care services who are adopting their 'Always' question as to what women would always like to happen when they attend for their appointment antenatally. Also in the postnatal area they have utilised results from the 2015 Scottish Maternity Survey to focus their 'Always' event around what information women always want in the postnatal period.<br><br>We are also in the process of developing two additional care bundles - one to increase skin to skin contact within the operating theatres with the second one to provide more robust guidance on the management of the late preterm baby within the postnatal ward environment.<br>Theatre skin to skin bundle - draft<br>Late preterm baby bundle - draft |
| **B (ii)** Provide a description of quality improvement methodologies being applied to support the maintenance of breastfeeding during hospital discharge to **handover to Health Visitor** | • We seek to obtain feedback of mother's experiences during their hospital stay by means of regular audit using the Baby Friendly audit tool as well as anonymously using "How are we doing?" questionnaires.<br>All results shared with staff with action plans developed using the Plan, Do, Study, Act methodology.<br><br>• Feeding assessments: Formal feeding assessments encouraged prior to discharge from hospital in line with Baby Friendly Standards. This provides opportunity for sharing information as well as supporting feeding techniques. Assessment of feeding as well as provision of support continues within the community setting by community midwives, Maternity Care Assistant and |

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| | Breast Feeding Support Workers.<br>Monthly audits assessing compliance with recording of feeding assessments is undertaken.<br><br>• Breastfeeding clinic: Women with feeding challenges can either self refer of be referred by a Health Care Practitioner to the Breastfeeding Clinic if they are experiencing difficulties with feeding. Clinic service is evaluated using telephone questionnaires to service users.<br><br>• Annual audit, using the Baby Friendly Audit Tool, of all Baby Friendly Standards is undertaken across Maternity Services and submitted to Unicef. |
| **Action 12** | All staff working within the NHS who are pregnant are advised (prior to going on maternity leave and again prior to returning to work) of the Board policy to support breastfeeding on returning to work |
| **A** Evidence of an infant feeding policy for staff returning to work. Include details of how policy is communicated to line managers, pregnant staff and to mothers returning to work | All pregnant staff receive information about the policy. An equipment loan scheme is available for staff to borrow an electric breast pump and/or an electric cool box. Where a member of staff is returning to work their line manager will complete paperwork and equipment will be delivered to workplace. |
| **B.** Describe the facilities available to support mothers to continue to feed and/ or express their breast milk on returning to work | All NHS Tayside sites have either a dedicated room or a room made available on site for staff to express milk. The dedicated rooms are private, lockable, and have a comfortable chair with sink, fridge and power points for electric breast pump equipment. |
| **Action 13** (NEW) | Provide narrative on your assessment of the impact of maternity actions since their introduction in 2012.<br>Frame your narrative to reflect impact on patient-centred care, staff health and wellbeing and the hospital environment. |

Input your narrative on the page below. Refer to the guidance for associated themes and observe the word count of 500 words / 1 page:

The maternity actions have been welcomed throughout Tayside and have provided a holistic framework for infant feeding support and the development maternal / baby relationship. This approach has enabled patient centred care based on the individual, irrespective of mode of feeding, ensuring that each woman has an individualised 'conversation' to meet their needs.

Ensuring that the actions are met, has helped embed positive practices throughout Tayside and enabled the dissemination of evidence based guidance. Aspects of care such as skin to skin after birth have greatly improved and all members of the multidisciplinary team are aware of the significance of this. This has led to initiatives such as the use of baby wraps in

the ward environment and kanga wraps for women undergoing an elective caesarean section. Maximising every opportunity for skin to skin and bonding.

Focussing on the relationship and the importance of responsiveness for all, has minimised the negative connotations that previously were attributed to the 'baby friendly 'initiative, of overzealous emphasis on breast feeding.

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section D: Maternity**. Exception submitted:<br>[Limit each entry to 200 words] |
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**Food & Health:** Lead contributor

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| Name | **Susan Welsh** |
| Job Title | **Catering Training Officer, NHS Tayside** |

## Section E. Food and Health

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| **Action 14** (NEW) Section E Food & Health Guidance.do | Strategic responsibility for all non-patient food provision (catering, retail, vending, retail) | | | | | | |
| Provide name of lead(s) with strategic responsibility of non-patient food provision. | Fiona Kimmet, Catering Manager Dundee Locality - Catering Lead NHS Tayside. | | | | | | |
| **Action 15** Refer to guidance note | All **catering outlets** in healthcare settings must meet the Healthyliving Award Plus (HLA+) by 31 March 2017 (or, for private sector directly operated catering outlets, at the point of contract (re)negotiation). Vending machines located within catering outlets, or covered by the catering contract should be reported below. | | | | | | |
| | Number operated by the Health Board | | Number operated by voluntary sector organisations | | Number operated by private sector organisations | | Total number in operation |
| | HLA | HLA+ | HLA | HLA+ | HLA | HLA+ | |
| Catering outlets | - | 9/10 | 1/1 WRVS - PRI | - | 0/1 Level 7 cafe - Ninewells | - | 10/12 One NHST outlet awaiting result of HLA+ assessment |
| Vending machines within or part of, catering outlet /contract. | - | 113 | | | | | 113 all machine are compliant with HLA+ NHS Tayside made the decision to continue with 100% sugar free drinks although the award criteria has change to 70%. |

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| **Action 15 (**continued) Guidance for vending within heal | All **vending machines*** in healthcare settings must comply with NHS Guidance for vending within healthcare settings (which is aligned to HLA+ vending criteria) by 31 March 2017 (or for privately operated vending machines, at the point of contract (re)negotiation). * For the purposes of reporting this question refers to all vending machines **located out with** catering outlets and not covered by catering contracts. E.g. foyer, corridor etc. | | | |
| | Number of vending machines operated by the Health Board | Number vending machines operated by voluntary sector organisations | Number vending machines operated by private sector organisations | Total number in operation |
| Vending machines | - | - | 0/2 Level 7 cafe - Ninewells | 0/2 |

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| **Action 16** (NEW) | All retail outlets and retail trolley services operated in healthcare settings must meet the Healthcare Retail Standard (HRS) by the 31 March 2017 (or, for private sector directly operated outlets and trolley services, at the point of contract (re)negotiation). | | | |
| | Number meeting the HRS operated by the Health Board out of the total | Number meeting the HRS operated by voluntary sector organisations out of the total | Number meeting the HRS operated by private sector organisations out of the total | Total number operating |
| Retail outlets | 0/1<br>Murray Royal, Perth | 0/2<br>Lippen Care – Whitehills CCCH. Forfar<br>Loggie and St John Cross Church Tuck shop - Royal Victoria Hospital | 0/3<br>WHSmith- Ninewells<br>Level 7 cafe- Ninewells<br>Dundee University Student Association. - Ninewells | 0/6 |
| Retail trolley services | - | 0/2<br>Lippen Care – Whitehills CCCH. Forfar<br>WRVS - PRI | 0 /1<br>WHSmith- Ninewells | 0/3 |
| Issues or challenges in achieving HRS | Murray Royal's hospital shop is the only NHS owned retail outlet. Being a mental health unit this creates challenges around the food items which are available to the customers as many patients cannot assess other retail units. The catering department who run the shop are trying hard to find suitable alternatives which will fall into the HLA criteria.<br><br>Other retail outlets sited on NHS Tayside hospital sites are in current longstanding contracts. Although information has been passed to them concerning the HRS none has applied. This should be rectified when new contracts are discussed. Work has started to look at WH Smith's offer at Ninewells and the new concourse plans will implicate future models of operation. | | | |
| **Action 17** | Where appropriate, healthcare facilities have community food co-ops and /or other social enterprises in place, achieving the Healthcare Retail Standard. | | | |
| **A. (i)** Number of community food co-ops and /or other social enterprises achieving the Healthcare Retail Standard.<br>(include a brief description of the product / service offered) | | | | - |
| **A. (ii)** Total number of sites operating a community food co-op and /or other social enterprises (include number listed in box A (i)) | | | | - |
| **Action 18** (NEW) | Provide a narrative on your assessment of the impact of food and health actions, since their introduction in 2012.<br><br>Frame your narrative to reflect impact on patient-centred care, staff health and wellbeing and the hospital environment. | | | |

Input your narrative on the page below. Refer to the guidance for associated themes and observe the word count of 500 words / 1 page:

The inclusion of food and health actions in HPHS has influenced the NHS Tayside-run facilities regarding compliance with, and maintenance of, HLA+. Our Drinks4health programme has ensured for many years that only 0% sugar drinks are stocked in vending machines, NHS/privately operated catering outlets, or within WH Smith retail shop.

We have a good working relationship with Excel Vending and their understanding of our wish to ensure 'health choice is the easy choice' is growing. 2016 will see the first 100% healthy choice vending machine be installed in NHS Tayside.

In spring 2016 we opened dialogue with Esposito Café on the Ninewells concourse – this followed particularly negative Tweets from a member of the public regarding the promotion of unhealthy, cheaply priced food. They are being supported to comply with HRS and HLA+ (mixed outlet) by March 2017. The use of social media to highlight the matter inevitably brought input from the Board Chairman, who worked with our HPHS Champion to effect a change and open dialogue with colleagues in the Operations Directorate and within Procurement. The introduction of the target date for HRS compliance has worked as an effective tool to work with retailers who profit from their lease within our hospitals.

Our inclusion in the work to refurbish the concourse at Ninewells has allowed us to direct the company of consultants who will be leading the allocation of leases to food retailers and caters when the site is put to international tender. They are also understanding of our wish to include a social enterprise food provider as an element of the provision.

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section E: Food and Health**. Exception submitted:<br>[Limit each entry to 200 words] |
|---|---|
| **17 A (i)(ii)** | **NHS Tayside had social enterprise fruit and vegetable stalls in Ninewells, PRI and Kings Cross. They were not supported sufficiently by site users, or allowed to trade indoors in inclement weather, so the operators withdrew as they could not make the business model break-even. This will be readdressed in the refurbishment of Ninewells concourse.** |

**Staff Health and Wellbeing:** Lead contributor

| | |
|---|---|
| Name | **Pat Davidson** |
| Job Title | **Workplace Programme Manager, Directorate of Public Health** |

| **Section F: Staff Health and Wellbeing** | | | | | |
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| **Action 19**<br>Section F Staff Health & Wellbeing | NHS Boards have a staff safety, health and wellbeing strategy in place, including Healthy Working Lives, and a supportive and proactive approach to staff mental health and wellbeing, physical health and financial insecurity | | | | |
| | | | HR department | | Occupational Health |
| **A** Named lead responsible for delivery of staff safety, health and wellbeing strategy (include position) | | | Lesley McLay, Chief Executive | | Davina Clark: Health and Safety Manager |
| Note if there is no identified strategy or individual with responsibility | | | | | |
| **B.** Details of all hospital and community hospital sites HWL Award status and stage of progress | | | | | |
| Enter hospital name below | Bronze | Silver | Gold | Working towards (enter level) | Maintaining – (enter level) |
| Ninewells/PRI/Stracathro/Dundee Dental | | | Gold | | Gold |
| Centre for Brain Injury (Royal Victoria Hospital) | | | Gold | | Gold |
| Specialist Palliative Services (PRI) | Bronze | | | Silver | |
| Whitehills/Arbroath infirmary/Brechin Infirmary/Montrose Infirmary | | | Gold | | Gold |
| Crieff/Blairgowrie/Aberfeldy & Pitlochry Community Hospitals | | | Gold | | Gold |
| St Margaret's Auchterarder | | | Gold | | Gold |
| Medicine for the elderly and stroke unit (PRI) | | | Gold | | Gold |
| Murray Royal | | | Gold | | Gold |
| Specialist Services (Roxburghe House, hospice<br><br>) | | | Gold | | Gold |
| Ninewells Site Support Services | | | Gold | | Gold |
| Dundee Locality Site Support Services | Bronze | | | | |
| **19 C.**<br>(NEW) | Description of interventions which support staff in the areas below. Interventions should be tailored to meet the needs of different demographic staff groups and **include support for engagement**, **health literacy**, **fair work** and **financial inclusion.**<br>Refer to guidance for further information requested. | | | | |
| **C (i)** supporting the mental health and wellbeing of staff | NHS Tayside has a number of policies and practices in place which support staff health and wellbeing. Live Positive: a stress management resource pack (a stress awareness and stress risk assessment tool | | | | |

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| | developed by NHS Tayside's HR Department and OHSAS the occupational health and safety provider) is in place to assist staff in the identification of stress related issues and provide support. This is available on Staffnet. For the first 12 months (up to October 2015) the Live Positive site was visited 1,358 times. Stress is considered alongside all other risks in the organisation. In some cases teams request a risk assessment from OHSAS.<br><br>MindSET is an on-line introduction to mental health. This has been accessed by 560 NHS Tayside staff since its introduction in 2011.<br><br>Management Training: To recognise the key role of people management skills and help managers balance the aims of the organisation with concern for the health and wellbeing of employees a new line management programme of training is currently being piloted. This programme will focus on effective leadership and communication skills. Being able to support staff to do their job and be inclusive in developing workplace solutions and staff engagement are key aspects of this new training initiative.<br><br>NHS Tayside's Wellbeing Centre offers 1-1 confidential conversations about issues which may be causing stress either at home or work (this is available throughout Tayside).<br><br>Mentally Healthy Workplace training is provided at various locations throughout NHS Tayside (this training is aimed at anyone who manages staff).<br><br>Resilience and Wellbeing training offered at various sites (offered to anyone who manages staff and within specific teams if requested).<br><br>Welfare Reform Awareness sessions and/or staffed information stands at various NHS Tayside sites throughout 2015/16 (number of sessions were provided in order to include support services staff). These were promoted as "In Work Entitlement" sessions in order to raise awareness that individuals might be entitled to benefits even if they are in employment. These sessions were provided in partnership with Welfare Rights representatives from the three local authorities.<br><br>Healthy recipes were available on Staffnet (which is available to all staff) during 2015/16 in order to encourage and support healthy eating.<br><br>Currently iMatter is being rolled out across the organisations. This requires to be undertaken within |

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| | all teams and is a continuous improvement process which fundamentally contributes to the stress risk processes within the organisation. On completion of the iMatter tool all teams require to develop and record a plan of action to deal with any issues (including stress) which may have been identified. |
| **C (ii)** supporting the physical health of staff | An annual virtual pedometer challenge is provided which has resulted in increased participation year-on-year.<br><br>Cycle to Work Scheme is provided over a two month period on an annual basis.<br><br>Staff are encouraged to seek occupational health referral for a drug/alcohol related problem. They are then referred to specialist support.<br><br>Smoking cessation support is available throughout the organisation. |
| **C (iii)** Promotion of health screening | Spectra (staff magazine) which is produced bi-monthly features a Health Matters section within every edition (both bowel and cervical screening included within editions).<br><br>NHS Tayside staff and Macmillan Cancer Care provided an information stand at Ninewells in support of Bowel Cancer Awareness month.<br><br>Cervical cancer information event within concourse of Ninewells. This was supported by NHS Tayside Colposcopy team. This was held during March/April Cervical Cancer Prevention week.<br><br>April 2015: Detect Cancer Early campaign materials on all notice boards. Cancer awareness road shows at various sites. |
| **C (iv)** Promotion of immunisation | National Flu immunisation promoted in Spectra (staff magazine) Nov/Dec 2015 issue and Vital Signs (email alert system to all staff) October 2015 and November 2015. Also on Staffnet (intranet) during this time. |
| **Action 20** (NEW) | Provide a narrative on your assessment of the impact of staff health and wellbeing actions, since their introduction in 2012.<br>Frame your narrative to reflect impact on patient-centred care, staff health and wellbeing and the hospital environment. |

Input your narrative on the page below. Refer to the guidance for associated themes and observe the word count of 500 words / 1 page:

Sickness absence continues to be monitored on a monthly basis. All managers receive a monthly report detailing staff absences. Procedures are in place which all managers are required to implement when people return from absence e.g. return to work interview in order to identify any support which may be required.

iMatter continues to be rolled out throughout NHS Tayside with some directorates/teams now on phase two of this continuous improvement model. This is particularly useful as information is broken down into teams. This provides everyone with the opportunity to celebrate success and identifying any issues and allows both the manager and the team to develop actions in order to address issues. The fact that this process occurs on an annual basis allows all teams to see where improvements have been made and hopefully results in an improvement in staff engagement.

Staff Governance Action Plan 2015 – 2017 was agreed by Staff Governance Committee – 14 April 2015. It covers the five strands of staff governance. Six monthly updates are required of all directorates and monitored by HR.

The Healthy Working Lives Employee Wellbeing Survey is undertaken throughout the whole organisation on a three yearly basis. Results of the survey are given to directorate leads who again will act on any identified issues requiring to be addressed either by senior management or the organisation as a whole.

Mentally Health Workplace training has been ongoing for NHS Tayside managers/supervisors/team leaders since 2009. To date 644 people with line management responsibilities have completed this training.

Workplace health and wellbeing is a core priority for NHS Tayside. Creating a supportive environment that enables employees to be proactive and enhance their health and wellbeing is seen as critical. Encouraging staff engagement is seen as essential going forward for individuals and for the organisation.

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section F: Staff Health and Wellbeing**. Exception submitted: [Limit each entry to 200 words] |
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**Reproductive Health:** Lead contributor

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|---|---|
| Name | **Ann Eriksen** |
| Job Title | **Executive Lead – Sexual Health and BBV, NHS Tayside, Directorate of Public Health** |

## Section G: Reproductive Health

**Action 21**

Section G Reproductive Health

NHS Boards have a plan in place to support women with LARC in maternity and termination services, with a focus on vulnerable women

**A.** Describe evidence of impact on numbers of repeat terminations

ISD data demonstrates an overall decline in the rates of termination of pregnancy (TOP) in Tayside that broadly mirrors the national trends. Whilst Tayside has consistently reported the highest rates of TOP in Scotland the decline has been greater than the national average.

| Year | Scotland | Tayside |
|---|---|---|
| | **Rate per 1000 women aged 15-44** | |
| 2007 | 12.9 | 16.7 |
| 2008 | 13.1 | 15.3 |
| 2009 | 12.4 | 15.5 |
| 2010 | 12.2 | 14.4 |
| 2011 | 11.9 | 14.5 |
| 2012 | 12.0 | 14.2 |
| 2013 | 11.5 | 13.0 |
| 2014 | 11.3 | 13.2 |
| 2015 | 11.6 | 13.9 |

The reduction in rates of TOP has been most pronounced in the youngest age groups and corresponds with the significant reduction in all teenage conception. The decrease in terminations since 2007 is closely correlated with the increase in availability of Long Acting Reversible Contraception (LARC) over the same timeframe. This became a focus for action following the inclusion of specific standards in the Healthcare Improvement Scotland (HIS) Standards for Sexual Health Services (2008) relating to LARC uptake in women of reproductive age in the population as a whole and to the percentage of women leaving TOP services with an effective method of contraception.

Tayside shows the highest rates of repeat terminations in Scotland at 5.1 per 1,000 women of reproductive age compared to 3.6 for Scotland as a whole. As with the picture for Scotland, the rate of repeat termination has been relatively consistent over time.

Locally, data is now collated on the number and rate of rapid repeat terminations (RRT), defined as women who return within two years. This is further broken down by age. If represented as a proportion of all terminations, RRT account for 12% overall, with the highest being in the 20-29 age group at 15.5%. However, the rate is likely to be a

<table>
<tr><td></td><td>more useful reflection of the overall frequency of repeat termination. The rates for 2015/16, calculated as mid-year population estimates, for RRT show:<br><br><table><tr><th></th><th>Rate per 1000 women aged 15-44</th></tr><tr><td>All ages</td><td>1.77</td></tr><tr><td>Under 20</td><td>0.22</td></tr><tr><td>20 -29</td><td>1.12</td></tr><tr><td>30+</td><td>0.43</td></tr></table></td></tr>
<tr><td>B (i) Describe how you define vulnerable women in your area and collate termination information</td><td>The local definition of vulnerable women is those: living in areas SIMD 1 and 2; aged 20 and under; Looked After and Accommodated Children (LAAC); women with a learning disability; women with substance misuse problem and those who are commercially sexually exploited.<br><br>Women are assessed at the time of referral to identify ‘vulnerability’. Routine data is collected and reported to the Sexual Health and BBV MCN on women living areas SIMD 1 and 2 and on age.</td></tr>
<tr><td>(ii) Describe how you support vulnerable women within maternity services</td><td>The Tayside Pregnancy Pathway includes an assessment of individual women’s needs and life circumstances and where additional needs are identified there are specific tailored pathways that aim to ensure women are enabled to access the support they require.<br><br>The Tayside Maternity Services Pathway developed by the Midwifery Service Vulnerability Group incorporates specific interventions that require to be taken/considered where a woman has been identified as being ‘vulnerable’. Local vulnerability criteria and prompts have been adapted from the National Universal Pathway 0-5 (2011) to aid midwives in identifying and responding to vulnerability. Examples of tailored care are set out below for women with specific vulnerability criteria:<br><br>Where substance misuse is identified; the service follows the NHS Tayside Pathway of Care and implements an individual care plan, this includes routine bloods and Hepatitis C testing, urine toxicology as well as referral to drug/alcohol specialist services. Midwives discuss and seek formal agreement for information sharing and multiagency working and liaison to clarify professional responsibility.<br><br>Where the vulnerability criterion is mental health and where there is an increased risk; women are referred to the Community Mental Health Team as per Perinatal Mental Health Pathway.<br><br>Where the vulnerability criterion is Learning Disabilities: women are given a copy of My Pregnancy My Choice and referred to the Learning Disabilities Service.<br><br>In addition, there is specific tailored provision for young women</td></tr>
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| | through Family Nurse Partnership (FNP) or for those who do not meet its criteria but are under 20, there is enhanced Health Visiting. *New Beginnings* provides additional support in Dundee for women who have a substance misuse problem during their pregnancy and in early infancy.<br><br>There is also a range of multi-agency and third sector support available for 'vulnerable' women, including a Young Mums Unit in Dundee which enables young women to remain in full-time education.<br>Midwives and Health Visitors routinely explore contraception options with women during both ante-natal and post-natal care. |
| **(iii)** Describe how you support vulnerable women within **termination** services | There are no pathways designed specifically for groups defined as vulnerable within termination services. Each patient's care is individualised and the service use a clinic consultation form which helps identify women in vulnerable groups i.e. under 16, substance misuse, commercially sexually exploited, domestic abuse and those with a learning disability.<br><br>Links are in place with relevant clinical teams and health care professionals in order to refer patients for additional support as the need is identified. For example, the service would liaise with Social Care Health Workers for patients with a history of substance misuse and liaise with Mental Health Liaison Officer for patients with a learning disability. |
| **C (i)** Description of **maternity** services role in the delivery of the Sexual Health and Blood Borne Virus Framework 2015 – 2020 Update | Pathways are in place to identify STI and BBV risk and to carry out testing, together with immunisation for hepatitis B for mothers and babies born to HBV positive mothers. There are well established integrated pathways for pregnant women living with a BBV.<br><br>Currently maternity services are responsible for exploring contraception options and signposting women to services that can provide contraception, including LARC.<br><br>A local training package has been developed in conjunction with Sexual and Reproductive Health for staff working in maternity and TOP services to enable them to provide effective contraception counselling and provision of contraception, including LARC. In addition, the SHBBV MCN has identified funding to support the costs of training for staff working in these services as well as practice nurses in general practice.<br><br>The strategic aim is that maternity services should embed the provision of contraception, including post-partum and potentially intra-partum LARC as part of person-centred care.<br><br>Currently, performance and progress is exclusively reported to the Health Promoting Hospitals Steering Group. Consideration should be given to reporting outcomes to the SHBBV MCN who are in a position to provide additional expertise and support in relation contraception provision and the wider Framework outcomes. |
| **(ii)** Description of **termination** | Currently the TOP service provides STI/syphilis/HIV screening, and contraception counselling and contraception for women on |

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| services role in the delivery of the Sexual Health and Blood Borne Virus Framework 2015 – 2020 Update | discharge.<br><br>In 2015, 87% of women attending TOP services were discharged with preferred method of contraception; of these 23% were long-acting methods.<br><br>Nursing staff in TOP have been trained in inserting Nexplanon. A local training package has been developed in conjunction with Sexual and Reproductive Health for staff working in maternity and TOP services to enable them to provide effective contraception counselling and provision of contraception, including the full range of LARC.<br><br>The strategic aim is to provide integrated, community-based TOP services that include direct referral.<br><br>Data on TOP services, including RRT and contraception provision is reported to the SHBBV MCN and CEL1 indicators are reported to the Health Promoting Hospitals Steering Group. |
| **Action 22** (NEW) | Provide a narrative on your assessment of the impact of reproductive health actions, since their introduction in 2012.<br>Frame your narrative to reflect impact on patient-centred care, staff health and wellbeing and the hospital environment |

Input your narrative on the page below. Refer to the guidance for associated themes and observe the word count of 500 words / 1 page:

The main strategic drivers are provided by the Framework and the local health equity strategy, and are complemented by the HIS Standards and CMO HPHS Letter (previous CELs). The latter provided a specific focus on TOP and maternity services and has been a catalyst in raising the profile and in engaging colleagues in these services. There has been a positive impact on TOP where there is close collaboration with SRH, integrated pathways, joint training and development of a database and measures for improvement that include a focus on reducing RRT.

The MCN has influenced the culture for LARC by carrying out research with vulnerable populations: young people on attitudes to contraception; women with substance misuse problems and people with a learning disability to inform provision. It promotes contraception use across all ages by providing information in a variety of mediums – school, young people's services, websites, apps and across healthcare – and increasing access, especially to LARC as well as developed behaviour change interventions. Tayside has one of the highest rates of LARC, largely achieved through prescribing in general practice and expanded provision in young people's services. Extensive cross-agency training is provided by the MCN. This will be enhanced with input from Health Psychology inn 2017-19 that aims to increase uptake of contraception in women who inject drugs and those involved in CSE.

Work has focussed on TOP in light of the high rates of repeat termination. Strategic discussions commenced in 2012.

There have been considerable challenges: data has not been readily available; there are competing priorities and limited capacity that have presented barriers to engagement and reporting arrangements have been ambiguous meaning that accountability and leadership

have not always been clear. In TOP, reliable data is now available and continues to be refined to support improvement. There is a collective strategic view and commitment to realise these in practice. Professionals in TOP are part of the MCN and reporting CEL1 outcomes has been embedded in the MCN's performance management arrangements.

The strategic discussions are at a much earlier stage with maternity services, but require to be replicated. The challenges are similar but more pronounced and will require sustained leadership commitment.

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section G: Reproductive**. Exception submitted: [Limit each entry to 200 words] |
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| Name | **Sylvia Mudie** |
| Job Title | **Senior Health Promotion Officer, Directorate of Public Health** |

| **Section H: Physical Activity and Active Travel** | |
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| **Action 23**<br> <br>Section H Physical Activity & Active Trav | Physical activity interventions are routinely embedded into hospital settings. Boards are asked to focus efforts on the **priority settings** of: cardiology, pulmonary rehab, mental health, diabetes, paediatrics, oncology, orthopaedics, care of the elderly, pre-assessment and outpatient clinics<br>A system or process is developed and/ or in place to assess the delivery and impact of physical activity interventions in hospital settings. |
| **A.** Provide details on revising documentation to record physical activity status | **Surgical Pre assessment service in Ninewells and Stracathro Hospitals** - documentation has been used for audit purposes in 2015/16 to record details of patients physical activity levels using the NHS Health Scotland quality evaluation tool and brief advice/intervention recorded as well as length of time spent on this. Information is made available to patients on Dundee Healthy Living Initiative activities, local walk groups and the Ninewells Community garden as well as Get Active Your way booklet.<br><br>**Pain Service- Ninewells Hospital**- routine audit data collection records evidence of advice given to patients regarding physical activity. |
| **B.** Provide details and description of a development plan or assessment of impact in one or more of the **priority settings** listed above. Refer to guidance for further information requested. | **Surgical Pre assessment service**; the aim is to routinely ask all patients about physical activity levels using the national physical activity pathway and to offer brief advice along with providing written material as appropriate. In 2015/16 2 out of 3 of the services utilised the NHS Health Scotland quality evaluation tool and gathered information on specific dates of each patient accessing the service as follows:<br>• Physical Activity status<br>• Brief advice or brief intervention offered<br>• Intention to change<br>• Time spent exercising<br><br>The audit showed that between 88-100% of patients were asked about their PA levels. This information was fed back to the staff involved at Ninewells and Stracathro to inform their practice.<br><br>The plan in 2016/17 is to carry out this work quarterly at Ninewells, introduce in the Perth service area and to work more closely with the Stracathro service once they move into their new premises to enable data collection. Closer links with leisure trusts in Angus and P&K regarding signposting opportunities are being taken forward in 2016/17.<br><br>**Outpatient clinic-Pain Service, Ninewells Hospital** - An audit indentified 82% of patients seen between Feb 2015 and Feb 2016 were given advice on physical activity. The 12% not given information was made up of blank data and N/A. The aim is to continue to improve and continue strong links with voluntary and third sector |

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| | organisations to support this.<br><br>**Outpatient Clinic - Sleep Service, Ninewells Hospital** - there is a plan in place for 2016/17 for the national physical activity pathway to be used with patients attending the Sleep Service, brief advice offered and computer based records adapted to incorporate physical activity information.<br><br>**Macmillan Move More** - Changes in provider to Dundee Leisure from January 2016 include expansion of exercise opportunities available in Dundee to patients living with cancer. This includes 3 circuit classes over 3 sites and 2 walks weekly. Gardening and gentle movement classes are planned in 2016/2017 onwards. Macmillan Move More Co-ordinator will attend Ninewells Hospital in 2016/17 to raise awareness with patients about programme at outpatient appointments. Self referral system to be put in place 2016/17.<br><br>**Information provided** - information has been provided about the national physical activity pathway and range of resources including viewing of 23.5 hrs to a range of staff e.g. Perth and Kinross physiotherapy musculoskeletal team and Tayside podiatrists. |
| **Action 24** | NHS Boards develop an infrastructure to enable and signpost patients, staff and visitors to access local physical activity opportunities, accounting for equitable access for all. |
| | **A.** Evidence of hospital based physical activity support and/or services targeting individuals or populations experiencing inequalities (e.g. those with long term conditions, disabilities, in receipt of benefits, carers or living in areas of deprivation) |
| **A** Include:<br>**(i)** system for referral<br><br>**(ii)** system for signposting<br><br>**(iii)** assessment of use<br><br>Refer to guidance for further information requested. | (i)**Exercise referral** is available through the 3 leisure trusts in Tayside for people with long term conditions. In 2015 Dundee has revised their referral criteria to bring in line with the other two schemes. Compass Membership is also provided by Live Active Leisure in Perth and Kinross for priority groups which include people from lower Depcat areas. There are also schemes in Angus and Dundee for people from lower Depcat areas. Referrers complete a referral form for patients who they assess meet the referral criteria which is forwarded to the referral co coordinator for planning a programme of activity.<br><br>**Pain Service** - formal referrals through above exercise referral programmes across Tayside. Informal advice on exercise delivered by physiotherapist or nurses. Leaflets provided on supported self management – Pain Association Scotland, and Pain concern.<br><br>In Angus, there is a '**Steps Tay Health'** programme which consists of 11 health walks across Angus. Health walks are short, safe, accessible, low level walks led by trained volunteers and primarily aimed at people who would otherwise be inactive. Each group is led by volunteers and is self-directed in that they plan weekly walks together. Where local communities express a need for a new walk they are supported to develop this.<br><br>Information and referral opportunities are promoted to a wide range of services and staff through the local Physical Activity Group and other |

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| | means. The referral system consists of a simple form participants take along to their first week. All volunteers receive Walk Leader training from Paths For All and receive regular updates and workshops through the walk-leader forum.<br><br>**Macmillan Move More -** clinicians can refer people living with cancer to MacMillan Move More in operation in Dundee by completing the referral form.<br><br>**(ii) Pre-assessment Services** have access to the Active Scotland web site, and contact information for walk groups taking place in each of the three localities as a minimum.<br><br>**Pain Service** - Predominantly use written information for sign posting, or direct patients to our "Resource Leaflet" which includes websites, books, audio resources for chronic pain, including goal setting linked to activity.<br><br>**Macmillan Move More** - display stands and provision of information regarding the programme and range of activities for patients living with cancer. Will be further developed in 2016/17 to Macmillan representative attending at outpatient clinics.<br><br>**Various Patient Locations** - CMO info graphic displayed promoting exercise.<br><br>**Reducing In Activity in Palliative Care** - Seminar hosted by Macmillan Specialist Physiotherapist focussing on exercise and palliative care and signposting to services.<br><br>**Angus Adult Mental Health Service s-** there is a section on MIDIS to record where a patient has been signposted to (Physical activity information in Mental health services is reported fully in section K).<br><br>**(iii) Pain service** - feedback to the multi-disciplinary team on the above audit findings, to identify ways to improve.<br><br>**Pre-assessment Services -** feedback to teams on audit findings<br><br>**Exercise Referral programmes through 3 leisure trusts** - annual report of uptake linked to funding:<br><br>**Perth and Kinross Live Active Leisure** programme - 330 referred during reporting period however data systems do not allow analysis of who made referrals/ who attended and this will include referral from general practice.17 NHST staff/ departments registered as referrers.<br><br>**Dundee Active for Life** programme - 646 referred during reporting period however situation is similar in that data systems do not allow analysis of who made referrals/ who attended and this figure will include referrals from general practice. There are now 68 actively referring however data systems do not allow analysis of who is hospital/General Practice based.<br><br>**Angus Be Active Live Well** programme - 620 new people accessed the programme during reporting period. This includes people referred |

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| | by GP practice, pulmonary rehab referral, physiotherapy referral, mental health service referrals and self referral. In addition there were 42 referred from phase 3 cardiac rehabilitation.<br><br>**Macmillan Move More** - 23 people referred from Jan- March 2016 (start of new programme). 64% uptake of referrals into programme. Reasons for not taking up the programme analysed. Evaluations of programme and participation issued to participants at 0, 3, 6 and 12months. Evaluations also issued to Instructors. Quarterly reports produced |
| **B** Evidence of hospital based services working in partnership with local physical activity providers | **3 leisure trusts** - exercise referral schemes in operation and each receive funding to support the programmes.<br><br>**Ninewells Community Garden** - annual open days for public and staff, range of workshops provided for patients, staff, visitors and public, patient groups attending.<br><br>**Macmillan Move More Programme** - referrals from clinicians, display stands and provision of information regarding the programme and range of activities for patients living with cancer.<br><br>**Pain service**- liaises closely and refers to exercise referral schemes across Tayside.<br><br>**Forfar Community Garden**-promotion of therapeutic garden.<br><br>**Tayside Transforming Care After Treatment (TCAT**) team funded by Macmillan– organised Living Well sessions in Angus, Dundee and Perth in March and April 2016to help people improve general health and wellbeing and to manage the effects of their illness. Events included information on exercise and signposting to other support. Local leisure trust staff were in attendance to promote engagement around physical activity.<br><br>**Dundee Healthy Living Initiative** - signposting by Dundee hospital services to the range of activities offered.<br><br>**Links Park Community Trust** - Inreach walking football programme used by angus mental health patients.<br><br>**Angus Leisure Services** - 5 exercise instructors undertook training in Level 4 Mental Health.<br><br>**Angus Recovery Network:** Angus mental health service staff are active members. They share practice and discuss developments with other agencies including third sector partners. |
| **C** Provide details of use, and plans for improved access and use of outdoor estate for physical | **Susan Carnegie Centre, Stracathro** - daily walk around the Stracathro site for mental health patients<br><br>**Royal Victoria Hospital** - daily walks available on demand for day care and inpatients around the hospital grounds using risk assessed routes including Ramblers Scotland Medal Routes.<br><br>**NHS Tayside Staff Summer Walks and Picnics** – Healthy Working |

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| activity and promotion of active travel for patients, staff and local community | Lives (HWL) led walks for staff are arranged annually in June/July. Local green spaces at various hospital sites (including designated Ramblers Scotland Medal Routes) are used to encourage and promote further use of these spaces.<br><br>**Ramblers Scotland Medal Route Hubs** at Ninewells and Royal Victoria Hospital have been developed and promoted with the hospitals being identified as 'hubs'. 2016/17 plans included Perth Royal Infirmary and Murray Royal hospital being identified as Medal Route hubs<br><br>**Pool Bikes** - are available at four sites across NHS Tayside for employees' recreational and or business use.<br><br>**Dr Bike** events (3) held at Perth Royal Infirmary and Ninewells Hospital in 2015 including bike servicing and recycled bike sales.<br><br>**Cycle Friendly Employer Award** attained for Murray Royal Hospital March 2016. Perth Royal Infirmary has also registered interest in this award.<br><br>**Urban Fitness Programme** - this outdoor 'boot-camp' type exercise class has commenced in 2016 at Ninewells Hospital. However due to lack of numbers this class has had to be moved to an indoor location<br><br>**Ninewells Community Garden** - garden craft activities focused on patients/community/ staff held to encourage future use of the garden.<br><br>**Smarter Travel** initiatives were held across NHS Tayside hospital sites. This included manned display stands, bus time tables, lift-share sign up, journey planning web site promotion, active travel promotional items, and an active travel challenge in support of European Car Free day 2015. These were carried out in conjunction with TACTRAN, Perth on the Go and Angus on the GO.<br><br>**Travel Plans** - An annex to the Travel and Accommodation policy to include an overarching NHST Travel plan element is being taken forward by the policy review group. A review of Perth Royal Infirmary and Murray Royal Hospital travel plans is underway with TACTRAN and Perth and Kinross council representative involved.<br><br>**Biodiversity** initiatives completed by Estates department included<br>• Creation of approx 200 square meters of wildflower areas<br>• Extended naturalisation of grass within wooded areas – Tayside-wide<br>• Restricted/selective shrub pruning – improving flower yield Tayside-wide<br>• Naturalisation of internal courtyards at Ninewells - reduced cutting and carbon emissions<br>• Reduction in grass cutting frequencies – Tayside-wide reduction in carbon emissions<br>• Planted over 100 trees throughout hospital sites in Tayside<br>• Decrease in use of pesticides<br><br>**Electric vehicles** - EV car chargers installed and EV cars purchased |

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| | or leased through Co Wheels at NHST various sites.<br><br>**WWF Earth Hour March 2016** supported as part of NHST green agenda through promotion on staffnet.<br><br>**Travel Improvements at Stracathro Hospital** funded by Smarter Choices Smarter Places included provision of a new improved bus shelter facility, a covered bike stand facility for the use of staff and members of the public and provision of 3 secure bike lockers for staff use.<br><br>**Macmillan Move More** - people living with cancer are referred to the Move more programme which is now offered in Dundee through Leisure and Culture, Dundee. Assessments are carried out on all referrals by cancer rehabilitation specialist before taking part in physical activity sessions especially designed for them. Future plans include expansion of a led walking programme and gardening programme at Ninewells hospital. |
| **Action 25**<br>(NEW) | Provide a narrative on your assessment of the impact of physical activity and active travel actions, since their introduction in 2012. Frame your narrative to reflect impact on patient-centred care, staff health and wellbeing and the hospital environment. |

Input your narrative on the page below. Refer to the guidance for associated themes and observe the word count of 500 words / 1 page:

**Active Travel** - a travel survey of NHS Tayside staff was undertaken in 2015 with support from TACTRAN. 62% of responding staff travelled to work in sole occupancy car. The active travel promotion actions following this were taken forward in partnership in the delivery of the Travel Smarter promotions in 2015. Travel Smarter promotions will be carried out again in partnership in 2016/17 and a repeat Travel Survey scheduled for 2018. There is close working with TACTRAN and local authority representatives. The travel plan development is to be taken forward as an addendum to the Accommodation and Travel policy by the policy review group. At the CEL 01report in 2015 24.2% of staff were involved in active travel schemes. This figure provides baseline information for benchmarking.

**Physical activity interventions in clinical settings** - the surgical pre assessment services are now carrying out physical activity screening and providing brief advice as well as signposting to opportunities to be physically active. A recent audit found that physical activity was discussed with 88-100% of patients attending. Improvements to sign posting to physical activity opportunities through closer working with leisure trusts is being taken forward in 2016/17.

**Pain Service** - 82% of patients were given advice on physical exercise in their first consultation at a secondary care Chronic Pain Clinic. Links with Active for Life, Pain Association Scotland and Pain Concern have allowed the service to direct patients to more local resources. The service has commissioned Pain Management Programmes with the Pain Association, and hold monthly meetings to support LTC management for this group. While the programmes are not physical activity specific, they work with patients to identify “goals” often activity related that they want to achieve. The multi-disciplinary team consisting of Consultants, nurses, physiotherapists and pharmacists are now more informed and confident to direct patients to supported self management, which included exercise awareness. Working with community pharmacists through a project called “Teach and

Treat" they are up skilling community pharmacists, on the benefits and importance of supported self management, which includes sign posting patients earlier to self management and the importance of staying active.

**Use of Green space** - led walks for patients take place at key hospital sites. Ramblers Scotland medal routes have been developed at Ninewells and Royal Victoria hospitals. Further medal routes are planned in 2016/17 for Perth Royal Infirmary and Murray Royal Hospital. An urban fitness class has been tested at Ninewells Hospital and a range biodiversity initiatives have been undertaken by Estates. Macmillan Move More is increasing its capacity and has plans for more walks for cancer patients at Ninewells Hospital as well as gardening activities and gentle exercise classes.

**Challenges** for developing this area of work are mainly concerned with the reported limited time available to clinicians to discuss physical activity with patients. At consultations there are many issues they have to address. Formal referral to exercise schemes has been discussed as a development of brief advice currently being undertaken but this is felt to be too onerous a commitment for staff resource by the services to date. Signposting to physical activity schemes appears to be more favourably received by clinicians and progress in 2016/17 will focus on developing this way forward in discussions with leisure trusts and clinicians. The leisure trusts are also considering their data collection systems and are endeavouring to collect the required information for CMO reporting purposes.

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section H: Physical Activity & Active Travel**. Exception submitted:<br>[Limit each entry to 200 words] |
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**Managed Clinical Networks:** Lead contributor

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| Name | **Lesley Marley** |
| Job Title | **Directorate Manager, Public Health** |

| **Section I: Managed Clinical Networks - NEW** | |
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| **Action 26** (NEW) | All Managed Clinical Networks (MCNs) are aligned with HPHS and promote the use of health improvement pathways amongst clinical staff, with the appropriate support |
| **A.** Submit MCN improvement plans, with specific reference to embedding health improvement within clinical pathways. **Include at least one response for (i) – (iv):** | |
| **(i)** smoking cessation | |
| **(ii)** physical activity | |
| **(iii)** weight management | **The Tayside Nutrition MCN**<br>Provides NHS Tayside with overall strategic direction and governance in relation to nutrition across the malnutrition paradigm (under nutrition, **obesity** and therapeutic nutrition) and, the life course. It has a remit for the identification and agreement of priorities for **prevention**, treatment, care, support needs and service development in relation to nutrition. Two of the MCN's four work streams relate to the prevention and management of obesity across the life course:<br><br>**Public Health Nutrition** - Obesity is largely preventable and the development of obesity related disease can manifest during any part of the life course (i.e. prenatally, antenatally, infancy, childhood, adulthood and ageing). This work stream focuses on prevention and early interventions within groups of the population that are especially vulnerable to obesity and therefore focuses on Maternal and Infant Nutrition (MIN) and Workforce Nutrition.<br><br>**Weight Management** – One in three children and the majority of adults are already overweight/obese and so this work stream focuses on implementation of a tiered approach to weight management (as per Effective Prevention Bundle specification for adult weight management and child healthy weight (SG, 2015) & Outcomes Framework (SG, 2016). |
| **(iv)** routine enquiry to identify patients vulnerable to financial stress, homelessness or other social or environmental factors | **BBV and Sexual Health MCN:**<br>Do not specifically address these issues in MCN work plan but all the actions are tailored around reducing inequities in sexual health and |

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| | BBV, with a particular focus **on improving the health of vulnerable populations including those who are homeless.** A large proportion of our cohort will experience **financial stress**, related or unrelated to their diagnosis.<br><br>MCN work plan as it stands however it is under review at the moment to ensure it reflects the updated national Framework for Sexual Health and BBV 2015-2020. Actions around smoking cessation, physical activity and weight management are not specifically mentioned in the Sexual Health and BBV MCN work plan however key national outcomes we are working to achieve are "A reduction in the health inequalities gap in sexual health and BBV" and "People affected by BBV lead longer, healthier lives, with a good quality of life".<br><br>All areas of work focus on improving the health and wellbeing of vulnerable population groups often experiencing financial stress and issues such as homelessness.<br><br>Clinical teams across the Network promote smoking cessation and healthy lifestyle advice as part of their regular clinical activities. |
| **(v)** any other to note | |

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| **Action 27**<br>(NEW) | Provide a narrative on your assessment of the impact of MCNs.<br>Frame your narrative to reflect impact on patient-centred care, and if appropriate, staff health and wellbeing and the hospital environment.<br><br>**Note:** If you are unable to report on any MCNs already in place, submit information on activity and plans to develop MCNs. Include the setting, who is involved and a timescale for becoming operational. |

Input your narrative on the page below. Refer to the guidance for associated themes and observe the word count of 500 words / 1 page:

Since the development of the concept of Managed Clinical/care Networks (MCNs) back in 1998, there have been numerous examples of the significant benefits gained by both service users and service providers. This model, if implemented accordingly, addresses the many issues which hamper the delivery of high quality, equitable, accessible and effective patient centred care. Managed Care Networks take this concept further, as they have a key role in the integration of services across the health and local authority sectors by addressing the problems experienced by service users as they move from one provider or partner organisation to the next.

MCNs are an integral part of a systematic approach to service redesign, integration and improvement. They are also key to the development and implementation of the approaches

to long term conditions set out in Delivering for Health, as well as to the process of ‘shifting the balance of care’ away from the acute setting towards community-based services.

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section I: Managed clinical Networks**. Exception submitted: [Limit each entry to 200 words] |
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**Inequalities and person-centred care:** Lead contributor

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| Name | **Aileen Tait** (submitted by L Marley in her absence) |
| Job Title | **Senior Health Promotion/Improvement Specialist - Mitigating the Health Impact of Welfare Reform Programme, Directorate of Public Health** |

| **Section J: Inequalities and person-centred care -** NEW | |
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| **Action 28** (NEW) | All NHS Boards will plan and deliver hospital services that ensure routine enquiry for vulnerability is built into person-centred care and, therefore, those at risk of poverty or inequality attain the best possible health outcomes.<br>Boards are asked to focus efforts on priority settings: paediatrics, maternity, neurology, cancer, cardiology, mental health, respiratory and/ or HIV and Hepatitis C |

**A.** Provide a description and examples of inequalities sensitive practice in hospital settings. This can include routine enquiry in assessment of vulnerability through:

- Asking patients if they have money worries and offering a direct referral to advice services
- Support for patients who are, or at risk of, homelessness
- Support in access to services for vulnerable groups / examples of hospital based inequalities sensitive practice (as in updated required evidence).

The NHS Tayside Employability and Welfare Reform Forum met regularly with oversight of implementation and monitoring of NHS Tayside Managing the Health Impact of Welfare Reform Action Plan. 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.

Key service developments include -

Designing and launching in May 2015 a money worries/crisis help mobile device app. called 'Money Worries?'. A poster presentation highlighting the app. and showing its usage was accepted for the NHS Event 2016. The app. was developed as part of NHS Tayside's actions to mitigate the health impacts of welfare reform. The App is available from both Apple and Google App stores (search for Money Worries? Find the right help in a crisis). The poster has also been accepted for the Public Health Faculty event in October 2016.

Working towards establishing a Welfare Advice/Financial Inclusion Centre for all site users at Ninewells main concourse. The work started in late 2015 and the centre will open in October 2016. It is a partnership service comprising input from Citizens' Advice, Welfare Rights, Macmillan Cancer Care, Terrance Higgin's Trust, NHS Tayside Carers' Support and many others.

Developing a framework of indicators to monitor the impact of welfare reform over time on the population as a whole, and the impact of direct actions taken by NHS Tayside through the Welfare Reform Action Plan. Baseline data on these indicators has been collected.

NHS Tayside Healthy Working Lives Team continued to work with Welfare Rights Teams in the three Local Authority areas to deliver awareness sessions for staff in participating

organisations on in-work benefits.

Welfare Reform Awareness sessions delivered to NHS Tayside Equality and Diversity Champions

Welfare Rights advice service located within GP practices – now working out of 4 GP practices across Dundee with a view to extending this service, weekly outreach sessions at community centres. Social Prescribing link-workers based in 5 GP practices also link patients to welfare rights/money advice services.

NHS Tayside is the national health literacy demonstrator site where work is ongoing to raise awareness and support staff to work with patients to ensure understanding and capability to self manage their conditions and look after their health. Several clinical areas have been involved, including paediatrics, endoscopy, respiratory medicine, cardiology and anticoagulation. The learning and outcomes will be shared on the Scottish Government health literacy website healthliteracy.org.uk and rolled out across additional clinical and Board areas.

Wayfinding - a test pilot was set up to make use of large lettering and colours for different zones of Ninewells to ease the process of wayfinding for visitors. The intention was to link the colour-coded areas with the same colour-coding on the patient's appointment letter. All the clutter from the walls was cleared away to create a clearer landscape for wayfinding as suggested by feedback from BSL users. A number of walk-throughs had been carried out with people with varying sensory loss. The different colours and zones were discussed noting there would be innovative solutions to help blind/partially-sighted people as well as those with loss of hearing.

**B.** Evidence of actions within health inequalities strategy and/or community planning structures which demonstrate to what extent inequalities sensitive practice is implemented in the hospital sector.

Tackling health inequalities is central to the public health agenda. In 2010, on behalf of NHS Tayside and its partners, we published The Health Equity Strategy - Communities in Control – the stated aim is to eliminate health inequalities in Tayside within a generation.

In 2015 an internal audit of progress toward the implementation of the Strategy in Tayside identified many examples of encouraging progress; however, this was greater and more rapid in some areas than in others. In the areas where progress has not been substantial, the organisational culture around targeting of services and programmes towards those most in need has not been as receptive as it needs to be to deliver on what is a very radical strategy.

The audit has had the positive effect of encouraging NHS Tayside (along with other colleagues, IJBs and across the local partnerships) to re-energise our equity-focused work so that it becomes a core part of how all public sector organisations, including hospitals, work on a day-to-day basis. The principles and aims of the Health Equity Strategy will become increasingly visible within the strategic and commissioning plans or our health partners and IJB's. These plans will inform the development of a supplementary paper that will consolidate the aims of the Health Equity Strategy and refresh its direction.

In October 2015 NHS Tayside formed the multi-agency Health Equity Governance Board chaired by Lesley McLay, NHS Tayside Chief Executive, to guide this work and ensure progress. Given the disproportionate use of acute services by patients from deprived communities, health improvement in acute settings offers an opportunity to reduce health inequalities. The HPHS ethos is that 'every healthcare contact is a health improvement

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| opportunity' – the CMO Letter makes explicit the need to address health inequalities in the hospital setting. | |
| **Action 29** (NEW) | Provide a narrative on your assessment of the impact of inequalities and person-centred care.<br>Frame your narrative to reflect impact on patient-centred care, staff health and wellbeing and the hospital environment.<br><br>**Note:** If you are unable to submit evidence on impact, report activity underway to build this area of activity. |

Input your narrative on the page below. Refer to the guidance for associated themes and observe the word count of 500 words / 1 page:

The Directorate of Public Health leads on NHS Tayside's programme of work to mitigate the health impact of welfare reform. In response to national drivers (UK Welfare Reform: Final Guidance for NHS Boards in Scotland on Mitigating Actions, ScotPHN, 2013); National Outcome Focussed Plan to Mitigate Impact of Welfare Reform on Health and NHS Services, Scottish Government Welfare Reform and Health Impact Delivery Group, 2013), a local action plan has been in place since April 2014. Actions reflect the responsibilities of NHS Tayside both as an employer and as a service provider, as well as the contribution to this agenda from local authority and third sector partners. Significant progress has been made towards national short-term outcomes during 2015/16 and outcome indicators have been identified and data gathered in order to formulate a local monitoring and evaluation framework.

The continuing air of uncertainty around implementation of the programme of welfare reform at both UK Government and Scottish Government level has created ongoing challenges for efforts to mitigate the impact on the health of individuals and communities. NHS Tayside therefore continues to adopt a flexible approach to action planning and service delivery to meet those emerging challenges and needs.

Working in partnership with local authority and third sector colleagues is still recognised as an essential feature of working towards national recommended outcomes. Links to Community Planning and the local IJBs are now firmly established, with NHS Tayside represented on all relevant strategic planning groups. This, plus the key involvement of the Director of Public Health with the IJBs in all three areas of Tayside, as well as Dundee Fairness Commission, will ensure that due consideration is given to the welfare reform and health agenda in all service planning and delivery.

Progress has also been made in relation to the proposed development of a monitoring and evaluation framework linked to our local Welfare Reform Action Plan. Outcome and process indicators have been identified and baseline data gathered in order to monitor and measure progress against local and national proposed outcomes and a timeline of changes to the benefits system.

The timescale for our continued commitment to this work is not yet clear. For example, although Universal Credit has now been rolled out in Dundee, Angus and Perth and Kinross, the full effect of this has yet to be witnessed. The actions taken by Scottish Government using new devolved powers following the May 2016 election will inform further action. However, we will continue our efforts as before so long as there is evidence of a negative impact on health as a result of welfare reform.

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section J: Inequalities and person centred care**. Exception submitted:<br>[Limit each entry to 200 words] |
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**Mental Health:** Lead contributor

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|---|---|
| Name | **Lynsey Kemlo/ Gill McDonald/Linda Nicol** |
| Job Title | **Highly Specialist Physiotherapists/ Physiotherapy Team Lead Perth and Kinross** |

| **Section K: Mental Health - NEW** | | | |
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| **Action 30** (NEW) Section K Mental Health Guidance.do | All users of mental health services (with a diagnosis of severe and enduring mental illness) have an assessment for physical health on admission and an action plan for health improvement should be incorporated into their care plan. All discharged patients should have an action plan for physical health contained within their care plan, which informs community care and treatment. | | |
| **A.** Name of lead(s) | 1. (strategic)<br>Dundee - Gill McDonald;<br>Angus - Lynsey Kemlo;<br>Perth and Kinross (P&K) - Norma Patrick | 2. (operational)<br>Dundee - Val Johnson;<br>Angus - not identified;<br>P&K - Linda Nicol; | |
| Professional role | Highly Specialist Physiotherapist; Highly Specialist Physiotherapist; Physiotherapy Head of Service P&K | Head of Dundee Mental Health Angus- not identified Physiotherapy Team Lead P&K | |
| NHS Board or hospital site | General Adult Psychiatry (GAP) Carseview Centre, Dundee; Angus Adult Mental Health Services: General Adult Psychiatry, Murray Royal Hospital | Carseview Centre, Dundee; Murray Royal Hospital, Perth | |
| **B.** Number of staff trained to promote physical health | | | |
| | Undertaking physical health assessments | Developing action plans to support health improvement | Responsible for both assessments and action plans |
| **(i)** Total number of staff trained to promote physical health | 4 - GAP, Carseview<br>20 approx- Angus Adult Mental Health Team (AAMHT)<br>Not available- carried out by medical staff GAP | 4 - GAP Carseview<br>4 approx - AAMHT<br>4 - GAP Murray Royal | 4- GAP Carseview<br>2 approx - AAMHT<br>2 - GAP Murray Royal |

| | | | |
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| | Murray Royal | | |
| **(ii)** Name and format of course / module | **GAP Carseview**-RIPA, Brief Interventions, HBC 1 and 2<br><br>Online training and attendance at courses with clinical supervision sessions after the course completed.<br><br>**Angus Adult Mental Health Team**-, Medical Staff Induction covers physical activity pathway.<br><br>13 out of 37 nursing staff trained in smoking cessation<br><br>1 out of 1 physiotherapy support staff trained in smoking cessation<br><br>4 out of 37 nursing staff trained in Health Behaviour Change level 1(HBC1)<br>3 out of 3 AHP support staff trained in Health Behaviour Change level 2(HBC2)<br><br>**GAP Murray Royal**- HBC1 | | |
| Role of staff completing training | **GAP Carseview**-nursing and AHP<br><br>**Angus Adult Mental Health Team –** nursing, AHP and medical staff<br><br>**GAP Murray Royal Hospital** – AHP staff | | |
| **C.** Provide details confirming that relevant patient documentation has been revised to record physical health and action plan for health improvement. | **GAP Carseview**- Integrated Care Pathways have screening questions contained within the physical examination often completed by admitting doctor.<br><br>**Angus Adult Mental Health Team** screens for physical activity status and records maintained on the Multi-Disciplinary Information System (MiDIS) . Data have been collected from wards regarding the number of patients who are physically active and how much time is spent on moderate intensity activity.<br><br>**GAP Murray Royal Hospital -** physiotherapy activity assessment on MiDIS based on Brief Advice/Brief Intervention Scottish Government Guidance. | | |
| **Action 31** (NEW) | Provide a narrative on your assessment of the impact of mental health actions:<br>Frame your narrative to reflect impact on patient-centred care and if appropriate, also an impact on staff health and wellbeing and the hospital environment. **Note:** If you are unable to submit evidence on impact, report activity underway to build this area. | | |

Input your narrative on the page below. Refer to the guidance for associated themes and observe the word count of 500 words / 1 page:

**National Physical Activity Pathway:** All three areas in GAP Physiotherapy are now using the Scottish Physical Activity Pathway which allows delivery of Brief Advice and Brief Interventions. Brief Advice and Brief Intervention documentation is being used in all three sites and is located on MiDIS. The whole of the Multi Disciplinary Team (MDT) in GAP has access to the information.

**Training:** A Band 4 Physiotherapy Support Worker has completed his level Four Fitness Instructor Course in mental health. There are also one Band 3 and one Band 4 Physiotherapy Support Worker undertaking their Level 2 Fitness Instructor course.

**Sharing of learning**: In Carseview the Band 4's have shared learning with the Health Care Support workers in ward one. The seated exercise concept has been used; this method was chosen as it is easy to set up in a ward environment with little or no equipment, patients enjoy it, and all levels of ability can join in. This has been very successful and demonstrates a good example of shared learning and communication between nursing and AHP's. This training is to be rolled out to other Health Care Support staff in the unit.

Sharing information and learning opportunities under the physical activity umbrella is an example of how physical activity is everyone's business. Health Care Support staff have been signposted to local walking group training run by Dundee Healthy Living Initiative to allow them to participate in walking training. This will allow the support staff to run walking sessions off the ward on evenings and weekends to supplement the walking programme that is delivered by the physiotherapy team in Carseview.

Physical Activity is at the core of physiotherapy in the GAP setting. Physical activity awareness sessions have been run at the Dundonald Day Services in Dundee with staff and patients. GAP physiotherapists have delivered physical activity screening sessions in the Day Service Unit making physical activity sessions more accessible to patients who previously would not have engaged in community sessions.

The Nursing Support Staff and Occupational Therapy Support Staff have also received shared training and learning opportunities from the Physiotherapy Team to roll out further physical activity sessions in the Day Service Unit.

When physiotherapy posts in GAP have become vacant they have been advertised highlighting the essential role physical activity plays in this srea of health care.

The three Physiotherapists that lead on Physical Activity for Mental health in GAP have continued to use Peer Supervision and practice development time to further the role of physical activity in the GAP setting. Setting work for the next coming year is a priority for this small but hard working group.

**Impact**

- The target which ended in June 2015 was:

  By June 2015 60% of patients admitted to inpatients whose length of stay is greater than 3 days and are medically assessed as suitable for physical activity will be screened for physical activity.

  Target = 60% Achievement = 72%

An example of outcome of a brief intervention; In October 2015, a badminton group was started in response to the outcome of a brief intervention with a service user. This offered

another opportunity to another service users during his brief intervention and by November the group had 2 members. By March 2016 the group meets weekly with 4 members. The racquets were donated by Leisure Services; the service users pay the cost of the hire of the court at the Leisure Centre. There are plans to review the group in October 2016.

Complete the exception table below where you have been unable to provide the requested evidence:

| Action (provide number and any assigned letter) | **Section K: Mental Health**. Exception submitted: [Limit each entry to 200 words] |
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**Innovative and emerging practice:** Lead contributor

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| Name | **Lesley Marley** |
| Job Title | **Directorate Manager, Directorate of Public Health** |

Innovative practice should be interpreted as being a completely original project for your NHS Board e.g. either a new approach or adopting / testing new quality improvement methodology in the area.

| **Section L: Innovative and Emerging Practice** | |
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| Section L Inn & Em practice Guidance.d | **1.** Include: project name, setting, format, targeting, any collaborative working and outcomes |
| **1.** Development and piloting of opt out services for smoking cessation services | NHS Tayside No Smoking Policy is in line with national guidance and is tailored to providing an 'opt out' approach. Our 'Hospital Pathways' provide stepped guidance to clinical staff and managers helping us focus on care plans that deliver the best health outcomes for patients who smoke. The 'Prescribing Guidance' pathway ensures that staff can prescribe pharmacotherapy to support patients to abstain during their stay in hospital. |
| Name & contact details | Alice Burns, Smoking Cessation Co-ordinator, Acute. a.burns4@nhs.net |
| | **2.** Include: setting, role of person delivering ABI, reach, any targeting or collaborative working and outcomes |
| **2.** Alcohol brief intervention delivery in hospital settings | - |
| Name & contact details | - |
| | **3.** Include project name, setting, format and any targeting, collaborative working and outcomes |
| **3a.** Development of staff and / or patient weight management service | Weight loss for pre and post natal women since summer 2015 |
| Name & contact details | Joyce Thompson, Dietetic Consultant in Public Health Nutrition - Tayside Nutrition MCN Lead Clinician - Dietetic Professional Lead |
| **3b.** | |
| Name & contact details | |
| **3c.** | |
| Name & contact details | |
| Additional examples can be submitted below. These examples may include updated evidence from former CEL annual reports if there is any further development to report | |

| or assessment of impact. | | |
|---|---|---|
| Provide brief details on the name of the project; setting; format; targeting; collaborative work and why this is innovative in your NHS Board.<br>**Include name and contact details for each input**<br>Add extra rows if required. | Indicate if project has previously been reported | Indicate which core theme the project is aligned to:<br>1. Person-centred care<br>2. Staff Health<br>3. Hospital Environment |
| **Money Worries App** (see Inequalities Section)<br><br>Aileen Tait aileen.tait@nhs.net | This year's report | Person-centred care |
| **Welfare Reform Advice Centre** (see Inequalities Section)<br>Lesley Marley lesley.marley@nhs.net | This year's report | Person-centred care |
| **Concourse Redevelopment Group** (see Strategic Action Section)<br>Lesley Marley lesley.marley@nhs.net | This year's report | Person-centred care<br><br>Hospital Environment |
| **Health Literacy** (see Inequalities Section)<br>Phyllis Easton Phyllis.easton@neh.net<br><br>**Way-finding Project**<br>Work that is underway to improve signage at Ninewells. There is a great future opportunity to introduce technology e.g. smart phone apps to guide people. It will need a whole-systems approach; appointment letters must mirror the signage in the hospital to avoid confusion. | This year's report<br><br>No | Person-centred care<br>Hospital Environment<br><br>Person-centred care<br>Hospital Environment |
| **HPHS intranet (Staffnet)** – targeted to staff so they can access advice to support their input to HPHS launched in March 2016.<br>Lesley Marley lesley.marley@nhs.net | No | Person-centred care |

**Appendix A**

Additional contributors for each section can be named in the table below:

| Section | Name of contributor | Job Title |
|---|---|---|
| **A:** Strategic actions | Steven Valentine | Health Behaviour Change Co-ordinator |
| **B:** Smoking | Alice Burns<br><br>Jodi Moodie | Smoking Cessation Co-ordinator, Acute<br><br>Health Improvement Project Support Officer |
| **C:** Alcohol | | |
| **D:** Maternity | Carol Barnett | Programme Manager , MIN (retired) |
| **E**: Food & health | Rosemary Davidson | Public Health Nutrition Adviser |
| **F:** Staff health & wellbeing | | |
| **G:** Reproductive health | | |
| **H:** Physical activity & active travel | | |
| **I:** MCN | Joyce Thompson<br><br>Donna Thain | Dietetic Consultant in Public Health Nutrition - Tayside Nutrition MCN Lead Clinician - Dietetic Professional Lead<br><br>MCN Manager, BBV & Sexual Health |
| **J:** Inequalities & person centred care | Phyllis Easton<br><br>Hazel Scott | Health Intelligence Manager<br><br>General Manager. Public Health |
| **K:** Mental health | Sylvia Mudie | Senior Health Promotion Officer |

**Note:** insert additional rows if required.

23 January 2017

To: NHS Board's HPHS Network Lead

Copied in: NHS Board's HPHS Champion
NHS Board's CE

Dear Colleagues,

**Re: Health Promoting Health Service (HPHS) Annual Reporting: CMO (2015) 19 letter – Year 1 (2015-16)**

Please find attached your Board's feedback report based on your HPHS CMO (2015) 19 letter, Annual Report submission, 2015-16.

NHS Health Scotland has conducted an analysis of Annual Reports following submissions from all NHS Boards in September 2016. Feedback is a reflection of your Board's Annual Report submission as well as further information provided during the data mitigation process. Given the changes this year, in the performance measures required, we have not included the *'Delivery Analysis'* section. All NHS Board reports were assessed using the same methods, and have been cross-checked for consistency.

For your reference the reporting guidance requirements for Year 1 can be viewed at: CEL (1) 2012 Annual Report: Year 3 Submission Requirements. **CMO (2015) 19 Annual Report: Year 1 Evidence Requirements**

Further to the analysis at an individual NHS Board level, national topic/ policy reviews with Scottish Government and NHS Health Scotland leads were conducted. These reviews were used to reflect on data submissions, discuss progress and barriers that have been reported, and discuss potential changes to future evidence requirements and/or implement national-level actions (where appropriate).

Annual reporting will be discussed at the HPHS National Network meeting on 25th January 2017, between Boards' HPHS Leads, the Scottish Government HPHS programme team and the NHS Health Scotland national support team.

For any specific queries on your feedback report, please email: nhs.HealthScotland-hphsadmin@nhs.net

Kind Regards

**Kate Barlow**
**Health Improvement Manager, NHS Health Scotland**

| | |
|---|---|
| **NHS Board** | NHS Tayside |
| **Submission Date** | 30 September 2016 |
| **HPHS Lead** | Lesley Marley, Directorate Manager Public Health |
| **Contact email address** | lesley.marley@nhs.net |

| **Hospital sites represented within the submission** | |
|---|---|
| **Acute** | Ninewells Hospital, Dundee; Perth Royal Infirmary (PRI); Stracathro; Brechin. |
| **Community** | Dundee Dental Hospital<br>Royal Victoria Hospital, Dundee<br>Whitehills, Forfar<br>Arbroath Infirmary<br>Brechin Infirmary<br>Montrose Infirmary<br>Crieff Community Hospital<br>Blairgowrie Community Hospital<br>Aberfeldy Community Hospital<br>Pitlochry Community Hospital<br>St Margaret's Community Hospital, Auchterarder |
| **Maternity** | Acute Maternity Unit Ninewells; Community Midwife-led Maternity units in Ninewells, PRI, Arbroath Infirmary and Montrose Infirmary. |
| **Paediatric** | As part of Ninewells Hospital Dundee |
| **Mental health** | Murray Royal Hospital, Perth |

## 5. Summary Feedback

We recognise the positive impact that NHS Tayside HPHS Ministerial Group representatives have had in supporting the embedding of the HPHS ethos at a strategic level locally. Influence has also contributed to key developments such as HPHS and Public Health involvement in the concourse re-design at Ninewells Hospital.

Specific achievements in 2015-16 noted include:

- The comprehensive approach taken across tobacco actions. Including communication on smoke-free grounds, support and training for staff which has led to an increase in capacity to deliver smoking cessation on wards and the number of pathways in place to support stop smoking services.

- The quality improvement work being undertaken in relation to breastfeeding.

- The positive impact that food and health measures have had; including the influence of environmental developments such as the concourse redesign at Ninewells Hospital including the planned inclusion of a social enterprise food provider within the new concourse and the continuation of 100%healthy drinks vending.

- The greenspace and active travel work taken forward in NHS Tayside is noted as an example of good practice, the learning from which should be applied across all sites.

**6. Recommended improvement areas for action:**

- We encourage NHS Tayside to work with the local Integrated Joint Boards to raise the awareness of HPHS, and embed it within local plans.

- We encourage Boards to build in the measurement of impact of HPHS within any relevant strategic, or commissioning and implementation plans.

- We recognise the challenges of achieving HRS where longstanding contracts are in place, but note the positive impact that the target date of achieving HRS compliance is having on negotiations.

- We encourage Boards to consider a prevention approach to health and wellbeing, including effective interventions and impact. The collection of data for a range of measures/ indicators, including wellbeing indicators and not just staff sickness absence rates, may be helpful.

- We encourage measurement and analysis of the uptake of staff in physical activity programmes. In particular the uptake across staff groups to identify who is utilising the activities to help inform whether targeted interventions are required those staff not accessing interventions.

**7. Submission Feedback -** Details within the table below reflect submitted data only.

| Action | Named contributors | Exception Reported | Feedback |
|---|---|---|---|
| **Strategic Actions** | **SECTION A** | | |
| **1. Strategic Leadership** | Lesley Marley | | We note the partnership approach taken in relation to the Tayside Tobacco Action Plan, and note that local authorities wish to align their tobacco policies with those of the Board.<br><br>We encourage the Board to consider how HPHS can be integrated within the work of IJBs.<br><br>We highly recommend that Boards ensure that HPHS is embedded; a possible option for Boards to consider is to include HPHS actions within part of their regular clinical service reviews or equivalent. |
| **2. Workforce development** | | NHS Tayside Workforce Plan does not break down staff to the categories used by attendees registering on the course, so a meaningful proportion is not able to be calculated<br><br>NHS Health Scotland cannot provide accurate data from the Virtual Learning Environment | It is important for Boards to understand and monitor professional development that includes health improvement and inequalities competencies, we encourage Boards to demonstrate how they gain an improved understanding of the workforce, targeted and undergoing training, to support a sustainable approach to health improvement and inequalities within person-centred care. |

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| | | (VLE) on the number of staff undertaking the online courses, unless the staff member specifies they work in the NHS, and clearly type their role and team. Staff can also update their details later to ensure information is correct and consistent with their team, which will help to extract the most accurate information. Although these are not the only training courses available to staff.<br>. | |
| **3. Clinical and Medical Leadership** | | | We note the impact that NHS Tayside representation on the HPHS Ministerial Group, has had in contributing to the embedding of the HPHS ethos at a strategic level, and the influence that this has also had at an operational level. In addition, the involvement and active participation of the Board HPHS Champion is noted.<br><br>Quality improvement activity is an essential part of the consultant appraisal process. With a number of interventions noted that illustrate HPHS related activity supported by clinical staff. We encourage the Board to continue to work towards the ethos of HPHS being embedded within the work of medical staff and note the activities planned to support this aim. |

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| | | | We highly recommend that Boards ensure that HPHS is embedded; a possible option for Boards to consider is to include HPHS actions within part of their regular clinical service reviews or equivalent. |
| **4. Assessment of impact** | | | The future work planned for the embedding of HPHS with Health and Social Care Integrated Joint Boards is noted, we would encourage communication with other HPHS Leads to share learning around the development of local plans for health and social care integration.<br><br>We also encourage Boards to build in the measurement of impact of HPHS within any relevant strategic, or commissioning and implementation plans. |

| Action | Named contributors | Exception Reported | Feedback |
|---|---|---|---|
| **SECTION B: Smoking** | | | |
| **Action 5 A, B**<br><br>**Managing patient smoking and Referral pathways** | Margaret Winton | Unable to elicit prescribing data for 'Diabetes' due to there not being any specific inpatient wards for diabetic patients. Ongoing quits for this patient group are also not provided as unable to identify patients with diabetes for the same reason given above.<br><br>Manual records held within Diabetes outpatient areas and no prescribing data recorded for outpatients also means no data is able to be provided for this specific setting breakdown.<br><br>The only data that can be provided by Diabetes MCN is that 83.5% of Tayside diabetic patients have had their smoking status recorded with 2015/2016 period, down by 1% on previous year.<br><br>It is noted that there are issues of recording information (smoking | It is noted that smoking status is recorded by ward nursing staff as part of the manual collection of the nursing core data set, and that the use of a manual system impacts on data reporting in relation to the number of smokers admitted to hospital.<br><br>The number of pathways in place to support smoking cessation is commended and it is noted that all processes and pathways are built on an opt-out approach. |

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| | | status, referrals within the acute setting, provision of NRT) on local and national systems. We advise Boards to continue to develop a local solution whilst the national e-referral project is being scoped out. | |
| **Action 6**<br><br>**Maintenance of Tobacco policy** | | | The partnership approach in relation to the Tayside Tobacco Plan is noted and it is encouraging to note the joined-up approach that is sought in relation to the aligning of NHS and local authorities smoking policies.<br><br>The comprehensive approach taken to conveying information to staff, patients and visitors in relation to smoke-free grounds is welcome, with evidence detailed of the support and training provided to staff to support awareness and knowledge of the no smoking policy and their individual responsibilities with regards to it.<br><br>It is positive to note the training that has been undertaken with staff from the acute setting to increase the capacity of staff to support smoking cessation. With evidence of training being adapted in a timely manner to address issues being identified through ward prescribing data, as well individual assumptions in relation to tobacco use. In addition, the inclusion of smoking cessation related learning outcomes to |

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| | | | undergraduate medical and nursing student is very welcome.<br><br>We encourage the Boards to continue their good work and ensure appropriate action when this becomes legislation in Scotland. |
| **Action 7**<br><br>**Narrative - Impact of smoking actions** | | | It is encouraging to note the Hospital Smoke Free Service re-design that is ongoing. Building smoking cessation capacity within the medical and nursing workforce is welcome. We would encourage the Board to consider how to measure the impact of changes to service delivery in the acute setting, which can build upon the evidence already being gathered at ward level on nicotine replacement therapy prescribing. |

| Action | Named contributors | Exception Reported | Feedback |
|---|---|---|---|
| **Section C : Alcohol** | | | |
| **Action 8**<br><br>**Narrative - Impact of alcohol actions** | Neil Fraser | | The screening for, and delivery of, alcohol brief interventions (ABIs) in maternity settings, A&E and minor injury and illness units is noted; alongside some of the challenges that have been reported in embedding delivery in those settings.<br><br>We welcome the Boards' contribution to several years of over-performance of ABI delivery. Progress and embedding is evident in priority settings with examples of good practice, pragmatic delivery and continuous improvement. However there is still variation in practice and Boards are encouraged to share learning and experience. After discussions with Scottish Government and NHS Health Scotland policy leads, it has been agreed that we still need to maintain and embed ABI delivery in A&E, strengthen links to the wider health and social care settings and maintain workforce development. ADP Annual Reporting is the best route to have oversight of these. Going forward, the framework for HPHS will be revised and will not include performance measures for ABIs. This information is now captured through ADP Annual Reporting. |

| Section D : Maternity | | | |
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| **Action** | **Named contributors** | **Exception Reported** | **Feedback** |
| **Action 9**<br>**BFI Award Status** | Janet Dalzell | | Achievement of the UNICEF BFI Award implies compliance with the WHO code. The arrangements for the local approach for WHO compliance of: monitoring/ auditing of compliance; communication of code to staff; and the formal process of reporting any breaches are noted as being set out for staff in the local NHS Tayside Infant Feeding Policy. |
| **Action 10 A, B**<br><br>**Pathways to support continued breastfeeding** | | | There is a comprehensive approach outlined to the supporting of breastfeeding in wider acute settings. Equipment is available to support breastfeeding women and 'rooming in' is encouraged following appropriate risk assessment.<br><br>The availability of equipment to support breastfeeding mothers with pre-term and sick babies, or those encountering feeding problems is welcome, alongside other initiatives such as milk expression logs. |
| **Action 11 A, B** | | | The comprehensive nature of data regarding breastfeeding rates is noted. Analysis of this data |

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| **Reducing breastfeeding attrition rates**<br><br>**Supporting breastfeeding**<br>**(i) birth – hospital discharge**<br>**(ii) handover to health visitor** | | | contributes to focused service delivery and the development of targeted initiatives.<br><br>It is encouraging to note the initiatives that have been introduced to support initiation of, and continuation with, breastfeeding. Additionally, specific work is underway regarding supplementation, including staff communication and the development of action plans.<br><br>We commend the quality improvement (QI) work being undertaken in relation to the application of QI methodologies to support breastfeeding in the immediate post-natal and discharge to handover to health visitor period. A number of examples in the post-natal period were provided alongside a description of the national recognition that the interventions have achieved.<br>The use of questionnaires to gain mother's views and the completion of feeding assessments and subsequent audits of these have supported service changes to support continued breastfeeding on discharge from hospital. |
| **Action 12 A, B**<br><br>**Supporting breastfeeding staff returning to work** | | | All pregnant staff receive information about the breastfeeding policy and an equipment loan scheme is in place for women on their return to work. Each Board site has either a dedicated room or a room made available for women who wish to express milk. |

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| **Action 13**<br><br>**Narrative - impact of maternity actions** | | | It is encouraging to note the positive impact that the breastfeeding HPHS CEL and CMO measures have had in the delivery of breastfeeding-related services and we encourage the Board to explore ways of measuring the impact of this.<br><br>The use of improvement methodologies is encouraging and we support the continuation of this as a tool in changing services and assessing impact. |

| Section E : Food and Health | | | |
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| **Action** | **Named contributors** | **Exception Reported** | **Feedback** |
| **Action 15**<br>**Catering outlets with HLA & HLA+ (A,C,E)**<br>**Vending machines out with catering outlets with HLA + (B, D, F)** | Susan Welsh | | Nine catering outlets are operating at HLA+ level, with one Board outlet awaiting assessment results and a further outlet operating at HLA level.<br><br>All vending machines within the Board are HLA+ compliant. We commend the work that NHS Tayside has undertaken in relation to 100% sugar free drinks vending and we look forward to future reporting on the impact that the 100% healthy choice vending machine has had.<br><br>All outlets will require to operate at the HLA+ level by 31st March 2017. |
| **Action 16**<br>**Retail outlets meeting HRS**<br>**Retail trolley services meeting HRS** | | | None of the retail outlets or retail trolley services currently meet the Healthcare Retail Standard (HRS).<br><br>We note the challenges with regards to the current contract constraints with the private sector retailer; however, we encourage the Board to continue to work towards compliance with the HRS.<br><br>Boards must ensure compliance by the end of March 2017 (or at the point of re-negotiation of contracts). |

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| | | | We also encourage the Board to continue their work within Murray Royal Hospital to source healthy choices which meet HRS criteria, alongside balancing customer choice where the customers may be limited in their access to other retail choices. |
| **Action 17. Community food co-ops / other social enterprises achieving HRS** | | NHS Tayside had social enterprise fruit and vegetable stalls in Ninewells, PRI and Kings Cross. They were not supported sufficiently by site users, or allowed to trade indoors in inclement weather, so the operators withdrew as they could not make the business model break-even. This will be readdressed in the refurbishment of Ninewells concourse. | We encourage the work to identify a social enterprise food provider as part of the concourse development work at Ninewells Hospital.<br><br>The Board are encouraged to continue to explore and maximise opportunities in providing affordable fruit and vegetables. |
| **Action 18 Narrative - impact of food & health actions** | | | It is encouraging to note the positive impact that the inclusion of food and health HPHS CEL and CMO reporting measures have had with regards to local delivery and as a tool to support negotiations with contractors to work towards HRS compliance.<br><br>We encourage the Board to continue with these positive changes, on the availability and affordability of healthy food and drink choices for staff and visitors, and to measure the impact of this work. |

| Section F : Staff Health and Wellbeing | | | |
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| **Action** | **Named contributors** | **Delivery analysis Exception Reported** | **Feedback** |
| **Action 19 B**<br><br>**HWL award status** | Pat Davidson | | Across NHS Tayside six operational areas/sites have achieved Health Working Lives Gold status, one area is at Bronze level working Silver status and one area is maintaining Bronze status.<br><br>We encourage the Board to continue the good progress with HWL Award, ensuring that all sites maintain or attain Gold. |
| **19. C (i) Description of mental health & wellbeing interventions** | | | It is noted that a number of policies and practices are in place to support the mental health and wellbeing of staff, and that engagement with staff is seen as a key part of this.<br><br>We would encourage the board to ensure a strategic approach to mental health and wellbeing is implemented, which builds on the staff health and wellbeing interventions reported, but also identifies some of the underlying reasons for stress and poor mental health in the workplace, and outline the organisational / system wide approach required to address these. |

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| **19. C (ii) Description of physical health interventions** | | | There are a range of activities and incentives available to staff to support staff to undertake physical activity and support their own physical health.<br><br>We encourage measurement and analysis of the uptake of staff accessing physical health programmes. In particular the uptake across staff groups to identify who is utilising the activities to help inform whether targeted interventions are required for staff groups not accessing interventions. |
| **19. C (iii) & (iv)**<br><br>**Promotion of health screening & immunisation** | | | It is encouraging to note the promotion of various health screenings and vaccinations to staff. |
| **Action 20**<br><br>**Narrative - impact of staff health and wellbeing actions** | | | We recognise the range of work being undertaken to support staff health and wellbeing. We encourage all Boards to consider a preventative approach to health and wellbeing, including effective interventions and impact. The collection of data for a range of measures/ indicators, including wellbeing indicators and not just staff sickness absence rates, could support this preventative approach. |

| Section G : Reproductive Health | | | |
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| **Action** | **Named contributors** | **Delivery analysis Exception Reported** | **Feedback** |
| **Action 21 A**<br><br>**A. Repeat terminations – evidence of impact** | Ann Eriksen | | We note that the decline in rates of termination of pregnancy (TOP) has been greater than the national Scottish average.<br><br>Data on TOP from local and national sources are used to inform local service delivery with increased working between TOP and Sexual and Reproductive Health Services. Additionally, analysis of data has been used to target interventions and services to specific communities. |
| **Action 21 B**<br><br>**(i) Vulnerable women and termination information**<br>**(ii) Support for vulnerable women in maternity services**<br>**(iii) Support for vulnerable women in** | | | A comprehensive outline to how vulnerable women are identified within both termination and maternity services is provided, and routine data is collected in termination services and reported to the Sexual Health and BBV MCN.<br><br>The Tayside Maternity Services Pathway provides a clear route for staff to assess for, and identify, vulnerabilities and for onward referral into tailored care and appropriate services. With discussions about contraception routinely being undertaken in the ante and post-natal period. |

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| **termination services** | | | Within termination services there are no specific pathways for groups defined as vulnerable; however, an individualised approach is taken for each patient and vulnerabilities are identified through clinic consultation, with links to clinical and health care services in place for onward referral. |
| **Action 21C**<br><br>**(i) SH & BBV framework delivery - maternity service**<br>**(ii) SH & BBV framework delivery – termination service** | | | There is evidence of partnership working between Sexual and Reproductive Health staff to increase the capacity of staff within maternity and TOP services to provide contraception, including LARC, in a timely manner. It is noted that the SHBBV MCN is actively involved in supporting this roll-out, including through the identification of resources for training. |
| **Action 22**<br><br>**Narrative - impact of reproductive health actions** | | | The provision of LARC across TOP and maternity services has been supported by the evidence of strong partnership working and involvement from the SHBBV MCN.<br><br>We encourage the Board to continue with the strategic discussions that are ongoing in relation to the availability and provision of contraception in maternity especially in relation to vulnerable groups. |

| Section H : Physical Activity and Active Travel | | | |
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| **Action** | **Named contributors** | **Delivery analysis Exception Reported** | **Feedback** |
| **Action 23**<br><br>**A. Revised documentation**<br><br>**B. Development plan / assessment of impact in priority setting** | Sylvia Mudie | | It is noted that physical activity has been included in patient documentation within surgical pre-assessment and pain services. It would be beneficial for NHS Tayside to consider how this can be spread to other areas drawing on learning from other NHS Boards. |
| **Action 24 A**<br><br>**(i) Support/services for referral**<br>**(ii) Support /services for signposting**<br>**(iii) Support /services for assessment of use** | | | Progress has been made to integrate physical activity within a range of settings. NHS Tayside is encouraged to increase the spread of implementation within and across additional clinical specialities, by establishing physical activity within existing clinical pathways and associated Managed Clinical Networks. |

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| **Action 24 B**<br><br>**Evidence of partnership working** | | | A number of interventions and initiatives which involve partnership working are noted. NHS Tayside are encouraged to consider how the impact of interventions can be measured, including uptake and outcomes where measurable. |
| **Action 24 C**<br><br>**Access & use of outdoor estate**<br><br>**Promotion of active travel** | | | The greenspace and active travel work taken forward in NHS Tayside is noted as an example of good practice, the learning from which should be applied across all sites. |
| **Action 25**<br><br>**Narrative - impact of physical activity actions** | | | It is noted that without this CEL/CMO Letter directive there is no other governance mechanisms through which accountability for physical activity can be measured within NHS Boards. However the assessment of impact of these actions remains challenging across all NHS Boards. It is therefore suggested that all NHS Boards are engaged in the development of key performance indicators that can be recorded in order to report impact. |

| Section I : Managed Clinical Networks | | | |
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| **Action** | **Named contributors** | **Delivery analysis Exception Reported** | **Feedback** |
| **Action 26 A**<br><br>**MCN improvement plans & clinical pathways**<br><br>**(i) Smoking cessation**<br>**(ii) Physical activity**<br>**(iii) Weight management**<br>**(iv) Routine enquiry**<br>**(v) Other** | Lesley Marley | | There is work underway across the Nutrition and BBV and Sexual Health MCNs to embed health improvement activity within the work of the Networks, with clinical teams already undertaking health improvement related activities as part of their clinical work. Within the BBV and Sexual Health MCN a specific work stream focuses on vulnerable population groups, including those who may be experiencing, or at risk of, financial stress or other social and environmental factors. |
| **Action 27**<br><br>**Narrative – impact of MCNs** | | | We encourage Boards to continue to embed health improvement HPHS measures within clinical pathways; this does not necessarily need to be through MCNs but as you have active MCNs in your Board, you may wish to continue working with them to achieve this action. |

| Section J : Inequalities and person-centred care | | | |
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| **Action** | **Named contributors** | **Delivery analysis Exception Reported** | **Feedback** |
| **Action 28 A B**<br><br>**Description & examples of inequalities sensitive practice**<br><br>**Evidence of actions demonstrating implementation** | Aileen Tait (submitted by L Marley in her absence) | | The Board have described a range of inequalities sensitive practice that are delivered in, or accessed following referral from, hospital settings. Interventions described included: the development of a money worries app; the inclusion of a Welfare Advice / Financial Inclusion Centre as part of the redevelopment of Ninewells Hospital Concourse; participation as a national health literacy demonstrator site and pilot work to support wayfinding for patients and visitors with solutions identified for blind / partially sighted people and BSL users.<br><br>We encourage the Board to continue with its efforts of ensuring that staff are aware of financial inclusion services and signposting patients to them. |
| **Action 29**<br><br>**Narrative - impact of inequalities and person centred-care** | | | The Board has demonstrated a strong commitment to tackling health inequalities through the development of the Health Equity Strategy – Communities in Control, with a multi-agency governance group to guide this work. We note the recognition of variation in the progress of services and programmes in the delivery of the strategy and encourage the Board to continue with the implementation of the strategy. |

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| | | | We also encourage the Board to ensure that assessment of impact is embedded when designing and delivering inequalities sensitive practice, to further build the local evidence base. |

| Section K : Mental Health | | | |
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| **Action** | **Named contributors** | **Delivery analysis Exception Reported** | **Feedback** |
| **Action 30 A, B & C**<br><br>**Number and breakdown of staff trained to promote physical activity**<br><br>**Details of revised documentation** | Lynsey Kemlo<br>Gill McDonald<br>Linda Nicol | | We note that staff in mental health services have been able to access health behaviour change and smoking cessation training, alongside Mental Health First Aid and ASIST suicide training.<br><br>Work around the development of interventions to support physical activity within mental health settings is described, and it is noted that the target to screen the physical activity of inpatients whose stay is 3 or more days has been exceeded.<br><br>On admittance to mental health services all patients have their physical health assessed and this is recorded electronically. |
| **Action 31**<br><br>**Narrative - impact of mental health actions** | | | It is encouraging to note that patient documentation includes an assessment of physical health. We encourage the Board to consider how the assessments can lead to the development of action plans that promote (physical and mental) health improvement for patients, or if this is already being undertaken, how this can be reported in future. |

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

**Item 13**

**BOARD02/2017**
**NHS Tayside Board**
**23 February 2017**

**HEALTHCARE ASSOCIATED INFECTION (HAI) CONTROL IN TAYSIDE FOR NOVEMBER AND DECEMBER 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 November and December 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**

**February 2017**

# 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 November and December 2016

- CDI rate is just on target
- 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: An exception was noted for Q3 when compared to national data. The number of episodes for the first and second halves of 2016 are the same. The major influencing factor is the reduction in the denominator which increases the rate, 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

## 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, mumps and other infection cases continued to lead to contact tracing exercises. No secondary cases in patients or staff were detected. A small number of wards and bays had to be closed or restricted for less than 5 days due to respiratory viruses (for instance influenza A and RSV). National guidance was followed.


| **Other HAI Related Activity - See Appendices as below** | | Page(s) |
|---|---|---|
| Appendix 1 | MRSA | 9 |
| Appendix 2 | Vancomycin-resistant Enterococcus (VRE) | 10 |
| Appendix 3 | SAB Data | 10 |
| Appendix 4 | CDI Data | 11 |
| Appendix 5 | ESBLs and other multi-drug resistant Gram-negative bacteria | 11-12 |
| Appendix 6 | Antimicrobial Prescribing data | 12-14 |
| Appendix 7 | Surgical Site Infection (SSI) data | 15 |
| Appendix 8 | Hot Topics / Horizon Scanning | 15 |
| Appendix 9 | HAI and Medical Certificate of Death | 16 |
| Appendix 10 | Status of HEI Action Plans | 17-18 |
| Appendix 11 | Glossary | 19 |

# 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

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MRSA** | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 |
| **MSSA** | 12 | 18 | 13 | 11 | 5 | 12 | 12 | 14 | 10 | 8 | 10 | 18 |
| **Total SABs** | 12 | 19 | 13 | 12 | 5 | 13 | 12 | 14 | 10 | 8 | 10 | 20 |

Within the natural variation parameters

## *Clostridium difficile* infection monthly case numbers

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ages 15-64** | 1 | 3 | 4 | 1 | 5 | 6 | 2 | 3 | 5 | 5 | 4 | 2 |
| **Ages 65 plus** | 9 | 5 | 7 | 7 | 9 | 8 | 11 | 7 | 4 | 6 | 5 | 0 |
| **Total CDI** | 10 | 8 | 11 | 8 | 14 | 14 | 13 | 10 | 9 | 11 | 9 | 2 |

Within natural variation parameters

See Appendix 3 for related SAB information and Appendix 4 for CDI information

## Hand Hygiene (HH) Monitoring Compliance (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Medical** | 91 | 90 | 92 | 89 | 94 | 92 | 98 | 92 | 86 | 91 | 96 | 92 |
| **Nurse** | 98 | 96 | 97 | 97 | 98 | 98 | 96 | 98 | 97 | 98 | 99 | 96 |
| **AHP** | 98 | 93 | 98 | 94 | 96 | 88 | 99 | 94 | 91 | 94 | 99 | 99 |
| **Ancillary** | 98 | 81 | 84 | 87 | 95 | 90 | 88 | 91 | 92 | 94 | 90 | 99 |
| **Combined** | 96 | 90 | 93 | 92 | 96 | 92 | 95 | 94 | 92 | 94 | 99 | 97 |

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 (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Board Total** | 95 | 94 | 94 | 94 | 95 | 94 | 94 | 95 | 95 | 94 | 95 | 95 |

## Estates Monitoring Compliance (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Board Total** | 95 | 96 | 97 | 95 | 96 | 96 | 95 | 95 | 96 | 94 | 96 | 97 |

# NHS TAYSIDE

## NINEWELLS HOSPITAL REPORT CARD

### *Staphylococcus aureus* bacteraemia monthly case numbers

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MRSA** | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 |
| **MSSA** | 4 | 8 | 4 | 1 | 2 | 2 | 4 | 5 | 1 | 2 | 4 | 4 |
| **Total SABs*** | 4 | 9 | 4 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 4 | 6 |

### *Clostridium difficile* infection monthly case numbers

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ages 15-64** | 1 | 2 | 2 | 1 | 2 | 2 | 1 | 1 | 2 | 2 | 4 | 0 |
| **Ages 65 plus** | 4 | 1 | 3 | 1 | 3 | 4 | 5 | 2 | 3 | 3 | 2 | 0 |
| **Total CDI*** | 5 | 3 | 5 | 2 | 5 | 6 | 6 | 3 | 5 | 5 | 6 | 0 |

### Cleaning Compliance (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NWs Total** | 94 | 93 | 94 | 93 | 93 | 94 | 94 | 94 | 94 | 93 | 94 | 95 |

### Estates Monitoring Compliance (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NWs Total** | 94 | 95 | 94 | 93 | 93 | 93 | 92 | 93 | 93 | 93 | 94 | 94 |

## PERTH ROYAL INFIRMARY REPORT CARD

### *Staphylococcus aureus* bacteraemia monthly case numbers

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MRSA** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **MSSA** | 0 | 2 | 1 | 0 | 0 | 0 | 3 | 0 | 1 | 0 | 1 | 1 |
| **Total SABs*** | 0 | 2 | 1 | 0 | 0 | 0 | 3 | 0 | 1 | 0 | 1 | 1 |

### *Clostridium difficile* infection monthly case numbers

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ages 15-64** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| **Ages 65 plus** | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total CDI*** | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 |

### Cleaning Compliance (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PRI Total** | 96 | 92 | 89 | 96 | 95 | 92 | 94 | 96 | 94 | No data | 95 | 97 |

### Estates Monitoring Compliance (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PRI Total** | 98 | 99 | 97 | 100 | 99 | 100 | 99 | 100 | 99 | No data | 100 | 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

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MRSA** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **MSSA** | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total SABs*** | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### *Clostridium difficile* infection monthly case numbers

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 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 | 0 | 1 | 0 |
| **Total CDI*** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |

### Cleaning Compliance (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RVH Total** | 97 | 95 | 95 | 96 | 97 | 96 | 95 | 96 | 97 | 97 | 96 | 95 |

### Estates Monitoring Compliance (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RVH Total** | 100 | 100 | 99 | 100 | 98 | 100 | 99 | 100 | 98 | 97 | 99 | 98 |

# STRACATHRO HOSPITAL REPORT CARD

### *Staphylococcus aureus* bacteraemia monthly case numbers

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MRSA** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **MSSA** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total SABs*** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### *Clostridium difficile* infection monthly case numbers

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 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 (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SXH Total** | 92 | 96 | 95 | 92 | 91 | 94 | 93 | 98 | 96 | 97 | 94 | 97 |

### Estates Monitoring Compliance (%)

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SXH Total** | 97 | 99 | 99 | 98 | 98 | 99 | 97 | 96 | 98 | 98 | 97 | 98 |

* 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

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MRSA** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **MSSA** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total SABs** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### *Clostridium difficile* infection monthly case numbers

| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ages 15-64** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Ages 65 plus** | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total CDI** | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 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

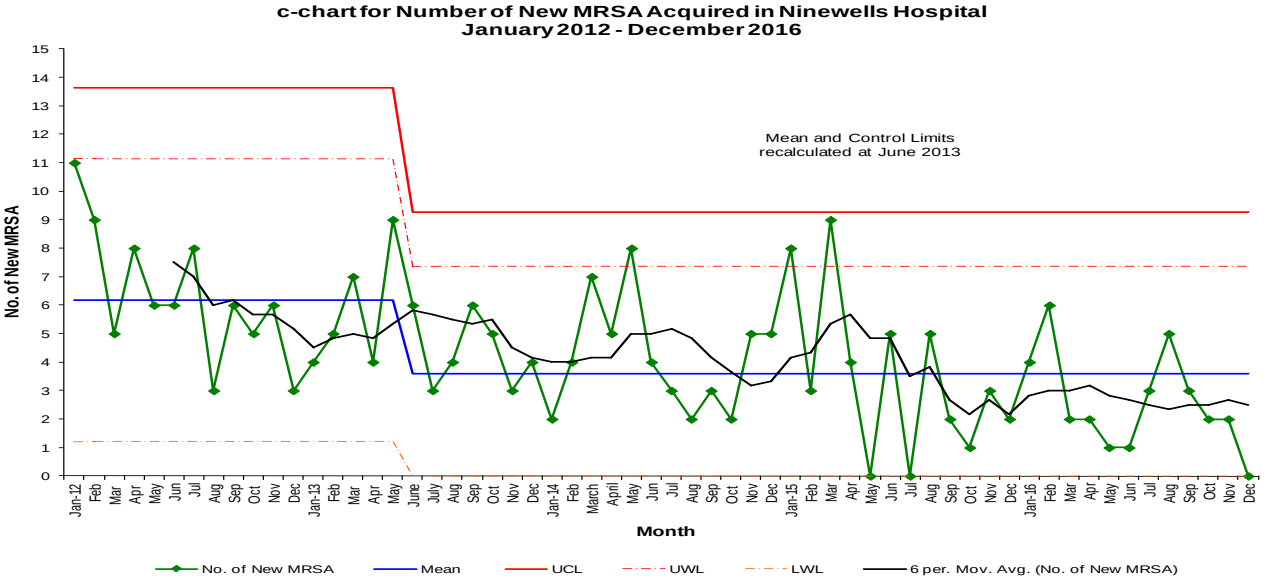
| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MRSA** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **MSSA** | 7 | 7 | 8 | 8 | 3 | 10 | 5 | 9 | 7 | 6 | 5 | 12 |
| **Total SABS** | 7 | 7 | 8 | 9 | 3 | 10 | 5 | 9 | 7 | 6 | 5 | 12 |

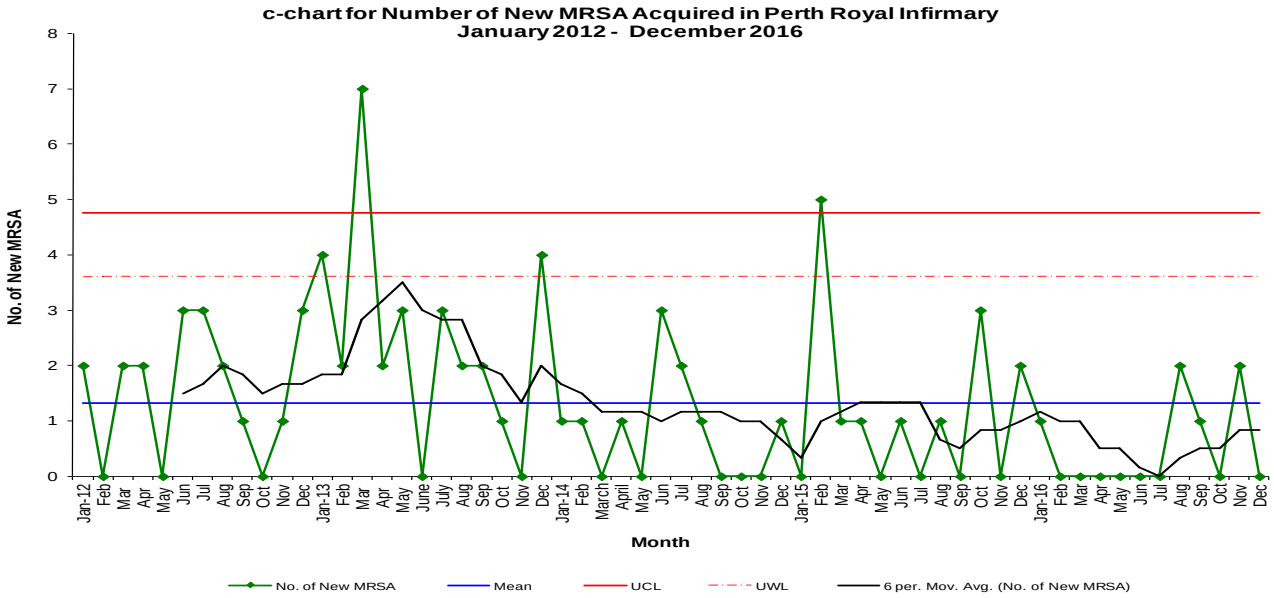
### *Clostridium difficile* infection monthly case numbers

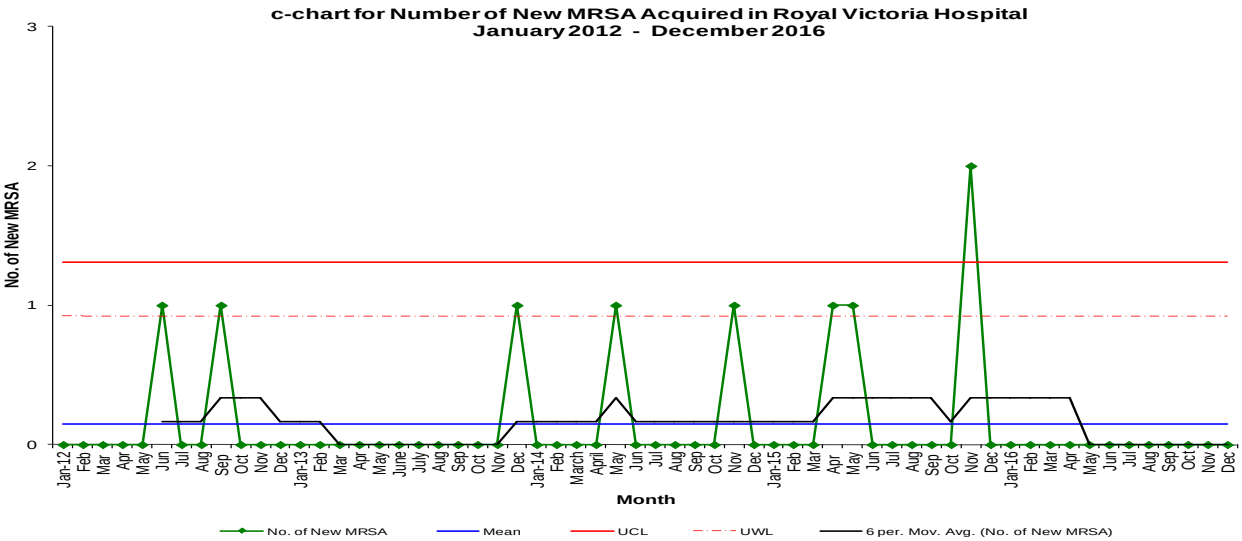
| | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ages 15-64** | 0 | 1 | 2 | 0 | 3 | 2 | 1 | 1 | 3 | 2 | 0 | 2 |
| **Ages 65 plus** | 4 | 3 | 2 | 4 | 4 | 1 | 3 | 5 | 1 | 3 | 2 | 0 |
| **Total CDI** | 4 | 4 | 4 | 4 | 7 | 3 | 4 | 6 | 4 | 5 | 2 | 2 |

**MRSA** **Appendix 1**

No outbreaks were reported.

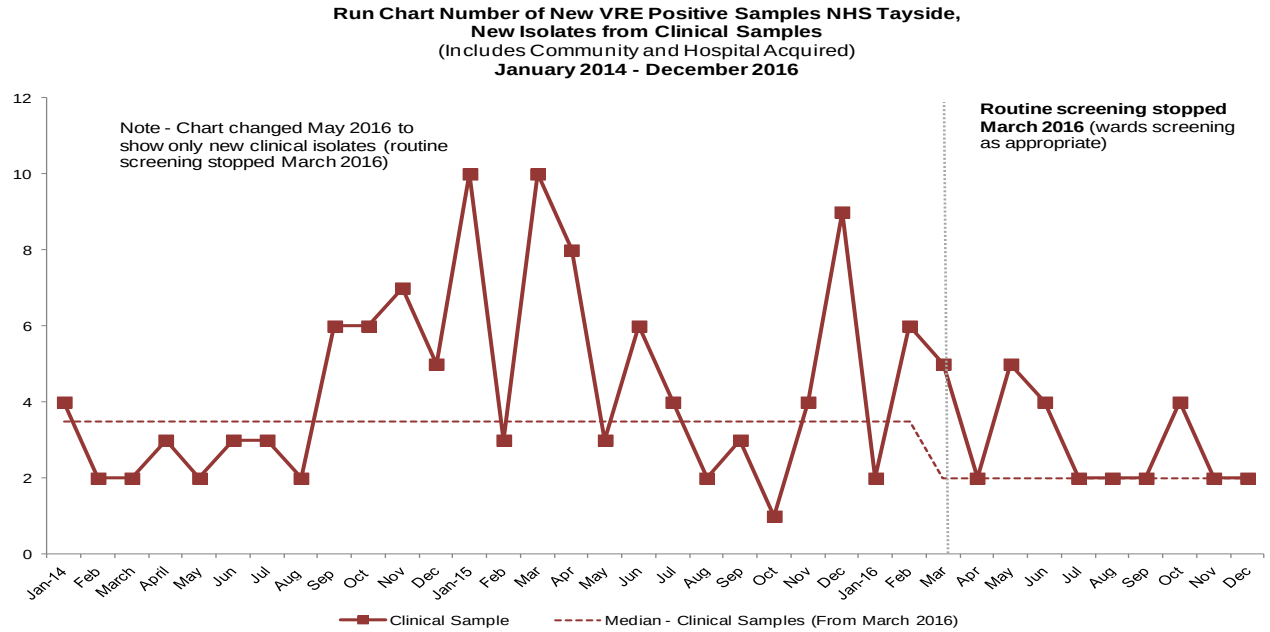


**Vancomycin-resistant Enterococcus (VRE)** **Appendix 2**

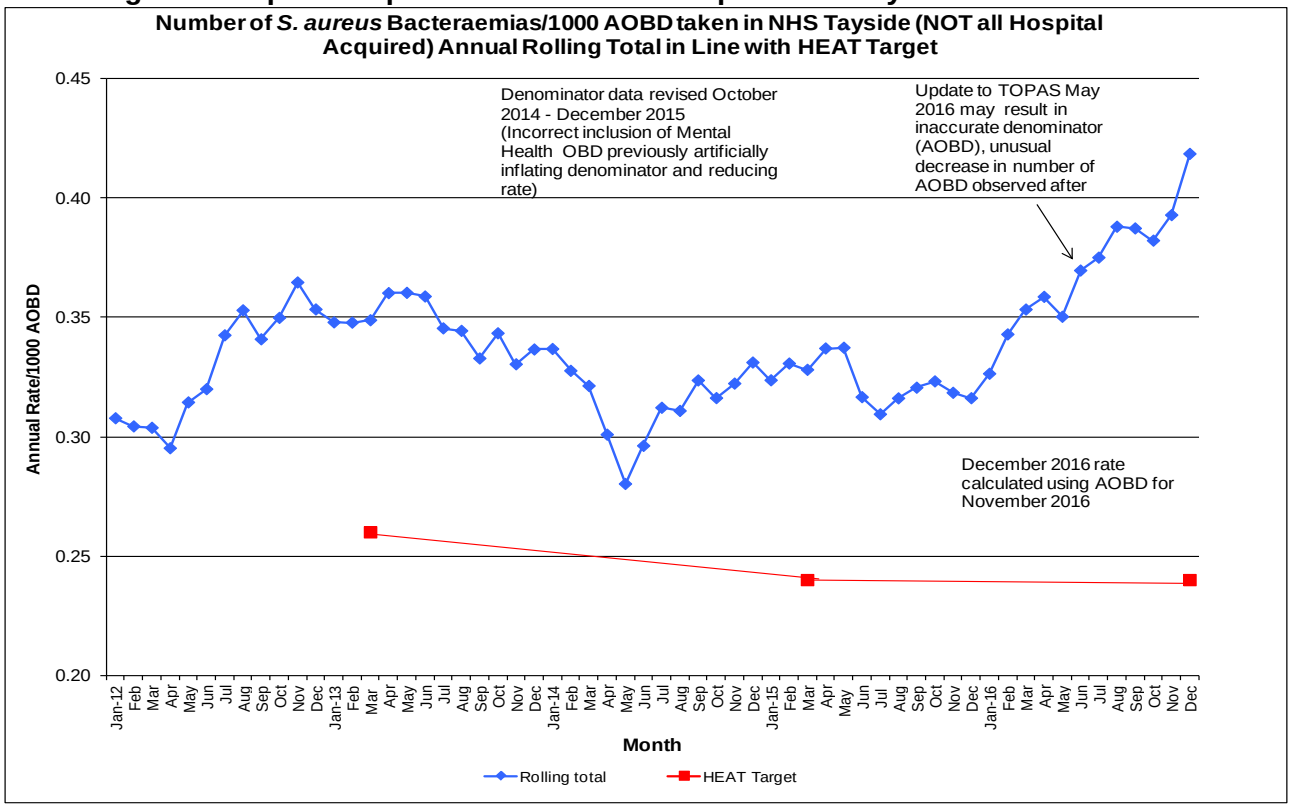
Nil to report. Clinical isolates remain stable with few invasive isolates from sterile sites (e.g. blood cultures).




As of May 2016 Epi-curves for the Surgical Floor, N22, N32 and N34 will no longer be included in the monthly update following the end of routine screening in these areas. New isolates from clinical samples associated with the wards will continue to be shown on the directorate dashboard.

***Staph aureus* bacteraemias (SABs)** **Appendix 3**

**HEAT target is 24 episodes per 100 000 Acute Occupied Bed Days**

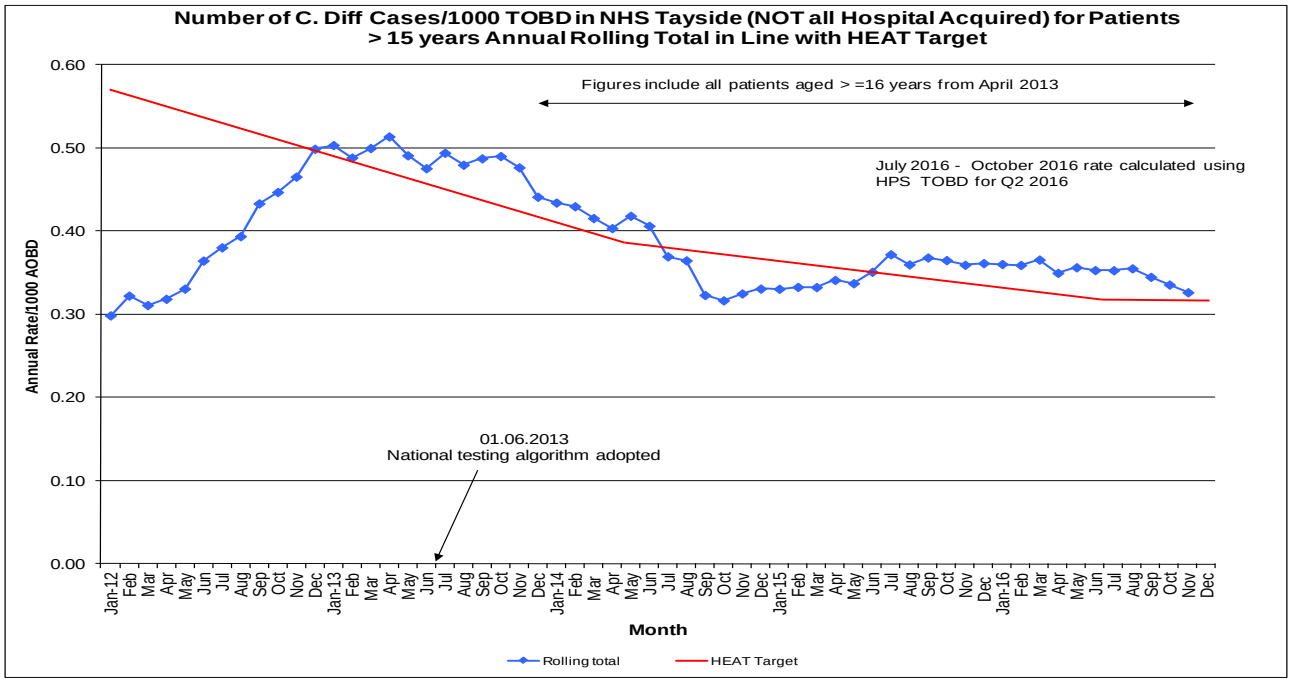



Significant proportion (about half) is associated with community acquisition.

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. An exception for MSSA SABs was called by HPS for Q3. The biggest influence is the

reduction in the denominator as previously noted. The number of episodes for the first and second 6 months of 2016 are the same.

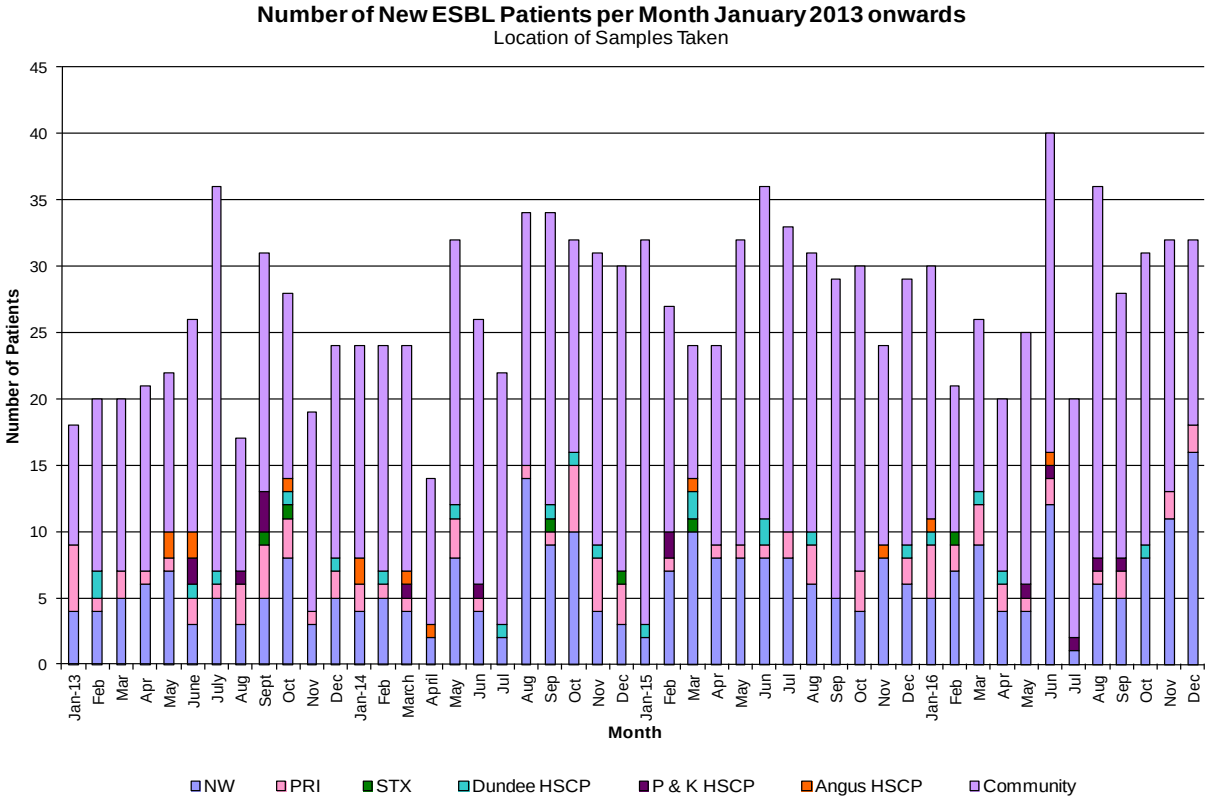
**_C.difficile_ Infection (CDI) HEAT target is 32 over the age of 15 years per 100 000 Occupied Bed Days.** **Appendix 4 NHS Tayside HEAT Target**




CDI rate is stable with no outbreaks but just 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 Section** **Appendix 6**

*Secondary Care Audit Process*

For 2016/17 the Scottish Antimicrobial Prescribing Group (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 and 8 and PRI Wards 1 and 6):

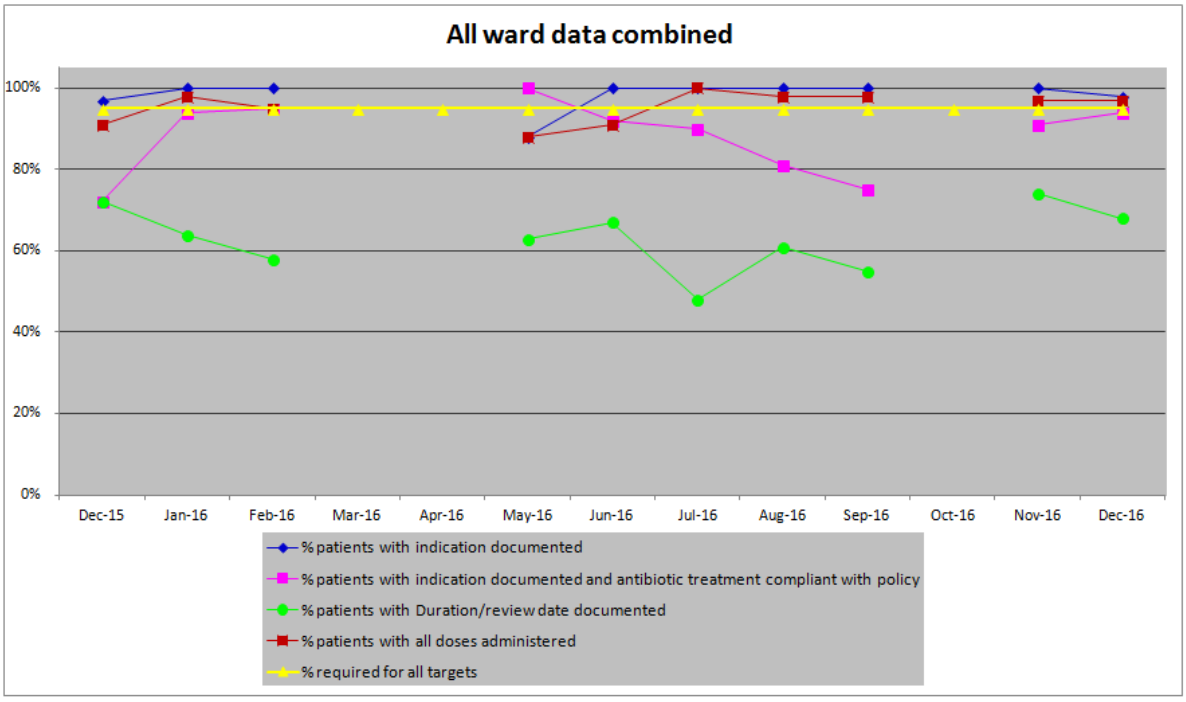
- missed doses of antibiotics
- duration/review date of antibiotic documented
- indication documented in notes
- antibiotic compliance with local guidance.

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 December 2016.

The AMT are awaiting confirmation of 2017/18 national antimicrobial prescribing indicators.

**Figure** 1: Combined % Compliance with nationally required target




No data collected in October due to national Point Prevalence Survey data collection.

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.

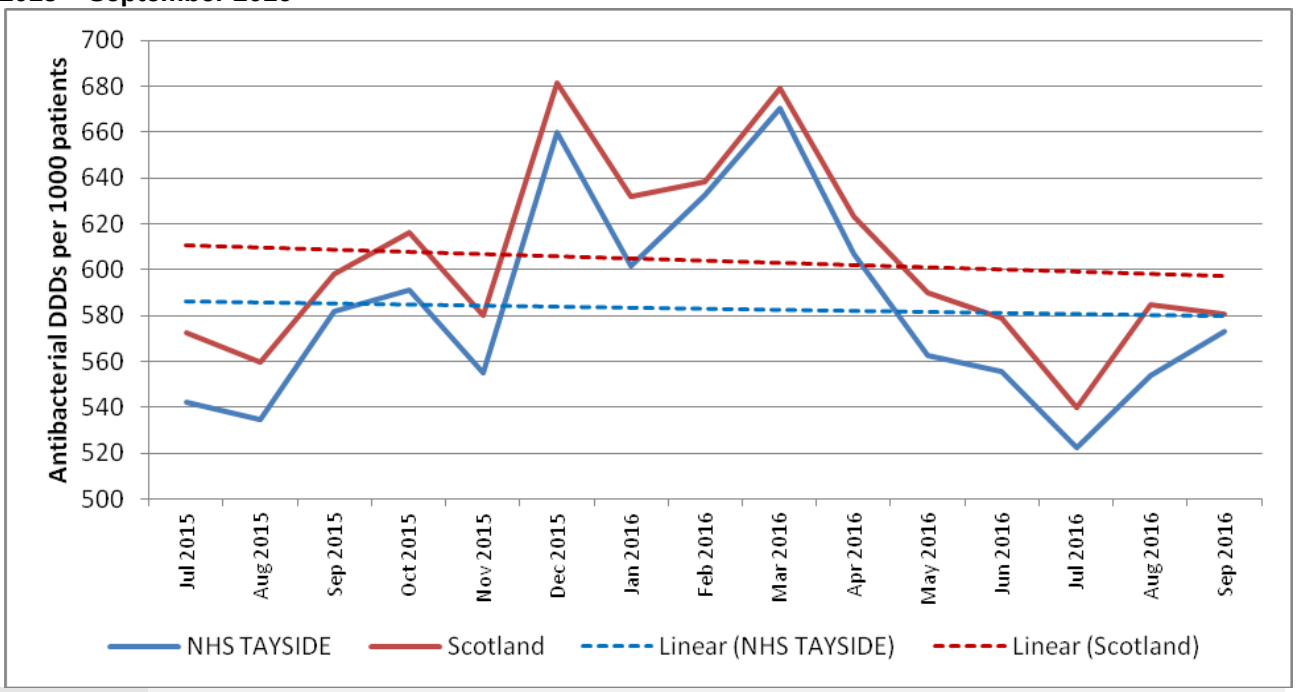
***Primary Care***

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.

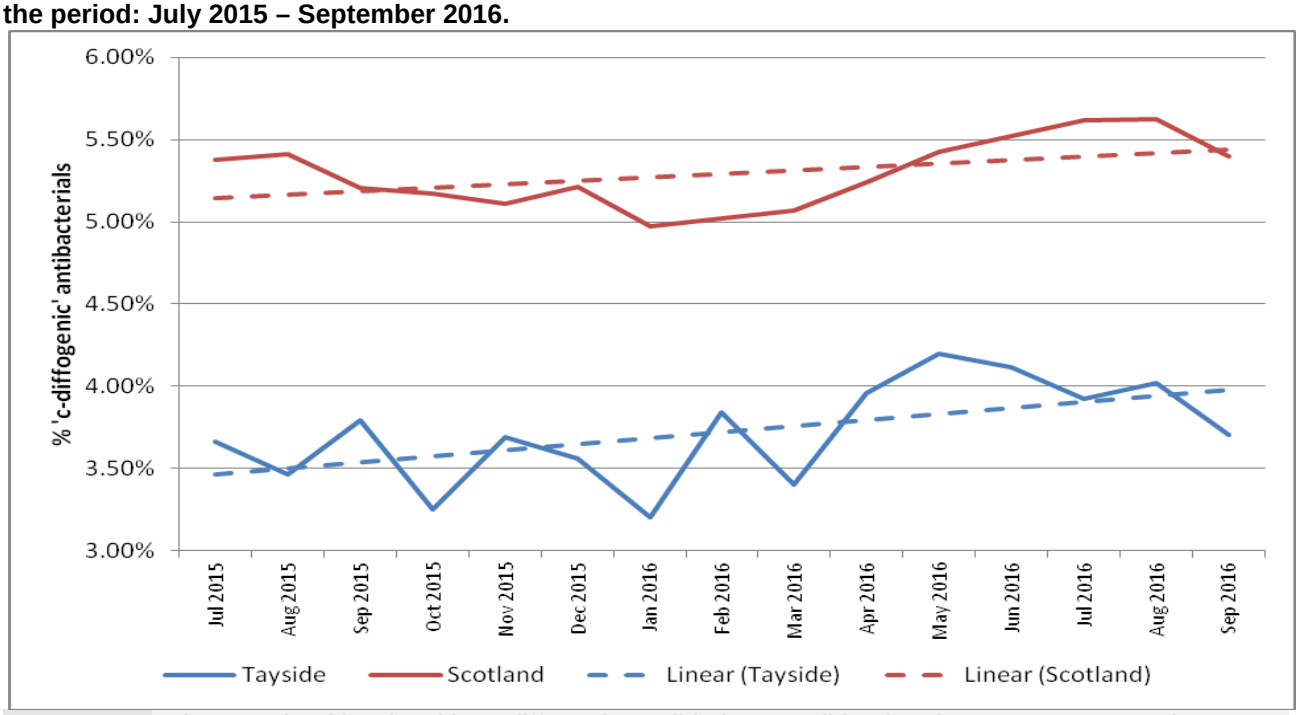
Excellent progress has been maintained in reducing the overall use of antibiotics and specifically those that carry a higher risk of *C difficile* infection for NHS Tayside as a whole. However, there continues to be significant variation in antibiotic prescribing between general practices within NHS Tayside. The National Quality Indicator for overall use of antibiotics will continue to be challenging due to the target being re-set from baseline data in 2016.

**Figure 2: NHS Tayside and Scotland: - Antibiotic DDDs per 1000 patients during the period: - July 2015 – September 2016**




It is encouraging to see the sustained downward trend.

**Figure 3: NHS Tayside and Scotland: - 'C-diffogenic' antibacterials as a % of all antibacterials during the period: July 2015 – September 2016.**




The sustained low level in 'c-diffogenic' antibiotic prescribing has been very encouraging. The very slight upward trend is likely to be due to a reduction in overall antibiotic use and a relatively steady use of '4-C' preparations; but will continue to be monitored.

**Surgical Site Infection Surveillance (SSI)** **Appendix 7**

Surveillance continues as per National requirements. No local exceptions to report for SSI this report. Local surveillance figures including 30 day post discharge figures where appropriate.

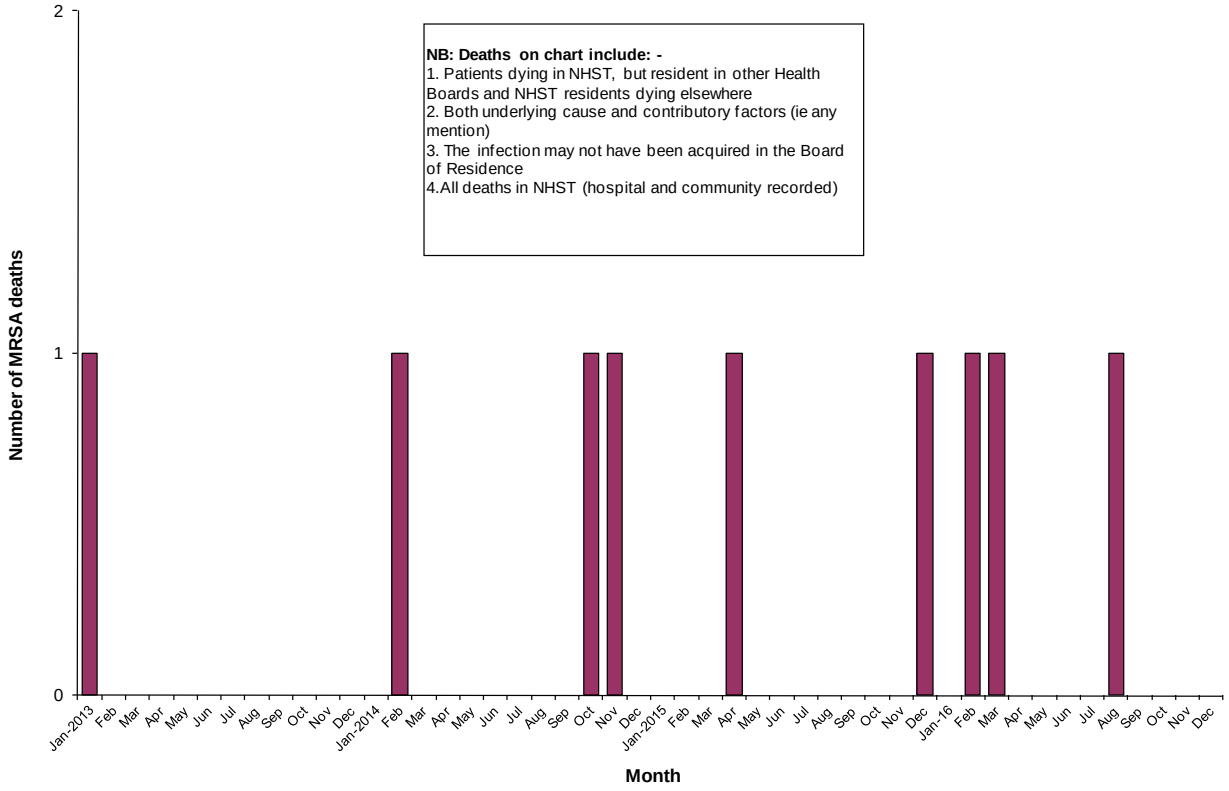
NOF = neck of femur Hip = Total hip replacement Knee = total knee replacement

| Month | C section no. (% infection) | NOF no. (% infection) | Hip no. (% infection) | Knee no. (% infection) | Colorectal no. (% infection) |
|---|---|---|---|---|---|
| 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 | 122 (3) | 42 (2) | 57 (0) | 38 (0) | 20 (0) |
| August | 111 (2) | 47 (0) | 67 (1) | 44 (0) | 20 (15) |
| Sept. | 110 (1) | 42 (5) | 63 (0) | 34 (0) | 22 (0) |
| Oct | 87 (2) | 38 (0) | 47 (2) | 40 (0) | 20 (0) |
| Nov | No data | 56 (2) | 68 (3) | 47 (0) | No data |

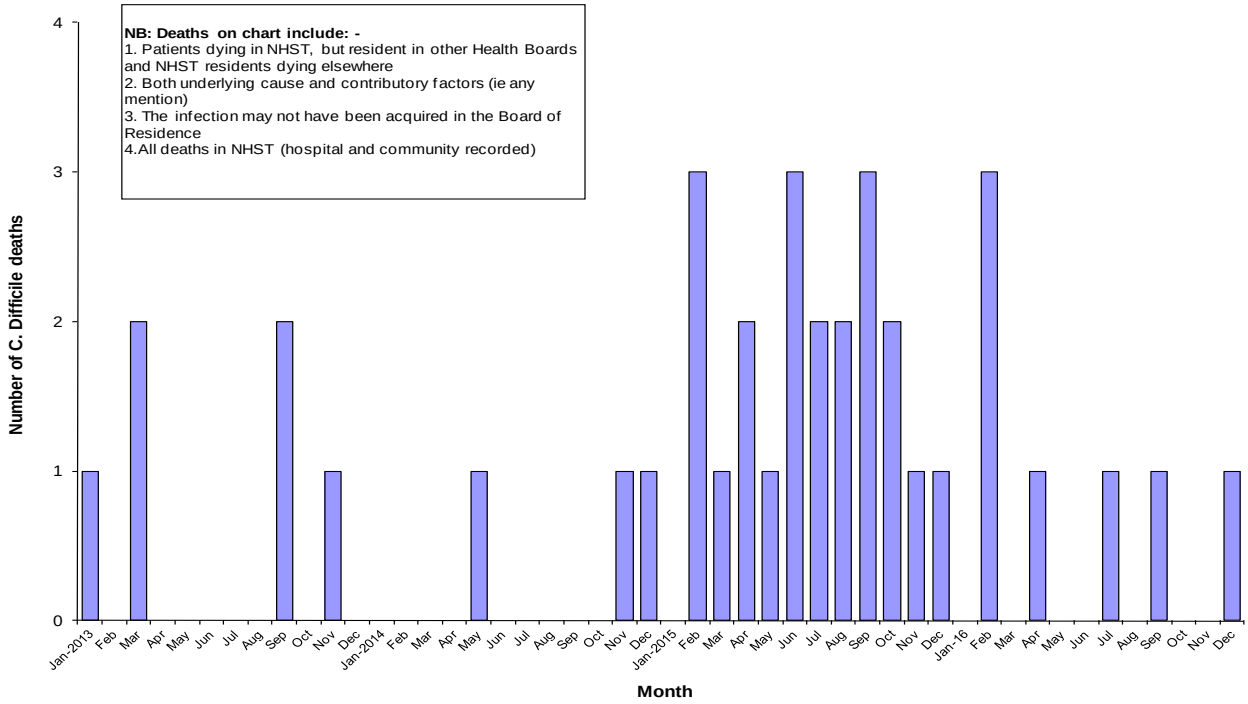
**Hot Topics/ Horizon Scanning** **Appendix 8**

- 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.

**Number of HAI Deaths (for MRSA) Recorded on any line on the MCCD for NHS Tayside per Month January 2013 - December 2016**




**Number of HAI Deaths (for *C. difficile*) Recorded on any line on the MCCD for NHS Tayside per Month, January 2013 - December 2016**



**HEI Inspections** **Appendix 10**

Update – January 2016

Previous Inspections to NHS Tayside by HEI:-

Announced
- Whitehills Health and Community Care Centre
- 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)

Whitehills Health and Community Care Centre
An announced inspection took place to Whitehills Health and Community Care Centre on 27th and 28th September 2016. This is the second inspection to a community facility within NHS Tayside and resulted in 2 requirements. One requirement was related to providing a lockable facility for clinical waste awaiting uplift and the second requirement related to the local estates team complying with the process to sign off works on completion. The final report and improvement action plan were published on Wednesday 7th December 2016 with the 16 week follow-up improvement action plan is expected mid-end January 2017.

Ninewells Hospital, 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. It is welcome to note that NHS Tayside was commended on significant improvement since the last inspection in March 2014. 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. A national SLWG has been established with representation from NHS Tayside included. The outcome of the SLWG is awaited and it is anticipated that this will assist NHS Tayside to achieve full compliance.

Infection Control Spot Audits
Within Infection Control, spot audits are undertaken twice yearly. Following the audits undertaken in July 2016, which showed a deteriorating position in compliance from the previous audit, clinical services across all areas within NHS Tayside were asked to provide information in relation to action being taken at ward level to improve compliance. The response rate was approximately 50%, despite a second reminder.

A summary of the responses is detailed below.

- Non-compliances added to daily Safety Brief discussion and also discussed at ward handover
- SCNs reiterating to staff re correct policy / procedures to follow e.g. sharps management, Hand Hygiene, etc.

- Increased awareness of completion of TEACH tool and requirement to act on non-compliances.
- Shared responsibility throughout team for local monthly environmental monitoring not just SCN.
- In some cases, daily monitoring until consistent compliance achieved i.e. sharps trays.
- There is potential for improvement with Cleaning Schedule compliance with the release of the new template which has been received positively following wide consultation and testing.
- Monthly Infection Control report being shared at Clinical Governance fora to heighten awareness and stimulate discussion.
- More frequent ward walkrounds being undertaken by relevant manager.

The next spot audits will be undertaken in February 2017.

**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.

Item 14

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

**BOARD03/2017**
**Tayside NHS Board**
**23 February 2017**

# TAYSIDE NHS BOARD PERFORMANCE REPORT

**Ms L Wiggin**
**Chief Operating Officer**

**Ms L McLay**
**Chief Executive**

**Dr A Cook**
**Medical Director – Operational Unit**

**February 2017**

# NHS Tayside

## Board Performance Report
## to December 2016

**Lorna Wiggin**
**Chief Operating Officer**
**NHS Tayside**

**Alan Cook**
**Operational Medical Director**
**NHS Tayside**

**Lesley McLay**
**Chief Executive**
**NHS Tayside**

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## Waiting Times Definitions — Board Performance Update, as at end December 2016

| 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)<br><br>*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.<br>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).<br><br>*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.<br><br>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.<br><br>SOT & Diagnostics available on 18th of month for previous month's data. | December 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.<br><br>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. | December 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. | December 2016 |
| **18 Week Referral to Treatment** | Measures the % performance and % completeness for admitted, non admitted and combined (admitted & non admitted) pathways.<br>*Performance* measures the % of patients seen within 18 weeks from referral to treatment.<br>*Completeness* measures the % of patients with a linked pathway, the whole pathway can be measured from date of receipt of referral to treatment date.<br>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. | December 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.<br>*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.<br>*Cancer Groups*: Colorectal, Breast, Haematology, Head & Neck, Lung, Skin, Upper GI, Urology, Gynaecology.<br>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.<br># 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. | December 2016 |

## ACCESS — Board Performance Update, as at end December 2016

| Improved performance ↑ | Same performance ↔ | Worse performance ↓ |
|---|---|---|

### Waiting Times

| | | Oct-16 | Nov-16 | **Dec-16** | Target | Actual vs. Trajectory | Ranking | Performance | On Track |
|---|---|---|---|---|---|---|---|---|---|
| Treatment Time Guarantee / Stage of Treatment | Inpatient/Daycase patients treated and waited more than the 84 days TTG target | 355 | 426 | **386** | 0 | N/A | 9th | ↑ | X |
| | Inpatient/Daycase patients waiting > 84 days TTG target as at month end | 994 | 1013 | **1124** | 0 | -73 | 8th | ↓ | X |
| | New Outpatients waiting > 12 weeks target as at month end | 5439 | 5036 | **4888** | 0 | -553 | 5th | ↑ | X |
| | % of New Outpatients waiting < 12 weeks as at month end | 74.6% | 75.6% | **74.6%** | 95% | N/A | 6th | ↓ | X |
| | Number of New Outpatients waiting > 16 weeks as at month end | 3434 | 3101 | **3019** | 0 | N/A | 6th | ↑ | X |
| | Diagnostics–8 key tests waiting > 6 weeks target as at month end | 183 | 153 | **325** | 0 | +226 | 5th | ↓ | X |

| | | Oct-16 | Nov-16 | **Dec-16** | Target | Scottish Ave | Performance | On Track |
|---|---|---|---|---|---|---|---|---|
| Unavailability | % total IP / DC unavailability | 10.3% | 10.9% | **11.0%** | - | 11.1% | ↓ | ✓ |
| | of total % medical | 2.1% | 2.5% | **2.1%** | - | 2.6% | ↑ | ✓ |
| | of total % patient advised | 7.5% | 7.7% | **8.4%** | - | 7.0% | ↓ | X |
| | of total % of patient requested | 0.7% | 0.7% | **0.6%** | - | 1.5% | ↑ | ✓ |
| | % total OP unavailability | 1.41% | 1.57% | **1.56%** | - | 1.6% | ↑ | ✓ |
| | of total % medical | 0.06% | 0.08% | **0.08%** | - | 0.2% | ↔ | ✓ |
| | of total % patient advised | 1.29% | 1.46% | **1.46%** | - | 1.2% | ↔ | X |
| | of total % of patient requested | 0.06% | 0.02% | **0.03%** | - | 0.3% | ↓ | ✓ |

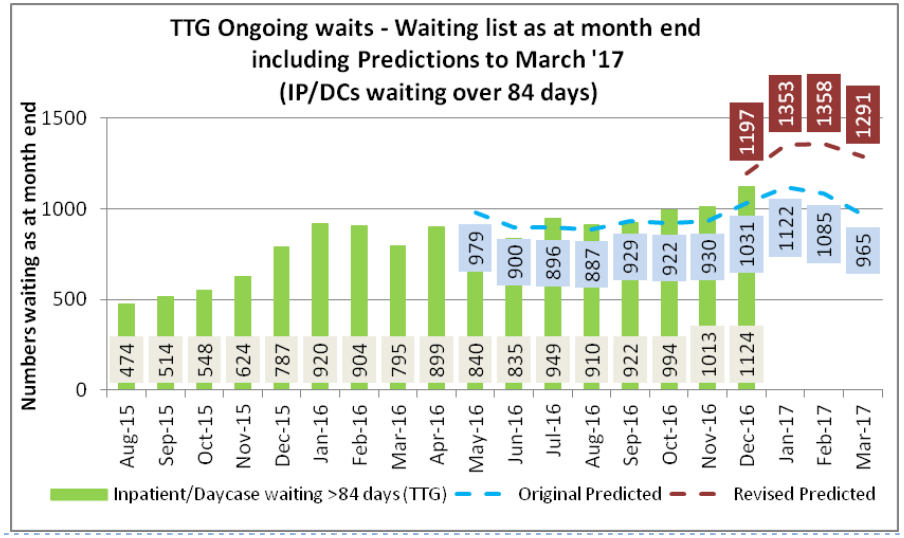
| | | Oct-16 | Nov-16 | **Dec-16** | Target | Variance from LDP | Ranking | Performance | On Track |
|---|---|---|---|---|---|---|---|---|---|
| A&E | A&E patients seen within 4 hour target | 97.9% | 98.2% | **97.1%** | 95% | -0.9% | 1st | ↓ | ✓ |

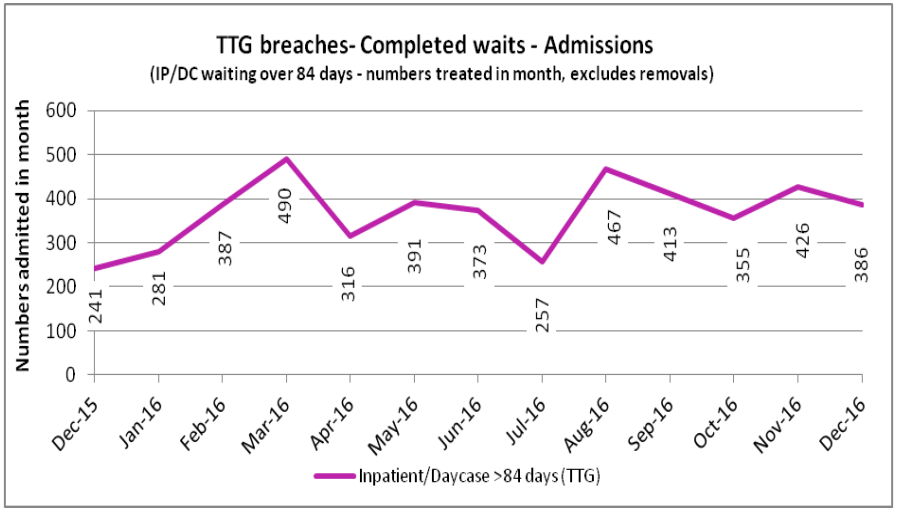
| | | Oct-16 | Nov-16 | **Dec-16** | Target | Ranking | Performance | On Track |
|---|---|---|---|---|---|---|---|---|
| 18 wks RTT combined (including Audiology) | % of patients seen within 18 weeks – combined performance | 84.4% | 83.5% | **84.2%** | 90% | 6th | ↑ | X |
| | % of admitted patients seen within 18 weeks | 53.8% | 55.5% | **51.7%** | 90% | 9th | ↓ | X |
| | % of non admitted patients seen within 18 weeks | 87.1% | 86.3% | **86.8%** | 90% | 7th | ↑ | X |
| | % of patients linked to original referral combined completeness | 99.6% | 99.5% | **99.7%** | 90% | 3rd | ↑ | ✓ |
| | % of admitted patients linked to original referral | 95.1% | 95.0% | **96.0%** | 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% | **98.6%** | 90% | 3rd # | ↔ | ✓ |

| | | Oct-16 | Nov-16 | **Dec-16** | Target | Ranking | Performance | On Track |
|---|---|---|---|---|---|---|---|---|
| Cancer Waiting Times | 31-day target | 85.2% | 88.6% | **93.3%** | 95% | 11th | ↑ | X |
| | 62-day target | 85.9% | 89.3% | **87.5%** | 95% | 11th | ↓ | X |

*Rankings and Scottish average for Unavailability – Please note these apply to the Sept'16 position across Scotland, excluding Island Boards. National data is only released quarterly; the December 2016 position will be available late February 2017. # Only 10 mainland boards provided data.*

## Inpatient/Daycase TTG – Ongoing Waits and Completed Waits




### Ongoing waits

At the end of December 2016, **1124** patients had been waiting over 12 weeks for admission compared to 1013 at the end of November 2016. The 1124 patients are in the following specialities; **426** Orthopaedics; **315** Urology; **194** General Surgery (ex Vascular); **61** Plastic Surgery; **35** Gynaecology (includes 19 patients for mesh procedures); **31** Vascular Surgery; **26** Ophthalmology; **16** Cardiology; **15** ENT Surgery; **2** Paediatric Dentistry; **2** OMFS and **1** Neurology.

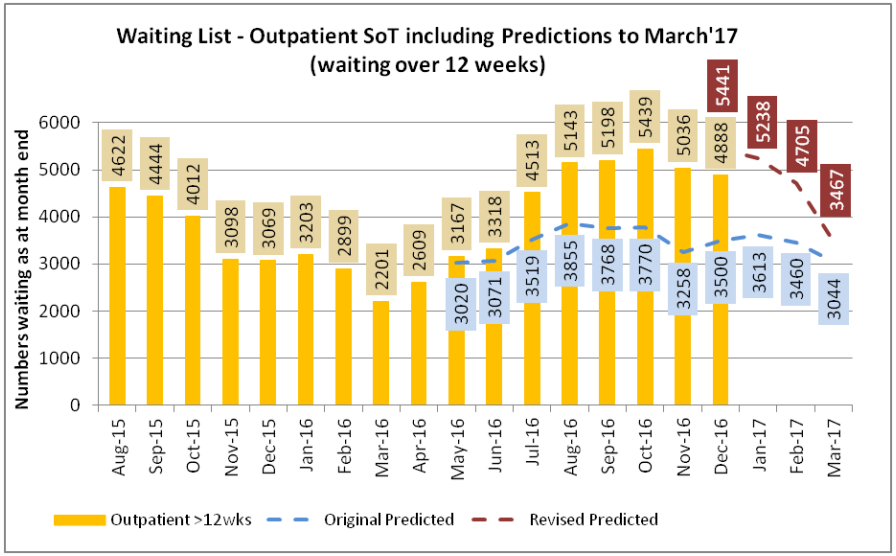
Current performance in respect of ongoing waits (1124 at the end of December 2016) places us ahead of the revised trajectory (1197), which was updated in December to take account of unplanned sickness absence which has impacted upon elective capacity.

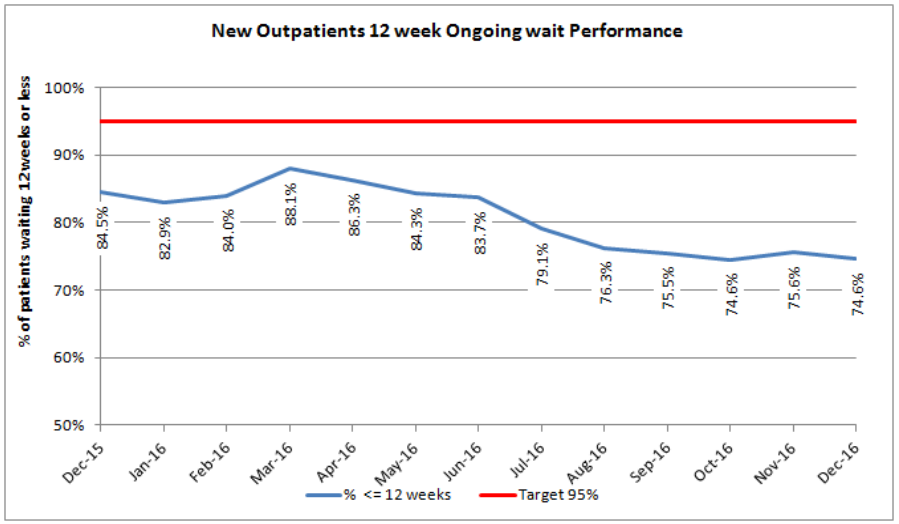
### Completed waits

In December 2016 the number of TTG breaches admitted reduced to **386** from 426 in November. Of the 386 breaches, **139** occurred within Orthopaedics; **63** in Urology; **49** General Surgery; **41** Ophthalmology; **34** Plastic Surgery; **19** Gynaecology; **17** Vascular Surgery; **14** ENT Surgery; **4** Cardiology; **2** Neurosurgery; **2** Paediatric Dentistry; **1** Medical Paediatrics and **1** OMFS.

Current performance in respect of ongoing waits (1124 at the end of December) places us ahead of the revised trajectory (1197) by 73 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. It should however be noted that the revised trajectory takes account of the known decline within Orthopaedics due to sickness absence levels across the consultant workforce. Efforts to secure a Locum to reduce the impact of these absences have not been successful to date.

## New Outpatients waiting over 12 weeks target <u>as at month end</u>




### 12 week breaches (inc unavailable patients)

The position at the end of December 2016 shows a decrease on November of 148 patients with **4888 (126 unavailable), November 5036 (189 unavailable).**

Current performance in respect of ongoing waits over 12 weeks (4888 at the end of December) places performance ahead of the revised trajectory (5411) by 553. Specialities are now on plan to deliver their revised trajectory however some risks remains regarding the ability to secure the level of independent sector support required.

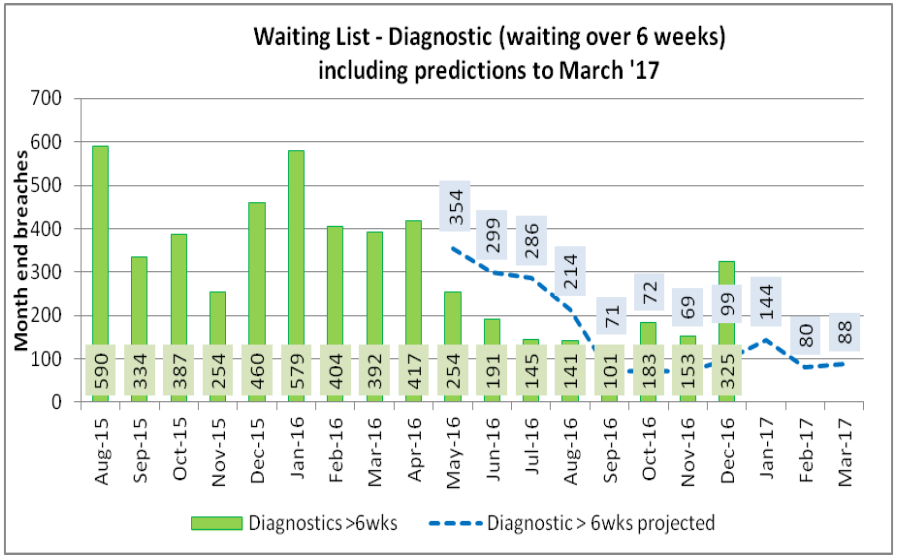
The five specialities with the greatest number of patients waiting over 12 weeks were Gynaecology 889; Gastroenterology 606; Dermatology 526; General Surgery 455 and Vascular Surgery 430. Gynaecology, Gastroenterology and Dermatology all have secured additional capacity through the independent sector to reduce their current queues, whilst General Surgery are planning to deliver additional activity in house. Vascular Surgery have recruited to a technician post within the vascular laboratory as well as filling a consultant vacancy which will support a reduction in the queue during the final quarter of 2016/17.

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 December 2016 the performance was 74.6%.

### 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 December 2016 was **3019** a decrease of 82 compared to the end of November 2016 (3101). This represents 84.3% of patients at the end of December 2016 having waited for 16 weeks or less to be seen.

## Diagnostic tests waiting over 6 weeks target as at month end




The number waiting over 6 weeks for Diagnostic Tests at the end of December **2016** was **325** comprising the following breaches: - **148** MRI**; 91** Colonoscopy; **52** Upper Endoscopy; **19** lower endoscopy (other than colonoscopy) and **15** Cystoscopy.

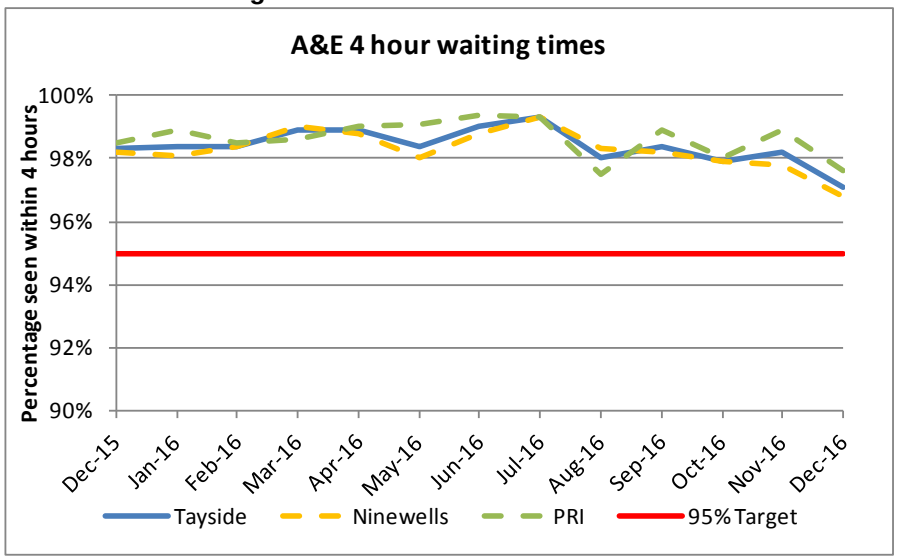
The December 2016 position (325) represents an increase on the November 2016 position (153) of 172 breaches with the majority of patients waiting being for MRI and Colonoscopy. Current overall Diagnostic tests performance is behind trajectory (99) by 226 cases.

The increase in MRI waits has occurred due to two key factors:

- a power surge at Stracathro which resulted in the need to cancel 50 scans; and
- scanner maintenance which reduced overall service capacity by 195 scans over an 8 week period.

All scanners were fully available again at the start of January and the service has implemented plans to deliver additional activity between January and March in order to return to the forecast level of performance.

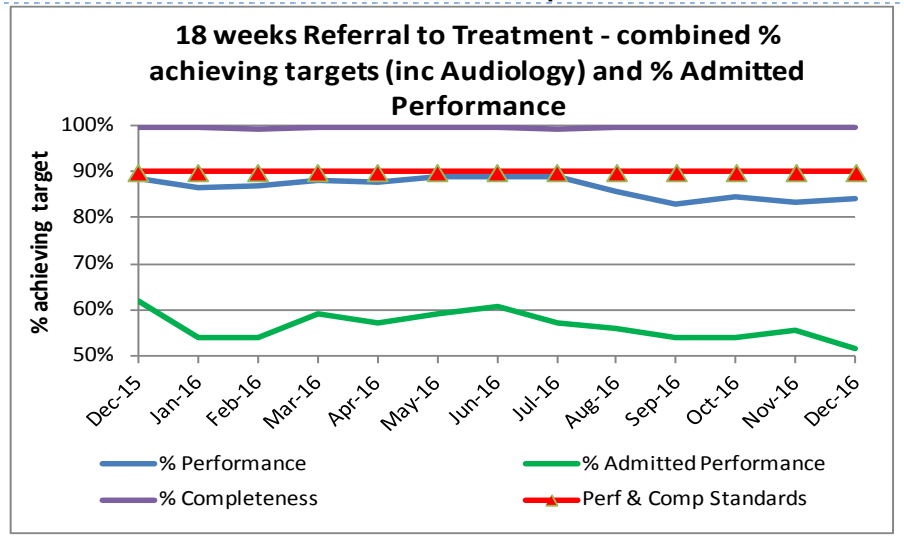
## A&E 4 hour 95% target




Tayside continued to meet the 95% national target in December 2016. However neither Ninewells or PRI reached the 98% Local Unscheduled Care Action Plan (LUCAP) target in December with an overall attainment of 97.1%. This position did however compare favourably to the rest of NHS Scotland with NHS Tayside's performance continuing to be the best of all territorial boards.

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

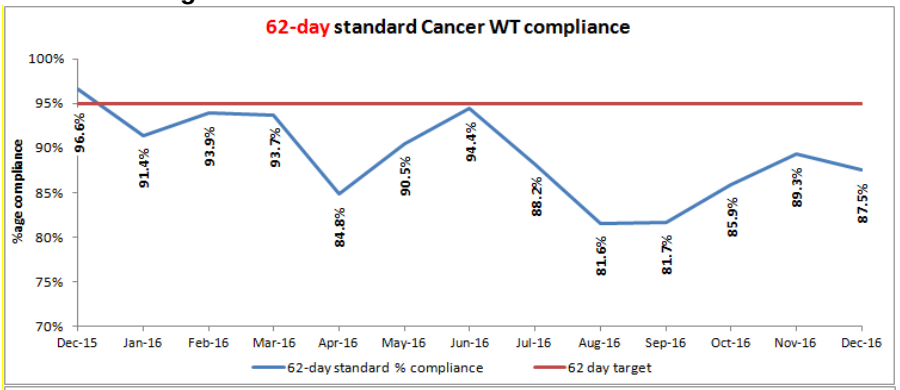


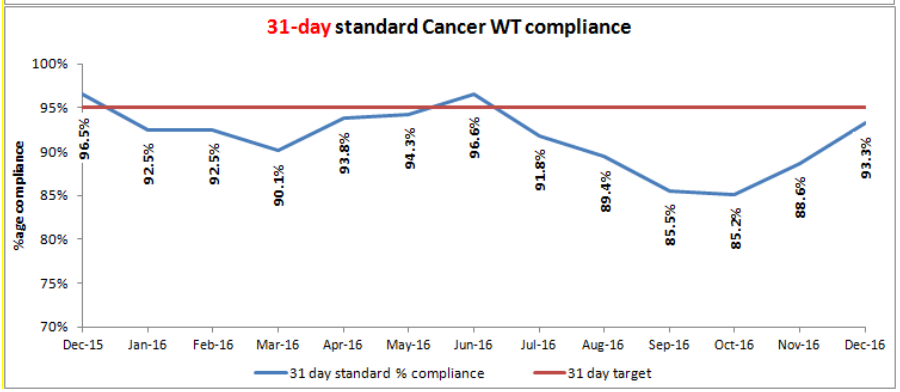

The 18 weeks referral to treatment combined performance continues to be below the 90% standard, and is impacted by the current waits for outpatients and TTG described above. The **December 2016** position improved with **84.2%** compared to November 2016 (83.5%).

The main area of challenge is our admitted pathway, which declined further in December 2016 to 51.7% from 55.5% in November 2016. Of the specialties with completed pathways in December 2016 Haematology, Community Dental Practice, Oral Surgery, Medical Paediatrics and Clinical Oncology achieved the admitted pathway standard; however these are all specialities with low volumes requiring inpatient treatment. There were 14 specialities with completed activity that did not achieve the admitted pathway standard in December 2016. These 14 include the specialities that currently have recovery plans in place for TTG.

The non-admitted pathway did not achieve the 90% standard in December 2016 with **86.8%** attained compared to 86.3% in November 2016.

## Cancer Waiting Times




The **62 day** performance was 87.5% in December 2016 compared to 89.3% in November 2016. The sites not delivering the 62 day standard in December 2016 were Breast (3 breaches); Colorectal (3); Head and Neck (1); Lung (1) and Urology (2).

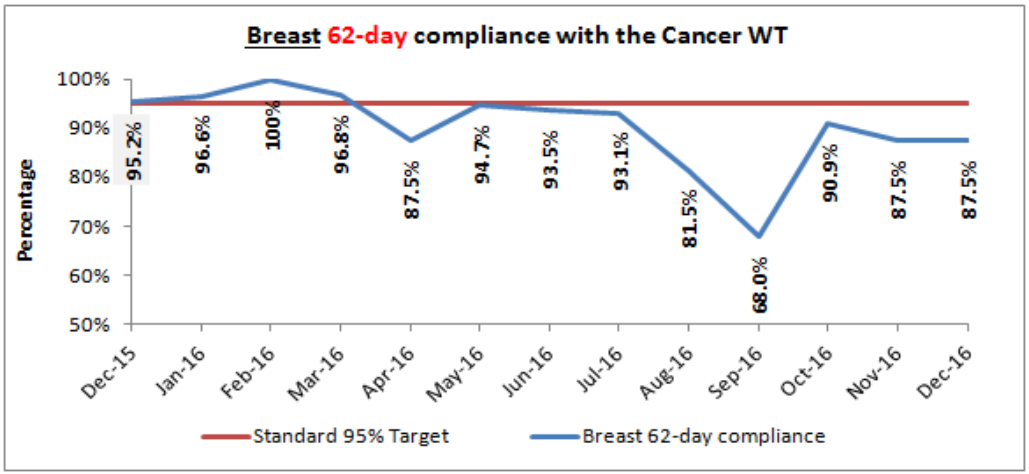
The **31 day** performance was 93.3% in December 2016, showing an improvement on November 2016 (88.6%). The sites not delivering the 31 day standard in December 2106 were Breast (7 breaches) and Urology (5).

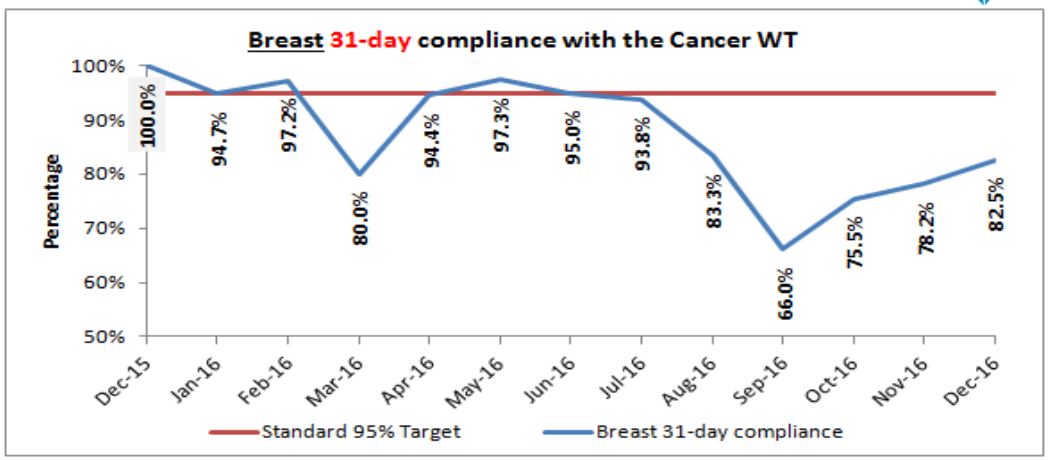
Whilst performance was below standard across the Breast pathway, early January figures are demonstrating the improvement that was forecast and it is envisaged this will continue through the final quarter of the year.

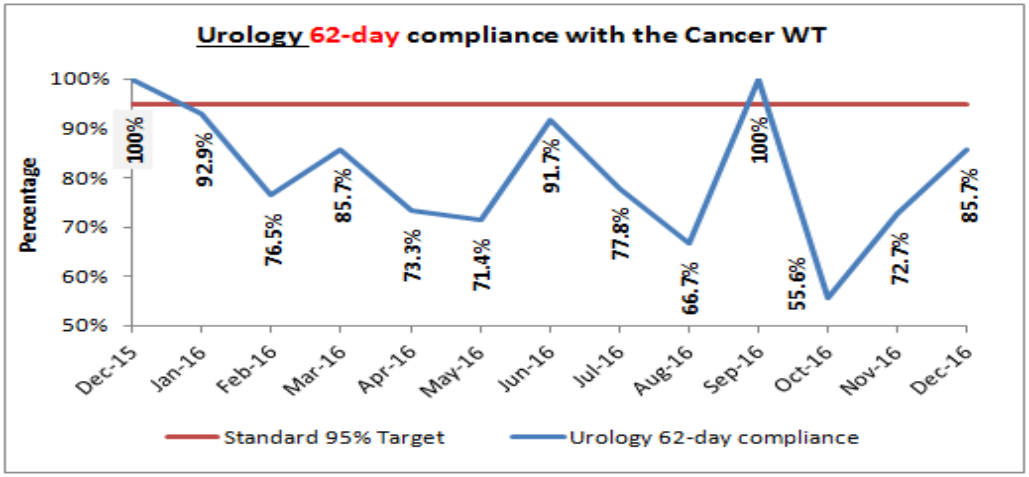
NHS Tayside continues to utilise the non-recurring funding received to increase scope, diagnostic and imaging capacity. In addition, recruitment to two cancer pathway co-ordinator posts has been achieved, these posts are aimed at supporting improvements to the pathways for both Urology and Colorectal cancer patients, the post holders commenced in January 2017.

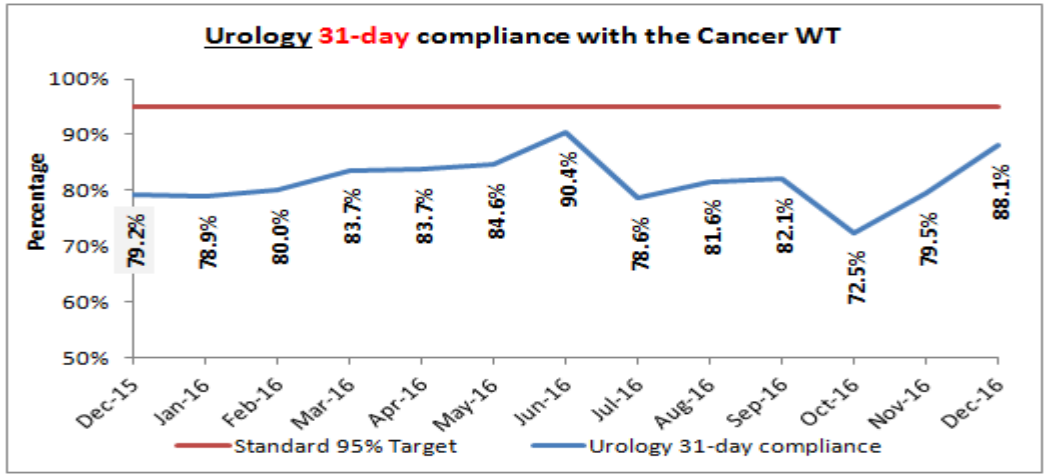
The Urology pathway, specifically prostate remains a challenge and whilst two consultant vacancies have been successfully appointed too (post holders due to commence in April 2017), these individuals do not have a prostate specialism and therefore there will remain a single-handed consultant for the delivery of laparoscopic prostatectomy.

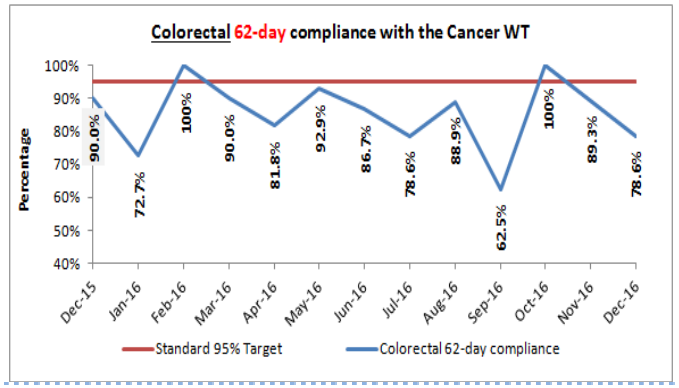
The 3 62 day breaches in colorectal were due to different factors either due to diagnostics or wait for surgery. Whilst these patients breached the 62 day standard, all were treated within 65 days.

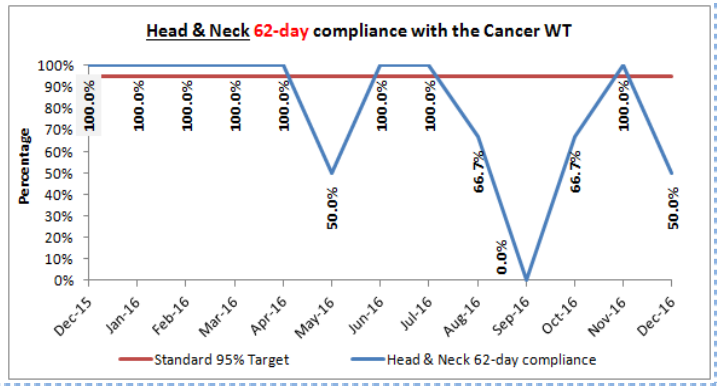

Breast 62-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
95.2%
96.6%
100%
96.8%
87.5%
94.7%
93.5%
93.1%
81.5%
68.0%
90.9%
87.5%
87.5%
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Standard 95% Target
Breast 62-day compliance

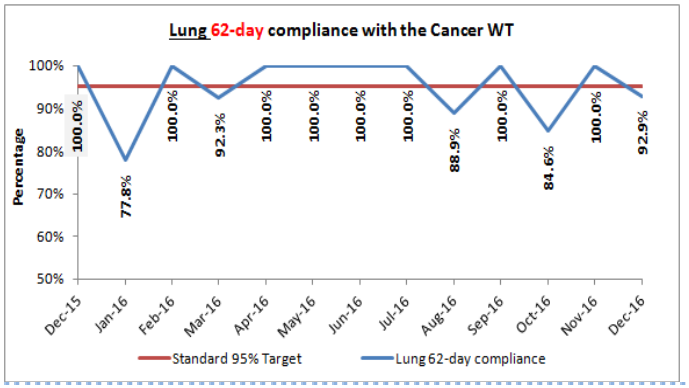

Breast 31-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
100.0%
94.7%
97.2%
80.0%
94.4%
97.3%
95.0%
93.8%
83.3%
66.0%
75.5%
78.2%
82.5%
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Standard 95% Target
Breast 31-day compliance


Urology 62-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
100%
92.9%
76.5%
85.7%
73.3%
71.4%
91.7%
77.8%
66.7%
100%
55.6%
72.7%
85.7%
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Standard 95% Target
Urology 62-day compliance


Urology 31-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
79.2%
78.9%
80.0%
83.7%
83.7%
84.6%
90.4%
78.6%
81.6%
82.1%
72.5%
79.5%
88.1%
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Standard 95% Target
Urology 31-day compliance


Colorectal 62-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
40%
90.0%
72.7%
100%
90.0%
81.8%
92.9%
86.7%
78.6%
88.9%
62.5%
100%
89.3%
78.6%
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Standard 95% Target
Colorectal 62-day compliance


Head & Neck 62-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100.0%
100.0%
100.0%
100.0%
100.0%
50.0%
100.0%
100.0%
66.7%
0.0%
66.7%
100.0%
50.0%
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Standard 95% Target
Head & Neck 62-day compliance


Lung 62-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
100.0%
77.8%
100.0%
92.3%
100.0%
100.0%
100.0%
100.0%
88.9%
100.0%
84.6%
100.0%
92.9%
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Standard 95% Target
Lung 62-day compliance

## Waiting Times (continued)

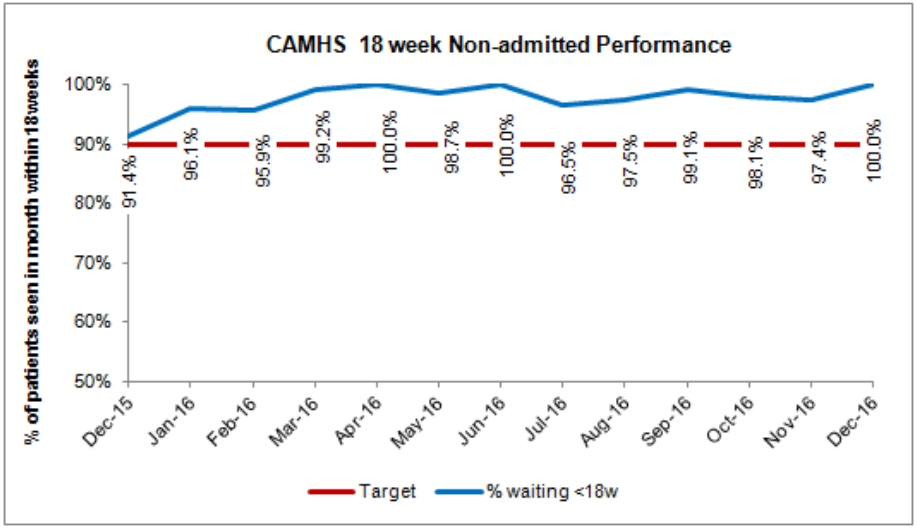
| Measure | Definition | Data Source | Data Validation | Time Period Reported |
|---|---|---|---|---|
| **Mental Health** | *Child and Adolescent Mental Health:* Measures the % of patients treated in the month within 18 weeks from referral to treatment. The HEAT target set by Scottish Government was to achieve 90% compliance with 18 week RTT by the end of December 2014.<br>*Psychological Therapies:* Measures the % of patients treated in the month within 18 weeks from referral to treatment. | TOPAS | Validated data is available on the 25th of each month for the previous month data. | December 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. | December 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. | December 2016 |

| Improved performance ↑ | Same performance ↔ | Worse performance ↓ |
|---|---|---|

| | | *Oct-16* | *Nov-16* | ***Dec-16*** | *Target* | *Ranking* | *Performance* | *On Track* |
|---|---|---|---|---|---|---|---|---|
| Mental Health | CAMHS patients treated within 18 weeks from referral to treatment | 98.1% | 97.4% | **100%** | 90% | 3rd | ↑ | ✓ |
| | Psychological Therapy patients treated within 18 weeks from referral to treatment | 80.1% | 75.4% | **83.8%** | 90% | 4th | ↑ | X |
| | | *Oct-16* | *Nov-16* | ***Dec-16*** | *Target* | | | |
| | Drug and Alcohol clients treated within 3 weeks from referral to treatment | 97.6% | 96.4% | **99.5%** | 90% | 5th | ↑ | ✓ |
| | | *Oct-16* | *Nov-16* | ***Dec-16*** | *Target* | | *Performance* | *On Track* |
| IVF | % of patients seen within 12 months from agreement to treat to screening | 100% | 100% | **100%** | 100% | 1st = | ↔ | ✓ |

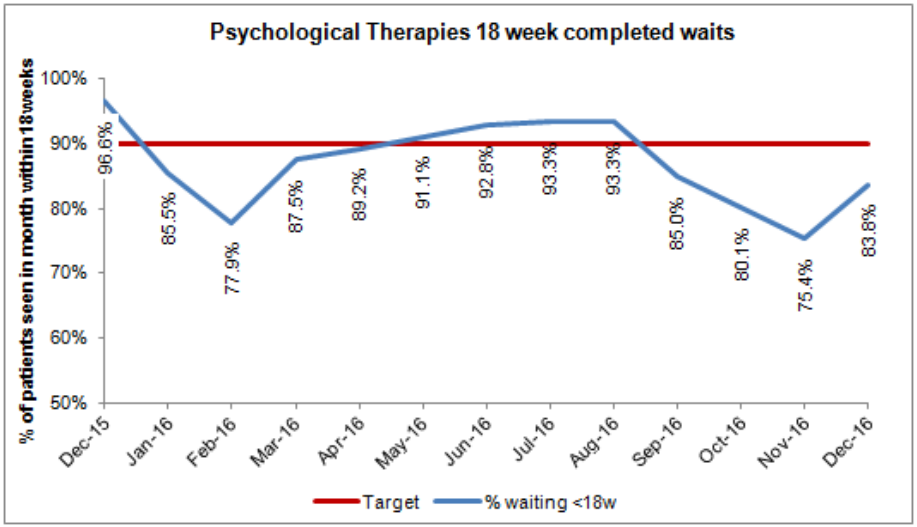
*Rankings – Please note these apply to the September'16 position across Scotland, excluding Island Boards. National data is only released quarterly; the December 2016 position will be available late February 2017. Completed waits = Quarter end position.*

## CAMHS



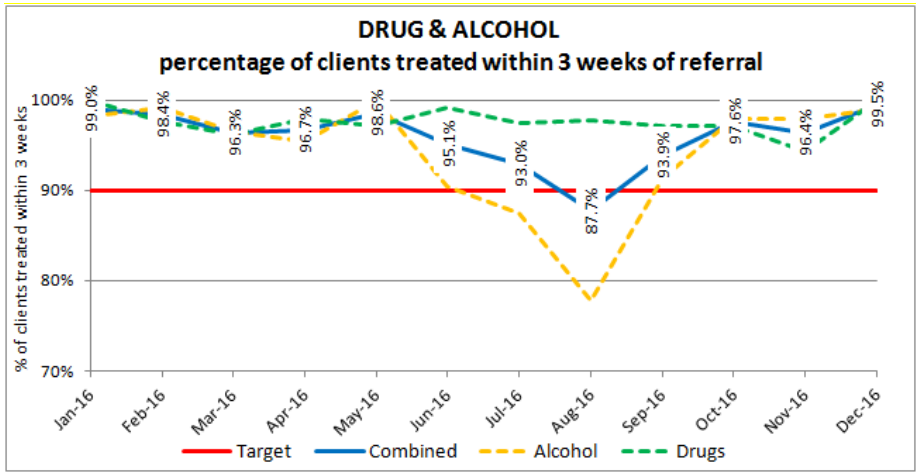

The 18 week performance standard was met in December 2016 with 100% being attained. The target has been met since December 2015.

## Psychological Therapies




The Psychological Therapy 18 week referral to treatment performance was not achieved in December 2016 with 83.8%. This shows an increase in attainment from the November position of 75.4%.

The decline in performance experienced already noted since September 2016 continues to be due to the reduction in service capacity due to maternity leave and career breaks in Clinical Health Psychology and capacity issues within Older Adult Psychology and Perth tier 3 Clinical Psychology General Adult Psychiatry service. The staff shortages in Health Psychology (5.1wte vacancies/maternity leave from a substantive complement of 9wte) and Clinical Neuropsychology (1.5wte vacancies/maternity leave from a substantive complement of 6.9wte) are now impacting on waiting times for ongoing waits. Vacancies are being advertised and it is anticipated that performance will improve in 2017/18 as staff return from maternity leave.




The HEAT standard is monitored on quarterly performance. This was a combined Drug and Alcohol performance of **97.7%** for the quarter to December 2016 (an improvement on the previous quarter, 91.4%) with the standard being achieved.

A decline was noted for the alcohol pathway in the previous 2 quarters of 2016/17 due to staffing shortages within Dundee alcohol service. These issues were resolved with overall performance in quarter 3 2016/17 of **98.2%** (Dundee 97.4%).

The Drug service achieved **97.1%** in quarter 3 2016/17, a slight decline from 97.5% in the previous quarter.

This measure is updated quarterly with the next update being available early May 2017.

## 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 December 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. | November 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).<br><br>Medical specialties and emergency activity excluded. | TOPAS | | November 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. | November 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 | | November 2016 |
| **Delayed Discharges** | Measures the total number of patients delayed at the census date (15th of every month).<br>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. | December 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 1 2016/17 (Apr 16 – Jun 16) |
| **Outpatient activity** | *New: Return ratio (1: )*<br>Measures the return attendances in proportion to new attendances for all acute consultant-led activity.<br><br>*Did Not Attend Rate*<br>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. | November 2016 |

## EFFICIENCY TARGETS — Board Performance Update, as at end December 2016

| Improved performance ↑ | Same performance ↔ | Worse performance ↓ |
|---|---|---|

| **Same Day Surgery** | *Sept-16* | *Oct-16* | ***Nov-16*** | *Benchmark** | *Performance* | *On Track* |
|---|---|---|---|---|---|---|
| Same Day Surgery Rate | 81.4% | 80.4% | **84.6%** | 87.6% | ↑ | x |
| Pre-operative Patient Stays | 0.30 | 0.26 | **0.32** | 0.27 | ↓ | ✓ |

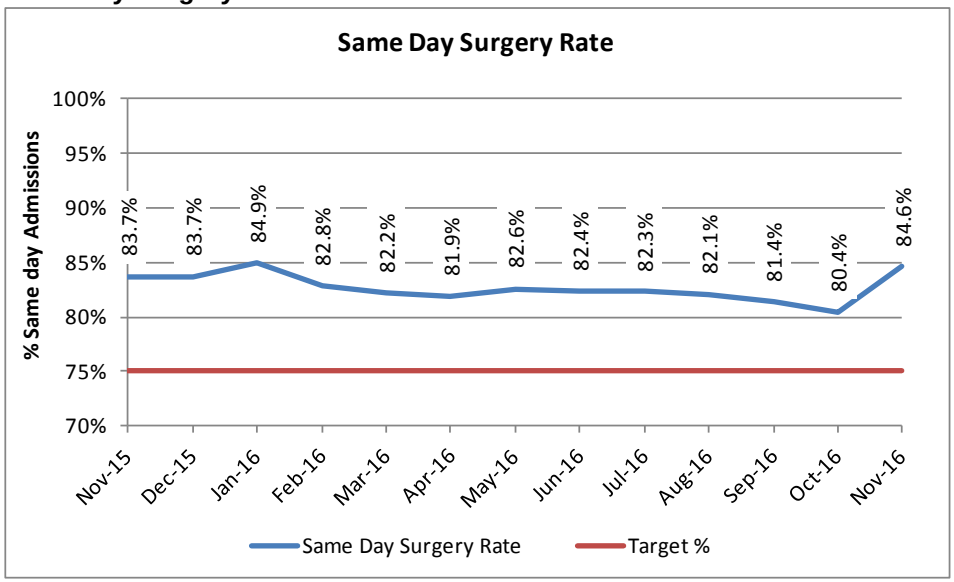
| **Patient Flow** | *Sept-16* | *Oct-16* | ***Nov-16*** | *Benchmark** | *Performance* | *On Track* |
|---|---|---|---|---|---|---|
| Elective Average Length of Stay in Days – Acute Services | 2.7 | 2.6 | **2.5** | 3.2 | ↑ | n/a |
| Emergency Average Length of Stay in Days – Acute Services | 3.6 | 3.7 | **3.8** | 4.6 | ↓ | n/a |

| | *Oct-16* | *Nov-16* | ***Dec-16*** | *Target* | *Performance* | *On Track* |
|---|---|---|---|---|---|---|
| Delayed Discharges as at census date (last Thursday of the month) | 109 | 78 | **67** | 0 | ↑ | x |

| | *Qtr 3 2015-16* | *Qtr 4 2015-16* | ***Qtr 1 2016-17*** | *Benchmark* | *Performance* | *On Track* |
|---|---|---|---|---|---|---|
| Re-admission Rate - Tayside **Medicine 7 day** | 52.9 | 61.3 | **64.01** | 56.55 | ↓ | x |
| Re-admission Rate - Tayside **Surgery 7 day** | 25.0 | 20.7 | **21.25** | 23.28 | ↓ | ✓ |
| Re-admission Rate - Tayside **Medicine 28 day** | 124.3 | 135.8 | **139.23** | 120.85 | ↓ | x |
| Re-admission Rate - Tayside **Surgery 28 day** | 46.0 | 43.8 | **44.50** | 43.43 | ↓ | x |
| **Outpatient Activity** | *Sept-16* | *Oct-16* | ***Nov-16*** | *Benchmark** | *Performance* | *On Track* |
| Outpatient Acute Services - New : Review Ratio | 2.1 | 2.2 | **2.1** | 1.9 | ↓ | n/a |
| New Outpatient Acute Services Did Not Attend Rate | 8.7% | 9.1% | **9.1%** | 9.1% | ↑ | n/a |

**Benchmarking obtained from NSS Discovery November 2016 position, Scottish average.*

## Same day Surgery rate




Same day surgery remains above target, achieving 84.6% in November 2016. All 3 acute sites have achieved the 75% target since August 2015, 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 (September - November 2016), our performance ranking had fallen to 12th (previous 3 month period 10th) when compared with the performance of all mainland boards and Golden Jubilee National Hospital (12 boards).

The areas with the greatest variance from national peers are Breast Surgery, General Surgery, Gynaecology, Ophthalmology, Orthopaedics and Vascular Surgery. Benchmarking data has been shared with the services, including a breakdown of procedure type and data to demonstrate variance in rates by individual staff. This will be utilised by services to inform improvement plans for inclusion within NHS Tayside's 2017/18 one year operational plan.

## 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 (36 as at December 2016 census point) with Dundee City reduced to similar volumes to Angus (16 and 11 respectively as at census point in December 2016). 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 continuing decline in September 2016. The 72 hour ambition which showed a decline in August 2016 has remained static in September (full monthly figures). 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.

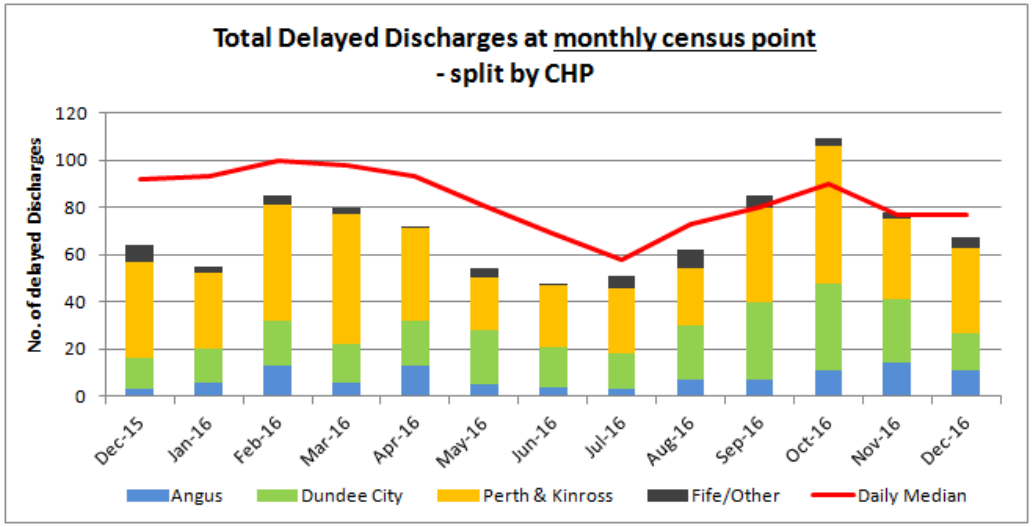
A significant programme of work has been initiated in Perth and Kinross (P&K) following the diagnostic visit by Brian Slater in January 2016. Comprehensive analysis of the patient pathway through acute care has demonstrated a number of factors impacting upon flow. Rather than considering the pressure 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. 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.

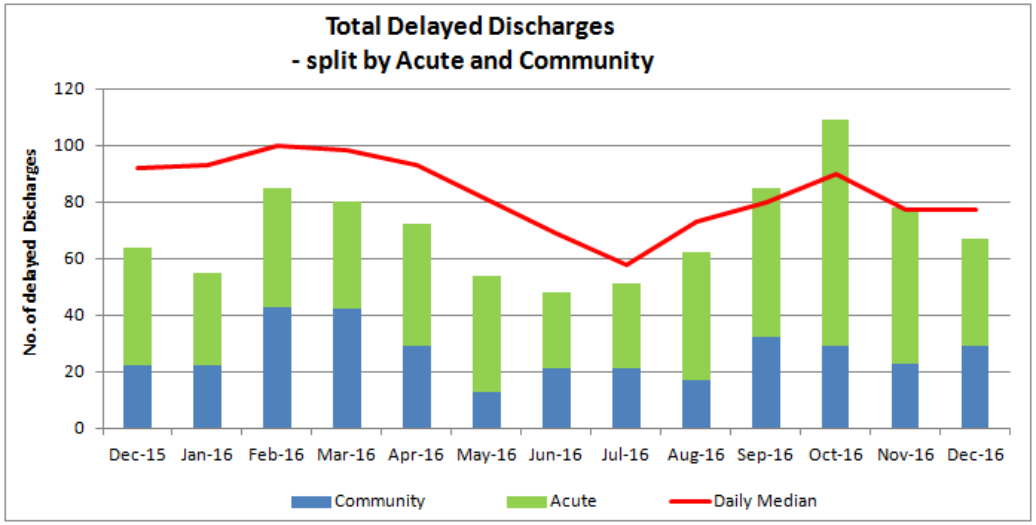
There is evidence in P&K of population need such that demand will continue to outstrip current resources and the HSCP team are working with the PRI General Manager to understand the trend data and communicate this back to NHS Tayside and PKC.

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 graphs 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. The Daily Median number of Delayed Discharges was less than or the same as the overall Census position between September and November 2016.

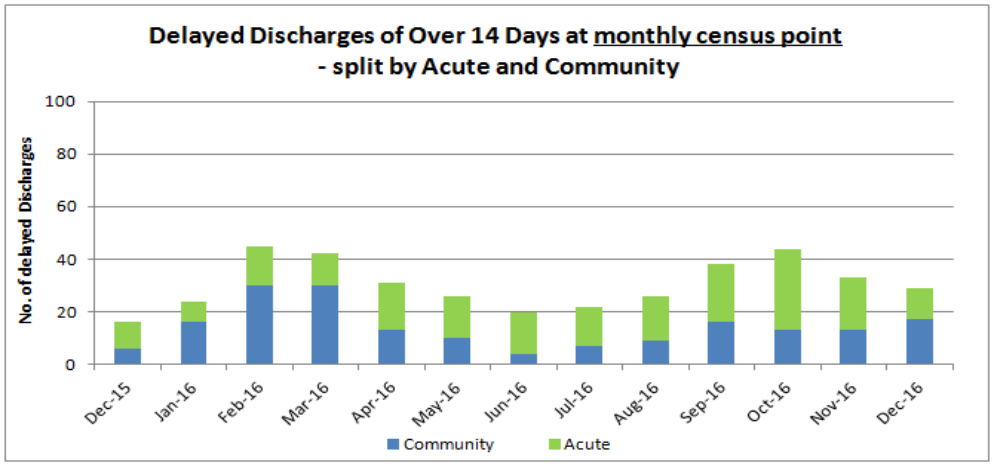
| Number of delayed Discharge patients by Site (Source:- Edison) | Aug-16 | | | Sep-16 | | | Oct-16 | | | Nov-16 | | | Dec-16 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Census date | Actual Median | Maximum | Census date | Actual Median | Maximum | Census date | Actual Median | Maximum | Census date | Actual Median | Maximum | Census date | Actual Median | Maximum |
| Perth Royal Infirmary | 13 | 18 | 32 | 18 | 22 | 30 | 33 | 28 | 33 | 15 | 13 | 23 | 9 | 12 | 25 |
| Ninewells Hospital | 14 | 13 | 18 | 15 | 15 | 18 | 17 | 14 | 17 | 14 | 8 | 17 | 13 | 16 | 22 |
| Royal Victoria Hospital | 17 | 18 | 26 | 18 | 17 | 19 | 28 | 24 | 31 | 20 | 21 | 30 | 12 | 11 | 17 |
| Murray Royal Hospital | 2 | 3 | 6 | 3 | 5 | 8 | 6 | 4 | 5 | 8 | 5 | 8 | 8 | 8 | 10 |
| Whitehills Health and Comunity Hospital | 2 | 2 | 3 | 3 | 2 | 3 | 2 | 1 | 3 | 3 | 3 | 6 | 2 | 4 | 8 |
| Crieff Community Hospital | 4 | 4 | 7 | 4 | 4 | 5 | 8 | 4 | 9 | 4 | 4 | 10 | 2 | 2 | 6 |
| Stracathro Hospital | 2 | 2 | 4 | 1 | 1 | 4 | 1 | 1 | 1 | 3 | 4 | 4 | 6 | 5 | 6 |
| Blairgowrie Community Hospital | 0 | 2 | 3 | 4 | 4 | 5 | 2 | 1 | 5 | 0 | 2 | 4 | 6 | 5 | 5 |
| St Margaret's Hospital | 2 | 4 | 6 | 5 | 4 | 6 | 2 | 4 | 6 | 3 | 2 | 4 | 1 | 0 | 4 |
| Arbroath Infirmary | 0 | 0 | 1 | 2 | 1 | 2 | 1 | 1 | 3 | 3 | 5 | 10 | 0 | 0 | 4 |
| Kingsway Care Centre | 3 | 3 | 6 | 8 | 4 | 8 | 5 | 6 | 8 | 2 | 3 | 5 | 2 | 2 | 3 |
| Pitlochry Community Hospital | 1 | 1 | 2 | 2 | 2 | 5 | 2 | 1 | 3 | 1 | 2 | 3 | 3 | 1 | 3 |
| Montrose Royal Infirmary | 2 | 0 | 2 | 1 | 0 | 2 | 1 | 1 | 3 | 1 | 1 | 2 | 2 | 3 | 3 |
| Bluebell Intermediate Care Centre | 0 | 3 | 4 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Strathmartine Hospital | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Carseview Centre | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total (All locations) | 62 | | | 85 | | | 109 | | | 78 | | | 67 | | |

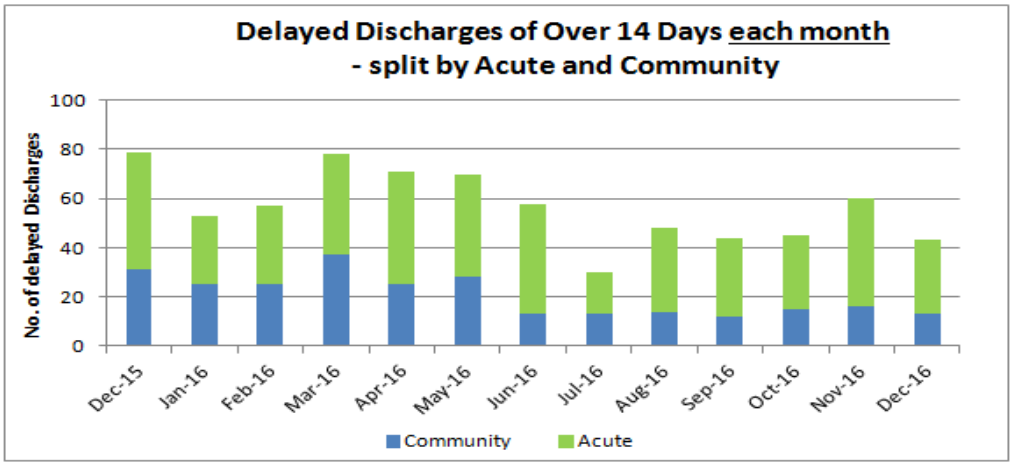
The table provides a breakdown by location of the patients delayed at census point for the 5 months to December 2016. In addition, the table shows the median daily number of patients delayed at each location in the month. This demonstrates that at census point the number of patients delayed is frequently 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 December 2016 was 25 patients in Perth Royal Infirmary.
*The measure excludes patients with a complex reason for delay and patients awaiting commissioning / reprovisioning of services. From July'16 Interim Care facility patients are also excluded.*

**Delayed Discharges**

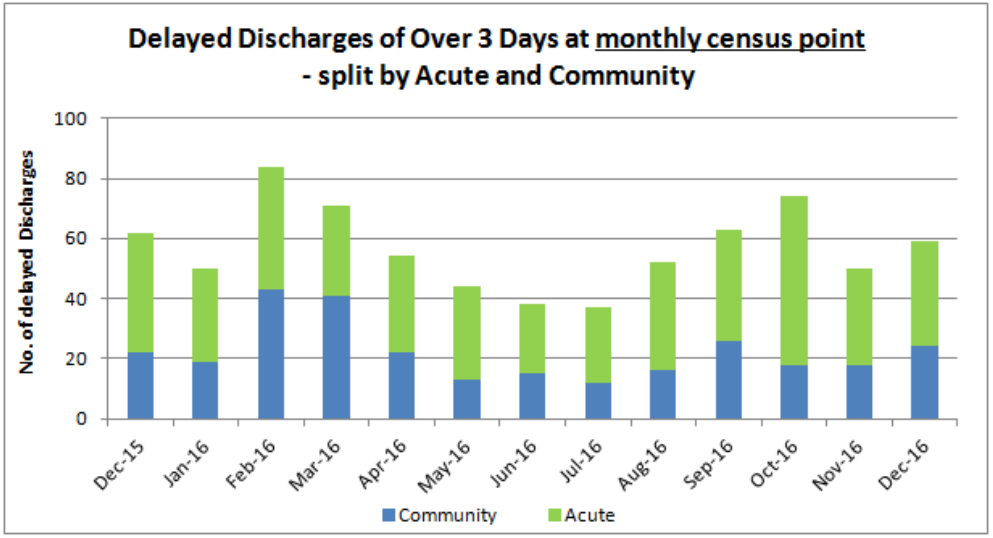
Scottish Government announced in October 2011, that from April 2015 no patient should wait more than 2 weeks from when they are clinically ready for discharge until they are discharged. This again is measured at the census date, and the first graph below shows the number of patients delayed at the census 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.

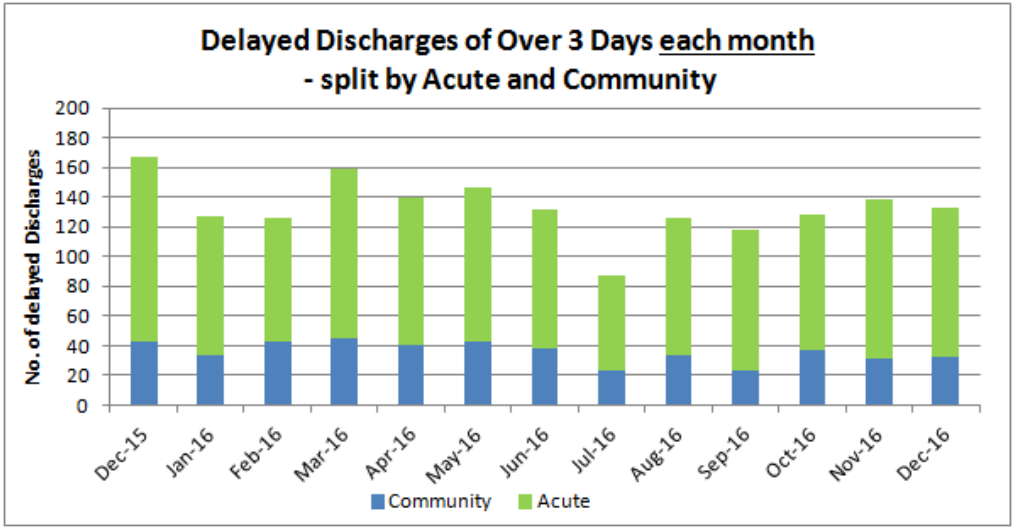
**No non-complex cases will be delayed for greater than 14 days from April 2015**




**No non-complex cases will be delayed for greater than 3 days**

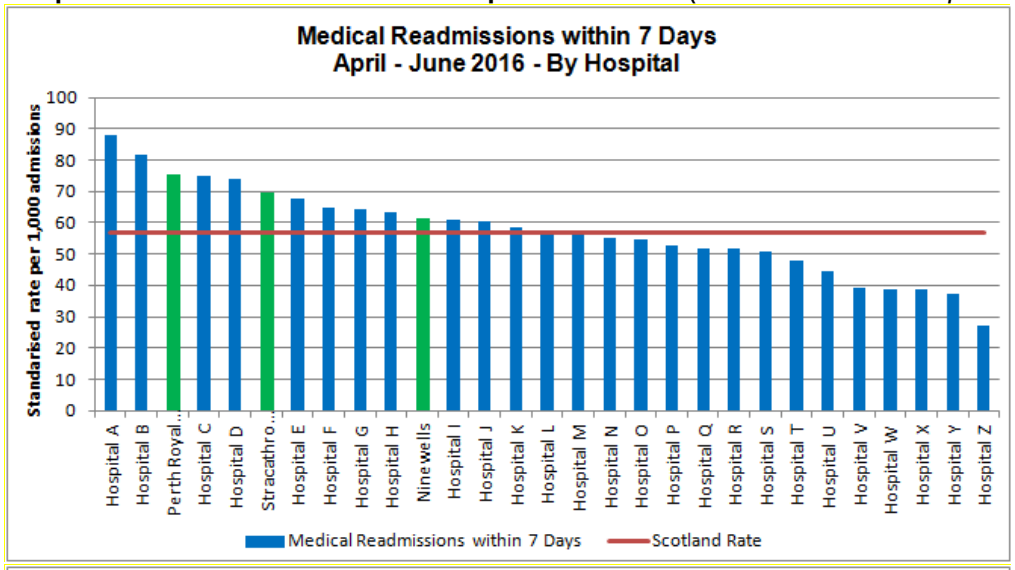


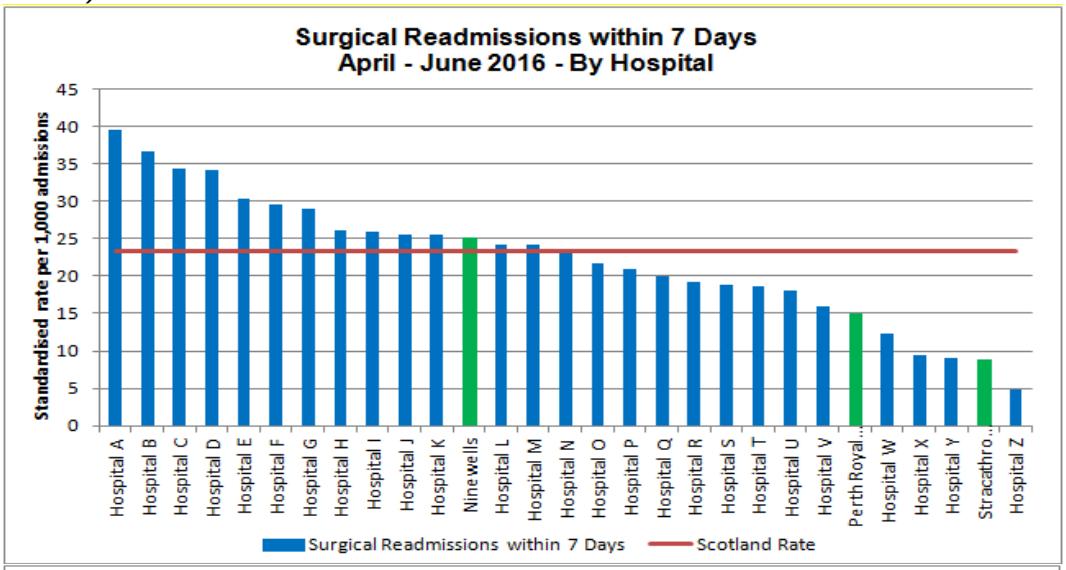



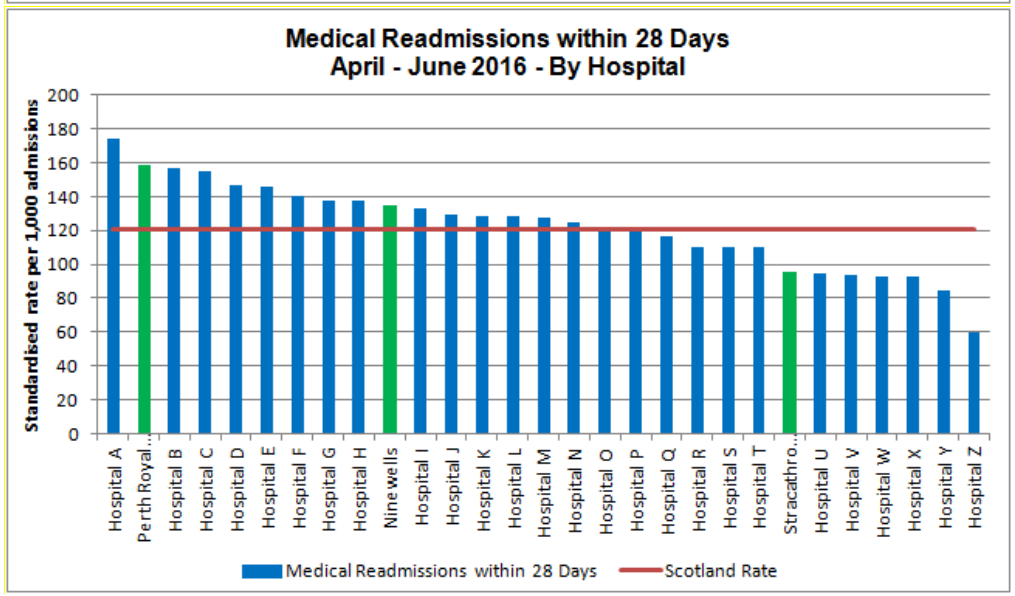
**Readmissions**

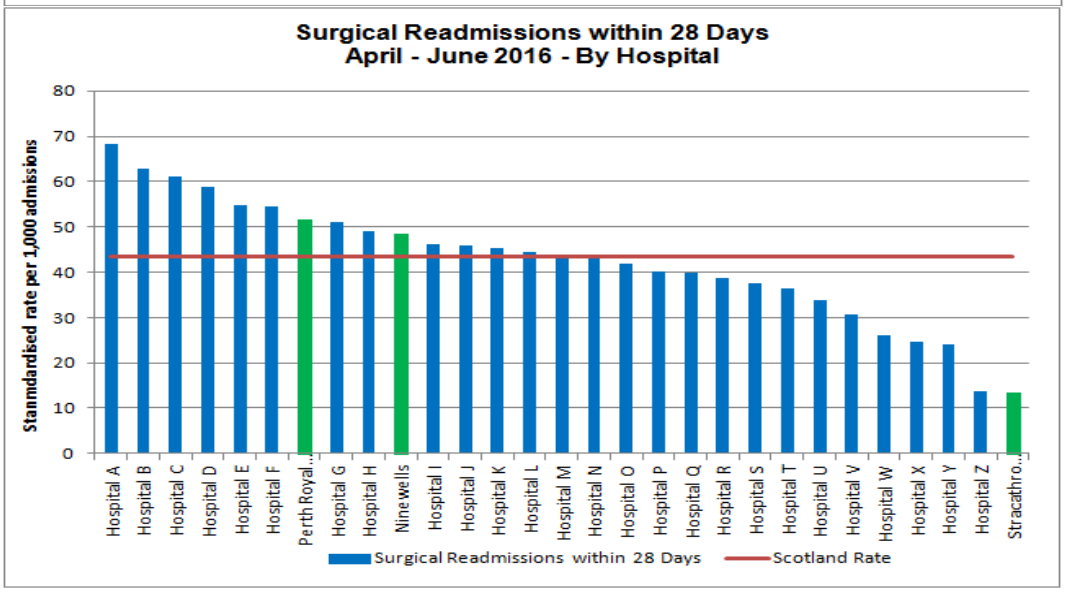
Every quarter Information Service Division (ISD) release a Hospital Scorecard which provides benchmark information in respect of key hospital based measures, including readmissions. This information enables comparison of our performance with that of other Boards and Hospitals. The latest information released by ISD covers the period 1st April – 30th June 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.

**Hospital Level Readmission Rates – April - June 2016** *(Data source ISD Hospital Scorecard)*

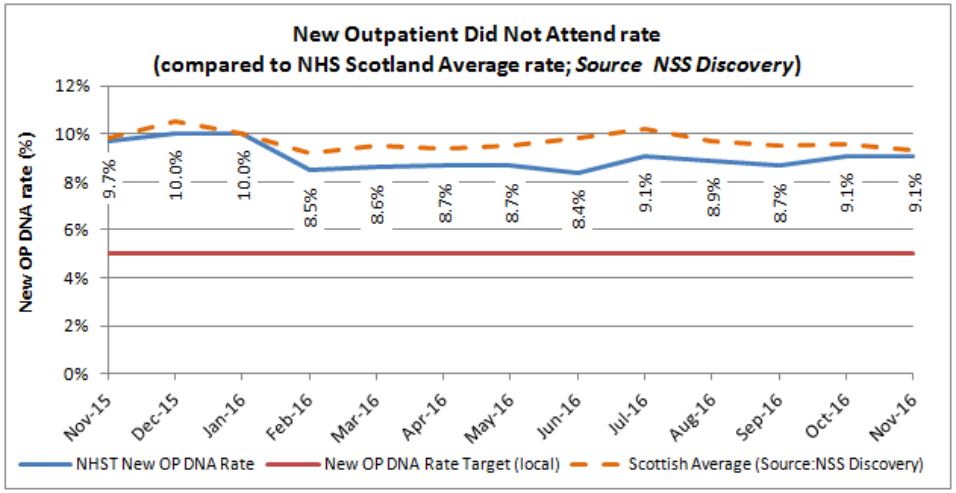


## New Outpatient Did Not Attend rate




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

| 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.<br><br>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. | April-June 2016p |
| **Clinical Quality Indicators** | *Pressure Ulcer Incidents*<br>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 avoidable and unavoidable pressure ulcers is also presented.<br><br>*Fall Incidents/Patients*<br>Measures the number of falls incidents reported through Datix.<br><br>*Fall with Harm*<br>Measures, of the falls incidents and patients affected reported, how many resulted in harm.<br><br>*Nutritional Care*<br>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. | December 2016 |

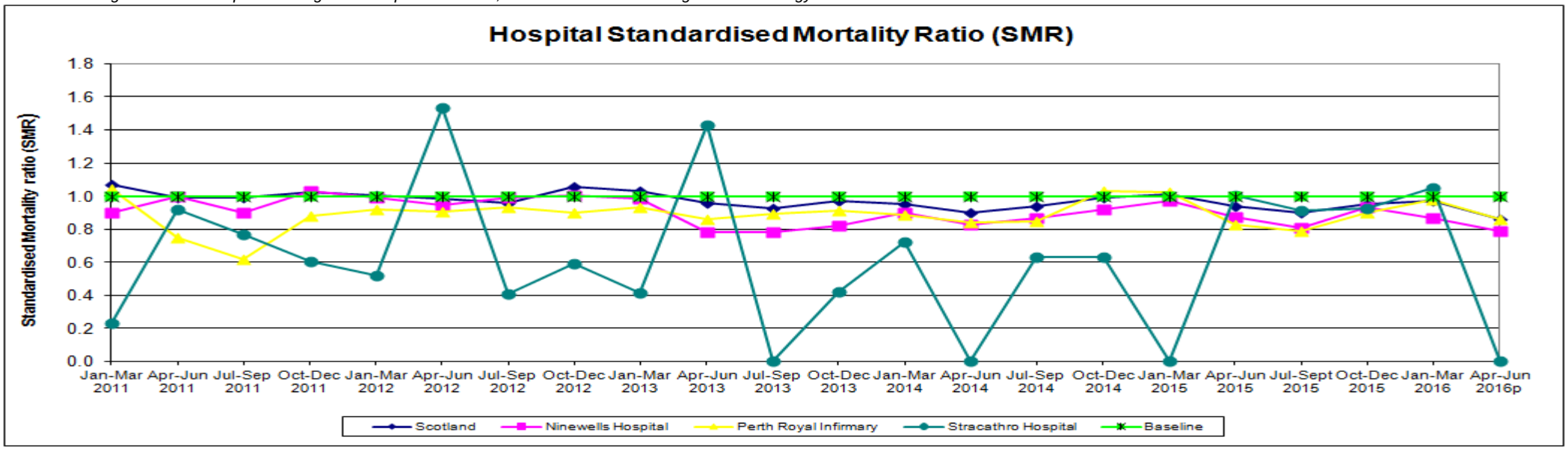
## Hospital Standardised Mortality Rate

| Improved performance ↑ | Same performance ⇔ | Worse performance ↓ |
|---|---|---|

*This rate is calculated by ISD Scotland and published on a quarterly basis*

| | *Oct-Dec 2015* | *Jan-Mr 2016p* | ***Apr-Jun 2016p*** | *Baseline* | *Performance* | *On Track* |
|---|---|---|---|---|---|---|
| Ninewells Hospital | 0.93 | 0.87 | **0.79** | 1.00 | ↑ | ✓ |
| Perth Royal Infirmary | 0.90 | 0.98 | **0.86** | 1.00 | ↓ | ✓ |
| Stracathro Hospital | 0.93 | 1.05 | **0.0** | 1.00 | ↓ | ✓ |
| Scotland Total | 0.95 | 0.97 | **0.86** | 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:

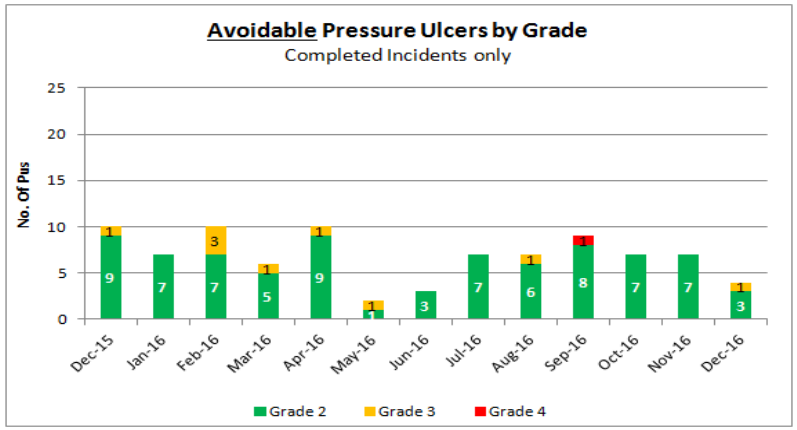
- Random variation: number of observed deaths particularly in smaller hospitals.
- Data quality: variations in completeness and accuracy of recording of data from patient records, particularly misattribution and coding of main diagnosis.
- Palliative care provision: the level of palliative care and terminal 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.
The HSMR for Scotland has decreased by 7.0% between January to March 2014 (first quarter after new baseline) and April to June 2016. Ninewells is reporting an overall reduction (7.8%) in HSMR from the revised baseline whereas PRI (+2.4%) and Stracathro (+0.5%) 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.

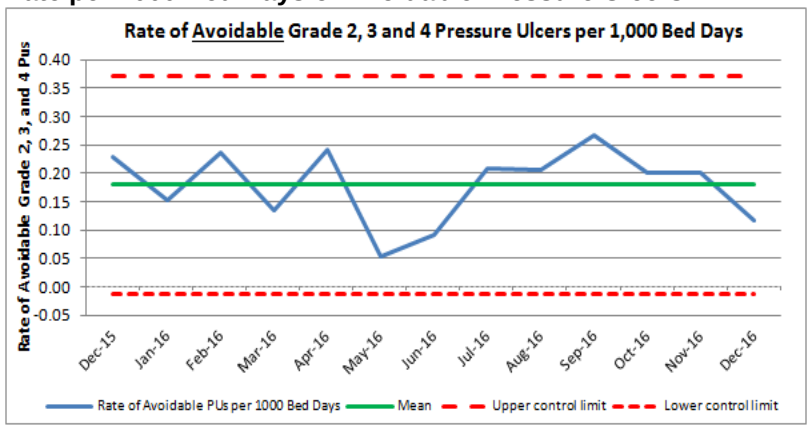
| Increasing Numbers ↑ | Same Numbers ↔ | Decreasing Numbers ↓ |
|---|---|---|

| Clinical Quality Indicators (all Directorates) | | *Oct-16* | *Nov-16* | ***Dec-16*** | ***Trend*** |
|---|---|---|---|---|---|
| Avoidable Pressure Ulcers | Numbers | 7 | 7 | 4 | ↓ |
| | Rate per 1000 Bed Days | 0.20 | 0.20 | 0.12 | ↓ |
| Unavoidable Pressure Ulcers | Numbers | 8 | 20 | 4 | ↓ |
| | Rate per 1000 Bed Days | 0.23 | 0.57 | 0.12 | ↓ |
| Patient Falls Incidents | | 300 | 292 | 306 | ↑ |
| Patient Falls with Harm | | 100 | 110 | 83 | ↓ |
| Nutritional Care – Incidents of Unintentional Weight Loss | | 2 | 1 | 2 | ↑ |

### Number of Avoidable Pressure Ulcers

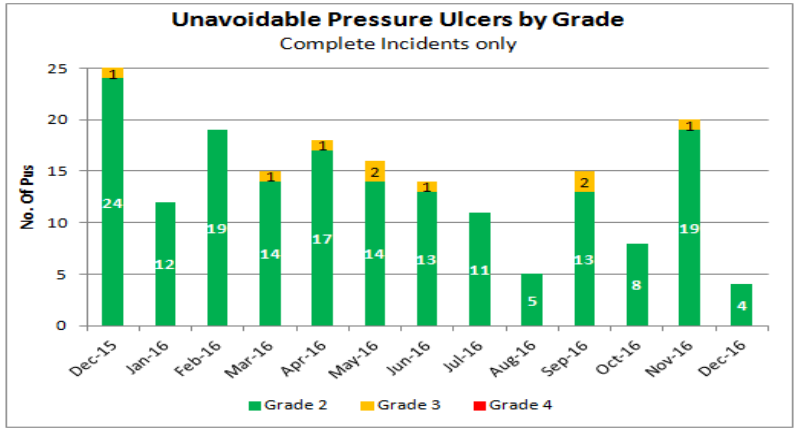



### Rate per 1000 Bed Days of Avoidable Pressure Ulcers

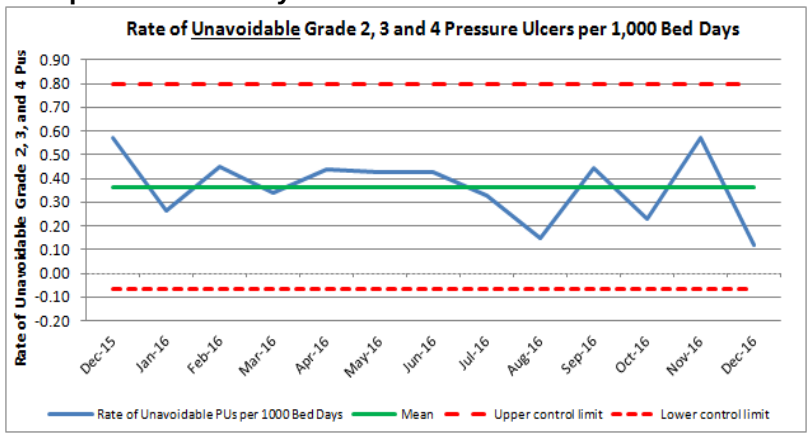



The information presented in respect of avoidable pressure ulcers demonstrates that in the 13 months to December 2016 there was 1 grade 4 (serious) pressure ulcer deemed as avoidable.
The rate of avoidable pressure ulcers is consistently below 0.30 per 1000 bed days and remains within the upper and lower control limits.
In the latest quarter (Oct-Dec'16 there was only 1 reported avoidable grade 3 (moderate) and 17 grade 2 (minor). Overall, there has been a reduction in the number of grade 3 avoidable pressure ulcers.

### Number of Unavoidable Pressure Ulcers



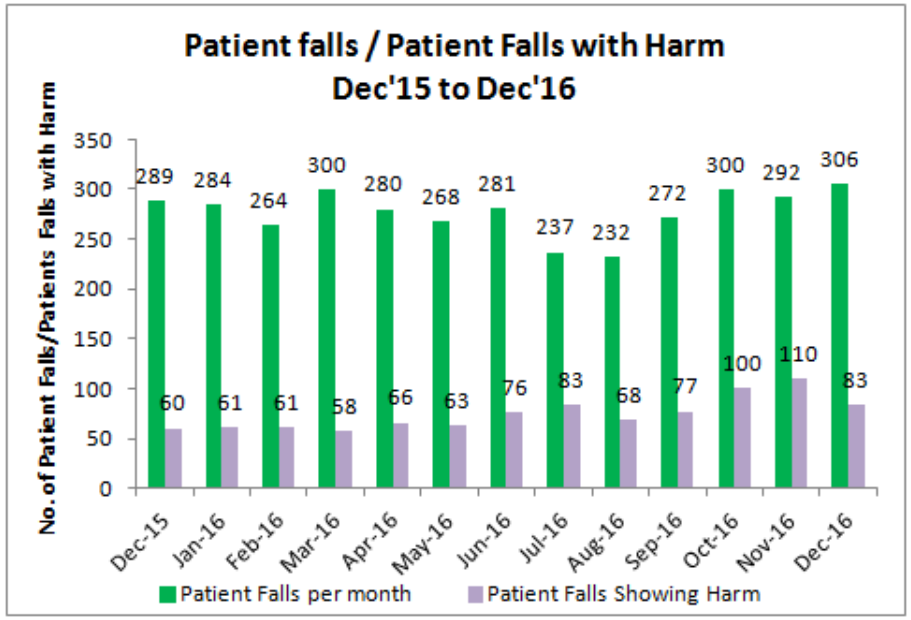

### Rate per 1000 Bed Days of Unavoidable Pressure Ulcers




The information presented in respect of unavoidable pressure ulcers demonstrates that in the 13 months to December 2016 there have been no grade 4 pressure ulcers deemed as unavoidable. The rate of avoidable pressure ulcers is consistently below 0.60 per 1000 bed days and remains within the upper and lower control limits. Quarter 3 16/17 (Oct-Dec'16) saw an increase in Grade 2 pressure ulcers (from 29 in qtr 2 2016/17 to 31 in qtr 3) and a reduction in Grade 3 (from 2 in qtr2 to 1 in qtr3).

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.

**Falls/Falls with Harm - Incidents**




The first meeting of a short life working group has established a number of improvements to progress in relation to numbers of falls occurring in toilets within surgical areas. These focus on environmental factors.

A revised format in Datix has been agreed to support staff to accurately record falls with harm in line with national criteria to address the perceived over-reporting of this harm. The revised version will be available and in use from week beginning 13th February 2017.

Improvement work within the Medicine Directorate continues with positive results. Several areas across Ninewells and PRI are demonstrating improvement with reduced numbers of falls over time. It is noted that the overall Board results do not reflect this and it is recommended that the approach taken within the Medicine Directorate is replicated across NHS Tayside.

**Nutritional Care**

Incidents of Unintentional Weight Loss – these are also reviewed regularly through the Directorate Performance Reviews and local clinical governance groups. It shows in December 2016 that there were two incidents of unintentional weight loss, one of the incidents was unavoidable and the other incident is awaiting a local adverse event review.

| 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.<br><br>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. | November 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.<br><br>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. | November 2016 |

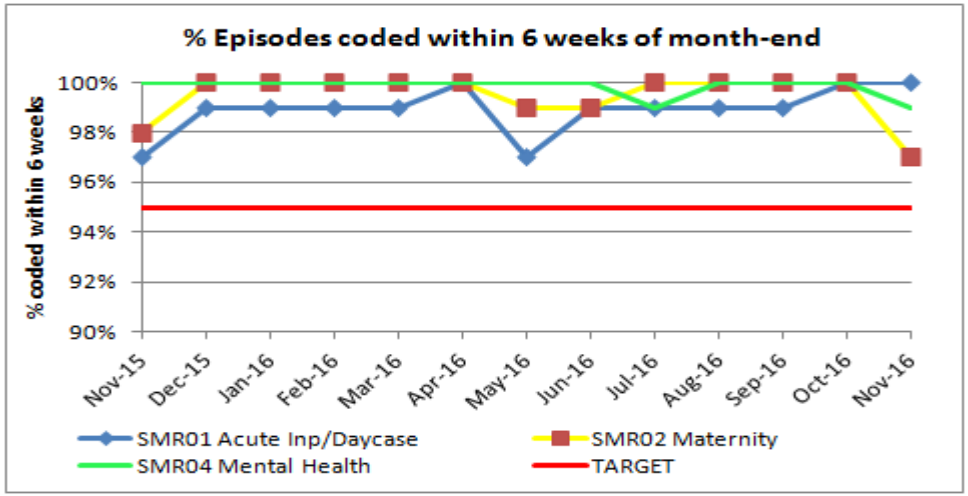
| Improved performance ↑ | Same performance ↔ | Worse performance ↓ |
|---|---|---|

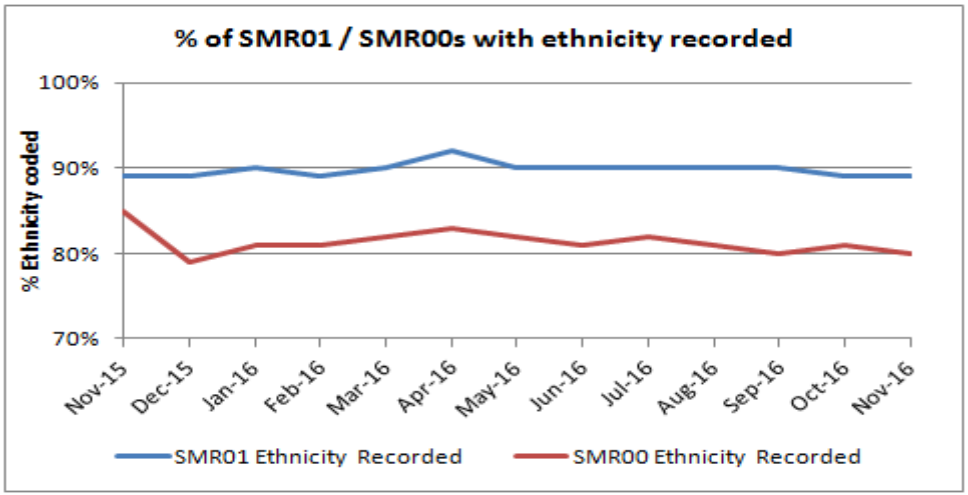
## Coding within 6 weeks of month-end

| | *Sept-16* | *Oct-16* | ***Nov-16*** | *Target* | *Performance* | *On Track* |
|---|---|---|---|---|---|---|
| % of Acute Inpatient/Daycase Episodes (SMR01) coded < 6 weeks of month-end | 99% | 100% | **100%** | 95% | ↔ | ✓ |
| % of Maternity Episodes (SMR02) coded < 6 weeks of month-end | 100% | 100% | **97%** | 95% | ↓ | ✓ |
| % of Mental Health Episodes (SMR04) coded < 6 weeks of month-end | 100% | 100% | **99%** | 95% | ↓ | ✓ |

## Ethnicity recording

| | *Sept-16* | *Oct-16* | ***Nov-16*** | *Target* | *Ranking* | *Performance* | *On Track* |
|---|---|---|---|---|---|---|---|
| % of SMR01 Activity with Ethnicity Recorded | 90% | 89% | **89%** | 95% | **2nd** | ↔ | **x** |
| % of SMR00 Activity with Ethnicity Recorded | 80% | 81% | **80%** | 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. The high level of performance attained continues for both SMR01 and SMR04 into November 2016, the national target being 95%. The decline in SMR02 coding was due to a backlog in case records being obtained due to the Public Holidays over the Festive period. The process has been reviewed giving assurance of timely provision of case records at all times including public holiday periods.

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 previously declined slightly for SMR01 in October and November and for SMR00 in September and November 2016.

*Rankings - Please note these apply to the March'16 position across Scotland, excluding Island Boards, no updated publication is currently available.*

| Feedback and Complaints | Board Performance Update, as at end December 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 | November 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 | November 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 | December 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 | December 2016 |

| | | | | | |
|---|---|---|---|---|---|
| Improved performance | ↑ | Same performance | ⇔ | Worse performance | ↓ |
| Increasing Numbers | ↑ | Same Numbers | ⇔ | Decreasing Numbers | ↓ |

| **Feedback and Complaints** | *Sept-16* | *Oct-16* | ***Nov-16*** | *Target* | *Performance* | *On Track* |
|---|---|---|---|---|---|---|
| Complaints Responded to within 20 working days | 47% | 40% | **55%** | 68% | ↑ | x |
| Complaints Acknowledged within 3 working days | 95% | 98% | **99%** | 80% | ↑ | ✓ |
| | *Oct-16* | *Nov-16* | ***Dec-16*** | *Target* | *Trend* | *On Track* |
| Number of all types of feedback received | 225 | 258 | **180** | - | ↓ | n/a |
| Number of complaints received | 137 | 170 | **113** | - | ↓ | 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**

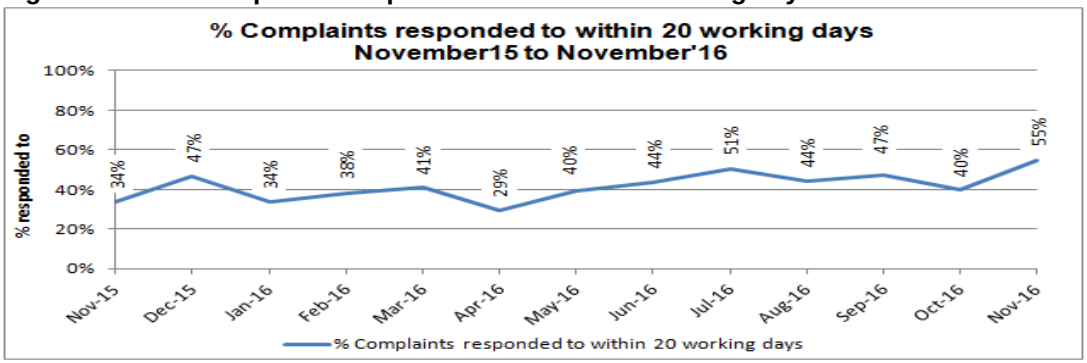
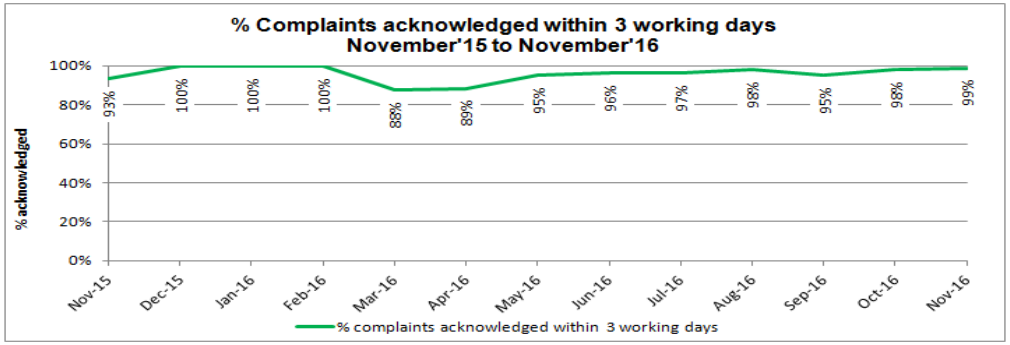



Figure 1 demonstrates NHS Tayside's timeliness of complaint responses. The 2015/16 NHS Complaints Statistics, Scotland, demonstrated that nationally, 68.5% of complaints were responded to within 20 days. For the most recent reportable month of November 2016, NHS Tayside achievement was 55% compliance.

**Figure 2 - % of complaints acknowledged within 3 working days**




Acknowledging complaints within 3 days improved in November 2016, achieving 99%.

**Figure 3 – All Feedback Received (Complaints, Compliments, Concerns & Enquiries**

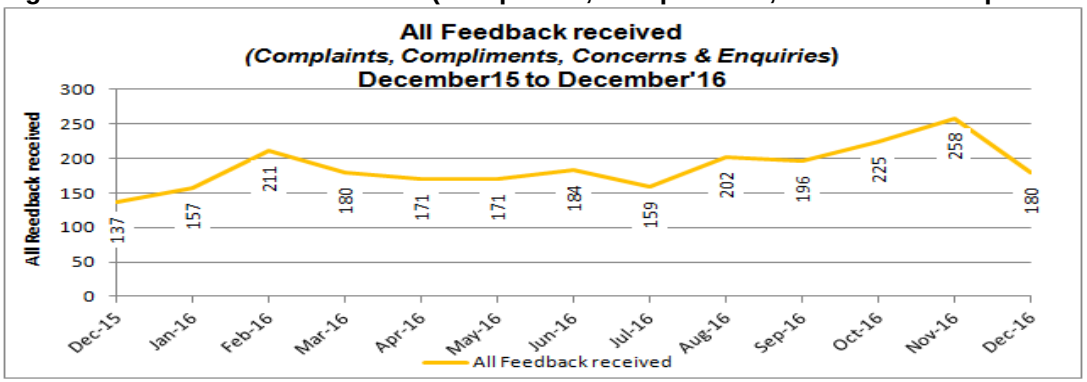
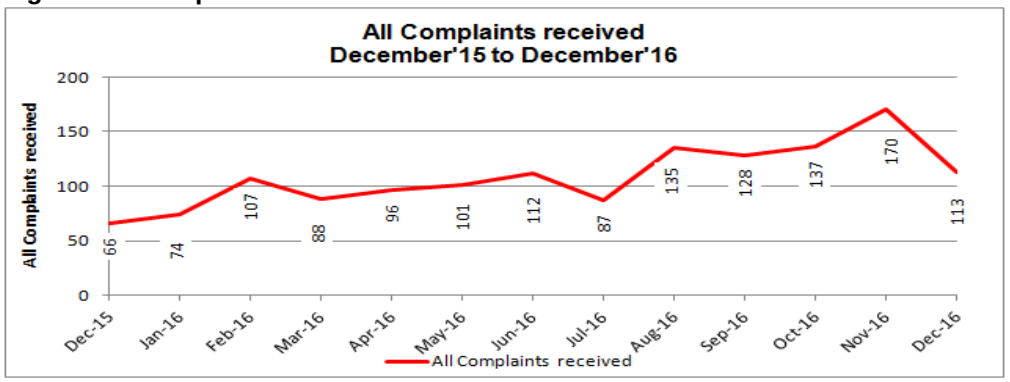



**Figure 4 – Complaints Received**




There has been a decrease in the number of complaints received over December 2016 (figure 4) at 113 complaints compared to 170 received in November 2016. The volume of complaints received from the Prison Services fell from 49 in November 2016 to 40 in December 2016. 4 of the 45 Perth & Kinross CHP complaints received in December 2016 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. This has led to the development of a 90 day plan which will support NHS Tayside improve the way we respond to feedback and complaints, and will also ensure we meet the requirements of the new NHS Complaints Procedure which comes into effect on 1 April 2017.

## Unscheduled Care Measures — Board Performance Update, as at end December 2016

| Measure | Definition | Data Source | Data Validation | Time Period Reported |
|---|---|---|---|---|
| **A&E Attendances & 4 Hour Attainment** | Number. of A&E Unplanned Attendances<br>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 1st January 2017 |
| **Unscheduled Admissions/Discharges** | Number of Unscheduled Admissions & Discharges<br>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 1st January 2017 |
| **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 1st January 2017 |
| **Patients awaiting an available bed in a ward** | No. of patients awaiting an appropriate bed in a ward<br>Both Ninewells or PRI and Medical or Surgical | Ward Staff in Ninewells and PRI | Local validation daily by ward staff | Week ending 1st January 2017 |
| **Length of Stay** | Average of full Length of Stay of Discharges for patients who had an unscheduled admissions only<br>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 1st January 2017 |
| **Elective cancellations due to Bed Pressures** | Number of patients booked as an Elective Inpatient or Daycase cancelled at short notice due to bed pressures<br>Both Ninewells or PRI and Medical or Surgical | Services (normally Waiting List Co-ordinators) | Local validation weekly by each directorate | Week ending 1st January 2017 |

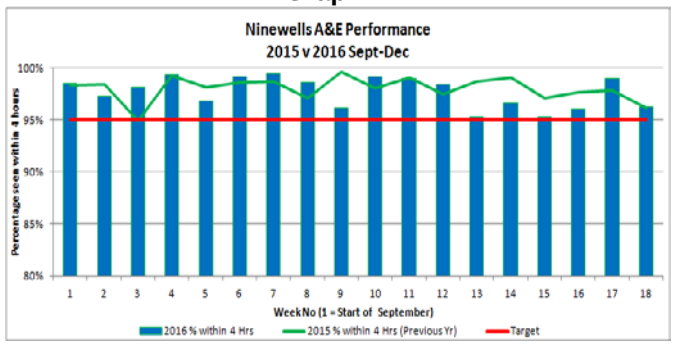
## Unscheduled Care Measures by Site — Board Performance Update, as at end December 2016

| NINEWELLS | | | Week ending | | |
|---|---|---|---|---|---|
| **Measures** | | | *18/12/2016* | *25/12/2016* | *01/01/2017* |
| A&E Attendances | | | 925 | 784 | 879 |
| A&E 4 Hour Attainment | | **Graph (A)** | 96.0% | 99.0% | 96.2% |
| Unscheduled Medical Admissions/Discharges | | **(B)** | 546/495 | 486/555 | 596/481 |
| Unscheduled Surgical Admissions/Discharges | | **(C)** | 237/246 | 209/252 | 227/212 |
| SystemWatch Unscheduled Admissions actual/predicted | Medical | **(D)** | 410/411 | 374/425 | 460/454 |
| | Surgical | **(E)** | 201/198 | 176/187 | 193/196 |

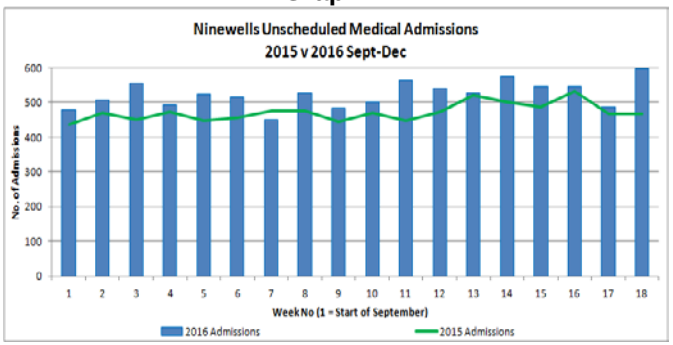
| **Measures** | | Week ending | | |
|---|---|---|---|---|
| | | *18/12/2016* | *25/12/2016* | *01/01/2017* |
| Medical– Average Length of Stay (Unscheduled) | | 5.3 | 5.0 | 2.6 |
| Surgical–Average Length of Stay (Unscheduled) | | 7.1 | 7.8 | 5.2 |
| Patients awaiting an available bed in a ward | Medical & Surgical | 41 | 4 | 25 |
| Elective Cancellations – due to bed pressures | Medical **(F)** | 2 | 0 | 0 |
| | 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 increased in July however have reduced again and continue to be lower than last year.

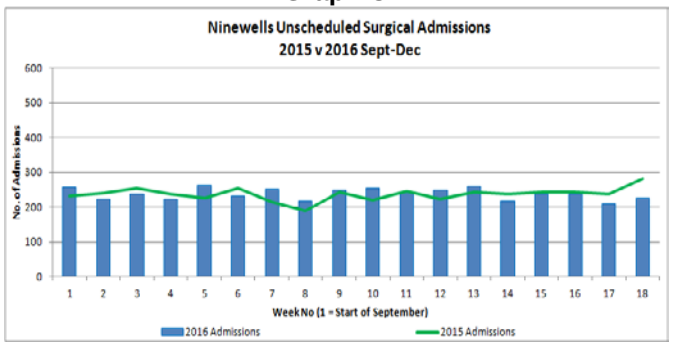
**Graph A**



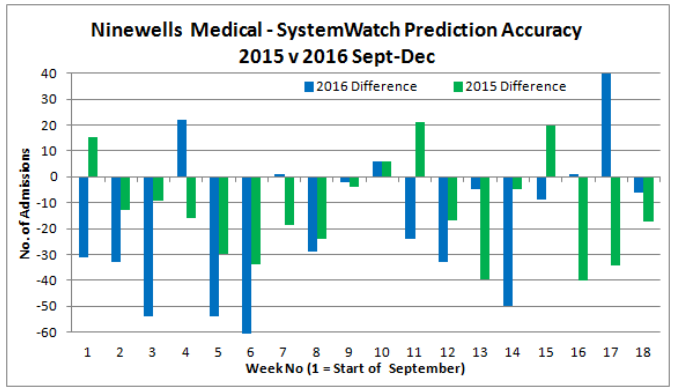

**Graph B**



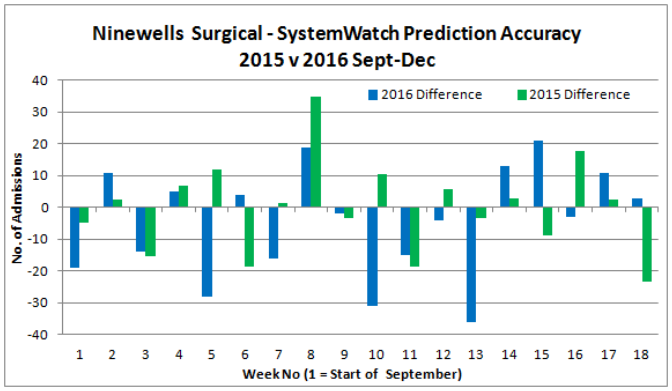

**Graph C**



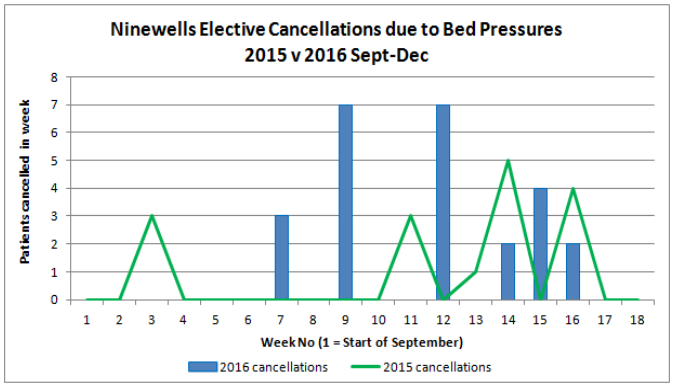

**Graph D**




**Graph E**



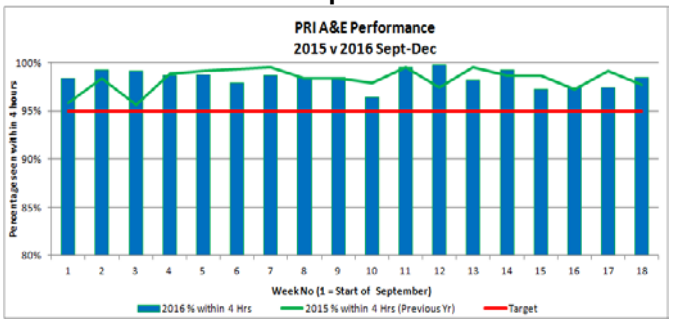

**Graph F**



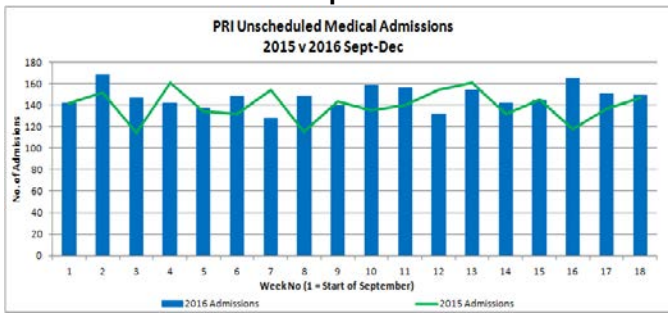
| PRI | | | Week ending | | | | | Week ending | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Measures** | | | *18/12/2016* | *25/12/2016* | *01/01/2017* | **Measures** | | *18/12/2016* | *25/12/2016* | *01/01/2017* |
| A&E Attendances | | | 464 | 429 | 407 | Medical– Average Length of Stay (Unscheduled) | | 9.0 | 7.9 | 4.7 |
| A&E 4 Hour Attainment | | **Graph (A)** | 97.4% | 97.4% | 98.5% | Surgical–Average Length of Stay (Unscheduled) | | 8.4 | 4.4 | 4.7 |
| Unscheduled Medical Admissions/Discharges | | **(B)** | 165/138 | 151/177 | 149/120 | Patients awaiting an available bed in a ward | Medical | 43 | 9 | 15 |
| Unscheduled Surgical Admissions/Discharges | | **(C)** | 20/20 | 40/36 | 30/23 | | Surgical | 0 | 0 | 0 |
| SystemWatch Unscheduled Admissions actual/predicted | Medical | **(D)** | 151/136 | 139/142 | 148/151 | Elective Cancellations - due to bed pressures | Medical **(F)** | 0 | 0 | 0 |
| | Surgical | **(E)** | 20/45 | 44/39 | 29/43 | | Surgical **(F)** | 1 | 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.

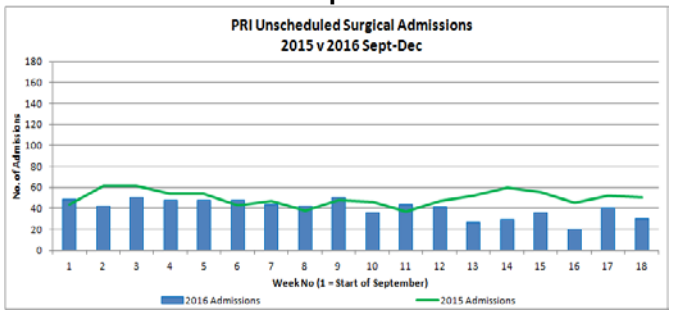
**Graph A**



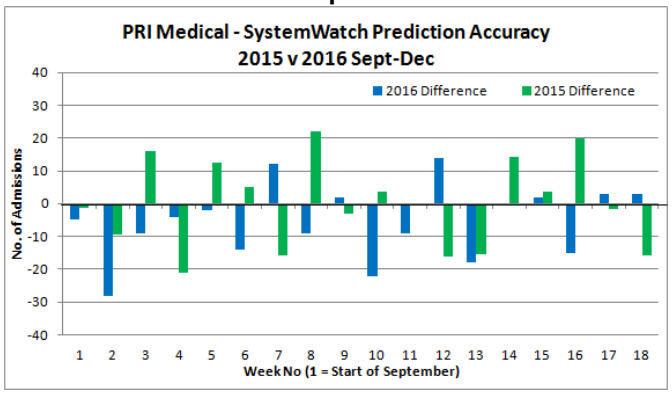

**Graph B**



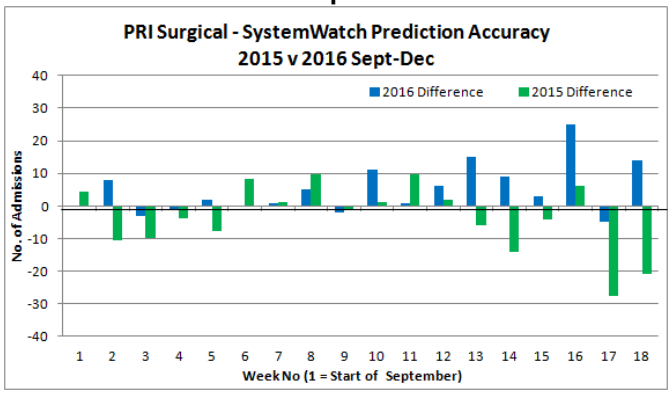

**Graph C**



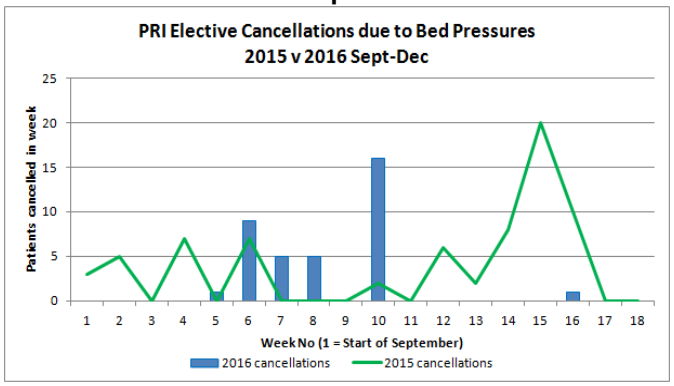

**Graph D**




**Graph E**




**Graph F**



**Item 15**

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

**BOARD04/2017**
**Tayside NHS Board**
**23 February 2017**

**ORGAN AND TISSUE DONATION AND TRANSPLANTATION – A CONSULTATION ON INCREASINGNUMBERS OF SUCCESSFUL DONATIONS**

## 1. SITUATION AND BACKGROUND

This consultation seeks the views of individuals and organisations on the introduction of a deemed or presumed consent system in Scotland.

Board Members were sent the information and requested to provide feedback on the consultation.

The consultation period ends on 14 March 2017 and a response will be prepared and circulated to the Board in advance of 14 March 2017.

## 2. ASSESSMENT

Board Members were asked to provide feedback and a response will be drafted to respond to the consultation.

## 3. RECOMMENDATIONS

The Board is asked to note that a response will be prepared and circulated to the Board in advance of the consultation closing date of 14 March 2017.

## 4. REPORT SIGN OFF

**Ms M Dunning**
**Board Secretary**
**February 2017**

**Ms L McLay**
**Chief Executive**

# Organ and Tissue Donation and Transplantation

## A consultation on increasing numbers of successful donations

December 2016

Scottish Government
Riaghaltas na h-Alba
gov.scot

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## Foreword

Organ and tissue donation and transplantation is an incredible development in modern healthcare. It is genuinely life-changing and one of the greatest gifts a person can give. Organ and tissue donation saves and improves lives. It allows people to lead full and happy lives, return to work, and contribute to society.

While the NHS in Scotland, with the amazing help of donors and their families, has already achieved a huge amount in increasing numbers of organ and tissue donors, we need to continue doing more in order to help reduce the numbers of people in Scotland waiting for transplants or dying waiting.

Much work is already in progress to help with this – we are already delivering meaningful improvements as a result of our *Donation and Transplantation Plan for Scotland, 2013-2020*. However, this consultation looks at two ways we could potentially increase numbers of deceased organ and tissue donors – by seeking to increase numbers of referrals and by seeking to increase the number of times when donation is 'authorised' to proceed. In particular, the Scottish Government has agreed to consider the introduction of an opt out system of donation if this can be developed in a way which will do no harm to trust in the NHS or to the safety of transplantation. We will also be monitoring the progress in Wales carefully to learn lessons from their experience of introducing a new opt out system.

Our presumption is in favour of taking an opt out system forward as part of a long-term process of culture change to encourage people to support donation. However, I am keen to hear your views on these proposals and others in this consultation so I would encourage you to respond to the questions we raise. Whatever the outcome of this consultation, rest assured the Scottish Government will continue to work both within Scotland and with our partners across the UK to increase organ and tissue donation and to allow more people to benefit from life-saving or life-changing transplants.

**Aileen Campbell**
**Minister for Public Health and Sport**

## Introduction

Organ and tissue transplantation can save and significantly improve lives, but at present there are insufficient donors to meet the number of organs needed by people on the transplant waiting list, as well as the need for tissue transplants. This consultation seeks views on ways in which we can increase the number of organ and tissue donors and transplants in Scotland. We have already made good progress in increasing organ donation and transplantation in Scotland over recent years, with an 83% increase in the number of people who donated organs after their death in Scotland between 2007-08 and 2015-16. In 2015-16 there were **183 organ donors in Scotland** (99 who had died and 84 living donors) and 415 people from Scotland received transplants. However, despite these successes, there were still 542 people on the active transplant waiting list in Scotland, waiting for an organ.

### Background – What is organ and tissue donation?

Over the past few decades, surgical advances have allowed hospitals to remove organs from one person – a donor – and then transplant each of the organs into a person who needs a new organ. Donors who donate their organs after they die can **potentially save the lives of up to nine people**[1].

Only a small proportion of people (less than 1%[2]) die in circumstances where it is possible for them to be an organ donor. At the moment, it is only possible to donate if you die in a hospital – normally in a Critical Care area (for example an intensive care unit) - and, even then, there may be a number of reasons why organ donation is not possible, such as medical reasons (if some or all of the organs are not functioning well) or for legal reasons (where there is an investigation into the cause of death and the Procurator Fiscal may not be able to allow some or all organs to be donated).

Therefore, this makes it very important that, where a person has died or has an unsurvivable brain injury, and where they could be a potential donor, they are identified as such and the procedures necessary to enable possible donation are initiated.

In Scotland, donors who have just died (known as deceased donors), can donate:

- Kidneys
- Liver
- Heart

[1] While most donate fewer organs, it is possible for one patient to potentially save or transform the lives of up to 9 people: 2 kidneys, heart, 2 lungs, pancreas, small bowel and 1 liver, which can in some cases be split in two and transplanted into 2 people (this does not include lives saved or transformed by tissue donation)

[2] *Taking Organ Transplantation to 2020 – A UK Strategy* notes that over half a million people die each year in the UK, but fewer than 5000 people each year die in circumstances or from conditions where they could become donors.

- Lungs
- Pancreas (including for islet cells)
- Small bowel (or multi visceral organs where a patient needs a transplant of several organs – this can include for example the stomach or spleen as well as the small bowel)

In addition to organs, donors can also donate **tissue**. This includes: eyes, tendons, heart valves, bone and skin. Such tissue can be used in anything from severe eye disease to reconstructive surgery and skin grafts. Donated tissue can significantly improve the lives of others – and in some cases, such as heart valves, saves lives. Unlike organs, which in most cases need to be transplanted within a few hours of the donor's death, it may be possible to donate tissue up to 48 hours after a person has died. Therefore, even if a person cannot be an organ donor, they may still be able to donate tissue. In this consultation, where we refer to measures to improve organ donation from people who have died, this would normally also include increasing tissue donation.

Over half of all donated organs in Scotland come from people who have died (deceased donors), but it is also possible for living people to donate some organs. Most living organ donors donate one of their two kidneys as it is possible to live healthily with just one kidney. It is also possible for a living donor to donate a part of their liver or occasionally their lung, but this happens less often. Some living people also donate some of their bone, for example if they have a hip replacement operation. The Scottish Government and NHS Scotland are working on a project to encourage an increase in the numbers of living kidney donors, but this consultation paper focuses on ways of increasing donation from deceased donors.

**How does organ and tissue donation currently work in Scotland?**

While Scotland has its own legislation governing organ and tissue donation and transplantation – currently the Human Tissue (Scotland) Act 2006 - organ donation and the allocation of organs to transplant recipients is managed across the UK by NHS Blood and Transplant (NHSBT). Organs need to be carefully matched to a recipient, taking into account things like the blood group, age, weight and the tissue type of the donor and potential recipient. This is important to give the best possible chance for a transplant to be successful. If an organ is not a good match with the recipient, there is a significant risk that it won't function effectively.

NHSBT is responsible for managing the UK's national transplant waiting list and for matching and allocating organs on a UK-wide basis. While this means that some organs from donors in Scotland may go to people in other parts of the UK (and occasionally elsewhere in Europe), it also means that people in Scotland may receive an organ from elsewhere in the UK or the rest of Europe.

If someone is dying or dies in circumstances where they could be an organ donor,

for example in an intensive care unit or occasionally an emergency medicine department, a Specialist Nurse for Organ Donation (SNOD) will check to see if the patient has authorised donation themselves. People can formally authorise donation by joining the NHS Organ Donor Register, or can make someone close to them aware of their donation wishes. At this point, a sensitive discussion with the patient's family will start to take place with regard to donation.

If donation is to proceed, the clinical team caring for the patient will work with the SNOD, who will ensure all the necessary clinical checks are made. This will include checking that there are suitable recipients for each organ that can be donated. Throughout this process, the comfort and needs of the donor patient remain paramount and the main focus of the clinical staff in the critical care unit will be on caring for their patient. SNODs also work hard to support the donor's family during this difficult time and to answer any questions the family has.

The organs are then retrieved by a completely different team of specialist surgeons who are not otherwise involved in the care of the patient. Organs are always removed with the greatest care and respect. They are then stored in fluid and usually kept cool to help preserve them and transported to whichever hospital or hospitals will carry out the transplant(s). As soon as possible, a separate team of surgeons will then transplant each organ into the patient who is going to receive it.

While donated organs can normally be retrieved at most acute hospitals, there are three transplant units in Scotland, which each have specialist facilities dedicated to the transplantation of organs into recipient patients:

- The Royal Infirmary of Edinburgh (liver, kidney, pancreas and islet cell transplants)
- The Queen Elizabeth University Hospital, Glasgow (kidney transplants)
- The Golden Jubilee National Hospital, Clydebank (heart transplants)

Most Scottish patients have their transplant undertaken in one of the three Scottish transplant units. However, a small number of Scottish patients receive their transplant in other parts of the UK. These usually relate to rarer transplants where it is in the best interest of patients to receive transplants in specialist centres. These treatments are fully paid for by NHS Scotland.

Meanwhile, most tissue donation in Scotland is managed by the Scottish National Blood Transfusion Service (SNBTS), although NHSBT manages donation of eyes across the UK. SNBTS has its own Tissue Donor Co-ordinators (TDCs), specialist nurses who work closely with NHSBT SNODs to coordinate donations in cases where both organs and tissue may be donated.

**Progress made so far**

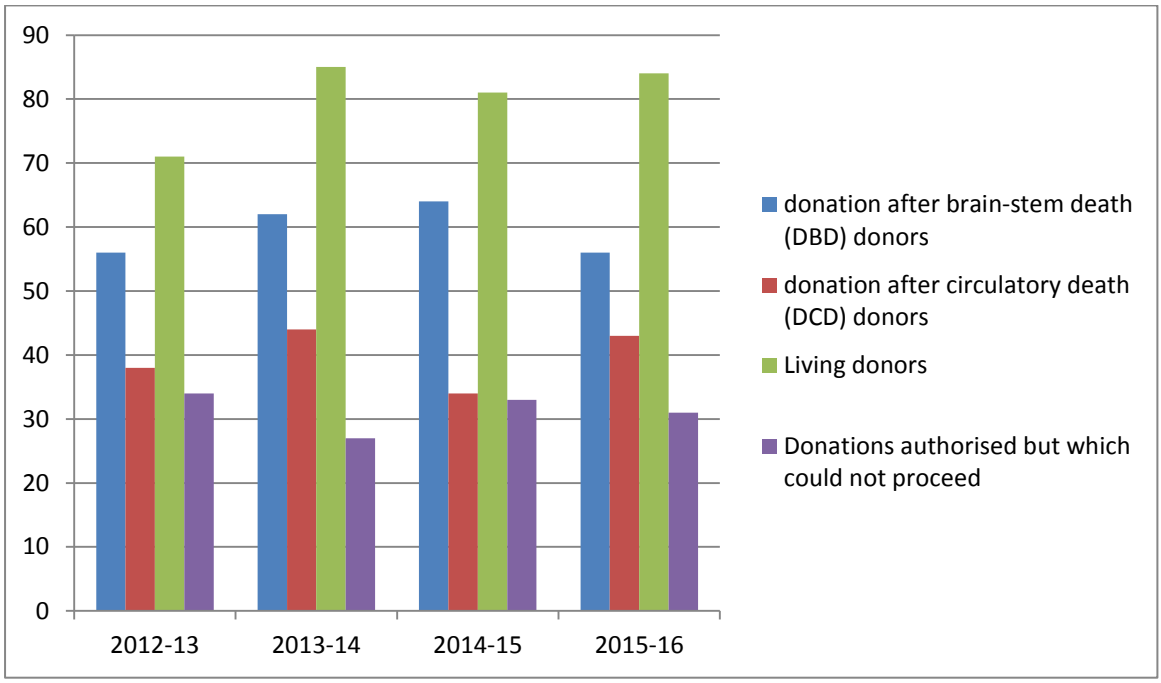
Considerable progress started being made after the publication of the UK Organ Donation Taskforce's report in 2008. In 2007-08 there were only 54 deceased donors in Scotland and 209 transplants from deceased donors. In particular, the development and training of dedicated SNODs to approach families, along with other improvements to the hospital infrastructure available to support donation, started to increase deceased donations. In 2013, the Scottish Government published *A Donation and Transplantation Plan for Scotland 2013-2020*. This set out 21 recommendations to increase donation and transplantation, building on the earlier Taskforce report.

Significant progress has already been made through implementing these recommendations, such as:

- successful and ongoing awareness-raising campaigns, which have encouraged more people to sign up to the NHS Organ Donor Register (ODR) – the proportion of the Scottish population who have joined the ODR increased from 29% in 2007/08 to 43% by October 2016;
- a project with Kidney Research UK which trains volunteers from black, Asian and minority ethnic (BAME) backgrounds to become peer educators to increase awareness of kidney disease and promote organ donation within BAME communities. This is important because families from BAME communities are much less likely to authorise organ donation, but statistically are more likely to need an organ transplant because of increased incidence of diabetes, heart disease and kidney disease;
- a schools educational resource pack has been provided to all secondary schools in Scotland. It has been recognised internationally as an important resource in increasing awareness about organ and tissue donation among young people;
- a new dedicated regional manager for Scotland is in post. Her role focuses on managing the SNODs in Scotland and taking forward key initiatives to help increase donation (previously the postholder covered both Scotland and the Northern region of England).

However, while **Figure 1** shows that numbers of organ donors has been gradually increasing overall over recent years, there is still more that can be done. Increasing the number of donors further remains a challenge, particularly given that fewer than 1% of people die in circumstances where they can donate.

**Figure 1 – numbers of organ donors and non-proceeding donors in Scotland by financial year[3]**




The Scottish Government, the Scottish Donation and Transplant Group and the dedicated Regional Manager for Scotland are taking forward a number of new initiatives, including:

- a project to raise awareness of and increase kidney donations from living donors in Scotland;
- considering piloting a model of designated requesters in two or more hospitals, which is based on an approach used in Australia where only clinicians and SNODs who have had specialist training approach families for authorisation of donation, to see if this helps increase authorisation rates further (currently any SNOD or clinician can approach a family about authorising organ donation);
- updating the existing agreement between the Scottish Donation and Transplant Group and the Crown Office and Procurator Fiscal Service (COPFS) which seeks to minimise the number of occasions when Procurators Fiscal are unable to allow donation to proceed due to needing a full post mortem examination of the potential donor's body;
- the Scottish Government will be working with clinicians, SNODs and NHSBT to explore opportunities for children or very young babies to donate their organs. This is a very sensitive subject, but we know that parents can draw some comfort from the fact that some good has come out of the tragic death of their baby or child;
- in 2015-16, 19 families refused to authorise donation because they felt the process was going to take too long. NHSBT is therefore working to try to shorten

[3] Source – NHS Blood and Transplant (NHSBT)

donation processes generally and also to see if donation processes can potentially be undertaken in a different order to allow for quicker, limited donations (of only kidneys and possibly also the liver) in cases where families would otherwise refuse authorisation due to concerns about the length of time the process will take. This trial might help increase donations in at least some extra cases in future.

**Summary of areas considered in the consultation paper**

This consultation is split into two sections. They cover different parts of the organ donation process, but are closely linked: the hospital identifying and referring potential donors and then the donation being authorised by the family. Delivering real increases in the number of donors and transplants will require progress in both of these areas.

The **first chapter** seeks views on alternative ways of potentially increasing the proportion of cases where organ and/or tissue donation is authorised. This looks at the pros and cons of an opt out system allowing authorisation to be deemed in certain circumstances, with safeguards – that is where, for most people, unless they have opted out of organ or tissue donation or their family know they did not want to donate their organs or tissue, donation can be deemed to be authorised. Such a system could potentially help tackle the problem of people 'not getting around' to making their wishes known.

Other potential options, such as a reciprocity system (where in cases of equal medical need, a person who had joined the ODR would get priority over someone who had not), were considered carefully, but have not been included in this consultation because they were not considered practical and raised significant ethical concerns. The option of a 'mandated choice' system – where everyone would be legally required to make clear whether or not they wished to be a donor – was also considered, but not included as it raised significant issues about how people could be forced to make such a decision, as well as significant practical issues in establishing and enforcing a system to collect everyone's views.

The **second chapter** looks at whether we should encourage hospital clinicians to refer to a SNOD patients who are expected to die in an intensive care unit or emergency department in circumstances which would potentially enable them to be an organ donor. This would also include referring most patients dying elsewhere in a hospital to a TDC, to consider further whether they could be a donor. Such an approach could help tackle the problem of people who have expressed a wish that they want to be a donor not being referred to a SNOD or TDC at the point of death. While in some of these cases it may not be possible for the person to be a donor for medical reasons, this would help ensure that, where needed, a case was considered by a transplant surgeon – in many cases, the person may at least be able to donate some organs or tissue.

# Chapter 1 – Increasing Authorisation for Organ and Tissue Donation

## Introduction

This chapter explores whether an 'opt out' system would increase the number of cases where donation is authorised – either through the explicit permission of the donor who has died, through the support of the family, or where authorisation can be deemed to be in place. Under Scottish legislation (the Human Tissue (Scotland) Act 2006), organs and tissue can only be donated from someone who has died if either the person themselves 'authorised' donation before they died – for example by joining the NHS Organ Donor Register (ODR) or by carrying a donor card – or if their nearest relative authorises the donation on their behalf.

The legislation does permit organs or tissue to be donated without needing the family's permission, if the person who has died has already authorised it. However, in practice, the support of the family is key to providing background information on the potential donor to enable the transplant surgeons to decide whether their organs or tissue are likely to be safe for transplantation. Therefore, currently donation would not proceed if the family were not content to authorise donation. Families are much more likely to authorise donation if their loved one was known to have wanted to be a donor. This is known as an 'opt in' system.

While authorisation is only one of several steps in enabling donation (and ultimately transplantation) to go ahead, it is important as each year a significant proportion of families refuse authorisation for their loved one's organs to be donated – in 2015-16 in 43% of cases in Scotland where family members were approached about donation authorisation was not given or the family overrode the authorisation the person had previously given themselves. That is despite surveys suggesting the great majority of Scottish people support organ donation[4], even if many of them do not get around to joining the ODR.

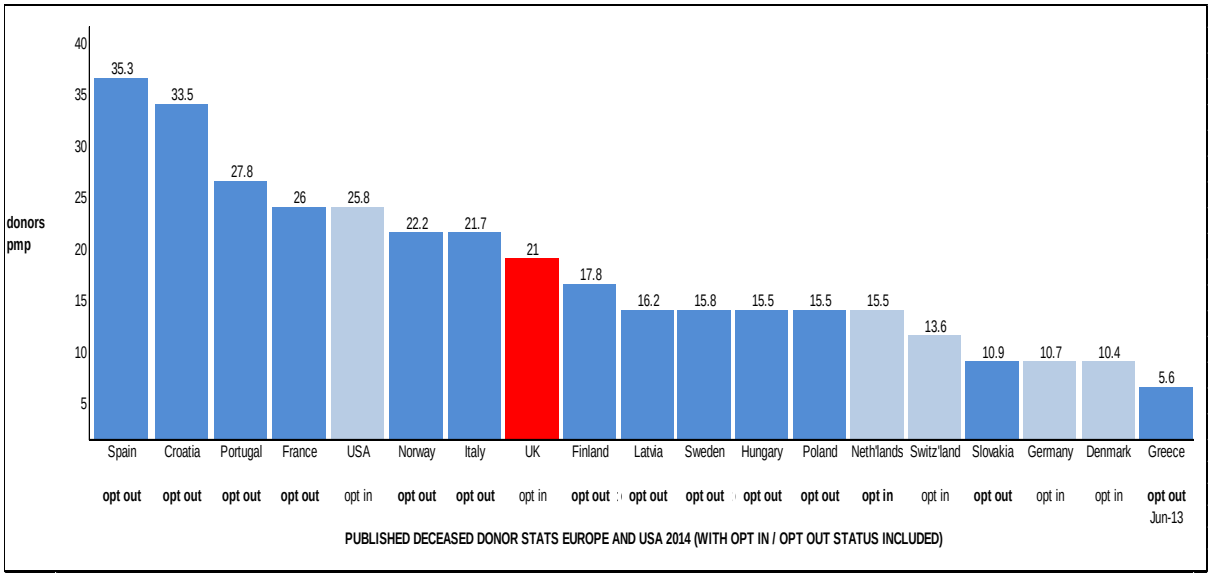
There are a number of different models of consent/authorisation used in different countries throughout the world. Most countries either use an opt in system, like the current Scottish system (where explicit authorisation or consent is needed), or an opt out system (where donation can usually take place unless someone has explicitly stated that they don't want to be a donor) and there can be a range of variations within these systems.

The chart below shows that numbers of organ donors per million people in the population varies dramatically across different European countries, although it is not always the case that those countries with opt out systems have higher donation

[4] For example, in a survey of 1032 people in Scotland in August 2016 carried out by TNS, 70% of people agreed that '*we should all register to be organ donors*'

rates. This is because donation rates are affected by a wide range of factors – authorisation (or consent) for donation is just one of them.

**Figure 2 – Deceased organ donors per million population in key countries – September 2014[5]**




## The current opt in system

Keeping the current system remains an option. As noted in the introduction, there are a number of other initiatives being taken forward through the Scottish Donation and Transplant Group (SDTG) to help increase donation rates, which do not need changes to the current legislation.

The current opt in system has the advantage of avoiding donation proceeding in cases where the family thinks the potential donor may have objected, but the donor never explicitly raised any concerns, or potentially in cases where it would cause distress to the family. Also, the current system – along with the SDTG's initiatives – has been shown to be effective at increasing numbers of donors and transplants, and is well understood by NHS staff and families. One survey this year also suggested that it may be more popular amongst the Great British public than an opt out system[6]. While our current system is an opt in system, people in Scotland can also already choose to actively make clear they do not wish to be a donor by registering to 'opt out' via the Organ Donation Scotland website.

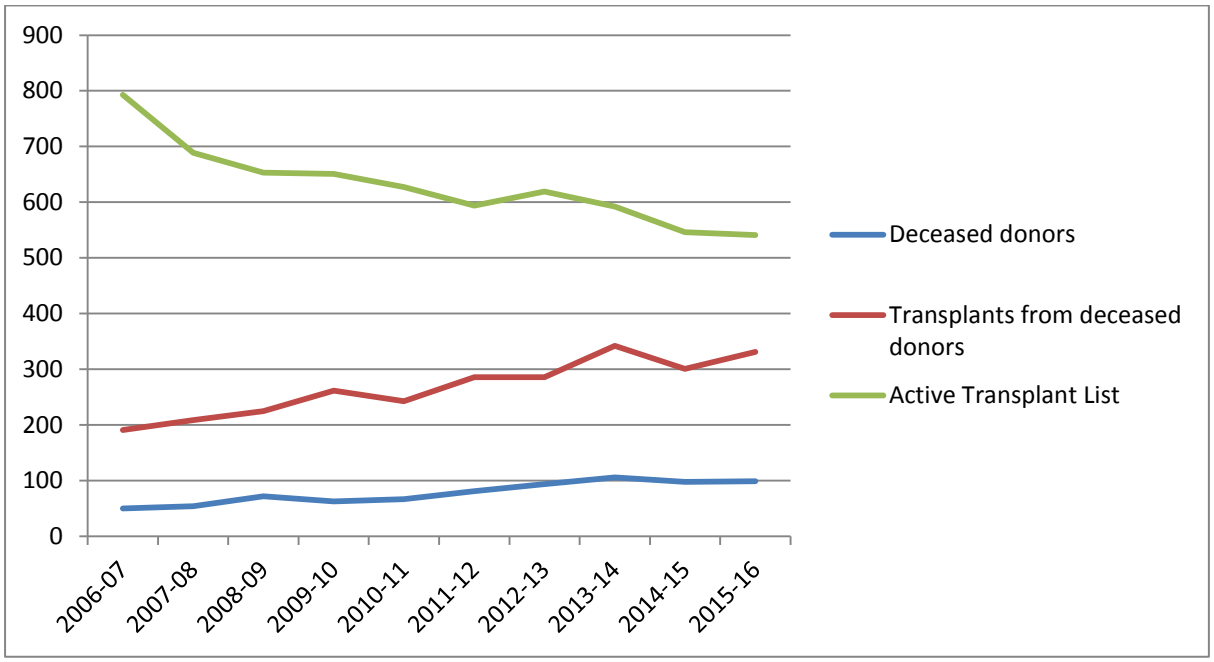
[5] See Council of Europe Transplant Newsletter September 2015: https://www.edqm.eu/sites/default/files/newsletter_transplant_2015.pdf

[6] See https://www.ipsos-mori.com/researchpublications/researcharchive/3728/Wishes-of-organ-donors-should-take-priority-over-wishes-of-their-families-public-says.aspx - a survey of 1001 adults in Great Britain (but this does not provide a breakdown of responses provided by those in Scotland). 49-50% favoured the current opt in model, while 37-42% favoured an opt out/deemed consent model.

## A soft opt out system

There has already been significant debate about whether or not there should be an opt out system of organ donation in Scotland. International evidence as to whether or not an opt out system in itself makes any significant difference to numbers of organ (or tissue) donors is unclear and subject to debate.

**Figure 3 – changes in number of deceased organ donors in Scotland, transplants and those on the waiting list over time[7]**




Rates of organ donation can be higher in countries with opt out systems, although it is often unclear whether it is the opt out system itself or other factors (such as developments in donation and transplant resourcing, prioritisation in hospitals or awareness raising amongst the public) which have helped increase donation rates. For example, Spain currently has the highest organ donation rates in the world (approx. 35 donors per million population) and is often quoted as an example of an opt out system working well. However, Spain only observed a significant increase in donation numbers after improvements to their infrastructure, and many years after the legal basis for opt out had been introduced. It is also worth noting that, due to differing donation procedures, a significant proportion of donors' organs in Spain are not transplanted[8]. In addition, as shown in Figure 2, Scotland and the rest of the UK already have higher donation rates per million population than some of the countries operating opt out systems.

[7] Source – NHS Blood and Transplant (NHSBT)

[8] For example, in 2014, an average of 24% of donated kidneys in Spain were not used for transplant because no transplant centre would accept them. This is compared to only 10% in the UK because in the UK no organs are removed from a donor unless they have already been accepted by a transplant hospital as being suitable for one of their patients.

A ‘soft’ opt out system was introduced in Wales in December 2015 and there have been mixed indications so far about the impact this legislative change has had. It is not yet clear if the new system is likely to lead to an overall increase in consent rates and donors. Data from NHSBT shows there were 25 deceased donors in Wales from April to September 2016, compared to 60 in 2014-15 and 64 in 2015-16. It is however too early to draw meaningful conclusions from the first short period of operation.

While the evidence from other countries is often inconclusive, given the increasing levels of public interest in developing an opt out system, the Scottish Government would consider the introduction of an opt out model if such a step would be supported by the general public and by stakeholders, and if it can be introduced in a way that will do no harm – either to the public perception of organ donation and trust in the NHS, or to the operation of processes required to take donation forward.

The existing UK NHS Organ Donor Register (ODR) allows anyone in Scotland to either opt in or to register their wish not to donate (often referred to as ‘opting out’), by confirming if they do or don’t want to be an organ or tissue donor when they die (people can also opt in on a qualified basis if they are willing to donate certain organs or tissue, but not others). A change to an opt out system of donation could legally permit donation to proceed where authorisation can be ‘deemed’ on the basis that a person has not opted out by recording that wish on the ODR, or by otherwise noting in writing that they did not wish to donate their organs and/or tissue.

However, there would be likely to be significant concerns that such a rigid opt out system – sometimes called a ‘hard’ opt out system - might lead to people becoming donors even if they would not have wanted to. It may be they had not got round to opting out or were not able to understand that they needed to opt out.

Therefore, it is likely that a ‘soft’ form of opt out system would be more acceptable, one that provides additional safeguards to ensure donation does not proceed in cases where the family knew that their loved one did not want to be a donor. These safeguards would have to be structured in a way that was not overly complex and did not cause delays to the organ donation process. An overly complex or time-consuming process will lead to donations being unable to proceed. Too many administrative obstacles would also mean that there would be little or no difference in practice from the current Scottish opt in system.

**Question 1 – what do you think of the principle of a soft opt out system for Scotland?**

**Question 2 - are there any changes you would make to the current ‘opt in’ authorisation system, other than moving to opt out?**

**Question 3 – where someone has joined the Organ Donor Register (ODR) or indicated in another way that they wish to donate, what do you think should happen if the potential donor's family opposes the donation?**

**How soft opt out could work in Scotland**

A workable soft opt out system would be expected to involve the following three 'steps'[9]:

1. high profile **awareness-raising campaigns**, for at least twelve months before introduction of the new system and on a regular basis after implementation. This would be designed to ensure as many people as possible think about organ and tissue donation, discuss it with their families and either opt in or, if they don't want to be a donor, opt out. It would be important to ensure these campaigns take account of the needs of people who either speak little or no English and people with disabilities or learning difficulties who may need extra support to understand the new system and/or to opt out if they want to. Efforts would also need to be made to allow people who may be harder to reach to opt out if they want to, including prisoners and others who may not have access to the internet. Education and training for a range of healthcare professionals and other professional groups involved would also be required during this time.

2. **deemed authorisation** - in the event of death of someone in hospital in circumstances where their organs or tissue could potentially be donated (and they were not in any of the 'excepted' categories under step three below), a Specialist Nurse for Organ Donation (SNOD) or a Tissue Donor Co-ordinator or person who takes authorisation for eye donation (TDC) would undertake the following checks to help them reach decisions:

    - if the person had registered as opting out, no donation could proceed (unless the family provided evidence that the person had confirmed in writing more recently that they had changed their mind);
    - if the person had registered as opting in, the family would be informed and SNODs/TDCs would start the process of examining the feasibility of donation (unless again the family provided evidence that the person had confirmed verbally or in writing more recently that they had changed their mind);
    - if the person had not registered any decision on the ODR, a SNOD/TDCs would approach the person's family to discuss the fact that the person was not on the ODR and therefore, in the absence of other information, would

[9] Note – this is just a summary of steps and steps 2 and 3 would be considered at the same time. Authorisation procedures would not be taken forward in cases where there were already known medical reasons why the person could not be a donor. These procedures would also not be taken forward if the Procurator Fiscal refuses to consent to any donation – NHS staff must inform the Procurator Fiscal under certain circumstances, such as if the death was suspicious.

be deemed to have authorised donation. The family or friends would be asked if their relative/friend had expressed any objections to organ donation. If the person was not known to have expressed any objections then the assumption would be that donation could proceed; **this would count as** '**deemed authorisation**';

- however, there could potentially still be scope for donation not to proceed if it was clear that proceeding would cause distress to the family (and lead to them potentially refusing to provide the important background information which is needed in most cases to decide if it is safe to proceed with donation and subsequent transplant). In Wales, families can still refuse to allow donation to proceed even where the legislation would allow donation to proceed on the basis of deemed consent and this has happened already;
- in the relatively rare cases where the person did not have any family or close friends – or at least none who were contactable within the necessary timeframe – then, if they did not come under any of the explicit authorisation categories below, donation could be considered to be authorised unless the person had opted out. However, in these cases, NHS staff would still need to consider whether or not they had sufficient information on the patient and his or her medical history to be sure the organs or tissue would be safe to transplant. In some cases, they may still be able to proceed where sufficient information is available from medical records.

**Question 4 – if there was a soft opt out system, what do you think of the proposed checks above?**

**Question 4(a) - if you think these are not sufficient, what other checks would be needed (apart from those set out under step 3 below)?**

**Question 5 – in any opt out system, what do you think should happen if a deemed authorisation donation was likely to distress the potential donor's family?**

3. In cases where someone dies and checks made by SNODs or TDCs suggest that they may fall into any of the following categories, donation (of either organs or tissue or both) could only be authorised with **explicit authorisation**, either from the person themselves or from their family:
   - someone who, over a period of time before their death, did not have capacity to take a decision on donation (see further details below on who this would cover);
   - a child under a certain age – we would still view it as appropriate for children of 12 years old or over to be able to self-authorise their own donation if they wish, but it may not be appropriate for someone's authorisation to be 'deemed' unless they are at least 16 years old;

- anyone who had not been resident in Scotland for at least 12 months before their death. It is proposed that this would be a relatively straightforward assessment of whether or not their 'main' home had been in Scotland for 12 months or more, but they would not necessarily need to live there all the time – for example, students or members of the armed forces would count as resident if they were generally in Scotland over 50% of the year even if they stayed somewhere else during their holidays or had periods working abroad during that time.

We are acutely aware of the importance of ensuring any opt out system takes account of the rights of people who are unable to make their own decisions. In hospital immediately before their death, almost all potential donors would be considered 'incapable' of making their own decisions, but these separate explicit authorisation provisions would only be expected to apply where the person suffered from incapacity over a period of time before their death due to a mental disorder or physical disability – with the result that they cannot be considered to have been capable of taking a decision on organ donation for some time before their death. This would probably mean it is likely they could not have made their own decisions for more than a year before their death. However, it might also be appropriate for the system to allow the flexibility to require explicit authorisation as appropriate in certain cases where a person's lack of capacity was over a shorter period. This would recognise that they may not have had sufficient ability or understanding to make their views on organ donation known. We are therefore keen to hear your views on when a person should be classed as not having capacity to make their own decisions under this provision (see question 7 below).

If a potential donor falls into any of the three 'excepted' categories above:

- Similar procedures would apply to the current ones in that donation would normally only be authorised in these circumstances where a family member provides authorisation on the person's behalf. The Human Tissue (Scotland) Act 2006 already defines who would be classed as the person's nearest relative (if there is no family member, the decision can be made by a friend of long-standing);
- However, if the adult or child had opted out of donation then their view would be respected. If they had opted in, then that should be sufficient to authorise a donation if they were 12 years old or over (particularly for anyone who had been living in Scotland for less than twelve months or if the person had opted in at a time when they did have the capacity to make that decision). However, there would still be scope for donation not to proceed if it was clear that proceeding would cause distress to the family or if the family and/or medical records made sufficiently clear that the person did not have the capacity to understand what they were doing at the point they opted in and the family did not agree to authorise donation;

- In cases where the person was not known to have expressed a view either way, the nearest relative would be asked to decide whether or not to authorise donation. As happens under the current system, they should base their decision on what they think their relative would have wanted in cases where it is possible to know this. In cases where it is not possible to know what the person might have wanted, their nearest relative would need to make their own decision;
- In the case of children, it would be the child's parent(s) or another person with parental responsibilities and rights who would decide. For looked-after children, a local authority currently cannot authorise donation if no parent is available, although there may be a case for reconsidering this restriction – for example, in England and Wales where a person in a local authority has parental responsibility for a child in care then the local authority staff member can give consent to donation.

The potential approach set out above would involve SNODs, TDCs and/or clinicians (or in some cases eye donation specialists if only eye donation is being considered) needing to make a judgement about a potential donor's situation in order to decide whether or not they fall into one of the categories where explicit authorisation is required. They would normally be the ones deciding whether or not explicit authorisation would be required, although they would consult their senior managers in NHSBT or SNBTS if they were unsure in a particular case. Given the limited timescales available to seek authorisation for donation, it might not always be possible, for example, to be sure if a person had been resident in Scotland for more than twelve months or if they had sufficient capacity to make their own decisions about donation before coming to hospital. Therefore, we would propose that detailed guidance and training should be provided for SNODs, TDCs and other healthcare workers before the implementation of any opt out system. We would also propose that, where there is some doubt about whether or not a person falls into one of the 'excepted' categories, explicit authorisation should always be sought from the person's nearest relative.

**Question 6 – if there was a soft opt out system, what do you think about the categories of people set out above for whom explicit authorisation would still be needed from the person themselves or family member?**

**Question 6(a) – if these are not sufficient, why do you think this?**

**Question 7 – in what circumstances do you think an adult should be viewed as not having the capacity to make their own decisions about donation and therefore should not be subject to any deemed authorisation provisions?**

**Question 8 – under what age do you think children should only be donors with explicit authorisation?**

**Question 9 – for children who are in care, what are your views on allowing a local authority which has parental responsibilities and rights for the child to authorise donation for the child if no parent is available?**

**Donations of less common types of organs or tissue under an opt out system**

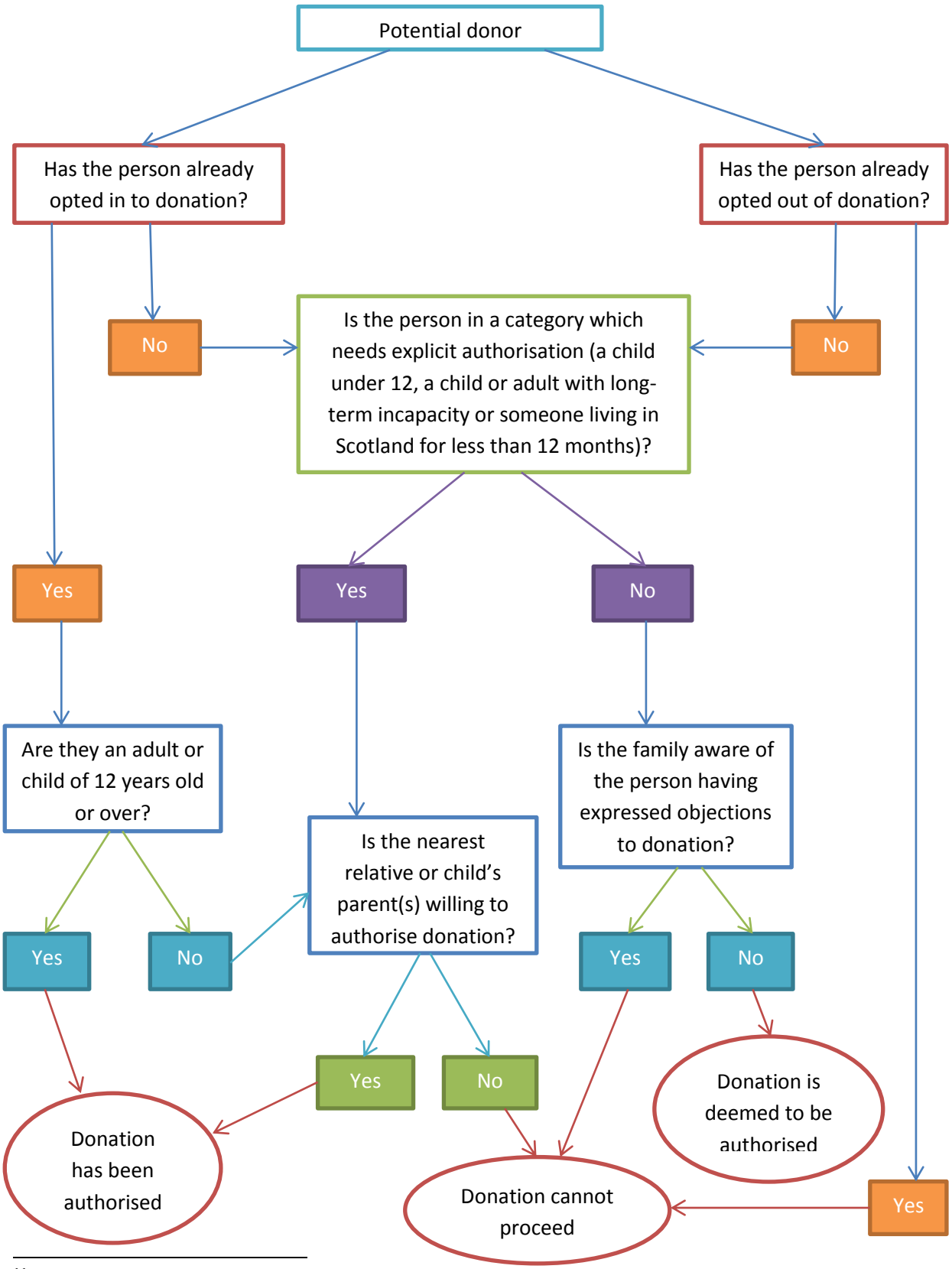
While this model of deemed authorisation could cover the more common types of organ and tissue donation, it may still be appropriate to only allow for more rare and novel types of tissue or organs to be donated with explicit authorisation from either the donor themselves or their family. For example, it is now possible for limbs to be transplanted; it is also possible to undertake facial tissue transplants, although this is not currently carried out in the UK. In the Welsh opt out legislation, there is a list of these rarer types of organs or tissue – referred to as 'excluded material' – where express consent is still required for it to be donated[10]. A similar provision could be considered in any future Scottish legislation to specify the types of organs and tissue where deemed authorisation either could or could not be used.

In addition, we would propose that any deemed authorisation approach would only apply to donation where this is for transplantation. It would not apply to donation for research purposes as this could still only happen with explicit authorisation from the donor or their family. While donation for research remains very important and there is significant demand for such organs, we do not feel this is sufficient to allow organs to be removed on the basis of deemed authorisation only.

**Question 10 – in any opt out system, what provisions do you think should apply to the less common types of organs and tissue?**

[10] See the Human Transplantation (Excluded Relevant Material)(Wales) Regulations 2015 at http://www.legislation.gov.uk/wsi/2015/1775/pdfs/wsi_20151775_mi.pdf

**Figure 4 - Flowchart of authorisation pathways for potential organ and tissue donors[11]**




[11] Note – this flowchart is based around donations of 'standard' organs and tissue for transplantation – it does not cover either donations for research or the proposals around rarer types of donation – in both cases explicit authorisation from either the donor or their family would be needed.

**Benefits and disadvantages of this soft opt out model**

This process would have potential benefits in a number of cases by permitting organs to be donated in cases where a person is in favour of donation, but has not got around to signing up to the Organ Donor Register. It may also in some cases make things easier for relatives by taking away much of the pressure in making what can be a very difficult decision, but still giving them the chance to object if they know that their relative did not want to be a donor. If there is sufficient ongoing awareness-raising through a range of media to ensure that people who do not want to donate have sufficient opportunity to easily opt out, then it may be acceptable to authorise donation on the basis that the person has chosen not to opt out.

**Table 1** below sets out the reasons given why families refused authorisation for organ donation in 2015-16. In 28 cases, the family said their relative had previously expressed a wish not to donate. The table also shows that in all the other cases, the donations could potentially have been 'deemed' to be authorised, assuming they did not fall into an excepted category where explicit authorisation was needed. However, it is likely that a majority of others would also not ultimately proceed because either a) explicit authorisation would be needed, b) because the family might override the deemed authorisation or c) due to medical reasons.

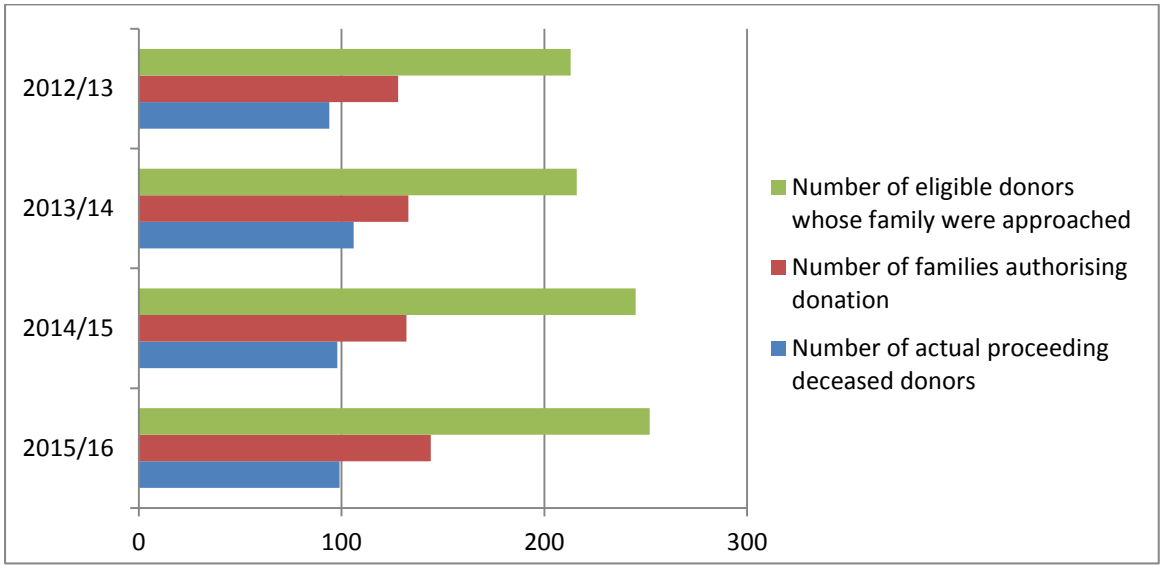
**Table 1 – Reasons given why families did not provide authorisation – 2015-16**

| **Reason** | **No of DBD donors** | **No of DCD donors** |
|---|---|---|
| Patient previously expressed a wish not to donate | 7 | 21 |
| Family were not sure whether the patient would have agreed to donation | <5 | 13 |
| Family did not believe in donation | <5 | <5 |
| Family felt it was against their religious/cultural beliefs | <5 | - |
| Family was divided over the decision | - | <5 |
| Family felt the patient had suffered enough | <5 | 7 |
| Family did not want surgery to the body | <5 | 5 |
| Family had difficulty understanding/accepting neurological testing | <5 | <5 |
| Family felt the length of time for donation process was too long | <5 | 16 |
| Family concerned that organs may not be transplanted | - | <5 |
| Strong refusal - probing not appropriate | <5 | 5 |
| Other | <5 | 11 |
| **Total refusals** | **23** | **85** |

*Source – NHS Blood and Transplant (NHSBT) – covers approaches in Scottish hospitals*
*Note – where fewer than 5 families refused for a particular reason, this has been marked <5 in order to help protect their identities*
*DBD donors are ones who have been diagnosed as brain dead, while DCD donors are ones who will be certified as dead after their heart stops beating and they have stopped breathing.*

However, clearly such a deemed authorisation approach could carry risks. Deemed authorisation would be a legal authorisation. Nonetheless, it is still likely to be difficult to assume it is accepted that someone authorises their donation just because they have not opted out. The model above however aims to provide sufficient safeguards for the groups of people who are less likely either to be able to sufficiently understand the meaning or implications of opting in or out or may be unaware of the legislation due to not having been in Scotland for very long.

**Figure 5 – numbers of families approached compared to those giving authorisation and actual donor numbers**




**Source - NHSBT – Note that families are only approached where initial checks based on the information the Critical Care unit has suggest the person's organs are likely to be suitable for donation**

**Figure 5** above suggests that an opt out system has the potential to increase authorisation rates, which in turn could increase the number of people who actually go on to donate organs. However, it is impossible to judge to what extent authorisation or actual donations would increase as more people are likely to opt out of donation (under the current system, only 1146 people in Scotland had so far opted out at the end of September 2016) and some would still need explicit (rather than 'deemed') authorisation. Based on the Welsh experience, it is likely that a number of families would also still refuse to support the donation and clinicians would feel unable to proceed.

Regardless of the amount of awareness-raising, there are still likely to be a significant number of people not in any of the listed categories needing explicit authorisation who would neither opt in or out – this is often likely to be either because they don't want to think about death or don't think it will happen to them for a long time or just because they don't get round to it. In Wales, the level of awareness of their new opt out legislation is high as a result of their awareness-

raising campaign. As a result, they have made clear to people that anyone who neither opts in or out of donation is still making an **active choice** to allow their organs to be donated. As at 31 March 2016, 165,129 people in Wales had opted out of donating their organs (just over 5% of the population), while 1,113,090 had opted in.

Surveys suggest the great majority of people do support donation (70% of people in an August 2016 survey[12]). It could also be argued that if people have been given sufficient information, it is their responsibility to explicitly opt out if they don't want to be a donor, but there is still a possibility a model based on 'deemed' authorisation leads to people becoming donors when they actually would not have wanted to donate. This could risk being viewed by some as the state taking people's organs, rather than people actively choosing to give them. Any such perception could lead to a loss of trust in the NHS and the system more widely, which might actually lead to an increase in numbers of people choosing to opt out. It could also lead to conflict with families, which would be likely to put SNODs, TDCs and doctors in a very uncomfortable position and make it difficult for them to gather sufficient information from the family about the patient's lifestyle to be reassured the organs or tissue will be safe to transplant. In such cases, NHS staff would often decide not to proceed with donation even if the legislation permitted it.

As suggested above, a model which allows for authorisation if someone has not opted out, but still recognises and allows for donation not to proceed if it is likely to cause severe distress or conflict with the family should help increase authorisations to some extent, but avoid the opt out system being too rigid.

**Pre-death tests for potential donors**

There also needs to be consideration for potential Donation after Circulatory Death (DCD) donors[13] to determine whether or not 'deemed authorisation' of donation should allow certain actions to be taken before death to help facilitate donation, such as blood tests, X-rays, urine tests or planning the timing of withdrawing the patient's life-sustaining treatment. If these were not allowed or were only permitted with explicit authorisation from the patient or their nearest relative then this is likely to prevent successful organ donation proceeding, even if the authorisation for donation could be deemed. Given time constraints in the organ donation process, it is vital that a number of tests have been carried out before treatment is withdrawn from a DCD patient to ensure that the organs are likely to be safe to transplant and are a good match for a transplant recipient. Organs need to be removed from the patient very soon after their death and be transplanted into a recipient within a few hours or

[12] Survey of 1032 people by TNS on behalf of the Scottish Government as part of the Organ Donation 2016 campaign evaluation – 70% agreed with the statement "*as organ donation saves lives, we should all register to be organ donors*"

[13] Note – this issue does not apply in the same way for donors who donate after being diagnosed as brain-stem dead (DBD donors). While tests also need to be carried out on DBD donors, they are only done after it is confirmed that the donor is dead.

a transplant will not be successful. DCD donation normally also requires NHS staff to plan the timing of withdrawing the patient's treatment (in discussion and agreement with the patient's family) in order to allow for the necessary tests and other checks to be carried out, for the recipients of each of the organs to be identified and for the team of retrieval surgeons to arrive at the donating hospital.

Currently, up until the point of death, for adults, the legislation governing support provided to and any tests carried out on patients, such as potential donors who are unconscious and therefore unable to express their own decisions at the time, is the Adults with Incapacity (Scotland) Act 2000. At the moment, a number of tests are carried out prior to death, although this currently only happens where either the donor themselves has previously made clear that they wish to be a donor or where the donor's family has authorised the donation on their behalf. In all cases, the SNODs or other medical professionals ensure the donor's family is aware of and comfortable with any tests being carried out. However, we are in the process of considering whether, in the future, people joining the ODR need to have more detailed information and a greater awareness about what tests might potentially be needed if they were to become a donor.

Currently in Scotland, a number of tests are already being carried out as part of the routine care of the type of patients who might go on to become DCD donors. All patients in an Intensive Care Unit already have an existing line placed in their artery which allows blood samples to be taken without needing further injections. Similarly all patients in Intensive Care will have had a urinary catheter inserted as part of their care so this also allows for urine samples to be taken in a non-invasive way. However, in a number of cases, additional tests will be needed, depending on which organs are being considered for donation, on the patient's medical circumstances and on, for example, any countries the potential donor had visited recently. Normally, this would not include tests which would be considered invasive. Tests such as bronchoscopies have very occasionally been carried out – and on the rare occasion this happens, the test is done with the support of relatives who have authorised the donation and in a way that minimises the possibility of the patient experiencing any discomfort. We would propose that, in future, bronchoscopies should not be carried out, unless it was clear that the donor themselves had indicated in advance that they were willing to consent to that sort of test.

**Question 11 – which tests do you think medical staff should be able to carry out on a donor before they withdraw life-sustaining treatment to check if their organs or tissue are safe to transplant, both where a patient's authorisation for donation is 'deemed', as well as where the donation is explicitly authorised:**

- **a) Blood tests?** - for tissue typing to find a good recipient match, to detect any infections, such as HIV or Hepatitis, or for testing the patient's blood gases to check how well the lungs function;
- **b) Urine tests?** - to check if the patient has any infections;

- **c) X rays?** - to check for any undiagnosed medical problems;
- **d) Tests on a sample of chest secretions?** - taken via a tube to test how well the lungs function. Chest secretions are often removed from patients in Intensive Care as part of their treatment to help make them more comfortable so would be removed anyway as part of their care – this would therefore involve testing samples of the secretions that have been removed;
- **e) Tests on the heart such as an ECG** (electrocardiogram) or **ECHO** (echocardiogram)[14]**?** – these tests check if the heart is functioning well.

**Question 12 – if you answered no to some or all options in question 11, are there any circumstances when particular tests could be permitted?**

**Question 13 – where it is agreed a patient's condition is unsurvivable and it will not cause any discomfort to them, what do you think about medical staff being allowed to provide any forms of medication to a donor before their death in order to improve the chances of their organs being successfully transplanted, such as providing antibiotics to treat an infection or increasing the dose of a drug the patient has already been given[15]?**

### Authorised representatives (also known as proxies)

In England and Wales, it is possible for people to nominate one or two representatives to make decisions about donation for them when they die. This is not an option at present in Scotland. In reality, very few people have nominated a representative (only 57 people in England and Wales had done so as at 31 March 2016) and including representatives in the chain of decision-making could make donation processes more complex and lengthy. Firstly, this is because it may be difficult to contact the representative(s), particularly if they have changed their contact details. Secondly, it is normally vital to keep the family involved as, unless they have been estranged from the donor for many years, they may have important information on the potential donor's history and lifestyle that will help doctors and SNODs or TDCs to decide if the person's organs or tissue are likely to be safe for transplanting. In addition, if a person is capable of nominating a representative, there are very few cases where they would not be capable of also deciding whether or not they wish to donate, so it is unlikely that a representative would be needed.

[14] Currently in Scotland these tests are not required for DCD patients as hearts are only donated by patients diagnosed as brain-stem dead. However, DCD heart donation has been trialled in some hospitals in England and might potentially be extended to include some Scottish donors in future.
[15] For example, a patient may be given a drug such as Noradrenaline to improve their blood pressure – maintaining or increasing the dose of this after the decision has been taken to withdraw life sustaining treatment will help improve the blood flow to the organs. If antibiotics are used to treat an infection which the donor has, that will help mitigate any impact of the infection on the organ transplant recipient(s)

It has been suggested that looked-after children are one category of people who might benefit from being able to nominate a representative, although again if the child is able to make the decision to nominate a representative they are probably sufficiently mature to opt in or opt out (if they are 12 years old or over then they could be a donor under the current system without needing permission of a parent or other person with parental responsibility if they are signed up to the ODR). Local authorities are not currently permitted to authorise donation for children in their care (see the section on an opt out system).

In addition, people who are estranged from their families or who know their family have very different views about donation from their own may also not want family members to make decisions for them, but again if they are able to nominate a representative, they should also be able to make their own advance decisions about donation in almost all cases. In cases where no partners or family members are available, the legislation already permits a friend of long-standing to authorise organ or tissue donation.

Therefore, on balance, we do not think that authorised representatives would be necessary. The evidence from England and Wales suggests they are very rarely appointed and have not been used. The Scottish Parliament has already considered this point when it debated the Human Tissue (Scotland) Act 2006, but it decided, at that time, that appointed representatives were unnecessary. Given that including them in the process would create potential delays and conflicts with families, we propose not to include them, but would be grateful for views on this.

**Question 14 – what do you think about allowing people to appoint one or more authorised representatives to make decisions for them?**

**Question 14(a) – if you think this should be allowed, in what circumstances do you think an authorised representative would be useful?**

**Question 15 – do you have any other comments which you think should be taken into account in relation to any Scottish opt out system?**

## Chapter 2 – Increasing Numbers of People considered as Potential Organ and Tissue Donors

### Introduction

It is already accepted that, as part of good end-of-life care, everybody should have the option to be a donor, particularly if they have expressed a wish to do so. This is both for the wider public good by helping deliver much-needed transplants, but also as it can, in time, help grieving families to know that something positive has come from the tragic loss of their loved one.

The number of referrals to the Special Nurses for Organ Donation (SNODs) has increased by 85% since 2011/12, despite a decline in numbers of people dying in circumstances where they could be organ donors. Therefore progress is already being made in identifying potential opportunities for donation. However, there are still some potential donors who are missed each year because the clinical teams caring for the patient do not consider donation and do not contact a SNOD or Tissue Donor Co-ordinator (TDC), mainly for patients who die after circulatory death.

**Figure 6 – proportion of total cases which met existing referral criteria that were referred to Specialist Nurses for Organ Donation – 2015-16**

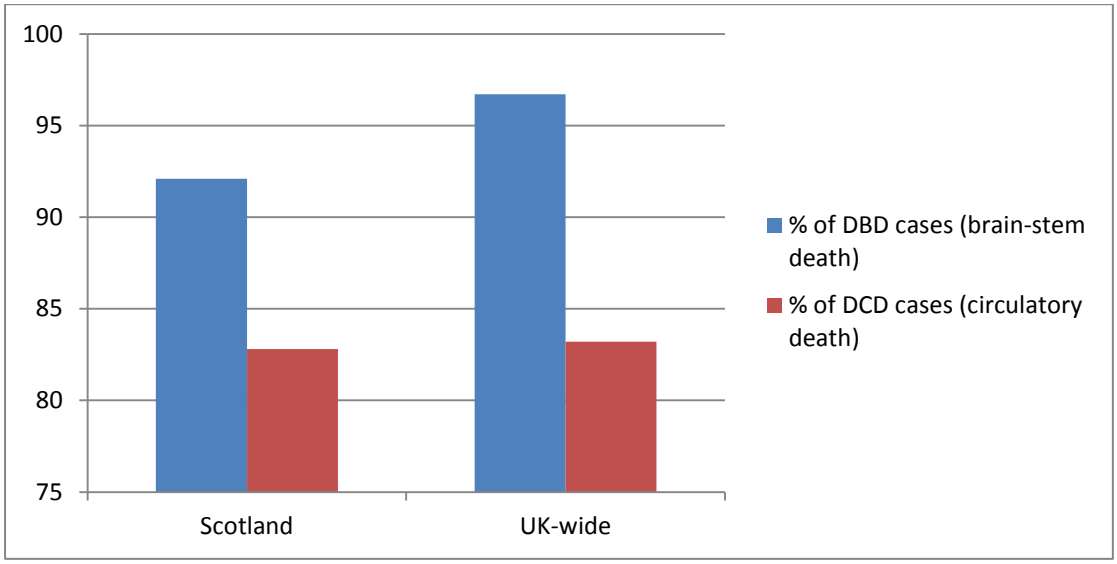



Figure 6 above shows that 17% of potential DCD patients in Scotland were not referred to the SNODs in 2015-16 – some of those patients were on the Organ Donor Register (ODR). While Scotland's performance is not significantly lower than the UK average, there is still scope for improvement as around 20 referrals of potential donors are being missed each year. Meanwhile, for tissue donation, while there are fairly good referral rates from some hospital units, many patients who could be tissue donors are not referred by the relevant hospital departments.

In some cases, this lack of referral was due to an oversight by clinical staff who had not thought about donation – for tissue donation this seems to be common due to

lack of awareness of the possibility of tissue donation, as well as, for example, staff in areas such as Emergency Departments feeling they are too busy to refer a patient. Further, in some cases, even though the patient met the current criteria for referral for donation, clinicians seem to have assumed the patient would not be a suitable donor. This is either because of health issues which may make the patient's organs/tissue unsuitable for transplantation or because the clinicians thought that the length of time between withdrawing treatment and the patient's death would be likely to mean the patient's organs would not be viable for transplantation. Organ or tissue donation should be considered in every case where the patient does not have any 'absolute' contraindication to donation i.e. where they definitely could not donate any of their organs[16] or tissue - for example if the patient was over a certain age (currently organs cannot be donated from those who are 85 years old or over, although it may be possible to donate corneas from patients who are older) or has certain 'live' cancers. For most patients, it may often be possible for at least some organs or tissue to be donated.

Hospital doctors may sometimes have concerns that the patient's health problems might be such as to make a particular patient unsuitable to be an organ/tissue donor. However, clinicians who are not dealing with organ/tissue transplantation on a daily basis are not necessarily experts in determining whether there are any contraindications to organ or tissue donation. It is the staff who deal with organ and tissue donation and transplantation on a daily basis who are the experts in this field and the ones who can best advise whether or not organs and/or tissue from a particular patient would be suitable for transplantation. Therefore, it is always best for the patient's case to be referred to the SNODs or TDCs early on to investigate if donation is possible, even if the doctor caring for the patient thinks it is unlikely. In some cases, the patient will indeed not be suitable for donation and he/she will be quickly ruled out after a telephone conversation with the SNOD or TDC; in other cases however, the patient may be able to successfully donate.

A limited system has been implemented in Scotland where the relevant Regional Clinical Lead for Organ Donation will require an NHS Board's donation committee (which is there to help support donation in their area) to investigate and provide an explanation, especially if a person who was pronounced brain-stem dead in an intensive care unit and was on the ODR was not referred to a SNOD.

**Proposals to reduce numbers of missed referrals**

If all patients in critical care areas were referred either at the point a doctor decides to carry out brain-stem death testing (for potential donation after brain-stem death (DBD) cases) or at the point the doctor documents the decision to withdraw treatment (for potential donation after circulatory death (DCD) cases) this would be likely to **increase the number of organ donation referrals in Scotland by around 20-30 each year**. We would consider whether the guidance should provide specific

[16] See the NHSBT policy note at http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf

clinical triggers which should lead to an organ donation referral[17]. While not all of these patients would become actual donors, a proportion of them should do. For tissue donation, doctors should also refer patients who die outwith Critical Care Units as tissue donation can still take place up to 48 hours after the patient has died (or up to 24 hours in the case of eye donation)[18].

Therefore, greater encouragement should be given to all hospital doctors to **refer any patient for consideration as an organ and/or tissue donor if they are expected to die in a critical care area and are under the age of 85,** with other parts of hospitals also encouraged to refer those who have recently died for consideration as a potential tissue donor. Greater awareness raising of organ and tissue donation and the role of SNODs and TDCs among staff working across hospitals could be helpful in making staff who have never or rarely been involved in donation more aware of the advice and support that SNODs or TDCs can provide. While some staff working in Intensive Care Units will be very familiar with organ donation, others in Emergency Departments may be much less familiar with it. Similarly, staff in other hospital departments are not always aware of the potential for tissue donation.

When a patient is referred to the donation service, the local SNOD or TDC will discuss the patient's key health issues with the clinician by telephone to decide if any absolute contraindications to donation apply and to check whether the patient had either opted in or opted out on the ODR. If there are any health concerns which might prevent a particular organ/tissue being donated, the SNOD or TDC would speak to transplantation medical staff to get their view on whether or not the organ(s) or tissue could be transplanted.

To help encourage further increases in referrals, the Chief Medical Officer (CMO) could for example issue guidance to hospitals to encourage them to refer all patients who meet the criteria above – either as a potential organ or tissue donor. As SNODs and TDCs work closely together, staff would only need to refer a patient to one or other, not both. In cases where this did not happen and the patient was on the ODR, there may be a case in some circumstances for the Regional Clinical Lead for Organ Donation asking the relevant hospital to investigate the circumstances. That would help those hospitals to learn lessons for the future and address any issues identified locally, such as around lack of awareness of organ and tissue donation or misunderstandings about what constitutes a contraindication to donation.

The CMO's guidance could also re-emphasise the importance of all hospital staff doing what they can to facilitate donation, stress that SNODs and TDCs are there to

[17] For example there are some existing guidance documents which set out suggested clinical triggers for considering donation, such as the National Institute for Health and Care Excellence (NICE) guidance for England on improving donor identification https://www.nice.org.uk/guidance/cg135/chapter/1-recommendations

[18] Note – outside the central belt of Scotland, currently heart valves and corneas are the only tissue that can be donated. Within the central belt, tendons and skin can also be donated.

support hospital staff, and encourage clinicians to always involve SNODs or TDCs in approaches made to families about donation. On average in 2015-16, SNODs were involved by doctors in only 69% of approaches to families in Scotland, although involvement rates improved during the second half of the year (across the UK they were involved in 83% of cases). Authorisation rates are significantly higher where a SNOD is involved in the approach discussions with the family.

The proposed CMO guidance has advantages in that it can be implemented relatively quickly and encourages all potential donors to be fully considered, even if it is later agreed that the person would not be a suitable donor for medical or other reasons. Some clinicians may have concerns that it could put additional work pressure on them and other NHS staff and lead to difficult discussions with families. However, given that these proposals would only be expected to lead to around 20 to 30 extra cases each year across Scotland where families would be approached about organ donation, it is unlikely to place individual departments under significant extra pressure. There would also be a likelihood of some extra approaches to families about donating tissue only (where the patient has been ruled out as a potential organ donor), but these would all be carried out by the TDCs. It is worth noting that, for example, the North West region of England already has a 'required referral' policy for hospitals – evidence from the operation of this policy could be considered in developing any new CMO guidance.

Strengthened guidance on referrals should help generate greater awareness and lead to more referrals to the donation service. It would reduce the risk of referrals being missed due to an oversight and some of these patients could reasonably be expected to become donors. It would also promote consistency in practice across NHS Boards and promote equity in the approach taken across Scotland. For those patients who are on the ODR, referral helps to ensure that attempts are made to see if their wish to be a donor can be taken forward. Where the person cannot be an organ donor for medical reasons, the referral may still help enable them to be a tissue donor instead.

**Question 16 – what do you think about providing CMO guidance to encourage clinicians to refer almost all dying or recently deceased patients – particularly those who are under 85 years old - for consideration as a potential organ or tissue donor?**

**Question 17 – what do you think about making it a procedural requirement for clinicians to involve a specialist nurse for organ donation, tissue donor co-ordinator or another individual with appropriate training in approaches to families about donation, wherever that is feasible?**

## Equalities Impact Assessment

If there are proposed changes to legislation as a result of the findings of this consultation, the Scottish Government will be carrying out a number of Impact Assessments, including an Equalities Impact Assessment. We are required to carry out an Equalities Impact Assessment in order to ensure compliance with our duties under the Equality Act 2010 and associated regulations. The Equalities Impact Assessment aims to ensure that any new Scottish Government policies or legislation help promote opportunities where possible for a range of equalities groups and at the very least avoid any discrimination or other unfair treatment of any particular groups of individuals, based on, for example, their gender, race, religion or disability.

We do not feel that the proposals in this consultation would be likely in most cases to impact on individuals in any equalities group differently from others, although there are some specific provisions for children and adults who do not have the capacity to understand or make their own decisions about organ or tissue donation – likely to be those with serious disabilities – to help protect their interests. There may also be some implications for some people from minority ethnic groups if they do not have a good understanding of English, as well as those with visual or hearing impairments, in ensuring that they are sufficiently aware of any changes that may be adopted in relation to a deemed authorisation system.

We would be grateful for your views on any equalities impacts to ensure that they can be fully considered as part of the Impact Assessment.

**Question 18 – do you think there are particular impacts or implications for any equalities groups from any of the proposals in this consultation, either positive or negative? If yes, please provide details.**

In the question above, equalities groups should be taken to mean any different impacts the proposals might have on any particular groups of people based on their:

age
being pregnant or on maternity leave
disability
gender reassignment
race
religion or belief
sex, or
sexual orientation

Please note, we will also be carrying out a Children's Rights and Wellbeing Impact Assessment, which will take account of responses to a number of the earlier questions in this consultation, where those relate to children (either directly or indirectly).

## How to respond and what happens next

### Responding to this Consultation

We are inviting responses to this consultation by **14 March 2017**.

If you only wish to answer some of the questions, feel free to do so. If you wish to make additional comments that relate to organ and tissue donation and transplantation, but are not directly relevant to any of the questions, please add in your comments at the end of your response.

Please respond to this consultation using the Scottish Government's consultation platform, Citizen Space. You can view and respond to this consultation online at https://consult.scotland.gov.uk/health-protection/organ-and-tissue-donation-and-transplantation

You can save and return to your responses while the consultation is still open. Please ensure that consultation responses are submitted before the closing date of **14 March 2017**.

If you are unable to respond online, please complete the Respondent Information Form (see "Handling your Response" below) to:

email: Organ_donation_scotland@gov.scot

or write to us at:

Organ and Tissue Donation consultation
Scottish Government
Health Protection Division
St Andrew's House
Regent Road
Edinburgh EH1 3DG

### Handling your response

If you respond using Citizen Space (http://consult.scotland.gov.uk/), you will be directed to the Respondent Information Form. Please indicate how you wish your response to be handled and, in particular, whether you are happy for your response to published.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form attached included in this document. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

## Next steps in the process

Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at http://consult.scotland.gov.uk. If you use Citizen Space to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so.

## Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to sharon.grant@gov.scot.

## Scottish Government consultation process

Consultation is an essential part of the policy-making process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: http://consult.scotland.gov.uk. Each consultation details the issues under consideration, as well as a way for you to give us your views, either online, by email or by post.

Consultations may involve seeking views in a number of different ways, such as public meetings, focus groups, or other online methods such as Dialogue (https://www.ideas.gov.scot).

Responses will be analysed and used as part of the decision making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise, the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

If you have any questions about responding to the consultation, please email organ_donation_scotland@gov.scot or call us on 0131 244 9228. You can also use these contact details if you would like to request a copy of this consultation in a different format.

## Consultation on Organ and Tissue Donation and Transplantation

## RESPONDENT INFORMATION FORM

**Please Note** this form **must** be completed and returned with your response.

Are you responding as an individual or an organisation?

☐ Individual

☐ Organisation

Full name or organisation's name

| |
|---|
| |

Phone number

Address

Postcode

Email

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

☐ Publish response with name

☐ Publish response only (anonymous) – Individuals only

☐ Do not publish response

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

☐ Yes

☐ No

## List of Questions

**Question 1 – what do you think of the principle of a soft opt out system for Scotland?**

- I support the principle of a soft opt out system in Scotland ☐

- I do not support the principle of a soft opt out system ☐

**Question 2 – are there any changes you would make to the current 'opt in' authorisation system, other than moving to opt out?**

**Question 3 – where someone has joined the Organ Donor Register (ODR) or indicated in another way that they wish to donate, what do you think should happen if the potential donor's family opposes the donation?**

- medical staff should still proceed with the donation ☐

- medical staff should not proceed with the donation ☐

**Question 4 – if there was a soft opt out system, what do you think of the proposed checks set out in step 2 (on pages 14 to 15)?**

- these are sufficient to decide if a donation can be deemed to be authorised ☐

- these are not sufficient to decide if a donation can be deemed to be authorised ☐

- don't know ☐

**Question 4(a) - if you think these are not sufficient, what other checks would be needed (apart from those covered in questions 6 to 8 below)?**

**Question 5 – in any opt out system, what do you think should happen if a deemed authorisation donation was likely to distress the potential donor's family?**

- the donation should still proceed ☐

- the donation should not proceed ☐

- don't know ☐

**Question 6 – if there was a soft opt out system, what do you think about the categories of people set out under step 3 (pages 15 to 17) for whom explicit authorisation would still be needed from the person themselves or family member?**

- the categories above are sufficient ☐

- the categories above are not sufficient ☐

- don't know ☐

**Question 6(a) – if these are not sufficient, why do you think this?**

**Question 7 – in what circumstances do you think an adult should be viewed as not having the capacity to make their own decisions about donation and therefore should not be subject to any deemed authorisation provisions?**

**Question 8 – under what age do you think children should only be donors with explicit authorisation?**

- under 12 ☐

- under 16 ☐

- under 18 ☐

- other (please specify) ☐

**Question 9 – for children who are in care, what are your views on allowing a local authority which has parental responsibilities and rights for a child to authorise donation for the child if no parent is available?**

- they should be allowed to authorise donation of a child's organs or tissue in those circumstances ☐

- they should not be allowed to authorise donation of a child's organs or tissue ☐

- don't know ☐

**Question 10 – in any opt out system, what provisions do you think should apply to the less common types of organs and tissue?**

- deemed authorisation provisions should only apply to the more common organs and tissue (kidneys, liver, pancreas, heart/heart valves, lungs, small bowel and stomach, tendons, skin, corneas, bone) ☐

- deemed authorisation provisions should apply to all organs and tissue ☐

**Question 11 – which tests do you think medical staff should be able to carry out on a donor before they withdraw life-sustaining treatment to check if their organs or tissue are safe to transplant, both where a patient's authorisation for donation is 'deemed', as well as where the donation is explicitly authorised:**

- **a) Blood tests?** - for tissue typing to find a good recipient match, to detect any infections, such as HIV or Hepatitis, or for testing the patient's blood gases to check how well the lungs function;
  - yes ☐
  - no ☐
  - don't know ☐
- **b) Urine tests?** - to check if the patient has any infections;
  - yes ☐
  - no ☐
  - don't know ☐
- **c) X rays?** - to check for any undiagnosed medical problems;
  - yes ☐
  - no ☐
  - don't know ☐
- **d) Tests on a sample of chest secretions?** - taken via a tube to test how well the lungs function. Chest secretions are often removed from patients in Intensive Care as part of their treatment to help make them more comfortable so would be removed anyway as part of their care – this would therefore involve testing samples of the secretions that have been removed;
  - yes ☐
  - no ☐
  - don't know ☐
- **e) Tests on the heart such as an ECG** (electrocardiogram) or **ECHO** (echocardiogram)[19]**?** – these tests check if the heart is functioning well.
  - yes ☐
  - no ☐
  - don't know ☐

**Question 12 – if you answered no to some or all options in question 11, are there any circumstances when particular tests could be permitted?**

- if the person had previously made clear they wished to be a donor ☐

- if the donor's family provided consent on the donor's behalf ☐

- such tests should never be permitted before death ☐

[19] Currently in Scotland these tests are not required for DCD patients as hearts are only donated by patients diagnosed as brain-stem dead. However, DCD heart donation has been trialled in some hospitals in England and might potentially be extended to include some Scottish donors in future.

**Question 13 – where it is agreed a patient's condition is unsurvivable and it will not cause any discomfort to them, what do you think about medical staff being allowed to provide any forms of medication to a donor before their death in order to improve the chances of their organs being successfully transplanted, such as providing antibiotics to treat an infection or increasing the dose of a drug the patient has already been given[20]?**

- they should be able to provide such forms of treatment ☐

- they should be able to provide such treatment, but only where the donor's family provides consent ☐

- they should not be able to provide any such treatment just to help the donation ☐

**Question 14 – what do you think about allowing people to appoint one or more authorised representatives to make decisions for them?**

- this should be allowed ☐

- this is not necessary ☐

- don't know ☐

**Question 14(a) – if you think this should be allowed, in what circumstances do you think an authorised representative would be useful?**

**Question 15 – do you have any other comments which you think should be taken into account in relation to any Scottish opt out system?**

**Question 16 – what do you think about providing Chief Medical Officer (CMO) guidance to encourage clinicians to refer almost all dying or recently deceased patients for consideration as a potential organ or tissue donor?**

- CMO guidance should be provided to encourage more referrals ☐

- CMO guidance should not be provided ☐

- other (please specify) ☐

[20] For example, a patient may be given a drug such as Noradrenaline to improve their blood pressure – maintaining or increasing the dose of this after the decision has been taken to withdraw life sustaining treatment will help improve the blood flow to the organs. If antibiotics are used to treat an infection which the donor has, that will help mitigate any impact of the infection on the organ transplant recipient(s)

**Question 17 – what do you think about making it a procedural requirement for clinicians to involve a specialist nurse for organ donation, tissue donor co-ordinator or another individual with appropriate training in approaches to families about donation, wherever that is feasible?**

- this should be a requirement ☐

- this should not be a requirement ☐

- don't know ☐

**Question 18 – do you think there are particular impacts or implications for any equalities groups from any of the proposals in this consultation, either positive or negative? If yes, please provide details.**

## Glossary of terms and acronyms used in this consultation

**Authorisation** – under the Human Tissue (Scotland) Act 2006, organ or tissue donation can proceed where it has been 'authorised', either by the donor themselves or their nearest relative. Authorisation can be given in writing (such as by joining the ODR) or by telephone. This is similar to 'consent', which is required in England, Wales and Northern Ireland. However, in the case of consent, the donor or their nearest relative has to have been given certain detailed information before they can consent; for authorisation, information is available if people want it, but they do not have to show they have seen the information before they can authorise donation.

**DBD – Donation after Brain-stem Death (or Brain Death)** – this is where donation takes place after two doctors have confirmed that the person is dead using neurological criteria to show that the person no longer has any brain-stem function, (where the patient is on life support and has completely and irreversibly lost the capacity for consciousness and the ability to breathe independently). The patient will usually have suffered either some form of severe head trauma, for example in a car accident, or have had a severe stroke.

**DCD – Donation after Circulatory Death** – this is where donation takes place after doctors have confirmed that the person is dead using cardio-respiratory criteria (where their heart has stopped beating and they have stopped breathing for a period of five minutes). The person will have suffered some form of critical illness and death happens after it is agreed that their life-sustaining treatment should be withdrawn because they cannot recover or breathe without life support.

**CLOD – Clinical Lead for Organ Donation** – each Scottish hospital where donation can take place has a doctor who leads on championing organ donation in their hospital and making their colleagues aware of developments in procedures or opportunities associated with donation. There are also two Regional CLODs who oversee the work of the CLODs in their area.

**HTA – Human Tissue Authority** – this is the organisation which regulates organ donation and transplantation across the UK. It carries out certain checks to ensure, for example, that no living donors are being paid to donate a kidney or any other organ.

**NHSBT – National Health Service Blood and Transplant** – a UK NHS body which coordinates preparations for organ donation and manages operations to remove organs from donors. It also oversees the allocation of organs to transplant recipients. Its staff work with NHS staff in Scottish hospitals to ensure the donation process works as smoothly as possible. The Scottish Government provides funding to NHSBT to cover its costs for delivering its service in Scotland. NHSBT also provides blood and tissue services, but these do not operate in Scotland, although they do manage Scottish eye donations (see SNBTS below for the Scottish equivalent).

**ODR – the National Health Service Organ Donor Register** – this is the UK-wide register of people who have confirmed that they agree that some or all of their organs or tissue can be donated after their death. People can either join the register online or by filling in a paper form. People can now also use the ODR to confirm if they do NOT wish to donate any of their organs, known as 'opting out'. If someone has just died or is about to die, SNODs or TDCs (defined below) can access the register to check if that person had either signed up to the register or opted out of donation.

**Opt in system** – an opt in system of organ donation is one where donation can only proceed if there is explicit authorisation or consent for donation, either from the donor themselves or in some cases from their family. Scotland currently has an opt in system of donation.

**SDTG - Scottish Donation and Transplant Group** – this Group brings together a range of stakeholders with different interests and/or expertise to provide advice to Ministers on donation and transplantation. The Group aims to help increase donation and transplantation, particularly by implementing the recommendations in the Scottish Government's *A Donation and Transplantation Plan for Scotland 2013-2020*.

**Soft opt out** – this is a system of organ and tissue donation, also known as a deemed consent (or authorisation) system. A soft opt out system starts from the assumption that most adults can be a donor when they die unless they have stated that they do not wish to donate, but it normally allows for the family's views to be taken into account in some way.

**SNBTS – Scottish National Blood Transfusion Service** – SNBTS is part of NHS Scotland and is the Scottish body which collects blood in Scotland and delivers it to Scottish hospitals so it is available, for example, where someone needs a blood transfusion. It also manages Scottish tissue donations and services, such as donations of skin, heart valves and tendons.

**SNOD – Specialist Nurse for Organ Donation (or Special Nurse – Organ Donation)** – these nurses are employed by NHSBT and work in hospitals to support donor families and, where donation is likely to proceed, they help make arrangements to ensure the donation can take place and that the organs have been allocated to transplant recipients by NHSBT.

**TDC - Tissue Donor Co-ordinator** - these nurses are employed by SNBTS and work in hospitals to raise awareness and provide teaching about tissue donation. Where donation is likely to proceed, they help make arrangements to ensure the donation can take place.

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

**Item 16**

**BOARD05/2017**
**Tayside NHS Board**
**23 February 2017**

# NORTH OF SCOTLAND PLANNING GROUP - ANNUAL REPORT 2015/16

## 1. SITUATION AND BACKGROUND

The Annual Report of the North of Scotland Planning Group (NoSPG) summarises regional achievements throughout 2015/16 across the range of work which NoSPG supports, on behalf of North of Scotland (NoS) Boards. Progress of inter-regional and national initiatives led by the NoSPG or by the Director of Regional Planning is also reported. NHS Tayside is a member Board of the NoSPG and each year NoSPG prepares an Annual Report for submission to the NoS Boards.

This provides reassurance to Boards around regional engagement, and also that NHS Tayside Board is sighted on the benefits and investment in regional projects, services and networks.

## 2. ASSESSMENT

The Board is asked to note the NoSPG Annual Report for 2015/16

## 3. RECOMMENDATIONS

The Board is asked to note the NoSPG Annual Report for 2015/16.

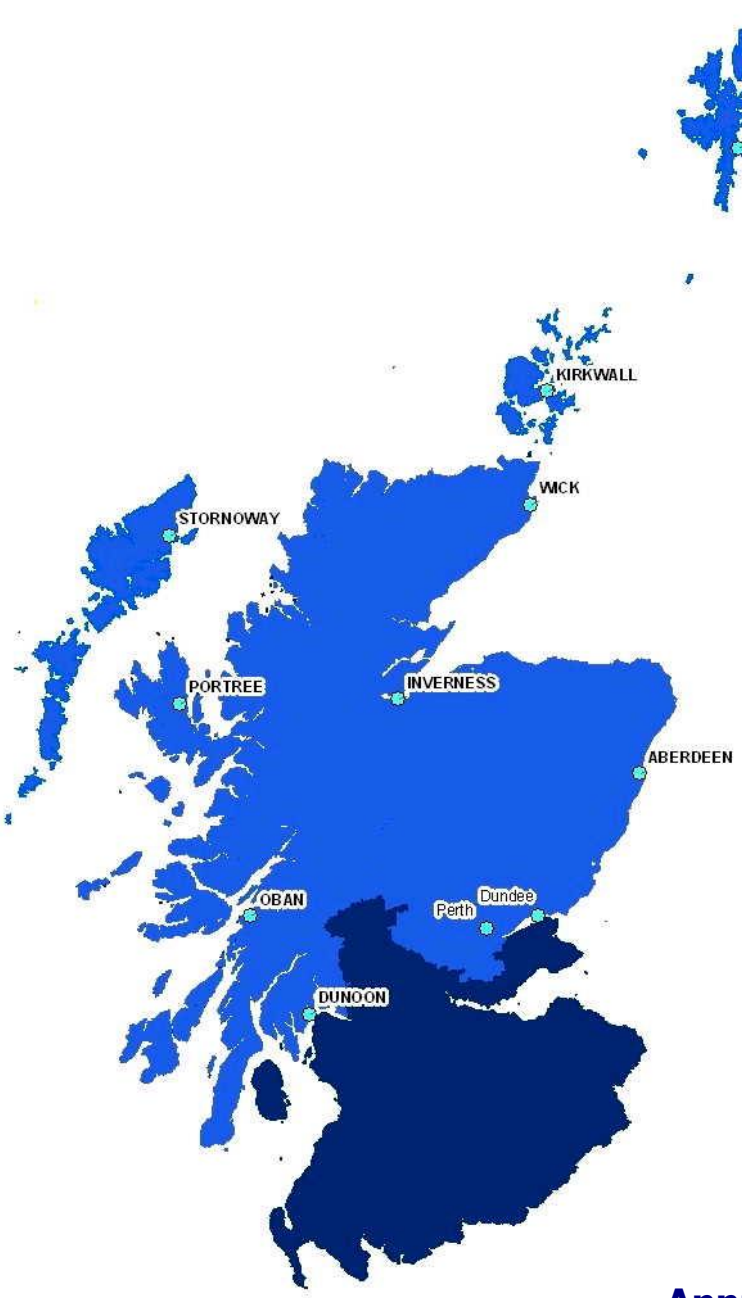
## 4. REPORT SIGN OFF

**Mr J Cannon**
**Director of Regional Planning**

**Ms L McLay**
**Chief Executive**

**February 2017**

# NORTH OF SCOTLAND PLANNING GROUP




# Annual Report

# 2015-16

Version 7

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## 1. Chair's Introduction

This year's annual report demonstrates the breadth of work which we in the north have committed to, and serves as a reminder of the growing need to collaborate across boundaries, as we integrate more, constantly seeking to improve and deliver the most sustainable and highest quality services across the north region.

Particular sustainability challenges which were acute at the beginning of this period have abated (Oncology) yet others have emerged as coming under increasing pressure (Radiology). We must continue to develop our resilience by building closer relationships between our teams, which will serve us well when it comes to negotiating closer working either on a temporary or more permanent basis.

This will be my last Annual Report as chair of the Regional Planning Group and I would like to thank my colleagues from across the region for supporting me through the challenges in this role, over the past 3 years.

During 2016 I will hand over the chair role to Cathie Cowan and I will continue to support the regional agenda as we guide our way through impending public service reform.

**Elaine Mead**
**CEO NHS Highland**
**Chair -North of Scotland Planning Group**

## 2. Background

This report covers the period April 2015 – March 2016.

Although the detail within this report is outdated almost as quickly as it is written, it records achievements and progress, giving a flavour of the challenges and successes of each piece of work, who is involved and timescales for delivery.

We welcome feedback and would be happy to discuss or answer any questions you might have which arise from reading the report.

## 3. Report Purpose/Aim

This report serves as a reporting vehicle for collaborative services, networks and projects across the north. It also acts as a means of communication for those not closely involved in these collaborative initiatives and outwardly to our colleagues across the wider NHS in Scotland. Finally the report aims to act as a catalyst for discussion at Board level and within services.

## 4. Context

### 4.1. Regional Team

The North of Scotland Planning Group has team members based in all three of the north mainland Boards. We remain committed to our approach of open recruitment across the North of Scotland.

We have developed our Project Management capability and capacity through the year and now host project management posts for a range of regional work such as Transforming Care after Treatment and the North of Scotland Major Trauma project. Specific project updates are included later in this report.

A team of Clinical Network Managers continue to provide the collaborative framework needed to deliver regional work plans and initiatives. Specific Network updates are included later in this report.

### 4.2. North of Scotland Public Health Network (NOSPHN)

#### Contacts

- Dr Louise Wilson – NoSPHN Lead / Director of Public Health NHS Orkney
- Pip Farman – NoSPHN Coordinator / Public Health Specialist

#### Participating Boards

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | N* | NHS Western Isles | Y |

*NHST are not part of NoSPHN but engage in areas of agreed interest

#### Finances

NoSPHN is funded through the Directors of Public Health in each of the participating NoS Boards. The total budget is £50K which covers 0.5 WTE Network Manager post, 0.2 WTE Administrative support and project costs.

#### Outline

The work of NoSPHN is guided by a Steering Group comprising the NoS Directors of Public Health, the NoSPG Director; representatives from regional working groups and programmes; and national bodies e.g. the Scottish Public Health Network (ScotPHN).

NoSPHN supports NoSPG through NoS meetings and in agreed pieces of work to ensure that regional initiatives are informed by the best available evidence and identified population need and by using a range of relevant tools so that NoSPG make the best possible decisions within the resources available for the people of the North of Scotland. NoSPHN also develops regional approaches to Public Health services, activities and continuing education (further details of this work are available on the NoSPHN website www.nosphn.scot.nhs.uk).

#### Progressed During Last Year

This year NoSPHN work for NoSPG has focussed on:

- Low Volumes, Outcomes and Sustainability project – the resource previously developed has been tested and further developed through the SLWG for Upper GI Cancer and subsequently

through the surgical services working group.

- Intelligent region developments – NoSPHN has worked with NoSPG colleagues continuing to develop the concept of the Intelligent Region and has held development sessions on data visualisation and data profiling and mapping.
- Population of 1.3 Million – as part of the NoSPG sustainability programme a number of discussions with NoS colleagues and at NoSPG alluded to a piece(s) of work intended to support strategic thinking and regional planning when focussing on the needs of and planning for a NoS population of 1.3 million. A meeting has been held with colleagues under the auspices of NOSCAN to explore the development of a Cancer Intelligence Hub which it is intended will provide a framework for taking this work forward.
- NoSPHN have supported NoSPG colleagues through a range of groups and activities including NOSCAN, Major Trauma, Child Health, Dental Health and NoSPG events.

NoSPHN develops regional approaches to Public Health services, activities and continuing education. This year key work has focussed on:

- A project focussing on Securing and Strengthening the Delivery of Public Health Functions in the North of Scotland. The work has been developed in two phases firstly with the aim of ensuring short term service plans are robust, resilient and sustainable and to set these in the context of longer terms plans to strengthen Public Health functions in and across the NoS. Phase two will detail work to optimise opportunities for further active regional planning in the delivery of public health functions and collaborative working arrangements in the future.
- Workforce planning - in particular promoting the North of Scotland as a place to train and work
- Health protection - a number of sessions have been held to understand practice and variation across Health Protection on call services in the NoS Boards; share CPD sessions and ensure collaborative links to the national Health Protection Oversight Group. A shared island on call rota has been developed which is being reviewed at NoSPHN.
- Health Improvement - the main focus for health improvement activity has been on CPD sharing and responding jointly to national developments.
- Continuing Professional Development – a number of activities have been held including an introduction to 3 Horizons[1] thinking in which NoSPG colleagues have been involved.
- Raising the profile of the North of Scotland and NoSPHN at conferences through the presentation and sharing of NoSPHN work.
- National developments - NoSPHN has responded and contributed to national working groups including the Public Health Review focusing in particular on highlighting the challenges of working in remote and rural areas and related impacts for public health activities. Links have been maintained with a range of national organisations in support of local and regional activities eg SCOTPHN, ISD, NHS Health Scotland.

[1] International Futures Forum http://www.internationalfuturesforum.com/three-horizons

## Intentions for Coming Year

NoSPHN will progress ongoing developments from the 2015/16 workplan and discuss new and developing areas of support as required including:

- Continued close collaborations and support to NoSPG groups and networks including the Regional Clinical Strategy Group; NoSCAN, Cardiac and Dental Health
- Continuing work on low volumes / outcomes and sustainability in the NoS aligned to wider

NoSPG work on the sustainability of services in the North of Scotland

- To promote and deliver activities in support of the 'Intelligent Region' and 'Population of 1.3 million' working with colleagues across the North to maximise local, regional and national activities
- Continue to develop regional approaches to Public Health services, activities and continuing professional education with a particular focus on remote and rural public health practice.

## 4.3. Regional Workforce Groups

### Regional workforce Group

The Regional Workforce Group, developed in response to actions from the 2014 Regional Annual Event, have continued to meeting regularly during the year.

- A 'Big Questions' regional workforce intelligence project looking to establishing whether recruitment and retention rates for staff are better, worse or the same in the North of Scotland.
- Combined attendance at Careers Fairs.
- Support for Remote and Rural recruitment and retention programmes in the North of Scotland.

### Workforce Learning Network

The Regional Learning Network has continued to meet regularly during the year. This regionally facilitated forum provides a link between the workforce planning teams of the six north of Scotland NHS Boards and has provided a discussion platform for both general issues, such as identifying common issues from Board workforce plans, as well as specialty or staff group specific issues.

## 4.4. Director of Regional Planning - Specific Work

The Director leads a number of projects and pieces of work within the regional work plan and also continues to represent the region in a number of national and inter regional groups, maintaining the profile of the north, ensuring an equitable voice and appropriate links with other work.

National Groups:

- Sustainability & 7 day services taskforce (Director of Planning Representative)
- Shared Services Customer Reference Group (Chair)
- Shared Services Project Board (member)
- National Patient Public & Professional Reference Group (member)
- Directors of Planning (member representing the north)
- National Planning Forum (member)
- National Clinical Cancer Strategy Group (member)

Inter Regional Groups:

- Directors of Regional Planning / National Services Division / Scottish Government
- Inter regional Cot Capacity

## 4.5. Projects Ended in 2016

The "planning" heart of NoSPG's work tends to dictate that projects are often lengthy in duration. NoSPG's contribution can start from the initial enquiry stage into options reviews through project planning and on to delivery and handover in to business as usual: often spanning years. Amongst much ongoing work the period of this annual report saw one significant project reach its conclusion whilst another evolved into a new phase.

NoSPG's capabilities were also enhanced by the establishment of a project office delivering to a revised project framework and approval process.

**Paediatric Unscheduled Decision Support (PUDS)**

During the current period the Paediatric Unscheduled Decision Support (PUDS) project arose from last year's Paediatric Unscheduled Care (PUCs) pilot project. PUCs provided consultant-led advice and support, in the subject area, to rural and community hospitals. PUDS was created to assess the awareness of the initial pilot work and any subsequent implementation across the North of Scotland.

A short life working group (SLWG) garnered a detailed picture across twenty-three hospitals. Subsequently the SLWG described a number of recommendations contained in a report presented to the NOSPG Child Health Clinical Planning Group. The projects have fed into national policy development on clinical decision support processes and video conferencing facilities for remote and rural services.

**Sustaining Oncology Services in the North of Scotland (SOSNOS)**

Begun in 2014 the Sustaining Oncology Services in the North of Scotland (SOSNOS) project came, in 2016, to the conclusion of its initial two year programme. The project was highly successful in supporting the Boards' stabilisation of oncology services across the north's three cancer centres.

With the contribution of a Scottish Government Gateway review the NoSPG regional team were able to propose the next stage of work in a Project Initiation Document for Regional Oncology Services (see below, Regional Projects). The latter was approved at the NoSPG Executive meeting of March 2016. In the summer of 2016 the proposals will be the foundation of intensive engagement across stakeholders aiming to validate and endorse the planned change programme.

**Project Framework & Approval Process**

Upon appointment in summer 2015, the NoSPG project team was tasked with designing a framework for NoSPG's projects that would improve a project's stakeholder endorsement and provide appropriate levels of approval and monitoring.

A revised process was presented to and approved by the Integrated Planning Group in autumn 2015 and is now adopted. Introduced are standard practises around project initiation and documentation enabling robust foundations for projects. A summary Project Bulletin has proved particularly popular in communicating progress on the whole landscape of NoSPG's project from early enquiry to delivery stage.

## 4.6. E-Health

Through the work of the North of Scotland Planning Group a number of regional services and Multidisciplinary Team meetings have been established to support the sustainability of services across the region. As part of these developments there has been an increasing demand for robust and efficient eHealth solutions that can deliver effective information transfer across Board boundaries.

Work has been progressed to scope the range of issues impacting on the delivery of services and co-ordination of care. From this work, areas have been identified which require to be addressed and will be

used to develop a regional work plan. These include;

- Access to clinical information
- Addressing clinical risk
- Developing patient support systems

The development of the work plan/scoping is being taken forward in partnership with the Regional E-health Leads Group and the Regional E-health Programme Manager. The work plan will be an element of the wider National, Regional and local issues the E-Health leads are taking forward within the North of Scotland.

## 4.7. Neuromuscular Care Co-ordination

Following a commitment by the Scottish Government to the Muscular Dystrophy Campaign, regarding the establishment of a Neuromuscular Care Advisor in each of the three Regional Planning Group areas, work has been progressing to identify a sustainable solution for the North of Scotland. A pilot was established to assess the impact of a single Care Advisor role, with funding provided by the Scottish Government. From this, it was identified that a single handed solution does not provide a sustainable way forward for patients in the North of Scotland, due to the various pathways involved in providing care and geography.

Neuromuscular patients living in the North of Scotland currently receive care and support through a number of different pathways, which will include health, local authority and third sector services. Co-ordinating this care is crucial and there is increasing evidence [1] which suggests that the care co-ordination function is vital, for the following:

- Reduces emergency admission and re-admissions
- Reduces hospital stays
- Improves coordination of care reducing crisis situations
- Improves Multi-disciplinary team coordination and delivery of care based on an individual's needs
- Reduces specialist consultant's time

To ensure that the level of care co-ordination required can be established and sustained for people with neuromuscular conditions, a number of options have been considered, for both adult and paediatric services. Whilst this work is not concluded for adult services, a co-ordination function has been introduced as part of the Paediatric Neurology Network. Following the redesign of a regional physiotherapist role, the post-holder will provide support, co-ordination and advice to paediatric patients and their families living with a neuromuscular condition.

Similar opportunities are currently being investigated regarding the provision of co-ordinated support within adult services.

[1] Invest to Save: Improving services and reducing costs in Scotland MDC 2011

## 4.8. Regional Work Prioritisation

As part of the ongoing prioritisation of the North of Scotland Planning Group resources it was agreed to conduct a review of all regional networks and projects, to identify whether they were still aligned to regional priorities.

A process to undertake this prioritisation was agreed, and the following criteria for regional priority

agreed.

**Criteria for prioritisation**

| | |
|---|---|
| **Sustainability** | Solving current workforce issues |
| | Solving future workforce issues |
| | Potential cost savings |
| | Increasing cross-boundary co-ordination between existing services |
| | Changing the organisation of services across boundaries to improve co-ordination |
| | Delivering education and training |
| **Mandate** | Delivering a regional service |
| | Supporting Inter-regional working |
| | NoSPG Executive request or other regional mandate |
| | National mandate or remit (including legislation) |
| | One or more Boards requires collaborative solution |
| **Equality** | Actively working to reduce waiting times |
| | Actively working to increase equality of access |
| **Governance** | Regional governance role |
| | Unique regional governance role |
| | Improving patient experience |
| **Interface** | Facilitates other NoSPG projects |
| | Interfaces with another NoSPG programme |
| | Interfaces with a national programme |

Networks and projects are assessed against these criteria and any opportunities for re-prioritising regional planning resources identified.

A pilot of the process has been successfully completed and the workstreams to be included in the prioritisation review agreed are being scheduled.

## 4.9. Risk Management

The NoSPG team have been working with National Services Scotland through the year, to implement an electronic system to support the management of regional risks, and the integration of this process with risk management at NHS Board level.

This will provide an additional support to the risk based prioritisation approach to regional planning work, and facilitate the management of cumulative risks across the North of Scotland.

## 4.10. 2016/17 Priorities

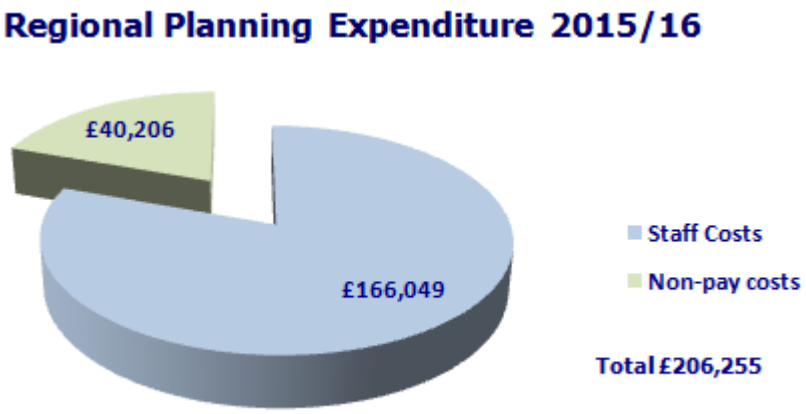
Priority areas of work for 2016 / 17 include:

- Developing the Major Trauma network and centres within the north
- Moving the Oncology project into the next phase of implementation

## 4.11. Finance

### NoSPG Funding by NoS NHS Boards

The core NoSPG team is funded by the NoS Boards through an NRAC share each year. Total expenditure is shown below.




Expenditure is demonstrated by Board split with planned versus actual spend during 2015/16, as shown in the table below.

| Regional Planning Expenditure 2015/16 by NHS Board | NRAC % | Proposed £ | Actual £ |
|---|---|---|---|
| Grampian | 37.71% | 73,272 | 77,778 |
| Highland | 25.14% | 48,848 | 51,858 |
| Orkney | 1.72% | 3,342 | 3,551 |
| Shetland | 1.88% | 3,653 | 3,876 |
| Tayside | 30.60% | 59,456 | 63,105 |
| Western Isles | 2.95% | 5,732 | 6,087 |
| | **1.0** | **190,686** | **206,255** |

## Child Health Including Neonatal Funding

| Table 3: Spec Child Inc Neonatal | 2015/16 £ |
|---|---|
| Funding available | 579,983 |
| NDP Clinical Leaders | 93,507 |
| Slippage from previous year | 342,765 |
| | **1,016,255** |
| **Estimated Expenditure** | |
| Associate Director | 58,605 |
| Network Managers | 157,629 |
| Support Costs | 45,007 |
| Clinical leader - Gastroenterology | 18,162 |
| Clinical leader - Neurology | 18,162 |
| Clinical leader - Respiratory & CF | 18,162 |
| Clinical leader - Infrastructure | 18,162 |
| Clinical leader - Child Protection | 23,345 |
| Regional Physiotherapist/Neuromuscular | 20,961 |
| Remote & Rural | 50,240 |
| Regional Dietetic Support - Ketogenic | 20,859 |
| External Consultant National Review | 16,000 |
| Misc | 16,326 |
| Travel | 16,496 |
| | **498,116** |
| **NoSPG Team Underspend** | **518,139** |

## Temporary Post

| Temporary Post | 2015/16 £ |
|---|---|
| **Funding available** | |
| Slippage earmarked for temporary posts | 303,545 |
| | **303,545** |
| **Estimated Expenditure** | |
| Programme Manager | 65,030 |
| Programme Manager | 47,124 |
| NOSCAN Programme Manager | 58,895 |
| Data Audit Manager | 32,884 |
| Medical Director | 44,000 |
| CAMHS Capital Project Consultant | 10,106 |
| Travel | 11,500 |
| Misc | 1,562 |
| | **271,101** |
| **Slippage to be carried forward** | **32,444** |

## Restorative Dentistry

| Restorative Dentistry | 2015/16 £ |
|---|---|
| **Funding available** | |
| Grampian | 117,098 |
| Highland | 103,390 |
| Shetland | 6,360 |
| Orkney | 5,760 |
| Western Isles | 7,392 |
| Academic (NES) | 116,000 |
| Slippage from previous year | 429,077 |
| | **785,077** |
| **Estimated Expenditure** | |
| Consultant (NHS Highland) | 155,076 |
| Consultant (NHS Grampian) | 200,924 |
| Highland set up costs | 10,026 |
| Materials | 12,031 |
| | **378,057** |
| **Slippage carried forward to following year** | **407,020** |

## NOSCAN

| Table 6: NOSCAN | 2015/16 £ |
|---|---|
| **Funding available** | |
| NHS Board Allocation | 169,673 |
| Slippage from previous year | 62,815 |
| | **232,488** |
| **Estimated Expenditure** | |
| Clinical Lead | 9682 |
| Admin Support | 26,915 |
| Management | 134,500 |
| Equipment | 845 |
| Travel | 6,793 |
| Misc | 15,128 |
| | **193,863** |
| **Slippage carried forward to following year** | **38,625** |

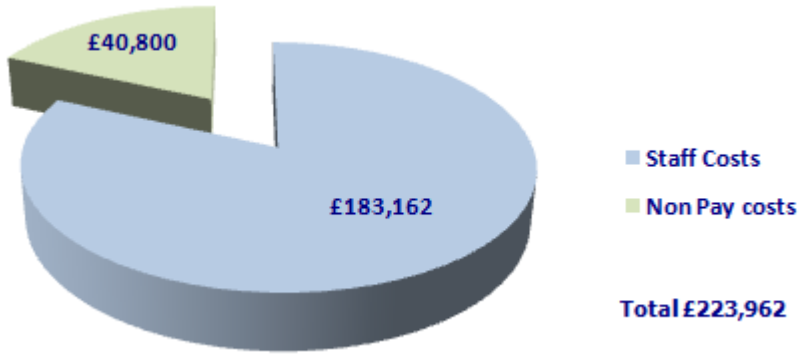
## MacMillan

| Table 7: McMillan | 2015/16 £ |
|---|---|
| **Funding available** | |
| Income from McMillan | 38,964 |
| | 38,964 |
| **Estimated Expenditure** | |
| Staff costs | 33656 |
| Travel | 2,728 |
| Misc | 2,573 |
| | **36,384** |

## Cancer Modernisation

| Cancer Modernisation | 2015/16 £ |
|---|---|
| **Funding available** | |
| Allocation | 100,000 |
| | 100,000 |
| Estimated Expenditure | |
| eCase license | 16,166 |
| | 16,166 |
| **Slippage carried forward** | **83,834** |

## Regional Planning Projected Costs 2016/17




| Projected Cost Shares for 2016/17 by NoS Board | | % |
|---|---|---|
| Grampian | £86,315 | 38.54% |
| Highland | £56,528 | 25.24% |
| Orkney | £4,166 | 1.86% |
| Shetland | £4,166 | 1.86% |
| Tayside | £66,964 | 29.90% |
| Western Isles | £5,823 | 2.60% |
| | **£223,962** | **100.00%** |

| 2016-17 NDP and CAMHS Slippage returned to Boards | CAMHS £ | NDP £ | Total £ |
|---|---|---|---|
| Highland | 49,422 | 122,201 | 171,623 |
| Orkney | 2,980 | 8,667 | 11,647 |
| Shetland | 2,714 | 8,667 | 11,381 |
| Tayside | 101,478 | 139,349 | 240,827 |
| Western Isles | | 12,120 | 12,120 |
| | **156,594** | **291,004** | **447,598** |

**Summary Table**

| Summary of Costs 2015/16: | Funding £ | Expenditure £ | Slippage £ |
|---|---|---|---|
| Spec Child Inc Neonatal | 1,016,255 | 498,116 | 518,139 |
| Temporary Posts | 303,545 | 271,101 | 32,444 |
| Restorative Dentistry | 785,077 | 378,057 | 407,020 |
| NOSCAN | 232,488 | 193,863 | 38,625 |
| Cancer Modernisation | 100,000 | 16,166 | 83,834 |
| McMillan | 38,964 | 38,964 | 0 |

## 5. Regional Networks

## 5.1. Adult Networks

### 5.1.1. The North of Scotland Cardiac Network

**NoSPG Contacts**

- Clinical Lead – Mr Hussein El-Shafei (Cardiothoracic Surgeon, NHS Grampian)
- NOSPG Support – Jaime Lyon (Regional Network Manager)
- Current Chair – Deb Jones (Director of Strategic Commissioning, Planning & Performance)

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | N |

**Timeframe**

2015 - 2016

**Outline**

The North of Scotland Cardiac Network is collaboration between 5 Health Boards in the North (excludes Western Isles). Within this Network are the Regional Cardiac Thoracic Service and Regional Electrophysiology Service, both hosted by Grampian.

**Progressed During Last Year**

Grampian have given authorisation for CRT to commence at Raigmore Hospital officially from 01st May 2016. Dr Affolter will do one of the patients on his list at Raigmore on 28th April and use this as a

training opportunity.

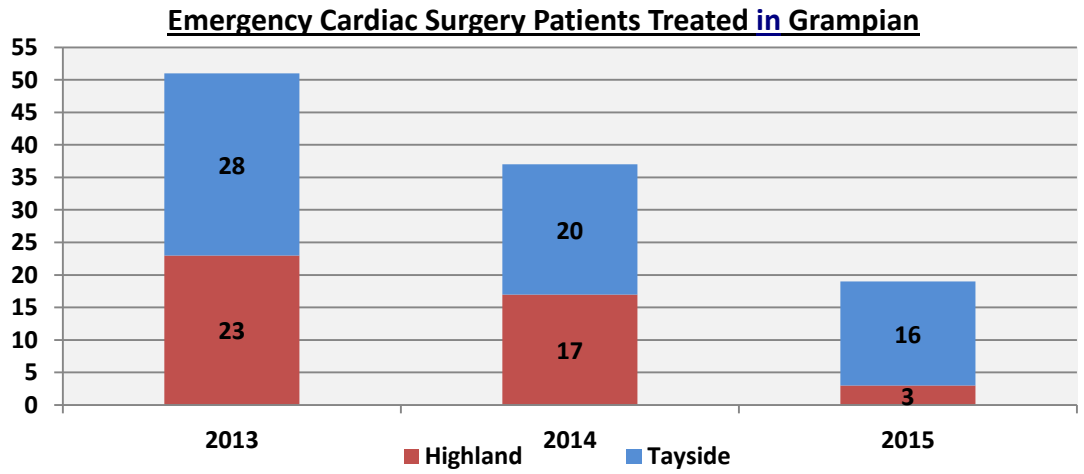
This is limited to 20 CRT devices per annum whilst monitoring demand across the North of Scotland and feeding this back to NoSPG with a view to assessing patient requirements.

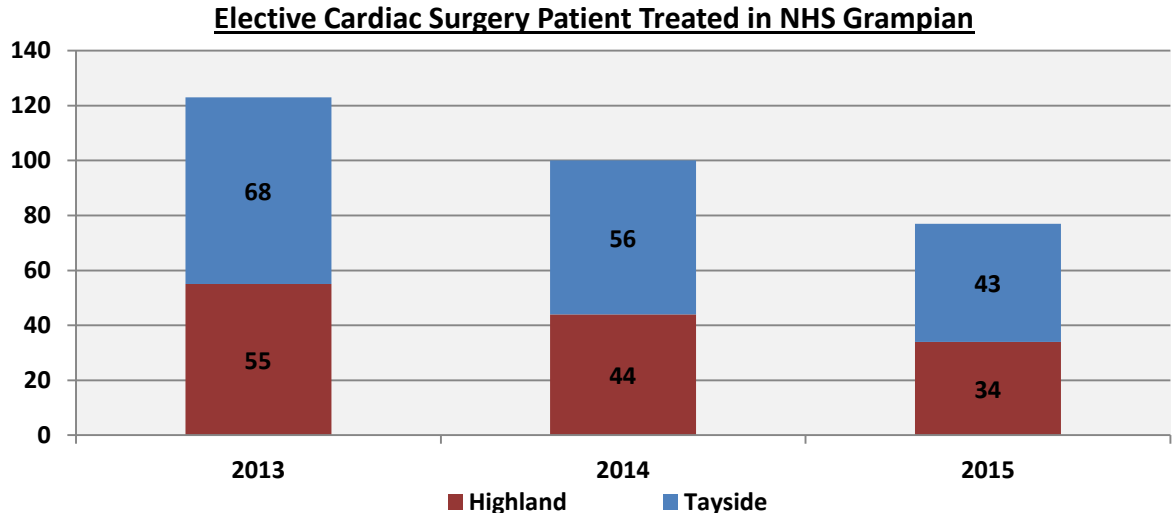
## Intentions for Coming Year

Following the Cardiac Services Review paper which has now been endorsed by the Regional Cardiac Sub-Group (meeting March 2016) it was agreed that the 5th recommendation in this review (establishment of a Cardiac Patient Pathway Co-ordinator) was pivotal to the sustainability of Cardiac Services in the North.

The initial scoping work has been undertaken around this post and is with NHS Grampian to finalise the job description. Once this post is in place it is hoped that referrals to NHS Grampian from both Tayside and Highland will start to increase helping to ensure a sustainable service in the North.

The bar charts detailed below illustrate the falling numbers for both emergency and elective referrals to NHS Grampian from both NHS Highland and Tayside respectively.




In terms of the Tayside patients being referred to Lothian further analysis is required to understand the spread across Tayside as historically there were always a cohort of patients particularly the Perth end of Tayside who would always be referred to Lothian.

The Network will also be running a Regional Event later in 2016 as well as developing a Quality

Framework for Cardiac Surgery in the North.

The Cardiac Network is also subject to a review which is currently underway with Network Manager and Clinical Lead at the request of the NOSPG Prioritisation Process.

## 5.1.2. Restorative Dentistry Network

### NoSPG Contacts

- Ken Mitchell – Programme Manager
- Kerry Russell – Associate Director of Regional Planning

### Participating Boards

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | N | NHS Western Isles | Y |

### Finances

The Restorative Dentistry Network has a recurrent budget of £356k.

This is made up of contributions from all Boards, along with funds to support education and training, and is allocated on a population basis to NHS Highland and NHS Grampian who deliver the two elements of the Restorative Dentistry Service in the Region.

There is a current underspend of £439k (of which £329k is currently uncommitted) which resulted from delays in recruitment within NHS Grampian and commencing elements of the service within NHS Highland, plus some pump priming funds from the Scottish Government. The recurrent budget is now being fully utilised and plans for the non-recurrent underspend will be prioritised against regional proposals for the service, agreed through the Restorative Dentistry Network and the Maxillofacial, Oral and Dental Health Planning Group.

### Outline

The Restorative Dentistry Network consists of consultants, service managers from the five North of Scotland Health Boards along with regional planning staff and other stakeholders.

Restorative Dentistry includes endodontic, periodontic and prosthodontic services

The Network was formed as part of the Business Case to develop additional capacity in Restorative Dentistry and an intermediate tier of enhanced skills practitioners between Primary and Secondary care. This intermediate tier would address some of the secondary care capacity issues and provide increased locality based care.

### Progressed During Last Year

Review of Network financial governance

Refreshed the Restorative Dentistry Network and recommenced regular Network activity

Grampian Endodontic pilot commenced (upskilling three Primary Dental Service (PDS) dentists)

### Intentions for Coming Year

Hold a region wide Development Day in November 2016

Continue with quarterly Network meetings

Agree Network objectives

Agree governance route for forthcoming financial decisions

Agree regional priorities for currently unallocated network finance

Three year evaluation of the Business Case

**Timeframe**

Quarterly Network meetings throughout the year

Underspend plan agreed by the end of December 2016.

Evaluation of the Business Case complete by the end of October 2016

## 5.1.3. Vascular Network

**NoSPG Contacts**

- Clinical Lead – Paul Bachoo (Vascular Surgeon, NHS Grampian)
- NOSPG Support – Jaime Lyon (Regional Network Manager)
- Current Chair – Kerry Russell (Assistant Director Regional Planning, NOSPG)

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | N | NHS Western Isles | Y |

**Timeframe**

2015 - 2016

**Outline**

The Regional Vascular Steering Group was established to take forward a "single Vascular service" in the North of Scotland which followed the review of Vascular Services in Scotland which was undertaken by the National Planning Forum in October 2011.

**Progressed During Last Year**

Varicose Vein workload has been seen as a priority for some time by the steering group, therefore a piece of work was commenced by the Network Manager at the time to scope out the current pathway and service delivery across the region which would allow variation to be understood.

**Intentions for Coming Year**

Following the most recent steering group meeting in March 2016 the group agreed to move forward with a regional MDT where patients who were diagnosed with an Aortic Aneurysm would be discussed. This

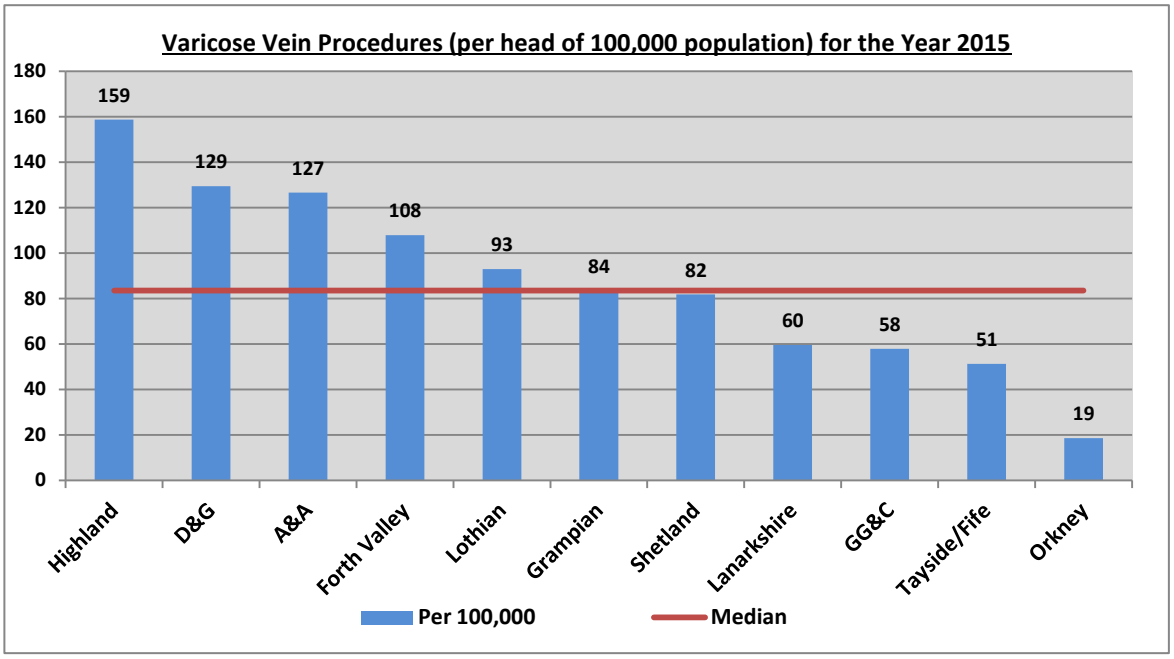
is being progressed and is on course to meet as a group for the first time before Summer 2016.

The Scottish Government also require quarterly updates around the recommendations of the Vascular Quality Framework. May 2016 will be the second time the Framework has been submitted for the North of Scotland. Returns from each Health Board in the North (excluding Tayside) will be analysed, compared to first submission and action plans drawn up for each health Board to ensure that collectively as a group the North of Scotland are working towards implementing all the recommendations in a timely fashion.

The Network also agreed to review varicose vein service delivery and pathways across the North, using the whole of Scotland as a comparator. The first stage in this process is to review service delivery across the North and the whole of Scotland and understand what services are offered where. As stated above the previous network manager had begun scoping this work out and the current network manager will continue with this.

Further to this it was also agreed to collect data on Varicose Vein procedures for all HB's within Scotland to understand variation across the country.

The bar chart below illustrates per head of 100,000 population the number of varicose vein procedures undertaken in 2015.




This will provide a baseline for discussion at the forth-coming steering group meeting in June 2016 where the group will be looking at an agreed pathway across the North for the treatment of Varicose Veins.

## 5.2. Child Networks

### 5.2.1. Child & Adolescent Mental Health Services (CAMHS)

#### NoSPG Contacts

- Ruth Masson, Network Manager
- Dr Helen Smith, Consultant Adolescent Psychiatrist
- Dr Anne Gilchrist, Consultant Psychiatrist CAMHS and Clinical Lead

#### Participating Boards

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | N |

#### Outline

Child and Adolescent Mental Health Services (CAMHS) is a specialist network aiming to provide improved access to appropriate psychiatric care and support for some of the most vulnerable young people aged 12-18 years of age. There are broadly three elements to the network: Local tier 4 services; Regional tier 4 network team; and access to a regional inpatient service

The service works closely with the named NHS Boards and local authorities amongst whom particular mention is made for Dundee City Council, where the inpatient service is located.

#### Progressed During Last Year

Currently the Consultant post for the network is vacant however the Network Liaison Nurses (NLN) have continued their tier 4 work across the North supported by the Advanced Nurse Practitioner. With the opening of the new unit focus this year has been around smooth transitions into and out of hospital, as well as maintaining young people with tier 4 need in the community we are monitoring the effect of their input around length of admissions and time to first pass home.

Communication across the network has improved with the use of Video Conferencing. Grampian and Highland CAMHS have recently acquired their own VC equipment which was funded by NoSPG.

Significant training, across a variety of topics, has occurred throughout the year for own staff and for sharing experiences with partner organisations. Additionally speaking events have been accepted to extol the virtues of the inpatient unit to national organisations.

The in-patient unit has a 12 week waiting time target, of referral to treatment, which has not been breached over the last year. The CAMHS network produces a standalone annual report which provides a comprehensive review of their work. This can be obtained by contacting the network manager, Ruth Masson.

#### Intentions for Coming Year

The CAMHS network aims to continue to build upon its first year of the dedicated inpatient unit in Dundee. After an initial fluctuation in staff absence and sickness (for a variety of reasons) the inpatient unit is now reaping the benefits of stability in this area, recently bettering expected set standards.

A Mental Welfare Commission visit report, survey feedback from north of Scotland clinicians and the continued collection and enhancement of service data will all inform the next year's developments.

**Timeframe**

The regional tier 4 network team were first recruited to in the first half of 2013. The dedicated inpatient service received its first patient in April 2015.

## 5.2.2. General Surgery for Childhood Network

**NoSPG Contacts**

- Anne-Marie Pitt, Child Health Network Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Outline**

General Surgery for Childhood (GSC) is currently provided in the north of Scotland within 8 District General Hospitals/Rural General Hospitals by adult general surgeons; Oben, Caithness, Fort William, Western Isles, Orkney, Shetland, Inverness and Elgin. National Delivery Plan for Specialist Children's Services (NDP) investment was made to develop a network and increase services. The investment provided for one extra paediatric surgeon at the Royal Aberdeen Children's Hospital (RACH) and 3 PAs of a general surgeon's time at Raigmore Hospital which has enabled the paediatric surgeons at RACH to provide the following additional support to rural hospitals:

- Outpatient clinic x 2 / month in Inverness
- Outpatient clinic x 1/ month in Elgin
- Outpatient clinic x 1 / month Fraserburgh (started late 2015)
- Outpatient clinic x 4 / year in Shetland
- Outpatient clinic x 4 / year in Orkney
- Outpatient general urology clinic x 1 / month in Inverness (added in 2014)
- Outpatient specialist urology clinic x 4 / year in Inverness
- Operative sessions x 2 / month in Inverness
- Operative sessions x 4 / year in Shetland

There is, however, scope for more improvement, including an increase in communication between clinicians, multi-disciplinary teaching and a more formalised networking approach. During 2013/14 the Network Manager facilitated a number of initial network meetings with general surgeon representation from the majority of sites carrying out GSC. The outcome was an agreement to work in a more networked manner and explore how improvements could be made. However, participation has been slow with minimal engagement from non-surgical disciplines i.e. anaesthetists, theatre staff, nursing staff. A multi-disciplinary education day was organised in 2014 to try and rectify this which included a discussion on improved networking. This revealed an appetite to do this but showed a complex landscape of inter-dependencies. The lack of capacity for clinicians to take on leadership in this area and capacity and staff changes within the NoSPG team has resulted in a fragmented and uncoordinated approach which has meant the network has not developed further.

**Progressed During Last Year**

Little has been progressed in addition to the outreach services described above.

**Intentions for Coming Year**

The intention of the network was to increase joint working between the visiting paediatric surgeons and local surgeons by encouraging joint clinics and operating lists as well as increasing the teaching from visiting surgeons locally. There was also the willingness to consider rural team members rotating through the RACH and ensuring referrals are made to local services whenever feasible, rather than directly to the RACH. The aim overall is to facilitate the development of local skills in anaesthetic and nursing staff, as well as surgeons, and ensure new appointments in all these disciplines are competent in providing a quality service to children and young people out with tertiary centres.

The NoSPG team is undergoing a prioritisation process for its work programme and the GSC network will be reviewed as to its ability to add value in addition to the outreach services already provided above.

## 5.2.3. MCN for Specialist Paediatric Child Protection

**NoSPG Contacts**

- Dr Mike Bisset – Regional Medical Director
- Dr Joy Mires - MCN Clinical Lead
- Anne-Marie Pitt - MCN Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Outline**

Throughout the UK it has been difficult to retain a commitment to child protection from General Paediatricians, and it has been exceptionally difficult to recruit Paediatricians to train and specialise in Child Protection work. In response to these concerns about the sustainability of child protection specialist medical services, central funding was made available from the National Delivery Plan for Specialist Children's Services (NDP) to establish a Managed Clinical Network for child protection in the north of Scotland. The principle is that, wherever possible, children should be seen within their own locality and robust local inter-agency networks are essential. Although there is clear recognition of the importance of sustaining specialist medical services, it is acknowledged that the whole spectrum of clinical expertise in this area should be sustained and developed. A Child Protection Working Group was established in 2009 which formally became a Managed Clinical Network in February 2015.

**Progressed During Last Year**

The Steering Group have met 4 times between the period June 2015 and April 2016, and the Clinical Sub-Group have met 3 times during this period also. The network continues to focus on priority areas which have been highlighted by individual Health Boards or indicated as high risks on the risk register. Particular significant developments in the work plan this year have been:

- The production of a full year's data report (14/15) showing activity of child protection examinations throughout the region, consequent outcomes and learning from variances in activity. The collection of data has continued through the year for 15/16 activity data and is being considered by the other two regions to be collected across the country.
- The collaboration between NHS Grampian and NHS Orkney/NHS Shetland to establish training provided by the lead child protection doctor in NHS Grampian. This will deliver child protection

support to clinicians in Orkney and Shetland, establish closer working relationships that will allow more medical examinations to be carried out by GPs on the islands.

- Development of regional and national policies has progressed with regional guidance on the storage of intimate images agreed and a pilot established for a national examination proforma.
- Collaboration with the three regional MCNs is firmly established with a national training programme agreed and implemented and the national Complex Cases Forum continuing with the lead specialist from each Health Board meeting virtually for an hour monthly, allowing the specialists to discuss with their peers current complex cases for advice and support.
- The three MCNs have also worked with Scottish Government and the RCPCH to agree draft national standards for child protection medical examinations, competency requirements for specialists and national training and support requirements to meet the competencies.

**Intentions for Coming Year**

Areas for development this coming year include:

- Improving communication methods across the MCN and with stakeholders i.e. engaging with children, young people, their families and the third sector, producing a regular newsletter etc.
- Further developing secure systems of electronic storage for intimate images with IT and IT governance departments that can be rolled out across the country.
- Continuing to work with the other MCNs, Scottish Government, the RCPCH and Health Boards to develop quality indicators alongside the draft national standards and consequently facilitating quality performance measurement and improvement.
- Continuing to work with the other regional MCNs on national guidance and training programmes.
- Continuing to improve the collection of regional data and address variance in practice.

## 5.2.4. Neonatal Network

**NoSPG Contacts**

- **Steering Group Chair** Kerry Russell
- **Network Manager** Craig Millar (previous) /Cathy Grieve (current)
- **Clinical Lead** Ian Laing (previous) /Jane Couper (current)

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | N | NHS Western Isles | Y |

**Timeframe**

The North of Scotland Neonatal MCN is one of three regional Neonatal MCNs set up following the Maternity Services Review in 2011.

**Outline**

The North of Scotland Neonatal MCN Steering Group was re-established in 2015 and the group have continued to meet quarterly in the last year with good engagement from all the North of Scotland participating Boards. The group have recently established key priorities for the coming year and have set new aims and objectives.

**Progressed During Last Year**

The annual Neonatal Quality Framework submission was made to Scottish Government in December 2015 and the report was well received in the subsequent review meeting that was held in January 2016. The Neonatal Network was commended on its openness and transparency and clear commitment to improvement. The Clinical Lead and MCN Manager are continuing to progress actions to address the issues raised in the Quality framework responses.

In the latter half of 2015/16 the North of Scotland Planning Group, in partnership with the Scottish Government, supported an interim regional clinical Neonatal lead role, as part of the interim clinical leadership arrangements for the NHS Grampian Neonatal service. This role successfully led improvement and development work across both portfolios.

The Scottish Government have tasked the Neonatal Networks with identifying options for a neonatal cot locator system for Scotland as the current cot management systems are manual and time consuming. At a local level systems have been put in place by the previous clinical lead to improve communication between the units involved in the daily cot management call.

The MCN supported a one day Simulation Instructor course in March 2016 for Neonatal Units in the North of Scotland Network. A joint training plan is in the process of being developed with the NHS Education for Scotland to scope the use of the Mobile Skills Unit in the continued development of Simulation training for the North of Scotland.

The neonatal clinical guidelines used in the West of Scotland have now been implemented in Aberdeen and the Neonatal Steering Group will further support this work with other units in the North to adapt the guidelines to ensure they are suitable for smaller units.

The links with the other Neonatal Networks in Scotland remain strong with regular meetings re-established with the Neonatal MCN Managers in the East and West of Scotland.

**Intentions for Coming Year**

The Inter-regional group intend to develop and co-ordinate a National Parent experience questionnaire. A national website is also in the development phase.

The NoS Neonatal MCN will continue to contribute towards the planning of the new Maternity Hospital in Aberdeen, and working towards delivery of the agreed objectives for the Network.

## 5.2.5. North East Scotland Child & Adolescent Neurology Network (NeSCANN)

**NoSPG Contacts**

- Clinical Lead: Dr. Martin Kirkpatrick (Consultant Paediatric Neurologist, NHS Tayside)
- NoSPG support: Mrs. Carolyn Duncan (Child Health Network Manager)

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | N |

**Timeframe**

The North of Scotland Child and Adolescent Neurology Network (NeSCANN) has been in operation for 12

years delivering neurology, neurodisability and epilepsy in- and out-patient services across 5 Health Boards in the North of Scotland. The network was formalised following the injection of National Delivery Plan funding from 2008-2011, which is now embedded in the network and providing funding for various posts across medical, nursing and Allied Health Professions.

## Outline

The network is committed to ensuring the sustainability of the tertiary and local neurology services and it has been another very busy year providing patients and families with patient-centred, safe, efficient, timely access to those neurological services. Network clinics were delivered in Dundee, Perth, Aberdeen, Inverness, Orkney and Shetland. Use of video-conferencing has been used to deliver review clinics with NHS Orkney and on an ad hoc basis for clinical purposes with several centres across the region. Staffing pressures were challenging during the year due to medical staff vacancies and the lack of capacity within epilepsy nursing teams. However we were delighted to welcome back to Aberdeen Dr Vipin Tyagi, Consultant Paediatrician with a special interest, who will be working in Aberdeen and Dr Gray's in Elgin.

Staff continually review the models of care to make improvements to services provided across the wide geographical area in the north of Scotland. Multi-disciplinary teams of dedicated, experienced clinicians based in Royal Aberdeen Children's Hospital, Tayside Children's Hospital, Dundee and Raigmore Hospital, Inverness collaborate across health board boundaries on a daily basis to deliver the best quality care as close to patients' homes as possible. Patient safety is at the heart of the care provided and staff work hard to drive standards up and to ensure equity of service across the North.

The Network has defined links with other national networks – Scottish Paediatric Epilepsy Network, Scottish Muscle Network, Inherited Metabolic Disease Network etc., and has provided input into the National Review of paediatric epilepsy surgery and the Scottish Neurosurgery MSN.

## Progressed During Last Year

NeSCANN is committed to ensuring a highly skilled and trained workforce and again during the year a large number of learning and educational opportunities were provided. An excellent network study day incorporating topics on patient safety, neurophysiology, investigation of developmental delay and the ketogenic diet was held at Raigmore in September. In addition our network clinicians have been leading the distance learning Paediatric Epilepsy Training (PET) both nationally and internationally through the British Paediatric Neurology Association.

Professional support continues to be regularly available by way of formal and informal training opportunities and case discussions. One of the strengths of the network are the "enhanced" tertiary outreach clinics that provide more than just a simple visiting clinic. Monthly multi-disciplinary meetings take place in the 3 main centres providing teaching and education sessions, i.e.

- "Brainwave" (Ninewells) –available across the region by VC
- "Neurology Open Day" (Royal Aberdeen Children's Hospital)
- Raigmore Hospital, Inverness – lunchtime sessions alongside the visiting Consultant Neurologist clinics.

Good progress was made during the year on the network work plan which is continually performance managed by the traffic light system. A lot of collaborative work was undertaken during the year, e.g.

- Production of a network patient information leaflet for families.
- Publishing of a guide for families for using video-conference in an out-patient appointment.
- Review of network clinics following new clinical appointments.
- Network staff participation in the PIE study, Epilepsy 12, GACE and SANAD2 studies

**Intentions for Coming Year**

The lack of a fit-for-purpose data collection system is a long-standing issue for the network (as well as for other regional paediatric networks). It has been recognised for a number of years that there are highly likely to be clinical governance issues at times regarding access to patient information and the ability to make clinical decisions on patients' outwith their home Board. Clinician access to the 5 north Health Boards' IT systems such as Sci Store to sign/view clinical letters or to review test or EEG results is limited but is a slowly improving picture. It is hoped that discussions at the NoS e-Health Leads' Group will assist with resolution of some of these issues.

It has been a very demanding year for all multi-disciplinary team members in each of the main centres. Staff have been working extremely well collaboratively across the region during the year and will continue to ensure delivery of safe, efficient, effective, person-centred quality care in future

## 5.2.6. North of Scotland Paediatric Gastroenterology, Hepatology and Nutrician Network (NoSPGHANN)

**NoSPG Contacts**

- Clinical Lead: Ms Kathleen Ross (Lead Paediatric Dietician, NHS Grampian)
- NoSPG support: Mrs. Carolyn Duncan (Child Health Network Manager)

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | N |

**Timeframe**

The North of Scotland Paediatric Gastroenterology, Hepatology and Nutrition Network (NOSPGHANN) has been in operation for over 12 years and was formally established following National Delivery Plan funding from 2008-11. Clinicians support children and young people with problems of the gastrointestinal tract, the liver and complex nutritional issues across 5 North of Scotland Health Boards.

**Outline**

Multi-disciplinary teams of doctors, nurses, dieticians, psychologists and other allied health professionals are based in Royal Aberdeen Children's Hospital, Tayside Children's Hospital, Dundee and Raigmore Hospital, Inverness delivering in- and out-patient services. Network clinics were delivered in Aberdeen, Elgin, Shetland, Dundee, Perth and Inverness during the year. Good use is also made of video-conferencing across the region for clinical purposes to review patients or for case discussions e.g. with Wick, Skye, Fort William, Ballachulish and Shetland. Aberdeen nursing staff has also set up weekly telephone clinics with families which have been very well received.

Staffs work in a collaborative environment and are proud of the excellent team working, communication and relationships that have been built up over the past 12 years. Staff continually strive to drive up standards and to ensure they provide the best quality of care safely and timeously across the North of Scotland whilst working in partnership with patients and families to enable them to better manage their conditions. Provision of a highly trained workforce continues to be very important and the network encourages staff training and education through formal and informal educational opportunities, case discussions and cross boundary working, e.g. weekly MDT in RACH and Ninewells and monthly case

discussions in Raigmore.

**Progressed During Last Year**

The network medical workforce experienced challenges during the year. Dr Bisset took up the post of Regional Medical Director for the North of Scotland Planning Group in April and a 5 PA post was advertised but was unable to be recruited to. However Dr Gamal Mahdi (previously employed by NHS Grampian) agreed to carry out this post on a flexible basis and was very successful in undertaking a large number of additional out-patient clinics and theatre endoscopy sessions resulting in the reduction of waiting times. Dr Sabari Loganathan sadly moved back to Nottingham in January however a Locum Consultant, Dr Savvas Karkelis joined the team in Aberdeen to assist until the substantive post is filled in summer 2016. Both dietetic services in Aberdeen and Dundee have experienced staffing pressures due to absences and vacancies but services were delivered as best as possible despite the lack of staff.

Numbers of chronically ill gastro & hepatology patients continue to rise year on year, many with Inflammatory Bowel Disease (IBD) are now on biologics therapies which are very time consuming for professionals to administer.

**Intentions for Coming Year**

Workforce capacity in relation to the above and more generally across the network has become increasingly challenging and work will be undertaken to review requirements in the coming year.

The lack of a database to collect data on network patients continues, which is also the case for other NoS child health networks. Access to other Health Boards' IT systems to check test results or sign clinical letters when a clinician is based in their home Board is improving however there are still challenges with this and it is hoped that the NoS e-Health Leads' Group will be able to assist in resolving some of these issues.

It has been an extremely busy year for the multi-disciplinary teams however the work has been carried out by a flexible workforce and it is hoped that appointment to the Consultant vacancy in Aberdeen will put the network in a good position to take the network forward positively next year. The excellent team working across the region continues to ensure provision of safe and sustainable services for patients.

## 5.2.7. North of Scotland Paediatric Respiratory Network (NoSPRN)

**NoSPG Contacts**

- Dr Jonathan McCormick, Clinical Lead (Consultant in Paediatric Respiratory Medicine, NHS Tayside)
- Carolyn Duncan, Child Health Network Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | N |

**Outline**

The North of Scotland Paediatric Respiratory Network delivers specialist inpatient and outpatient care including the diagnostic testing and monitoring of respiratory patients across the 5 NHS boards in the North of Scotland.

Tertiary and secondary care multi-disciplinary clinicians work collaboratively to deliver, to develop, and to sustain services for children with respiratory conditions as close to their homes as possible. The NOSPRN has helped link the teams delivering these services with the aim of providing mutual support and further professional development for the benefit of patients.

**Progressed During Last Year**

In 2015, the network continued collaborative working to harmonise patient protocols and patient information leaflets, with small groups of individuals tackling different projects. The NoSPRN Respiratory Specialist Nurse Group, CF Specialist Nurse Group and the Physio Group met during the year to discuss staffing, equipment, care pathways, protocols, training and the sharing of information across the network. These sub-groups provide a very positive environment for professionals to access support and advice from colleagues by way of videoconference.

A proposal by Dr McCormick to create an innovative videoconference ventilation meeting on a quarterly basis was accepted by RHSC Edinburgh. This meeting was set up to discuss and communicate on North of Scotland Long Term Ventilation (LTV) patients' annual reviews. The forum has proved to be an excellent way for clinicians to keep up-to-date with the treatment plans that have been initiated and continue to be managed by Edinburgh after the patients return home to the North. It is hoped that this meeting will evolve into a pan-Scotland meeting in future.

Specialist visiting clinics were run in Portree (CF only), Raigmore (CF and Respiratory), Orkney (Respiratory) and Shetland (Respiratory) with respiratory clinics continuing in Dundee, Aberdeen, Elgin and Perth. Nurse-led asthma clinics are also held in Grampian and Tayside with a joint consultant/nurse clinic in Inverness.

Staffing absences across physiotherapy, nursing, dietetics and admin continued to be a major challenge during the year, due to departures for career progression, sick leave and maternity leave. However this is an improving picture from the end of 2015 with vacancies having been filled and staff returning to work. There was continued pressure on CF teams with a significant increase again from previous years in newly diagnosed babies in all areas during 2015.

**Intentions for Coming Year**

The NOSPRN is committed to ensuring a skilled workforce and a range of training opportunities for staff were available to staff during the year, e.g. respiratory teaching, complex respiratory case discussions, CF annual review meetings, which were all available by video-conference across the network. A successful CF Away Day was held in Inverness in October that was attended by the multi-disciplinary teams from the three major centres.

Network staff continued to be involved in national and international research and audit projects, from local initiatives to accepting proposals for network-wide participation, as well as attending and participating at international conferences.

## 5.2.8. Paediatric High Dependency Care Network

**NoSPG Contacts**

- Anne-Marie Pitt, Child Health Network Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |

| | | | | | |
|---|---|---|---|---|---|
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | N |

**Outline**

A regional network was established in 2012, following recommendations in the national High Dependency Care Audit 2009, to support the sustainability of the HDC Units in the north. Significant investment has been provided to support paediatric high dependency care (HDC) throughout the region, via the National Development Plan for Children's Specialist Services funding (NDP). This has resulted in an increased capacity for children and young people to receive more locally provided care (e.g. establishment of high dependency care beds at Raigmore Hospital in Inverness).

The network manager carried out an initial scoping exercise to ascertain the provision of high dependency care in DGHs in the north and levels of training and support available to DGHs. Staff working within this area were brought together on several occasions to ascertain the support for a network and priority areas of working together. It was agreed by the group that, although they were willing to meet as a virtual group, they did not wish for a formal network to be developed. This was mainly due to the need to maintain existing networks with the paediatric intensive care units in Edinburgh/Glasgow. However, there were concerns that could be progressed together, such as critical care transfers and education & training.

**Progressed During Last Year**

It was agreed that the highest priority for co-ordination through the network was the safe inter-hospital transfer of critically ill children across the north of Scotland. During 2015 it became evident that the risks to safe transfer for critically ill children were similar to the risks for critically ill adults, including those with major trauma. Consequently members of the network have been working with the North of Scotland Major Trauma Pre-Hospital, Transfer and Retrieval Group to establish a case for change to the existing transfer and retrieval systems in the north of Scotland.

In addition to regional networking there was increasing agreement that quality improvement and training and education in high dependency care should be co-ordinated across Scotland in respect to agreeing national audit, performance measurement indicators and organising training for staff. Consequently an Inter-Regional HDU Group has been established, where the three regional networks are working together to improve paediatric high dependency care in non-tertiary settings i.e. District General Hospitals and Rural General Hospitals. Representatives from the NoSPG network contribute and distribute information from this national group which, during 2015/6, has included a national definition of HDC in Scotland and an audit of the top five HDC conditions (policies and admissions).

**Intentions for Coming Year**

The regional network will need to agree if there are developmental priorities which can be achieved working across the north of Scotland or whether the main focus should be to contribute to the inter-regional group and national audits, training and development.

From a national perspective the west of Scotland has been piloting an audit using the national HDC definition with the intention of each of the regional networks carrying out the audit during 16/17. This will be the first time a national audit has been carried since 2009 and hopefully will lead to recommendations for improvement in District and Rural General Hospitals. At this stage the data is collected manually but the intention is that through 2106 a way to collect the data electronically through existing systems will be pursued.

## 5.3. North of Scotland Cancer Network (NOSCAN)

### NoSPG Contacts

- Lesley McLay – Chief Executive NHS Tayside and NOSCAN Chair
- Mr Sami Shimi – Consultant Surgeon, NHS Tayside and NOSCAN Clinical Lead
- Keith Farrer – NOSCAN Network Manager

### Participating Boards

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

### Finances

Funding held by NoSPG

### Outline

First established in 2001 to co-ordinate the work of regional cancer MCNs that were at that time being developed in response to NHS MEL (1999) 10, the North of Scotland Cancer Network (NOSCAN) is one of three Scottish overarching regional cancer networks that each work through a series of smaller tumour or other cancer-specific regional and national networks, to facilitate communication and encourage partnership working wherever possible.

As such, NOSCAN promotes wherever possible:

- High standards of safe cancer care
- Equity of access to cancer services
- Cancer services that meet the need of all patients across its administrative area, and supports;
- Partnership working across traditional organisational and professional boundaries
- Involving patients in the planning of cancer services
- Strategic cancer planning that is more regionally-co-ordinated to individual Board requirements and national drivers
- Clinical audit as a tool to improve the quality of cancer services.

Whilst its principal remit continues around better co-ordinating and improving the quality of cancer services in its designated Board administrative areas, more recently (and in line with its two partner regional networks SCAN and WoSCAN), NOSCAN has been nationally afforded through the national Cancer Quality Improvement Strategy, a much more defined regional Quality Assurer role for some of the cancer specific services that are presently Board provided in the North of Scotland.

### Progressed During Last Year

The role having sat vacant for the preceding 14 months, July 2015 saw the conclusion of the wider NoSPG reorganisation and the appointment of Keith Farrer as NOSCAN Manager following which stalled work on identifying and progressing the regional cancer priorities was recommenced.

Around the same time, Mr Sami Shimi (NHST) was appointed succeeding Clinical Lead following standing down of Mr Peter King (NHSG) in April 2015

Early 2016 saw the position of Regional Cancer Audit and information Manager (Christine Urquhart, NHSH) being extended for a further 12 months. This provided an opportunity to explore the early development and further consolidation of the progress that had been regionally made earlier around co-ordination of Board QPI reporting and a greater analytical understanding of cancer outcomes in the NoS

Appointment of TCAT Lead Clinician (Jackie Roger, NHST), TCAT Project Manager (initially Craig Millar on secondment until latterly succeeded by Julie Gowans) and formal establishment of a TCAT Project Board. [See separate report]

Earlier started work to evaluate regional SACT CEL compliance was recommenced e: work had been suspended for a time pending appointment of NOSCAN manager. Consequent to need for accelerated programme of remedial work identified still outstanding, and lack of regional resource available to take on at that time, NOSCAN Manger and MCN Manager travel embargoed during early 2016 to ensure completion.

NOSCAN Chair and Manager visit to NHS Orkney.

**Intentions for Coming Year**

Secure position of Regional Cancer Audit and information Manager in longer term: present funding runs out in February 2017

Completion of first peer review and initial quality audit of chemotherapy services in the NoS

Completion of a programme to identify and develop initial sets of regional Clinical Management Guidelines (CMG) for all of the principle cancer/tumour types

NOSCAN Senior Team visits to each of NHS Shetland and NHS Eileanan Siar (Western Isles)

Timeframe

12 months

## 5.3.1. Breast MCN

**NoSPG Contacts**

- Neil McLachlan – NOSCAN MCN Manager
- Mr Douglas Brown – NOSCAN Clinical Lead: Breast Cancer (Confirmed in post August 2015)

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Finances**

No funds allocated/held

**Outline**

Though there is only very limited diagnostic or therapeutic intervention that continues to be locally provided on island Boards/at DGH level across the NoS, Breast cancer generates a high volume of clinical activity overall in the NoS. In part this is due to improved early detection and earlier first intervention, but also, for many patients the treatment pathway can be considerably prolonged due to the expanded number of therapeutic options now available.

Prior to 2014, there was no formalised regional Breast MCN/Group and any active demonstration of regional collaborative or network working in the NoS was essentially minimal: the three principle service providers in the NoS functioned independently with only very limited interface which sometimes resulted

in a disparity of service quality or accessibility for patients which was no longer tolerable. The introduction of mandatory annual QPI reporting has therefore brought a more formal requirement for Boards and their teams to demonstrate a quality and consistency of care for patients that were not previously evident.

After a slow start, the last 2 years has seen the formal establishing of a functioning Breast Cancer MCN in the NoS: the role of Breast Lead has been more properly established during 2015, and there has been clear demonstration of improved clinical engagement and of the principles of quality improvement through regional collaboration and joint working having been embraced. Whilst good work has been achieved to date, considerable further work remains to be addressed particularly around ensuring service resilience.

**Progressed During Last Year**

- Full engagement and participation with national partners in pilot HIS reviews of Breast QPI process
- Consolidation of QPI Action Planning for Breast Cancer
- Initial Development of a regional Clinical Management Guideline (CMG) for Breast Cancer has been progressed well and presently nears its completion

**Intentions for Coming Year**

- First national HIS Review of Breast QPI reporting (due June 2016)
- Completion and implementation of CMG including stratification of aftercare and follow-up in line with TCAT principles
- Hosting of Collaborative Networks National Breast meeting (in February 2017) as part of national Cancer Quality Improvement Programme – subject to senior NoSPG approval
- Review of MDTs to consolidate shared principles across the network

**Timeframe**

12 months

## 5.3.2. Colorectal (Bowel) MCN

NoSPG Contacts

- Neil McLachlan – NOSCAN MCN Manager
- Mr Malcolm Loudon - NOSCAN Clinical Lead: Colorectal Cancer

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Finances**

No funds allocated/held.

**Outline**

Predominately a condition of older age, Colorectal cancer constitutes a considerable volume of clinical activity for all 6 NoS Boards, be that from first investigation and initial diagnosis, to therapeutic intervention and aftercare. Furthermore, due to their being sufficient clinical staff with the specialist skills required to locally provide much of the surgical and nearly all non-surgical interventions network required, there is presently limited requirement for the MCN to consider any further around the regional centralisation of the more specialist clinical interventions required beyond that already achieved.

That being said, it remains at times difficult to ensure that the high volume of diagnosis and/or therapeutic interventions presently required in the NoS are consistently able to be timely delivered within the deadlines nationally demanded.

With the imminent move of Bowel Screening from FOB to FIT, it is presently envisaged that there may be some longer opportunity for service economy (or alternative resource utilisation), however as increased numbers of systemic treatments also become effective and more readily available, so likely will the numbers of patients and their expectations for intervention in the NoS also become more. Clarifying and reconciling the resource implications within the staff and skills network available is likely to be the focus of immediate future MCN activity

**Progressed During Last Year**

Mr Malcolm Loudon concluded his term of office as NOSCAN CRC Lead in March 2016 after 5 years of very diligent and active leadership of the MCN, during which time good links have been established with MCN counterparts in both SCAN and WoSCAN, and enthusiasm established for closer and more joint national approaches to some areas identified in potential need of quality improvement

Unfortunately Board and clinical engagement has been more lacking at times over the last year with work delaying consequences, particularly around the review of the regional CMG for CRC.

More positive however, has been the recognition that due to the small numbers annually presenting, and the need for more sub-specialised clinical expertise to be involved, the management of patients with either Anal Cancer and/or relapsed pelvic disease needs to be more regionally addressed in the NoS.

Similarly, the remote supervision of patients domiciled in the W.Isles and Highland whilst receiving SACT by Oncologists based in NHSG over the last 18-24 months has not only worked well and been well tested, but has also been favourably received by the patients concerned.

**Intentions for Coming Year**

- Complete CMG revisions and updates
- Submit annual QPI report and prepare Action Plan
- Further explore around regional preferred model of care for patients with Anal Cancer or relapsed pelvic disease
- Through advanced data analysis and clinical discussion, further explore on the variation in neo-adjuvant treatment across the NoS and the implications for patient outcomes.
- Preparation for HIS triennial review of CRC QPI process

**Timeframe**

12 months

## 5.3.3. Gynaecological MCN

### NoSPG Contacts

- Neil McLachlan, NOSCDAN MCN Manager
- Lead Role – NOSCAN Clinical Lead: Gynaecological Cancer [currently vacant/unable to recruit]

### Participating Boards

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | N/A* |

*The pathway for NHS WI patients with a gynaecological malignancy is to NHS GG&C/WoSCAN

### Finances

No funds allocated/held

### Outline

The NoS Gynaecology Cancer MCN provides a forum for female reproductive cancers and its five main Tumour Sites (i.e. Cervix, Endometrium, Ovarian, Vagina, Vulva), the latter two in comparison being of much lower incidence. Whilst some aspects of these disease management are delivered locally in each NoS Board as appropriate, in recognition of the quality advantages, more complex GO care is increasingly being confined to being provided in Aberdeen only, but with some visiting service provision in each of Dundee and Inverness where identified clinically appropriate

As a network, NOSCAN Gynae cancer MCN has been without a formal lead for more than a year following the standing down of the last incumbent and inability to recruit a replacement. However, excepting for vagina, each of the five anatomical/cancer sub-types has a sub-group lead group identified to co-ordinate relevant QPI reporting (Cervix, Endometrium & Ovary only) as well as any other tumour-specific work (such as around Clinical Management Guidelines or pathways)

### Progressed During Last Year

- First reporting of QPIs for Ovarian (in July 2015), and preparation for first reporting of QPIs for Cervix and Endometrial cancer (both due May 2016)
- Completion of SLWG recommending on a preferred regional service model for future provision of specialist Gynaecology Oncology in the NoS
- Sub-Group commissioned to identify and work on weekly MDT improvements required

### Intentions for Coming Year

- Second reporting of QPIs for Ovarian (in July 2015)
- First reporting of QPIs for Cervix and Endometrial cancer (both due May 2016)
- The position having sat vacant now for over 12 months, a priority for this year will to be to recruit an MCN Lead: the restoration of clinical enthusiasm and leadership that will re-invigorate the work required of the MCN will be invaluable to ensuring its future success.
- The good functioning of the MCN will also be essential to supporting and facilitating the identification and implementation of any new regional pathways that might arise as a consequence of the new Baird Family Hospital opening in Aberdeen (presently scheduled for 2020)
- Pre-requisite to this however, will be the smoother functioning of the weekly regional MDT,

| |
|---|
| particularly around the cross boundary e-sharing of supporting clinical information with partner providers and Primary Care |
| Timeframe |
| 12 months |

## 5.3.4. Haematological MCN

**NoSPG Contacts**

- Neil McLachlan – NOSCAN MCN Manager
- Dr David Meiklejohn – NOSCAN Clinical Lead: Haematological cancer

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Finances**

No funds allocated/held

**Outline**

The NoS Haematology Cancer MCN provides a forum for malignant blood disorders and as such encompasses a number of quite distinct disease conditions, each with its own patient/treatment pathways and range of therapeutic options. Whilst some aspects of care can be delivered locally across each NoS Board as appropriate, in the main all of the more acute and complex care is provided in the principle mainland centres only: there is some limited visiting or outreach service provision to more local mainland or island centres, but in the main all specialist clinical activity takes place in Dundee, Aberdeen and Inverness only.

Regional co-ordination and quality improvement work required led by the Haematology MCN to date is quite different to that requiring led or co-ordinated by other NOSCAN cancer MCNs. In part due to the relatively small number of clinicians nationally involved, but also because almost the entirety of specialist clinical care for this group of patients is delivered within the confines of the haematology services only (ie there is minimal surgical or radiological intervention applicable), much of the clinical consensus and other work regionally required is identified or agreed via other professional or research forum.

Consequently the haematology MCN meets only as a small co-ordinating core group three times each year to formally reflect and consider local departmental or service progress against QPI and other performance monitoring, a continuing area of concern being around ensuring the appointment of consultant grade clinical staff in NHS Highland.

**Progressed During Last Year**

Completed programme of regional CMG development

First reporting and Action Planning for Lymphoma QPIs and preparation for first reporting of Acute Leukaemia QPIs: Dr Catherine Ogilvie (NHS Highland) to clinically lead

**Intentions for Coming Year**

Mr David Meiklejohn whose enthusiasm and leadership in steering the work of the MCN over the past three years has been invaluable in ensuring identification of all the regfional CMGs required concludes his term of office Sept 2016. Consequently, an immediate MCN priority will to be to appoint a succeeding Haematology Lead

First reporting and Action Planning for Acute Leukaemia QPIs and second reporting of Lymphoma QPIs

**Timeframe**

12 months

## 5.3.5. Head and Neck MCN

**NoSPG Contacts**

- Neil McLachlan – NOSCAN MCN Manager
- Vacant (not presently funded) – NOSCAN Clinical Lead: Head & Neck Cancer

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Finances**

No funds allocated/held

**Outline**

Head & Neck cancer is a collective term encompassing several quite distinct and separate malignant conditions affecting either/both the head & neck, and which due to a combination of anatomical site of primary, sometimes rapid alteration in the severity of patient symptoms, the need in many cases for patients to receive complex and potentially disfiguring surgery and/or prolonged radiotherapy within short windows of therapeutic opportunity, can all combine to present considerable challenge for all concerned

Traditionally associated with a fairly well defined patient group, in recent years due to evolving societal and personal lifestyle choices this has changed to include not only wider social and professional/age groups, but also who now also tend to have much heightened expectations for their clinical outcome than was perhaps previously the case.

It is only since the inception of cancer QPIs that the need for a regional network arrangement for Head & Neck Cancer in the NoS has become more apparent. Furthermore, it is only within the last year that clarity has been reached on how the governance of such a regional network for Head & Neck Cancer could be appropriately governance arranged within the other pre-existing Board and regional structures. As such, a first NOSCAN Head & Neck Cancer Lead has still to be appointed, but the early engagement required has so far been established, and potential areas for future collaborative working are beginning to be identified

**Progressed During Last Year**

- Led by Mr Michael Rogers, Consultant Otolaryngologist NHS Highland, the first Head & Neck QPIs reporting completed – report published by ISD in March 2016
- Clarification of regional group Terms of Reference and reporting arrangements
- Work commenced on first round of regional CMGs for Head & Neck Cancer (i.e. Anterior Tongue Cancer, Laryngeal Cancer, Nasopharyngeal Cancer, Oral Cavity Cancer, Sinonasal Cancer, Oropharyngeal Cancer)

**Intentions for Coming Year**

- Appointment of Group Lead to be secured
- Preparation for 2nd Head & Neck QPIs reporting and 1st year Action Planning
- Regional group CMG formal sign-off

**Timeframe**

12 months

## 5.3.6. Upper Gastrointestinal MCN

**NoSPG Contacts**

- Neil McLachlan – NOSCAN MCN Manager
- Mr Sami Shimi – NOSCAN Lead Clinician: Upper GI (OG) Cancer

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Finances**

No funds allocated/held

**Outline**

The decision made some years ago to nationally establish a hepatopancreobiliary (or HPB) MCN that concerns itself with the 'non-luminal' Upper Gastrointestinal cancers, NOSCAN Upper GI MCN provides a forum for cancer of the oesophagus and stomach only.

As such, the numbers of patients and volume of clinical activity is comparatively small when compared to some of the more common cancers (such as lung or prostate for example). Furthermore, patients often present late, or with disease that is already advanced or incurable resulting in poor prognosis and very limited therapeutic options. Consequently, clinical activity predominately is concentrated around initial investigation and first treatment only.

A continuing debate ensues nationally around the low numbers of patients being offered curative surgery in the NoS. Furthermore, there is a drive (as reflects international trends) to rationalise the number of sites where that highly specialised and technically challenging surgery should be provided. Over recent years, considerable good work has been led by the MCN to identify and prepare transition of existing Board arrangements to a preferred regional NoS service model. This has included work during

the period of this report towards the establishing of a weekly regional OG MDT that will underpin any future service model that finally emerges.

**Progressed During Last Year**

- Preparation work on establishing a weekly regional MDT
- QPI reporting and Action Planning for Cancer of the Oesophagus and Gastric Cancer
- Commenced recruitment for succeeding Clinical Lead: incumbent term of office ended during 2015

**Intentions for Coming Year**

- Confirm succeeding Clinical Lead in post (due to commence Sept 2016)
- Consolidation and further development of the weekly regional MDT
- Hosting of Collaborative Networks OG Meeting scheduled for 4th November 2016 (Perth)
- Continued QPI reporting and Action Planning for Cancer of the Oesophagus and Gastric Cancer
- Preparation for Triennial HIS Review of Oesophageal and Gastric Cancer QPI Reporting Process

**Timeframe**

12 months

## 5.3.7. Urology MCN

**NoSPG Contacts**

- Derick Macrae, MCN Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Outline**

This MCN compromises a forum for Urology and its four main Tumour Site of Prostate, Urethelial (Bladder), Upper Tract (Renal) and Testes each of which has a Tumour Site Lead and Sub group with representation for each Board.

**Progressed During Last Year**

This MCN compromises a forum for Urology and its four main Tumour Site of Prostate, Urethelial (Bladder), Upper Tract (Renal) and Testes each of which has a Tumour Site Lead and Sub group with representation for each Board.

The NOSCAN MCN hosted the 1st National Urology Meeting and QPI review on 31 March 2016. The introduction of the Robotic Prostatectomy Service in Aberdeen has been managed at the MCN. The MCN also progressed the development of several Clinical Management Guidelines:

1. Testes
2. Renal
3. Bladder:
   Advanced Bladder Cancer First Line
4. Prostate
   General

| | |
|---|---|
| Advanced Bladder Cancer Second Line | Adjuvant Therapy after Primary Radical Therapy |
| Muscle Invasive Non Metastatic | Local Relapse after Primary Radical Therapy |
| Non Muscle Invasive Bladder Cancer | Palliative Therapy in Metastatic Disease |
| | Active Surveillance |
| | Brachytherapy |

**Intentions for Coming Year**

A priority for this year will to be to recruit a replacement for Mr Chris Goodman who retired in May 2016. His enthusiasm and leadership in re-invigorating the work of the MCN over the past two years has been invaluable.

The MCN will also be used to facilitate the participation of the North of Scotland Urology Departments in the National Review of Urology which is expected to conclude at the end of 2016.

## 5.3.8. North of Scotland Skin MCN

The Regional Clinical Lead has been appointed and begins September 2016. The first regional network meeting is scheduled to take place in November 2016.

# 6. Regional Services

## 6.1. Regional Mohs micrographic surgery service

**NoSPG Contacts**

- Lead Clinician: Dr Colin Fleming, Consultant Dermatologist, NHS Tayside
- Manager: Mrs Wendy Croll, Clinical Services Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Outline**

Mohs surgery is a technique involving microscopically controlled surgery used to treat common types of skin cancer. During the surgery, after each removal of tissue, while the patient waits, the Mohs surgeon examines the tissue specimen for cancer cells, and that examination informs the surgeon where to remove tissue next. The Macmillan Mohs micrographic surgery service is hosted by NHS Tayside and has been funded regionally since 2007.

Mohs is a cost effective treatment, particularly for recurrent or aggressive tumours, which are one of the main types of tumour treated in Dundee. This cost effectiveness comes from a reduction in further operations and treatment in comparison with standard procedures; and from a reduction in tissue removed in four out of five cases, which reduces reconstruction requirements.

## Progressed During Last Year

During 2015, four hundred and five patients were provided the Mohs service and it is anticipated the workload will maintain at the three hundred to three hundred and fifty level for each of the next five years.

NHS Grampian and NHS Tayside are the two largest referrers to the service. Dr Sanjay Rajpar, a Grampian based consultant dermatologist, joined the Mohs surgical rota to support the development of, and increasing demand for, the service. The introduction of a third operating day from April 2014 has had a considerable benefit on waiting times, currently at three weeks. The reputation of the service has attracted successive post CCT trainees from Singapore, at no cost to NHS Tayside, which assists in cost effective service delivery. Funding to provide the required third surgical list per week was supported by NOSPG and commenced in April 2014.

## Intentions for Coming Year

Challenges for the service continue to be the rising incidence of skin cancer, ageing population, increased recognition of Mohs technique, and increasing indications for Mohs.Priorities for the service over next 12 months are to explore the role of confocal microscopy in improving service delivery, continue current level of waiting times for treatment, continued training of new colleagues in the biomedical scientist support group, and to continue to lead nationally on the development of UK standards for Mohs surgery and development of an exam for UK Mohs histo-technologists.

# 6.2. MCN for Eating Disorders (North of Scotland)

## NoSPG Contacts

- Lead Clinician: Dr Jane Morris, Consultant Psychiatrist, NHS Grampian
- Manager: Mrs Linda Keenan, Manager MCN – Eating Disorders, NHS Grampian

## Participating Boards

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

## Finances

| MCN FOR EATING DISORDERS | Annual Budget | YTD Budget | YTD Actuals | YTD Variance | Period Budget | Period Actuals | Period Variance | Period Estab | Avg Wte | Period Wte |
|---|---|---|---|---|---|---|---|---|---|---|
| MISC INCOME - NHS SCOTLAND | (74,094) | (74,094) | (71,513) | (2,581) | (6,175) | (9,666) | 3,492 | 0.00 | 0.00 | 0.00 |
| **MISCELLANEOUS INCOME** | **(74,094)** | **(74,094)** | **(71,513)** | **(2,581)** | **(6,175)** | **(9,666)** | **3,492** | **0.00** | **0.00** | **0.00** |
| MEDICAL & DENTAL | 43,691 | 43,691 | 42,984 | 707 | 3,641 | 3,641 | 0 | 0.30 | 0.30 | 0.30 |
| ADMINISTRATIVE SERVICES | 62,477 | 62,477 | 60,284 | 2,192 | 5,206 | 4,687 | 519 | 1.60 | 1.52 | 1.40 |
| **PAY** | **106,168** | **106,168** | **103,268** | **2,900** | **8,847** | **8,327** | **520** | **1.90** | **1.82** | **1.70** |
| EQUIPMENT COSTS | 500 | 500 | 232 | 268 | 42 | 54 | (13) | 0.00 | 0.00 | 0.00 |
| TRANSPORT COSTS | 5,300 | 5,300 | 3,125 | 2,175 | 442 | 6 | 435 | 0.00 | 0.00 | 0.00 |
| ADMINISTRATION COSTS | 1,600 | 1,600 | 725 | 875 | 133 | 0 | 133 | 0.00 | 0.00 | 0.00 |
| **NON-PAY** | **7,400** | **7,400** | **4,082** | **3,318** | **617** | **61** | **556** | **0.00** | **0.00** | **0.00** |
| **MCN FOR EATING DISORDERS** | **39,474** | **39,474** | **35,837** | **3,637** | **3,290** | **(1,278)** | **4,568** | **1.90** | **1.82** | **1.70** |

## OUTLINE

The Managed Clinical Network (MCN) drives provision of high quality specialist services across the North of Scotland. The MCN steers creative developments in the field and identifies, and manages, areas where improvements can be made.

A comprehensive documentation of the MCN's year can be found at:
www.eatingdisorder.nhsgrampian.org

## Progressed During Last Year

Due to a variety of reasons, including ill health within the team, the MCN has been slightly quieter than previous years. Despite activities being curtailed the network still made progress- many training days, visits and events continued.

Following sick leave and the sad death of our beloved colleague Dr Yvonne Edmonstone, the Highland Eating Disorders (ED) service has been without a Consultant Psychiatrist for eighteen months, despite advertising for substantive or locum appointments. The unexpected bereavement, however, highlights the difficulties in recruiting specialists in the absence of explicit planning which the MCN actively been trying to address. Tayside Eating Disorders service have also had challenges recruiting staff to their service. There is no specialist ED service in the Island Health Boards, so in a recent MCN innovation, clinicians bring their cases to an Islands Monthly Consultation Group, using VC to link Western Isles, Orkney and Shetland with the MCN Offices. This service has received enthusiastic feedback.

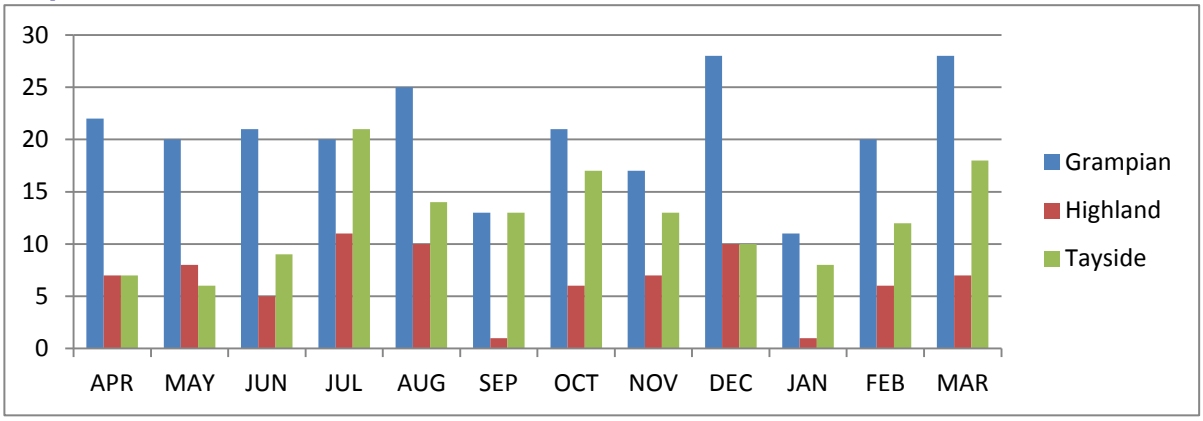
The Scottish Eating Disorder Interest Group (SEDIG) hosted a one day Conference in the Scottish Parliament which was, in part, organised by Linda Keenan and the SEDIG Committee of which she is a member.

Eating Disorders Education and Training Scotland (EEATS) operates from within the North of Scotland MCN and provides a nationwide syllabus. In the North of Scotland, a total of 20 clinicians are Accredited or Re-accredited on the training, with a further 4 currently undergoing the accreditation. The NHS Highland team can be considered the 'flagship' in terms of virtually all their clinicians having EEATS accreditation.

The MCN maintained close relationships with our CAMHS colleagues including supporting their conference through EEATS. The MCN manager sits on the Scottish Eating Disorder Interest Group (SEDIG) and contributes to their events and conferences. The MCN Clinical Lead is Chair of ScotFED, the Faculty of Eating Disorders of the Royal College of Psychiatrists in Scotland.

## Clinical Activity (Split by NHS Board of residence of patient)

### Outpatient services



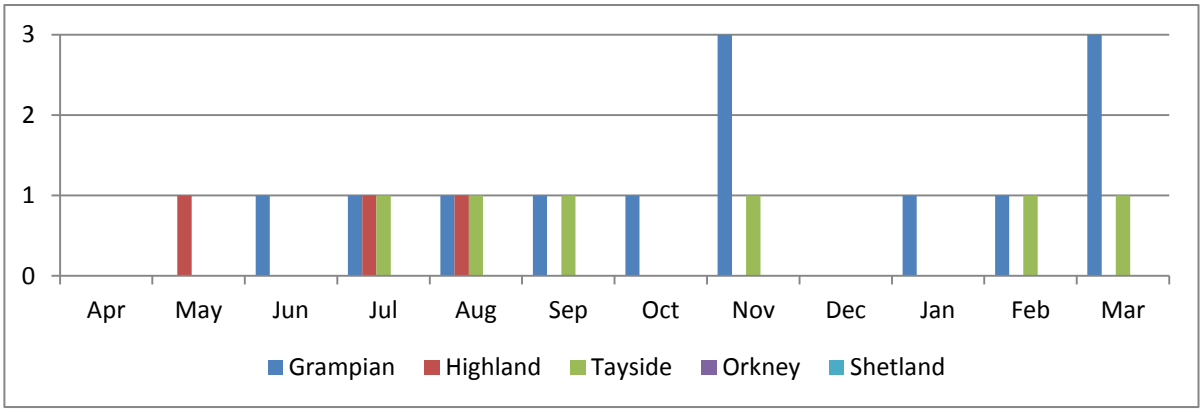

to

Outpatient Services referrals – Apr 2015 – Mar 2016

*NB No figures available for Islands, as eating disorder patients usually seen within general services*

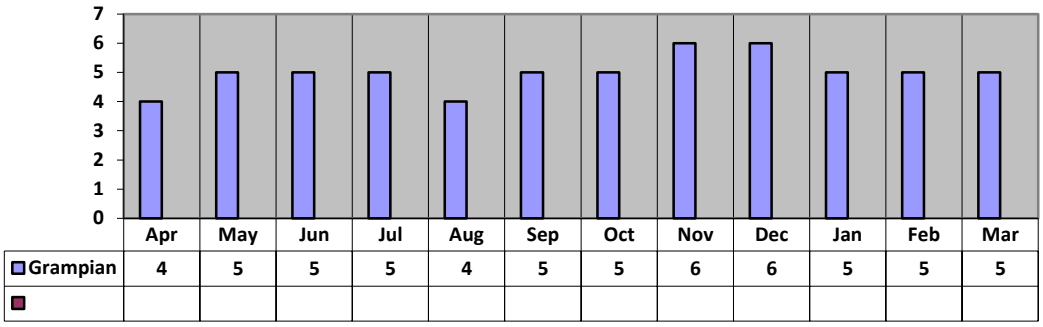
**Inpatient and Day Programme Activity, Regional Unit (Eden Unit)**

Admission to Eden Unit – April 2015 – Mar 2016




**Day patients**

Day Patient Activity by month - Apr 2015 - Mar 2016




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Grampian | 4 | 5 | 5 | 5 | 4 | 5 | 5 | 6 | 6 | 5 | 5 | 5 |
| | | | | | | | | | | | | |

## Intentions for Coming Year

Some of the regular annual visits to Health Boards have been delayed this year, largely because of staffing difficulties but all sites have been offered dates for the forthcoming year. The MCN visits provide invaluable teaching and discussion opportunities.

The next SEDIG meeting will host a research review, main floor talk and a carers' stream and will be held in Autumn 2016.

It has been recently decided to undertake a ten year review of the work of services within the MCN. This will allow modifications to protocols and practice in the light of experience and evidence. The first subgroup meeting has been held to start planning.

## 6.3. Regional Medium Secure Care Services, Rohallion Clinic

### Contacts

- Mrs Barbara Wilson, Regional Service Manager (NHS Tayside)
- Dr Alistair Hay Consultant Psychiatrist and Lead Clinician, (NHS Highland)

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Yes | NHS Highland | Yes | NHS Orkney | Yes |
| NHS Shetland | Yes | NHS Tayside | Yes | NHS Western Isles | No |

**Finances**

The table below details the overall financial contribution per Health Board to the Rohallion Clinic, the annual income returned to each health board as a result of ECR income and non recurring efficiency savings. The savings in total for 2015/16 was £1,059,000.

**Table 1**

| **Health Board Contributing** | | NHS Grampian | NHS Tayside | NHS Highland | NHS Orkney | NHS Shetland | **Total** |
|---|---|---|---|---|---|---|---|
| **Current contribution overall to Rohallion per Health Board** | £k | 3,230 | 2,645 | 960 | 74 | 74 | **6,983** |
| **Annual Income returned as a result of providing beds for Other Scottish Boards** | £k | -408 | -334 | -121 | -9 | -9 | **-881** |
| **Annual Excess Costs incurred as a result of non-recurring cost pressures** | £k | 82 | 67 | 24 | 2 | 2 | **177** |
| **Contribution of net income from providing beds for other Scottish Boards and efficiency savings** | £k | 2,904 | 2,378 | 863 | 67 | 67 | |

**OUTLINE**

The North of Scotland Medium Secure Care Service opened in September 2012. It is collaboration between 5 Health Boards, NHS Grampian, NHS Highland, NHS Tayside NHS Orkney and NHS Shetland. The service is hosted by NHS Tayside at Rohallion Clinic on the Murray Royal Hospital site in Perth. The regional Medium Secure service, which has 32 beds, shares the facility with NHS Tayside's low secure services, which has 35 beds.

## Progressed During Last Year

### Bed Activity Data

Total Bed Day Occupancy April 2014 – March 2015

The table below sets out the overall annual number of bed day occupancy per Health Board from a total of 11712 bed days (32 beds).

**Table 2**

| Health Boards | Grampian | Highland | Tayside | Orkney | Shetland | GGC | Highland / Argyll | Lothian | England |
|---|---|---|---|---|---|---|---|---|---|
| **Annual Total** | | | | | | | | | |
| 2014 / 2015 | 1548 | 1886 | 1653 | 77 | 0 | 570 | 365 | 266 | 1 |
| 2015 / 2016 | 1948 | 1994 | 3036 | 0 | 0 | 1116 | 366 | 40 | 0 |

**Admissions:**

There were a total of 19 admissions to medium secure Rohallion from April 2015 – March 2016.

**Discharge:**

There were a total of 16 discharges and 1 deceased in from Medium Secure Rohallion from April 2015 – March 2016.

**Quality:**

**Royal College of Psychiatrist FORENSIC Quality Network for Forensic Mental Health Services**

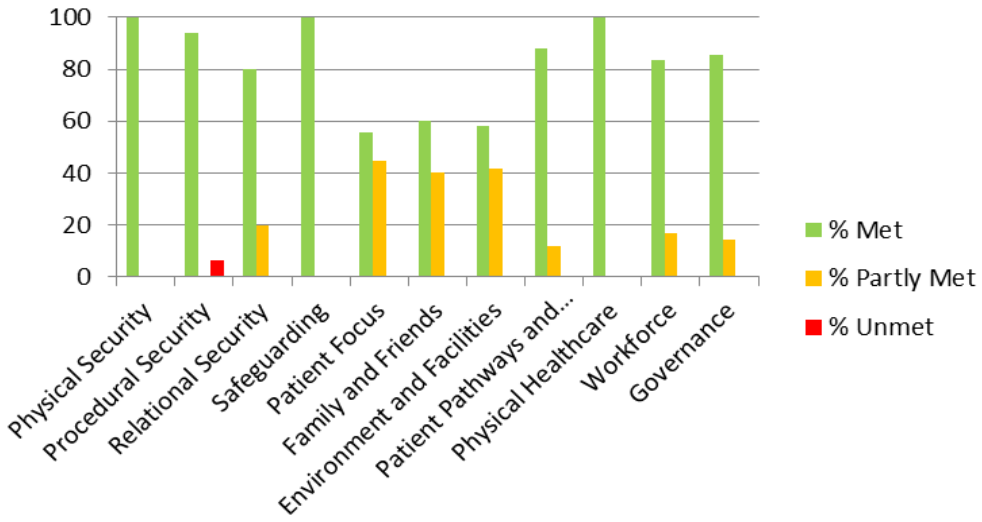
Rohallion Clinic Medium Secure Care Services subscribes to the Royal College of Psychiatrist FORENSIC Quality Network for Forensic Mental Health Services. Rohallion is the only Forensic service in Scotland to subscribe to this quality network. The Quality Network: -

- Develop and apply standards for forensic mental health services through a system of self review and external peer-review.
- Produce reports for participating services that highlight areas of achievement and areas for improvement.
- Provide a national "benchmarking" service to allow services to compare their activity with other services.

Facilitate information sharing about best practice between members of the Network.

- Organise workshops to support services to share information and troubleshoot on shared problem areas.
- Support routine data collection.
- Promote patients and family/friends involvement at all stages of the review process.
- Cycle 10 peer review for 2015/16 was carried out in Rohallion Clinic on 1st / 2nd March 2016.

Overall, Rohallion Service fully met 82% of medium secure standards. The peer-review team commended several aspects of the service provided, in particular the unit scored highly on areas such as Physical Security, Procedural Security, Safeguarding, Patient Pathways and Physical Healthcare. Areas such as Patient Focus, Family and Friends alongside Environment and Facilities were identified as areas in need of improvement over the coming year.




**Mental Welfare Commission Announced Visit March 2016**

The Commission's report was very positive, they included a number of good practice areas and were happy to make no recommendations to current practice. Full details of this visit can be found http://www.mwcscot.org.uk/media/318884/murray_royal_hospital__rohallion_clinic__10_march_2016.pdf

**Intentions for Coming Year**

1. **Further Pathway Development for Women requiring Secure Care across NoS.**

**Medium Secure Care for Women:**

Discussions are ongoing with NHSGGC to develop a pathway for women from the North of Scotland who require Medium Secure Care in line with NHS HDL (2006) 48 Forensic Mental Health Services, Services for Women. This guidance document described such services as these being delivered on a supra regional basis in NHS Lothian and / or NHSGGC. However, due to bed availability in both Health Boards this model has never been implemented and has led to women from the North of Scotland having to be transferred to NHS England for care and treatment. NHSGGC have recently developed low secure services for women, which has released beds in their Medium Secure Unit. It is envisaged that funding for these beds would be provided individually on an ECR basis by each health board if and when required.

**Low Secure Care for Women.**

Women who require low secure care from the North of Scotland are currently managed in the private sector. Discussions are on going across the region in relation to the development of a low secure women's service based primarily on a regional approach. A paper was presented to the NoSPG in February of this year requesting permission to develop options for the North of Scotland. The paper was accepted in principle and work is currently on going to further develop the options for consideration later on in the year.

2. **Bed Availability across the Forensic Estate.**

Penny Curtis, Acting Head of Mental Health and Protection of Rights Division Scottish Government Mental Health Division has asked Andreana Adamson NHS Director of Health and Justice to set up a Forensic Review Reference Group to review and affirm the original assumptions made in NHS HDL (2006) 48 Configuration of Forensic Mental Health Services around the provision of beds across the Forensic Estate in Scotland and to come up with a further set of options to address the ongoing pressure

on beds in the West of Scotland. Barbara Wilson, Regional Service Manager Secure Care is representing North of Scotland on this group.

**3. Appeals against Excessive Levels of Security from Medium Secure Care to Low Secure Care.**

The appeals against excessive levels of security from medium secure care to low secure care came in to force in November 2015. The first Tribunal Hearings took place in January 2016. It is not envisaged that this will cause any problems for low secure services across the North of Scotland in the coming year. Senior clinicians and managers at Rohallion Clinic are keeping a close eye on the activity through the Forensic Network and will report on any issues that may arise.

## 7. Regional Projects

### 7.1. Custody Healthcare & Forensic Service (CHeFS))

**NoSPG Contacts**

- Jim Cannon, Senior Responsible Officer and chair of Project Board
- Sally Patrick, Clinical Team Leader
- Alan Connor, Project Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Finances**

£60,000 for Clinical Team Leader for twelve months.

**Outline**

To varying degrees all NoS boards are facing difficulties in Custody Healthcare & Forensic Services provision. This project aims to identify the gaps & assist boards to work collaboratively to resolve forensic & paediatric cover, infrastructure issues & leverage the role of nurses.

**Progressed During Last year**

The project was established in the latter half of 2015. A Project Board with membership from participating boards and Police Scotland has been formed. The board is supported by an Advisory Group comprising the diversity of interested parties across the region, Police Scotland, Public and third sectors. The North of Scotland Regional Forensic Steering Group remains a crucial influence on the project.

Since starting in post January 2016 Sally Patrick, Clinical Team Leader, has undertaken visits throughout the region to comprehend local situations. There is agreement from the top down and across all stakeholders that one size does not fit all in the North of Scotland.

A map of the service pathways and an associated risk overview was presented for discussion to the project board in June 2016. This activity will define where the project can be most effective in 2016.

**Intentions for Coming Year**

Whilst the benefits of this project will extend beyond the end of 2016 there are distinct deliverables planned for the second half of the year. Removing barriers to enable all boards in the region to use the approved IT system (Adastra) will bring efficiency to the service, alignment to Police Scotland and create the potential for collaboration across the region. It is a critical success indicator that NoS Adastra usage is increased.

The existing nurse led model in NHS Tayside has proven to successfully support the service and decrease reliance on Forensic Physicians whilst leveraging changes in nurse contributions from the Fiscal Office. NHS Grampian is currently being advised by the project clinical lead as it develops a similar system. There is a project aim to identify one of the mainland boards that could provide a nurse-triage model for the Island boards.

A variety of collaborative provisions from telephone support to bespoke training will be delivered.

**Timeframe**

The project was mandated by NoSPG executive in summer 2015. A Project Brief was approved by IPG October 2015 and a subsequent PID approved by NoSPG executive March 2016. Funding is to end of 2016.

## 7.2. North of Scotland Major Trauma Network

**NoSPG Contacts**

- Graeme Smith, Executive Lead for the NoS Major Trauma Programme
- Lorraine Scott, Programme Manager
- Candida Elton, Project Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | N | NHS Western Isles | Y |

**Outline**

Major Trauma describes serious and often multiple injuries where there is a strong possibility of death or disability. Each year in Scotland around 1,000 - 1,100 cases are defined as 'major trauma'. Estimates indicate 120 cases could be within the north region.

Initiated as a discussion nationally by the National Planning Forum (NPF) in 2012. In November 2013, the NHS Chief Executives Group endorsed the "National Quality Framework for Major Trauma" along with the recommendations to establish a single national major trauma system which comprises regional trauma networks, each with a major trauma centre (MTC) i.e. in Aberdeen, Dundee, Edinburgh and Glasgow. The specific programme to establish a North of Scotland Major Trauma Network began in earnest in May 2014.

In 2014 there was a mandate for four MTCs in Scotland although this would be informed further by another 2015 report - "Geospatial Evaluation of Systems (GEOS) of Trauma for Scotland". A consultation and risk analysis of the latter's findings (two MTCs in Glasgow & Edinburgh) was due to deliver in April 2016. At a similar time commitment was made by the returning Scottish Government to the original

four-MTC model.

The NoS programme is designed with the Aberdeen Royal Infirmary site being the northern hub around which a network of, amongst many, Scottish Ambulance Service, Trauma Units, Local Emergency Hospitals, Community Hospitals and Services et al would operate. Ninewells Hospital, Dundee is also a confirmed location for a MTC but it is not currently in this programme's scope.

**Progressed During Last Year**

It is critical that the north's programme delivers on a MTC itself but also across the whole spectrum from pre hospital care, rehabilitation and ongoing care. Significant progress has been made during the last year building the foundation, consensus and educational aspects of the network whilst discussion continued on the number of MTCs in Scotland. There has been a focus on a videoconference education programme commencing in January 2016 and rehabilitation and repatriation based on key priorities identified by front line staff.

**Intentions for Coming Year**

Based on learning from elsewhere, implementation of a robust network will take approximately three to five years. A draft Implementation Plan for the delivery of the north's network was presented nationally in autumn 2015 and this will underpin the forthcoming year. NoSPG has funded an Improvement Manager and a Project Manager to support the next eighteen months' work.

## 7.3. NoSPG Website Update

**NoSPG Contacts**

- Anne-Marie Pitt, Child Health Network Manager
- Julie Gowans, Project Support

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | N | NHS Highland | N | NHS Orkney | N |
| NHS Shetland | N | NHS Tayside | N | NHS Western Isles | N |

**Timeframe**

Commissioned in November 2015. Implementation date yet to be confirmed.

**Outline**

The current North of Scotland Planning Group (NoSPG) website was created in 2009 and is thought not to be fit for purpose. Consequently a project has been commissioned to investigate, with the NoSPG team and stakeholders, the type of website that will met the requirements of NoSPG going forward from 2015. An options appraisal will subsequently be carried out and the final option for the new website implemented.

**Progressed During Last Year**

The first and parts of the second phases of the project have been completed which were:

- to gather information on the current website i.e. who supports the website, the current contents and costs
- establish the expected deliverables for a new website i.e. who would support the website and team requirements

**Intentions for Coming Year**

The remaining information gathering will be completed on stakeholder requirements and costs to develop and maintain a new site. Subsequently an options appraisal will be carried out and a decision to move ahead with implementation of the new website made at that time.

## 7.4. Oesophago-gastric Cancer Regional MDT

**NoSPG Contacts**

- Jim Cannon, Senior Responsible Officer and chair of Short Life Working Group
- Alan Connor, Senior Project Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | N |
| NHS Shetland | N | NHS Tayside | Y | NHS Western Isles | N |

**Outline**

The West of Scotland Cancer Network 2010 Regional MDT Review (Regional MDT Review Version 1, January 2010, KJ Campbell) neatly summarises MDT's as:

> "Multi-Disciplinary Team working is widely accepted as a prerequisite of provision of high-quality cancer care [...] Effective MDT working provides a cohesive treatment and care planning function, ensuring provision is individualised to patients needs"

The North of Scotland Oesophago-gastric MDT (OG MDT) delivered on this outline.

**Progressed During Last Year**

A Short Life Working Group (SLWG) was brought together at the start of 2016. Primary focus was on securing rooms with the appropriate technology in each of the three boards. This was achieved and thanks goes to those colleagues who agreed to vacate rooms to facilitate the agreed day and time.

The SLWG moved its focus to the cultural hurdles that existed. With the help of boards' Clinical Directors clinicians were proposed who would represent their colleagues to reach a consensus. Clinical input agreed the value of the multi-disciplinary attendance but required the regional instance to complement local activity. Agreement was reached whereby patients identified as requiring "radical" intervention i.e. surgery, chemotherapy, or radiotherapy would be presented to the regional MDT.

The initial series of regional MDTs would begin with as many participants as could be secured across the region. The intended aim is for the meeting's success to encourage further attendance.

**Intentions for Coming Year**

The project is now closed and the maintenance of the regional MDT is monitored by the Upper GI MCN.

**Timeframe**

The NOSCAN Upper GI Review (Nov 2015) recommended a regional MDT. In December 2015 the NoSPG executive accepted this recommendation. The OG MDT is recognised as an integral part of the Upper GI surgery review but can be delivered independently.

The first Regional MDT took place on 16th June 2016.

## 7.5. Regional Clinical Strategy

**NoSPG Contacts**

- Cathie Cowan (SRO)
- Dr Mike Bisset (Clinical Lead)
- Kerry Russell (Project Manager)

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Finances**

No financial implications identified at this stage.

**Outline**

The North of Scotland Regional Clinical Strategy will provide the first regionally determined vision for collaborative working between Health Boards in the North of Scotland.

The process of collaboration and consultation to reach this shared vision will provide stronger clinical and managerial networks across the North of Scotland.

The Regional Clinical Strategy will be a document of no more than twenty pages, which can be understood by typical range of representatives of patient, public and staff groups.

The document will underpin current and future planning for healthcare services across the North of Scotland and provide a foundation for strategic planning into the future.

The Regional Clinical Strategy will describe the space between national health service planning and local Board/ Integrated Joint Board (IJB) planning. It will describe the range of tertiary and secondary services that the IJBs can rely on to deliver the healthcare component of their Strategic Plans.

**Progressed During Last Year**

Clinical Stakeholder Day in Aberdeen September 2015

Workshops at the Annual Event November 2015

Agreement to proceed

Signing off Product Description

Convening of Project Board and Project Advisory Group

Case for Change presented to north of Scotland NHS Boards

**Intentions for Coming Year**

Launch Regional Clinical Strategy Foundation and full Strategy

Create stakeholder-led implementation plan

Undertake consultation programmes with staff and patients

Launch Regional Clinical Strategy Foundation at Annual Event November 2016

## 7.6. Regional Oncology Service

**NoSPG Contacts**

- James Cannon, NoSPG Lead
- Alan Connor, temporary Project Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Outline**

The Regional Oncology Service (ROS) is the second phase of a programme previously titled Sustaining Oncology Services in the North of Scotland (SOSNOS).

SOSNOS began in 2014 to attend regionally to acute workforce challenges requiring contingency support. Since then the regional programme has supported activity to maintain patients exclusively within the north region. The outstanding workforce issues stabilised in spring 2016.

The objective for ROS is to facilitate the development of a future sustainable service model for the north's three cancer centres in Inverness, Aberdeen and Dundee. This will provide a collaborative North of Scotland cancer service delivered across three sites with harmonised clinical processes and protocols.

**Progressed During Last Year**

The year began with a Memorandum of Understanding to support development of the planned collaborative model. A Regional Oncology Clinical Board (ROCB) was established in June 2015 to provide direction and guidance to the regional programme team.

In parallel with providing some operational support t the programme team developed a Clinical and Strategic 2020 Vision for the service. This was informed and directed by the ROCB and subsequently incorporated into their Vision Report due in summer 2016.

In November 2015 a Scottish Government Gateway Review Healthcheck was undertaken by the team. Their report offered independent assurance to the programme and provided valuable insight in developing the next stage within a suitable governance and decision making environment. The Gateway team echoed the programme team's perception that resolving cross-board IT issues was critical to success and this should be concurrent with the proposed change management programme.

By March 2016 a substantial Project Initiation Document (PID) was written and presented to the NoSPG Executive meeting of that month. Approval to proceed was received with the proviso that further work

was undertaken to consult widely on the content and governance was reflective of any NoSPG revision.

**Intentions for Coming Year**

Since March 2016 the ROS programme is being directed as Senior Responsible Officer (SRO) by Lesley McLay, Chief Executive NHS Tayside, in her role as chair of the Regional Cancer Advisory Forum (RCAF). Defining how the programme sits within a wider cancer landscape and how it can meaningfully provide impact across that portfolio will be a primary objective.

It is intended that an Engagement event in late summer 2016 will stimulate the clinical and management stakeholders who have committed much already. Revalidating the current thinking, as described in the ROS PID, and refining the scope will be essential before embarking on the next stage.

## 7.7. Transforming Care After Treatment (TCAT)

**NoSPG Contacts**

- Jackie Rodger - Clinical Lead
- Julie Gowans - Project Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | Y | NHS Western Isles | Y |

**Outline**

"The Transforming Care After Treatment (TCAT) programme is a partnership between the Scottish Government, Macmillan Cancer Support, NHS Scotland and local authorities to support a redesign of care following active treatment of cancer. Macmillan Cancer Support is providing £5 million over five years to facilitate the development and implementation of models of care that:

- Enable people affected by cancer to play a more active role in managing their own care
- Provide services which are more tailored to the needs and preferences of people affected by cancer
- Give people affected by cancer more support in dealing with the physical, emotional and financial consequences of cancer treatment
- Improve integration between different service providers and provide more care locally"

*Scottish Government website TCAT pages*

The NoSPG input is to support the rollout of TCAT principles and learning across northern Health Boards, oversight of local projects, and governance of additional funding released by Macmillan and Scottish government for TCAT related projects. It is currently intended to continue into 2018.

**Progressed During Last Year**

Since last year significant progress has been made in developing and implementing Holistic Needs Assessments (HNA). HNAs are a simple questionnaire completed by the patient to help identify their physical, practical, emotional, spiritual and social needs. A bespoke care plan can then be designed accordingly. NHS Tayside has achieved great success already and this will inform their next stage and importantly their learning can be shared with other boards. The latter is a core principle of the

programme whereby projects in one board "trial" ideas that can apply across many boards.

It also worth highlighting the considerable achievements made by NHS Highland in progressing a "My Cancer Portal" that incorporates electronic HNAs and treatment summaries providing a one-stop shop for patients to engage with and take control of their treatment.

Follow-up TCAT funding provided by the Scottish Government will soon be applied to work in NHS Grampian and Tayside around Colorectal and NHS Highland in Prostate to develop risk-stratified models of care.

**Intentions for Coming Year**

Development of the Western Isles "Looking Forward" programme and Tayside's "Late effect of Pelvic Radiotherapy" will continue along with earlier phases of work. Summer 2016 will see phase 3 monies provided by Macmillan. This will focus the region to identify existing projects from here and across Scotland already showing an impact that can be greatly enhanced and broadened through additional funds. A TCAT Project Board has been established to provide direction and governance with the guidance of the existing steering group.

## 7.8. Radiology

Initial scoping work, carried out during 2014/15 has resulted in a renewed mandate from the NoSPG executive, to focus on out of hour's sustainability of general Radiology services. Work planned during 2016/17 will align this regional scoping work directly to the national Shared Services programme, which is currently working on a national framework for Radiology services. This alignment will include specific regional elements, reflecting the north boards' need. We will work closely with the national programme team to ensure synergy with emerging principles and prevent duplication of effort.

## 7.9. Safe and Sustainable Critical Care (Level 2/3) Retrievals and Transfers in the North of Scotland

**NoSPG Contacts**

- Anne-Marie Pitt, Child Health Network Manager

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | Y | NHS Orkney | Y |
| NHS Shetland | Y | NHS Tayside | N | NHS Western Isles | Y |

**Timeframe**

Began December 2014, PID to NoSPG February 2015, draft project report document to Health Boards and SAS March 2016, final document for sign off at NoSPG September 2016.

**Outline**

ScotSTAR provides a single national transport retrieval service governed by the Scottish Ambulance Service. The provision of retrieval services originating in predominantly central locations and retrieving from the remote northern areas and islands of Scotland is thought to have led to a service which is not as equitable, efficient or patient-centred as it could be for patients living in the north. This has been highlighted by the national development of a Major Trauma Network for Scotland and the work of the North of Scotland Major Trauma Pre-Hospital, Retrieval and Transfer (PHEM) Group.

The key aim of this project is therefore to establish the risks and case for change to existing transfer and retrieval services for critical care patients in the north of Scotland. The objectives are:

- To identify within each Health Board in the north of Scotland the categories and numbers of patients who require pre-hospital care or level 2/3 retrieval.
- To identify which of these patients' care/retrievals are seen by Health Boards to be provided in a suboptimal manner and/or present risks to patient, staff or services.

**Progressed During Last Year**

Throughout the year the risks and numbers involved in critical care retrievals and transfers in the north, both adult and paediatric, have been assessed and brought together in one document. This has involved consultation with ScotSTAR, the North of Scotland Major Trauma Pre-Hospital, Transfer and Retrieval Group and the North of Scotland Paediatric High dependency Care network. Data has been gathered from ScotSTAR and relied on local data gathered by individual clinicians over a period of time in hospitals throughout the north.

The paper has been shared for consultation with the North of Scotland Major Trauma Programme Board, the North of Scotland Integrated Planning Group, senior Health Board managers and the Scottish Ambulance Service. The risks highlighted in the paper have also been shared as part of the national MTOG Trauma System Configuration Short Life Working Group risk analysis.

**Intentions for Coming Year**

The results of the consultation process with Health Boards, ScotSTAR and the Scottish Ambulance Service will be incorporated into the paper and presented to the NoSPG Executive to decide on the next steps to be taken.

## 7.10. Upper Gastro-Intestinal (GI) Cancer Surgery in the North of Scotland

**NoSPG Contacts**

- Jim Cannon, Director of Regional Planning
- Kerry Russell, Associate Director of Regional Planning

**Participating Boards**

| | | | | | |
|---|---|---|---|---|---|
| NHS Grampian | Y | NHS Highland | N | NHS Orkney | N |
| NHS Shetland | N | NHS Tayside | Y | NHS Western Isles | N |

**Timeframe**

None required at the present time, although it is recognised that there may be financial implications

associated with any preferred option.

**Outline**

Following a review of the Upper GI Cancer QPIs for the north of Scotland a proposal has been made to increase the volume of surgery by reducing the number of services offering Upper GI Cancer in the north of Scotland. At the time of the review there were three locations in the north where some elements of Upper GI Cancer surgery were carried out.

NHS Highland have indicated that they no longer intend to provide this specific element of Upper GI Surgery and a process has been commenced to decide between the following options:

1. NHS Tayside becomes the sole location for Upper GI Cancer Surgery in the north
2. NHS Grampian becomes the sole location for Upper GI Cancer Surgery in the north
3. Elements of the upper GI Cancer Surgery service are combined to create a single service between the two sites

**Progressed During Last Year**

Short life (clinical and managerial) working group created to make recommendations.

NoSPG Executive decision to move to a single site/service in the north of Scotland.

Regional planning team developing a process for making the decision on the location of the surgical provision.

Implementation of an Upper GI Regional MDT process.

**Intentions for Coming Year**

Completion of the decision making process

Presentation of the preferred option to the NoSPG Executive

Ensure the regional MDT process is sustainable

Present a preferred option to the NoSPG Executive by December 2016

# 8. Appendices

## 8.1. North of Scotland Planning Group Executive

**North of Scotland Planning Group Chief Executive**

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Isle of Lewis

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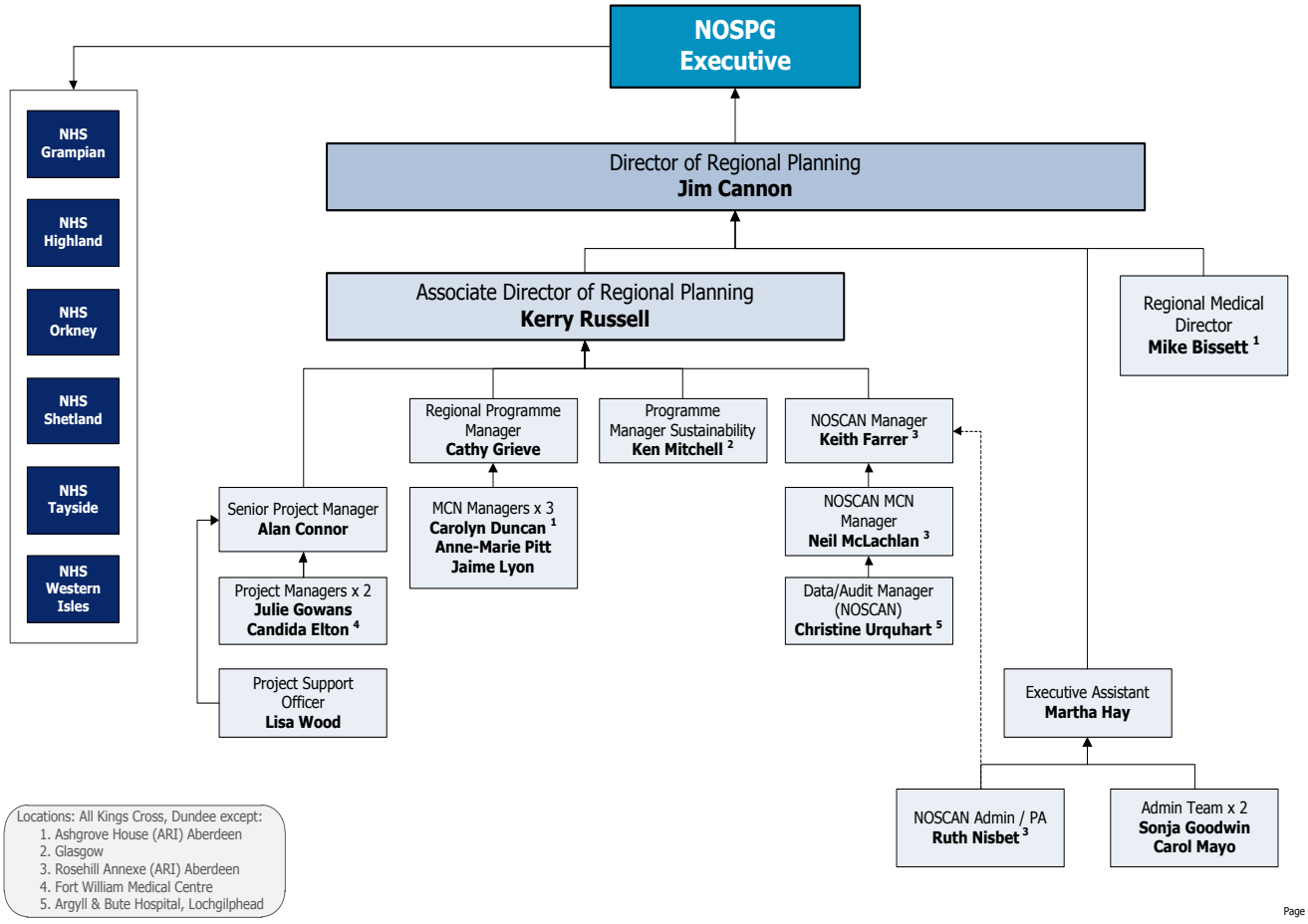
gordon.jamieson@nhs.net

## 8.2. Current Team Structure

### North of Scotland Team Structure



## 8.3. Contacts List

### NoSPG Contacts

| | | |
|---|---|---|
| Director | Jim Cannon | jamescannon1@nhs.net |
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| Project Manager - TCAT | Julie Gowans | julie.gowans@nhs.net |
| Project Support Officer | Lisa Wood | lisa.wood36@nhs.net |
| Executive Assistant | Martha Hay | marthahay@nhs.net |
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| NoSPG PA/Administrator | Carol Mayo | Nospg.awf@nhs.net |

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

**BOARD10/2017**
**Tayside NHS Board**
**23 February 2017**

## SCOTTISH PATIENT SAFETY PROGRAMME IN MENTAL HEALTH REPORT

## SITUATION AND BACKGROUND

The Scottish Patient Safety Programme for Mental Health (SPSP-MH) was launched in August 2012 running until September 2016. This four year programme had an overall aim of reducing harm experienced by individuals in receipt of care from mental health services with the initial focus being adult inpatient services, including forensic services (Appendix A).

The first year of the Programme, phase one, was a prototyping year, with nominated wards from each NHS Board in Scotland testing a change package and measures to improve patient safety. Faskally Ward from the Rohallion Secure Care Unit at Murray Royal Hospital was the Tayside pilot ward for testing the Communication at Transitions and Leadership and Culture workstreams. The team tested and implemented elements of the change packages, collected real time data and reflected on lessons learned. They also benefited from attendance at learning session as well as access to regular conference calls, online dialogue, frequent written updates and face to face meetings/visits.

Phase two began in September 2013 and saw a spread of involvement across the board to all in-patient units. However, NHS Tayside's aim and ambition with raising awareness and improving patient safety within the mental health had already begun when we were involved in the Improving Safety in Mental Health Programme, funded by the Health Foundation 2009. The Safety in Mental Health Programme gave staff the opportunity to lead improvements to patient safety within their local areas using small tests of change to achieve sustainable results, work included improving error free prescribing, focussing on improving communication through the use of SBAR and the implementation of daily safety briefings.

In NHS Tayside we are moving to a whole system approach where improving patient safety is seen as more than a programme, with improvements that address local safety priorities identified by frontline clinicians and the voice of patients and staff. This has been a driver for the work in Mental Health and other programmes such as the Safety Measurement and Monitoring Programme are supporting the realisation of that ambition.

This paper highlights the ongoing patient safety activity within in-patient general adult psychiatry, and secure care units in NHS Tayside.

## ASSESSMENT

There are five workstreams in the programme and within each of these worsktreams key safety principles

have been identified nationally.

| | |
|---|---|
| **Leadership and Culture**<br>• Patient safety climate tool<br>• Staff climate tool<br>• Leadership Walkrounds/safety conversations<br>• Learning from adverse events | **Risk Assessment and Safety Planning**<br>• Training and refresher training<br>• Risk assessment timing and review – 2 hours on admission/72 hour review<br>• Live risk assessment – linked to goal setting<br>• Discharge<br>• Inclusion of sexual, physical, child protection, social and psychological risk |
| **Violence, Restraint, and Seclusion Reduction**<br>• Training – right balance of theory and practical with a trauma informed point of view<br>• Debrief following restraint/near miss<br>• Trauma Informed Care<br>• Restraint monitoring – techniques used, de-escalation methods, length of restraint….<br>• Seclusion Policy and monitoring | **Safer Medicines Management**<br>• As required psychotropic monitoring, review and assessment<br>• High risk monitoring and management – lithium/Clozapine (no avoidable treatment breaks) and polypharmacy<br>• Patient, staff and carer education<br>• Medicines reconciliation<br>• Safer Administration processes – missed dose, correct administration, error free<br>• Safer prescribing |
| **Communication at Transitions**<br>• Admission/Discharge- including discharge pause 24 hours in advance of discharge<br>• Daily Goal Setting/What matters to you – developed in Person Centred<br>• Safety Briefings and Huddles<br>• Physical health at key transition points – deteriorating patients (physical and mental health)<br>• Absconding/Missing Persons/Pass Plan | **Overarching themes**<br>• Data and measurement for improvement<br>• Human factors<br>• Human rights based approach<br>• Legislative framework<br>• Service user, carer, families and staff engagement<br>• Communication<br>• Education & training |

A revised measurement plan was published in February 2014 with boards reporting a bi-monthly cycle of data and leadership reports.

The Scottish Patient Safety Programme for Mental Health Outcome Measures are as follows:

- Rate of violence and aggression
- Percentage of patients engaged in violent and aggressive behaviour
- Rate of patients being restrained
- Percentage of patients being restrained
- Percentage of patients who experience one or more episodes of seclusion
- Percentage of patients who experience self harm
- Days between inpatient suicide
- Percentage of patients who have emergency detention or use of nurse holding power

Balancing measures are:

- Average length of stay
- Total number of hours of patients receiving high level observations
- Percentage of patients receiving high level observations

**Mulberry Unit Activity:**

Mulberry unit have been the pilot site within NHS Tayside for the Measurement and Monitoring of Safety (MSS) Programme. This work saw them use the MMS framework (Appendix B) to undertake a focussed project on reducing medication omissions in the unit, which included:

- Developing a Theory of Change
- Assessing current experience for patients via individual stories and climate surveys
- Gathering baseline data in relation to the current practice
- Developing a person centred approach to medication administration
- Monitoring the data against baseline measures
- Examining any improvements against the domains of the framework

This resulted in a run of 57 weeks without a medication administration error and an increase in staff and patient satisfaction in relation to medication rounds.

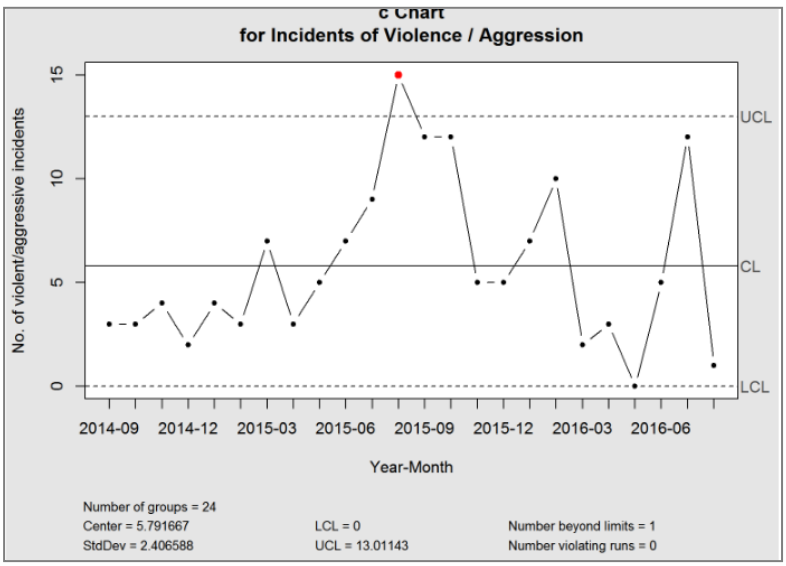
Other work going on across the workstreams include:

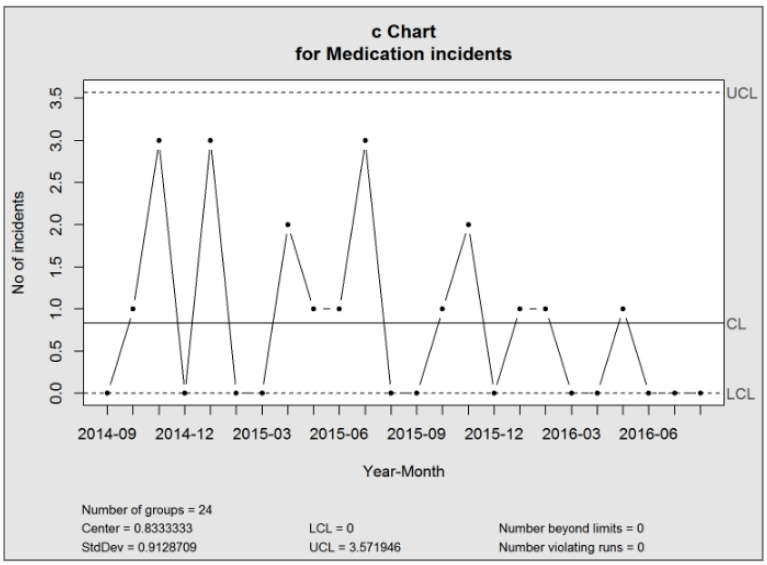
- Sustaining recovery plans and improving overall communication between community and in-patient services
- Implementation of the NEWS chart, structured response and treatment escalation plans
- Patient climate surveys are supported by a peer support worker who is meeting with patients regularly and provides feedback to the ward team in regard to areas for improvement
- The last cycle of the staff climate survey was followed up with a staff focus group and areas of improvement were identified in relation to medicines and de-brief
- Incident reporting is being looked at in relation to quality and completeness of information but also in relation to using this data to be aware of daily issues and plan and predict for safe care in the future
- Audits in relation to the use of as required (PRN) medication are ongoing in the unit. This work links to the overall use of PRN medication particularly at night. A test of change is currently underway promoting sleep hygiene
- Pass medication is being reviewed with pharmacy colleagues to improve safety and reduce waste in the system
- The pharmacist is continuing to audit the medication reconciliation compliance and there is a plan to test an MDT approach
- There is an increase in Prevention Management of Violence and Aggression (PMVA) trainers with a focus on reviewing incidents of violence and aggression and using the information to plan and predict activity within the unit
- Incidents of restraint are low and the focus is on one to one contact with patients and building up trust and confidence between patients and staff
- Risk assessments are being completed within standard times scales, 2hrs, 72 hours, thereafter for 7 days. Updated when any risks change
- Risk management plans are completed in collaboration with patients and the MDT
- Daily safety briefings have been in place in the ward for a number of years however, they are being reviewed to reflect the principles of the MMS framework. This was following a site visit to colleagues in Bradford
- Using the MMS framework the unit looked at patient observation and therapeutic engagement reflecting Milan and Chime principles. Liaising with HIS around the process within Tayside which ensures greater focus on person centeredness.

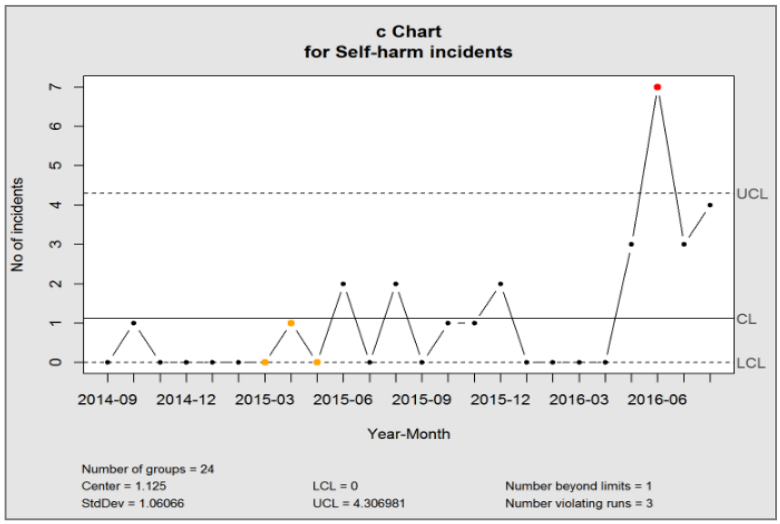
**Challenges**

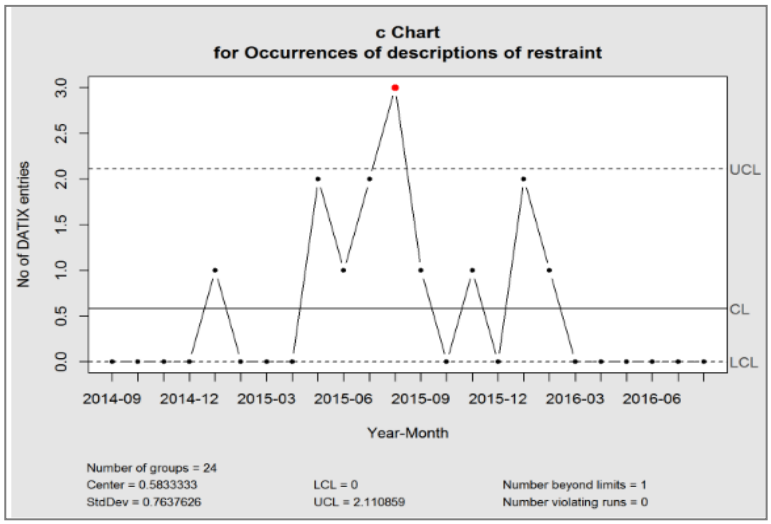
Due to proposed changes in service delivery across Tayside the team report maintaining motivation for improvement work is challenging during a time of uncertainty.

Capacity to support improvement work is challenging and there is a realisation following the involvement in the MMS Programme that dedicated time is required to plan, develop and deliver improvements in the unit. There has been a degree of success in giving ownership of work to particular members of staff but that has been facilitated by using Health Foundation monies to back fill posts in the ward.




**Data**

We are currently testing the use of c- charts to display the data with Mulberry unit, examples of which are shown here. Detailed reports of the incidents accompany these charts and the team are testing how they ensure this data is used to plan and predict safety in the unit.

**<u>Carseview Unit Activity:</u>**

Carseview unit have been actively involved in making improvements in patient safety since the Health Foundation collaborative in 2009. Current improvement activity includes:

- Emergency scenario sessions are being held in the unit. The sessions have highlighted common themes to be addressed to improve staff knowledge and standardise equipment. Staff have reported that the training has been valuable and would welcome further sessions
- Implementation of the NEWS chart, structured response and treatment escalation plans. Training for band 3's undertaking vital signs is also in place
- Band 5 group clinical supervision sessions have been implemented with two staff from each ward attending each session

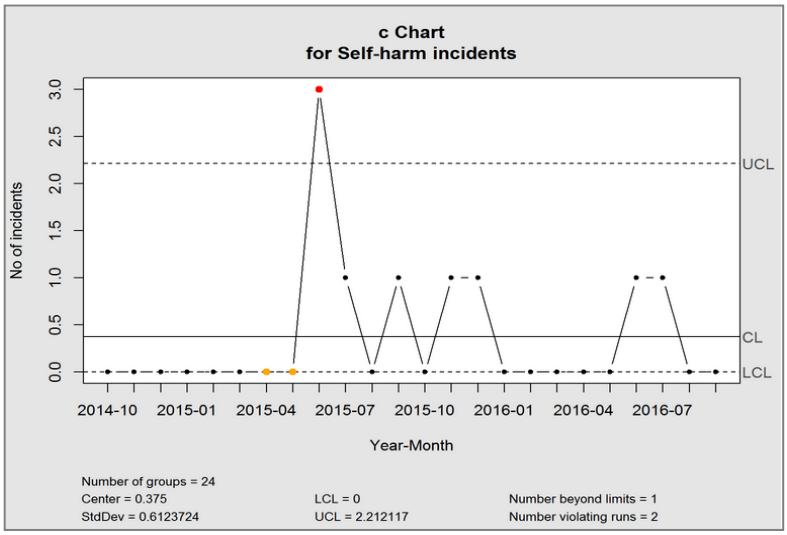
- Patient ward activities groups have been identified as an area for improvement and work is about to commence
- Work to reduce medication incidents continues with an exemplar kardex model being used to raise awareness with medical staff
- The unit have tested a national Anti-Absconding toolkit with good feedback and there is a plan to roll this out to other in-patient units in Tayside
- Ward 2 are involved in the review of incident reporting in relation to quality and completeness of information along with Moredun and Mulberry as seen above
- Nursing risk assessments are being completed within standard times scales, 2hrs, 72 hours, thereafter for 7 days and updated when risks change. Nursing risk assessment, recovery care planning and relapse prevention documentation is audited with guidance documentation given to ward staff. Patient's are routinely involved as part of risk assessment and care planning. Further developments in recovery care planning using toolkit akin to emotional touch points is being planned
- Safety Briefings are carried out at shift handovers with diary sticker and ward door poster
- There is a test of change in relation to developing an "at a glance board"
- Patient and staff safety climate surveys have been completed in the month of October and a follow up focus group with staff is being held in November. Feedback will also be provided to patients on the results from the patient survey
- Administration of medicines continue to be protected using the principles of individualisation and queue busting
- As required (PRN) medication audits are ongoing in all wards. The audit includes time, reason, route, who initiated it, and the medication and post administration review
- There has been an increase in Prevention Management of Violence and Aggression (PMVA) trainers as seen above
- In relation to prevention of restraint there has been the development of simple literature on distraction techniques for patients. Other work relates to oral as required documentation and monitoring; intra muscular as required documentation and monitoring. IPCU are developing an aide memoire and documentation standards for post incident/post restraint debrief
- Further developments on observation training for nursing staff is about to commence

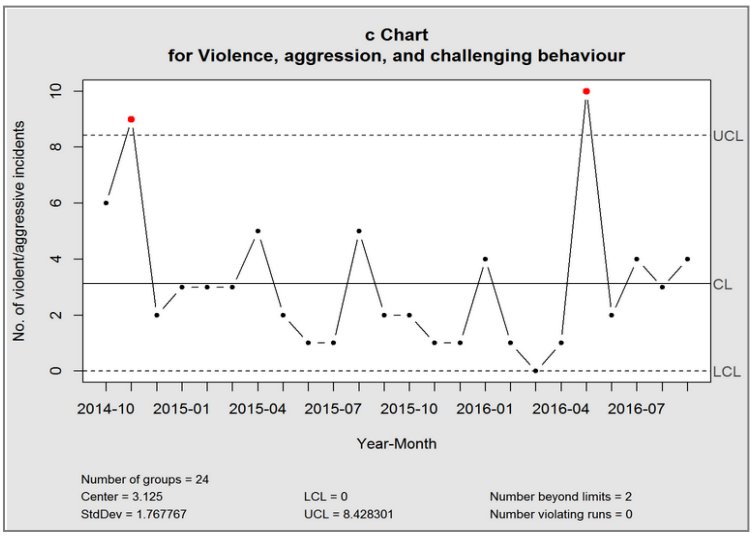
**Challenges**

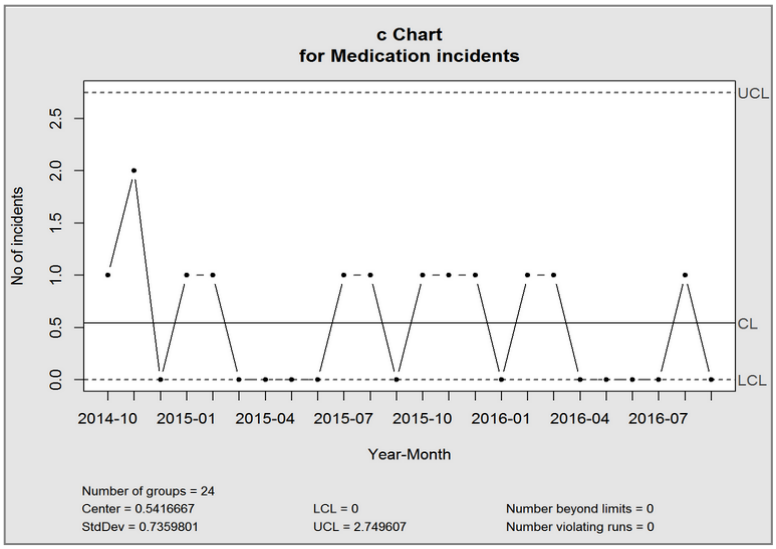
Clinical activity can create challenges for taking forward improvement work.

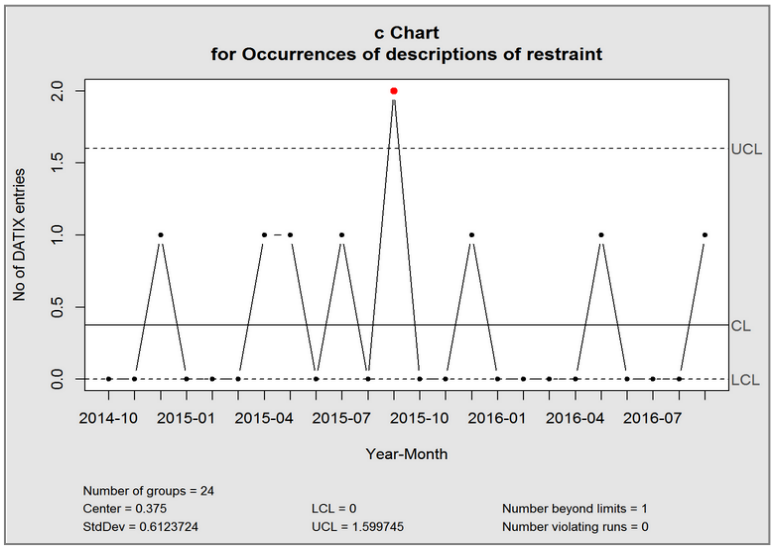
Following a Mental Welfare Commission visit nursing documentation is being reviewed to support an improvement in this area.

## Data




Moredun ward have recently been involved in a ward improvement support project following two significant incidents on the ward. The aim of the project was to identify and act on key areas for improvement and was supported by the Service Improvement Team.

Priority areas identified were:

- improving learning from incidents with a particular focus on management of self harm
- reducing medication delays around discharge process
- reorganising medication rounds so they are more person centred
- testing the application of the care programme approach to increase involvement of patients around discharge planning and reduce risk of readmission
- Increase range of activities for patients in evenings and weekends

Improvement activity includes:

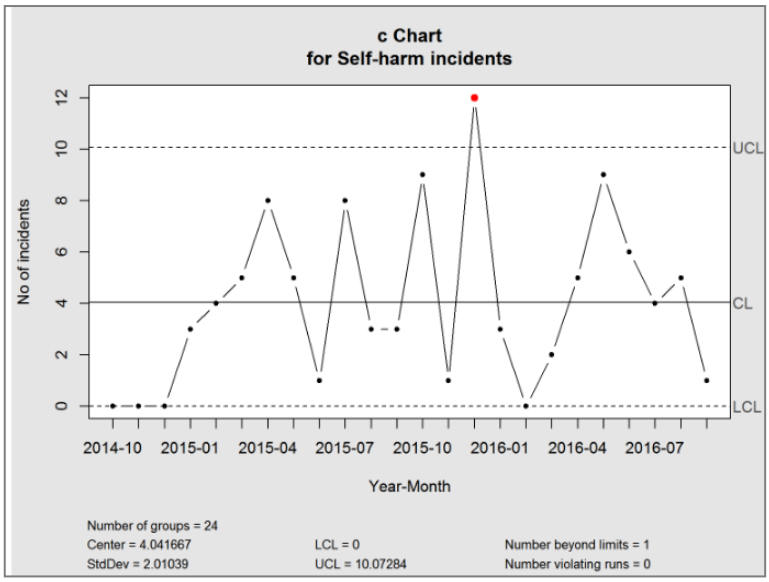
- Focussed risk assessment for patients at risk of self harm
- Maximising opportunities to review datix information through ensuring there are opportunities to review data weekly with the MDT
- Implementation of rapid run down's every morning with MDT
- Daily safety briefings are in place and work is about to commence looking at the quality of these
- Working with staff to develop ways of working by focussing on values and beliefs

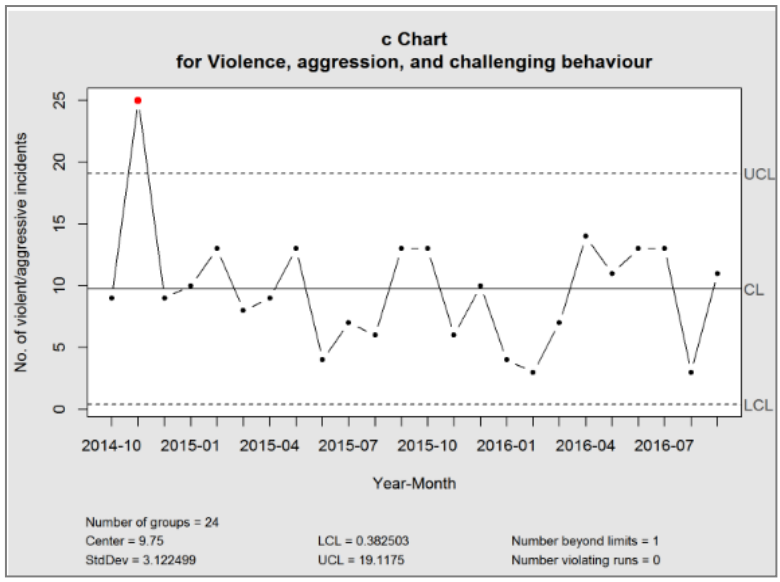
- Implementation of the NEWS chart, structured response and treatment escalation plans
- Provision of feedback in relation to medicines reconciliation to medical staff by pharmacy staff

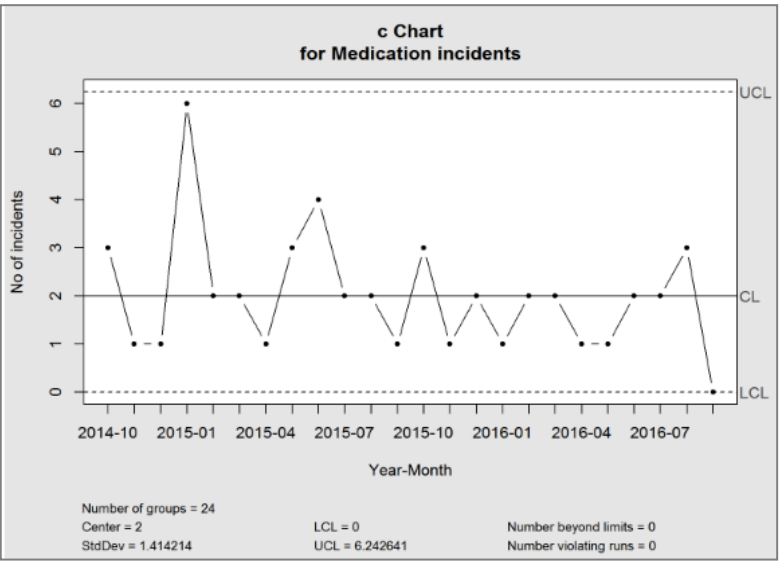
**Challenges**

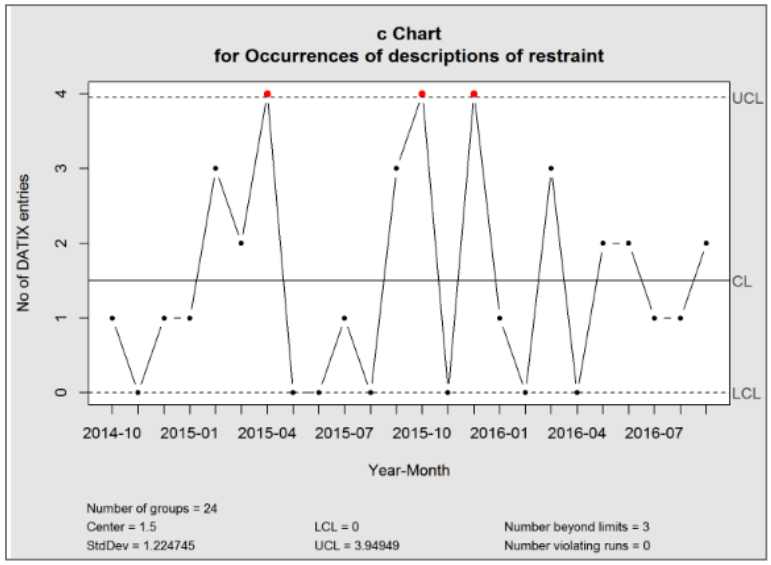
Challenges within the ward have been well documented through a variety of reports and it is not the intention of this report to go into that detail.

**Data**



**Rohallion Activity:**

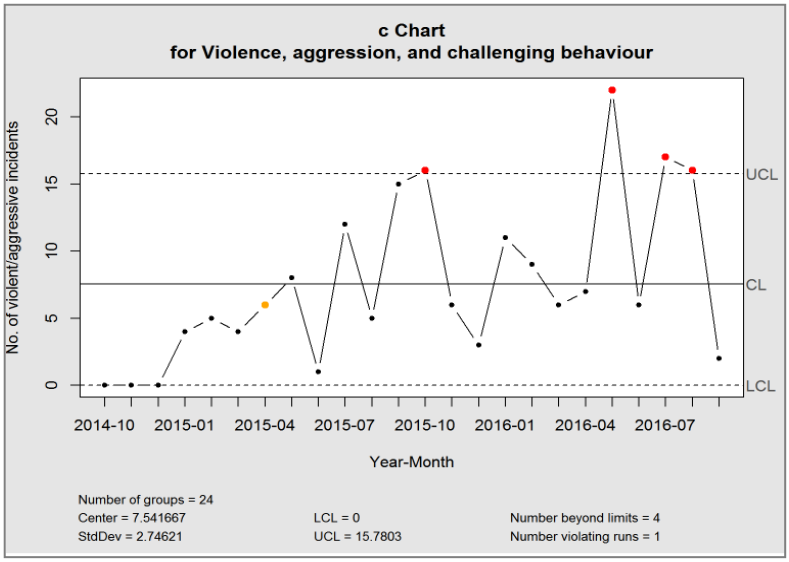
- Pilot test of new nursing assessment & care planning report with executive summary report for CPA meetings
- Datix reports are being discussed at individual ward business meetings, trends identified and learning outcomes and action plans assigned where applicable
- Rohallion have full MDT engagement with safety brief, who recognise this as an effective way of communication to highlight risk management within the clinical areas and departments
- Testing the use of the as required medication (PRN) sticker within the point of care record within the two admission wards has supported nursing staff to give an accurate reflection of as required medication usage, patient's presentation pre administration, reasons for administration and post administration at the clinical team meetings
- Carers champions are completing the Triangle of Care assessment tool for the individual wards to define a benchmark for improvement. Engaging carers as part of the teaching of staff will help support the carers champions
- A nursing letter of introduction to carers is being used in the low secure admission ward and has been identified as an area of good practice. This has been shared locally within general adult psychiatry
- Medication omissions and error free prescribing – a guidance note has been established by nursing and pharmacy staff to ensure a consistent approach to completing the safety crosses appropriately throughout the clinic
- Patient safety brief is embedded into practice across the unit
- Draft discharge document is being developed by the MDT
- Nursing risk assessments being completed within in standard times scales, 2hrs,daily thereafter for 7 days
- Patient's are involved routinely as part of risk assessment and care planning. Physical health screening audit at time of admission, update reviews and annual review
- Patient and staff safety climate surveys are completed annually. Focus groups will be held with staff locally to share insight and learning. Patient safety climate surveys are being supported by advocacy
- T2/T3 audit completed over the unit with high % fully completed as standard
- MDT tool to collect medicine reconciliation data is to be tested on all new admission for 2016 retrospective audits to be completed on 2015 patients
- Rohallion are involved in a national programme of work in relation to observation guidance

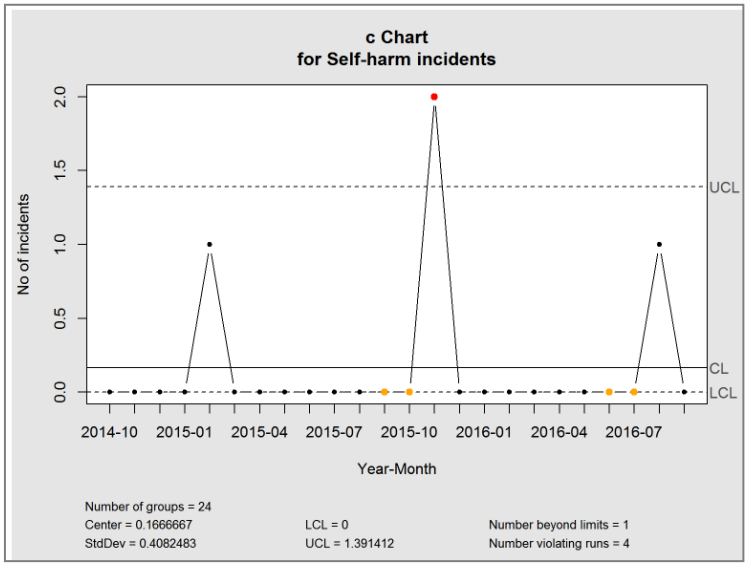
**Challenges**
Ensuring that there is support to take on new projects as these are often not sustainable. There can be a tendency to react to situations and attempt quick fixes.

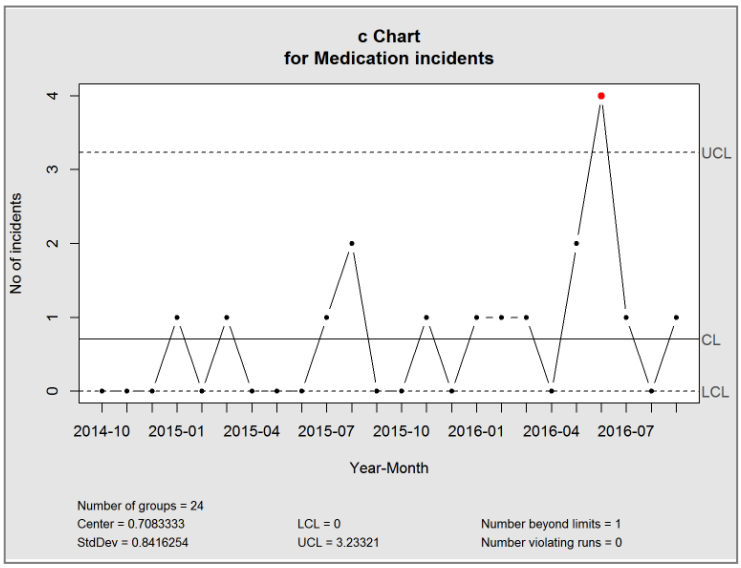
Ensuring that patients and carers are involved with the process of change when it affects them.

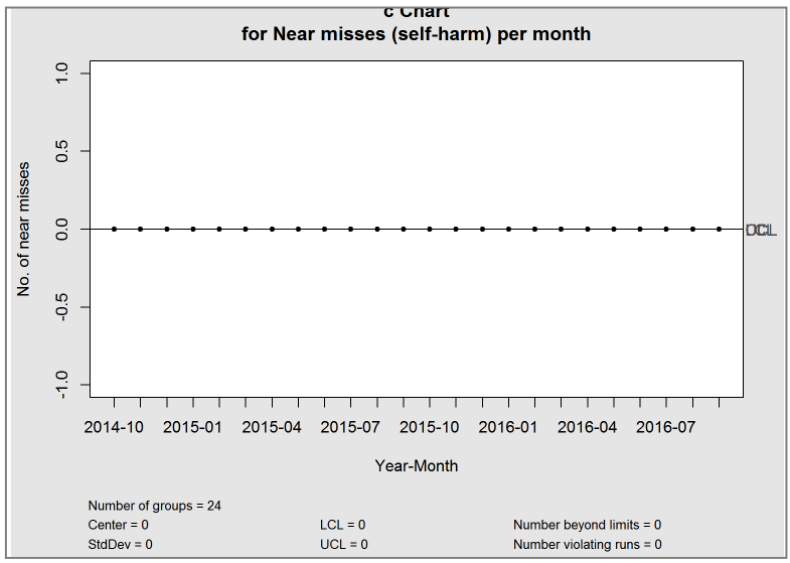
Ensure the full MDT are involved and understand the quality approach being used.

## Data for Faskally Ward, Rohallion Unit



A significant challenge with the programme has been the collection of data. Initially wards were collecting data on spreadsheets, however were challenged with the burden of multiple measures on a monthly basis that were also being recorded in Datix. Work was undertaken with the business unit and the Datix team to provide the data to teams but this was also challenging as teams did not trust the data and felt there were discrepancies between what was being reported and the data in these reports. There are a number of reasons why this could be, including coding of incidents and variation of reporting.

The graphs used in this report have been taken from reports provided by Dr David Christmas. Mulberry, Moredun and ward 2 in Carseview are now being provided with more detailed standardised reports summarising Datix incidents and providing tables of incident details with an aim that it will support teams to drive quality and patient safety activities. This is a pilot for six months and links with the work undertaken in the Monitoring and Measurement of Safety Programme in Tayside. We recognise the need to support a move towards a more proactive approach to safety through use of qualitative information, as well as providing opportunities for discussing real time concerns, building relationships and creating a common understanding of safety issues.

Nationally the programme is moving into phase three. A scoping future activity event was held in Dundee on the 10th March this year and looked at where the safety principles cross over into the next proposed areas for development which are:

- Community Mental Health
- Children and Adolescent Mental Health
- Older People's Services and,
- Perinatal Psychiatry

Locally we need to consider the challenge of resourcing the support required to develop the programme as it moves into Phase 3.

## 3. RECOMMENDATIONS

Tayside NHS Board is asked to:

- Acknowledge the above progress, achievement and challenges by each of the acute adult psychiatry and secure care in-patient units
- Support and provide guidance for the next phase of the programme

## 4. REPORT SIGN OFF

**Mrs G Costello**
**Nurse Director**

**Professor A Russell**
**Medical Director**

**February 2017**

**Overall Aim: To reduce harm experienced by individuals receiving care from mental health services.**

*Need to develop method for reliably measuring levels of harm and then set a 'how much by when to this'*

**Types of Harm** — Social — Sexual — Physical — Psychological

Treatment
- Medication
- Interventions

Accidents
Including falls

Can result from one causal factor or a combination of factors

**Category A Harm Incidents**
Harm caused to person resulting from interaction with service

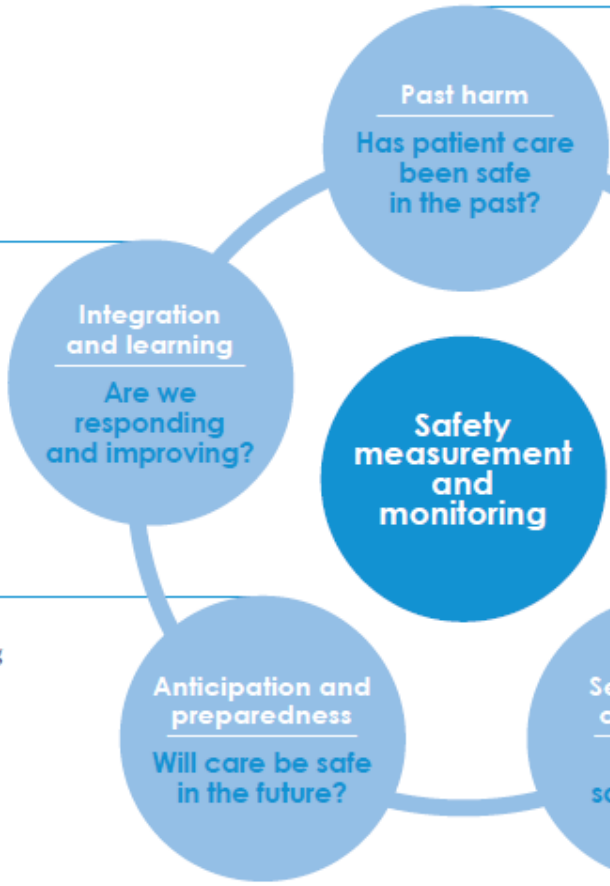
Self Harm — Violence & Aggression* — Suicide — Sexual Harm — Self Neglect

Complex interaction between patient factors, environment, staff factors illness and treatment **which is far more prevalent within Mental Health Services**

**Category B Harm Incidents**
Harm behaviours of patient towards self and others

**Underpinning foundations** — Leadership — Positive Safety Culture — Data used to drive improvement

*This covers all levels from verbal abuse through to homicide. It is important to note that the rate of homicides committed by people with mental illness is no higher than that of the general population. Further there is evidence that people with mental health problems are significantly more likely to be victims themselves of homicide than are members of the general public.




**Prompts**

- Identify the different types of harm that can exist in your setting
- Use a range of safety measures, while understanding their strengths and limitations
- Ensure the measures are valid, reliable and specific

**Prompts**

- Specify the level of reliability you would expect in areas of standardised practice
- Use local and national audits and initiatives to monitor reliability
- Understand what contributes to poor reliability

**Prompts**

- Select an appropriate mix of formal and informal safety monitoring mechanisms
- Use this information to take timely action to avert safety issues
- Reflect on whether current structures and committees enable timely action to be taken

**Prompts**

- Don't wait for things to go wrong before trying to improve safety
- Explore new opportunities to develop systematic ways to anticipate future risks
- Use a variety of tools and techniques to build an understanding of the factors that give rise to safety issues

**Prompts**

- Use the analysis of incidents as a starting point to reveal the wider issues in the system
- Place more emphasis on learning, feedback and action than simply on data collection
- Integrate and tailor information to make it meaningful from the ward to the board

12 13

Vincent et al, 2013, Health Foundation

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

**BOARD06/2017**
**Tayside NHS Board**
**23 February 2017**

## TAYSIDE NHS BOARD AND COMMITTEES SCHEDULE OF MEETINGS 2017/2018

### 1. SITUATION AND BACKGROUND

In accordance with the Code of Corporate Governance, How Business is Organised, paragraph 1.3 the Board has to approve the timetable of meetings for the Board and its Committees.

Appendix 1 attached details the rota of meetings and provides the detail of the meetings scheduled for the Board and its Committees during 2017/2018.

The Code of Corporate Governance states that the Board's Committees shall meet no fewer that four times per year, with the exception of the Universities Strategic Liaison Committee which will meet at least twice a year.

### 2. ASSESSMENT

Members are reminded of the importance of their commitment to attend meetings of their respective committees.

### 3. RECOMMENDATIONS

The Board is asked to approve the Schedule of Meetings for the Board and its Committees for 2017/2018. This would be effective from 1 April 2017 and the Lead Officer is the Board Secretary, Tayside NHS Board.

**Ms M E Dunning**
**Board Secretary**

**Ms L McLay**
**Chief Executive**

**February 2017**

**Tayside NHS Board and Committees**
**Schedule of meetings 2017/18**

| MONTH | DAY | DATE | MEETING | TIME | VENUE |
|---|---|---|---|---|---|
| **2017** | | | | | |
| **February** | **Thursday** | 23 | Tayside NHS Board | 0930 hours | Board Room, Ninewells |
| **March** | **Thursday** | 16 | Tayside NHS Board - Special Meeting after F&R Cttee | 1100 hours | Board Room, Kings Cross |
| **May** | **Thursday** | 4 | Tayside NHS Board | 0930 hours | Board Room, Kings Cross |
| **June** | **Thursday** | 29 | Tayside NHS Board - including Annual Accounts | 0930 hours | Board Room, Ninewells |
| | | | **RECESS** | | |
| **August** | **Thursday** | 31 | Tayside NHS Board | 0930 hours | TBC, possible Angus venue |
| **October** | **Thursday** | 26 | Tayside NHS Board | 0930 hours | James Murray Suite, Murray Royal Hospital |
| **December** | **Thursday** | 7 | Tayside NHS Board | 0930 hours | Board Room, Ninewells |
| **2018** | | | | | |
| **February** | **Thursday** | 22 | Tayside NHS Board | 0930 hours | Board Room, Kings Cross |
| **March** | **Thursday** | 8 | Tayside NHS Board - Special Meeting after F&R Cttee | 1100 hours | Board Room, Kings Cross |
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| **2017** | | | | | |
| **May** | **Thursday** | 4 | Board Development Session | 1330 hours | Board Room, Kings Cross |
| **May** | **Thursday** | 25 | Board Development Event | 0930 hours | Board Room, Ninewells |
| **June** | **Thursday** | 29 | NO SESSION - Annual Accounts | | |
| **August** | **Thursday** | 31 | Board Development Session | 1330 hours | TBC, possible Angus venue |
| **September** | **Thursday** | 28 | Board Development Event | 0930 hours | Board Room, Ninewells |
| **October** | **Thursday** | 26 | Board Development Session | 1330 hours | James Murray Suite, Murray Royal Hospital |
| **November** | **Thursday** | 30 | Board Development Event | 0930 hours | Board Room, Ninewells |
| **2018** | | | | | |
| **January** | **Thursday** | 25 | Board Development Event | 0930 hours | Board Room, Ninewells |
| **January** | **Friday** | 26 | Board Development Event | 0930 hours | Board Room, Ninewells |
| **February** | **Thursday** | 22 | Board Development Session | 1330 hours | Board Room, Kings Cross |
| **March** | **Thursday** | 29 | Board Development Event | 0930 hours | Board Room, Ninewells |
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| **2017** | | | | | |
| **March** | **Thursday** | 9 | Audit Committee | 0930 hours | Board Room, Kings Cross |
| **May** | **Thursday** | 11 | Audit Committee | 0930 hours | Board Room, Kings Cross |
| **June** | **Thursday** | 22 | Audit Committee | 0930 hours | Board Room, Kings Cross |
| **August** | **Thursday** | 24 | Audit Committee | 0930 hours | Board Room, Kings Cross |
| **December** | **Thursday** | 14 | Audit Committee | 0930 hours | Board Room, Kings Cross |

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| **2018** | | | | | |
| **March** | **Thursday** | 15 | Audit Committee | 0930 hours | Board Room, Kings Cross |
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| **2017** | | | | | |
| **May** | **Thursday** | 18 | Board of Trustees | 0900 hours | Board Room, Kings Cross |
| **June** | **Thursday** | 22 | Board of Trustees | 1230 hours | Board Room, Kings Cross |
| **October** | **Thursday** | 19 | Board of Trustees | 0900 hours | Board Room, Kings Cross |
| **November** | **Thursday** | 16 | Board of Trustees | 0900 hours | Board Room, Kings Cross |
| **2018** | | | | | |
| **February** | **Thursday** | 20 | Board of Trustees | 0900 hours | Board Room, Kings Cross |
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| **2017** | | | | | |
| **March** | **Thursday** | 16 | Finance & Resources Committee & Special Board Meeting | 0930 hours | Board Room, Kings Cross |
| **May** | **Thursday** | 18 | Finances & Resources Committee | 0930 hours | Board Room, Kings Cross |
| **August** | **Thursday** | 17 | Finance & Resources Committee | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **November** | **Thursday** | 16 | Finance & Resources Committee | 0930 hours | Board Room, Kings Cross |
| **2018** | | | | | |
| **January** | **Thursday** | 18 | Finance & Resources Committee | 0930 hours | Board Room, Kings Cross |
| **February** | **Thursday** | 15 | Finance & Resources Committee | 0930 hours | Board Room, Kings Cross |
| **March** | **Thursday** | 8 | Finances & Resources Committee & Special Board Meeting | 0930 hours | Board Room, Kings Cross |
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| **2017** | | | | | |
| **May** | **Thursday** | 11 | Clinical and Care Governance Committee | 1330 hours | Board Room, Kings Cross |
| **August** | **Thursday** | 17 | Clinical and Care Governance Committee | 1330 hours | Board Room, Kings Cross |
| **November** | **Thursday** | 9 | Clinical and Care Governance Committee | 1330 hours | Board Room, Kings Cross |
| **2018** | | | | | |
| **February** | **Thursday** | 8 | Clinical and Care Governance Committee | 1330 hours | Board Room, Kings Cross |
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| **2017** | | | | | |
| **October** | **Tuesday** | 31 | Universities Strategic Liaison Committee | 1400 hours | Board Room, Kings Cross |
| **2018** | | | | | |
| **March** | **Tuesday** | 27 | Universities Strategic Liaison Committee | 1400 hours | Board Room, Kings Cross |
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| **2017** | | | | | |
| **March** | **Tuesday** | 14 | Staff Governance Committee | 1400 hours | Board Room, Kings Cross |
| **June** | **Tuesday** | 13 | Staff Governance Committee | 1400 hours | Board Room, Ninewells |
| **September** | **Tuesday** | 26 | Staff Governance Committee | 1400 hours | Board Room, Kings Cross |
| **December** | **Tuesday** | 12 | Staff Governance Committee | 1400 hours | Board Room, Kings Cross |
| **2018** | | | | | |

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| **March** | **Tuesday** | 13 | Staff Governance Committee | 1400 hours | Board Room, Kings Cross |
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| **2017** | | | | | |
| **March** | **Tuesday** | 14 | Remuneration Committee | 1200 hours | Kinnoull Room, Kings Cross |
| **June** | **Tuesday** | 13 | Remuneration Committee | 1200 hours | Board Room, Ninewells |
| **September** | **Tuesday** | 26 | Remuneration Committee | 1200 hours | Kinnoull Room, Kings Cross |
| **December** | **Tuesday** | 12 | Remuneration Committee | 1200 hours | Kinnoull Room, Kings Cross |
| **2018** | | | | 1200 hours | Kinnoull Room, Kings Cross |
| **March** | **Tuesday** | 13 | Remuneration Committee | 1200 hours | Kinnoull Room, Kings Cross |
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| **2017** | | | | | |
| **March** | **Thursday** | 2 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **April** | **Thursday** | 6 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **May** | **Wednesday** | 3 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **June** | **Thursday** | 1 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **July** | **Thursday** | 6 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **August** | **Thursday** | 3 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **September** | **Thursday** | 7 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **October** | **Thursday** | 5 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **November** | **Thursday** | 2 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |
| **December** | **Wednesday** | 13 | Transformation Programme Board | 0930 hours | Committee Room 1, Level 10, Ninewells |

**2018**

TBC

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

**Item 19**

**BOARD07/2017**
**Tayside NHS Board**
**23 February 2017**

# APPOINTMENT OF NEW NON EXECUTIVE BOARD MEMBER TO COMMITTEES

## 1. SITUATION

To seek the Board's approval for the appointment of Dr Robert Peat, Non Executive Member to the Clinical and Care Committee.

## 2. BACKGROUND

Following the appointment of Dr Robert Peat as a Non Executive Board Member from 1 January 2017, the Board is asked to note and approve the undernoted Committee membership and appointment for Mr Peat

- Member of the Clinical and Care Governance Committee

## 3. ASSESSMENT

The Board is asked to approve the appointment of Dr Robert Peat as a member of the Clinical and Care Governance Committee

## 4. RECOMMENDATIONS

The Board is asked:

- To approve appointment of Dr Peat as a Member of the Clinical and Care Governance Committee

## 5. REPORT SIGN OFF

The Lead Officer for this report is the Board Secretary.

**Ms M Dunning**
**Board Secretary**

**Ms L McLay**
**Chief Executive**

**February 2017**

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

**Item 20**

**BOARD08/2017**
**Tayside NHS Board**
**23 February 2017**

# UPDATES TO THE NHS TAYSIDE CODE OF CORPORATE GOVERNANCE

## 1. PURPOSE OF THE REPORT

The purpose of the report is to seek the approval of Tayside NHS Board to the amendments and updates to the Code of Corporate Governance.

## 2. RECOMMENDATIONS

The Board is asked to:

- Approve the amendments and updates to the Code of Corporate Governance as detailed in appendix 1and as discussed at the Audit Committee on 17 January 2017
- Recommend approval of the communications process as detailed in paragraph 16 to the Board

## 3. EXECUTIVE SUMMARY

Updates to the Code of Corporate Governance are attached to this report as appendix 1. This update has been shared with the Corporate Governance Review Group and was scrutinised by the Audit Committee at its meeting on 17 January 2017

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 updates and to approve recommendation of these to Tayside NHS Board. The Board retains the responsibility for approving any updates to the Code of Corporate Governance.

## 4. REPORT DETAIL

A number of updates and amendments are included as Appendix 1 and tracked changes are also attached as requested by Board Members. These cover updates to the Introduction, Section A, How the Business is Organised, Section C, The Standards of Business Conduct for NHS Staff, Section E, Reservation of Powers and Delegation of Authority and Section F, The Standing Financial Instructions.

## 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 Code of Corporate Governance allows these to be achieved.

## 6. HEALTH EQUITY

There are no implications for tackling health inequalities in respect of these updates to the Code of Corporate Governance.

## 7. MEASURES FOR IMPROVEMENT

The Code of Corporate Governance provides the standards to be achieved with regard to Corporate Governance in NHS Tayside.

## 8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

A Rapid Impact Assessment was completed for the revised Code in June 2010 and there is no change to this assessment.

## 9. PATIENT EXPERIENCE

The Code of Corporate Governance provides the overarching governance framework for NHS Tayside and describes the main control systems and processes. It ensures that governance and assurance systems are embedded in NHS Tayside, which will ultimately contribute to the patient experience.

## 10. RESOURCE IMPLICATIONS

### Financial

There are no financial implications.

### Workforce

There are no workforce implications.

## 11. RISK ASSESSMENT

NHS Tayside Code of Corporate Governance is subject to regular review and update which ensures NHS Tayside has a framework in place for its governance arrangements.

The likelihood of the Code of Corporate Governance not being up to date is low as the Governance Review Group was established with the remit to ensure the Code of Corporate Governance is reviewed and updated regularly.

Processes are also in place to review the Code of Corporate Governance against changes in legislation or guidance and therefore the consequence of the Code of Corporate Governance not being up to date is moderate. The control levels around this area are high and with these in place the risk is well mitigated.

## 12. LEGAL IMPLICATION

There are no legal implications.

## 13. INFORMATION TECHNOLOGY IMPLICATIONS

The Code is available electronically on Staffnet and the NHS Tayside website.

## 14. HEALTH & SAFETY IMPLICATIONS

There are no Health & Safety implications.

## 15. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no Healthcare Associated Infection implications.

## 16. DELEGATION LEVEL

The making, alteration and revocation of the Code of Corporate Governance are a matter reserved for Board agreement.

The Lead Officer is the Board Secretary who will keep the Code of Corporate Governance under continuous review to ensure it is updated and reflects changes occuring during the year.

## 17. TIMETABLE FOR IMPLEMENTATION/ COMMUNICATON PROCESS

Following approval by the Board the following communications process will be put in place:

- A document detailing the changes will be posted on Staffnet and the NHS Tayside wbsite alongside the Code of Corporate Governance;
- The Code of Corporate Governance will be updated and posted on Staffnet and the NHS Tayside website;
- All previous versions of the Code of Corporate Governance will be archived on Staffnet and the NHS Tayside website

## 18. REPORT SIGN OFF

**Ms M Dunning**
**Board Secretary**

**February 2017**

## 19. SUPPORTING DOCUMENTS

Appendix 1 - Details of proposed changes to Code of Corporate Governance
Appendix 2 – Tracked changes in each Code Section

| **Page No.** | **Section/ Paragraph** | **Suggested change** |
|---|---|---|
| Front page of Code | Front page of Code | Version Control to be updated |
| Throughout Code | | Remove reference to Director of Acute Services, Director of Primary and Community Services, Director of Mental Health and the Director of Operations |
| Throughout Code | | Change Director of Human Resources to Director of Human Resources and OD |
| Throughout Code | | Remove reference to Operational Directors and Change to Directors |
| 2 | Introduction | 2. The NHS in Scotland, first bullet point, removal of “abortion”. This is now a transferred power to the Scottish Parliament and is no longer reserved |
| 8 | Introduction | 14. Definitions **Board Executive Member**, remove the Director of Finance |
| 9 | Introduction | 14. Definitions Remove reference to **Chief Officers** |
| 9 | Introduction | 14. Definitions Add in **Directors,** All direct reports to the Chief Executive. This includes the Chief Operating Officer, the Medical Director, the Director of Public Health, the Nurse Director, the Director of Human Resources and OD, the Director of Finance, the Director of Strategic Change, the Director of Performance, the Chief Officers of the Integrated Joint Boards and the Board Secretary. |
| 16 | Section A How the Business is Organised | 1. Calling and Notice of Meetings, 1.9, update to read, Notification of the time and place of the Board meeting shall be displayed on the NHS Tayside website. The dates and times of Committee meetings will also be available on the NHS Tayside website |

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| 40 | Section A | **33. Records Management** second paragraph , " intranet " to read " staffnet" |
| 44 | Section A | Purpose and Remits, a) Audit Committee, In Attendance, change The Associate Director of Finance (Lead Officer ) to The Director of Finance (Lead Officer) |
| 48 | Section A | Purpose and Remits, b) Finance and Resources Committee , update with new remit as attached as Annex A |
| 67 | Section A | Purpose and Remits, i) Staff Governance Committee, update with new remit as attached as Annex B |
| 74 | Section A | Purpose and Remits, j) Universities Strategic Liaison Committee, update with revised remit as attached at Annex C |
| 7 | Section C<br>Standards of Business Conduct for NHS Staff | **6. Acceptance of Gifts, Hospitality and Prizes**<br><br>**Gifts to now read:**<br><br>**6.1.1**<br>The Standards of Business Conduct state that "under the Prevention of Corruption Act 1916, and Bribery Act 2010, any money, gift or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary"<br>**6.1.2**<br>Staff should therefore be very cautious if faced with the offer of a gift, and refuse all but the most trivial of gifts as accepting them could be interpreted as an attempt to gain preferential treatment.<br>**Contractors**<br>Casual gifts offered by contractors or others should be declined.<br>**Patients, relatives or carers**<br>**6.1.3** Trivial Items of low intrinsic value e.g. boxes of biscuits, chocolates or flowers, from patients, |

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| | | relatives, or carers may be accepted for sharing in the workplace. Staff should be guided by the Code of Conduct of their professional body and refuse gifts.<br><br>Where an unsolicited or inappropriate gift, such as alcohol, vouchers, or offers of service, is received and the individual is unable to return it or the donor refuses to accept its return, they should report the circumstances to the Board Secretary. The Board Secretary will determine if the gift can be accepted. This will be recorded in the Register of Gifts.<br><br>Any gifts of money from patients, relatives and carers should be handled in accordance with the Tayside Health Fund Policy and Procedures.<br><br>Gifts of equipment not for individual use but which are to be used for the purposes of NHS Tayside may be accepted, but only in accordance with the requirements of the Non Monetary Donations Section of Tayside NHS Board Tayside Health Fund Policy & Procedures.<br><br>The Board Secretary will maintain a register to record gifts reported by staff. It is the responsibility of the recipients of such gifts to report all such items received to the Board Secretary for recording. The form in Annex 2 should be used for this purpose. |
| 12 | Section C | **11. Free Samples**<br><br>11.1 “paragraph 18.6” to be changed to “paragraph 20.6”<br><br>11.2 “See also Section 18.6...” to be changed to “ See also Section 20.6....” |
| 22 | Section C | **20.4 Requirements of representatives when meeting healthcare staff**<br><br>(vii) .....paragraph 18.6.2 to be changed to..... paragraph 20.6.2<br><br>**20.6 Samples**<br><br>20.6.1 last sentence to be amended to read, Exceptions are highlighted in paragraph 20.6.2 below. |

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| Throughout Section E | Section E<br><br>Reservation of Powers and Delegation of Authority | Change Director of Finance – Financial Services and Governance, Fraud Liaison Officer to Associate Director of Finance with the exception of:<br><br>2.5.4 Patients Private Property<br><br>3.3.3 Signing of Documents ; Agreements and Research Sponsorships<br><br>3.6 Management of Tayside Health Fund, correspondence re legacies and giving goods discharge to executors<br><br>3.7 Management of Land, Buildings and Other Assets Owned or Leased by the Board<br><br>3.8 Management and Control of Stock; Stores recording and Operating Procedures<br><br>3.9 Management and Control of Computer Systems and Facilities (including Data Protection); Design implementation and documentation of non-clinical computer systems and facilities and those designed to provide national statistic returns<br><br>3.10 Recording and Monitoring of Payments under the Losses and Compensation Regulations; Notification to the Scottish Government Health Directorates of discovered fraud/criminal offences, maintenance of loss and compensation register, action to safeguard Board's interest in bankruptcies and company liquidations<br><br>3.15 Patients' Property ; Arrangements for the opening and management of back accounts; establishment of detailed procedures for the safe custody and management of patients and residents property, provision of receipts and payments statement in the approval format annually |
| 162 | Section E<br><br>Reservation of Powers and Delegation of Authority | **2.2.4 Procurement**<br><br>To now read:<br><br>The Chief Executive shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders. |

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| | | Where post tender negotiations are required, the Chief Executive shall nominate in writing, officers and/or agents to act on behalf of the Board.<br><br>The Chief Executive, acting together with the Director of Finance, has authority to approve on behalf of the Board, the acceptance of tenders, submitted in accordance with the Board's Code of Corporate Governance, up to a value of £1,000,000 (including VAT suffered) within the limits of previously approved Revenue and Capital Budgets.<br><br>The exercise of this authority for tenders in excess of £150,000 up to £1,000,000 must be reported to the Finance and Resource Committee. The exercise of this authority for tenders in excess of £25,000 up to £150,000 must be included in the tender register.<br><br>Process should evidence actions commensurate with the guidance under the Procurement Reform (Scotland ) Act 2014, and meet criteria of Most Economically Advantageous Tender.<br><br>The Chief Executive shall provide the Director of Finance with a listing, including specimen signatures, of those officers or authorised agents to whom he has given delegated authority to sign official orders on behalf of the Board. |
| 167 | Section E | **2.4.4 Procurement of Supplies & Services**<br><br>To now read**:**<br><br>The Chief Operating Officer shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders on behalf of the Board.<br><br>Where post tender negotiations are required, the Chief Operating Officer shall nominate in writing, officers and/or agents to act on behalf of the Board.<br><br>The Chief Operating Officer, acting together with the Associate Director of Finance has authority to approve on behalf of the Board the acceptance of tenders, in respect of the Operational Unit submitted in accordance with the Board's Code of Corporate Governance, up to a value of £1,000,000 (including VAT suffered) within the limits of previously approved Revenue and Capital |

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| | | Budgets.<br><br>The exercise of this authority for tenders in excess of £150,000 up to £1,000,000 must be reported to the Finance and Resources Committee.<br><br>The exercise of this authority for tenders in excess of £25,000 up to £150,000 must be included in the tender register. In accepting a tender, the process should follow the guidance under the Procurement Reform (Scotland) Act 2014, and meet criteria of Most Economically Advantageous Tender. |
| 27 | Section F<br><br>Standing Financial Instructions | **Quotations**<br><br>13.17 The Chief Executive or nominated officer should evaluate the quotations and select the one which gives best value. The process should follow the guidance under the Procurement Reform (Scotland) Act 2014, and must meet criteria of Most Economically Advantageous Tender. |
| 32 | Section F | **Contracts**<br><br>13.37 NHS Tayside may only enter into contracts within their statutory powers and shall comply with:<br><br>13.37.1 Standing Orders;<br><br>13.37.2 Standing Financial Instructions;<br><br>13.37.3 Such of the NHS Standard Contract Conditions as are applicable.<br><br>13.37.4 No act or omission contained within the Standing Financial Instructions shall prevent adherence to the Statutory Guidance published under the Procurement Reform (Scotland) Act 2014. Statutory Guidance takes precedence. |
| 36 | Section F | **Section 15 Losses and Special Payments**<br><br>Paragraph 15.4 to read, In accordance with the Scheme of Delegation , the Chief Executive may, acting together with the Director of Finance or the Chief Operating Officer may acting together with |

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| | | the Associate Director of Finance or any other officer authorised by the Director of Finance, approve the writing – off of losses within the following limits delegated to the Board by the Scottish Government Health Directorate |
| 55 | Section F | **Section 13 Contracting and Purchasing**<br>**Annex 1**<br><br>**Tendering Procedure**<br><br>To now read:<br><br>4.9 Acting in accordance with the guidance under the Procurement Reform (Scotland ) Act 2014, as directed by Scottish Government March 2016, it is required that relevant selection criteria, linked to the subject matter of the contract, be established, and that a tender shall not be accepted unless it meets the criteria of Most Economically Advantageous Tender. This is applicable to all contracts laid down.<br><br>Contracts should be awarded after consideration of cost or price, quality and sustainability and always ensuring delivery of value for money. |

## Finance and Resources Committee

### 1.1 Purpose

To keep under review the financial position of Tayside NHS Board, to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and provide assurance that these arrangements work effectively

**Composition**

Membership of the Finance and Resources Committee shall consist of a minimum of six Non-Executive Members of the Board including the Employee Director and the Chair of the Area Clinical Forum.

In addition, there will be in attendance the Director of Finance (Lead Officer)

Other Directors will only attend if they are presenting a report to the Committee or the Committee requests their attendance.

### 1.2 Meetings

Meetings of the Committee will be quorate when at least three Members are present.

### 1.3 Remit

**Financial Framework**

The Committee will oversee the development of a Financial Strategy that is consistent with national and local priorities, and specifically:-

- oversee the development of the Board Financial Strategy in support of the Local Delivery Plan, including aligning service and financial planning arrangements with community planning priorities;
- recommend to the Board annual revenue and capital budgets, and financial plans consistent with its statutory financial responsibilities;
- examine in detail the financial plan for NHS Tayside to ensure that planning assumptions are soundly based and reflect known pressures, potential investments and opportunities for cost reduction;
- review the financial impact of planned future policies and known or foreseeable future developments;
- review the capital plan of NHS Tayside no less frequently than twice per year and consider the impact of development opportunities and any risks arising from delivery of the current programme, and
- ensure that there is an integrated approach to workforce, finance and service planning.

**Financial Investment**

- ensure robust appraisal around business case development and delivery;

- scrutinise business cases for proposed investment ensuring that outcomes and benefits are clearly defined, are measureable and support delivery of key objectives for the Board;
- monitor delivery of approved investment projects against agreed outcomes and benefits, ensuring action is taken to address any shortcomings;
- approve standard documentation for business case and project monitoring;
- review business cases for significant changes in procurement methodology/approach, e.g. changes to NPDO, use of new procurement methods (e.g. managed equipment service, joint ventures, outsourcing, shared services), and
- review the benefits realisation of business cases and post implementation review to ensure the full potential has been realised.

**Financial Management**

- consider reports on the financial position of NHS Tayside that highlight significant trends and risks;
- monitor the deliverability of the Transformation Programme and the overall efficiency programme reflecting on both the in year delivery and contribution towards the recurring savings target;
- consider forecast positions reported by NHS Tayside and risks to achievement of forecast, and
- review the content and format of strategic financial information focussing on:-
  - clarity and appropriateness of presentation;
  - timeliness and accuracy;
  - provision of sufficient and relevant detail to inform decision making, and
  - best practice

**Performance Management**

The Committee shall have oversight of systems and processes to ensure economy, efficiency, and effectiveness in the use of resources. The Committee will, from time to time, review individual services in relation to performance management, ensuring that health care is delivered to an efficient and cost effective level. Specifically the Committee will:-

- promote an integrated approach to performance management and risk, and
- oversee an effective approach to prioritisation of resources, supported by appropriate and relevant benchmarking and comparative information to inform decision making

**Policy Endorsement**

- adopt all finance and governance policies, and
- adopt all information governance/assurance policies

**eHealth**

eHealth will report through the Finance and Resources Committee and the Finance and Resources Committee should approve the eHealth Delivery Plan

**Information Governance**

The Committee will receive an annual assurance report/action plan followed by a mid-year and annual report to provide assurance that NHS Tayside has the necessary information assurance arrangements in place

**Financial Training & Briefing**

To promote a culture in which:-

- financial awareness is valued and encouraged amongst all stakeholders;
- financial skills are developed to ensure regular and wide consideration of financial issues, and
- financial information is shared openly and transparently.

**Property and Asset Management Strategy**

- to ensure that the Property & Asset Management Strategy is aligned with the Clinical Strategy, and is:-
  - supported by affordable and deliverable Business Cases;
  - supported by detailed Project Plans, and
  - delivered within agreed timescales and resources to secure modern, well designed, patient focussed services and facilities.
- to ensure that Tayside NHS Board's Property & Asset Management Strategy is developed, supported and maintained, and that it meets the strategic service plan needs;
- to ensure that Tayside NHS Board's property asset base is effectively utilised in support of the clinical strategy;
- to ensure that the property portfolio of NHS Tayside and key activities relating to property are appropriately progressed and managed within the relevant guidance and legislative framework;
- to ensure that all aspects of major property and land issues are dealt with in accordance with due process;
- to ensure that there is a robust approach to property rationalisation;
- to oversee the management of risk associated with both individual projects and asset strategy, and
- to monitor delivery of agreed Key Performance Indicators in respect of the Property and Asset Management Strategy

**Strategic/Capital Projects**

- to review overall development of major schemes, including capital investment business cases and consider the implications of time slippage and/or cost overrun. Instruct and review the outcome of the post project evaluation;
- to receive and review reports on significant capital projects and the overall capital programme, and

- to receive reports on relevant legislation and best practice including the Scottish Capital Investment Manual (SCIM), audit reports and other Scottish Government Guidance.

**Assurance**

- to receive assurance reports at every meeting on the Strategic Risks that the Finance and Resources Committee has delegated responsibility for, including Strategic Financial Risk, Strategic Capital Risk and Information Governance Risk, and
- ensure that robust operational and service risk management systems and processes are in place.

### 1.4 Best Value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure best value for these delegated areas. The assurance to the Chief Executive should be included as an explicit statement in the Committees Annual Report.

### 1.5 Authority

The Committee's authority shall be within the following framework. In performing these functions, the Committee is expected to operate at a strategic governance level. Through the Accountable Officer, and with Internal and External Audit assistance where required, it must satisfy itself that there are appropriate operational controls in place throughout NHS Tayside.

## Tenders, Contracts, Business Cases within the Limits of previously approved Revenue and Capital Budgets

**See also:-**

- Section E, Reservation of Powers and Delegation of Authority - Scheme of Further Delegation, and
- Section F Standing Financial Instructions, Section 13, Contracting and Purchasing and Annex 1, Tendering Procedures.

The Finance and Resources Committee has delegated authority to approve the acceptance of tenders and business cases on behalf of Tayside NHS Board up to a value of £4.0 million (IM&T Schemes up to £2.0 million), which cannot be accepted by any other Committee or

Accountable Officer in terms of delegated powers, and where the most economically advantageous tender is to be accepted.

The Chief Executive, as Accountable Officer, acting together with the Director of Finance, has delegated authority to approve acceptance of tenders and business cases up to a value of £1.0 million, and where the most economically advantageous tender is to be accepted.

The Board Executive Directors and Operational Unit Directors, acting together with the Director of Finance, have delegated authority to approve acceptance of tenders and business cases up to the value of £1.0 million, and where the most economically advantageous tender is to be accepted.

The Chief Executive shall submit to the Finance and Resources Committee a report detailing all tenders and business cases in excess of £0.15 million and accepted by her in terms of the above delegated powers during the preceding two months in an appropriate format.

**Authority to Spend Funds and Virement**

**(See Section E - Reservation of Powers and Delegation of Authority - Scheme of Further Delegation)**

Delegated authority is granted, as undernoted, to approve the funding of individual items of expenditure, provided that approval can be funded within the Board's overall Revenue and Capital Budgets, and to transfer funds up to this level between budgets including transfers from reserves and balances:

The Finance and Resources Committee up to a value of £4.0 million (IM&T Schemes up to £2.0 million) in any one instance. This authority shall be exercised in respect of all proposals greater than the delegated limits below:-

- The Chief Executive as the Accountable Officer, acting together with the Director of Finance of the Board, to a value of £1.0 million;
- The Chief Executive, acting together with the Associate Director of Finance - Financial Planning and Operational Services, up to the value of £1.0 million, and
- Board and Operational Unit Executive Directors, acting together with the Director of Finance/Associate Director of Finance - Financial Planning and Operational Services up to the value of £1.0 million.

**Capital Programme**

The Board's Capital programme shall be managed within the framework approved each year by the Board.

The Committee shall, within this framework, approve tenders and business cases up to a value of £ £3.0 million. Variations in cost from the approved framework in excess of 5% or £0.15 million, whichever is the higher, shall be reported to the Committee.

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

The Finance and Resources Committee will appoint a Capital Scrutiny Group to co-ordinate the production of the five year Capital Plan, to oversee the implementation of the Capital Programme and to ensure the appropriate levels of governance is in place regarding NHS Tayside's Capital Programme.

**Reporting Arrangements**

The Finance and Resources Committee reports to Tayside NHS Board.

Following a meeting of the Finance and Resources Committee the minutes of that meeting should be presented at the next Tayside NHS Board meeting.

The Finance and Resources 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 Finance and Resources Committee.

The Finance and Resources 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 Finance and Resources Committee before it is presented to the Audit Committee considering Annual Accounts.

**Annex B**

## Staff Governance Committee

### 1. Purpose

To provide assurance to the Board that NHS Tayside meets its obligations in relation to staff governance under the National Health Service Reform (Scotland) Act 2004 and the Staff Governance Standard.

In particular, the Committee will seek to ensure that staff governance mechanisms are in place that take responsibility for performance against the Staff Governance Standard and are accountable for progress towards achievement of the Standard.

The Staff Governance Committee will also play a key role in monitoring overall Board performance by ensuring full consideration of the impact of key policy and operational decisions that affect staff, on the Board aims in relation to quality and cost of service delivery.

### 2. Composition

Membership of the Staff Governance Committee will be:

A minimum of six Non Executive Members including the Employee Director

The Staff Governance Committee will be co-chaired by the Employee Director and a Non Executive Member appointed by the Board from the membership of the Committee.

Other members are:

The Director of Human Resources and Organisational Development (Lead Officer)
The Staff Side Co-Chair of the Area Partnership Forum
The Staff Side Secretary
The Chair of the Workforce & Governance Forum

Members of the Area Partnership Forum listed below shall be in attendance at the Staff Governance Committee:

- Chief Executive
- Chief Officer (representing Health and Social Care Partnerships)
- Chief Operating Officer
- Co Chairs of other Partnership Forums
- Associate Director of HR- Resourcing

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

Other Directors will only attend if they are presenting a report to the Committee or the Committee requests their attendance.

## 3. Meetings

Meetings of the Committee will be quorate when at least five Members are present, at least 3 of whom should be Non Executive Members

## 4. Remit

To support the creation of a culture within the health system, where the delivery of the highest possible standards of staff management is understood to be the responsibility of everyone working within NHS Tayside and this is built upon partnership and co-operation.

To act for the Board in ensuring that structures and processes to ensure staff are:

- Well informed;
- Appropriately trained and developed;
- Involved in decisions;
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and,
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

The Committee shall monitor and evaluate progress through the approval of local human resource strategies and implementation plans.

The Committee shall be authorised by the Board to support any policy amendment, funding or resource submission to achieve the Staff Governance Standard.

The Committee shall oversee the timely submission of all the staff governance data required as part of the Annual Review.

## Joint Working with Other Board Committees

The Committee shall ensure the implications of workforce performance are fully understood and that all decisions taken relating to staff are subject to appropriate scrutiny in relation to quality and cost of service delivery. In doing so the Committee will share information with, and receive information from, the Board's Finance & Resources Committee and the Clinical Care Governance Committee, and lead officers of these Committees will meet

jointly on at least two occasions per year to review performance and agree priorities for future reporting.

The Committee will, through its lead officer, also regularly consider key issues arising through other Committees of the Board to ensure that relevant information is shared to aid understanding of workforce strategic and operational performance matters.

## 7. Risk Reporting

Quarterly reports from strategic risk owners of the risks aligned to this Committee.

## 8. Best Value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure the best value for these delegated areas. The assurance to the Chief Executive should be included as an explicit statement in the Committee's Annual Report.

## 9. Authority

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

## 10. Reporting Arrangements

The Staff Governance Committee reports to Tayside NHS Board.

Following a meeting of the Staff Governance Committee, the minutes of that meeting should be presented at the next Tayside NHS Board meeting.

The Staff Governance 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 Staff Governance Committee.

The Staff Governance 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 Staff Governance Committee before it is presented to the Audit Committee.

The Staff Governance Committee will receive for approval the Annual Report of the Remuneration Committee, which reports through the Staff Governance Committee to the Board, while remaining a substantive standing Committee of the Board itself.

The Committee shall oversee the effectiveness of the Area Partnership Forum, and through the Area Partnership Forum, the performance of Local Partnership Fora, in managing change and promoting a positive culture of staff engagement through the submission of regular reports.

**Annex C**

## 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)
- 3 representatives from the University of Dundee covering Medicine, Nursing and Dentistry

- 2 representatives from St Andrews University covering Medicine
- 2 representatives from Abertay University covering Professions Allied to Medicine
- 2 representatives from Fife NHS Board
- 1 representative NHS Education for Scotland
- 2 representatives from the Academic Health Science Partnership
- 1 Director of Medical Education, NHS Tayside
- 1 Director of Medical Education, NHS Fife
- Post Graduate Dean (or nominated Deputy) NHS Education Scotland

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.

### 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 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.

# INTRODUCTION

## 1. Code of Corporate Governance

The Code of Corporate Governance includes the following sections:

Section A – How business is organised
Section B – Members' code of conduct
Section C – Standards of business conduct for NHS staff
Section D – Fraud standards
Section E – Reservation of powers and delegation of authority
Section F – Standing financial instructions
Section G – Commercial Sponsorship Standards

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

The Board reviews and approves the Code of Corporate Governance each year. Sections A to E are NHS Tayside's Standing Orders. The Standing Orders are made in accordance with the Health Board's (Membership and Procedure) (Scotland) Amendment Regulations 2016.

Statutory provision, legal requirement, regulation or direction by Scottish Ministers take precedence over the Code of Corporate Governance if there is any conflict.

## 2. The NHS in Scotland

The National Health Service (NHS) was established in Britain in 1948. Despite a growth in private health provision and insurance, the NHS provides the vast majority of health care in Scotland.

"The purpose of the NHS is to secure through the resources available the greatest possible improvement in the physical and mental health of the nation by: promoting health, preventing ill-health, diagnosing and treating injury and disease and caring for those with long-term illness and disability who require the services of the NHS". (Department of Health, 1996)

Health policy was, in the main, devolved to the Scottish Parliament under the terms of the Scotland Act 1998 (the '1998 Act'). However there are some areas of health policy which remain reserved. These are:

- ~~abortion~~
- xenotransplantation (the use of non-human organs for transplantation.
- embryology, surrogacy and genetics
- licensing of medicines, medical supplies and poisons (although decisions on whether the NHS should fund licensed medicines are devolved)
- welfare foods
- the regulations of health professions (although regulation of professions not regulated prior to the 1998 Act is devolved)
- health and safety

The NHS is Scotland carries on the principle of collective responsibility by the state for the provision of comprehensive health services free at the point of use for all. Services are funded from central taxation and access should be based on need.

## 3. NHS Boards

The National Health Service (Scotland) Act 1972 (c.58) allowed for the establishment of area health boards to assess health needs and administer the provision of relevant health care. There are 14 NHS Boards in Scotland one of which is Tayside NHS Board.

The main legislation providing the legal framework for the NHS in Scotland is the National Health Service (Scotland) Act 1978 (c.29).

The Functions of Health Boards (Scotland) Order 1991, sets out the requirements of Scottish Ministers in terms of the functions that Health Boards are to provide for health care to their local population. This Order details the high level functions which the Health Board is directed by the Minister to provide. The Board is a board of governance, not a representative body nor a management board.

## 4. Tayside NHS Board

Tayside NHS Board, 'The Board', means Tayside Health Board which is the legal name. It is a strategic body, accountable to the Scottish Government Health Directorates and to Scottish Ministers for the functions and performance of NHS Tayside. It consists of the Chair, Non-Executive and Executive Members appointed by the Scottish Ministers to constitute Tayside Health Board. (National Health Services (Scotland) Act 1978 as amended).

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

**The Overall Purpose of Tayside NHS Board is:**

- To ensure the efficient, effective and accountable governance of NHS Tayside
- To provide strategic leadership and direction
- To focus on agreed outcomes

**The Role of the Board is:**

- To improve and protect the health of local people
- To improve health services for local people
- To focus clearly on health outcomes and people's experience of NHS Tayside
- To promote joint health and community planning by working closely with local organisations
- To be accountable for the performance of NHS Tayside as a whole
- To involve the public in the design and delivery of healthcare services

**The Functions of the Board are:**

- Strategy development (including regional planning and cross Board working alongside health promotion, health improvement and community planning )
- Resource allocation to address local priorities
- Development and implementation of the Local Delivery Plan
- Performance Management of the local NHS system as a whole.

## 5. Members of Tayside NHS Board

15 Non Executive Members which include the Chairman and 6 stakeholder members representing the following:

- Angus Council
- Dundee City Council
- Perth & Kinross Council
- University of Dundee
- Area Clinical Forum
- Staff side Employee Director

4 Executive Members

- Chief Executive
- Medical Director
- Nurse Director
- Director of Public Health

Total of 19 members

In attendance

- Board Secretary
- Head of Committee Administration
- Staff side representative
- Medical Director, Operational Unit
- Director of Human Resources
- Director of Finance

**6. Responsibilities of Members of Tayside NHS Board include:**

You will be expected to adhere to Section B, the Members Code of Conduct and:

- Support the Chair and work with the other members to discharge the functions of the Board, which will comprise:
    - strategy development – to develop a Local Delivery Plan which address the health priorities and health care needs of the resident population;
    - monitoring the effective performance of the Board's activities and ensuring achievement of its aims;
    - ensuring that resources (staff, finance and premises) are used effectively and responsibly to support local priorities and strategic objectives;
    - ensuring that governance arrangements are robust, rigorous and effective; and
    - ensuring probity and propriety in the workings of the organisation

**In addition**

- actively participate in collective decision making, and chair, or participate in, where required, one or more of the committees of the Board;
- act on the principle of collective responsibility for decisions of the Board;
- question intelligently, challenge rigorously and debate constructively and dispassionately;
- listen to the views of others, inside and outside the Boardroom;
- be an ambassador for the local health system and have a unique opportunity to help the Board focus on people's experience of their local health services and support public involvement and engagement;
- work with and fully represent the Board's activities, in an honest and positive way, whilst encouraging and maintaining good relationships with interested parties, including:
    - NHSScotland
    - patients, the public and local communities
    - MSPs, MPs, MEPs and Councillors
    - local authorities
    - the business sector
    - the voluntary sector
    - the media
- actively work with the Scottish Government, other NHS Boards, health organisations and local service providers to ensure an integrated approach to providing the functions of the Board and to putting government health policy into practice;

- put into action the Scottish Government's policies and priorities;

- develop an effective working relationship with members of the Board and staff within the NHS system;

- gain the trust and respect of other Board members and adhere to NHS Tayside's Dignity at Work principles.

- commit to ongoing personal development activities;

- uphold the highest ethical standards of integrity and probity and comply with the Board's Code of Conduct in Section B of the Code of Corporate Governance;

- uphold the 9 principles of public life set out by the Committee on Standards in Public Life(based on the Nolan principles) see paragraph 8

In addition Non Executive Members of the Board will:

- ensure they are sufficiently informed in order to hold executives to account for the implementation of Board decisions;
- maintain a focus on strategy performance: it is not the role of the Chair and non-executive Board members to have a detailed involvement in the day-to-day management of the organisation;
- challenge and support executives in their leadership of the business while monitoring performance

**7. Corporate Governance**

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

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

Tayside NHS Board is responsible for:

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

## 8. Conduct, accountability and openness

All Board Members of Tayside NHS Board (Non Executive and Executive) are required to comply with the Members' code of conduct and the Standards of business conduct for NHS staff.

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

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

## 9. Understanding our responsibilities arising from the Code of Corporate Governance

It is the duty of the Chair and Chief Executive to ensure that Board Members and staff understand their responsibilities. Board Members and Managers shall receive copies of the Code of Corporate Governance and the Board Secretary will maintain a list of managers to whom the Code of Corporate Governance has been issued. Managers are responsible for ensuring their staff understand their responsibilities.

## 10. Tayside Health Fund

The principles of the Code of Corporate Governance apply equally to Members of Tayside NHS Board who have distinct legal responsibilities as Trustees of the Tayside Health Fund.

## 11. Advisory and other Committees

The principles of the Code of Corporate Governance apply equally to all NHS Tayside's Advisory Committees and all Committees and groups which report directly to a Tayside NHS Board Committee.

## 12. Review

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

## 13. Feedback

NHS Tayside wishes to improve continuously and reviews the Code of Corporate Governance regularly. To ensure that this Code remains relevant, we would be happy to hear from you with regard to new operational procedures, changes to legislation, confusion regarding the interpretation of statements or any other matter connected with the Code. Comments and suggestions for improvement are most welcome, and these should be sent to:

The Board Secretary
Tayside NHS Board Headquarters
Ninewells Hospital & Medical School
Dundee DD1 9SY
Telephone: 01382 740709 Fax: 01382 425562
Email: generalcomments.tayside@nhs.net

## 14. Definitions

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

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

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

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

**Board Executive Member** or 'Executive' means the Chief Executive, the ~~Director of Finance~~ and the Director of Public Health, the Nurse Director and the Medical Director. All other Members are Non-Executive Members. (This distinction is made for the purposes of defining the numbers of Non-Executive Members who are Members of Committees or other working groups).

**Board Secretary** a senior administrative officer in a public organisation with a role similar to that of a Company Secretary; who is responsible for ensuring procedures are followed in accordance with good governance

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

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

**Chief Executive** means the Chief Officer of NHS Tayside.

~~**Chief Officers** means the Chief Executive, Director of Finance, Director of Human Resources, Director of Public Health, Medical Director and Nurse Director.~~

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

**Committee Members** are people formally appointed by the Board to sit on or to Chair specific Committees. All references to Members of a Committee are as 'Committee Member' and when the reference is to a Member of the Board it is 'Board Member'.

**Contract** includes any arrangement including an NHS Contract.

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

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

**Directors** means all direct reports to the Chief Executive. This includes the Chief Operating Officer, the Medical Director, the Director of Public Health, the Nurse Director, the Director of Performance, the Chief Officers of the Integrated Joint Boards and the Board Secretary

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

**Member** means a person appointed as a Member of the Board by Scottish Ministers, and who is not disqualified from membership. This definition includes the Chair, Executive and Non-Executive Members. Health Boards (Membership and Procedure) Amendment Regulations 2016.

**Motion** means proposal.

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

**Non-Executive Member** means any Member appointed to the Board in terms of the Health Boards (Membership and Procedure) Amendment Regulations 2016 and who is not listed under the definition of an Executive Member above.

**Officer** means an employee of NHS Tayside.

~~**Operational Directors** means the Director of Acute Services, the Director of Primary and Community Services, Director of Mental Health, the Director of Operations and the Medical Director – Operational Unit~~

**SOs** means Standing Orders.

**SFIs** means Standing Financial Instructions.

**Special Committee** a group appointed to study a particular matter. Once it has made its final report, the Committee ceases to exist.

**The Code** means the Code of Corporate Governance.

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

**Working Day** means any day between Monday and Friday inclusive but not including public holidays.

**The Key Principles of Public Life**

**Duty**
You have a duty to uphold the law and act in accordance with the law and public trust placed in you. You have a duty to act in the interests of Tayside NHS Board and in accordance with the core functions and duties of the Board.

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

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

**Objectivity**
You must make decisions solely on merit and in a way that is consistent with the functions of Tayside NHS Board when carrying out public business including make appointments, awarding contracts or recommending individuals for rewards and benefit.

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

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

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

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

**Respect**
You must respect fellow Members of Tayside NHS Board and employees of the body and the role they play, treating them with courtesy at all times. Similarly you must respect Members of the public when performing duties as a Member of your public body.

You should apply the principles of this Code to your dealings with fellow Members of Tayside NHS Board, its employees and other stakeholders.

Similarly you should also observe the principles of this Code in dealings with the public when performing duties as a Member of Tayside NHS Board.

# SECTION A

# HOW BUSINESS IS ORGANISED

This section explains how the business of Tayside NHS Board and its Committees is organised.

## 1. THE BOARD AND ITS COMMITTEES (DIAGRAM)

## 2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGANISED

1. Calling and notice of meetings
2. Appointment of Chair of Tayside NHS Board
3. Appointment of Vice-Chair or Tayside NHS Board
4. Duties of Chair and Vice-Chair
5. Membership
6. Membership of committees due to office held
7. Resignation and removal of members of committees
8. Process for the appointment of non executive members, chairs and vice-chairs
9. Quorum
10. Human rights
11. Order of business
12. Order of debate
13. Motions and amendments
14. Notice of motions
15. Questions
16. Time allowed for speaking during formal debate
17. Closure of debate
18. Voting
19. Voting in the case of vacancies and appointments
20. Adjournment and duration of meetings
21. Conflict of interest
22. Reception of deputations
23. Receipt of petitions
24. Submission of reports to the Board
25. Right to attend meetings and/or place items on agenda
26. Alteration or revocation of previous decision
27. Suspension of Standing Orders
28. Admission of public and press
29. Members' Code of Conduct
30. Suspension of Members from meetings
31. Minutes, agendas and papers
32. Guidance to exemptions under the Freedom Information (Scotland) Act 2002
33. Records management

## 3. COMMITTEES

1. Establishing Committees
2. Membership
3. Functioning
4. Minutes
5. Frequency
6. Delegation
7. Committees
8. Purpose and remits

a) Audit Committee
b) Finance and Resources Committee
c) Clinical and Care Governance Committee
d) East of Scotland Research Ethics Service (EoSRES) REC 1
e) Pharmacy Practices Sub-Committee

f) Practitioners Services Reference Sub-Committee
g) Remuneration Committee
h) Staff Governance Committee
i) Universities Strategic Liaison Committee

## Tayside NHS Board

**Purpose:**

- to ensure the efficient, effective and accountable governance of NHS Tayside
- to provide strategic leadership and direction
- to focus of agreed outcomes

**Role:**

- **to improve and protect the health of local people**
- **to improve health services for local people**
- **to focus clearly on health outcomes and people's experience's of NHS Tayside**
- **to promote joint heath and community planning by working closely with local organisations**
- **to be accountable for the performance of NHS Tayside as a whole**
- **to involve the public in the decision and delivery of healthcare services**

**Functions:**

- Strategy development
- Resource allocation to address local priorities
- Oversee implementation of the Local Delivery Plan
- Performance management of NHS Tayside including risk management

STANDING COMMITTEES

**Audit**

Ensures the Board's activities are within the law and regulations governing the NHS and that an effective internal control system is maintained to safeguard assets, avoid waste, avoid inefficiency produce accurate financial information and seek value for money, and ensures that suitable arrangements are in place to provide formal assurance to the Accountable Officer by providing an opinion on the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources.

**Primary Care Practitioners Discipline Committee**

**Pharmacy Practices Sub-Committee**

**Practitioners Service Reference Sub-Committee**

**Clinical and Care Governance Committee**
Assures that mechanisms are in place and effective throughout the locate NHS system to support improvement, that the principles and standards of Partnership for Care 2003 are applied to the improvement activities of NHS Tayside, ensures that a strategic framework for Delivering for Health and Better Health Better Care clinical governance mechanisms are in place and effective throughout the whole of the NHS system including health improvement activities and ensures that a strategic framework for Public Involvement is in place.

**Universities Strategic Liaison**

Advises the Board on strategic matters concerning clinical teaching, research, additional costs of teaching (ACT) funding and facility requirements. Provides an inclusive forum for strategic dialogue, development and planning between the Universities of Dundee, Abertay and St Andrews with the NHS in Tayside and Fife.

**Finance and Resources**

Development and review of Board's Financial Strategy, reviews resource allocations outwith authority delegated to other committees, monitors use of all resources, oversees development of e-Health and IT systems and monitors strategic policy and planning objectives and priorities.

**Staff Governance**

Advises the Board on its responsibility, accountability and performance against the NHS Scotland Staff Governance Standard, addressing the issues of policy, targets and organisational effectiveness

**Remuneration Committee**

Approves performance assessments, salary uplifts, objectives disciplinary procedures and job evaluation arrangements for Executive and Senior Management posts.

**East of Scotland Research Ethics Service (EoSRES) REC 1**
Assures the ethical review of medical research.

## 2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGAINSED

### How Board and Committee meetings must be organised

This section regulates how the meetings and proceedings of the Board and its Committees will be conducted and are referred to as 'Standing Orders'. The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 confirms the matters to be included in the Standing Orders. The following is NHS Tayside's practical application of these Regulations.

### 1. Calling and Notice of Meetings

1.1 The first meeting of the Board shall be held on a day and at a place fixed by the Chair.

1.2 The Chair may call a meeting of the Board at any time and the chair of a Committee may call a meeting of that Committee at any time or when required to do so by the Board.

1.3 Ordinary meetings of the Board or Committees will be held in accordance with the timetable approved by the Board. Meetings of the Board will normally be held every two months. In any event, Board meetings shall be held at least every three months.

1.4 Meetings of the Board and its Committees may be conducted in any way in which each member is enabled to participate such as video conferencing or teleconferencing.

1.5 A meeting of the Board may be called if one third of the Members make the request in writing. If the Chair does not call a meeting within seven days of the request, the Members who signed the request may call the meeting provided that only the requested business is transacted.

1.6 The notice (agenda and papers) must be delivered to each member, at least seven clear days before the date of the meeting, other than in exceptional circumstances when it must be delivered three clear days before the meeting.

1.7 Before each Board meeting a notice (agenda and papers) specifying the time, place and business to be transacted, shall be sent to every member. The notice of a Board meeting shall be signed by the Board Chairman.

1.8 Before a Committee meeting a notice (agenda and papers) specifying the time, place and business to be transacted, shall be sent to every member. The notice of a Committee meeting shall be signed by the Committee Chairman.

~~1.9 Notification of the time and place of the Board meeting shall be published in the Courier and the NHS Tayside website will display the dates and times of the Board and Committee meetings.~~

1.9 Notification of the time and place of the Board meeting shall be displayed on the NHS Tayside website. The dates and times of Committee meetings will also be available on the NHS Tayside website

1.10 Lack of service of the notice on any Member shall not affect the validity of a meeting.

1.11 Special meetings of Committees shall be held on the dates and times that the Chairs of those Committees determine.

1.12 It is within the discretion of the Chair of any Committee to cancel, advance or postpone an ordinary meeting if there is a good reason for doing so.

1.13 Four or more members of any Committee may, by notice in writing require a special meeting to be called to consider the business specified in the notice. Such a meeting shall be held within fourteen days of receipt of the notice by the Board Secretary or Lead Officer.

**2. Appointment of Chair of Tayside NHS Board**

2.1 The Chair is appointed by the Cabinet Secretary for Health and Well Being. The Regulations governing the period of terms of office and the termination or suspension of office of the Chair are contained in the National Health Services (Scotland) Act 1978.

**3. Appointment of Vice-Chair of Tayside NHS Board**

3.1 To enable the business of the Board to be conducted in the absence of the Chair, a Non-Executive Member who is not an NHS employee or an independent Primary Care Contractor (for example Employee Director, Chair of the Area Clinical Forum or University of Dundee representative shall be appointed Vice-Chair by Non-Executive Members.

3.2 The Vice-Chair will normally hold office for two years, provided that the individual's membership of the Board continues throughout that period. Nominations for the position of Vice-Chair will be identified by the Chairman as part of the personal development and review process of the Non Executive Members sought.

The nomination for the Vice Chair of Tayside NHS Board will be submitted for approval by the Cabinet Secretary for Health and Wellbeing.

The retiring Vice-Chair will be eligible to be appointed as long as the individual remains a Non-Executive Member of the Board.

3.3 The Vice-Chair may resign from the office at any time by giving notice in writing to the Chair. The Non-Executive Members may appoint another Non-Executive Member as Vice-Chair in accordance with 3.1 above.

3.4 Where the Chair of the Board has ceased to hold office or has been unable to perform their duties as Chair owing to illness, absence or any other cause, the Vice-Chair shall take the place of the Chair in the conduct of the business of the Board and references to the Chair shall be taken to include references to the Vice-Chair

**4. Duties of Chair and Vice-Chair**

4.1 At every meeting of the Board the Chair shall preside. If the Chair is absent the Vice-Chair shall preside. If the Chair and Vice-Chair are both absent, the Members present shall elect a Non-Executive Member to act as Chair for that meeting. This cannot be an NHS Tayside employee.

4.2 If both the Chair and Vice-Chair (if any) of a Committee are absent from a meeting, the members shall elect a member to act as Chair for that meeting.

4.3 It shall be the duty of the Chair to:

- Ensure that Standing Orders are observed and to facilitate a culture of transparency, consensus and compromise
- Preserve order and ensure that any member wishing to speak is given due opportunity to do so and a fair hearing
- Call members to speak according to the order in which they caught their eye
- Decide all matters of order, competence and relevance

4.4 The Chief Executive, Board Secretary or Committee Support Officer shall draw the attention of the Chair to any apparent breach of the terms of these Standing Orders.

4.5 The decision of the Chair on all matters referred to in this Standing Order shall be final and shall not be open to question or discussion in any meeting of the Board.

4.6 Deference shall at all times be shown to the authority of the Chair. When the Chair commences speaking, they shall be heard without interruption

## 5. Membership

### Non executive membership

5.1 Each Committee (excluding the East of Scotland Research Ethics Service (EoSRES) REC 1, Pharmacy Practices Sub Committee, Practitioners Service Reference Sub Committee and Primary Care Practitioners Discipline Committee, as these are covered by legislation or guidance) will have a minimum number of Non-Executive Members which includes those Non-Executive Members who are members due to the office they hold.

| | |
|---|---|
| Audit Committee | 6 |
| Finance & Resources Committee | 6 |
| Clinical and Care Governance Committee | 6 |
| Remuneration Committee | 7 |
| Staff Governance Committee | 6 |
| Universities Strategic Liaison Committee | 4 |

## 6. Membership of Committees due to office held

**Tayside NHS Board Chair**
All Committees except Audit Committee

**Employee Director**
Audit Committee
Staff Governance Committee
Universities Strategic Liaison Committee

**Chair of the Area Clinical Forum**
Finance & Resources Committee
Clinical and Care Governance Committee
Universities Strategic Liaison Committee

**Chair of the Staff Governance Committee**
Remuneration Committee

**7. Resignation and removal of members of Committees**

7.1 A member may resign as a Committee Member at any time during the period of appointment by giving notice in writing to the Board Secretary to this effect.

7.2 If the Chairman considers that it is not in the interests of NHS Tayside that a Committee Member should continue to be a member of a particular Committee they can terminate that person's membership of the Committee.

7.3 If a Committee Member has not attended any Committee of which they are a member for three consecutive meetings, the Chair of NHS Tayside shall forthwith terminate that person's appointment unless they are satisfied that :

- The absence was due to illness or other reasonable cause; and
- The member will be able to attend meetings within such period as the Chairman considers reasonable

**8. Process for the appointment of Non-Executive Members, chairs and vice chairs**

8.1 The East of Scotland Research Ethics Service (EoSRES) REC 1 is not included as they are subject to additional governance arrangements by the National Research Ethics Service (NRES).

8.2 The process will commence on a two yearly cycle in January. As a consequence of personal development appraisal and review process, the Chairman will decide with the relevant Non Executive Members which of the Committees they will serve on as member or as Chair or Vice Chair. The positions of Chair and Vice Chairs of Committees carry no further remuneration

8.3 In order to avoid any potential conflict of interest, the Chairperson and Vice Chairperson of the Audit Committee shall not be the Chairperson of any other statutory governance Committee of the Board and the F**i**nance and Resource Committee.

**9. Quorum**

9.1 The quorum for Board meetings is one-third of the whole number of Members, of which at least two are Non-Executive Members, all present and entitled to vote. No business shall be transacted at a meeting of the Board unless this is met

9.2 The number of Non-Executive Members required for the Committees to be quorate is half of the Non-Executive membership.

9.3 The quorum for the Committees shall be as follows:-

| | | |
|---|---|---|
| 1. | Audit Committee | Three members who must be Non-Executive Members |
| 3. | Finance & Resources Committee | Three members who must be Non-Executive Members |
| 4. | Clinical and Care Governance Committee | Five members, three of whom shall be Non-Executive Members |
| 5. | East of Scotland Research Ethics Service (EoSRES) REC 1 | Seven members, of whom one must be the Chair, Vice Chair or alternate Vice Chair, one must be lay and one must be an expert member |
| 6. | Pharmacy Practices Sub-Committee | Five members, one of whom shall be a Non-Executive Member as Chair/Vice Chair, 2 Pharmacists and 2 Lay Members |
| 7. | Practitioner Service Reference Sub-Committee | Two members being the Chair and the professional member |
| 8. | Primary Care Practitioners Discipline Committees | Meetings will be quorate when the Chairperson, Lay Member and Professional Member(s) are present |
| 9. | Remuneration Committee | Four members all of whom must be Non-Executive |
| 10. | Staff Governance Committee | Five members, three of whom must be Non-Executive Members |
| 11. | Universities Strategic Liaison Committee | Five members, two of whom must be Non-Executive Members |

9.4 If a quorum is not present ten minutes after the time specified for the start of a meeting of the Board or Committees the Chair will seek agreement to adjourn the meeting or reschedule.

9.5 If during any meeting of the Board or of its Committees a Member or Members are called away and the Chair finds that the meeting is no longer quorate, the meeting shall be suspended. If a quorum is not present at the end of ten minutes, the Chair will seek agreement to adjourn the meeting or reschedule

**10. Human Rights**

10.1 If the business before the Board or its Committees involves the determination of a persons' individual civil rights and obligations, no member shall participate in the taking of a decision on an item of business unless they have been present during consideration of the whole item, including where the item of business was discussed at a previous meeting. (Article 6 of the European Convention of Human Rights).

**11. Order of Business**

11.1 For ordinary meetings of the Board or its Committees, the business shown on the agenda shall normally proceed in the following order:

- Business determined by the Chair to be a matter of urgency by reason of special circumstances
- Minutes of the previous meeting for approval
- Minutes of Committees
- Reception of deputations, followed by consideration of any items of business on which the deputations have been heard
- Petitions
- General Business
- Questions of which due notice has been given
- Motions of which due notice has been given

11.2 No item of business shall be transacted at a meeting unless either:

- It is included on the agenda which has been published in advance on NHS Tayside's website
- It has been determined by the Chair to be a matter of urgency by reason of special circumstances

**12. Order of debate**

12.1 Any Board or Committee Member wishing to speak shall indicate this by raised hand and, when called upon, shall address the Chair and restrict their remarks to the matter being discussed.

12.2 There shall be no discussion on any motion or amendment except by the mover until such motion or amendment is seconded.

12.3 No Member shall speak more than once in a debate on any one motion or amendment unless raising a point of order, making a clarification, moving or seconding a procedural motion. However the mover of the substantive motion (or an amendment which has become the substantive motion) in any debate shall have a right of reply, but shall not introduce any new matter.

12.4 After the mover of the substantive motion has commenced their reply, no Member shall speak except when raising a point of order or moving or seconding a procedural motion. Any member wishing to raise a point of order may do so by stating that they are raising a point of order immediately after it has arisen. Any member then speaking will cease and the Chair shall call upon the Member raising the point of order to state its substance. No other Member shall be entitled to speak to the point of order except with the consent of the Chair. The Chair shall give a ruling on the point of order, whether immediately or after such adjournment as they consider necessary. After this the Member who was previously speaking shall resume their speech, provided the ruling permits.

12.5 Any Member wishing to ask a question relating to the matter under consideration may do so at any time before the formal debate begins.

**13. Motions and amendments**

A motion is a proposal

13.1 When called to speak, the mover of any motion or amendment shall immediately state the exact terms of the motion or amendment before proceeding to speak in support of it. The mover shall also provide the terms in writing at the request of the Chair to the Board Secretary or Committee Support Officer before any vote is taken, except in the case of:

- Motions or amendments to approve or disapprove without further qualification
- Motions or amendments to remit for further consideration
- Motions or amendments where the terms have been fully set out in a minute of a Committee or report by an Executive Member or other officer

13.2 Every amendment must be relevant to the motion to which it is moved. The Chair shall decide as to the relevance and shall have the power, with the consent of the meeting, to conjoin motions or amendments which are consistent with each other.

13.3 All additions to, omissions from, or variations on a motion shall be considered amendments to the motion and shall be disposed of accordingly.

13.4 A motion or amendment once moved and seconded shall not be withdrawn without the consent of the mover and seconded.

13.5 Where an amendment to a motion has been moved and seconded, no further amendment may be moved until the result of the vote arising from the first amendment has been announced.

13.6 If an amendment is rejected a further amendment to the original motion may be moved. If an amendment is carried it shall take the place of the original motion and any further amendment shall be moved against it.

13.7 A motion for approval of a minute or a report of a Committee shall be considered as an original motion and any proposal involving alterations to or rejection of such minute shall be dealt with as an amendment.

13.8 The Chair of a Committee shall have the right to move the approval of the minute of that Committee.

13.9 A motion or amendment moved but not seconded, or which has been ruled by the Chair to be incompetent, shall not be put to the meeting nor shall it be recorded in the minute, unless the mover immediately gives notice to the Board Secretary or Committee Support Officer requesting that it be so recorded.

13.10 A Member may request their dissent to be recorded in the minute in respect of a decision with which they disagree and on which no vote has taken place.

**14. Notice of motions to be placed on an Agenda**

14.1 Notice of motions must be given in writing to the Board Secretary no later than noon, fourteen days before the meeting and must be signed by the proposing Member and at least one other Member.

14.2 A Member may propose a motion which does not directly relate to an item of business under consideration at the meeting.

14.3 The terms of motions of which notice have been given shall appear as items of business for consideration at the next meeting.

14.4 If a Member who has given notice of a motion is absent from the meeting when the motion is considered or, if present, fails to move it, any other Member shall be entitled to move it, failing which the motion shall fall.

**15. Questions**

15.1 A Board or Committee Member may put a question to the Chair relating to the functions of that Committee, irrespective of whether the subject matter of the question relates to the business which would otherwise fall to be discussed at that meeting, provided that notice has been given three days prior to the meeting.

15.2 The original questioner may ask a supplementary question, limited to seeking clarity on any answer given.

15.3 Questions of which notice has been given in terms of 14.1 above, and the answers thereto, shall be recorded in the minutes of the meeting only if the questioner so requests, but any supplementary questions and answers shall not be recorded.

**16. Time allowed for speaking during formal debate**

16.1 The Chair is entitled to decide the time that members may be allowed to speak on any one issue.

16.2 As a guide, a member who is moving any motion or amendment shall not normally speak for more than five minutes. Other members shall not normally speak for more than three minutes, and the mover in exercising a right of reply shall not normally speak for more than three minutes.

**17. Closure of debate**

17.1 A motion that the debate be adjourned, or that a question be put, or that the meeting now pass to the next business may be made at any stage of the debate and such motion, if seconded, shall be the subject of a vote without further debate.

17.2 No motion in terms of 16.1 above may be made during the course of a speech.

**18. Voting**

18.1 Every question coming or arising before the Board or its Committees shall be determined by a majority of the members present and voting. Majority agreement may be reached by a consensus without a formal vote but at the request of a member a formal vote will be taken. (Subject to 26.1 and any statutory provisions).

18.2 In the case of an equality of votes, the Chair shall have a second or casting vote except in any vote relating to the appointment of a Member of the Board to any office or Committee or to represent the Board on any other body, where in the case of equality of votes the matter shall be determined by lot.

18.3 Where a formal vote is taken, this shall be done by a show of hands except:

- Where the members present agree unanimously that it be taken by a roll call
- Where the members present resolve by simple majority that it be taken by a secret ballot

- In the case of any matter relating to the appointment of a member of staff or relating to any disciplinary or grievance proceedings affecting a member of staff, when the vote shall be taken by a show of hands or by secret ballot

**18.4** Immediately before any vote is taken, the question on which the vote is to be held shall be read out. Thereafter, no-one shall interrupt the proceedings until the result of the vote has been announced.

**19. Voting in the case of vacancies and appointments**

19.1 In filling vacancies in the membership of any Committee and making appointments of Board Members to any other body, where more than one candidate has been nominated and seconded, members shall be entitled to vote for up to as many candidates as there are places to be filled. Candidates shall be appointed in the order of number of votes received until all vacant places have been filled.

19.2 In the event of two or more candidates tying with the lowest number of votes to fill the last vacant place, a further vote shall be taken between or among those candidates. Each member shall have one vote.

19.3 In the event of a further tie, the appointment shall be determined by lot.

**20. Adjournment and duration of meetings**

20.1 During any meeting of the Board, any Member may move that the meeting be adjourned, at any time, except in the course of a speech by another member. No motion for adjournment may be made within thirty minutes of a motion for adjournment having previously been rejected if the Board is still considering the same item of business.

20.2 A motion for adjournment has precedence over all other motions and if moved and seconded, shall be put to the meeting without discussion or amendment.

20.3 If carried, the meeting shall be adjourned until the time and place specified in the motion. Unless the time and place are specified, the adjournment shall be until the next ordinary meeting of the Board or Committee.

20.4 Where a meeting is adjourned without a time for its resumption having been fixed, it shall be resumed at a time fixed by the Chair.

20.5 When an adjourned meeting is resumed, the proceedings shall be commenced at the point at which they were interrupted by the adjournment.

20.6 In case of disorder, the Chair may adjourn the meeting to a time fixed then or decided afterwards. Vacating the Chair shall indicate that the meeting is adjourned.

20.7 Every meeting of the Board or its Committees shall last no longer than four hours.

20.8 It shall, however, be competent before the expiry of the time limit for any Member to move that the meeting be continued for such further period as is deemed appropriate.

**21. Conflict of interest**

21.1 If a Board or Committee Member or associate of theirs has any interest, direct or indirect, in any contract or proposed contract or other matter, they shall disclose the fact and shall not take part in the consideration and discussion of the contract, proposed contract, or other matter or vote on any question with respect to it. Except a contract for the provision of any of the services mentioned in Part II of the Act.

21.2 The Scottish Ministers may, subject to such conditions as they may think fit to impose, remove any disability imposed by the 2001 Regulations in any case in which it appeared to them in the interests of the health service that the disability should be removed.

21.3 Remuneration, compensation or allowances payable to a Chair or other member shall not be treated as an interest for the purpose of the 2001 Regulations. (Paragraphs 4, 5 or 14 of Schedule 1 to the Act).

21.4 A member or associate of theirs shall not be treated as having an interest in any contract, proposed contract or other matter if the interest is so remote or insignificant that they cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of, or in voting on, any question with the respect to that contract or matter.

21.5 The 2001 Regulations apply to a Committee as they apply to the Board and apply to any member of any such Committee (whether or not they are also a Member of the Board) as they apply to a Member of the Board.

21.6 For the purposes of the 2001 Regulations, the word ‘associate’ has the meaning given by Section 74 of the Bankruptcy (Scotland) Act 1985 (a).

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

21.8 The oral declaration of interest should identify the item of business to which it relates. The declaration should begin with the words ‘I declare an interest’. The declaration must be sufficiently informative to enable those at the meeting to understand the nature of the interest but need not give a detailed description of the interest.

**22. Reception of deputations**

22.1 Every application for the reception of a deputation must be in writing, duly signed and delivered, faxed or e-mailed to the Board Secretary or Committee Lead Officer at least three clear working days prior to the date of the meeting at which the deputation wish to be received.
The application must state the subject and the action which it proposes the Board or Committee should take.

22.2 The deputation shall consist of not more than ten people.

22.3 No more than two members of any deputation shall be permitted to address the meeting and they may speak in total for no more than ten minutes.

22.4 Any member may put any relevant question to the deputation but shall not express any opinion on the subject matter until the deputation has withdrawn. If the subject matter relates to an item of business on the agenda, no debate or discussion shall take place until the relevant minute or other item is considered in the order of business.

**23. Receipt of petitions**

23.1 Every petition shall be delivered to the Board Secretary or Committee Lead Officer at least three clear working days before the meeting at which the subject matter may be considered. The Chair will be advised and will decide whether the content of the petition should be discussed at the meeting or not.

**24. Submission of reports**

24.1 Reports shall be submitted by Executive Members or other Senior Officers when requested or when, in the professional opinion of such an Officer, a report is required to enable compliance with any statute, Regulation or Ministerial Direction or other rule of law or where the demands of the service under their control require.

24.2 Any report to be submitted shall be provided no later than fourteen days prior to the meeting of the Board or Committee to the Board Secretary, Committee Lead Officer or Committee Support Officer. The Director of Finance should be consulted on all proposals with significant financial implications. No paper with significant financial implications should be presented at a meeting when this has not been done. Any observations by those officers on matters within their professional remit shall be incorporated into the report. Only those reports which require a decision to be taken by the Board or Committee or are necessary to enable the Board or Committee to discharge its business or exercise its monitoring role, will normally be included on the agenda.

It shall be delegated to the Board Secretary or Committee Lead Officer in conjunction with the Chair of the Committee to make the final determination on whether or not an item of business should be included on an Agenda.

24.3 All reports requiring decisions will be submitted in writing. Verbal reports will only be accepted in exceptional circumstances and with the prior approval of the Chair of the Board or Committee.

**25. Right to attend meetings and/or place Items on an agenda**

25.1 Any Board or Committee Member shall be entitled to attend any meeting of any Committee and shall, with the consent of the Committee, be entitled to speak but not to propose, second any motion or vote. Executive Members cannot attend the Remuneration Committee when matters pertaining to their terms and conditions of service are being discussed and the Audit Committee when deemed necessary by the Chair of that Committee.

25.2 A Board Member, who is not a member of a particular Committee and wishes that Committee to consider an item of business which is within its remit, shall inform in writing the Lead Officer no later than 12 noon on the fourteenth day prior to the meeting of the issue to be discussed. The Lead Officer shall arrange for it to be placed on the agenda of the Committee. The Member shall be entitled to attend the meeting and speak in relation to the item but shall not be entitled to propose or second any motion or to vote.

25.3 Board or Committee Members who wish to raise any item of business which is within its remit shall inform in writing the Committee Lead Officer no later than 12 noon on the fourteenth day prior to the meeting the issue to be discussed. The Committee Lead Officer shall arrange for it to be placed on the agenda of the Committee.

25.4 The Chief Internal Auditor and the External Auditor have a right of attendance at all Committees. The Chief Internal Auditor and External Auditor shall have the right to direct access to the Chairs of the Board and all Committees.

25.5 The Public Partnership Networks (PPNs) shall be invited to send a maximum of two representatives to attend the meetings held in public except the East of Scotland Research Ethics Service (EoSRES) REC 1 and Remuneration Committee.

25.6 The Area Clinical Forum and Area Partnership Forum shall be invited to send a maximum of two representatives to attend Committee meetings except the East of Scotland Research Ethics Service (EoSRES) REC 1, the Pharmacy Practices Sub Committee, Practitioners Service Reference Sub Committee and the Remuneration Committee.

The Chair of the meeting will have the discretion to decide if the representatives will not be issued with reserved business and will be required to leave due to the nature of business to be discussed in Reserved Business.

Persons attending in this capacity shall be entitled to speak but not to propose or second any motion or to vote.

No deputies are allowed for Members of Committees except for the East of Scotland Research Ethics Service (EoSRES) REC 1. In a Member's absence a representative can attend. A representative is not allowed to take part in any vote and is not included as part of the quorum for a meeting. A representative would only be allowed to speak during any part of a meeting with the approval of the Chair of the Committee.

Deputies at the East of Scotland Research Ethics Service (EoSRES) REC 1 have full voting rights.

**26. Alteration or revocation of previous decision**

26.1 Subject to 26.2 below, a decision shall not be altered or revoked within a period of six months from the date of such decision being taken.

26.2 Where the Chair rules that a material change of circumstances has occurred to such extent that it is appropriate for the issue to be reconsidered, a decision may be altered or revoked within six months by a subsequent decision arising from:

- A recommendation to that effect by an Executive Member or other officer in a formal Report
- A motion to that effect of which prior notice has been given in terms of 13.1

**27. Suspension of Standing Orders**

27.1 So far as it is consistent with any statutory provisions, any one or more of the Standing Orders may be suspended at any meeting but only as regards the business at such meeting, provided that two-thirds of the members present and voting so decide.

**28. Admissions of public and press**

Members of the public and representatives of the press will be admitted to every meeting of the Board and its Committees except the Remuneration Committee, East of Scotland Research Ethics Service (EoSRES) REC 1, the Pharmacy Practices Sub Committee and the Practitioners Service Reference Sub-Committee but will not be permitted to take part in discussion. (Public Bodies (Admissions to Meetings) Act 1960).

28.1 The Board or its Committees may exclude the public and press while considering any matter that is confidential. Exemptions include under, Freedom of Information (Scotland) Act 2002 (the Act) and Environmental Information (Scotland) Regulations 2004 (the Regulations).

A summary of the exemptions specified in the Act is contained at the end of this section at paragraph 32 but should not be relied upon as a comprehensive application of the exemptions in restricting access to information.

For guidance on application of the Act and Regulations please contact the Board Secretary on 01382 740709 or extension 40709 or the Information Governance Manager on 01382 424413 or extension 70413.

28.2 The terms of any such resolution specifying the part of the proceedings to which it relates and the categories of exempt information involved shall be specified in the minutes.

28.3 Members of the public and representatives of the press admitted to meetings shall not be permitted to make use of photographic or recording apparatus of any kind unless agreed by the Board. (1960 Act).

28.4 Members of the public and press should leave when the meeting moves into reserved business. It is at the discretion of the Chair of that meeting if NHS Tayside staff can remain.

**29. Members' Code of Conduct**

29.1 All those who are appointed as Members of the Board must comply with the Members' Code of Conduct as incorporated into the Code of Corporate Governance and approved by the Scottish Government. This also applies equally to all members of Committees, whether they are employed by NHS Tayside or not, when undertaking Committee Business.

29.2 For the purposes of monitoring compliance with the Members' Code of Conduct, the Board Secretary has been appointed as the designated monitoring officer.

29.3 Board and Committee Members having any doubts about the relevance of a particular interest should discuss the matter with the Board Secretary.

29.4 Board and Committee Members should declare on appointment any material or relevant interest and such interests should be recorded in the Board and Committee minutes. Any changes should be declared and recorded when they occur. Interests will also be entered into a register that is available to the public, details of which will be disclosed in the Board's Annual Report. Arrangements for viewing the register shall also be published.

**30. Suspension of Members from meetings**

30.1 If any Board or Committee Member disregards the authority of the Chair, obstructs the meeting or, in the opinion of the Chair, acts in an offensive manner at a meeting, the Chair may move that such member be suspended for the remainder of the meeting. If seconded, such a motion shall be put to the vote immediately without discussion.

30.2 If such a motion is carried, the suspended Member shall leave the meeting immediately. If the member fails to comply, the Chair may order the suspended member to be removed from the meeting.

30.3 A Member, who has been suspended in terms of this Standing Order shall not re-enter the meeting room except with the consent of the meeting.

30.4 In the event of a motion for suspension of a member being defeated, the Chair may, if they think it appropriate to do so, adjourn the meeting as if a state of disorder had arisen.

**31. Minutes, agendas and papers**

31.1 The Board Secretary is responsible for ensuring that Minutes of the proceedings of a meeting of the Board or its Committees, including any decision or resolution made at that meeting, shall be drawn up. The minutes shall be submitted to the next meeting of the Board or relevant Committee for approval by Members as a record of the meeting, subject to any amendments proposed by members and shall be signed by the person presiding at that meeting.

31.2 The names of Members present at a meeting of the Board or of a Committee of the Board shall be recorded in the Minute, together with the apologies for absence from any member.

31.3 The Freedom of Information (Scotland) Act 2002 gives the public a general right of access to all recorded information held. Therefore when minutes of meetings are created, it should be assumed that what is recorded will be made available to the public.

31.4 The Minute of a meeting being held where authority or approval is being given by the Committee, and the Minutes are intended to act as a record of the business of the meeting, then the Minute should contain:

- A summary of the Committee's discussions
- A clear and unambiguous statement of all decisions taken
- If no decision is taken, a clear and unambiguous statement of where the matter is being referred or why the decision has been deferred
- Where options are presented, a summary of why options were either accepted or rejected
- Reference to any supporting documents relied upon

- Any other relevant points which influenced the decision or recommendation
- Any recommendation which require approval by a higher authority

31.5 The contents of a Minute will depend upon the purpose of the meeting.

If the meeting agrees actions they will be recorded in an action point update which should include:

- A description of the task, including any phases and reporting requirements
- The person accepting responsibility to undertake the task
- The time limits associated with the task, its phases and agreed reporting

31.6 The Agenda should normally be divided into two sections

- Open Business would include items where there would be no issue with information on these items being released in a minute.
- The second section would include items of reserved business that are excluded from inclusion in the minute.

31.7 The basis for exclusion will rely on the Exemptions specified in the Freedom of Information (Scotland) Act 2002. Please refer to the Guide on exemptions at the end of this section at paragraph 32.

In these circumstances, the information should be excluded from the Minute and placed in a separate document. The separate document, Reserved Minute, should be referred to in the Minute.

The Reserved Minute will be clearly marked and the exemption being relied upon will be recorded against each item recorded in the Reserved Minute.

31.8 Consideration will have to be given to recording individual items for Reserved Business separately where there are timing issues. Some information will be sensitive for longer than other information or may not be suitable for publication at all. For example, some policy decisions might be sensitive while they are being considered, but that sensitivity declines once the decision is announced. Information relating to security arrangements may remain sensitive for many years. There will be some Reserved Business that will remain confidential indefinitely, such as information on individual disciplinary matters etc.

For guidance on application of the Act and Regulations please contact the Board Secretary on 01382 740709 or extension 40709 or the Information Governance Manager on 01382 424413 or extension 70413.

## 32. Guide to the Exemptions under the Freedom of Information (Scotland) Act 2002

32.1 All the exceptions operate in different ways, and when applying the individual exemptions, we may need to consider the following factors:

- The content of the information
- The effect that disclosure would have
- The source of the information
- The purpose for which the information was recorded

The Act also recognises that the disclosure of certain categories of information may, at the time of request, be harmful to the wider public interest, for example:

- Where disclosure might be harmful to an important public interest, such as national security or international relations
- Where disclosure is prohibited by statute
- Where responding to the request might involve providing personal information
- Where disclosure might breach a duty of confidentiality

Because the Act strikes a balance between different and important interests, a decision to withhold or release information will require careful consideration. Access to information legislation is about providing the framework within which decisions can be made on where the balance of public interest lies on the release or withholding of information, and on the merits of each case. The Act contains a number of exemptions to the general right of access. The exemptions ensure that decisions to release or withhold information are taken with the interest of the public as a whole firmly to the fore.

**There are two types of exemption under the Freedom of Information (Scotland) Act 2002:**

**Absolute Exemptions:** If an absolute exemption applied, there is no obligation under the Act to consider the request for information further.

**Qualified Exemptions:** Are subject to the public interest test. Qualified exemptions do not justify withholding information unless; following a proper assessment, the balance of the public interest comes down against disclosure.

## 32.2 Absolute Exemptions

### Section 25, Exemption Information Otherwise Accessible

Information is exempt where the applicant can reasonably obtain it by means other than by making a request under the Act. This would include information available through our publication scheme, information available in published form to purchase such as a book, or information generally available in a public library.

**Key Points**

- The question is whether the information is reasonably accessible to the applicant and it is important that we need to be aware of any attributes of an individual applicant which may mean that information is more or less accessible to them than it is to the public at large.
- This section may apply even if a fee is charged for supplying the information
- There is no exclusion in this section of the duty to confirm or deny whether information is held. Even if information is exempt under this section we may still have to tell the applicant whether or not we hold the information requested.

### Section 26, Exemption Prohibitions on Disclosure

Information is exempt if its disclosure is prohibited by an enactment of law, is incompatible with an EC obligation or would constitute or be punishable as a contempt of Court.

**Key Points**

- The Human Rights Act 1998 can be a statutory bar to the disclosure of information if to do so would breach one of the Convention rights that have been incorporated into domestic law.

### Section 36(2), Exemption Confidentiality

**Key Points**

- This section will only apply where a person would be able to bring a successful action for breach of confidence as a result of disclosure to the public.
- This section is not subject to a public interest balance imposed by the FOISA but the courts have recognised that a person will not be successful in an action for breach of confidence if the public interest in disclosure outweighs the public interest in keeping the confidence.
- The application of this section may require detailed consideration of the law of breach of confidence and expert advice will often be necessary.

**Section 37, Exemption of Court Records**

Information is exempt where it is held as part of the documentation provided by/for a court, tribunal case or a statutory enquiry.

**Section 38, Exemption Personal Information**

Under 38(1), information which constitutes person data under the Data Protection Act 1998 is exempt if the applicant is requesting information about themselves (to be handled as a subject access request under the DPA) or if the information is personal census information or a deceased persons' health record. There is also an exemption if the information being requested is the personal data of a third party and disclosure would breach one of the eight Data Protection Principles.

**Key Points**

- If information is exempt under this section because it is the personal data of the applicant, then its disclosure must be considered under the subject access provisions in the Data Protection Act 1998; the Act **may require the disclosure** of information which would otherwise have been exempt under the FOISA.
- Where we receive requests for personal data of someone other than the applicant, the application of this section will in most circumstances focus on whether disclosure of the information to a member of the public would be 'unfair'.
- We must be aware of the need to consult experts where the application of this section is difficult or unclear: getting a decision wrong **may result in breach** of the Data Protection Act 1998.
- The majority of this section is not subject to a public interest balance.

### 32.3 Qualified Exemptions and the Public Interest

When considering the application of a Qualified Exemption we must take into account that they are subject to the Public Interest Test. In applying the Public Interest Test we must show that the public interest in withholding the information is greater than the public interest in releasing it. If this is not established then we will release the information being considered.

**Section 27(1), Information Intended for Future Publication**

**Relevance**

Under 27(1) information is exempt if it is due to be published within 12 weeks at the point of the request, where it is reasonable in all the circumstances that the information be withheld until the publication date. This would apply to information such as policy documents or reports which are due to be released within 12 weeks.

**Section 27(2), Information Intended for Future Publication – Research Programmes**

**Relevance**

Under 27(2) (research exemption) information is exempt if it is part of an ongoing programme of research where there is an intention to publish a report of the research and disclosure would substantially prejudice the programme, the interests of the participants, the public authority or the publisher. This would apply to ongoing programmes of active research.

**Section 28, Relations within the United Kingdom**

**Relevance**

Information is exempt if it is likely to substantially prejudice relations between the UK administrations; UK Government, Scottish Government, Welsh and Northern Irish Assemblies.

**Section 29, Formulation of Scottish Administration Policy etc**

**Relevance**

Information held by the Scottish Administration is exempt if it relates to policy development, Ministerial communications, advice provided by law officers or the operation of any Ministerial private office.

**Section 30, Prejudice to Effective Conduct of Public Affairs**

**Relevance**

Information is exempt if its disclosure would:

(a) Substantially prejudice the maintenance of the convention of the collective responsibility of the Scottish Ministers

(b) Substantially inhibit the free and frank provision of advice and exchange of views

(c) Substantially prejudice the effective conduct of public affairs

Parts (b) and (c) of this exemption could apply where we wish to restrict disclosure of information on matters and decisions still under consideration and discussion.

**Section 31, National Security and Defence**

**Relevance**

Information is exempt if it is required for the purposes of safeguarding national security or where disclosure would substantially prejudice the defence of the British Isles or any colony or the capability or security of any relevant forces.

**Section 32, International Relations**

**Relevance**

Information is exempt where it would substantially prejudice the UK's international relations or interests.

**Section 33, Commercial Interests and the Economy**

**Relevance**

Under 33 (1) information is exempt if it constitutes a trade secret or its disclosure would substantially prejudice the commercial interests of any person, including our organisation. This exemption could apply where NHS Tayside wished to protect its research, teaching materials or information provided by contractors.

**Key Points**

- This section protects not only commercial interests of third parties but also the commercial interests of the Scottish public authority that holds the information.
- Consideration should be given to the fact that commercial sensitivity (particularly the market sensitivity) of information will usually decrease with time.
- 33 (2), where the information is exempt if disclosure would substantially prejudice the economic interests of the UK or its administrators is unlikely to apply.

**Section 34, Investigations by Public Authorities and Proceedings Arising out of such Investigations**

**Relevance**

Information held for the purpose of criminal investigations and proceedings and information obtained from confidential sources relating to these or civil proceedings arising out of them is exempt. Information is also exempt where it is held for purposes of an inquiry or investigation into a fatal accident or sudden death.

This section is concerned primarily with preserving the integrity of certain proceedings and investigations which Scottish public authorities have the power or duty to conduct.

There are two ways in which the application of this section may be triggered:

a) Where the information has at anytime been held for the purpose of specified criminal and other investigations or proceedings
b) Where information relates to the obtaining of information from confidential sources and was obtained or recorded for a number of specified investigations or proceedings

**Key Points**

- This section can only be relied on by a Scottish Authority which itself exercises one of the investigation or litigation functions that are specified in the exemption
- This is a complex exemption and the precise terms in which its two limbs are expressed would need detailed analysis
-

**Section 35, Law Enforcement**

**Relevance**

Information is exempt where it would substantially prejudice a range of investigations and conduct including the prevention or detection of crime, apprehension or prosecution of offenders, tax assessment and collection, immigration controls, regulatory enforcement, health and safety and civil proceedings.

This section applies where the exercise by any Scottish public authority of certain specified functions would be prejudiced by disclosure. Those functions include ascertaining whether a person is responsible for improper conduct, determining the cause of an accident and ascertaining a person's fitness to carry on a profession.

**Key Points**

- This section only applies in cases where the information does not fall within the previous Section 34.
- The structure of this section is complex and it will be necessary to have careful regard to the important differences between the ways in which the various categories of information are framed.
- The categories within this section may overlap and consideration should be given to all categories that may apply.

**Section 36, Confidentiality – Legal Proceedings**

**Relevance**

Under 36 (1) information is exempt where a claim of confidentiality of communications could be claimed in legal proceedings.

**Section 39, Health, Safety and the Environment**

**Relevance**

Under 39 (1) information is exempt if its disclosure would endanger the physical or mental health or the safety of an individual. This could be applied to prevent disclosure of information that might enable individuals working in sensitive area or on a project of particular concern to a pressure group, to be identified and targeted. For example, information on security procedures, the location of laboratories and staff involved.

Under 39 (2) information is exempt if it constitutes environmental information as defined in the Environmental Information Regulations. The request should instead be dealt with under these Regulations. If the information is subject to a discretionary exemption under the EIRs then the FOISA public interest test would apply.

**Section 40, Audit Functions**

**Relevance**

Information is exempt where it is held by a Scottish public authority with a statutory duty to audit the accounts or examine the economy, efficiency and effectiveness of the use of resources of other public authorities and where release of the information would substantially prejudice those functions.

**Key Points**

This section only applies where one Scottish public authority has audit or monitoring functions in relation to another Scottish public authority. It does not apply where a Scottish public authority has such functions in relation to private sector bodies, nor does it cover internal audit and monitoring.

**Section 41, Communications with Her Majesty etc. and Honours**

**Relevance**

Information is exempt if it relates to communications with Her Majesty, members of the Royal Family or Royal Household or the conferring of Honours.

**33. Records Management**

Under the Freedom of Information (Scotland) Act 2002, NHS Tayside must have comprehensive records management systems and process in place.

Separate guidance has been produced for records management. This can be found on NHS Tayside's Staffnet ~~Intranet:~~

- GV11 Records Management Policy
- GV14 Records Management Strategy
- GV15 Records Retention Schedules
- GV15 Records Creation and Registration

These documents give clear guidance on the time limits for the retention of records and documents.

**3. COMMITTEES**

**1. Establishing Committees**

1.1 The Board shall create such Committees as are required by statute, guidance, Regulation and Ministerial direction and as are necessary for the economical, efficient and effective governance of its business.

1.2 The Board shall delegate to such Committees those matters it considers appropriate. The matters delegated shall be set out in the Purpose and Remits of those Committees detailed in paragraph 8, Purpose and Remits.

1.3 The Board may, by resolution of a simple majority of the whole number of Members of the Board present and voting, vary the number, constitution and functions of Committees at any meeting at which due notice has been given specifying the proposed variations.

1.4 Committees shall meet in locations that encourage public involvement in the business of the Board.

**2. Membership**

2.1 The Board shall appoint the membership of Committees. By virtue of their appointment the Chair of the Board is an ex officio Member of all Committees except the Audit Committee.

2.2 Any Committee, shall include at least one Non-Executive Member of the Board, and may include persons, who are co-opted, and may consist wholly or partly of Members of the Board.

2.3 In determining the membership of Committees, the Board shall have due regard to its purpose, role and remit, and accountability requirements. Certain Members may not be appointed to serve on a particular Committee as a consequence of their positions. Specific exclusions are:

- Audit Committee – Chair of the Board together with any Executive Member or Officer.
- Finance and Resources Committee – any Executive Member or Officer.
- Remuneration Committee – any Executive Member or Officer.

2.4 The Board has the power to vary the membership of Committees at any time provided that:

- In any case this is not contrary to statute, Regulation or Direction by Scottish Ministers.
- Each Member of the Board is afforded proper opportunity to serve on Committees.

2.5 The Board shall appoint Chairs and Vice-Chairs of Committees who shall hold office for two years. In the case of Members of the Board, this shall be dependent upon their continuing membership of the Board.

2.6 The persons appointed as Chairs of Committees shall usually be Non-Executive Members of the Board and only in exceptional circumstances shall the Board appoint a Chair of a Committee who is not a Non-Executive Member. Such circumstances are to be recorded in the Minutes of the Board meeting making the appointment.

2.7 As a consequence of the personal development appraisal and review process, the Chairman will decide with the relevant Non Executive Members which of the Committees they will serve on as member or as Chair or Vice Chair.

2.8 Casual vacancies occurring in any Committee shall be filled as soon as may be by the Board after the vacancy takes place.

**3. Functioning**

3.1 An Executive Member or another specified Lead Officer shall be appointed to support the functioning of each Committee.

3.2 Committees may seek approval of the Board to appoint Sub-Committees for such purposes as may be necessary.

3.3 An Executive Member or another specified Lead Officer and a Committee Support Officer shall be appointed to support the functioning of each Committee.

3.4 Where the functions of the Board are being carried out by Committees, the membership, including those co-opted Members who are not Members of the Board, is deemed to be acting on behalf of the Board. During intervals between meetings of the Board or its Committees, the Chair of the Board or Committee, or in their absence the Vice-Chair, shall, in conjunction with the Chief Executive and the Lead Officer concerned, have powers to deal with matters of urgency which fall within the Terms of Reference of the Committee and require a decision which would normally be taken by the Committee.

It shall be for the Chair of the Committee, in consultation with the Chief Executive and Lead Officer concerned, to determine whether a matter is urgent in terms of this Standing Order.

**4. Minutes**

4.1 The Minute of each Committee of the Board shall be submitted as soon as is practicable to an ordinary meeting of the Board for information and for the consideration of any recommendations having been made by the Committee concerned.

4.2 The Minute of each Committee shall also be submitted to the next meeting for approval as a correct record and signature by the Chair.

4.3 Minutes of the proceedings at a meeting of a Special Committee shall be made but these proceedings may be reported to the Board or to any Committee of the Board either by the Minutes or in a report from the Special Committee as may be considered appropriate.

**5. Frequency**

The Committees of the Board shall meet no fewer than four times a year with the exception of the Universities Strategic Liaison Committee, which will meet at least twice a year.

**6. Delegation**

6.1 Each Committee shall have delegated authority to determine any matter within its Purpose and Remit, with the exception of any specific restrictions contained in Section E, paragraph items 1.2.1 to items 1.2.22.

6.2 Committees shall conduct their business within their Purpose and Remit and in exercising their authority shall do so in accordance with the following provisions. However, in relation to any matter either not specifically referred to in the Purpose and Remit, or in this Standing Order, it shall be competent for the Committee, whose remit the matter most closely resembles, to consider such matter and to make any appropriate recommendations to the Board.

6.3 Committees must conduct all business in accordance with NHS Tayside policies and the Code of Corporate Governance.

6.4 The Board may deal with any matter falling within the Purpose and Remit of any Committee without the requirement of receiving a report or Minute of that Committee referring to that matter.

6.5 The Board may at any time vary, add to, restrict or recall any reference or delegation to any Committee. Specific direction by the Board in relation to the remit of a Committee shall take precedence over the terms of any provision in the purpose and remit.

6.6 If a matter is of common or joint interest to a number of Committees and is a delegated matter, no action shall be taken until all Committees have considered the matter.

6.7 In the event of a disagreement between Committees in respect of any such proposal or recommendation which falls within the delegated authority of one Committee, the decision of that Committee shall prevail. If the matter is referred but not delegated to any Committee, a report summarising the views of the various Committees shall be prepared by the appropriate officer and shall appear as an item of business on the agenda of the next convenient meeting of the Board.

**7. Committees**

a) Audit Committee
b) Finance & Resources Committee
c) Clinical and Care Governance Committee
d) East of Scotland Research Ethics Service (EoSRES) REC 1
e) Pharmacy Practices Sub-Committee
f) Primary Care Practitioners Discipline Committee
g) Practitioners Services Reference Sub-Committee
h) Remuneration Committee
i) Staff Governance Committee
j) Universities Strategic Liaison Committee

## 8. Purpose and Remits

### a) Audit Committee

#### 1.1 Purpose

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

- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Financial Statements are prepared timeously and give a true and fair view of the financial position of the Board for the period in question
- Affairs are managed to secure economic efficient and effective use of resources
- Reasonable steps are taken to prevent and detect fraud and other irregularities

#### 1.2 Composition

The Audit Committee shall consist of a minimum of six Non-Executive Members including the Employee Director but not the Chair of the Board.

Ordinarily the Audit Committee Chair cannot Chair any other Governance Committee of the Board. The Governance Committees are the Staff Governance Committee, the Clinical and Care Governance Committee and the Finance and Resources Committee.

In Attendance
~~The Associate~~ The Director of Finance (Lead Officer)
Board Secretary

Other Directors will only attend if they are presenting a report to the Committee or the Committee requests their attendance.

The External Auditor and the Chief Internal Auditor shall also receive a standing invitation to attend.

## 1.3 Meetings

A schedule of meetings will identify the key items of business to be discussed at each meeting. Meetings of the Committee shall be quorate when at least three Non-Executive Members of the Board are present. If deemed necessary by the Chair, meetings of the Committee shall be convened and attended exclusively by Members of the Committee and/or the External Auditor or Internal Auditor

## 1.4 Remit

The main objectives of the Audit Committee are to ensure compliance with NHS Tayside's Code of Corporate Governance and that an effective system of internal control is maintained. The duties of the Audit Committee are in accordance with the NHS Audit Committee Handbook and are as detailed below:

### Risk Reporting

The Committee has a duty:

- To review the organisations risk management arrangements, systems and processes
- To review quarterly reports from strategic risk owners with risk aligned to this Committee
- To review and approve the risk management workplan
- To approve the terms of reference and Committee Annual Report of the Strategic Risk Management Group
- To receive the minutes from the Strategic Risk Management Group and Risk/Health and Safety Management Group
- To approve the mid year and annual risk management/health and safety reports on effectiveness, adequacy and robustness of the risk management system.

### Policy Adoption

- Adopt Health and Safety/Risk Management (including fire safety) policies.

### Internal Control and Corporate Governance

To review the framework of Internal Control and Corporate Governance comprising the following components:

- Control environment
- Information and communication
- Risk Management
- Control procedures
- Monitoring and corrective action

To review the system of internal financial control, this includes:

- The safeguarding of assets against unauthorised use and disposition
- The maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication
- To ensure that the Board's activities are within the law, Regulations, Ministerial Direction and the Board's Code of Corporate Governance
- To present an annual Statement of Assurance on the above to the Board, in support of the Statement of Internal Control by the Chief Executive

**Internal Audit**

- To review and approve the Internal Audit Strategic and Annual Plans
- To receive and review Internal Audit reports in line with the Internal Audit Protocol
- To receive and review management reports on action taken in response to audit recommendations in line with the agreed follow-up protocol
- To consider the Chief Internal Auditor's Annual Report and Assurance Statement
- To review the operational effectiveness of the Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures
- To ensure that there is direct contact between the Audit Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors

**External Audit**

- To review the annual Audit Plan including the Performance Audit programme
- To review the terms of reference, appointment and remuneration of external auditors for the Board Endowment Funds
- To review Audit Plan produced by the external auditors appointed in relation to the Board Endowment Funds
- To consider all statutory audit material for the Board, in particular
  - Audit Reports (including Performance Audit studies);
  - Annual Report
  - Chief Executive Letters
  - Matters relating to the Certification of Annual Accounts (Exchequer Funds), Annual Patients' Funds Accounts and Annual Tayside Health Funds Accounts
  - To monitor management action taken in response to all External Audit recommendations, including VFM studies

- To hold meetings with the External Auditors at least once per year and as required, without the presence of the Executive Directors
- To review the extent of co-operation between External and Internal Audit
- Annually appraise the performance of the External Auditors To note the appointment and remuneration of the External Auditors and to examine any reason for the resignation or dismissal of the Auditors
- To appoint the External Auditors of Patients' Funds and approve the remuneration

**Code of Corporate Governance**

- To review the Code of Corporate Governance which includes Standing Orders, Schemes of Reservation and Delegation;
- Standing Financial Instructions and recommend amendments to the Board;
- To examine the circumstances associated with each occasion when Standing Orders have been waived or suspended;
- To monitor compliance with the Members' Code of Conduct.

**Annual Report Accounts**

- To review the Annual Report for the Board
- To review and recommend for approval the Annual Accounts for Exchequer Funds
- To review and recommend for approval the Annual Accounts for Endowment Funds to the Endowment Trustees of the Board
- To review and recommend for approval the Annual Accounts for Patients' Funds
- To review at least annually the accounting policies and approve any changes thereto
- To review schedules of losses and compensation payments

**Other Matters**

- The Committee has a duty to review its own performance and effectiveness, including its running costs and terms of reference on an annual basis
- The Committee has a duty to keep up to date by having a mechanism to ensure topical legal and regulatory requirements are brought to Members' attention
- The Committee shall monitor how the Board controls risk and possible litigation
- The Committee shall agree the level of detail it wishes to receive from the Internal and External Auditors.

### 1.5 Best Value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure the best value for these delegated areas. The assurance to the Chief Executive should be included as an explicit statement in the Committees Annual Report.

### 1.6 Authority

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure best value for these delegated areas.

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

### 1.7 Reporting Arrangements

The Audit Committee reports to Tayside NHS Board.
Following a meeting of the Audit Committee, the minutes of that meeting should be presented at the next Tayside NHS Board meeting.

The Audit 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 Audit Committee.

The Audit Committee will produce an Annual Report for presentation to Tayside NHS Board. The Annual Report will describe the outcomes from the Audit Committee during the year and will provide an assurance to the Board that the Audit Committee and the other Committees have fulfilled their remits during the year.

The Audit Committee Annual Report must be presented to the Board meeting considering the Annual Accounts.

## b) Finance and Resources Committee

### 1.1 Purpose

To keep under review the financial position of Tayside NHS Board, to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and provide assurance that these arrangements are working effectively.

### 1.2 Composition

Membership of the Finance and Resources Committee shall consist of a minimum of six Non-Executive Members of the Board including the Employee Director and the Chair of the Area Clinical Forum.

In addition, there will be in attendance the, the Director of Finance (Lead Officer~~), and the Associate Director of Finance~~

Other Directors will only attend if they are presenting a report to the Committee or the Committee requests their attendance.

### 1.3 Meetings

Meetings of the Committee will be quorate when at least three Members are present.

### 1.4 Remit

~~**Financial Position**~~

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

- ~~Such financial monitoring and reporting arrangements as may be specified~~
- ~~Compliance with statutory financial requirements and achievement of financial targets~~
- ~~Levels of balances and reserves~~
- ~~The impact of planned future policies and known or foreseeable future developments on the financial position~~

~~**Policy Adoption**~~

~~Adopt all finance and governance policies.~~
~~Adopt all information governance/assurance policies.~~

**eHealth**

eHealth will report through the Finance and Resources Committee and the Finance and Resources Committee should approve the eHealth Delivery Plan.

~~**Performance Management – Arrangements for Securing Value for Money**~~

~~The Committee shall keep under review arrangements and provide an annual opinion to the Board with regard to the arrangements for securing economy, efficiency and effectiveness in the use of resources.~~

~~These arrangements will include procedures for:~~

- ~~Planning, appraisal authorisation and control, accountability and evaluation of these resources~~
- ~~Reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner~~

**~~Allocation and Use of Resources~~**

**~~The Committee has key responsibilities:~~**

- ~~To oversee the development of the Board's Financial Strategy in support of the Local Delivery Plan~~
- ~~To review all resource allocation proposals outwith the authority delegated by the Board to any Committee , and making recommendations to the Board thereon~~
- ~~To monitor the use of all resources available to the Board~~
- ~~Specifically, the Committee is charged with recommending to the Board, annual revenue and capital budgets, and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme and the review of the Property Strategy (including the acquisition and disposal of property)~~

**Information Governance**

The Committee will receive an annual assurance report/action plan followed by a mid-year and annual report to provide assurance that NHS Tayside has the necessary information assurance arrangements in place.

**~~1.5 Best Value~~**

~~The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure best value for these delegated areas. The assurance to the Chief Executive should be included as an explicit statement in the Committees Annual Report.~~

**~~1.6 Authority~~**

~~The Committee's authority shall be within the following framework. In performing these functions, the Committee is expected to operate at a strategic governance level. Through the Accountable Officer, and with Internal and External Audit assistance where required.~~

~~It must satisfy itself that there are, appropriate operational controls in place throughout NHS Tayside.~~

**Tenders, Contracts, Business Cases within the limits of previously approved revenue and capital budgets:**

See also

- Section E, Reservation of Powers and Delegation of Authority – Scheme of Further Delegation, and
- Section F, Standing Financial Instructions, Section 13, Contracting and Purchasing and Annex 1, Tendering Procedures.

The Finance and Resources Committee has delegated authority to approve the acceptance of tenders and business cases on behalf of the Board up to a value of £4,000,000 (IM&T Schemes up to £2,000,000) which cannot be accepted by any other Committee or Accountable Officer in terms of delegated powers and where the most economically advantageous tender is to be accepted.

The Chief Executive, as Accountable Officer, acting together with the Director of Finance, has delegated authority to approve acceptance of tenders and business cases up to a value of £1,000,000 and where the most economically advantageous tender is to be accepted.

The nominated Operational Director, Board Executive Directors and Operational Unit Directors, acting together with the Director of Finance/ Associate Director of Finance – Financial Planning & Operational Services, have delegated authority to approve acceptance of tenders and business cases up to the value of £1,000,000 and where the most economically advantageous tender is to be accepted.

The Chief Executive shall submit to the Finance and Resources Committee a report detailing all tenders and business cases in excess of £150,000 and accepted by them in terms of the above delegated powers during the preceding two months, in an appropriate format.

**Authority to Spend Funds and Virement**
**(See Section E – Reservation of Powers and Delegation of Authority – Scheme of Further Delegation)**

Delegated authority is granted, as undernoted, to approve the funding of individual items of expenditure provided that approval can be funded within the Board's overall Revenue and Capital Budgets and to transfer funds up to this level between budgets including transfers from reserves and balances.

- The Finance and Resources Committee up to a value of £4,000,000 (IM&T Schemes up to £2,000,000) in any one instance. This authority shall be exercised in respect of all proposals greater than the delegated limits below:
    - The Chief Executive as the Accountable Officer, acting together with the Director of Finance to a value of £1,000,000
    - The nominated Operational Director, acting together with the Associate Director of Finance – Financial Planning & Operational Services, up to the value of £1,000,000
    - The Board and Operational Unit Executive Directors, acting together with the Director of Finance/ Associate Director of Finance – Financial Planning & Operational Services up to the value of £1,000,000

**Capital Programme**

The Board's Capital Programme shall be managed within the framework approved each year by the Board.

The Committee shall, within its framework, approve tenders and business cases up to a value of £3,000,000. Variations in cost from the approved framework in excess of 5% or £150,000, whichever is the higher, shall be reported to the Committee.

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

The Finance and Resources Committee will appoint a Capital Scrutiny Group to co-ordinate the production of the 5 year Capital Plan, to oversee the implementation of the Capital Programme and to ensure the appropriate levels of governance are in place regarding NHS Tayside's Capital Programme.

~~**Reporting Arrangements**~~

~~The Finance and Resources Committee reports to Tayside NHS Board.~~

~~Following a meeting of the Finance and Resources Committee the minutes of that meeting should be presented at the next Tayside NHS Board meeting.~~

~~The Finance and Resources 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 Finance and Resources Committee.~~

~~The Finance and Resources 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 Finance and Resources Committee before it is presented to the Audit Committee considering Annual Accounts.~~

Financial Framework

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The Committee will oversee the development of a Financial Strategy that is consistent with national and local priorities, and specifically:-

- oversee the development of the Board Financial Strategy in support of the Local Delivery Plan, including aligning service and financial planning arrangements with community planning priorities;
- recommend to the Board annual revenue and capital budgets, and financial plans consistent with its statutory financial responsibilities;
- examine in detail the financial plan for NHS Tayside to ensure that planning assumptions are soundly based and reflect known pressures, potential investments and opportunities for cost reduction;
- review the financial impact of planned future policies and known or foreseeable future developments;
- review the capital plan of NHS Tayside no less frequently than twice per year and consider the impact of development opportunities and any risks arising from delivery of the current programme, and
- ensure that there is an integrated approach to workforce, finance and service planning.

Financial Investment

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- ensure robust appraisal around business case development and delivery;
- scrutinise business cases for proposed investment ensuring that outcomes and benefits are clearly defined, are measureable and support delivery of key objectives for the Board;
- monitor delivery of approved investment projects against agreed outcomes and benefits, ensuring action is taken to address any shortcomings;
- approve standard documentation for business case and project monitoring;

- review business cases for significant changes in procurement methodology/approach, e.g. changes to NPDO, use of new procurement methods (e.g. managed equipment service, joint ventures, outsourcing, shared services), and
- review the benefits realisation of business cases and post implementation review to ensure the full potential has been realised.

Financial Management

- consider reports on the financial position of NHS Tayside that highlight significant trends and risks;
- monitor the deliverability of the Transformation Programme and the overall efficiency programme reflecting on both the in year delivery and contribution towards the recurring savings target;
- consider forecast positions reported by NHS Tayside and risks to achievement of forecast, and
- review the content and format of strategic financial information focussing on:-
  - clarity and appropriateness of presentation;
  - timeliness and accuracy;
  - provision of sufficient and relevant detail to inform decision making, and
  - best practice

Performance Management

The Committee shall have oversight of systems and processes to ensure economy, efficiency, and effectiveness in the use of resources. The Committee will, from time to time, review individual services in relation to performance management, ensuring that health care is delivered to an efficient and cost effective level. Specifically the Committee will:-

- promote an integrated approach to performance management and risk, and
- oversee an effective approach to prioritisation of resources, supported by appropriate and relevant benchmarking and comparative information to inform decision making

Policy Endorsement

- adopt all finance and governance policies, and
- adopt all information governance/assurance policies.

- Financial Training & Briefing

To promote a culture in which:-

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- financial awareness is valued and encouraged amongst all stakeholders;
- financial skills are developed to ensure regular and wide consideration of financial issues, and
- financial information is shared openly and transparently.

Property and Asset Management Strategy

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- to ensure that the Property & Asset Management Strategy is aligned with the Clinical Strategy, and is:-
  - supported by affordable and deliverable Business Cases;
  - supported by detailed Project Plans, and
  - delivered within agreed timescales and resources to secure modern, well designed, patient focussed services and facilities.
- to ensure that Tayside NHS Board's Property & Asset Management Strategy is developed, supported and maintained, and that it meets the strategic service plan needs;
- to ensure that Tayside NHS Board's property asset base is effectively utilised in support of the clinical strategy;
- to ensure that the property portfolio of NHS Tayside and key activities relating to property are appropriately progressed and managed within the relevant guidance and legislative framework;
- to ensure that all aspects of major property and land issues are dealt with in accordance with due process;
- to ensure that there is a robust approach to property rationalisation;
- to oversee the management of risk associated with both individual projects and asset strategy, and
- to monitor delivery of agreed Key Performance Indicators in respect of the Property and Asset Management Strategy

Strategic/Capital Projects

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- to review overall development of major schemes, including capital investment business cases and consider the implications of time slippage and/or cost overrun. Instruct and review the outcome of the post project evaluation;
- to receive and review reports on significant capital projects and the overall capital programme, and
- to receive reports on relevant legislation and best practice including the Scottish Capital Investment Manual (SCIM), audit reports and other Scottish Government Guidance.

Assurance

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- to receive assurance reports at every meeting on the Strategic Risks that the Finance and Resources Committee has delegated responsibility for, including Strategic Financial Risk, Strategic Capital Risk and Information Governance Risk, and

- ensure that robust operational and service risk management systems and processes are in place.

1.5 Best Value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure best value for these delegated areas. The assurance to the Chief Executive should be included as an explicit statement in the Committees Annual Report.

1.6 Authority

The Committee's authority shall be within the following framework. In performing these functions, the Committee is expected to operate at a strategic governance level. Through the Accountable Officer, and with Internal and External Audit assistance where required, it must satisfy itself that there are appropriate operational controls in place throughout NHS Tayside.

Tenders, Contracts, Business Cases within the Limits of previously approved Revenue and Capital Budgets

See also:-

- Section E, Reservation of Powers and Delegation of Authority - Scheme of Further Delegation, and
- Section F Standing Financial Instructions, Section 13, Contracting and Purchasing and Annex 1, Tendering Procedures.

The Finance and Resources Committee has delegated authority to approve the acceptance of tenders and business cases on behalf of Tayside NHS Board up to a value of £4.0 million (IM&T Schemes up to £2.0 million), which cannot be accepted by any other Committee or Accountable Officer in terms of delegated powers, and where the most economically advantageous tender is to be accepted.

The Chief Executive, as Accountable Officer, acting together with the Director of Finance, has delegated authority to approve acceptance of tenders and business cases up to a value of £1.0 million, and where the most economically advantageous tender is to be accepted.

The Board Executive Directors and Operational Unit Directors, acting together with the Director of Finance, have delegated authority to approve acceptance of tenders and business cases up to the value of £1.0 million, and where the most economically advantageous tender is to be accepted.

The Chief Executive shall submit to the Finance and Resources Committee a report detailing all tenders and business cases in excess of

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£0.15 million and accepted by her in terms of the above delegated powers during the preceding two months in an appropriate format.

Authority to Spend Funds and Virement

(See Section E - Reservation of Powers and Delegation of Authority - Scheme of Further Delegation)

Delegated authority is granted, as undernoted, to approve the funding of individual items of expenditure, provided that approval can be funded within the Board's overall Revenue and Capital Budgets, and to transfer funds up to this level between budgets including transfers from reserves and balances:

The Finance and Resources Committee up to a value of £4.0 million (IM&T Schemes up to £2.0 million) in any one instance. This authority shall be exercised in respect of all proposals greater than the delegated limits below:-

- The Chief Executive as the Accountable Officer, acting together with the Director of Finance of the Board, to a value of £1.0 million;
- The Chief Executive, acting together with the Associate Director of Finance - Financial Planning and Operational Services, up to the value of £1.0 million, and
- Board and Operational Unit Executive Directors, acting together with the Director of Finance/Associate Director of Finance - Financial Planning and Operational Services up to the value of £1.0 million.

Capital Programme

The Board's Capital programme shall be managed within the framework approved each year by the Board.

The Committee shall, within this framework, approve tenders and business cases up to a value of £ £3.0 million. Variations in cost from the approved framework in excess of 5% or £0.15 million, whichever is the higher, shall be reported to the Committee.

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

The Finance and Resources Committee will appoint a Capital Scrutiny Group to co-ordinate the production of the five year Capital Plan, to oversee the implementation of the Capital Programme and to ensure the appropriate levels of governance is in place regarding NHS Tayside's Capital Programme.

Reporting Arrangements

The Finance and Resources Committee reports to Tayside NHS Board.

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Following a meeting of the Finance and Resources Committee the minutes of that meeting should be presented at the next Tayside NHS Board meeting.

The Finance and Resources 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 Finance and Resources Committee.

The Finance and Resources 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 Finance and Resources Committee before it is presented to the Audit Committee considering Annual Accounts.

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## c) Clinical and Care Governance Committee

### 1.1 Purpose

To provide Tayside NHS Board with the assurance that robust governance and management systems and processes are in place and effective throughout NHS Tayside and within the three Joint Integration Boards areas detailed within the remit.

### 1.2 Composition

- A minimum of six Non-Executive Members including the Chair of the Area Partnership Forum (Employee Director) and the Chair of the Area Clinical Forum
- Medical Director (Lead Officer for Clinical Governance)
- Nurse Director (Lead Officer for Person Centred Care)

Other Directors will only attend if they are presenting a report to the Committee or the Committee requests their attendance.

### 1.3 Meetings

Meetings of the Committees will be quorate when at least five Members are present, at least three of whom should be Non-Executive Members of NHS Tayside.

### 1.4 Remit

To provide Tayside NHS Board with the assurance that robust governance and management systems and processes are in place and effective throughout NHS Tayside in areas of Clinical Risk Management, Clinical Care and Public Health Effectiveness, Person Centredness and Continuous Improvement.

To support the work of this Committee and provide assurances, it will establish a performance review monitoring process and a Clinical Quality Forum. These assurances should be provided through the agreement of a workplan within the first quarter of the financial year, receipt of reports, action notes, a mid-year report and an annual report.

**Clinical Risk Management**

*To provide assurance regarding Incident Reporting, Regulating Compliance, Continuity Planning, Risk Management, SCEAs and Patient*

*Safety and that there are adequate systems and processes in place across NHS Tayside to ensure that:*

- Robust clinical control frameworks are in place for the effective management of clinical risk and that they are working effectively across the whole of NHS Tayside.
- Incident Management and reporting is in place and lessons are learned from adverse events and near misses.
- Clinical standards and patient safety are not compromised within the Board's annual efficiency programme which is Steps to Better Healthcare and that the financial and capital frameworks support the Clinical Strategy.
- Data and measurement systems underpin the delivery of care and these are monitored through organisational performance and review and reported at the Clinical Quality Forum.
- Robust workforce and workload planning and evidence to support this.
- Assurance of standards and quality of care.

**Clinical and Public Health Effectiveness**

*To provide assurance regarding evidence based practice, research and development, health economics, outcome measures, clinical audit and guidelines and that there are adequate systems and processes in place across NHS Tayside to ensure that:*

- There is compliance with national standards for quality and safety
- Where results of inspection are below required standards, appropriate action plans will be developed and monitored by the Clinical Quality Forum or the Public Health Governance Group and reported to the committee
- Through the Clinical Audit Function, the Committee will receive reports on the effectiveness of controls in place to mitigate against Clinical Risk
- Where performance improvement is necessary within NHS Tayside, the Committee will approve appropriate improvement intervention and seek assurance regarding the reliability of the improvement intervention
- Research and Development – to provide assurance that governance arrangements for research and development are in place and effective, the Committee will receive an annual report relating to the quality of research and processes within NHS Tayside

**Person Centredness**

*To provide assurance regarding patient experience, equality and diversity, feedback, patient information, participation, communication and engagement.*

- Feedback and complaints are handled in accordance with national guidance and lessons are learned and improvements made from complaints investigations and their resolution. Improvements are also made from investigations by the Scottish Public Services Ombudsman (SPSO), Mental Welfare Commission (MWC) and the Equality and Human Rights Commission (EHRC)
- To provide assurance that NHS Tayside is complying with the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 and to provide assurance that robust Equality and Diversity systems and processes are in place and effective throughout NHS Tayside

**Continuous Improvement including Training and Education**

*To provide assurance regarding Healthcare Improvement Scotland, Collaboratives, Improvement Programmes, Education/Training/Evaluation and Revalidation/Appraisal that there are adequate systems and processes in place across NHS Tayside to ensure that*

- Staff governance issues which impact on service delivery and quality of services are appropriately managed through clinical governance mechanisms and effective training and development is in place for all staff
- To provide assurance on training and education, the Committee will receive an annual report that NHS Tayside is providing an appropriate training environment at undergraduate and postgraduate levels across the professions
- The Committee will receive an annual report from the Academic Health Science Partnership (AHSP)

**Clinical and Nursing & Midwifery Policies**

The Committee will adopt all Clinical and Nursing & Midwifery Policies.

**Strategic Risks**

The Committee will receive quarterly reports in the format of the Board Assurance Framework (BAF) from risk owners with Strategic Risks aligned to the Committee.

**Donation Committee**

To provide assurance on the framework for the ethical and legal implications of organ donation in NHS Tayside, a Donation Committee will

be established. The Committee will receive an annual report from the Donation Committee.

**1.5 Best Value**

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board. The Committee will put in place the arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure best value for these delegated areas. The assurance to the Chief Executive should be included as an explicit statement in the Committee's Annual Report.

**1.6 Authority**

The Clinical and Care Governance Committee is accountable to Tayside NHS Board and as such is authorised by the Board to approve Clinical Governance and Improvement within its terms of reference, and in doing so is authorised to seek any information it requires in this area.
In order to fulfil its remit, the Clinical and Care Governance Committee may obtain whatever professional advice it requires, and require Directors or other officers of NHS Tayside bodies to attend meetings.

**1.7 Reporting Arrangements**

The Clinical and Care Governance Committee reports to Tayside NHS Board.

Following a meeting of the Clinical and Care Governance Committee the minute and a summary of that meeting should be presented at the next Tayside NHS Board meeting.

The Clinical and Care Governance 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 Clinical and Care Governance Committee.

The Clinical and Care Governance 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 Clinical and Care Governance Committee before it is presented to the Audit Committee considering the Annual Accounts.

**d) East of Scotland Research Ethics Service (EoSRES) REC 1**

**1.1 Purpose**

To provide Tayside NHS Board with the assurance that:

- A mechanism is in place to undertake the ethical review of medical research
- The dignity, rights and wellbeing of the participants in medical research are suitably protected
- Independent advice on medical research ethics is available to the Board and its Committees when requested
- There is appropriate liaison between the Medical Research Ethics Committees and researchers (including students and their supervisors), funders, sponsors and participants in medical research
- The interests, needs and safety of researchers are protected within medical research

## 1.2 Composition

The East of Scotland Research Ethics Service (EoSRES) REC 1 will include up to 18 Members to provide the level of expertise and lay membership set out in the Governance Arrangements for Research Ethics Committees (GAfREC), a harmonised edition, published in September 2011.

GAfREC requires that the membership provides relevant methodological and ethical expertise in:

- Clinical Research
- Non-Clinical Research
- Qualitative or other research methods applicable to health/community care research

Relevant experience and support from:

- Hospital and community staff (medical, nursing and other)
- Qualitative or other research methods applicable to health/community care research

Relevant experience and support from:

- A statistician with a background in research
- A pharmacist with experience and knowledge of pharmacology, therapeutics and medicines management issues.

Lay Members accounting for at least one-third of the total membership at least half of whom must never have been health or community care professionals or involved in carrying out research involving human participants, their organs, tissue or data.

Membership is as follows:

2 x Pharmacist (Deputise for each other)
1 x Nurse Member
1 x Statistician
1 x General Practitioner
4 x Secondary Care Clinicians
7 x Lay Members
4 x Professional Members

There are 18 members and 2 deputies (20 Members in total) appointed in order to ensure that all committee meetings are quorate.

The Scientific Officer for the East of Scotland Research Ethics Service attends meetings.

### 1.3 Meetings

EoSRES REC 1 meets on the third Friday of the month other than in December, when alternative arrangements are made for a meeting. Meetings of the Committee will be quorate when at least seven Members are present, including the Chair or Vice-Chair or Alternate Vice-Chair;

- At least one expert Member with relevant clinical and/or methodological expertise;
- One Lay Member
- At least one other Member who is independent of the institution or specific location where the research is to take place.

### 1.4 Remit

To review ethics issue within research proposals involving:

- Patients and other users of the NHS including all potential research participants recruited by virtue of their past or present treatment by the NHS. It also includes NHS patients treated under contract with private sectors institutions
- Individuals identified as potential research participants because of their status as relatives or carers of patients and other users of the NHS, as defined above
- Access to data, organs or other bodily material of past and present NHS patients
- Foetal material and IVF involving NHS patients
- The recently dead in NHS premises
- Use of, or potential access to, NHS premises or facilities

To provide ethical advice on request on other research proposals e.g. in the private sector.
To comply with ICH/GCP Guidelines in respect of the above.
To produce an annual action plan which details the work plan of EoSRES REC 1.
To monitor and evaluate the progress of EoSRES REC 1.
To produce an Annual Report for presentation to the Board and the public.

### 1.5 Authority

The Committee is a Committee of Tayside NHS Board but is independent of the Board in respect of the decisions taken about research proposals. As such, it is authorised to approve Medical Research in Tayside from the point of view of ethics before it can be undertaken and seek any information they require regarding research in progress. Final management authority to proceed with research in Tayside is delegated to the Tayside Medical Science Centre (TASC).

In order to fulfil their remit, EoSRES REC 1 may obtain whatever professional advice they require, and may also require Chief/Principal investigators to attend meetings.

### 1.6 Reporting Arrangements

EoSRES REC 1 report to Tayside NHS Board.

Following a meeting of EoSRES REC 1, the minute of that meeting should be presented at the next Tayside NHS Board meeting. EoSRES REC 1 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 EoSRES REC 1. EoSRES REC 1 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 EoSRES REC 1 before it is presented to the Audit Committee considering the Annual Accounts.

## e) Pharmacy Practices Sub-Committee

### 1.1 Purpose

To exercise the functions of the Board in terms of the Regulations detailed in 1.4.

### 1.2 Composition

The Pharmacy Practices Sub-Committee shall consist of seven Members of whom:

a. Two Non-Executive Members who shall be Chair and Vice-Chair but who are not, nor have previously been or employed by a doctor, dentist, ophthalmic optician or pharmacist.

b. Three pharmacists of whom:

   i) One shall be a pharmacist whose name is not included in any pharmaceutical list and who is not the employee of a person whose name is so listed, and they shall be appointed by the Board from persons nominated by the Area Pharmaceutical Committee.
   ii) Two shall be pharmacists each of whom is included in a pharmaceutical list or is an employee of a person whose name is so listed, and each shall be appointed by the Board from persons nominated by the Area Pharmaceutical Committee.

c. Three shall be appointed by the Board otherwise than from the Members of the Board but none shall be nor previously have been a doctor, dentist, ophthalmic optician or a pharmacist, or an employee of a person who is a doctor, dentist, ophthalmic optician or pharmacist.

d. In instances where the premises that are the subject of the application are located in the same neighbourhood as premises from which a dispensing doctor dispenses, the Pharmacy Practice Sub-Committee shall have an additional Member appointed by the Board from persons nominated by the Area Medical Committee.

Deputies for and corresponding in number to each of those categories of person appointed to the Sub-Committee shall be appointed by the Board, provided they satisfy the same criteria specified above.

In the absence of any of those persons a deputy from the appropriate category shall be entitled to act in his place.

If a nomination sought for the purposes of sub-paragraph 1.2 (b) (i) or (ii) or paragraph (d) above is not made before such date as the Board may determine, the Board may appoint as a Member a person who satisfies the criteria specified in the relevant sub-paragraph.
The Members of the Pharmacy Practices Sub-Committee shall be appointed for a period of two years. Casual vacancies shall be filled by the Board as soon as practicable and, where appropriate, from nominations submitted by the Area Pharmaceutical Committee and the Area Medical Committee.

The Board shall prepare and maintain lists of the persons who have been appointed in accordance with paragraph 1.2 as the case might be, and who currently serve as Members of the Pharmacy Practices Sub-Committee, and shall provide the First Minister with a copy of such lists from time to time.

**1.3 Meetings**

The Sub-Committee will meet as and when required.

No business shall be transacted at a meeting of the Pharmacy Practices Sub-Committee unless the Chair, or in his absence the person acting as Chair, one Member appointed under each of paragraph 1.2 (b) (i) and (ii), and two other Members appointed under paragraph (c) are present.

**1.4 Remit**

The Pharmacy Practices Sub-Committee shall, on behalf of the Board, exercise the functions of the Board in terms of Regulation 5(10) and paragraph 3 of Schedule 3 of the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 as amended.

The Pharmacy Practices Sub-Committee shall assess and determine the need for additional contracts or services in relation to the provision of National Health Service Pharmaceutical Services and shall consider applications for new or relocated pharmacies (other than those deemed to be a minor relocation) to be admitted to the Board's Pharmaceutical List in accordance with the procedures laid down in Schedule 3 of the aforementioned Regulations.

**1.5 Voting**

a) Every application considered by the Pharmacy Practices Sub-Committee shall be considered by all Members present but shall be determined only by a majority of votes of the Members present who are entitled to vote. (Subject to sub-paragraphs (b), (c) and (d) below).

b) A Member appointed by virtue of paragraph 1.2 (c) is entitled to vote.

c) A Member appointed by virtue of paragraph 1.2 (b) (i) or (ii) or (d) above is not entitled to vote and shall withdraw immediately before a decision on an application by voting takes place.

d) The Chair shall not be entitled to vote except in the case of an equality of votes of the other persons present and voting, in which case he shall have the casting vote.

e) The Pharmacy Practices Sub-Committee shall within ten working days of taking its decision, give written notification of it to Tayside NHS Board with reasons for that decision.

**1.6 Authority**

The Committee is authorised by the Board to investigate any activity within its terms of reference and in so doing may seek any information it requires from any employee. All Members and employees of the Board are directed to co-operate with any request made by the Committee.

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

**1.7 Reporting Arrangements**

The Pharmacy Practices Sub-Committee reports to Tayside NHS Board.

Following a meeting of the Pharmacy Practices Sub-Committee the minutes of that meeting should be presented at the next Tayside NHS Board meeting.

**f) Primary Care Practitioners Discipline Committee**

**1.1 Purpose**

To hear and consider the evidence presented in relation to a disciplinary matter raised against a Primary Care Practitioner.

To produce and submit a report to the referring NHS Board.

(The provisions relating to investigation of alleged breaches of the terms of service for practitioners and the rules of procedure for Discipline Committees are contained in the National Health Service (Discipline Committees) (Scotland) Regulations 2006).

**1.2 Composition**

Separate Discipline Committees must be established for each of the professions and there must also be a joint Discipline Committee for issues in which practitioners from more than one profession are involved. Each Discipline Committee will have the following:

- A legally qualified Chairperson who may be a practising or retired solicitor or advocate.
- One Lay Member (a Lay Member is someone who is not and never has been a doctor, dentist, ophthalmic medical practitioner, optician, dispensing optician, pharmacist, nurse, midwife, health visitor, or an officer of or otherwise employed by a NHS Board).
- One Professional Member appointed by the NHS Board from a list of nominees provided by the relevant Area Professional Committee i.e. a doctor, a dentist, a pharmacist and ophthalmic medical practitioner or optician.

Each joint Discipline Committee will have the following membership:

- A legally qualified Chairperson (as above)
- One Lay Member (as above)
- One Professional Member from each of the professions of the respondent practitioners (as above) and whom shall already be a Member of the relevant Discipline Committee referred to above

Chairmen and Lay Members will be common to each of the Committees.

No Professional Member as listed above shall take part in an investigation by the joint Discipline Committee unless the matter to be investigated involves a question relating to a practitioner relevant to their profession.

It is important that Members and Chairmen live, and where appropriate work, in Tayside to avoid possible conflicts of interest.

The period of appointment to the Committee is for one year, after which Members may be re-appointed.

**1.3 Meetings**

Meetings shall be held as and when required.

Meetings of the Committees will be quorate when the Chairperson, Lay Member and Professional Member(s) are present.

### 1.4 Remit

Matters in which there is an allegation of a breach of a practitioner's terms of service will be referred to a Discipline Committee by a different NHS Board.

The Primary Care Practitioners Discipline Committees are required to consider written evidence produced and to meet to hear cases. During a hearing Members may question the parties involved and any witnesses called.
Members will be required to consider all the evidence presented and decide whether or not the practitioner was in breach of his terms of service. They must then make a recommendation on penalty, if any, which should be imposed.

A report of the meeting, which will include the Committees recommendation, will be prepared and sent to the NHS Board which referred the case. The referring NHS Board must accept the Committees decision on whether or not the practitioner was in breach of their terms of service but will have discretion to adopt the Committees recommendation or to take alternative action.

### 1.5 Authority

The Committees are authorised by the Board to investigate any activity within their terms of reference, and in so doing, are authorised to seek any information they require from any employee.

In order to fulfil their remit, the Primary Care Practitioners Discipline Committees may obtain whatever professional advice they require, and require Directors or other officers of NHS Tayside bodies to attend meetings.

The External Auditor and Chief Internal Auditor shall have the right of direct access to the Chair of the Primary Care Practitioners Discipline Committees.

### 1.6 Reporting Arrangements

The Primary Care Practitioners Discipline Committees report to Tayside NHS Board.

Following a meeting of the Primary Care Practitioners Discipline Committees the minutes of these meetings should be presented at the next Tayside NHS Board meeting.

## g) Practitioners Service Reference Sub-Committee

**1.1 Purpose**

To exercise certain functions of the Board in relation to the National Health Service (Discipline Committees) (Scotland) Regulations 2006.

**1.2 Composition**

Membership of the Sub-Committee will be:

- The nominated Operational Director or Nominee who will be Chair
- One Non-Executive Member to be drawn from a pool of Non-Executive Members representing Tayside NHS Board
- One Professional Member appointed by the Board and nominated by the Area Professional Committee relevant to the case to be heard

**1.3 Meetings**

Meetings shall be held as and when required.

Meetings of the Sub-Committee will be quorate **w**hen the Chair and one Professional Member are present.

**1.4 Remit**

To exercise the functions of the Board in relation to the National Health Service (Discipline Committees) (Scotland) Regulations 2006.

**1.5 Authority**

The Sub-Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, is authorised to seek any information it requires from any employee or any practitioner.

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

**1.6 Reporting Arrangements**

The Practitioners Service Reference Sub-Committee reports to Tayside NHS Board.

Following a meeting of the Practitioners Service Reference Sub-Committee the minutes of that meeting should be presented at the next Tayside NHS Board meeting.

**h) Remuneration Committee**

**1.1 Purpose**

The fourth edition of the Staff Governance Standard made clear that each NHSScotland Board is required to establish a Remuneration Committee whose main function is to ensure application and implementation of fair and equitable pay systems on behalf of the Board, as determined by Ministers and the Scottish Government.

**1.2 Composition**

- The Chair of Tayside NHS Board (who will be the Chair)
- The Vice-Chair of Tayside NHS Board (who will be the Vice-Chair)
- The Chair of the Staff Governance Committee
- Employee Director
- Four Non-Executive Members

Non-Executive Members cannot be Members of this Committee if they are Members of staff or independent primary care contractors. In addition there will be in attendance:

- Associate Director of Human Resources (Business Support)
- Head of Committee Administration

At the request of the Committee, other Senior Officers also may be invited to attend.

All Members of the Remuneration Committee will require to be appropriately trained to carry out their role on the Committee.

No employee of the Board shall be present when any issue relating to their employment is being discussed.

**1.3 Meetings**

The Committee will meet 4 times per annum.

Remuneration issues may arise between meetings and will be brought to the attention of the Chair of the Remuneration Committee by the Chief Executive or the Director of Human Resources. The Chair may call a special meeting of the Remuneration Committee to address the issue.

Meetings of the Committee will be quorate when four Non-Executive Members are present.

**1.4 Remit**

The Remuneration Committee will oversee the remuneration arrangements for Executive Directors and others under the Executive Cohort and Senior Management Pay Systems and also to discharge specific responsibilities on behalf of Tayside NHS Board as an employing organisation.

Ensure that arrangements are in place to comply with NHS Tayside Performance Assessment Agreement and Scottish Government direction

and guidance for determining the employment, remuneration, terms and conditions of employment for Executive Directors, in particular:

- Approving the person objectives of all Executive Directors in the context of NHS Tayside's Local Delivery Plan, Corporate Objectives and other local, regional and national policy.

- Receiving formal reports on the operation of remuneration arrangements and the outcomes of the annual assessment of performance and remuneration for each of the Executive Directors.

Ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for other staff employed under the 'Executive Cohort' and 'Senior Manager' pay systems. The Committee will receive formal reports annually providing evidence of the effective operation of these arrangements.

Promote the adoption of an NHS Tayside approach to issues of remuneration and performance assessment to ensure consistency.

Undertake reviews of aspects of remuneration/employment policy for Executive Directors (e.g. Relocation Policy) and other Senior Staff (e.g. Special Remuneration), when requested by NHS Tayside.

Consider any redundancy, early retirement or termination arrangement in respect of all NHS Tayside staff, excluding early retirement on grounds of ill health, and approve these or refer to Tayside NHS Board as it sees fit.

Approve payment of Discretionary Points to eligible specialist, medical and dental staff based on competent recommendations from the appropriate advisory bodies.

**Confidentiality and Committee Decisions**

Decisions reached by the Committee will be by agreement and with all Members agreeing to abide by such decisions (to the extent that they are in accordance with the constitution of the Committee). All Members will treat the business of the Committee as confidential. The Committee may in certain circumstances decide a voting approach is required with the Chair having a second and casting vote.

**Minutes and Reports**

Reports issued to Members will contain full details of the issues to be considered with clear recommendations of the Committee.

The minutes will record the decisions reached by the Committee with due regard to confidentiality in relation to individuals. Only Non-Executive Members who are not NHS Tayside Employees will receive the full minute. All other Board Members will receive a summarised minute.

### 1.5 Best Value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board.

The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure best value for these delegated areas. The assurance to the Chief Executive should be included as an explicit statement in the Committees Annual Report.

### 1.6 Authority

The Remuneration Committee is authorised by the Board to investigate any activity within its terms of reference and in doing so is authorised to seek any information it requires about any employee.

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

### 1.7 Reporting Arrangements

The Remuneration Committee reports to Tayside NHS Board

Following a meeting of the Remuneration Committee the minutes of that meeting shall be presented at the next Tayside NHS Board meeting. Only Non-Executive Members who are not NHS Tayside employees will receive the full minute. All other Board Members will receive a summarised minute.

The Remuneration 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 Remuneration Committee.

The Remuneration Committee will produce an Annual Report for presentation to the Staff Governance Committee and 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 its remit during the year.
The Annual Report must be approved by the Remuneration Committee and the Staff Governance Committee before it is presented to the Audit Committee meeting considering the Annual Accounts.

The Remuneration Committee will through the Staff Governance Committee provide an annual assurance that systems and procedures are in place to manage the pay arrangements for all Executive Directors

and others under the Executive Cohort and Senior Management pay systems so that overarching Staff Governance responsibilities can be discharged.

The Staff Governance Committee will not be given the detail of confidential employment issues that are considered by the Remuneration Committee, these can only be considered by the Non-Executive Members of the Board. The Annual Report will be prepared as close as possible to the end of the financial year but in enough time to allow it to be considered by the Staff Governance Committee. This is to ensure that the Staff Governance Committee is in a position in its annual report to provide the annual assurance that systems and procedures are in place to manage the pay arrangements for all staff employed in NHS Tayside.

**i) Staff Governance Committee**

**1.1 Purpose**

~~To advise the Board on its responsibility, accountability and performance against the NHS Scotland Staff Governance Standard addressing the issues of policy, targets and organisational effectiveness.~~

~~The NHS Reform (Scotland) Act requires Boards to put and keep in place arrangements for the purpose of improving the management of the officers employed, monitoring such management, and workforce planning.~~

~~This will be demonstrated through achievements and progress towards the Staff Governance Standard through:~~

- ~~Scrutiny of performance against individual elements of the Staff Governance Standards~~
- ~~Data collected during the self-assessment audit conducted under the auspices of the Area Partnership Forum~~
- ~~The action plans submitted to, and approved by, the Staff Governance Committee~~
- ~~Staff Survey Results~~
- ~~Data and information provided in statistical returns reports to the Committee~~

- To provide assurance to the Board that NHS Tayside meets its obligations in relation to staff governance under the National Health Service Reform (Scotland) Act 2004 and the Staff Governance Standard.
- 
- In particular, the Committee will seek to ensure that staff governance mechanisms are in place that take responsibility for performance against the Staff Governance Standard and are accountable for progress towards achievement of the Standard.
- 
- The Staff Governance Committee will also play a key role in monitoring overall Board performance by ensuring full consideration of the impact of key policy and operational decisions that affect staff, on the Board aims in relation to quality and cost of service delivery.

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## 1.2 Composition

~~Membership of the Staff Governance Committee will be:~~

~~A minimum of six Non-Executive Members including the Employee Director.~~
~~The Director of Human Resources (the Lead Officer)~~
~~Staff Side members of the Partnership Secretariat.~~

~~Other Directors will only attend if they are presenting a report to the Committee or the Committee requests their attendance.~~

Membership of the Staff Governance Committee will be:

A minimum of six Non Executive Members including the Employee Director

The Staff Governance Committee will be co-chaired by the Employee Director and a Non Executive Member appointed by the Board from the membership of the Committee.

Other members are:

The Director of Human Resources and Organisational Development (Lead Officer)
The Staff Side Co-Chair of the Area Partnership Forum
The Staff Side Secretary
The Chair of the Workforce & Governance Forum

Members of the Area Partnership Forum listed below shall be in attendance at the Staff Governance Committee:

- Chief Executive
- Chief Officer (representing Health and Social Care Partnerships)
- Chief Operating Officer
- Co Chairs of other Partnership Forums
- Associate Director of HR - Resourcing

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

Other Directors will only attend if they are presenting a report to the Committee or the Committee requests their attendance.

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### 1.3 Meetings

Meetings of the Committee will be quorate when at least five Members are present, three of whom shall be Non-Executive Members.

### 1.4 Remit

~~To monitor performance of the Board against the Staff Governance Standard including key deliverables from the 2020 Workforce Vision and associated implementation plan~~

~~To monitor the Workforce Strategy through the Annual Workforce Plan.~~

~~To monitor the progress of the Staff Governance Committee against the annual Work Plan.~~

~~To establish an Area Partnership Forum that will have the responsibility for facilitation and monitoring the effectiveness of partnership working between management and staff at all levels in NHS Tayside and Contractors and to develop and approve Employment Policies through the Partnership process.~~

~~To monitor the progress of the Area Partnership Forum through the annual report from the joint chairs.~~

~~To provide timely Staff Governance information required for national monitoring arrangements, and for the governance statement.~~

~~To be responsible for reviewing strategic risks relating to staff and workforce issues.~~

~~Development and monitoring of the workforce strategy to support the Board's new health strategy.~~

~~To adopt Human Resources and Operations policies.~~

To support the creation of a culture within the health system, where the delivery of the highest possible standards of staff management is understood to be the responsibility of everyone working within NHS Tayside and this is built upon partnership and co-operation.

To act for the Board in ensuring that structures and processes to ensure staff are:

- Well informed;
- Appropriately trained and developed;
- Involved in decisions;
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and,

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- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

The Committee shall monitor and evaluate progress through the approval of local human resource strategies and implementation plans.

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The Committee shall be authorised by the Board to support any policy amendment, funding or resource submission to achieve the Staff Governance Standard.

The Committee shall oversee the timely submission of all the staff governance data required as part of the Annual Review.

**Joint Working with Other Board Committees**

The Committee shall ensure the implications of workforce performance are fully understood and that all decisions taken relating to staff are subject to appropriate scrutiny in relation to quality and cost of service delivery. In doing so the Committee will share information with, and receive information from, the Board's Finance & Resources Committee and the Clinical Care Governance Committee, and lead officers of these Committees will meet jointly on at least two occasions per year to review performance and agree priorities for future reporting.

The Committee will, through its lead officer, also regularly consider key issues arising through other Committees of the Board to ensure that relevant information is shared to aid understanding of workforce strategic and operational performance matters.

### 1.5 Risk Reporting

Quarterly reports from strategic risk owners ~~with~~ of the risks aligned to this Committee.

### 1.6 Best Value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure the best value for these delegated areas. The assurance to the Chief Executive should be included as an explicit statement in the Committees Annual Report.

### 1.7 Authority

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

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

### 1.8 Reporting Arrangements

The Staff Governance Committee reports to Tayside NHS Board.

Following a meeting of the Staff Governance Committee, the minutes of that meeting should be presented at the next Tayside NHS Board meeting.

The Staff Governance 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 Staff Governance Committee.

The Staff Governance 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 Staff Governance Committee before it is presented to the Audit Committee considering the Annual.

The Staff Governance Committee will receive for approval the Annual Report of the Remuneration Committee, which reports through the Staff Governance Committee to the Board, while remaining a substantive standing Committee of the Board itself.

The Committee shall oversee the effectiveness of the Area Partnership Forum, and through the Area Partnership Forum, the performance of Local Partnership Fora, in managing change and promoting a positive culture of staff engagement through the submission of regular reports.

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## j) 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)
- 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~~ Professions Allied to Medicine
- 2 representatives from Fife NHS Board
- 1 representative NHS Education for Scotland
- ~~4~~ 2representatives from Academic Health Science Partnership
- 1 Director of Medical Education, NHS Tayside
- 1 Director of Medical Education, NHS Fife
- Post Graduate Dean ( or nominated Deputy) NHS Education Scotland

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.

### 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 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.

# SECTION C

# STANDARDS OF BUSINESS CONDUCT FOR NHS STAFF

This section is for all staff and all staff are required to adhere to the Standards of Business Conduct for NHS staff.

These Standards of Business Conduct for NHS staff form part of the NHS Board's standard contract of employment for all staff.

**STANDARDS OF BUSINESS CONDUCT FOR NHS STAFF**


1. Introduction
2. The Bribery Act 2010 – Statement from the Chief Executive
3. The Bribery Act 2010 – Key Points
4. Responsibility of Staff
5. Key Principals of Business Conduct
6. Acceptance of Gifts, Hospitality and Prizes
7. Register of Staff Interests
8. Purchase of Goods and Services
9. Purchase, Sale and Lease of Property
10. Benefits Accruing from Official Expenditure
11. Free Samples
12. Contracts and Agreements
13. Provision of Hospitality or use of External Facilities
14. Secondary Employment
15. Acceptance of Fees
16. Work Undertaken for Professional Bodies
17. Contact with the Media
18. Conduct during Elections
19. Involvement in Commercial Undertakings/Trading Entities/Membership of Voluntary Bodies
20. Working with Suppliers of Clinical Products
21. Intellectual Property Rights (IP)
22. Distribution of Products
23. Remedies
24. Contact for further guidance
25. Induction of new staff
26. Review process

**Annex 1**
Registration of Interests

**Annex 2**
Registration of Gifts of Hospitality

**Annex 3**
Glossary of Terms Relating to the Guidance on Working with Clinical Suppliers

**Annex 4**
Registration of Interests Relating to Working with Clinical Suppliers

**Annex5**
Declaration of Interests at Meetings Relating to Working with Clinical Suppliers

**Annex 6**
Distribution and endorsement of products from commercial companies

## 1. INTRODUCTION

This section of NHS Tayside Code of Corporate Governance provides instructions on those issues or matters which staff are most likely to encounter in carrying out their day to day duties. This is not exhaustive and is supplementary to (and therefore should be read in conjunction with) the Standards of Business Conduct for NHS Staff [NHS Circular MEL (1994) 48] and A Common Understanding 2012: Working Together for Patients.

The Standards of Business Conduct for NHS Staff will be incorporated into the contract of employment of each member of staff.

Guidance regarding accepted practice in NHS Tayside is detailed in these Standards; however, professionally registered staff should also ensure they do not breach the requirements in respect of their Processional Codes of Conduct.

## 2. THE BRIBERY ACT 2010 – STATEMENT FROM THE BOARD

"The Bribery Act 2010 ("The Act") came into effect on 1 July 2011, aiming to tackle bribery and corruption in both the private and public sectors.

NHS Tayside welcomes the Act and in line with our commitment to maintain strict ethical standards and integrity in the conduct of our business activities and to ensure that the work we do remains fair, honest and free of bribery, we are keen to ensure that we comply with the Act's standards. One of the six principles of the Act demands that there is top level commitment to the prevention of bribery.

In line with following good NHS business practice, we have robust controls, policies and procedures in place to prevent bribery. However, we cannot afford to be complacent and it is important that our employees, contractors and agents comply with NHS Tayside's policies and procedures, particularly with regard to procurement and sponsorship.

On behalf of NHS Tayside, we confirm that NHS Tayside does not tolerate any form of bribery, whether direct or indirect, by its staff, agents or external consultants or any persons or entities acting for it or on its behalf. NHS Tayside is committed to implementing and enforcing systems to prevent, monitor and to eliminate bribery within NHS Tayside and to the rigorous investigation of any such cases.

## 3. THE BRIBERY ACT 2010 – KEY POINTS

3.1 The Bribery Act 2010 is one of the strictest pieces of legislation on bribery and makes it a criminal offence for any individual (employee, contractor, agent) associated with NHS Tayside, to give, promise or offer a bribe, and to request, agree to receive or accept a bribe (sections 1, 2 & 6 offences), and this can be punishable for an individual by imprisonment of up to ten years.

3.2 In addition, the Act introduces a corporate offence (Section 7 offence) which means that NHS Tayside can be exposed to criminal liability, punishable by an unlimited fee, if it fails to prevent bribery by not having adequate preventative procedures in place that are robust, up-to-date and effective. The corporate offence is not a stand-alone offence and will follow from a bribery/corruption offence committed by an individual associated with NHS Tayside, in the course of their work. NHS Tayside therefore takes its legal responsibilities very seriously.

3.3 If a bribery offence is proved to have been committed by an outside body corporate with the consent or connivance of a Director or Senior Officer of NHS Tayside, under the Act, the Director or Senior Officer would be guilty of an offence (section 14 offences) as well as the body corporate which paid the bribe.

3.4 Whilst the exact definition of bribery and corruption is a statutory matter, the following working definitions are given together with some examples:

- Bribery is an inducement or reward offered, promised or provided in order to gain any commercial, contractual, regulatory or personal advantage;
- Corruption relates to a lack of integrity or honesty, including the use of trust for dishonest gain. It can be broadly defined as the offering or acceptance of inducements, gifts, favours, payments or benefits in kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly, however they may be unreasonably using their position to give some advantage to another;

Examples of bribery:

Offering a Bribe

A bribe would occur if:

- A payment was made to influence an individual who was responsible for making decision on whether NHS Tayside should be selected as the preferred bidder for the provision of services in a procurement process;

- A member of staff conducted private meetings, other than on NHS premises, with a public contractor hoping to tender an NHS Tayside contract, each time accepting hospitality far in excess of that deemed appropriate within the Standards of Business Conduct for NHS Tayside within the Code of Corporate Governance and without guidance being sought in advance from the line manager or Board Secretary, or subsequently being declared.

Receiving a Bribe

A bribe would occur if:

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

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

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

## 4. RESPONSIBILITY OF STAFF

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

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

This primary responsibility applies to **all NHS staff**, but is of particular relevance to those who commit NHS resources directly (e.g. by the ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.

4.3 The NHS must be impartial and honest in the conduct of its business and its employees should remain beyond suspicion. It is an offence under the Prevention of Corruption Acts 1906 and 1916 for an employee corruptly to accept any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts.

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

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

**If you are in any doubt at all as to what you can or cannot do, you should seek advice from your Line manager/Head of Department/Director or Board Secretary.**

## 5. KEY PRINCIPLES OF BUSINESS CONDUCT

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

Public Service values must be at the heart of the NHS Board's activities. High standards of corporate and personal conduct, based on the recognition that patients come first, are mandatory. The NHS Board is a publicly funded body, accountable to Scottish Ministers and through them to the Scottish Parliament for the services and for the economical, efficient and effective use of resources placed at the Board's disposal.

If staff follow these principles, the Board should be able to demonstrate that it adheres to the three essential public sector values.

| | |
|---|---|
| **Accountability:** | **Everything done by those who work in the organisation must be able to stand the tests of parliamentary scrutiny, public judgements on propriety, and meet professional codes of conduct.** |
| **Probity:** | **Absolute honesty and integrity should be exercised in dealing with NHS patients, staff, assets, suppliers and customers.** |
| **Openness:** | **The organisation's activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, staff and public.** |

## 6. ACCEPTANCE OF GIFTS, HOSPITALITY AND PRIZES

### 6.1 Gifts

6.1.1 The Standards of Business Conduct state that "under the Prevention of Corruption Act 1916, and Bribery Act 2010, any money, gift or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary".

6.1.2 Staff should therefore be very cautious if faced with the offer of a gift, and refuse all but the most trivial of gifts as accepting them could be interpreted as an attempt to gain preferential treatment

**Contractors**

~~.~~ Casual gifts offered by contractors or others ~~should be declined excluding patients, relatives, or carers (for example, at the festive season) may not be in any way connected with the performance of duties so as to constitute an offence under the Prevention of Corruption Acts.~~

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**Patients, relatives or carers**

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~~Such gifts should nevertheless be declined.~~ Trvial i~~t~~tems of low intrinsic value e.g. boxes of biscuits, chocolates or flowers from patients, relatives, or carers ~~can~~ may be accepted for sharing in the workplace. Staff should be guided by the Code of Conduct for their professional body and refuse gifts.

~~Any gifts of money should be handled in accordance with the Tayside Health Fund Policy and Procedures.~~

Where an unsolicited or inappropriate gift such as alcohol, vouchers or offers of service is received and the individual is unable to return it or the donor refuses to accept its return, they should report the circumstances to the Board Secretary. The Board Secretary ~~who will~~ determine if the gift can be accepted and this should be recorded in the Register of Gifts.
Any gifts of money from patients , relatives and carers should be handled in accordance with the Tayside Health Fund Policy and Procedures.

~~Financial donations to a department fund, which are to be used for the purposes of NHS Tayside must be administered through Tayside NHS Board Tayside Health Fund and handled in accordance with the Tayside Health Fund Policy and Procedures.~~

Gifts of equipment not for individual use but which are to be used for the purposes of NHS Tayside may be accepted, but only in accordance with the requirements of the Non Monetary Donations Section of Tayside NHS Board Tayside Health Fund Policy & Procedures.

The Board Secretary ~~should~~ will maintain a register to record gifts reported by staff. It is the responsibility of the recipients of such gifts to report all such items received to the Board Secretary ~~for recording.~~ The form in Annex 2 should be used for this purpose. ~~This register will be published on the NHS Tayside website.~~

### 6.2 Hospitality

6.2.1 Standards of Business Conduct state that hospitality may be acceptable provided it is normal and reasonable in the circumstances e.g. lunches in the course of a working visit. Any hospitality accepted should be similar in scale to that which the NHS as an employer would be likely to offer and must not exceed £25. All other offers of hospitality should be declined.

6.2.2 Staff should seek guidance from their Line Manager prior to accepting any such hospitality. In cases of doubt, advice should be sought from the Board Secretary.

6.2.3 It may not always be clear whether an individual is being invited to an event involving the provision of hospitality (e.g. formal dinner) in a personal/private capacity or as a consequence of the position which they hold in NHS Tayside.

(i) If the invitation is the result of the individual's position with NHS Tayside, only hospitality which is modest and normal and reasonable in the circumstances should be accepted. If the nature of the event dictates a level of hospitality which exceeds this, then the individual should ensure that his/her Head of Department/Director is fully aware of the circumstances. An example of such an event might be an awards ceremony involving a formal dinner. If the Head of Department/Director grants approval to attend, the individual should declare his/her attendance for registration in the Register of Hospitality held by the Board Secretary.

(ii) If the individual is invited to an event in a private capacity (e.g. as result of his/her qualification or membership of a professional body), they are at liberty to accept or decline the invitation without referring to his/her Line Manager. The following matters should however be considered before an invitation to an individual in a private capacity is accepted.

(a) The individual should not do or say anything at the event that could be construed as representing the views and/or policies of NHS Tayside.

(b) If the body issuing the invitation has (or is likely to have, or is seeking to have) commercial or other financial dealings with NHS Tayside, then it could be difficult for an individual to demonstrate that his/her attendance was in a private and not an official capacity. Attendance could create a perception that the individual's independence had been compromised, especially where the scale of hospitality is lavish. Individuals should therefore exercise caution before accepting invitations from such bodies and must inform their Line Manager.

(iii) Where suppliers of clinical products offer hospitality it should only be accepted if it complies with the guidance in the Sponsorship Policy.

(iv) The Board Secretary should maintain a register to record hospitality reported by staff. It is the responsibility of the recipients of such hospitality to report all such items received to the Board Secretary for recording in NHS Tayside's Register of Hospitality. The form in Annex 2 should be used for this purpose. This register will be published on the NHS Tayside website.

### 6.3 Competitions/Prizes

Individuals should not enter competitions including free draws organised by bodies who have or are seeking to have financial dealings with NHS Tayside. Potential suppliers may use this as a means of giving money or gifts to individuals with NHS Tayside in an effort to influence the outcome of business decisions. If in doubt contact the Board Secretary.

## 7. REGISTER OF STAFF INTERESTS

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

7.2 Interests that it may be appropriate to register (see also Annex 1), include:

(i) Other employments including self employment

(ii) Directorships including Non-Executive Directorships held in private companies or public limited companies (whether remunerated or not).

(iii) Ownership of, or an interest in, private companies, partnerships, businesses or consultancies.

(iv) Shareholdings in organisations likely or possibly seeking to do business with the NHS (the value of the shareholdings need not be declared).

(v) Ownership of or interest in land or buildings which may be significant to, of relevance to, or bear upon the work of NHS Tayside.

(vi) Any position of authority held in another public body, trade union, charity or voluntary body.

(vii) Any connection with a voluntary or other body contracting for NHS services.

(viii) Any involvement in joint working arrangements with Clinical (or other) Suppliers.

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

7.3 The completed register of interests form should be returned to the Board Secretary. The Register of Staff Interests will be retained for a period of 5 years.

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

## 8. PURCHASE OF GOODS AND SERVICES

8.1 NHS Tayside has established a central Procurement Department under the direction of the Head of Procurement & Logistics. Specialist teams have been set up within the Procurement Department to purchase the goods and services required for the functioning of NHS Tayside. With the exception of staff who have delegated authority to purchase goods and services, no other member of staff is authorised to make a commitment to a third party for the purchase of goods or services. The Procurement Department should be contacted for advice on all aspects of the purchase of goods and services.

8.2 All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services are expected to adhere to professional procurement standards and NHS Tayside Standing Financial Instructions (SFIs).

8.3 Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of SFIs and of EC Directives on Public Purchasing for Works and Supplies. This means that:

(i) No private or public company, firm or voluntary organisation which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.

(ii) Each new contract should be awarded solely on merit in accordance with the SFIs.

8.4 SFIs describe the process to be followed to purchase goods and services. Key points to note are:

(i) SFIs define the limits above which competitive quotations and competitive tenders must be obtained and describe the process which should be followed to achieve fair and open competition.

(ii) No organisation should be given unfair advantage in the competitive process e.g. by giving advance notice of NHS Tayside's requirements.

8.5 No special favour should be shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or managerial capacity.

Contracts must be won in fair competition against other tenders and scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

8.6 All invitations to potential contractors to tender for NHS business should include a notice warning tenderers of the consequences of engaging in any corrupt practices involving NHS Tayside's employees and that facilitation payments are prohibited in line with the Bribery Act 2010.

## 9. PURCHASE, SALE AND LEASE OF PROPERTY

9.1 Scottish Government Health Directorates has issued a strict set of rules governing all types of property transactions and these rules require that, each year, all NHS Tayside's property transactions are subject to close scrutiny by Finance and Resources Committee and Tayside NHS Board. The results of this scrutiny are reported to Scottish Government Health Directorates. Failure to comply with the rules governing property transactions could be viewed as a serious disciplinary matter.

9.2 Where it is necessary to acquire, dispose of or lease property land and/or buildings, the proposed transaction should be referred to the Director of Operations in the first instance, who has the responsibility for property matters, including the conduct of all property transactions.

9.3 Authority to sign off property transactions is limited to officers to whom authority has been formally and specifically delegated by Scottish Ministers. These officers are:

- Chief Executive
- Director of Finance
- The nominated Operational Director

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

## 10. BENEFITS ACCRUING FROM OFFICIAL EXPENDITURE

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

10.2 Staff should not use their official position for personal gain or to benefit their family and friends

10.3 Employees should not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had or may have official dealings on behalf of NHS Tayside. This does not apply to concessionary agreements negotiated on behalf of NHS staff as a whole.

## 11. FREE SAMPLES

11.1 Free samples should not be accepted. For further guidance see Samples paragraph ~~18.6.~~20.6

11.2 See also Section ~~18.6~~ 20.6 on samples of pharmaceutical or any other clinical product and Annex 6 Distribution and endorsement of products from commercial companies.

## 12. CONTRACTS AND AGREEMENTS

12.1 Where it is proposed to enter into an agreement with a non-NHS body (for example, a service agreement or a collaborative agreement), the legal status of the agreements needs to be considered. It is very likely that, to safeguard NHS Tayside's interests, a formal, legally binding document will be required which among other matters will specify the service to be provided and the payment to be made by NHS Tayside. Input from NHS Tayside legal advisors, Central Legal Office will be required to prepare such a document.

12.2 Where the agreement is commercial in nature, the Procurement Department must be involved at the earliest stage to ensure that all contractual issues are fully addressed.

12.3 It is recognised that each agreement may be different and staff should therefore contact the Procurement Department for advice at an early stage.

1.1 In cases of doubt, individuals should contact the Head of Procurement & Logistics/Board Secretary for advice.

## 13. PROVISION OF HOSPITALITY OR USE OF EXTERNAL FACILITIES

Where it is necessary to provide hospitality outwith an NHS catering facility, or use external facilities this should be authorised in writing, by the Chief Executive, nominated Operational Director, Director of Finance, Director of Human Resources or Director of Change and Innovation. The hospitality provided should be on a modest scale. NHS Tayside should not provide alcohol as part of the hospitality.

Written approval as above should be passed to the Head of Procurement & Logistics together with a non-stock requisition detailing the dates and any specific event requirements. This will enable a purchase order to be placed against the national contract for event accommodation. Favourable contract rates are available through key hotel chains located throughout Tayside and only contracted venues are available.

The Head of Procurement & Logistics is available to consult on the most suitable and cost effective accommodation for events.

## 14. SECONDARY EMPLOYMENT

14.1 Staff should obtain approval of NHS Tayside prior to committing to secondary employment including paid appointments or private practice. Staff should approach their Line manager to seek approval. Approval should be in writing and recorded in the individual's personal file.

14.2 NHS Tayside will require assurance that the secondary employment:

(i) Will not create a conflict of interest.

(ii) Will not interfere with or have a detrimental effect on the employee's duties with NHS Tayside.

(iii) Will not contravene the European Union Working Time Directive.

(iv) Will not damage NHS Tayside's reputation

14.3 The exception to the above:

(i) Career Grade Medical and Dental staff will be free to undertake Private Practice without requiring the approval of NHS Tayside, however, if they intend to undertake Private Practice, they must inform NHS Tayside, in writing. Any work undertaken must be outside the time agreed in the job plan for programmed activities.

(ii) Section 6 of the terms and conditions of service for Consultant grade staff and Schedule 10 of the terms and conditions of service for Speciality Doctor grade staff must be adhered to, if Private Practice is to be undertaken.

(iii) Career Grade Medical and Dental staff should confirm in writing to the HR Medical Lead eDeployment their intention to undertake private practice and that this will be undertaken outside the time agreed in the job plan for programmed activities as per CEL(2007) 2 seniority progression within consultant contract.

14.4 All staff including Consultants and Speciality Doctor Grade Hospital Medical and Dental staff and Doctors in Public Health and the Community Health Service as per 12.3 should note the requirement to declare any secondary employment, including self employment and private practice, in the Register of Interests (see Section 5).

## 15. ACCEPTANCE OF FEES

15.1 Where staff are offered fees by outside agencies, including a clinical supplier, for undertaking work or engagements (e.g. radio or TV interviews, lectures, consultancy advice, membership of an advisory board etc.) within their normal working hours, or draw on his/her official experience, the employee's Line Manager must be informed and his/her written approval obtained before

any commitment is given by the employee. Directors must obtain written approval from the Chief Executive and the Chief Executive must obtain written approval from the Chair of NHS Tayside before committing to such work.

An assurance will be required that:

(i) The individual concerned is not making use of his/her NHS employment to further his/her private interests.

(ii) Any outside work does not interfere with the performance of his/her NHS duties.

(iii) Any outside work will not damage NHS Tayside's reputation.

The position in respect of Medical and Dental staff is set out in paragraph 13.7.

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

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

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

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

15.6 Certain other provisions apply specifically to the provision of lectures or interviews. A lecturer/interviewee should ensure that the audience is made aware of whether is speaking on behalf of NHS Tayside or in a private capacity.

(i) It may not always be clear whether an individual is acting in a private capacity or as a representative of NHS Tayside. An individual will be deemed to be acting in a private capacity where is invited to speak because of his/her position within NHS Tayside but is expected to express his/her personal thoughts and opinions on a subject.
It is acknowledged that this may be a grey area and, in cases of doubt, staff should consult their Line Manager. (Directors should seek the endorsement of the Chief Executive).

(ii) Where an individual gives a lecture in a private capacity on a matter unrelated to the NHS and the individual's job or profession (e.g. a hobby), does not have to seek permission from his/her Line Manager. In these circumstances, the individual should avoid referring to his/her official position with NHS Tayside.

15.7 Consultant Grade and Specialty Doctor Grade Hospital Medical and Dental Staff and Doctors in Public Health and the Community Health Service may undertake additional work and receive fees in accordance with their respective terms and conditions of service and local agreements.

## 16. WORK UNDERTAKEN FOR PROFESSIONAL BODIES

16.1 If an employee wishes to serve as an office bearer with a professional body of which he/she is a member, he/she should obtain written approval from his/her Line Manager before takes up the duties with the professional body. Directors should obtain the written approval of the Chief Executive and if the Chief Executive wishes to fulfil such a role, should obtain written approval of the Chair of NHS Tayside.

16.2 As part of the approval process, NHS Tayside will require assurance that the individual's duties as an office bearer with the professional body will not interfere with his/her duties with NHS Tayside, or damage NHS Tayside's reputation. The following matters will be agreed in writing before the individual takes up his/her duties with the professional body:

(i) The time off to be granted to allow the individual to fulfil his/her duties with the professional body.

(ii) Whether this time off is to be paid or unpaid.

(iii) The extent to which expenses will be met by NHS Tayside in respect of travel and subsistence relating to the individual's work for the professional body.

(iv) The nature and extent of any support to be provided by NHS Tayside in terms of secretarial duties, access to email/internet, photocopying, printing and faxes etc.

(v) Whether the costs of this support are to be charged to the professional body or met by NHS Tayside.

16.3 In deciding whether to allow an individual to act as an office bearer for a professional body and the level of financial and administrative support to be provided, the following questions will be considered:

(i) Will the individual's activities as an office bearer of the professional organisation benefit the NHS in general and NHS Tayside in particular? It would normally be expected that the activities to be undertaken and the nature of the professional organisation would be relevant to some aspect of the provision of healthcare services.

(ii) Will the individual's activities interfere significantly with his/her NHS duties and/or the duties of any support staff that may be required to assist the individual?

16.4 Provided that the individual's activities in respect of the professional organisation will not interfere unreasonably with his/her duties and the duties of any relevant support staff, permission to act as an office bearer for a professional organisation will not be unreasonably withheld.

16.5 NHS Tayside will not pay or reimburse the costs of subscriptions to professional bodies. It is the responsibility of each individual to meet the cost of his/her membership of the relevant organisation(s).

16.6 If an individual wishes to apply for study leave to attend an event organised by a professional body of which is a member or any other event as part of a programme of continuing professional development, should submit a formal application for study leave to his/her Line Manager. If the application for study leave is granted, it may be granted with or without reimbursement of travel expenses in respect of his/her attendance at the event at the discretion of his/her Line Manager.

16.7 Reimbursement of expenses associated with study leave for Consultant Grade and Specialty Doctor Grade Hospital Medical and Dental staff and Doctors in Public Health and the Community Health Service will be in accordance with their respective terms and conditions of service. Doctors in the training study leave budget are managed through the Post Graduate Deanery

16.8 If an individual chooses to attend in his/her own time an event organised by a professional body of which is a member, any travel expenses incurred will be met by the individual

## 17. CONTACT WITH THE MEDIA

17.1 All press and media enquiries are dealt with by the NHS Tayside Corporate Communications Department. If an employee is contacted directly by the media the employee should contact the NHS Tayside Corporate Communications Department or direct the journalist to the NHS Tayside Corporate Communications Department (01382 424138 – 24 hours).

Employees should also inform their Line Manager so they are aware of the approach.

17.2 Staff must not invite journalists, photographers or camera crews onto any NHS Tayside premises without the prior agreement of NHS Tayside Corporate Communications Department.

17.3 Staff in dealing with the media may only provide copies of NHS Tayside material which are within the public domain.

17.4 Where an individual exercises the right in a private capacity to publish an article, give an interview or otherwise participate in a media event or debate in a public forum (including the internet), they should make it clear that they are acting in a private capacity and any opinions expressed are not necessarily those of NHS Tayside.

17.5 The general principles contained in paragraph 15.4 are applicable to other external bodies and further guidance is available in the Good Practice Guide : Procedure for engaging with politicians when acting on behalf of NHS Tayside.

## 18. CONDUCT DURING ELECTIONS

### 18.1 General Principles

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

(i) There should be even-handedness in meeting information requests from candidates from different political parties. Such requests should be handled in accordance with the principals laid down in the Standards of Conduct, Accountability and Openness in NHS Scotland and the Freedom of Information (Scotland) Act 2002.

(ii) Care should be taken over the timing of announcements of decisions made by NHS Tayside to avoid accusations of political controversy or partisanship. In some cases it may be better to defer an announcement until after the election but this would have to be balanced against any implication that the deferral itself could influence the outcome of the election.
Each case should be considered on its merits and any cases of doubt should be referred to Scottish Government for advice.

(iii) Existing advertising campaigns should be closed and there should be a general presumption against undertaking new campaigns unless agreement has been reached in advance with Scottish Government.

(iv) In carrying out day to day work and corporate activities, care should be taken to do nothing which could be construed as politically motivated or as taking a political stance.

Public resources must not be used for Party political purposes.

### 18.2 Freedom of Information (Scotland) Act 2002

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

## 19. INVOLVEMENT IN COMMERCIAL UNDERTAKINGS/TRADING ENTITIES/MEMBERSHIP OF VOLUNTARY BODIES

### 19.1 On behalf of NHS Tayside

As NHS Tayside becomes increasingly involved in partnership working with other agencies, a member of staff may be asked to hold a Directorship with a Company which has been established to progress a particular project. It is important that all staff are aware of NHS Tayside's legal position.

(i) NHS Tayside has limited powers to become involved in the conduct of a Company or by being entitled to nominate Directors to the Board of Directors of a Company. While there is the power to form companies to provide facilities or services under the National Health Service (Scotland) Act 1978 as amended, such powers will only be exercised in very limited circumstances with the consent of Scottish Ministers.

(ii) Where NHS Tayside collaborates with another agency on a specific project which will result in the establishment of a separate company or trading entity, the considerations at Section 16 apply equally here.

(iii) Staff should be aware that as Members of a voluntary body there is a potential for unlimited liability on the part of individual employees and of NHS Tayside as their employer. While this risk could be addressed by the body granting an indemnity to individuals and NHS Tayside in respect of any claims arising, this indemnity would only be worthwhile if there was some significant financial backing to meet the claim, or related claims. If the voluntary body had little or no funds, such an indemnity could in fact be worthless.

On balance, therefore, it is recommended that NHS Tayside and its officers normally take an advisory role in respect of a voluntary body rather than become a full member.

(iv) No employee will accept a directorship of a company or become a member of a voluntary body without the prior written consent of the Board. Staff should in the first instance discuss this with the Board Secretary.

### 19.2 In a Private Capacity

If an individual in a private capacity was appointed to the Board of a Company or becomes a member of a voluntary association, they must comply with NHS Tayside's requirements in respect of secondary employment and the declaration of interests and should make it explicit to the body concerned that they are not representing the views of NHS Tayside.

## 20. WORKING WITH THE SUPPLIERS OF CLINICAL PRODUCTS

20.1 Scottish Government has published guidance 'A Common Understanding 2012: Working Together for Patients. This SGHD guidance promotes consistency of approach across the NHS in Scotland through a model framework to ensure responsibility, transparency and probity in the joint working process. NHS Tayside is committed to providing high quality, innovative healthcare to the population it serves. In striving to achieve this aim, it acknowledges the considerable benefits and opportunities arising from collaboration between the NHS, the Pharmaceutical Industry and other Clinical Suppliers. However, all relationships between the NHS and suppliers, or potential suppliers, must be conducted in an appropriate, transparent and cost effective manner.

To ensure this is the case, the NHS has strict Standards of Business Conduct (NHS MEL (1994) 48) and these are incorporated within the Standards of Business Conduct for Staff.

### 20.2 Registration and Declaration of Interests

20.2.1 The over-riding principles contained in Section 5 on Registration of Staff Interests apply equally to staff who work jointly with clinical suppliers and should be read in conjunction with that section. However, the registration process requires additional detail to be provided and for registration for those who are neither employed by nor contracted with NHS Tayside, e.g. Honorary Consultants.

20.2.2 The requirement to register interests is applicable to holders of honorary contracts and research partnerships.

20.2.3 Interests should be declared on appointment or when the interest is acquired. Any change in circumstances, include acquisition of an interest, amendment to an interest or termination of an interest, should be declared within 4 weeks of the change occurring (Annex 4 refers).

20.2.4 A Register of Staff Interest will be held for all staff and interests declared under these provisions will be open to public inspection and will be retained for a period of 5 years from when the individual ceased to have the declared interest

20.2.5 Declarations should also be made at relevant meetings and this may affect the level of participation in some circumstances (Annex 5 refers).

20.2.6 If suppliers of clinical products approach NHS staff, including honorary contract holders for advice, this may be construed as a commercial interest, in potential conflict with public duties. Therefore, all individuals providing comparable advice to NHS Tayside, for example through their participation in advisory committees, must declare any relevant interests and must withdraw or modify their participation, as necessary, in meetings, consultation exercises etc. Advisory Committees include but is not restricted to:

(i) NHS Tayside Drug and Therapeutics Committee.

(ii) Groups with a specialist interest in specific therapeutic topics.

(iii) Guideline Development Committees/Groups.

(iv) Managed Clinical Networks.

(v) NHS Tayside Professional Advisory Committees.

(vi) Any Sub-Groups/Committees of the above.

(vii) East of Scotland Research Ethics Service (EoSRES) REC 1

20.2.7 This requirement to declare an interest also applies to any individuals, including patient and lay representatives, who provide advice and/or influence decisions made by the above.

20.2.8 Staff should be aware that the requirements for declaration at meetings are also applicable to independent primary care contractors directly involved with NHS decision-making on the procurement of medicines and other clinical products, those undertaking research and development and those participating in Board Committees, for example, on issues related to the General Pharmaceutical Services Regulations. Community pharmacists and other independent primary care contractors who have commercial relationships with a wide range of suppliers, will require to declare relevant interests if they are involved with Board Committees where particular products are being considered for inclusion in local policies.

### 20.3 Requirements of NHS staff when meeting with representatives of Clinical Suppliers

20.3.1 Meetings between NHS personnel and representatives of clinical suppliers can provide an opportunity for awareness raising and information sharing, such as advance notification of new clinical products, education/training and support for clinical research. The benefits of this exchange are recognised for both parties. However, interactions must follow the NHS values/principles outlined above and, where appropriate, the Association of British Pharmaceutical Industry (ABPI) Code, which require:

Meetings should only involve those whose roles justify their participation.

(i) Individuals should obtain approval from their Line Manager or equivalent before participation. It is acceptable to arrange prior approval up to an agreed level of interaction, as part of the annual job planning, performance review or appraisal process, as appropriate for different professions.

(ii) Only senior staff should participate in one to one meetings with representatives (see definition in Annex 3).

(iii) Staff taking part in such meetings should ensure there is a clear understanding of the purpose of the meeting, including the aims and the potential outcomes which benefit the NHS and patients.

(iv) No commercial commitments should be made during the course of such a meeting. Any appropriate recommendations should be referred to the Procurement Department, and Research and Development Services as required.

(v) Employees should keep a personal log of attendance at all such meetings and this should be made available to their Line Manager or equivalent at annual job planning or performance review.

(vi) Any information provided at such meetings should be critically evaluated. In the case of pharmaceuticals, the ABPI Code governs the approval of promotional materials, directs that statements should be evidence based and restricts distribution to 'persons who can reasonably be assumed to have a need or interest in the information'. If staff are in any doubt or need any assistance, the following additional resources are available:

- The Medicines Governance Department has access to independent sources of information and can be a useful conduit between Clinical Suppliers and NHS personnel.
- The Tayside Area Formulary provides advice on prescribing in primary and secondary care.

**20.4 Requirements of representatives when meeting healthcare staff**

20.4.1 Industry representatives are advised of the following requirements which relate to interactions with staff; NHS Tayside employees are also expected to ensure they adhere to these requirements:

(i) Clinical areas (e.g. wards or outpatient clinics) should be visited only by pre-arranged appointment.

(ii) Trainee medical staff should be visited only when a senior staff member is present.

(iii) Non medical clinical staff should be visited only with the approval of the relevant manager or professional head.

(iv) For any product discussed within NHS Tayside, representatives should describe the status of the product (in relation to the Scottish Medicines Consortium, NHS Tayside Formulary, Paediatric Formulary or equivalent clinical product catalogue), both when arranging the meeting and at the outset of the discussion. Cognisance should also be taken when products are restricted for use or initiation by specialist clinical staff.

(v) Only products within the NHS Tayside Formulary or comparable clinical product catalogues may be actively promoted.

(vi) Distribution of promotional materials for Formulary medicines should be in accordance with the ABPI Code.

(vii) No samples should be left, with the exception of the conditions in paragraph ~~18.6.2~~ 20.6.2

**20.5 Printing of Guidelines**

20.5.1 On occasion, the industry may offer to sponsor the printing of clinical guidelines, leaflets etc. This is acceptable provided the following criteria are met:

(i) The funding should be restricted to printing costs only.

(ii) More than one supplier should have the opportunity to give support through an unrestricted educational grant.

(iii) Clinical and editorial matters must be under NHS control and developed by a local NHS group, involving relevant clinicians.

(iv) Recommendations must be in line with local NHS Formulary or corresponding clinical product catalogues or policies.

(v) Generic names for medicines should be used throughout, unless otherwise specified in the Formulary (or equivalent).

(vi) Only NHS logos should appear on printed documents.

(vii) Acceptance of the sponsorship should be acknowledged on the printed document e.g. “printing supported by an unrestricted educational grant from …….” The declaration of sponsorship should be sufficiently clear that readers are aware of it at the outset.

(viii) Approval of such documents should proceed through the agreed NHS process e.g. clinical guidelines approval by the NHS Tayside Area Drug and Therapeutics Committee and Sponsorship Policy see Section G of the NHS Tayside Code of Corporate Governance.

**20.6 Samples**

20.6.1 This refers to pharmaceuticals or any other clinical product including dressings, sundries, products for wound care and stoma care, equipment and devices. Samples should not be accepted as NHS Tayside may be liable for the quality of items utilised in patient care. Exceptions are highlighted in paragraph ~~18.6.2~~20.6.2 below.

20.6.2 There are specific exemptions from the above restrictions:

(i) Medicines provided as part of a clinical trial or research collaboration.

(ii) Co-ordinated 'assessment' of certain products (e.g. equipment or devices) or supply of a single sample for demonstration purposes.

(iii) Supply of clinical monitoring equipment (e.g. glucometers, glucose testing strips, insulin pen devices or insulin pumps for use by newly diagnosed diabetic patients) as part of an individual evaluation of the suitability of use for the patient.

(iv) Assessment by Research and Development Services for relevant cost recovery and contractual terms and conditions.

20.6.3 While it is recognised there may be value in gaining pragmatic experience in this way, supplying samples for these purposes should be:

(i) In response to a written request, dated and signed.

(ii) Discussed and agreed with the local pharmacy or procurement teams.

(iii) Approved by the NHS Tayside Wound Management Committee or other appropriate Committee.

(iv) Subject to appropriate disclaimers to avoid liability on part of NHS Tayside.

20.6.4 Devices and equipment should be inspected, approved and regulated via normal NHS procedures to include:

(i) Completion of a 'Form of indemnity for equipment on loan'.

(ii) Completion of training in use of the equipment to the required standards.

(iii) Assessment by Research and Development Services for relevant cost recovery and contractual terms and conditions.

20.6.5 Any requirements for pre-packed medication, for example, to be used as starter packs in compliance with the Tayside Area Prescribing Guide, should normally be satisfied through NHS Manufacturing Units. Advice should be sought from local pharmacy departments.

### 20.7 Partnership working at corporate level

20.7.1 In developing a joint working agreement at corporate level, consideration should be given to the following:

(i) The costs and benefits of any arrangement.

(ii) Likely impact on purchasing decisions across the NHS structure, with such decisions being based on best clinical practice and value for money.

(iii) Joint working linked to the purchase of particular products or services, or to supply from particular sources, is not permitted unless as a result of an open and transparent tendering process for a defined package of goods and services. In particular, no sponsorship, funding or resources should be accepted from a supplier who is actively engaged, or shortly to be engaged, in a potential supply to NHS Tayside unless it can clearly be demonstrated that the sponsorship has not influenced the procurement decision. Is should be assumed that influence will be perceived unless it can be clearly demonstrated it was not.

(iv) A requirement that all participants observe Data Protection Legislation and respect patient confidentiality.

(v) The employment or seconding of any person as a result of the agreement.

(vi) Participants are made fully aware of the duration of the project with a clear definition of (1) the 'exit strategy' and (2) the implications for both patients and the service once the project comes to an end.

(vii) The need for 'registrations of interest' with any such agreement.

20.7.2 Any possible partnerships should always be discussed with the relevant Line Manager or equivalent, and local pharmacy, procurement teams and Research and Development Services before proceeding beyond the initial stages.

20.7.3 Procurement teams (and in the case of medicines, pharmacy teams) will work with suppliers to establish the best arrangements for the supply of clinical products, in line with NHS Tayside Standards of Business Conduct, purchasing legislation and NHS Tayside's Standing Financial Instructions (SFIs).

20.7.4 No commercial relationships can be entered into other than by staff with formal delegated authority, see Section E of Code of Corporate Governance. Any discussion on commercial matters should be referred to the relevant Procurement, Pharmacy teams or Research and Development Services.

### 20.8 Industry sponsored research/clinical trials

20.8.1 In general the NHS does not require confidentiality agreements (Non Disclosure Agreements) for clinical studies sponsored by third parties. Such documents are primarily intended to protect the interest of the sponsor. NHS confidentiality will normally be covered in the main contract where appropriate. Any confidentiality agreements requested by a sponsor must be referred to Research and Development for review.

Once an agreeable form of confidentiality agreement has been agreed the agreement should be signed by the Research and Development Director, authorised signatory as specified in Section E, Scheme of Further Delegation, sub section 3.3, Signing of Documents.

20.8.2 NHS Tayside, in collaboration with its academic partners, wishes to enhance patient care through advancement in clinical practice. NHS Tayside recognises the support that industry provides to research, with the resultant benefits of interaction between NHS staff and their scientific counterparts representing companies who supply clinical products.

20.8.3 Research partnerships need to meet the rigorous requirements of clinical relevance and governance as set out in current guidelines and legislation. All projects must be formally approved by the relevant Research Ethics Committee(s) and Tayside Medical Science Centre (TASC).

20.8.4 All industry sponsored research/clinical trials should be registered not only with Tayside Medical Science Centre (TASC), but also as an interest by the Head of Department or the Principal Investigator. This requirement applies equally to Pharmacy Departments who are in receipt of 'fee for service' in support of clinical trials.

20.8.5 On conclusion of the sponsored research/clinical trial period, the clinical product may be proposed for extended commercial use. The appropriateness of this development should be ascertained by a Peer Review Group, with membership drawn from relevant senior clinical and management personnel who are independent of the trial participants. This Peer Review Group will determine, in liaison with the appropriate NHS Tayside Committee, if the development supports the clinical/financial strategies of NHS Tayside in promoting cost effective patient care.

20.8.6 If a product is subject to transfer from a research setting to commercial use, this should be planned through a formal agreement for service development, with an agreed funding stream. Medicines are subject to separate process of 'managed introduction', given the role of (1) the regulatory authorities in marketing authorisation at a European or UK level; (2) the Scottish Medicines Consortium; and (3) the Area Drug and Therapeutics Committee.

20.8.7 Trial subjects/patients should be informed that NHS Tayside cannot guarantee that a new medicine will be available in clinical practice following clinical trial activity, compassionate use prescribing or 'expanded access' programme (or equivalent). Such availability is dependent on marketing authorisation and national guidance (e.g. Scottish Medicines Consortium and/or National Institute for Health and Clinical Excellence), in addition to individual patient circumstances.

20.8.8 Market research activities, post marketing surveillance studies clinical assessments and the like must be conducted with a primarily scientific or educational purpose and must not be disguised promotion. In the event that this activity involves a non-Formulary medicine, NHS prescribing should be conducted in line with accepted prescribing policies in secondary or primary care. Collaborative research will be referred to Tayside Medical Science Centre (TASC) for contract negotiation including NHS cost recovery.

## 21. INTELLECTUAL PROPERTY RIGHTS (IP)

21.1 Anyone entering into a joint working or sponsorship agreement must ensure that any intellectual property rights arising are properly protected for the benefit of NHS Tayside, in accordance with NHS MEL (1998) 23 – Policy Framework for the Management of Intellectual Property within the NHS and NHS HDL (2004) 09 – Management of Intellectual Property in the NHS.

21.2 If an employee invents a new technology, for instance, a device or diagnostic, or otherwise creates intellectual property (IP) as part of their normal duties of their employment, the patent rights in the invention belong to the employer (Patents Act 1977).

Although legally the employee is not automatically entitled to any royalty or reward derived from such an invention, they would expect to be acknowledged as the inventor in any patent application.

21.3 NHS Tayside operates an IP Policy, 'Ownership and Exploitation of Intellectual Property' that sets out inventor reward. Any member of staff who has an innovative concept or invention that may have commercial potential should contact Tayside Medical Science Centre (TASC).

21.4 Where relevant, the innovation may move forward through formation of a spinout company, in which the inventor may potentially hold personal equity. The inventor will require to declare such an interest via Tayside Medical Science Centre (TASC) in line with procedure.

21.5 Ownership of any Intellectual Property (IP) created by a member of staff whether in the course of the performance of his/her duties of field of responsibility as a member of staff, or in the performance of duties specifically assigned to him/her by NHS Tayside or whilst making use of NHS Tayside funds, resources, equipment, materials or information belonging to NHS Tayside will belong to and be the property of NHS Tayside.

21.6 Tayside Medical Science Centre (TASC) must be contacted before any conduct with an external organisation is entered into or negotiated, where IP will be generated or is likely to be generated from the contract or there is likely to be any IP implications arising or likely to arise from the contract. All contracts must be signed by an authorised signatory of NHS Tayside to ensure that they have legal validity.

21.7 It is the policy of NHS Tayside to use services via Tayside Medical Science Centre (TASC) in concluding any agreements or licences necessary to deal with the commercial exploitation of Intellectual Property owned by NHS Tayside.

New disclosures for technologies may be evaluated by Scottish Health Innovations Ltd (SHIL), and advice will be provided to inventors. A commercialisation licence may be agreed with SHIL for certain selected technologies. NHS Tayside may also go forward with IP exploitation with a University partner, where IP is jointly owned with a University.

21.8 Agreements and contracts may, in certain cases, involve the participation only of member(s) of staff and/or student(s); in other cases external collaborators may be involved. In negotiating and concluding agreements or licences, Tayside Medical Science Centre (TASC) will involve the service group leaders, project leader(s) any other member(s) of staff, including University members of staff or students, who have been directly involved in generating the IP.

21.9 IP may be patentable or otherwise capable of protection. It may also have commercial value even if not patentable or otherwise registrable. Failure to secure adequate protection prior to publication or non-confidential disclosure of IP may prevent NHS Tayside from making full commercial return of its IP.

21.10 NHS Tayside requires that any royalties or other income arising out of the commercial exploitation of IP belonging to NHS Tayside is fairly and equitably distributed between NHS Tayside, the service group and the member(s) of staff and student(s) directly involved in its generation and/or commercial exploitation.

## 22. DISTRIBUTION OF PRODUCTS

22.1 It is NHS Tayside's duty to provide health services for its population and it would not be appropriate to be used as a distribution point for commercial manufacturers and their products.

22.2 The commercial promotion and distribution of company products is a retail responsibility and is not the role of NHS Tayside health care professionals.

22.3 Distribution of products from commercial companies can be viewed as endorsement of the product being distributed. Staff should not unfairly advantage one competitor over another or show favouritism in awarding contracts. This applies to the distribution of products or samples to pregnant women or new mothers. For further guidance regarding this please see Annex 6.

## 23. REMEDIES

The Standards of Business Conduct for NHS Staff is applicable to all NHS Tayside employees and therefore it is imperative that all staff are informed of its contents through their annual Personal Development Plan.

Each manager within NHS Tayside will receive a copy of the Standards of Business Conduct and will confirm their receipt and understanding of this in writing as well as confirming that they have a permanent record of having informed their staff.

Managers or staff who fail to comply with the guidance detailed in the Standards of Business Conduct could be subject, following full investigation, to disciplinary action up to and including dismissal and loss of superannuation rights. If through their actions or omissions, managers or staff are found to be in contravention of either this guidance or indeed their legal responsibilities then NHS Tayside reserves the right to take legal action, if necessary.

Where staff suspect, or are aware of non-compliance with these Standards, they should report any such instances to their line manager, or as outlined in the Voicing Concerns Policy or Fraud Standards, Section D of the Code of Corporate Governance.

## 24. CONTACT FOR FURTHER GUIDANCE

The Board Secretary will provide advice and guidance on the Standards of Business Conduct for NHS Staff and its interpretation.

## 25. INDUCTION OF NEW STAFF

All new staff will receive a copy of the Standards of Business Conduct for NHS Staff and its implications for them at induction as part of their contract of employment.

## 26. REVIEW PROCESS

The Standards of Business Conduct for NHS Staff is kept under continual review by managers and trade union/professional organisation representatives through the Corporate Governance Review Group.

**Annex 1**

**NHS Tayside**

**REGISTRATION OF INTERESTS**

**NAME:**

**OCCUPATION:**
**(Office, Trade, Profession or Vocation)**

**CURRENT EMPLOYER:**

***Guidance is contained in Section C of the Code of Corporate Governance, the Standards of Business Conduct:***

- ***Paragraph 7, Register of staff interests***
- ***Paragraph 20, Working with the suppliers of clinical products, registration and declaration of interests***
- ***Annex 4 Registration of interests relating to working with clinical suppliers***

***Each category must be completed, including NOTHING TO REGISTER.***

**1. Remuneration**

(a) description of remuneration received by the virtue of being:- employed or self employed; the holder of an office; a director of an undertaking; a partner in a firm; and involved in undertaking a trade, profession, vocation or any other work;

(b) any allowance received in relation to membership of any organisation;

(c) the name, and registered name if different, and nature of any applicable employer, self-employment, business undertaking or organisation;

(d) the nature and regularity of the work that is remunerated; and

(e) the name of the directorship and the nature of the applicable business.

**2. Related undertakings**

A description of a directorship that is not itself remunerated, but is of a company or undertaking which is a parent or subsidiary of a company or undertaking which pays remuneration.

**3. Contracts**

A description of the nature and duration, but not the price of, of a contract which is not fully implemented where:-

(a) goods and services are to be provided, or works are to be executed for NHS Tayside

(b) any responsible person has a direct interest, or an indirect interest as a partner, owner or shareholder, director or officer of a business or undertaking, in such goods and services.

**4. Houses, land and buildings**

A description of any rights of ownership or other interests that may be significant to, of relevance to, or bear upon, the work or operation of NHS Tayside.

**5. Interest in Shares and securities**

A description, but not the value, of shares in a company or other body where –

(a) The responsible person's interest in the shares may be significant to, of relevance to, or bear upon, the work or operation of NHS Tayside

(b) The nominal value of the shares is greater than-

(i) 1% of the issue share capital of the company or other body; or

(ii) £25,000

***6.*** **Gifts and Hospitality**

A separate Register of Hospitality is maintained by the Board Secretary and a description of any gifts and hospitality received should be recorded except –

(a) Isolated gifts of a trivial character,

(b) Normal hospitality associated with the responsible person's duties and which would reasonably be regarded as appropriate; or

(c) Gifts received on behalf of NHS Tayside

**7. Non-financial interests**

A description of such interests as may be significant to, of relevance to, or bear upon, the work or operation of NHS Tayside, including without prejudice to that generality membership of or office in:-

(a) other public bodies;

(b) clubs, societies and organisations;

(c) trades unions; and

(d) voluntary organisations.

**9. Election expenses**

A description of, and statement of, any assistance towards election expenses relating to election to the Board.

**10. Joint Working arrangements with Clinical Suppliers.**

**11. Other Interests**

**Signature** **Date**

**Member/Attendee**

**Tick which applies**

□ **Employee**
□ **Tayside NHS Board Member**
□ **Member of Group or Committee**

**Name of Group/Committee**

**ANNEX 2**
**Ref**

**NHS TAYSIDE NHS BOARD**
**REGISTRATION OF HOSPITALITY**

This form must be completed by Members and staff of Tayside NHS Board who receive hospitality of any nature. For further information please see Standards of Business Conduct paragraph 6.2.

## YOUR DETAILS

| |
|---|
| Name<br><br>Designation<br><br>Telephone Number Email |

## DETAILS OF HOSPITALITY

Please give as much detail as you can, including approximate value and nature of hospitality

| |
|---|
| |

Signature Date

**FOR OFFICIAL USE**

| |
|---|
| Date Received Recorded in register<br><br><u>Form completed by</u><br>Officer who received hospitality ☐<br>Person notified of the receipt of hospitality ☐<br><br>Notified by -: Phone ☐ Letter ☐ Form ☐ Email ☐<br><br>Signature Date<br>*Officer of Tayside NHS Board* |

**ANNEX 3**

## GLOSSARY OF TERMS RELATING TO THE GUIDANCE ON WORKING WITH CLINICAL SUPPLIERS

**Association of the British Pharmaceutical Industry (ABPI)**
The ABPI is the trade association representing the manufacturers of prescription medicines. Membership is voluntary.

It sets standards for the promotion of medicines to health professionals and includes guidance on interactions with NHS personnel. It is drawn up in consultation with the BMA, the Royal Pharmaceutical Society of Great Britain, the Medicines & Healthcare Products Regulatory Agency (MHRA) and the Royal College of Nursing. The code has been revised in 2006; a full copy can be found at:

http://www.abpi.org.uk/links/assoc/PMCPA/code06use.pdf
and an abbreviated guide is available at:
http://www/abpi.org.uk/links/assoc/PMCPA/PMPCA.pdf

The Code applies automatically to members and may be adopted by non-member companies. These guidelines are considered to be compliant with the principals of the code but in the event of any conflict, the NHS requirements will take precedence.

**Clinical Products:**
These are defined as any material, item, or equipment designed to prevent disease, diagnose or treat patients of NHS Tayside. This includes:

- Medicinal products (pharmaceuticals)
- Medical devices (e.g. dressings, appliances, sundries, prostheses)
- Is conducted within the ethos of the A Common Understanding 2012:Working Together for Patients.
- Consumables such as syringes, needles and filters used in the preparation or administration of products for treatment or diagnosis.

**Clinical product catalogue**
Agreed Dressings and Sundries products that can be accessed by clinical teams across NHS Tayside. The range is controlled by clinical peer group review to provide the most appropriate products to deliver patient care. Discretion will be applied to a product range which is not covered by such a catalogue.

**Clinical Supplier**
The manufacturer/supplier of a clinical product as defined above.

**Industry**
This term covers the full range of clinical product suppliers or manufacturers, unless otherwise specified, including the Pharmaceutical Industry which covers ABPI and non-ABPI members.

**Joint Working**
Joint working should be compatible with the principles of the NHS Scotland Quality Strategy. Any partnership, across the range of section headings of this Code, between the NHS (or one or more of its employees) and suppliers of clinical products which:

- is for the benefit of patients
- should be in the mutual interest of both parties
- is conducted within the ethos of 'A Common Understanding' (SGHD Guidance 2003) which advocates a framework to ensure responsibility, transparency and probity in the process
- is compliant with the Data Protection Act 1998
- should not conflict with Scottish Government policy or advice issued by the Scottish Medicines Consortium (SMC) or Healthcare Improvement Scotland (HIS), unless endorsed for local implementation by the Area Drugs and Therapeutics Committee (ADTC)/Prescribing Management Group (PMG)
- should promote equitable access and evidence based healthcare
- should not be seen as an endorsement of any product or technology
- should not undermine or conflict with the professional or ethical requirements of any healthcare professional

This should yield improvements in patient care, service provision, support or development of NHS employees/independent primary care contractors etc. Any report from such activity should not be published without the explicit permission of all partners.

Research partnerships between the NHS and Clinical Suppliers also fall within the scope of this Code, although the financial and commercial implications will be considered separately.

**Post marketing surveillance**
Such activity is subject to 'Guidelines for Company Sponsored Safety Assessment of Marketed Medicines' (SAMM) which have been produced jointly by the ABPI, the British Medical Association, the Committee on Safety of Medicines, the Medicines and Healthcare products Regulatory Agency and the Royal College of General Practitioners.

**Promotion (of clinical products)**
Active detailing of product(s) to NHS staff (e.g. displays, AV presentations, issue of promotional materials) with the aim of changing current prescribing practice in NHS Tayside. Promotion is restricted to those products included in the Formulary (medicines) or other clinical product catalogues (e.g. dressings and sundries). This therefore excludes any medicine prior to its review by SMC and approval by the NHS Tayside Area Drug and Therapeutics Committee.

**Research partnership**
A partnership where one or more NHS employees and/or contractors have a formal partnership agreement in place with a clinical supplier to undertake ethically approved research studies.

**Senior staff**

- For hospital doctors, this includes Consultant and Associate Specialists and Speciality Grades
- For NHS pharmacists (those employed in hospital and the managed service), this includes managers, specialists and clinical pharmacy leads at Band 8a or higher
- For hospital nurses, this includes Senior Managers, Nurse Consultants and Clinical Nurse Specialists.
- For Allied Health Professionals, this includes Senior managers, Clinical Leads and Clinical Specialists

**ANNEX 4**

**REGISTRATION OF INTERESTS RELATING TO WORKING WITH CLINICAL SUPPLIERS**

**General**
All relevant joint working with clinical suppliers should be declared.

All employees should register their interests on appointment or when the interest is acquired. Any change in circumstances (either acquisition of an interest or termination of an interest) should be declared within 4 weeks of the change occurring.

**Publication**
Information about interests declared by NHS staff, including membership of the relevant Committees and Sub-Committees, will be open to scrutiny.

Additional Guidance in respect of clinical suppliers:

**Personal**
Personal payment or benefit to an individual. The main examples are:

a) Consultancies: any consultancy, directorship, position in or work for a clinical supplier which attracts regular or occasional payments in cash or kind
b) Fee-paid work: any work commissioned by a clinical supplier for which the employee is paid in cash or in kind
c) Shareholdings: any shareholding in or other beneficial interest in the pharmaceutical industry or other clinical supplier

**Non-Personal**
Payment to a department, or organisation for which an individual is responsible, without personal gain. For example: any payment, other support or sponsorship by a clinical supplier which benefits the position of a department e.g.

- A grant to support the activities of a department for which the employee is responsible
- A grant, fellowship or other payment to sponsor a post or a member of staff in the unit/department for which the employee is responsible
- The commissioning of research or other work or advice from a unit/department for which the employee is responsible

**Specific**
Relating to a particular product.

**Non-Specific**
Relating to a general interest in or involvement with a pharmaceutical company or clinical supplier, which is not product specific.

**ANNEX 5**

**DECLARATIONS OF INTERESTS AT MEETINGS RELATING TO WORKING WITH CLINICAL SUPPLIERS**

**Impact on provision of advice and participation**

There are particular implications for members of, and advisors to, Board Committees or Sub-Committees. Each is required to declare relevant interests prior to or during such meetings, and to state whether they are personal or non-personal interests and whether they are specific to the product under consideration. In the record of the meeting, a statement should be made of those declarations, including the nature of the interest and whether the member took part in the proceedings.

A member who is uncertain whether an interest should be declared should ask the Chair for guidance. The Chair may use discretion to determine how a member with a declared interest shall participate – e.g. 'taking part in the proceedings' includes both speaking and voting.

**Personal, specific**
A member must declare a 'personal specific interest' if he or she has a current (within the previous 12 months) personal interest in the company concerned which does not relate to the product under discussion. The member shall take no part in the proceedings as they relate to the product, except, at the Chair's discretion, to answer questions from other members.

**Personal, non-specific**
A member must declare a 'personal non-specific interest' if he or she has a current (within the previous 12 months) personal interest in the company concerned which does not relate to the product under discussion. The member shall take no part in the proceedings as they relate to the product, except, at the Chair's discretion, to answer questions from other members.

If a member has a current personal interest in a competitor of a product under consideration, he or she should declare this interest in the company manufacturing/marketing/supplying the rival product. The member should seek the Chair's guidance but, normally, they should not take part in the proceedings.

**Non-personal, specific**
A member must declare a 'non-personal specific interest' if the organisation/department/group for which they are responsible has at any time worked on the product. The member may take part in the proceedings, assuming they have not personally received payment and has no direct knowledge of the product through personal involvement or direct supervision of other people's work.

**Non-personal, non-specific**
A member must declare a 'non-personal, non-specific interest' if the organisation/department/group for which they are responsible is currently (active within the previous 12 months) receiving payment from the relevant clinical supplier – unrelated to the product under discussion. The member may take part in the proceedings unless, exceptionally, the Chair rules otherwise.

**ANNEX 6**

## DISTRIBUTION AND ENDORSEMENT OF PRODUCTS FROM COMMERCIAL COMPANIES

Commercial companies aggressively target new parents at the point of market entry during pregnancy and birth. They are viewed as a 'niche market, but a lucrative niche Global Baby Marketing (GBM) 2007. Specialist direct marketing companies exist to reach pregnant women and new mothers. Maternity services are subsequently targeted by commercial companies or agencies to distribute their promotional literature, commercial packs and products directed at pregnant women and newborn infants.

The Nursing & Midwifery Council (NMC) Code of Conduct states that "you must ensure that registration status is not used in the promotion of commercial products or services declare any financial or other interests in relevant organisations providing such goods or services and ensure that your professional judgement is not influenced by any commercial considerations".

The purpose of this guidance is to ensure that there is no distribution of promotional literature, commercial packs and products within NHS Tayside.

### Analysis of current practice of distribution

| | **Companies** | **NHS Tayside** | **Service Users** |
|---|---|---|---|
| Advantages to: | ● High Profile Advertisement<br>● Free promotion<br>● Direct marketing<br>● Professional Endorsement<br>● Increased Sales<br>● Increased Profits | ● Occasional small monetary incentive<br>● Usually none | ● Free Products<br>● Free magazines |
| Disadvantages: | Loss of above | ● Storage Capacity difficult<br>● Resource time used for moving and handling products, delivery through system, storage and distribution<br>● Conflict of interest | ●Products expensive<br>●Sense of failure if unaffordable<br>● Duplication of information<br>● Exposure to inappropriate health messages<br>●Information overload |

The distribution of promotional literature, commercial packs and products has clear disadvantages to NHS Tayside. More importantly service users may be disadvantaged within this system. NHS Tayside maternity services therefore has a responsibility to:

- Protect the interests of individual pregnant women and new mothers e.g. guard against the endorsement of any single product to the exclusion of other reputable brands on the market.
- Protect health professionals from distribution and endorsement of products presenting a conflict of interest in their professional role and duty of care.

- To ensure that there is no distribution of promotional literature, commercial packs and products. Companies or suppliers requesting the distribution of company products directed at pregnant women, new mothers or other vulnerable groups should be sent a copy of this policy.

**References**

**Global Baby Marketing (2007)** Accessed September 2007
http://www.baby-marketing.co.uk/sampling/pages/global_pregnancy.htm
**Nursing and Midwifery Council (2004) The NMC code of professional conduct: standards for conduct, performance and ethics.**
http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=201

# SECTION E

# RESERVATION OF POWERS AND DELEGATION OF AUTHORITY

This section gives details and levels of delegation across all areas of our business.

**1. Schedule of matters reserved for Boards agreement**

1.1 Background

1.2 Matters Reserved for Board Agreement

**2. Schedule of matters delegated to Board Executive Directors**

2.1 Interpretation

2.2 Chief Executive

2.3 Director of Finance

2.4 Nominated Operational Director

2.5 Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer

2.6 Provisions applicable to other Executive Directors of the Board

**3. Scheme of further delegation**

3.1 Introduction

3.2 Tender Negotiations and Orders

3.3 Signing of Documents

3.4 Delegation of Budgets/Approval to spend funds

3.5 Detailed Financial Matters – Banking etc

3.6 Management of Tayside Health Fund

3.7 Management of Land, Buildings and Other Assets Owned or Leased by the Trust Board

3.8 Management and Control of Stock

3.9 Management and Control of Computer Systems and Facilities (including Data Protection)

3.10 Recording and Monitoring of Payments under the Losses and Compensation Regulations

3.11 Making Ex-Gratia Payments

3.12 Health and Safety Arrangements

3.13 Insurance Arrangements

3.14 Contracts of Employment

3.15 Patients' Property

3.16 Legal Matters

**4. Delegation of powers for appointment of staff**

4.1 Use of Powers

4.2 Appointment of Staff

4.3 Authority to Appoint

4.4 Composition of Appointment Committees

4.5 Disciplinary Procedures

## 1. Schedule of matters reserved for Board agreement

### 1.1 Background

Under the proposals contained in the NHS Circular HDL (2003) 11 'Working Towards Single System Working', Tayside NHS Board will retain its focus as a board of governance, delivering a corporate approach to collective decision making based on the principles of partnership working and devolution of powers. Local leadership will be supported by delegating financial and management responsibility as far as is possible consistent with the Board's own responsibility for governance.

The Board has a corporate responsibility for ensuring that arrangements are in place for the conduct of the affairs of NHS Tayside. This includes compliance with applicable guidance and legislation, and ensuring that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The Board has a responsibility to ensure that it monitors the adequacy and effectiveness of these arrangements in practice.

The Board is required to ensure that it conducts a review of its systems of internal control, including in particular its arrangements for risk management, at least annually, and to report publicly on its compliance with the principles of corporate governance codes.

### 1.2 Matters Reserved for Board Agreement

The following shall be reserved for agreement by the Board:

1.2.1 The Five Year Strategic Plan, Local Delivery Plan, the Corporate Plan and commissioning plans.

1.2.2 All Strategic plans and those policies with resource implications of greater than £4,000,000.

1.2.3 Business plans with resource implications greater than £4,000,000.

1.2.4 Approval of the revenue and capital budgets.

1.2.5 The making, alteration and revocation of the Code of Corporate Governance.

1.2.6 The establishment of terms of reference and reporting arrangements for all Committees acting on behalf of the Board and the determination of differences between such Committees

1.2.7 Approval of the disposal of all property assets including land. The requirement for the Board to accept the offer received for the sale of land and/or buildings which have previously been declared surplus by the Board.

1.2.8 The acceptance in respect of the Capital Programme Budget where the value exceeds £3,000,000. Where the contract exceeds £3,000,000, prior approval of the full business case

by the Capital Investment Group of the Scottish Government Health Directorate must be obtained before the Board can accept the contract

1.2.9 The acceptance of contracts in respect of the Board's Revenue where the value exceeds £4,000,000.

1.2.10 Approval of transfer of funds between budget heads including transfers from reserves and balances where the value in any one instance exceeds £4,000,000.

1.2.11 Financial and performance reporting arrangements.

1.2.12 To review the Terms of Reference and appointment of the Internal Auditors.

1.2.13 Approval of arrangements for discharge of Board Members' responsibilities in relation to Tayside Health Fund.

1.2.14 Approval of the Annual Report and accounts.

1.2.15 The incurring of expenditure for which no provision or insufficient provision has been made in the Budget of the Board.

1.2.16 Approval of the annual best value work plan.

1.2.17 The dismissal of Executive Members of the Board and other Senior Members of staff where the filling of posts concerned require the involvement of Non-Executive Members of the Board.

1.2.18 Approval of all appointments of Non-Executive Members to Committees, Steering Groups, Project Boards or if allocated a role by the Chair or Chief Executive.

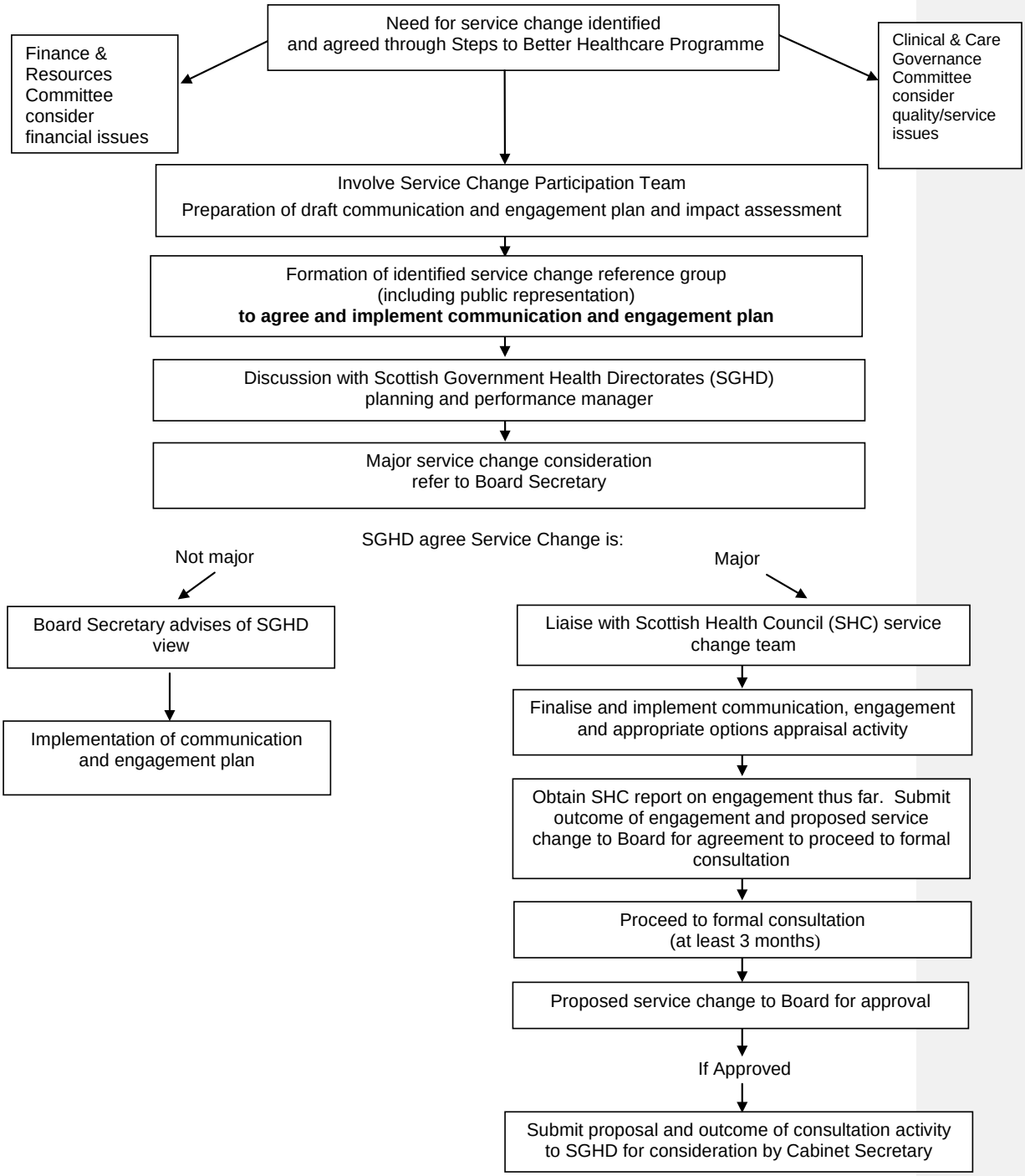
1.2.19 Approval of the North of Scotland Planning Group (NoSPG) and the South East and Tayside (SEAT) Regional Planning Group Work Plans as detailed in HDL (2004) 46.

1.2.20 Monitoring of all matters related to HAI which are delegated to the Infection Control and Management.

1.2.21 Approval of the Risk Management Strategy

1.2.22 Major service change which has been confirmed through the Scottish Government Health Directorate as having a major impact on patients, carers and communities following the application of the guidance contained in CEL4 (2010), Informing, Engaging and Consulting People in Developing Health and Community Care Services and the Scottish Health Council Guidance on Identifying Major Health Service Changes.

Flow chart describing process:



## 2. Schedule of matters delegated to Board Executives Directors

### 2.1 Interpretation

- Any reference to a statutory or other provision shall be interpreted as a reference amended from time to time by any subsequent legislation.

- The Chief Executive as Accountable Officer can exercise delegated authority across all NHS Tayside services and functions. However for the purpose of this section of the Code of Corporate Governance, it will be assumed that the Chief Executive will exercise delegated authority for the services and functions at Board level and will delegate to the nominated Operational Director delegated authority for the services and functions within the Operational Unit.

- Powers delegated to a Chief Officer in terms of this scheme may be exercised by such an officer or officers as the Chief Officer may authorise.

### 2.2 Chief Executive

#### 2.2.1 General Provisions

In the context of the Board's principal role to protect and improve the health of Tayside residents, the Chief Executive as Accountable Officer shall have delegated authority and responsibility to secure the economical, efficient and effective operation and management of NHS Tayside and to safeguard its assets in accordance with:

- The statutory requirements and responsibilities laid upon the Chief Executive as Accountable Officer for NHS Tayside;

- Direction from the Scottish Government Health Directorates;

- Current policies and decisions made by the Board;

- Within the limits of the resources available, subject to the approval of the Board;

- The Code of Corporate Governance.

The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to consulting, where possible, the Chair and the Vice-Chair of the Board, and the relevant Committee Chair. Such measures that might normally be outwith the scope of the authority delegated by the Board or its Committees shall be reported to the Board or appropriate Committee as soon as possible thereafter.

The Chief Executive is authorised to give a direction in special circumstances that any official shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the appropriate Committee.

### 2.2.2 Finance

Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Chief Executive, after taking account of the advice of the Director of Finance. The Chief Executive acting together with the Director of Finance has delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances, up to a maximum of £1,000,000 in any one instance. The Chief Executive shall report to the Finance and Resources Committee for formal inclusion in the minutes those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest.

The Chief Executive may, acting together with the Director of Finance, and having taken all reasonable action to pursue recovery, approve the writing-off of losses, subject to the limits laid down from time to time by the Scottish Government Health Directorates.

### 2.2.3 Legal Matters

The Chief Executive is authorised to institute, defend or appear in any legal proceedings or any inquiry, including proceedings before any statutory tribunal, board or authority, and following consideration of the advice of the Central Legal Office to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests.

In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, the Chief Executive shall implement the decision of the relevant Court on behalf of the Board.

In circumstances where the advice of the Central Legal Office is to reach and out-of-court settlement, the Chief Executive may, acting together with the Director of Finance, settle claims against the Board; subject to a report thereafter being submitted to the Finance and Resources Committee.

The Chief Executive, acting together with the Director of Finance, may make ex-gratia payments, subject to the limits laid down from time to time by the Scottish Government Health Directorates.

The arrangements for signing of documents in respect of matters covered by the Property Transactions Manual shall be in accordance with the direction of Scottish Ministers. The Chief Executive is currently authorised to sign such documentation on behalf of the Board and Scottish Ministers.

The Chief Executive shall have responsibility for the safekeeping of the Board's Seal, and together with the Chair or other nominated Non-Executive Member of the Board, shall have the responsibility for the application of the Seal on behalf of the Board.

### 2.2.4 Procurement

The Chief Executive shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders.

Where post tender negotiations are required, the Chief Executive shall nominate in writing, officers and/or agents to act on behalf of the Board.

The Chief Executive, acting together with the Director of Finance, has authority to approve on behalf of the Board, the acceptance of tenders, submitted in accordance with the Board's Code of Corporate Governance, up to a value of £1,000,000 (including VAT suffered) within the limits of previously approved Revenue and Capital Budgets.

The exercise of this authority for tenders in excess of £150,000 up to £1,000,000 must be reported to the Finance and Resource Committee.

The exercise of this authority for tenders in excess of £25,000 up to £150,000 must be included in the tender register.

~~In accepting a tender, which is not the lowest tender, received, it is mandatory that a detailed explanation for accepting the tender must be clearly recorded in the tender register. This must include an explicit detail of why this is the most advantageous tender for NHS Tayside.~~

Process should evidence actions commensurate with the guidance under the Procurement Reform (Scotland ) Act 2014, and meet criteria of Most Economically Advantageous Tender.

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The Chief Executive shall provide the Director of Finance with a listing, including specimen signatures, of those officers or authorised agents to whom he has given delegated authority to sign official orders on behalf of the Board.

### 2.2.5 Human Resources

The Chief Executive may appoint staff in accordance with the Board's Scheme of Delegation for the Appointment of Staff as detailed in the Code of Corporate Governance at Section E.

The Chief Executive may, after consultation and agreement with the Director of Human Resources, and the relevant officer, amend staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must have been consulted, and have confirmed that the cost of the mended establishment can be contained

within the relevant limit approved by the Board for the current and subsequent financial years.
Any amendment must also be in accordance with the policies and arrangements relating to human resource planning, approved by the Board or Staff Governance Committee.

The Chief Executive may attend and may authorise any member of staff to attend, within and outwith the United Kingdom, conferences, courses or meeting of relevant professional bodies and associations, provided that:

- Attendance is relevant to the duties or professional development of such member of staff; and
- 
- Appropriate allowance has been made within approved budgets; or
- External reimbursement of costs is to be made to the Board.

The Chief Executive may, in accordance with the Board's agreed Disciplinary Procedures, take disciplinary action in respect of members of staff, including dismissal where appropriate.

The Chief Executive shall have responsibility for ensuring that the Board complies with Health and Safety legislation, and for ensuring the effective implementation of the Board Policies.

The Chief Executive may grant paid compassionate leave or unpaid special leave of absence to any employee for up to five working days. The Chief Executive may approve other paid or unpaid leave within the limits defined in the Board's Leave Policy.

The Chief Executive may, following consultation and agreement with the Director of Human Resources and the Director of Finance, approve payment of honoraria to any employee.

#### 2.2.5 Patients Property

The Chief Executive has overall responsibility for ensuring that the Board complies with legislation in respect of patient's property. The term 'property' means all assets other than land and building (e.g. furniture, pictures, jewellery, bank accounts, shares, cash).

#### 2.2.6 Records Management

The Chief Executive has overall strategic accountability for records management.

### 2.3 Director of Finance

Authority is delegated to the Director of Finance to take the necessary measures as undernoted, in order to assist the Board and the Chief Executive in fulfilling their corporate responsibilities.

### 2.3.1 Accountable Officer

The Director of Finance has a general duty to assist the Chief Executive in fulfilling his responsibilities as the Accountable Officer of the Board.

### 2.3.2 Financial Statements

The Director of Finance is empowered to take all steps necessary to assist the Board to:

- Act within the law and ensure the regularity of transactions by putting in place systems of internal control to ensure that financial transactions are in accordance with the appropriate authority;
- Maintain proper accounting records;
- Prepare and submit for audit, timeous financial statements, which give a true and fair view of the financial position of the Board and its income and expenditure for the period in question.

### 2.3.3 Corporate Governance and Management

The Director of Finance is authorised to put in place proper arrangements to ensure that the financial position of the Board is soundly based by ensuring that the Board, it's Committees and supporting management groupings receive appropriate, accurate and timely information and advice with regard to:

- The development of financial plans, budgets and projections;
- Compliance and statutory financial requirements and achievement of financial targets;
- The impact of planned future policies and known or foreseeable developments on the Board's financial position.

The Director of Finance is empowered to take steps to ensure that proper arrangements are in place for:

- Developing, promoting and monitoring compliance with the Code of Corporate Governance;
- Developing and implementing systems of internal control, including systems of financial, operational and compliance controls and risk management;
- Developing and implementing strategies for the prevention and detection of fraud and irregularity;
- Internal Audit.

### 2.3.4 Performance Management

The Director of Finance is authorised to assist the Chief Executive to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures:

- For planning, appraisal, authorisation and control, accountability and evaluation of the use of resources;
- To ensure that performance targets and required outcomes are met.

### 2.3.5 Banking

The Director of Finance is authorised to oversee the Board's arrangements in respect of accounts held in the name of the Board with the Government Banking Service, the Scottish Government Banking & Treasury Branch and nominated commercial bankers appointed by the Board.

The Director of Finance will maintain a panel of authorised signatories.

The Director of Finance will be responsible for ensuring that the Government Banking Service, the Scottish Government Banking & Treasury Branch and nominated commercial bankers are advised in writing of amendments to the panel of authorised signatories.

## 2.4 Operational Director

### 2.4.1 General Provisions

The Operational Director has delegated authority and responsibility to secure the economical, efficient and effective operation and management of the Operational Unit and to safeguard its assets:

- In accordance with the current policies and decisions made by the Board;
- Within the limits of the resources made available to the Operational Unit by the Board:
- In accordance with the Code of Corporate Governance.

The Operational Director has a general duty to assist the Chief Executive in fulfilling his responsibilities as the Accountable Officer of the Board.

The Operational Director is authorised to take such measures as may be required in emergency situations, subject to consulting, where possible, the Chair or the Vice-Chair of the Board, the Chief Executive and where appropriate, the relevant Committee Chair. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Committees and shall be reported to the Board or appropriate Committee as soon as possible thereafter.

The Operational Director is authorised to give a direction in special circumstances that any officer within the Operational Unit shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the Chief Executive and Directors.

### 2.4.2 Finance

Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Operational Director, after taking account of the advice of the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer.~~ The Operational Director acting together with the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer,~~ has delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances, up to a maximum of £1,000,000 in any one instance. The Operational Director shall report to the Finance and Resources Committee for formal inclusion in the minutes those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest.

The Operational Director may, acting together with the Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer, and having taken all reasonable action to pursue recovery, approve the writing-off of losses in the Division, subject to the limits laid down from time to time by the Scottish Government Health Directorates.

### 2.4.3 Legal Matters

The Operational Director is authorised to institute, defend or appear in any legal proceedings or any inquiry, (including proceedings before any statutory tribunal, board or authority) in respect of the Operational Unit, and following consideration of the advice of the Central Legal Office and in consultation with the Chief Executive, to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests.

In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, the Operational Director shall report this to the Chief Executive and Director of Finance, and implement the decision of the relevant Court on behalf of the Board.

In circumstances where the advice of the Central Legal Office is to reach an out-of-court settlement, the Operational Director may, acting together with the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer,~~ may settle claims against the Board, subject to a report thereafter being submitted to the Audit Committee, the Chief Executive and Director of Finance.

The Operational Director, acting together with the Associate Director of Finance ~~– Financial Services Governance, Fraud Liaison Officer~~, may make ex-gratia payments, subject to the limits laid down from time to time by the Scottish Government Health Directorates.

The Operational Director, acting together with the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ must bring to the attention of the Chief Executive and Director of Finance, any claim deemed to have a significant risk to the Board's Revenues.

### 2.4.4 Procurement of Supplies and Services

The Operational Director shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders on behalf of the Board.

Where post tender negotiations are required, the Operational Director shall nominate in writing, officers and/or agents to act on behalf of the Board.

The Operational Director, acting together with the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer,~~ has authority to approve on behalf of the Board the acceptance of tenders, in respect of the Operational Unit submitted in accordance with the Board's Code of Corporate Governance, up to a value of £1,000,000 (including VAT suffered) within the limits of previously approved Revenue and Capital Budgets.

The exercise of this authority for tenders in excess of £150,000 up to £1,000,000 must be reported to the Finance and Resources Committee.

The exercise of this authority for tenders in excess of £25,000 up to £150,000 must be included in the tender register. In accepting a tender, which is not the lowest tender, received, it is mandatory that a detailed explanation for accepting the tender must be clearly recorded in the tender register. This must include an explicit detail of why this is the most advantageous tender for NHS Tayside.

### 2.4.5 Human Resources

The Operational Director may appoint staff in accordance with the Board's Scheme of Delegation for the Appointment of Staff as detailed in the Code of Corporate Governance at Section E.

The Operational Director may, after consultation and agreement with the Associate Director of Human Resources (Operational Services), and the relevant officer, amend staffing establishments in respect of the number and grading of posts. In so doing, the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to human resource planning, approved by the Board or the Staff Governance Committee.

The Operational Director may attend and may authorise any member of staff to attend within and outwith the United Kingdom conferences, courses or meetings of relevant professional bodies and associations, provided that:

- Attendance is relevant to the duties or professional development of such member of staff; and
- Appropriate allowance has been made within approved budgets; or
- External reimbursement of costs is to be made to the Board.

The Operational Director may, in accordance with the Board's agreed Disciplinary Procedures, take disciplinary action, in respect of members of staff, including dismissal where appropriate.

The Operational Director has overall responsibility for ensuring that the Operational Unit complies with Health and Safety legislation, and for ensuring the effective implementation of the Board's policies in this regard.

The Operational Director may grant paid compassionate leave or unpaid special leave of absence to any employee within the Operational Unit for up to five working days. The Operational Director may approve other paid or unpaid leave within the limits defined in the Board's Leave Policy.

### 2.4.6 Patients' Property

The Operational Director has overall responsibility for ensuring that the Operational Unit complies with legislation in respect of patients' property and that effective management arrangements are in place.

## 2.5 Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~

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Authority is delegated to the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ to take the necessary measures as undernoted, in order to assist the Operational Unit and the nominated Operational Director in fulfilling their corporate responsibilities.

The Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ has a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of the Board. In exercising these delegated powers the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ is also acting as the Director of Finance's representative.

### 2.5.1 Financial Statements

The Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ is empowered to take all steps necessary to assist and contribute to the Board in order that it:

- Acts within the Law;
- Ensures the regularity of transactions by maintaining approved systems of internal control to ensure that financial transactions are in accordance with the appropriate authority;
- Maintains proper accounting records;
- Assists and participates as appropriate in the completion of the Board's Annual Accounts.

### 2.5.2 Corporate Governance and Management

The Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ is authorised to put in place proper arrangements to ensure that the financial position of the Operational Unit is sound and by ensuring that the supporting management groupings receive appropriate, accurate and timely information and advice with regard to:

- The development of financial plans, budgets and projections;
- Compliance with statutory financial requirements and achievement of financial targets;
- The impact of planned future policies and known or foreseeable developments on the Operational Unit's financial position

The Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ is empowered to take steps to ensure that proper arrangements are in place for:

- Monitoring compliance with the Code of Corporate Governance and appropriate guidance on standards of business conduct.
- Contribute to the development and promotion of the Code of Corporate Governance.
- Developing and implementing systems of internal control, including systems of financial, operational and compliance controls and risk management.
- Developing and implementing strategies for the prevention and detection of fraud and irregularity.

### 2.5.3 Performance Management

The Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ is authorised to assist the nominated Operational Director to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures:

- For planning, appraisal authorisation and control, accountability and evaluation of the use of resources;
- To ensure that performance targets and required outcomes are met and achieved.

### 2.5.4 Patients' Property

The Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer shall have delegated authority to provide detailed operating procedures in relation to the management of the property of patients (including the opening of bank accounts where appropriate) for use by staff involved in the management of patients' property and financial affairs.

## 2.6 Provisions applicable to other Executive Directors of the Board

- Medical Director
- Nurse Director
- Director of Public Health

### 2.6.1 General Provisions

Executive Directors have delegated authority and responsibility with the Chief Executive, for securing the economical, efficient and effective operation and management of their own Directorates or Departments and for safeguarding the assets of the Board.

Executive Directors are authorised to take such measures as may be required in emergency situations, subject to consulting, where possible, the Chief Executive, the Chair and the Vice-Chair of the Board or relevant Committee Chair as appropriate. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Committees to the relevant Executive Director/Chief Officer, shall be reported to the Board or appropriate Committee as soon as possible thereafter.

### 2.6.2 Human Resources

Executive Directors may appoint staff in accordance with the Board's Scheme of Delegation for the Appointment of Staff as detailed in Standing Orders Section E.

Executive Directors may, after consultation and agreement with the Director of Human Resources or appropriate Head of Operational Human Resources, amend staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved by the Board for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to human resource planning, approved by the Board or Staff Governance Committee.

Executive Directors may authorise any member of staff to attend within and outwith the United Kingdom, conferences courses or meetings of relevant professional bodies and associations, provided that:

- Attendance is relevant to the duties or professional development of such member of staff; and
- Appropriate allowance is contained within approved budgets; or
- External reimbursement of costs is to be made to the Board.

Executive Directors have overall responsibility within their Directorates/Departments for ensuring compliance with Health and Safety legislation, and for ensuring the effective implementation of the Board's policies in this regard.

## 3. Scheme of further delegation

### 3.1 Introduction

The Chief Executive has delegated authority to secure the efficient operation and management of services in accordance with the current policies of the Board, and within the limits of the resources available, subject to the approval of the Board, through Standing Financial Instructions. Any officer listed in the Scheme of Further Delegation (Paragraph 3.2 to 3.16) is authorised to further delegate their authority in accordance with the Local Scheme of Delegation.

The Local Scheme of Delegation can be accessed by clicking the link here.

Any changes to this Scheme of Further Delegation must be notified to the Board Secretary in writing.

### 3.2 Tender Negotiations and Orders

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Issuing Tenders* | Area Supplies Manager or Chief Pharmaceutical Officer or Head of Property Services. | |
| Receiving and Opening Tenders* | Chief Executive or The nominated Operational Director or Authorised Officer | |
| Post Tender Negotiations* | Officers authorised is writing by the Chief Executive or by The nominated Operational Director | |
| Official Order/Requisition Signing* | Officers authorised in writing by the Chief Executive acting with the Director of Finance or The nominated Operational Director acting with the Director of Finance – Operational Unit | |
| Acceptance of Tenders and Contracts in respect of services and functions for the Board and Delivery unit | Chief Executive or Board Executive Directors acting with the Director of Finance or the The nominated Operational Director acting with the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ | Up to £1,000,000 |

| | | |
|---|---|---|
| Acceptance of Tenders and Contracts in respect of services and functions delegated towith Directorates | Operational Unit General Managers and Operational Unit Directors acting Associate Director of Finance ~~, Financial Services and Governance, Fraud Liaison Officer~~ | Up to £1,000,000 |
| Award of Contracts Following Quotations | Area Supplies Manager Chief Pharmaceutical Officer or Head of Property Services | up to £1,000,000 |

* These functions may be delegated to authorised agents acting on behalf of the Board.

### 3.3 Signing of Documents

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Signing in of documents for the acquisition and disposal of property where the Board Seal is not required | Chief Executive/ Director of Finance | |
| Signing in of documents for renting or leasing of property where the Board Seal is not Required | Chief Executive/ Director of Finance | |
| Signing other documents not covered in the Standing Financial Instructions | Two authorised offices | |
| Signing of documents in relation to commercial drug trials | Director of Finance (or delegated officer authorised by the Director of Finance/Lead Clinician) | Evidence that (a) the drug company has an insurance policy in place to cover the specific trial or has a generic insurance policy to cover all drug trials and (b) the drug company has been verified as being of a sound financial position |

| | | |
|---|---|---|
| Signing of documents in relation to confidentiality agreements (Non Disclosure Agreements) for clinical studies sponsored by third parties | Research and Development Director (delegated officer authorised by the Director of Finance | |
| <u>Agreements</u><br>Signing of legally binding agreements which contain financial obligations either to or by Tayside Health<br><br>Board in relation to:<br>(i) Commercial and non commercial clinical trials and clinical research studies;<br>(ii) Collaborative research and/or development<br>(iii) Material transfers, data-sharing/data-transfers, services subcontracts, research consultancy, research devices, research drugs, research equipment or any other research related matters;<br>(iv) The ownership, development or exploitation of intellectual property | Director of Finance, the Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer or a delegated officer authorised by the Director of Finance | (i)In relation to commercially sponsored drug or device trials, evidence the commercial sponsor has an insurance policy in place to cover the trial and the commercial sponsoring company has been verified as being of a sound financial position.<br>(ii) For all trials and studies, an assessment by (TASC) of Tayside Health Board costs and approval of the arrangement for cost recovery.<br>(iii) For IP agreements an assessment by TASC (or SHIL) of the commercial potential and approval of the arrangement for securing financial benefit |
| <u>Research Sponsorship</u><br>Signing of documents (including electronic versions of such) providing sponsor of approval of:<br>(i) research grant funding Applications;<br>(ii) submissions for research ethics approval via the Integrated Research Application System (IRAS)<br>(iii) Submissions for any other research approval from third parties including, for example, Clinical Trial Authorisation from the Medicines and Healthcare | Research & Development Director (TASC), Senior R&D Manager or a delegated officer authorised by the Research & Development Director | Appropriate and relevant reviews undertaken in TASC relating to risk assessment, research governance, R&D approval, commercial potential and/or contractual terms and conditions |

Products Regulatory Agency (MHRA);
(iv) final written confirmation of sponsorship of non-commercial clinical trials and clinical research studies

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Costing Approval
Signing of documents (including electronic versions of such) providing confirmation and/or approval for the recovery of NHS Tayside research costs in relation to applications for research funding, commercial research services or proposals for collaborative research

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Agreements
Signing of legally binding agreements which do not contain financial obligations either to or by Tayside Health Board in relation to:
(i) commercial and non-commercial clinical trials and clinical research studies;
(ii) collaborative clinical research and/or development;
(iii) material transfers, data-sharing/data-transfers, services, subcontracts, research consultancy, research devices, research drugs, research equipment or any other research related matters;
(iv) the ownership, development or exploitation of intellectual property;
(v) the arrangements for sponsorship, oversight or governance of non-commercial studies sponsored by Tayside Health Board,

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|---|---|---|
| either on its own account or as part of a co-sponsorship agreement;<br><br>(vi) the confidentiality (non-disclosure) of information relating to proposed or actual clinical trials or clinical research studies whether sponsored by third parties or by Tayside Health Board | | |
| <u>NHS R&D Management Approval</u><br>Signing of documents providing final management authority to proceed with research in Tayside | | |
| <u>Signing of documents for the Academic Health Sciences Partnership in Tayside</u><br>Non-Disclosure Agreements<br>Memorandum of Understanding (MOU) (including those legally Binding)<br>Collaboration Agreements<br>Supply of Educational/ Training Services Agreements (particularly for internationalisation)<br>Consultancy “in” and “out” Agreements<br>Strategic Partnership Agreements<br>Grant Applications and Acceptance of awards | NHS Tayside Co Director Academic Health Sciences Partnership in Tayside | Subject to the required due diligence, risk assessment, pricing/ costing and CLO review – up to £150,000 |

### 3.4 Delegation of Budgets/Approval to Spend Funds

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Preparation and submission of budgets | Director of Finance and Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ | |
| Budgetary Control System Establishment and Maintenance | Director of Finance/Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ | |
| Approval to spend funds | Chief Executive or The nominated Operational Director | Within limits specified by the Board and within Delegated power of virement as set out in the Standing Financial Instructions |
| Approval to spend Funds | Chief Executive acting together with the Director of Finance and the nominated Operational Director/General Manager | Approval of individual items over £1m up to £3m Exercise of this authority to be reported to the Finance & Resources Committee |
| Approval to spend funds joint working with Local Authorities and other NHS Boards via Regional Planning | Chief Executive or a Director delegated to act on behalf of the Chief Executive | Within limits as agreed from time to time by the Board and within delegated power of virement as set out in the Standing Financial Instructions, ie approval of individual items up to £1,000,000 |
| Approval to spend funds – joint working in respect of services and functions devolved to Directorate | Executive Directors or General Managers acting with Director of Finance or Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ | Approval of individual items up to £1,000,000 |

| | | |
|---|---|---|
| Approval to transfer funds between budget heads including reserves and balances | Chief Executive acting along with Director of Finance or the nominated Operational Director acting with Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ | Up to £1,000,000 in any instance |
| Approval to transfer funds between budget heads (including reserves and balances) in respect of services and functions devolved to Directorate | Executive Directors or General Managers acting with Director of Finance or Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ | Approval of individual items up to £1,000,000 |
| Hub Initiative Projects Approval of Stage 1 pricing report | Chief Executive/ Director of Finance | Up to £3 million, subject to the submission of a Standard Business Case to the Finance & Resources Committee |
| In relation to funds received from the annual Chief Scientist Office (CSO)/National Research (NRS) net funding allocation for research support in the NHS – approval to allocate or spend funds on researcher support, service support, generic infrastructure, networks, speciality groups, fellowships, management or other related initiatives, services or functions devolved to TASC | Devolved to TASC R&D Director | Within budget limits agreed from time to time with the Director of Finance or Assistant Director of Finance |

### 3.5 Detailed Financial Matters – Banking etc

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Opening of Bank Accounts in the Board's name | Director of Finance | Must report details of accounts so opened annually to the Audit Committee (including conditions under which they are to be operated) |
| Transfers between Government Banking Services bank accounts | One authorised signatory from panel authorised by the Board | Intra public finance transfers |
| BACS*/CHAPS*/SWIFT*/ Faster Payments*/ Cheque/Payable Order | One signatory from panel authorised by the Board | Individual payments of less than £150,000 or within a series of payments any individual payment more than £150,000 |
| | Two signatories from panel authorised by the Board | Individual payments greater than £150,000 or within a series of payments any individual payment more than £150,000 |
| Other payments from Board's Bank Accounts (not specified above) | One signatory from panel authorised by the Board | |
| Notification to bankers of authorised signatories (and cheques) on bank | Director of Finance | Authorisation by the Audit Committee on an annual basis. In year signatory changes authorised by the Director of Finance and reported annually to the Audit Committee. |
| Banking Service Level Agreements | Director of Finance | |

* BACS – Bankers Automated Clearing System
* CHAPS – Clearing Houses Automated Payment System
* SWIFT – Society for World-wide Interbank Financial Telecommunications

### 3.6 Management of Tayside Health Fund

| Areas of Responsibility | Nominated Members | Scope of Authority |
|---|---|---|
| Expenditure from Tayside Health Fund | Board of Trustees | i) all items of expenditure in excess of £100,000 to be charged against restricted funds on the advice of the Endowment Advisory Group<br><br>ii) annual budget for unrestricted funds<br><br>iii) items of expenditure in excess of £100,000 outwith the annual budget for unrestricted funds, on the advice of Endowment Advisory Group |
| | Endowment Advisory Group | i) all items of expenditure in excess of £10,000, but not more £100,000, to be charged against restricted funds<br>ii) items of expenditure not more than £100,000 outwith the annual budget for unrestricted funds<br>iii) appointment to endowment funded posts where the cost impact is not more than £100,000 |
| | Authorised Fundholders | Expenditure of restricted funds not exceeding £10,000 within the terms of the restricted fund, but excluding items reserved for approval by Board of Trustees on the advice of the Endowment Advisory Group and those items reserved for approval by Trustee Members of the Endowment Advisory Group. |

| Areas of Responsibility | Nominated Members | Scope of Authority |
|---|---|---|
| Maintenance of accounts and records | Director of Finance | |
| Access to share and stock Certificates, property deeds | Director of Finance | |
| Opening of Bank accounts in the Tayside Health Fund name | Director of Finance | Must report details of accounts so opened, to the Trustees (including conditions under which they are to be operated |
| Acceptance and banking of Tayside Health Funds | Director of Finance or any officer nominated by the Director of Finance | Can only accept funds for purposes related to the Health Service |
| Correspondence re legacies and giving good discharge to executors | Director of Finance or Associate Director of Finance - Financial Services and Governance, Fraud Liaison Officer | |
| Investment of Tayside Health Funds | Director of Finance | In accordance with Trustees' policy and subject to statutory requirements |
| Nominee for grants of probate or letters of administration | Director of Finance | Where necessary to obtain a legacy due to the Trustees under the terms of a will |
| Issue of cheques, standing orders and direct debits | Panel of signatories as authorised by Director of Finance or other senior staff who has delegated authority | Any two signatories from panel |

### 3.7 Management of Land, Buildings and Other Assets Owned or Leased by the Board

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Land, buildings and other Fixed assets – Management and upkeep | Chief Executive advised by the Director of Finance or the Chief Operating Officer/Associate Director of Finance – Financial Services And Governance, Fraud Liaison Officer<br>Head of Property – Services | Excludes acquisitions and disposals – (1.2) |
| Management of other Assets, e.g. Debtors, Investments | Director of Finance/Associate Director of Finance - Financial Services and Governance, Fraud Liaison Officer or any other officer Authorised by the Director Of Finance/Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer | Excludes Endowment Funds (1.5), bank accounts (1.4) and stocks (1.7) |
| Maintenance of Asset Register | Director of Finance/Associate Director of Finance - Financial Services and Governance, Fraud Liaison Officer | |

### 3.8 Management and Control of Stock

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Stores recording and operating procedures | Director of Finance or Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer | All stocks |
| Day to day management Security arrangements | Pharmaceutical Officer | Pharmacy Stock |
| Day to day management Security arrangements | Director of Operations | All other stock |

### 3.9 Management and Control of Computer Systems and Facilities (including Data Protection)

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Design implementation and documentation of non-clinical computer systems and facilities and those designed to provide national statistical returns | Director of Finance or Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer or any officer authorised by the Director of Finance/ Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer | Subject to other procedures and controls regarding tenders and asset acquisition and disposal, further instructions to ensure that computer systems are purchased with the approval of the IT Officers or NHS Tayside |
| Non-statutory clinical information computer systems | Consultant for clinical area concerned | Subject to other procedures and controls regarding tenders and asset acquisition and disposal |
| Data protection responsibilities | Line Managers taking advice from the Information Security Officer | |
| Caldicott Guardian | Director of Public Health and Medical Director | |

### 3.10 Recording and Monitoring of Payments under the Losses and Compensation Regulations

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Notification to the Scottish Government Health Directorates of discovered fraud/criminal offences (Circular No HDL(2005) 5 refers) | Director of Finance or Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer | |
| Maintenance of loss and compensation register | Director of Finance or Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer | |

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Writing off of losses | The Director of Finance or ~~one of~~ the Associate Director of Finance ~~– Financial Services & Governance, Fraud Liaison Officer~~ | Limits of Authority for Losses and Special Payments (see section 15 of Standing Financial Instructions) |
| Action to safeguard Board's interest in Bankruptcies and company liquidations | Director of Finance/ Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer | |

### 3.11 Making Ex-Gratia Payments

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Making ex-gratia payments | The Chief Executive or one of the Directors acting with the Director of Finance Signatories authorised to deputise for the Director of Finance are the Associate Director of Finance | Limits of Authority for Losses and Special Payments (see section 15 of Standing Financial Instructions). |

### 3.12 Health and Safety Arrangements

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Health and Safety Arrangements | Chief Executive | Overall and ultimate responsibility for Board's Health and Safety Policy |

### 3.13 Insurance Arrangements

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Establishment and Administration of Insurance arrangements | Director of Finance or Associate Director of Finance ~~- Financial Services & Governance, Fraud Liaison Officer~~ | Within guidance laid down by the Scottish Government Health Directorates and in Accordance with NHS Tayside's Risk Management Strategy |

### 3.14 Contracts of Employment

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| For all employees | Director of Human Resources | |

### 3.15 Patients' Property

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Authorisation of Manager and Establishment to manage residents' affairs | Chief Executive | Within the terms of the Adults with Incapacity (Scotland) Act 2000 |
| Monitoring and reviewing arrangements for the management of residents' affairs | Chief Executive | Within the terms of the Adults with Incapacity (Scotland) Act 2000 |
| Arrangements for the opening and management of bank accounts | Director of Finance or Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer | Within guidance laid down by the Scottish Government |
| Establishment of detailed Procedures for the safe custody and management of patients and residents property | Director of Finance or Associate Director of Finance – Financial Services & Governance, Fraud Liaison Officer | Within guidance laid down by the Scottish Government |
| Provision of receipts and payments statement in the approved format annually | Director of Finance or Associate Director of Finance – Financial Services & Governance, Fraud Liaison Officer | Within guidance laid down by the Scottish Government |

### 3.16 Legal Matters

| Areas of Responsibility | Nominated Officers | Scope of Authority |
|---|---|---|
| Institute, Defend, or appear in legal proceedings or any inquiry | Chief Executive following advice of the Central Legal Officer or the Chief Operating Officer following advice of the Central Legal Office or officers authorised by the Chief Executive | |
| Appoint or consult with Counsel | Chief Executive following advice of the Central Legal Office | |

## 4. Delegation of powers for appointment of staff

### 1. Use of Powers

1.1 The powers delegated are to be exercised in accordance with procedures or guidance issued by the Scottish Government Health Directorates, or approved by the Board.

1.2 Procedures governing the appointment of Consultants and certain other medical and dental grades are contained in Statutory Instruments issued by Scottish Ministers and PMETB.

1.3 Appointments will be made within the delegated authority and budgetary responsibility in accordance with Standing Financial Instructions. Schemes of Delegation for appointment of staff will specify appointing officers, and, where necessary, the composition of appointment panels.

### 2. Appointment of Staff

2.1 Canvassing of Appointing Officers of members of the Appointment Panel directly or indirectly for any appointment shall disqualify the candidate for such appointment.

2.2 A Member of the Board shall not solicit for any person any appointment under the Board, or recommend any person for any such appointment. This, however, shall not preclude any Member from giving a written testimonial of a candidate's suitability, experience or character for submission to the Board.

2.3 Every Member of the Board shall disclose to the Board any known relationship to a candidate for an appointment with the Board, it shall be the duty of the Chief Executive/nominated Operational Director to report to the Board any such disclosure made.

2.4 It shall be the duty of the Appointing Officer to disclose to their Line Manager any known relationship to a candidate for an appointment for which he or she is responsible.

2.5 Where a relationship of a candidate for appointment to a Member of the Board is disclosed, that Member must play no part in the appointment process.

Two persons shall be deemed to be related if they are husband and the son or grandson, daughter or granddaughter, or brother or sister, or nephew or niece, of the other, or of the spouse or partner of the other.

## 3. Authority to Appoint

| | | |
|---|---|---|
| 3.1 | Chief Executive/Chief Operating | The appropriate Board |
| 3.2 | Officer and posts at Director level. | Appointments Committee |
| 3.2 | Other Staff | Appointment Panel or Officer specified in the Scheme of Delegation |

## 4. Composition of Appointment Committees

### 4.1 **Chief Executive/** Nominated Operational Director

The Board Appointments Committee shall consist of:

4.1.1 Chair of the Board (and Chair of the Panel).

4.1.2 One Non Executive Member of the Board

4.1.3 Chair or other member of the National Performance Management Committee

4.1.4 One additional Chair of another Health Board

4.1.5 The Director General/Chief Executive of the NHS in Scotland

### 4.2 Posts at Executive Director Level (Other than Medical)

The Board Appointments Committee shall consist of:

4.2.1 Chair of the Board or their nominee;

4.2.2 Chief Executive/ Nominated Operational Director;

4.2.3 Up to two Non-Executive Members of the Board;

4.2.4 Up to two External Assessors, one of whom shall be a representative of the Scottish Government Health Directorates or his/her nominee, the other a representative of another NHS or local authority partner organisation.

### 4.3 Director of Public Health and Medical Director

The appointment is made by a Board Committee on the recommendation of an Advisory Appointments Committee, constituted in accordance with The National Health Service (Appointment of Consultants) (Scotland) Regulations 1993.

### 4.4 Other Staff

Appointment of other staff will be in accordance with the Scheme of Delegation.

## 5. Disciplinary Procedures

**5.1** The Disciplinary Procedures regarding the Board staff are contained in The Employee Conduct Policy. In the case of Executive Members and other Directors, written warnings and dismissals shall be a matter for panels convened on behalf of the Board.

**5.2** It is delegated to Chief Executive/Nominated Operational Director, as appropriate, to apply the terms of the Board's Employee Conduct Policy.

# SECTION F

# STANDING FINANCIAL INSTRUCTIONS

This section explains how staff will control the financial affairs of NHS Tayside and ensure proper standards of financial conduct.

## STANDING FINANCIAL INSTRUCTIONS


1. Introduction
2. Responsibilities of Chief Executive as Accountable Officer
3. Financial Strategy, Planning and Control
4. Commissioning/Providing Health Care Services
5. Annual Report and Accounts
6. Banking Arrangements
7. Security of Cash and Physical Assets
8. Income
9. Payment of Accounts
10. Construction Industry Scheme
11. Payment of Salaries and Wages
12. Travel, Subsistence and Other Allowances
13. Contracting and Purchasing
14. Stores
15. Losses and Special Payments
16. Tayside Health Funds
17. Primary Care Contractors
18. Aligned and Pooled Budgets
19. Patients' Funds and Property
20. Audit
21. Information Management and Technology
22. Fixed Assets
23. Risk Management and Insurance
24. Joint Ventures and Consortia


## ANNEX


**Annex 1**
Tendering Procedure

**Annex 2**
Common Seal

**Annex 3**
Budgetary Control Framework

**Annex 4**
Capital Approvals and Business Guide

**Annex 5**
Process for the Engagement of a Management Consultant and Consultant Categories

**Annex 6**
Pre Engagement Review and Post Engagement Review

## Standing Financial Instructions

## Section1. Introduction

### Made in terms of regulation 4 of the National Health Service (Financial Provisions) (Scotland) regulations, 1974

### Background

1.1 These Standing Financial Instructions are issued in accordance with the financial directions issued by the Scottish Government Health Department under the provisions contained in Regulation 4 of the NHS (Financial Provisions) (Scotland) Regulations, 1974 together with the guidance and requirements contained in NHS Circular No 1974 (GEN) 88 and Annex, and NHS Circular MEL (1994) 80. Their purpose is to provide sound control of NHS Tayside's financial affairs and shall have the effect as if incorporated in the Standing Orders of the Board.

1.2 The purpose of such a scheme of control is:

- To ensure that NHS Tayside acts within the law and that financial transactions are in accordance with the appropriate authority;
- To ensure that proper accounting records which are accurate and complete, are maintained;
- To ensure that financial statements, which give a true and fair view of the financial position of NHS Tayside and its expenditure and income, are prepared timelously;
- To protect NHS Tayside against the risk of fraud and irregularity;
- To safeguard NHS Tayside's assets;
- To ensure that proper standards of financial conduct are maintained;
- To enable the provision of appropriate management information;
- To ensure that NHS Tayside seeks best value from its resources, by making proper arrangements to pursue continuous improvement, having regard to economy, efficiency and effectiveness in NHS Tayside's operations;
- To ensure that any delegation of responsibility is accompanied by clear lines of control and accountability, together with reporting arrangements.

1.3 NHS Tayside shall exercise financial supervision and control by requiring the submission of financial estimates, by authorisation of budgets, by approving the specification of financial systems and their feeder systems and arrangements in respect of important key procedures and by defining specific responsibilities of officers, all within the financial resources made available to it, both directly and also through the framework introduced by Section 4 of the NHS and Community Care Act 1990.

### Compliance

1.4 The Director of Finance is responsible for assisting the Chief Executive as Accountable Officer therefore has ultimate responsibility for ensuring that Standing Financial Instructions are in place, up to date and observed in NHS Tayside. The responsibilities of the Director of Finance specified in the Standing Financial Instructions may be carried out by the Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer or such other senior finance officers as he or she might specify.

1.5 Members, officers and agents of NHS Tayside, including Local Authority employees who are employed in Joint Health and Social Care Projects, shall observe these Standing Financial Instructions. Executive and Operational Unit Directors shall be responsible for ensuring that the Standing Financial Instructions are made known within the services for which they are responsible and shall ensure that they are adhered to.

1.6 Failure to comply with these Standing Financial Instructions shall be a disciplinary matter.

1.7 Where these Standing Financial Instructions place a duty upon any person, this may be delegated to another person, subject to the Scheme of Delegation or the Local Scheme of Delegation contained within the Standing Orders.

## Section 2

### Responsibilities of Chief Executive as Accountable Officer

2.1 Under the terms of Sections 14 and 15 of the Public Finance and Accountability (Scotland) Act 2000, the Principal Accountable Officer for the Scottish Government has designated the Chief Executive of Tayside NHS Board as Accountable Officer.

2.2 Accountable Officers must comply with the terms of the **Memorandum to National Health Service Accountable Officers**, and any updates issued to them by the Principal Accountable Officer for the Scottish Government. The Memorandum was updated in April 2006.

### 2.3 General Responsibilities

2.3.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finance for NHS Tayside. The Accountable Officer must ensure that the Tayside NHS Board takes account of all relevant financial considerations, including any issues of propriety, regularity or value for money, in considering policy proposals relating to expenditure, or income.

2.3.2 It is incumbent upon the Accountable Officer to combine his or her duties as Accountable Officer with their duty to the Tayside NHS Board, to whom he or she is responsible, and from whom he or she derives his/her authority.

Tayside NHS Board is in turn responsible to the Scottish Parliament in respect of its policies, actions and conduct.

2.3.3 The Accountable Officer has a personal duty of signing the Annual Accounts of Tayside NHS Board. Consequently, he or she may also have the further duty of being a witness before the Audit Committee of the Scottish Parliament, and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.

2.3.4 The Accountable Officer must ensure that any arrangements for delegation promote good management, and that he or she is supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of special skills and services. He or she must ensure that staff are as conscientious in their approach to costs not borne directly by their component organisation (such as costs incurred by other public bodies), or financing costs, e.g. relating to banking and cash flow) as they would be, were such costs directly borne.

## 2.4 Specific Responsibilities

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

2.4.2 Sign the Accounts assigned to him or her, and in doing so, accept personal responsibility for ensuring that they are prepared under the principles and in the format directed by Scottish Ministers.

2.4.3 Ensure that proper financial procedures are followed incorporating the principles of separation of duties and internal check, and that accounting records are maintained in a form suited to the requirements of the relevant Accounting Manual, as well as in the form prescribed for published Accounts.

2.4.4 Ensure that the public funds for which he or she is responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official.

2.4.5 Ensure that the assets for which he or she is responsible, such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate.

2.4.6 Ensure that, in the consideration of policy proposals relating to expenditure, or income, for which he or she has responsibilities as Accountable Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and where necessary brought to the attention of the Board

Ensure that any delegation of authority is accompanied by clear lines of control and accountability, together with reporting arrangements.

2.4.7 Ensure that effective management systems appropriate for the achievement of the organisation's objectives, including financial monitoring and control systems have been put in place.

2.4.8 Ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them.

2.4.9 Ensure that best value from resources is sought, by making proper arrangements to pursue continuous improvement having regards to economy, efficiency and effectiveness, and in a manner which encourages the observance of equal opportunities requirements.

2.4.10 Ensure that managers at all levels have a clear view of their objectives, and the means to assess and measure outputs or performance in relation to those objectives.

2.4.11 Ensure managers at all levels are assigned well defined responsibilities for making the best use of resources (both those assumed by their own commands and any made available to organisations or individuals outside NHS Tayside) including a critical scrutiny of output and value for money.

2.4.12 Ensure that managers at all levels have the information (particularly about costs); training and access to the expert advice which they need to exercise their responsibilities effectively.

## 2.5 Regularity and Propriety of Expenditure

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

2.5.2 All actions must be able to stand the test of Parliamentary scrutiny, public judgements on propriety and professional Codes of Conduct. Care must be taken to avoid actual, potential, or perceived conflicts of interest when employing consultants and their staff.

## 2.6 Advice to Tayside NHS Board

2.6.1 The Accountable Officer has a duty to ensure that appropriate advice is tendered to the Board on all matters of financial propriety and regularity, and more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness.

2.6.2 If the Accountable Officer considers that, despite their advice to the contrary, the Board is contemplating a course of action which they consider would infringe the requirements of regularity or propriety, and that they would be required to take action that is inconsistent with the proper performance of his or her duties as Accountable Officer, they should inform the Scottish Government Health Directorates Accountable Officer, so that the Directorate, if it considers it appropriate, can intervene and inform Scottish Ministers. If this is not possible, the Accountable Officer should set out in writing his or her objection and the reasons, to the proposal. If their advice is overruled, and the Accountable Officer does not feel that he or she would be able to defend the proposal to the Audit Committee of the Scottish Parliament, as representing value for money, he or she should obtain written instructions from the Board for which he or she is designated, and send a copy of his or her request for instruction and the instruction itself as soon as possible to the External Auditor and the Auditor General for Scotland.

2.6.3 The Accountable Officer must ensure that their responsibilities as an Accountable Officer do not conflict with those as a Board Member. They should vote against any action that they cannot endorse as an Accountable Officer, and in the absence of a vote, ensure that his or her opposition as a Board Member, as well as Accountable Officer is clearly recorded.

## 2.7 Absence of Accountable Officer

2.7.1 The Accountable Officer should ensure that they are generally available for consultation, and that in any temporary period of unavailability a senior officer is identified to act on their behalf.

2.7.2 In the event that the Accountable Officer would be unable to discharge their responsibilities for a period of four weeks or more, NHS Tayside will notify the Principle Accountable Officer of the Scottish Government, in order that an Accountable Officer can be appointed pending their return.

2.7.3 Where the Accountable Officer is unable by reason of incapacity or absence to sign the Accounts in time for them to be submitted to the Auditor General, the Board may submit unsigned copies, pending the return of the Accountable Officer.

## Section 3

### Financial Strategy, Planning and Control

### Financial Strategy and Planning

3.1 In accordance with guidance issued by the Scottish Government Health Directorates, the NHS Tayside Chief Executive shall be responsible for leading an inclusive process, involving staff and partner organisations, to secure the compilation and approval by Tayside NHS Board, of the Local Delivery Plan for Tayside.

3.2 By concisely setting out how these will be tackled and by whom, and by setting clear priorities, key milestones and other quantified improvement targets over time, the Local Delivery Plan will help to secure understanding of important health issues, a shared approach to taking action, and a common commitment to achieving results.

3.3 In order to ensure that the planned actions within the Local Delivery Plan are affordable, the Chief Executive, with the assistance of the Director of Finance, shall be responsible for the annual development and updating of the strategic NHS Tayside Strategic Financial Plan.

3.4 The Strategic Financial Plan shall comprise both Revenue and Capital components, and shall be compiled within available resources, as determined by reference to the Revenue Resource Limit and Capital Resource Limit as notified or indicated by the Scottish Government Health Directorates, and as forecast for subsequent periods.

3.5 The Strategic Financial Plan shall be submitted to the Finance and Resources Committee for detailed scrutiny and risk assessment, following which the Committee shall be responsible for recommending approval of the Strategic Financial Plan by the Board.

3.6 The Strategic Financial Plan shall be an appendix to the Local Delivery Plan and shall be reconcilable to an annual update of the financial planning returns which the Director of Finance will prepare and submit to the Scottish Government Health Directorates, in accordance with guidance or direction issued from time to time.

### Control

3.7 The Director of Finance shall ensure that adequate financial and statistical systems are in place to monitor and control income and expenditure and to facilitate the compilation of financial plans, estimates and any investigations which may be required from time to time.

3.8 The Director of Finance shall devise and maintain systems of budgetary control and all officers whom the Board may empower to engage staff or otherwise incur expenditure or to collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of (and investigation into) financial, activity or workforce variances from budget.

The Director of Finance and the Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer shall be responsible for providing budgetary information and advice to enable the Chief Executive, nominated Operational Director and other officers to carry out their budgetary responsibilities.

3.9 The Chief Executive may, within limits approved by the Board, delegate authority for a budget or a part of a budget to the individual officer or group of officers who will be responsible for the activities provided for within that budget. The terms of delegation shall include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of service and the provision of regular reports upon the discharge of those delegated functions to the Chief Executive. Responsibility for overall budgetary control, however, shall remain with the Chief Executive.

3.10 Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by powers of virement delegated by him or her.

3.11 Expenditure for which no provision has been made in an approved budget shall only be incurred after authorisation by the Chief Executive, subject to his/her authorised virement limit.

Delegated authority is granted, as undernoted, to approve the funding of individual items of expenditure, provided that approval can be funded within the Board's overall Revenue and Capital Budgets:

- The Finance and Resources Committee has authority to approve individual items up to a value of £4,000,000 in any one instance. This authority shall be exercised in respect of all proposals not covered below;
- The Chief Executive as Accountable Officer, acting together with the Director of Finance, has authority to approve individual items up to a value of £1,000,000;

This includes authority to approve the transfer of funds up to this level between budget heads, including transfers from reserves and balances.

3.12 The Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets, and shall advise on the financial and economic aspects of future plans and projects.

3.13 There is no duty requiring the Chief Executive, other officers and agents of NHS Tayside, not to exceed approved budgetary limits.

3.14 The Chief Executive is responsible for the negotiation of funding for the provision of services in accordance with the Local Delivery Plan and for establishing the arrangements for the cross-boundary treatment of patients in accordance with the guidance of the Scottish Government Health Directorates. In carrying out these functions the Chief Executive shall take into account the advice of the Director of Finance regarding;

- Costing and pricing of services;
- Payment terms and conditions;
- Arrangements for funding in respect of patients from outwith Tayside, and for the funding of the treatment of Tayside residents other than by NHS Tayside.

3.15 The Chief Executive shall also be responsible for negotiating agreements for the provision of support services to/from other NHS Bodies.

**Reporting**

3.16 Any substantial funds arising from inability to action, or delay in the implementation of projects approved by the Board, shall be reported in the first instance by the Chief Executive, together with advice on the use of such funds, to the Finance and Resources Committee. The Committee shall report as appropriate to the Board.

3.17 The Director of Finance shall produce a regular Corporate Financial Report for submission to the Finance and Resources Committee. This report shall highlight any significant in-year variance from the Corporate Financial Plan together with a forecast of the outturn position for the financial year concerned, and shall recommend any proposed corrective action.

3.18 In order to fulfil these responsibilities, the Director of Finance shall have right of access to all budget holders on budgetary related matters.

## Section 4

**Commissioning/Providing Health Care Services**

4.1 The Chief Executive, in conjunction with the Director of Finance, shall be responsible for ensuring that all services required or provided are covered by a series of service agreements or, if not, that adequate funds are retained or requested to pay for services obtained outside service agreements, all within the context of the approved Local Delivery Plan and Corporate Financial Plan. They shall be responsible for ensuring that the total service framework is affordable within the overall Revenue and Capital Resource Limits set by the Scottish Government Health Directorates.

4.2 The Chief Executive is responsible for ensuring that service agreements are placed with due regard to the need to achieve best value and will personally authorise all agreed service agreements for health care purposes.

4.3 The Director of Finance is responsible for agreeing to the financial details contained in those service agreements agreed by the Board.

4.4 The Chief Executive is responsible for establishing robust financial arrangements, in accordance with guidance from the Scottish Government Health Directorates, for the treatment of Tayside residents by other NHS systems, or by the private sector, and for the treatment of residents of other health systems within NHS Tayside.

4.5 The Director of Finance is responsible for maintaining a system for the rendering and payment of service agreements invoices in accordance with the terms of service agreements, or otherwise in accordance with national guidance.

4.6 The Medical Director and Director of Public Health, in their capacities as Caldicott Guardians, are responsible for ensuring that all systems operate in a way to maintain the confidentiality of patient information as set out in the Data Protection Act 1998 under Caldicott guidance.

## Section 5

### Annual Report and Accounts

5.1 Tayside NHS Board is required under the terms of Section 86(3) of the National Health Service (Scotland) Act 1978 to prepare and transmit Annual Accounts to Scottish Ministers.

5.2 Scottish Ministers have issued Accounts Directions in exercise of the powers conferred by Section 86(1) of the National Health Service (Scotland) Act 1978 which contain the following provisions:

### Basis of Preparation

Annual Accounts shall be 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, International Financial Reporting Interpretations Committee (IFRIC) Interpretations and the Companies Act 2006 to the extent that they are meaningful and appropriate to the public sector.

- On a historical cost basis, as modified by the revaluation of property, plant and equipment, intangible assets, inventories, available-for-sale financial assets, and financial assets and liabilities at fair value.

**Form of Accounts**

The Annual Accounts shall comprise:

- A foreword (taken to be the Director's Report in the Accounts);
- An operating cost statement;
- A statement of total recognised gains and losses;
- A balance sheet;
- A cash flow statement;
- Such notes as may be necessary for the purposes referred to below.

The Annual Accounts shall give a true and fair view of the income and expenditure, total recognised gains and losses, balance sheet and cash flow statement. Subject to the foregoing requirement, the Annual Accounts shall also contain any disclosure and accounting requirements which Scottish Ministers may issue from time to time.

5.3 The Director of Finance shall maintain proper accounting records which allow the timeous preparation of the Annual Accounts, in accordance with the timetable laid down by the Scottish Government Health Directorates, and which give a true and fair view of NHS Tayside and its expenditure and income for the period in question.

5.4 Annual Accounts should be prepared by NHS Tayside in accordance with all appropriate regulatory requirements and be supported by appropriate accounting records and working papers prepared to an acceptable professional standard.

5.5 Under the terms of the Public Finance and Accountability (Scotland) Act 2000, the Auditor General for Scotland has appointed Mr D McConnell, Assistant Director of Audit (Health), Audit Scotland, to undertake the audit of NHS Tayside for the financial years 2005/2006 to 2011/2012.

5.6 The Director of Finance shall agree with the External Auditor a timetable for the production, audit, adoption by the Board of accounts to the Auditor General for Scotland and the Scottish Government Health Directorates. This timetable shall be consistent with the requirements of the Scottish Government Health Directorates.

5.7 The Annual Accounts shall be prepared in accordance with the relevant Accounts Direction and Accounts Manual issued by the Scottish Government Health Directorates.

5.8 The Chief Executive is responsible for preparing a Statement of Internal Control, and shall seek appropriate assurances, including that of the Chief Internal Auditor, with regard to the adequacy of internal control throughout the organisation.

5.9 The Annual Accounts shall be reviewed by the Audit Committee, which has the responsibility of recommending adoption of the Accounts by the Board.

5.10 Under the terms of the Public Finance and Accountability (Scotland) Act 2000, Annual Accounts may not be placed in the public domain, prior to them being formally laid before Parliament

5.11 Following the formal approval of the motion to adopt the Accounts by the Board, the Annual Accounts and relevant certificates shall be duly signed on behalf of the Board, and submitted to the External Auditor for completion of the relevant audit certificates.

5.12 Signed sets of Annual Accounts shall be submitted to the Scottish Government Health Directorates, and by the External Auditor to the Auditor General for Scotland.

5.13 The Chief Executive shall arrange for the production and circulation of an Annual Report for NHS Tayside in such form as may be determined by the Scottish Government Health Directorates.

5.14 The Annual Report, together with an audited financial statement, shall be presented at a public meeting which must take place no later than six months after the relevant accounting date.

## Section 6

### Banking Arrangements

6.1 All arrangements with NHS Tayside's bankers and the Government Banking Service, and the Scottish Government Banking & Treasury Branch will be made by or under arrangements approved by the Director of Finance who shall be authorised by the appropriate Scheme of Delegation to operate such bank accounts as may be considered necessary.

6.2 All funds should be held in accounts in the name of Tayside NHS Board, Tayside NHS Board Tayside Health Fund or Tayside NHS Board Patients' Fund. The Director of Finance shall report annually to the Audit Committee on the details of all accounts so opened, including the conditions on which they are operating.

6.3 The Director of Finance shall nominate, for each appropriate bank account, the officers, including him, authorised to release monies from each account, on a single signature basis up to a maximum of £150,000 **for any individual creditor**. Over that limit two signatures are required.

6.4 Cheques processed electronically will bear either a facsimile of the signature of the Assistant Paymaster General or be signed by the Director of Finance or other officers authorised by the panel approved by the Board. Where such cheques are in respect of Tayside Health Funds, two authorised officers will sign.

6.5 All cheques (which shall be crossed with 'Account Payee') to be treated as controlled stationery in the charge of a duly designated officer controlling their issue.

6.6 All cheques, postal orders, cash, etc, shall be banked intact promptly, in accordance with the Director of Finance's rules of procedures to the credit of the main account (or, if appropriate, Tayside Health Fund/patients fund interest bearing account – See Sections 16 and 19). Disbursements shall not be made from cash except under arrangements approved by the Director of Finance.

6.7 All arrangements for the receipt and payment of monies using BACS (the Bankers Automated Clearing Service), CHAPS (The Clearing Houses Automated Payment System), Faster Payments and SWIFT (The Society for World-Wide Interbank Financial Telecommunications) will be made by or under arrangements approved by the Director of Finance.

6.8 All arrangements for payments to be made by Standing Order or Direct Debit from any NHS Tayside bank account will be made by or under arrangements approved by the Director of Finance.

6.9 The use of credit cards will be made by or under arrangements approved by the Director of Finance.

## Section 7

### Security of Cash and Physical Assets

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

7.2 All officers, whose duty it is to collect or hold cash, shall be provided with a safe or with a lockable cash box which will normally be deposited in a safe. The officer concerned shall hold one key and all duplicates shall be lodged with a banker or such other officer authorised by the Director of Finance and suitable receipts obtained. The loss of any key shall be reported immediately to the Head of Financial Services, Maryfield House or the Chief Internal Auditor. The Director of Finance shall, on receipt of a satisfactory explanation, authorise the release of the duplicate key.

The Director of Finance shall arrange for all new keys to be despatched directly to him or her from the manufacturers and shall be responsible for maintaining register of authorised holders of safe keys.

7.3 The safe key-holder shall not accept unofficial funds for depositing in his safe unless deposits are in sealed envelopes or locked containers. It shall be made clear to the depositor that the Board is not to be held liable for any loss and written indemnity must be obtained from the organisation or individual absolving NHS Tayside from responsibility for any loss.

7.4 During the absence of the hold of a safe or cash box key, the officers who act in his place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for audit inspection

7.5 All cheques, postal orders and other forms of payment shall normally be received by more than one officer, neither of whom should be a Cashier and shall be entered immediately in an approved for of register which should be signed by both. All cheques and postal orders shall be crossed immediately 'Not Negotiable – account payee [Tayside NHS Board]'. The remittances shall be passed to the Cashier, from whom a signature shall be obtained in the register.

7.6 All cash payments shall normally be received by more than one officer neither of whom should be a Cashier and shall be counted and the details entered immediately in an approved form of register which should be signed by both officers and a receipt issued to the person making the payment. The Cash remittances shall then be passed to the cashier, preferably by two officers, where staffing allows, from whom a signature shall be obtained in the register and a receipt issued by the cashier to the officers. It should be noted that if the cash is handed over to other members of staff, the cash shall be recounted and each change over noted and signed for in the register.

7.7 The opening of coin-operated machines (including telephones) and the counting and recording of the takings in the register shall normally be undertaken by two officers together and the coin box keys shall be held by a nominated officer. The collection shall be passed to the cashier from whom a signature shall be obtained in the register.

7.8 The Director of Finance shall prescribe the system for the transporting of cash and uncrossed pre-signed cheques. Wherever practicable, the services of a specialist security firm shall be employed.

7.9 All unused cheques, receipts and all other orders shall be subject to the same security precautions as are applied to cash. Bulk stocks of cheques shall normally be retained by the Director of Finance or his nominated officers and released by them only against authorised requisitions.

7.10 All Prepayment Certificates and Prescription Pads in Primary Care should be subject to the same security precautions and controls as is applied to cash items.

7.11 In all cases where NHS Tayside officers receive cash, cheques, credit or debit card payments, empty telephone or other machine coin boxes, etc, personal identity cards must be displayed prominently. Staff shall be informed in writing on appointment by the departmental or senior officers of their responsibilities and duties for the collection, handling or disbursement of cash, cheques, etc.

7.12 Any loss or shortfall of cash, cheques etc, shall be reported immediately in accordance with the agreed procedure for reporting losses (see also Section 15).

Under no circumstances shall funds managed by the Board be used for the encashment of private cheques or the making of loans of a personal nature.

7.13 Where wages are made up by staff or bulk pay advices are sorted by staff prior to distribution, a secure room, to which no unauthorised person shall be admitted, shall be used.

**Security of Physical Assets**

7.14 Each employee has a responsibility to exercise a duty of care over the property of NHS Tayside and it shall be the responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Persistent breach of agreed security practices shall be reported to the Chief Executive.

7.15 Wherever practicable, items of equipment shall be marked as NHS property. Items to be controlled shall be recorded and updated in an appropriate register including all capital assets.

7.16 Nominated officers designated by the Chief Executive shall maintain up to date asset registers of items which are capital by definition as well as items classed 'special' and they shall ensure the responsible designated officers also maintain up to date and accurate copies.

7.17 There shall be an approved form of asset register and method of updating.

7.18 The items of the register shall be checked at least annually by the nominated officers and all discrepancies shall be notified in writing to the Director of Finance, who may also undertake such other independent checks as he considers necessary.

7.19 Any damage to premises, vehicles and equipment, or any loss of equipment or supplies shall be reported by staff in accordance with the agreed procedure for reporting losses (see also Section 15 – Losses and special payments).

7.20 Registers shall also be maintained by responsible officers and receipts retained for:

7.20.1 Equipment on loan;
7.20.2 Leased equipment;
7.20.3 All contents of furnished lettings.

7.21 On the closure of any facility, a check shall be carried out and a responsible officer will certify a list of items held showing eventual disposal. The disposal of fixed assets (including donated assets) shall be in accordance with Section 22 Fixed assets.

## Section 8

### Income

8.1 The Director of Finance shall be responsible for designing and maintaining systems for the proper recording, invoicing and collection of all money due.

8.2 All officers shall inform the Director of Finance of monies due arising from transactions they initiate, including all contracts, leases, tenancy agreement and any other transactions. The Director of Finance shall approve contracts with financial implications in excess of £5,000. Responsibility for arranging the level of rentals for newly acquired property and for the regular review of rental and other charges shall rest with the Director of Finance who may take into account independent professional advice on matters of valuation.

8.3 The Director of Finance shall take appropriate recovery action in all outstanding debts including the establishment of procedures for the write-off of debts after all reasonable steps have been taken to secure payment (see Section 15 – Losses and special payments).

8.4 In relation to Income Generation Schemes, the Director of Finance shall ensure that there are systems in place to identify all costs and services attributed to each scheme before introduction and such schemes should only proceed on the basis of providing income in excess of the cost of the scheme.

## Section 9

### Payments of Accounts

9.1 The Director of Finance and the Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer must approve the manual or electronic list of officers authorised to certify invoices, non-invoice payments, and payroll schedules, including where required by the Director of Finance, financial limits to their authority.

9.2 The Director of Finance and Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer will maintain details, together with his or her specimen signatures for manual authorisation. Electronic authorisation must be allocated by effective access control permissions to those approved by the Director of Finance.

9.3 The Director of Finance and Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer are responsible for the payment of all accounts, invoices and contract claims in accordance with contractual terms and/or the CBI Prompt Payment Code. Payment systems shall be designed to avoid payments of interest arising from non-compliance with the Late Payment of Commercial Debts (Interest) Act 1998.

9.4 All officers shall inform the Associate Director of Finance - Financial Services and Governance, Fraud Liaison Officer promptly of all monies payable by their organisation arising from transactions which they initiate, including contracts, leases, tenancy agreements and other transactions. To assist financial control, a register of regular payments should be created.

9.5 Where a manual payment system is in place, all requests for payment should, wherever possible, have relevant original invoices or contract payment vouchers attached and shall be authorised for payment by an approved officer from the list of authorised signatories agreed by the appropriate organisation. Where an electronic payment system has been approved by the Director of Finance or Associate Director of Finance - Financial Services and Governance, Fraud Liaison Officer, the system must ensure that payment is made only for goods matched against an authorised Purchase Order.

9.6 The Director of Finance and Associate Director of Finance - Financial Services and Governance, Fraud Liaison Officer is responsible for designing and maintaining systems for the verification, recording and payment of all amounts payable, including monies relating to clinical services. Certification is required either manually or electronically (within a tolerance level approved by the Director of Finance) that systems shall provide for the following:

9.6.1 Goods have been duly received or matched against an electronic purchase order, examined, are in accordance with specification and order, are satisfactory and that the prices are correct;

9.6.2 Work done or services rendered have been satisfactorily carried out in accordance with the order; that where applicable, the materials used were of the requisite standard and that the charges are correct;

9.6.3 In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the appropriate rates, that the materials have been checked as regards quantity, quality and price and that the charges for the use of vehicles, plant and machinery have been examined;

9.6.4 Where appropriate, the expenditure is in accordance with regulations and that all necessary Board or appropriate officer authorisations have been obtained;

9.6.5 The account or claim is arithmetically correct;

9.6.6 The account or claim is in order for payment;

9.6.7 VAT has been coded/recovered in good time as appropriate;

9.6.8 Clinical services have been carried out satisfactorily in accordance with Service Agreements and Unplanned Activity arrangements (UNPACs);

9.6.9 A timetable and system for submission to the Associate Director of Finance - Financial Services and Governance, Fraud Liaison Officer, of accounts for payment with provision shall be made for early submission of accounts, subject to cash discounts or otherwise requiring early payment, and

9.6.10 Instruction of staff regarding the handling, checking and payment of accounts and claims within the Maryfield Financial Services Centre.

9.7 Budget holders shall ensure, before an order for goods and services is placed , that the purchase has been properly considered and forms part of the department's allocations, agreed business plans, or other known and specific funds available to the department.

9.8 The Director of Finance shall ensure that payment for goods and services is only made once the goods and services are received other than under the terms of a specific contractual arrangement.

9.9 Where an officer certifying accounts or claims relies upon other officers to do preliminary checking he shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed an order and negotiated prices and terms. Budget Managers must therefore ensure, within delegated limits that there is effective separation of duties between:

- The person placing the order;
- The person certifying receipt of goods and services, and
- The person authorising the invoice manually or electronically.

That no one person should undertake all three functions.

9.10 In the case of contracts for building or engineering works which require payment to be made on account during process of the works, the Associate Director of Finance – Financial Services & Governance, Fraud Liaison Officer shall make payment on receipt of a certificate from the technical consultant or officer. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractor's account shall be subject to such financial examination by the Associate Director of Finance – Financial Services & Governance, Fraud Liaison Officer and such general examination by a works officer as may be considered necessary, before the person responsible for the contract issues the final certificate. To assist financial control, a contracts register should be created.

9.11 The Director of Finance or Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer may authorise advances on the imprest system for petty cash and other purposes as required. Individual payments must be restricted to the amounts authorised by the Director of Finance and appropriate vouchers obtained and retained in accordance with the policy on culling and retention of documents.

9.12 NHS Tayside officers responsible for commissioning self employed contractors (who were previously employees of the Board or other NHS bodies) must ensure that, subject to their delegated authority and before any work assignment is agreed, that evidence is obtained from the self employed contractor that confirms their status to ensure that NHS Tayside is not held liable for Income Tax and National Insurance by the Inland Revenue. This evidence must be submitted to the Associate Director of Finance – Financial Services & Governance, Fraud Liaison Officer.

9.13 Advance payment for supplies, equipment or services shall not normally be permitted. Should exceptional circumstances arise, any proposal must be submitted to the Associate Director of Finance – Financial Services & Governance, Fraud Liaison Officer at the earliest opportunity. The Assistant Director of Finance – Financial Services & Partnership, Fraud Liaison Officer shall take appropriate advice in determining a course of action.

9.14 Advance payments to general medical practitioners and community pharmacists shall comply with the specific contractor NHS plans and regulations.

9.15 The Budget Holder is responsible for ensuring that all items due under a payment in advance contract are received and he must inform the Director of Finance or Chief Executive immediately problems are encountered.

## Section 10

### Construction Industry Scheme

10.1 The scheme is to be administered in accordance with guidance supplied by the Inland Revenue in booklet IR14/15(CIS) – Supplement.

10.2 The Director of Operations is responsible for ensuring that all necessary certificates and/or vouchers are obtained from contractors/sub-contractors and are supplies to Financial Services in support of payment requests.

10.3 In the event of any doubt, the Head of Financial Services, Maryfield House, will determine whether a payment should be made gross or net of deduction of tax and shall consult with the Inland Revenue, as necessary.

10.4 The Director of Finance is responsible for remitting to the Inland Revenue any tax deducted from payments made to sub-contractors. The Director of Finance must ensure that this is done in accordance with the timetable(s) set out in IR14/15(CIS) – Supplement, as appropriate.

## Section 11

### Payment of Salaries and Wages

11.1 Staff may be engaged or regraded only by authorised officers within the limit of the approved budget and establishment when agreed by the Chief Executive or other authorised officer unless following successful grading appeals.

11.2 The Remuneration Committee will approve any changes to the remuneration, allowances and conditions of service of the Chief Executive and other Directors in accordance with the Code of Corporate Governance.

11.3 Each employee shall be issued with a contract which shall comply with current employment legislation and be in a form approved by the Board.

11.4 A signed copy of the engagement for and such other documents necessary for the payment of staff as they may require shall be sent to the Head of Payroll Services immediately upon the employee commencing duty.

11.5 A termination of employment form and such other documents as they may require, for payment purposes, shall be submitted to the Head of Payroll Services immediately upon the effective date of an employee's resignation, retirement or termination being known. Where an employee fails to report for duty in circumstances which suggest that he or she has left without notice, the Head of Payroll Services shall be informed immediately.

11.6 A notification of change form shall be sent to the Head of Payroll Services by the Director of Human Resources immediately upon the effective date of any change in state of employment or personal circumstances of an employee being known.

11.7 Where the personnel and payroll systems are connected by an electronic interface the requirement for contract/engagement forms, termination of employment forms and notification of change forms to be sent to the Head of Payroll Services may be altered to allow for such information to be transmitted by electronic means providing always that appropriate procedures for such transmissions are agreed by the Director of Finance.

11.8 All time records, staff returns and other pay records and notifications shall be in a form approved by the Director of Finance and shall be certified and submitted in accordance with his instructions.

Where this information is transmitted by electronic means, appropriate procedures covering such transmissions require to be agreed by him or her.

11.9 The Remuneration Committee will consider any redundancy, early retirement or termination arrangements in respect of all NHS Tayside staff, excluding early retirement on grounds of ill health, and approve these or refer to Tayside NHS Board as it sees fit.

11.10 The Director of Human Resources and the Director of Finance shall be jointly responsible for ensuring that rates of pay and relevant conditions of service are in accordance with current agreements. The Chief Executive or the Remuneration Committee in appropriate circumstances, shall be responsible for the final determination of pay, but subject to the statutory duty of the Director of Finance, who shall issue instructions regarding:

11.10.1 Verification of documentation or data;

11.10.2 The timetable for receipt and preparation of payroll data and the payment of staff;

11.10.3 Maintenance of subsidiary records for superannuation, Income Tax, National Insurance and other authorised deductions from pay;

11.10.4 Security and confidentiality of payroll information in accordance with the principle of the Data Protection Act, 1998

11.10.5 Checks to be applied to completed payroll before and after payment;

11.10.6 Authority to release payroll data to a security firm, if applicable;

11.10.7 Methods of payment available to various categories of staff;

11.10.8 Procedures for payment of cheques, bank credits or cash to staff;

11.10.9 Pay advances authorised in paragraph 11.13 and their recovery;

11.10.10 Maintenance of regular and independent reconciliation of adequate control accounts;

11.10.11 Separation of duties of preparing records and handling cash;

11.10.12 A system to ensure the recovery from leavers of sums due by them; and

11.10.13 A system to ensure recovery or write-off of payment of pay and allowances.

11.11 The Remuneration Committee shall approve performance assessments and salary uplifts of the Chief Executive and all other Executive and Management posts reporting directly to the Chief Executive.

11.12 The Medical Director and Director of Human Resources, acting together and with the agreement of the Chair of the Remuneration Committee, are given delegated authority to approve payments, in circumstances where recruitment has to be actioned urgently and requires agreement for expedience reasons. Where such approval is given, powers are delegated to the Director of Human Resources to agree appropriate contractual arrangements. There is a requirement for such payments to be homologated at the following Remuneration Committee.

11.13 The Director of Finance shall ensure salaries and wages are paid on the currently agreed dates, but may vary these when necessary due to special circumstances (e.g. Christmas and other Bank Holidays). Payment to an individual shall not be made in advance of normal pay, except;

11.13.1 As authorised by the Chief Executive or Director of Finance to meet special circumstances and limited to the net pay due at the time of payment.

All employees shall be paid by bank credit transfer monthly unless otherwise agreed by the Director of Finance.

## Section 12

### Travel, subsistence and other allowances

12.1 The Director of Finance shall ensure that all expense claims by employees of NHS Tayside or outside parties are reimbursed in line with the relevant national pay agreements or otherwise approved within the authority of the Staff Governance Committee and that all such claims should be supported by receipts wherever possible. Removal expenses will be limited to the amount specified by the Inland Revenue as being tax free (currently £8,000), except with the express approval of the Remuneration Committee.

12.2 All claims for payment of car allowances, subsistence allowances, travelling and incidental expenses will be submitted to the Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer, Maryfield House, duly certified in an approved form, and made up to a specified day of each month. The names of officers authorised to sign such records will be sent to the Associate Director of Finance - Financial Services and Governance, Fraud Liaison Officer, Maryfield House, by the Director of Finance and Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer together with specimen signatures for manual authorisations and an approved list of officers with appropriate access control permissions for electronic authorisation and will be amended on the occasion of any change.

12.3 The Chair shall personally authorise all expense claims from the Chief Executive. The Chief Executive shall personally authorise all expense claims from the Executive Members of the Board. The Chair shall personally authorise all expense claims from Non-Executive Board Members. In the absence of the Chair, this duty shall be undertaken by the Chief Executive or Director of Finance.

12.4 The certification by or on behalf of the Director of a service, or Head of Department shall be taken to mean that the certifying officer is satisfied that the journeys were authorised, the expenses properly and necessarily incurred and that the allowances are properly payable by NHS Tayside.

12.5 The Director of Finance shall issue additional guidance on the submission of expense claims, specifying the documentation to be used, the timescales to be adhered to and the required level of authorisation. The approval of the Director of Finance, Associate Director of Finance is required for claims other than claims relating to volunteers for clinical trials, received by Financial Services later than 3 months and no more than 6 months following the month of the claim, while claims relating to volunteers for clinical trials must be received no more than 6 months following the month of the claim. All claims received later than 6 months following the month of the claim will be treated as time barred and not approved unless the Director of Finance approves a case stating exceptional circumstances e.g. long term sickness absence.

## Section 13

### Contracting and purchasing

13.1 This section should be read in conjunction with Section E of the Code of Corporate Governance and the Tendering Procedure set out at Section F, Annex 1. These procedures specify the arrangements for the placing of contracts and for the purchase of supplies and equipment.

13.2 NHS Tayside shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services, for the design construction and maintenance of the building and engineering works.

13.3 The requisitioner shall seek to obtain best value through the application of Standing Orders, Standing Financial Instructions and the Tendering Procedure. In doing so, the advice of the appropriate procurement adviser (Supplies, Pharmacy, Estates or ICT) should normally be followed. Where the requisitioner has sound evidence that this advice is inappropriate or that it is divergent from best professional practice, the Director of Finance or Chief Executive shall be consulted, whose decision shall be final.

13.4 NHS Tayside shall comply as far as is practicable with the Scottish Capital Investment Manual and other Scottish Government Health Directorates guidance on contracting and purchasing.

13.4.1 The principle of additionality as specified in the Scottish Government Health Directorates Guidance; Additionality and Contracts with the Independent Sector issued in September 2005.

13.5 European Union Procurement Directives shall have effect as if incorporated in these Standing Financial Instructions.

**Acceptance and Award by Chief Executives, etc**

13.6 The Chief Executive as Accountable Officer, acting together with the Director of Finance are authorised to accept tenders and award contracts up to a value of £1,000,000 (including VAT suffered) and where the most economically advantageous tender is to be accepted. Tenders and contracts in excess of this amount will require to be approved by the appropriate Committee or the Board.

13.7 For significant procurements that are not covered by national procurement arrangements, a financial due diligence procedure should be performed, as directed by the Head of Procurement and Logistics.

13.8 The limits for delegation for the acceptance of tenders must be approved by the Board.

**Waiver**

13.9 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive as detailed in the Scheme of Further Delegation within Section E of the Code of Corporate Governance without reference to him or her, where:

13.9.1 The estimate expenditure or income does not, or is not reasonably expected to, exceed £50,000 (including VAT suffered).

| | |
|---|---|
| £15,001 - £50,000 | Competitive quotation (minimum of three required) |
| £5,001 - £15,000 | Written Quotation required |
| Under £5,000 | No requirement |

13.9.2 Where the supply is proposed under special arrangements negotiated by the Scottish Government in which event the said special arrangements must be complied with. Undertaking supply within the 'Framework Scotland' route is an example of supply proposed under special arrangements and avoids the requirement for a formal tendering process for each project, as this has already been undertaken in arriving at the key principal supply chain partners and Professional Services Contracts.

13.10 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive as detailed in the Scheme of Further Delegation within Section E of the Code of Corporate Governance without reference to him or her, where:

13.10.1 The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or

13.10.2 Specialist expertise is required and is available from only one source; or

13.10.3 The task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate or;

13.10.4 There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

13.10.5 Where provided for in the Scottish Capital Investment Manual.

The exercise of this authority and reason for the decision made must be recorded in the waiver of tender register.

13.11 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and reported by the delegated officers to the appropriate Committee in a formal meeting and recorded in a register kept for that purpose.

13.12 Formal tendering procedures may be waived for purchased goods and services not covered by national contracts below the value of £50,000 (including VAT suffered) (except contracts for works – see Sections 13.19 and 13.20) and, per the Code of Corporate Governance, when authorised by the Chief Executive, best value should, however be demonstrated and quotations sought in accordance with Standing Orders. Detailed procedures approved by the Director of Finance must also be followed by all staff in relation to such purchases below £50,000 (including VAT suffered).

**Quotations**

13.13 Quotations are required where formal tendering procedures are waived.

13.14 Where quotations are required they should be obtained from at least two firms/individuals based on specifications or terms of reference prepared by, or on behalf of, NHS Tayside.

13.15 Quotations should be in writing or by secure electronic means approved by the Chief Executive unless they determine that it is impractical to do so in which case quotations may be obtained by telephone/fax. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

13.16 All quotations should be treated as confidential and should be retained for inspection in accordance with NHS Tayside Records Retention Schedules.

13.17 The Chief Executive or nominated officer should evaluate the quotations and select the one which gives best value. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record and reported to the Director of Finance.

13.18 Non-competitive quotations in writing or by secure electronic means approved by the Chief Executive may be obtained for the following purposes with the recorded approval of the Director of Finance where:

13.18.1 The supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations;

13.18.2 The goods/services are required urgently.

**Single Tender**

13.19 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where accommodation is procured through the Third Party Developer Scheme in conjunction with General Medical Practitioners and the District Valuer independently determines the lease rent, the Contract price in this instance will not be set through competitive tender.

13.20 Where an NHS Tayside organisation procures accommodation through a Third Party Developer but in conjunction with General Medical Practitioners, the District Valuer independently determines the leased rent. The contract price in these instances will not be set through competitive tender.

Irrespective of the authority vested by 13.18 above, the supervising officer will seek to obtain best value through competition from approved jobbing contractors on NHS Tayside's list. The supervising officer will ensure strict adherence to the NHS Tayside jobbing contractor's conditions of service.

**Jobbing**

13.21 The Director of Operations shall annually approve a list of jobbing contractors.

13.21.1 Works not exceeding a value of £5,000 (including VAT suffered) may be instructed from the jobbing contractors listed on a time and material basis;

13.21.2 Works exceeding £5,000 (including VAT suffered) but not exceeding £10,000 (including VAT suffered) will be ordered on the basis of competitive tenders invited from the jobbing contractors listed or other approved contractors;

13.21.3 All contractors either listed as jobbing contractors or approved contractors may be invited to tender for works in excess of £10,000 (including VAT suffered).

13.22 Where a project exceeds the threshold set out in 13.21.1 above, for reasons that could not be foreseen before the project commenced, then the justification for continuing to complete the project without going out to tender should be documented on file and be approved by the Director of Operations unless the revised value exceeds £10,000 (including VAT suffered) in which case the authority of the nominated Operational Director or Chief Executive if out with the nominated Operational Directors delegation level is required.

**Third Party Developer Schemes**

13.23 Where an NHS Tayside organisation procures accommodation through a Third Party Developer Scheme but in conjunction with General Medical Practitioners, the District Valuer independently determines the leased rent. The contract price in these instances will not be set through competitive tender.

**Official Orders**

13.24 No goods, services or works other than works and services executed in accordance with a contract and purchases from petty cash shall be ordered except on an official order, whether hard copy or electronic, and contractors shall be notified that they should not accept orders unless on an official order form or processed via an approved secure electronic medium. Verbal orders shall be issued only by an officer designated by the Chief Executive and only in cases of emergency or urgent necessity. These shall be confirmed by an official order issued no later than the next working day and clearly marked 'CONFIRMATION ORDER'. National and Local contracts should be used where available/appropriate.

13.25 Official orders shall be consecutively numbered, in a form approved by the Director of Finance and shall include such information concerning prices or costs as he may require. The order shall incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations etc.

13.26 Manual official order/requisition forms shall only be issued to and signed by officers authorised by the Chief Executive or nominated Operational Director. Lists of authorised officers shall be maintained and a copy of such list supplied to the Director of Finance or Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer.

13.27 No order shall be issued for any item or items for which there is no budget provision or for which no funding has been provided under the delegated powers of virement, unless authorised by the respective Director of Finance on behalf of his Chief Executive.

**Purchases from Petty Cash**

13.28 Purchases from Petty Cash will be restricted in value and by type of purchase and records maintained in accordance with instructions issued by the Director of Finance, and shall not be placed in a manner devised to avoid the financial thresholds specified.

**Trial and Lending**

13.29 Goods e.g. medical equipment shall not be taken on trial or loan in circumstances that could commit any NHS Tayside organisation to a future uncompetitive purchase.

**Management Consultants**

13.30 Management Consultants are defined as always having two characteristics. Firstly they are engaged to work on specific projects that are regarded as outside the usual business of the NHS Tayside and there is an end-point of their involvement, and secondly the responsibility for the final outcome of the project largely rests with NHS Tayside. Management Consulting is distinct from 'outsourcing' or 'staff substitution'. The process for the engagement of a Management Consultant and Consultancy Categories are included as Annex 5.

Management Consultants should only be engaged after all other options have been explored. This should include an assessment of whether internal resources could be used instead. Documentary evidence based on the assessment should be recorded in the register to be held within Supplies of the benefit that will accrue to NHS Tayside. The officer responsible for seeking the engagement should carry out the assessment using the standard documentation devised for this purpose. The Pre Engagement Review and Post Engagement Review Forms are available at Annex 6 to the Standing Financial Instructions. Approval based on the outcome of the assessment, should be given by officers on a list of specified Executive Officers.

These are:

- Chief Executive
- Nominated Operational Director
- Director of Finance

The following guiding principles should be followed for the placing and controlling of all management consultancy assignments. These principles include the recommendations contained in the NHS Circular MEL (1994) 4, which advise health bodies of the results of a review undertaken on the use of Management Consultants and sets out a course of action to be adopted

13.31 In consideration of whether a particular Management Consultant should be accepted, officers shall have regard to whether the Management Consultants are capable of carrying out the assignment, whether value for money will be obtained and whether probity is demonstrated in awarding the contract and these decisions should be formally recorded, using the standard documentation devised for this purpose, in a register held within the Procurement Department.

Appointment of Management Consultants should be by competitive tender. This section should be read in conjunction with the detailed tendering procedures contained in Section F, Standing Financial Instructions Section 13, Section E, Scheme of Further Delegation on approval of tenders by officers to whom powers have been delegated by the Chief Executive and the Tendering Procedure set out in Annex 1, to this section in the Code of Corporate Governance. Where it is likely that there will be successive assignments, these should also be subject to tender arrangements. It may be appropriate, for follow on assignments to appoint one management consultant under a call off arrangement and to carry out periodic systematic reviews, to be documented in the register held within the Procurement Department, of such contracts, to ensure they are not self perpetuating, thus losing the benefit of commercial competition. To avoid self perpetuation, a clear contract duration with clear contract deliverability or financial cap must be specified.

It is recognised that tender action is not always appropriate. In this event, formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive as detailed within Section E, the Scheme of Further Delegation. Sections 13.7 to 13.10 of the Standing Financial Instructions to the Code of Corporate Governance set out the criteria to be followed for the approval of waiver of tenders and include detail on the information to be recorded in the waiver of tender register together with the reporting of the decision to the appropriate Committee.

13.32 Assignments should be made by entering into a contract and not simply by letter. NHS Tayside's own standard contract should be used where possible. Variation from standard terms and conditions should be discussed with and approved by the Procurement Department. The agreement should explicitly cover the payment of expenses and place a limit on the amount payable. Receipted

invoices, to ensure that the expenditure has been incurred, should always be provided to support claims for expenses.

13.33 At conclusion of an engagement, an overall review and evaluation for all projects more than £25,000 (inclusive of VAT), should be carried out using the standard documentation devised for this purpose, as formal records of the Management Consultant's effectiveness, by the officer responsible for engaging the Management Consultant, and recorded in the register held within the Procurement Department. Specific issues to be addressed in any review should be:

- Was the work completed on time
- Were the costs contained within the contracted figure
- Did the consultants carry out all their contractual obligations
- Were the terms of reference discharged
- How did the consultants key people perform
- Were effective and realistic solutions proposed
- Did the engagement represent value for money

The outcome of the review and evaluation must be reported to the same Executive Officer who approved the initial assessment.

The degree of record keeping will vary depending on the materiality of the contract.

It should be noted that Professional Advisor fees are exempt from the process contained in sections 13.28 to 13.31 above. Professional Advisors are defined as having two characteristics. Firstly they are engaged on work that is an extended arm of the work done in-house and secondly they provide an independent check. Examples include professional advice on the treatment of VAT work carried out in relation to ratings revaluations/appeals. Professional Advisor fees relating to capital projects such as architects, quantity surveyors, structural engineers etc. are also exempt from this process. Consultancy Categories are included as Annex 5 to the Standing Financial Instructions.

**Property Advisors**

13.34 The latest version of the NHS Scotland Property Transactions Handbook states that all external professional advisers, including Property Advisers, Independent Valuers and other valuers or consultants if engaged, should be appointed by competitive tender unless the fees for the work are estimated at less than £1000 when fee negotiation may by adopted. The Valuation Officer Agency offer a valuation service and may be included in the list of those invited to tender for this work.

**Invitation to Tender**

13.35 NHS Tayside shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate. This would normally consist of six, and in no case less than three, firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

13.36 NHS Tayside shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists (see Annex 1). Where in the opinion of the appropriate Director of Finance it is desirable to seek tenders from firms not on the approved lists, a record setting out the reasons shall be retained along with the tender documents (see Annex 1). Suppliers shall normally be chosen in rotation from the list unless the approval of the Chief Executive or nominated officer is given.

**Contracts**

13.37 NHS Tayside may only enter into contracts within their statutory powers and shall comply with:

13.37.1 Standing Orders;

13.37.2 Standing Financial Instructions;

13.37.3 EU Directives and other statutory provisions;

13.37.4 Any relevant directions including the Scottish Capital Investment Manual and guidance on the Use of Management Consultants;

13.37.5 Such of the NHS Standard Contract Conditions as are applicable.

13.38 Where specific contract conditions are considered necessary by the lead officer appointed by the Chief Executive or Director of Finance, or by the Project Team/Board, where appropriate, advice shall be sought from suitably qualified persons. Where this advice is deemed to be legal advice, this must be sought from the Central Legal Office.

13.39 Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

13.40 In all contracts made by NHS Tayside, Members and officers shall endeavour to obtain best value. The Chief Executive or Director of Finance shall formally nominate an officer who shall oversee and manage each contract.

13.41 All contracts entered into shall contain standard clauses empowering NHS Tayside to:

13.41.1 Cancel the contract and recover all losses in full where a company or their representative has offered, given or agreed to give, any inducement to us or officials;

13.41.2 Recover all losses in full or enforce specific performance where goods or services are not delivered in line with contract terms.

13.42 The Director of Finance shall ensure that the arrangements for financial control and financial audit of the building and engineering contracts and property transactions comply with the guidance contained within the current version of the Property Procurement Guidance for NHS Scotland – PROCODE and the Scottish Capital Investment Manual – SCIM. The technical audit of these contracts shall be the responsibility of the relevant Director.

13.43 Contracts shall be executed on behalf of the Board as follows:

13.43.1 A contract which is executed in the form of an attested deed shall be subscribed on behalf of the Board by the Chair or Vice-Chair and Chief Executive and the Common Seal shall be affixed to it where required.

13.43.2 A contract in writing, but not in deed form, shall be executed on behalf of the Board by the Chief Executive or other officer acting on their authority.

13.43.3 A contract which may be validly made verbally may be made on behalf of the Board by the Chief Executive or other officer acting on their authority, but shall be confirmed in writing.

13.43.4 A building, engineering property or capital contract should be signed by the Chief Executive or other officer acting on their authority.

**In-House Services**

13.44 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

13.45 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s);

b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support;

c) Evaluation group, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £1m, a Non-Executive Member should be a member of the evaluation team.

13.46 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

13.47 The evaluation group shall make recommendations to the Board.

13.48 The Chief Executive shall nominate an officer to oversee and manage the contract.

**Acceptance of Financial Assistance, Gifts and Hospitality, and Declaration of Interests**

13.49 The principles relating to the acceptance of financial assistance, gifts and hospitality from commercial sources and declaration of interest are stated in Section C of the Code of Corporate Governance.

13.50 Where the maintenance of a register is referred to for recording interests in contracts or receipt of gifts/inducements, a register will be maintained by the Chief Executive.

13.51 No order shall be issued for any item or items, for which an offer of gifts (other than low cost items, e.g. calendars, diaries, pens and like value items) or hospitality has been received, from the person interested in supplying goods or services. Any officer receiving such an offer shall notify his senior officer as soon as is practicable.

13.52 Visits at supplier's expense to inspect equipment, etc. should only be undertaken in exceptional circumstances and must have the prior written approval of the Chief Executive.

## Section 14

**Stores**

14.1 Subject to the responsibility of the Director of Finance for the systems of control, the overall control of stores, except for pharmaceutical stocks, shall be the responsibility of designated officers. The day to day management may be delegated to departmental officers and Stores Manager/Keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of pharmaceutical stocks shall be the responsibility of the Chief Pharmaceutical Officer.

14.2 The responsibility for security arrangements and the custody of keys for all stores' locations shall be clearly defined in writing by the Directors of Operations/Chief Pharmaceutical Officers and the

14.3 designated officer referred to in the above clause in the case of the Board. Wherever practicable, stocks shall be marked as health service property.

14.4 All stores records shall be in such form and shall comply with such system of control as the Director of Finance shall approve.

14.5 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specifications. A delivery note shall be obtained from the supplier at the time of delivery and shall be manually signed or receipt acknowledged electronically by the person receiving the goods. Instructions shall be issued to staff covering the procedure to be adopted in those cases where a delivery note is not available. Particulars of all goods received shall be entered on a goods received record or input to computer file on the day of receipt. Where goods received are seen to be unsatisfactory or short on delivery they shall be accepted only on the authority of the designated Supplies/Pharmaceutical Officer and the supplier shall be notified immediately.

14.6 The issue of stores shall be supported by an authorised requisition and a receipt for stores issued shall be given to the Procurement /Pharmaceutical Department, independent of the Storekeeper. Where a 'topping-up' system is used, a record shall be maintained in a form approved by the Director of Finance (such a form may be electronic in place of paper). Regular comparisons shall be made of the quantities issued to wards/departments, etc and explanations recorded of significant variations.

14.7 Requisitions whether for stock or non-stock items may be transmitted electronically and not held in paper form providing always that appropriate procedures for such transmissions are agreed by the Director of Finance.

14.8 All transfers and returns shall be recorded on forms provided for the purpose and approved by the Director of Finance.

14.9 Breakages and other losses of goods in stores shall be recorded as they occur, and a summary shall be presented to the Director of Finance at regular intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, e.g. shrinkage in the case of certain foodstuffs and natural deterioration of certain goods.

14.10 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one other officer other than the Storekeeper, and the Director of Finance and Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer shall have the right to attend, or be represented at their discretion. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check. Any surplus or deficiency revealed on stocktaking shall be reported immediately to the Director of Finance, and he may investigate as necessary. Any known losses of stock items not under the control of the stores department shall be reported to the Director of Finance.

14.11 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14.12 The designated Supplies/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow-moving and obsolete items for condemnation, disposal, and replacement of all unserviceable articles. The designated Supplies/Pharmaceutical Officer shall report to their Chief Executive any evidence of significant overstocking and of any negligence or malpractice (see also Section 22).

14.13 Instructions for stock-take and basis of valuation will be issued at least once per year by the Director of Finance where appropriate.

## Section 15

### Losses and Special Payments

15.1 Any officer discovering or suspecting a loss of any kind must inform their head of department, who must immediately inform the Director of Finance. Where a criminal offence is suspected, the Fraud Policy must be applied.

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

15.3 Losses are classified in accordance with SFR 18.1 'Details of Losses and Special Payments' issued by the Scottish Government Health Directorates in the NHS Board's Accounts Manual for Accounts.

15.4 In accordance with the Scheme of Delegation, the Chief Executive may, acting together with the Director of Finance, or the ~~nominated Operational Director~~ Chief Operating Officer may acting together with the Associate Director of Finance ~~– Financial Services and Governance, Fraud Liaison Officer~~ or any other officer authorised by the Director of Finance or Associate Director of Finance~~– Financial Services and Governance, Fraud Liaison Officer,~~ approve the writing-off of losses within the following limits delegated to the Board by the Scottish Government Health Department.

### Limits of Authority

| **Losses (Per Case)** | | **£** |
|---|---|---|
| **Theft/Arson/Wilful Damage** | | |
| 1. | Cash | 15,000 |
| 2. | Stores/procurement | 30,000 |
| 3. | Equipment | 15,000 |
| 4. | Contracts | 15,000 |
| 5. | Payroll | 15,000 |
| 6. | Buildings & Fixtures | 30,000 |
| 7. | Other | 15,000 |

**Fraud, Embezzlement & other irregularities (inc. attempted fraud)**

| | | |
|---|---|---|
| 8. | Cash | 15,000 |
| 9. | Stores/procurement | 30,000 |
| 10. | Equipment | 15,000 |
| 11. | Contracts | 15,000 |
| 12. | Payroll | 15,000 |
| 13. | Other | 15,000 |
| 14. | Nugatory & Fruitless Payments | 15,000 |
| 15. | Claims Abandoned | |
| | a) Private Accommodation | 15,000 |
| | b) Road Traffic Acts | 30,000 |
| | c) Other | 15,000 |

**Store Losses**

| | | |
|---|---|---|
| 16. | Incidents of the Service: | |
| | - Fire | 30,000 |
| | - Flood | 30,000 |
| | - Accident | 30,000 |
| 17. | Deterioration in Store | 30,000 |
| 18. | Stocktaking Discrepancies | 30,000 |
| 19. | Other Causes | 30,000 |

**Losses of Furniture & Equipment and Bedding & Linen in circulation**

| | | |
|---|---|---|
| 20. | Incidents of the Service: | |
| | - Fire | 15,000 |
| | - Flood | 15,000 |
| | - Accident | 15,000 |
| 21. | Disclosed at physical check | 15,000 |
| 22. | Other Causes | 15,000 |

**Compensation Payments – legal obligation**

| | | |
|---|---|---|
| 23. | Clinical | 250,000 |
| 24. | Non clinical | 100,000 |

**Ex-gratia Payments**

| | | |
|---|---|---|
| 25. | Extra-contractual payments | 15,000 |
| 26. | Compensation payments – Ex-gratia – Clinical | 250,000 |
| 27. | Compensation payments – Ex-gratia – Non Clinical | 100,000 |
| 28. | Compensation payments – Ex-gratia – Financial Loss | 25,000 |
| 29. | Other payments | 2,500 |

**Damage to Buildings and Fixtures**

| | | |
|---|---|---|
| 30. | Incidents of the Service | |
| | - Fire | 30,000 |
| | - Flood | 30,000 |
| | - Accident | 30,000 |
| | - Other Causes | 30,000 |

| | | |
|---|---|---|
| 31. | **Extra-Statutory & Extra-Regulatory Payments** | NIL |
| 32. | **Gifts in cash or kind** | 15,000 |
| 33. | *** Other Losses**<br>* This item includes:<br>- Cash losses – overpayments of salaries, wages and allowances<br>- Cash losses - other | 15,000 |

15.5 The exercise of powers of delegation in respect of losses and special payments will be subject to the submission of an annual report to the Audit Committee identifying which powers have been exercised and the amount involved.

15.6 The Board shall formally annually approve any losses and compensation payments when approving the Statutory Annual Accounts.

15.7 No special payments exceeding the delegated limits laid down and subsequent amendments thereto shall be made without prior approval of the Scottish Government Health Directorates.

15.8 The Director of Finance shall be authorised to take any necessary steps to safeguard the interests of the Board in bankruptcies and company liquidations.

15.9 All articles surplus to requirements or unserviceable shall be condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance.

15.10 The condemning officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance and Chief Executive, who shall take the appropriate action.

## Section 16

### Tayside Health Funds

16.1 The foregoing sections of these Standing Financial Instructions shall apply to the Endowment Funds of the Board, except that expenditure from Endowment Funds shall be restricted to the purposes of the appropriate Fund and made only with the approval of the respective Trustees.

16.2 All Members of the Board, appointed by Scottish Ministers are, by virtue of their appointment, Trustees of the Tayside NHS Board Tayside Health Fund.

The Trustees have specific responsibilities:

- Acting together and individually with all other Trustees;
- Ultimate control cannot be delegated to staff or fund holders;

- Must have an understanding of ideals and purposes of the Endowment Fund;
- Cannot carry out activities beyond the remit within the appropriate legislation;
- Money can only be spent for charitable purposes within the remit of the charity or the purposes of a restricted fund;
- Transactions entered into by Trustees, which although legal but are outwith the Charity's objectives and are deemed to be 'ultra vires', could lead to the Trustees being personally liable for any loss incurred by the Tayside Health Fund.

16.3 The Trustees have a responsibility to:-

- Control and manage the finances of the Tayside Health Fund, ensure proper accounts are kept as required by regulations and reported in a form prescribed by the Scottish Government;
- Prepare an annual statement of accounts comprising an Income and Expenditure Statement, Balance Sheet and Cash Flow Statement;
- The annual statement of accounts must be approved by the Trustees and signed by one of their members on their behalf and as authorised by them.

16.4 Trustees of Tayside Health Funds within NHS Tayside may appoint an Endowment Advisory Group to provide advice to Trustees of all Funds in the exercise of their responsibilities.

16.5 The Director of Finance shall ensure that annual accounts are prepared as soon as possible after the year end and that proper arrangements are made for these to be subject to audit by a separately appointed External Auditor.

16.6 The Director of Finance shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trustees as Trustees of Tayside Health Fund, including an Investments Register.

16.7 All share and stock certificates and property deeds shall be deposited either with the Trustee's Board's Bankers or Investment Advisors, or in a safe, or a compartment within a safe, to which only a designated responsible officer will have access.

16.8 The ownership of all shares and stock certificates, if managed by a commercial concern, shall be periodically verified by the auditors appointed by the Trustees.

16.9 All gifts, donations and proceeds of fundraising activities which are intended for Tayside Health Funds shall be handed immediately to the Director of Finance, or an officer nominated by him or her for the purpose, to be banked directly into the appropriate Tayside Health Fund, subject to the local use of smaller amounts as agreed from time to time.

16.10 All gifts accepted shall be received and held in the name of appropriate Trustees and administered in accordance with the Trustees' policy, subject to the terms of specific Funds. As Trustees may accept gifts for specific and non-specific purposes relating to the Health Service, officers shall, in cases of doubt or where there are material revenue expenditure consequences, consult the Director of Finance before accepting any gifts.

16.11 The Director of Finance shall be required to advise the appropriate Trustees on the financial implications of any proposal for fundraising activities which the Board may initiate, sponsor or approve under the guidance contained in Circular No MEL (2000) 13

16.12 The Director of Finance shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the death of a testator, all correspondence concerning a legacy shall be dealt with on behalf of the appropriate Trustees by the Director of Finance who alone shall be empowered to give an executor a good discharge.

16.13 Where it becomes necessary for the Trustees to obtain a grant of probate, or to make an application for Confirmation of Executor in order to obtain a legacy due to the Trustees under the terms of a will, the Director of Finance shall be the Trustees' nominee for the purpose.

16.14 Tayside Health Funds shall be invested subject to the provision of the Charity and Trustee Investment (Scotland) Act 2005, and subject to the agreement of the Trustees after considering any advice received from the Trustees' Investment Managers.

## Section 17

### Primary Care Contractors

17.1 In line with Scottish Government arrangements, the Practitioner Services Division (PSD) of National Services Scotland is the payment agency for all Family Health Services (FHS) contractor payments:

- GMS;
- Prescribing;
- FHS Non Discretionary.

17.2 The Director of Finance shall conclude a 'Service Level Agreement' with the PSD covering validation, payment, monitoring and reporting and the provision of an audit service by National Services Scotland Internal Auditors.

17.3 The Director of Primary Care will approve additions to, and deletions from, approved lists of contractors, taking into accounts the health needs of the local population, and the access to existing services. All applications and resignations received will be dealt with equitably within any time limits laid down in the contractors' NHS Terms and Conditions of Service.

17.4 The Director of Primary Care will:

17.4.1 Ensure that lists of all Primary Care contractors, are maintained and kept up to date; and

17.4.2 Ensure that systems are in place to deal with applications, resignations, inspection of premises, etc, within the appropriate contractor's terms and conditions of service.

17.5 The Director of Finance shall ensure that National Services Scotland systems are in place to provide assurance that:

17.5.1 Only contractors who are included on the Board's approved lists receive payments;

17.5.2 All valid contractors' claims are paid correctly, and are supported by the appropriate documentation and authorisations;

17.5.3 All payments to third parties are notified to the General Practice Independent Contractors on whose behalf payments are made;

17.5.4 Ensure that regular independent post payment verification of claims is undertaken to confirm that;

a) Rules have been correctly and consistently applied;
b) Overpayments are prevented wherever possible; if, however, overpayments are detected, recovery measures are initiated;
c) Fraud is detected and instances of actual and potential fraud are followed up.

17.5.5 Exceptionally high/low payments are brought to his/her attention;

17.5.6 Payments made via National Services Scotland are reported to Tayside NHS Board;

17.5.7 Payments made on behalf of the Board by National Services Scotland are pre-authorised;

17.5.8 Payments made by the National Services Scotland are reconciled with the cash draw-down reported by the Scottish Government to Health boards.

17.6 The Director of Finance shall issue operating procedures to cover all payments made by National Services Scotland (both payments made directly or payments made on behalf of the Board).

17.7 In relation to GP Independent Contractors, Tayside NHS Board shall ensure that all payments made by the Board are made to one bank account. This arrangement shall be agreed between both parties to ensure probity, regularity and accountability in the expenditure of public funds.

17.8 Payments made to all Primary Care independent contractors and community pharmacists shall comply with their appropriate contractor regulations.

## Section 18

### Aligned and Pooled Budgets

18.1 Partnership arrangements have been developing to give Health bodies and Local Authorities the flexibility to be able to work with other agencies to respond effectively to improve services, either by joining up existing services, or developing new, co-ordinated services. Such partnership arrangements provide for aligned and pooled budgets.

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

18.3 A pooled budget is a mechanism by which each partner to the agreement contributes funding to form a discrete 'fund' for the partnership arrangement or organisation. Within this fund or 'pool', initially the funding contributed by each partner, will be identifiable to each partner but in time the origin of individual contributions lose their original identity and are committed and accounted for against the joint aims of the partners. To meet their own statutory obligations, and justify their contribution to the fund, agencies must clearly state the purpose, scope and outcomes for services within the pooling agreement.

For accountability and legal reasons, a pooled budget resides in a 'host' partner, either a health body or a local authority organisation, which manages it on behalf of the partners and in accordance with its standards of financial governance and the requirements of the agencies for monitoring and review.

18.4 Partnership arrangements entered into by NHS Tayside must comply with the Community Care and Health Act 2002 and the detailed guidance issued by the Scottish Government Joint Futures Unit on aligned and pooled budgets.

The following paragraphs relate mainly to aligned budgets (as opposed to pooled budgets).

18.5 As a non-statutory body, the responsibility for the functions carried out by a partnership body will remain with each partner organisation.

18.6 A partnership agreement or Heads of Agreement must be drawn up between the partner organisations which will specify the services to be managed jointly, the governance arrangements, the accountability arrangements, the budgetary control arrangements, and the financial reporting and monitoring arrangements. The partnership agreement

must be approved by each partner organisation's Director of Finance before budgetary control can be devolved to a partnership body.

18.7 Each partner will agree the level of its contribution in advance of each financial year. The level of contribution from the Board will be agreed by the Finance and Resources Committee taking account of the need to balance the amount of flexibility that NHS Tayside wants to enable through the aligned budget against the risk of being able to fulfil all service needs. Levels of contribution will have to allow, among other things, for decisions made about inflation levels, developments, service pressures, service priorities, capital charges and savings targets.

18.8 The contribution to the aligned budget must be used on the agreed services set out in the partnership agreement. The aligned budget will be discrete, and will be ring-fenced to the extent specified in the partnership agreement. The partnership agreement must also specify the mechanism for changing in-year levels of contribution.

18.9 Accountability will be discharged at two levels in aligned budget arrangement, i.e. within the partnership body, and to the Boards or Committees of each partner organisation.

18.10 Each partnership body will appoint a lead officer who will be accountable to a Joint Board for the combined budget.

18.11 The Chief Executive will remain accountable to the Scottish Government for the financial contribution made by their organisation.

18.12 Partnership bodies will be subject to both financial and value for money audit by both internal audit and the Auditor General for Scotland.

18.13 A Memorandum of Income and Expenditure Account may require to be included in the Annual Accounts for aligned budget arrangements which shows income received, expenditure incurred and the remaining surplus or deficit for the financial year.

18.14 The lead officer of the partnership body shall prepare Standing Orders which will set out compliance with the Codes of Conduct, Accountability and Practice on Openness and the underlying principles of good Corporate Governance as set out in the Cadbury and Nolan Reports and the detailed guidance issued by the Scottish Government and others.

18.15 The lead officer of the partnership body shall issue Financial Regulations and Standing Financial Instructions in accordance with directions issued by the Scottish Government in order to regulate the conduct of the Joint Board, both Members and officers, in all financial matters. Such regulations and instructions will specify the arrangements for the provision of financial advice to the Joint Board.

18.16 The partnership body's Standing Orders and Financial Regulations and Standing Financial Instructions/Regulations shall be agreed by the Board and shall have the effect as if incorporated in the Standing Orders and Standing Financial Instructions of the Board.

18.17 The above instructions will equally apply to new formal partnership arrangements with Local Authorities which the Board may develop in future years.

## Section 19

### Patients' Funds and Property

19.1 NHS Tayside has the responsibility (NHS Circular 1976 (GEN) 68), and the Adults with Incapacity (Scotland) 2000 Act (Part 4) to provide safe custody for money and personal property (thereafter referred to as 'property') which is:

- Handed in by a patient;
- In the possession of an unconscious or confused patient;
- In possession of a patient dying in hospital or dead on arrival;
- Managed on behalf of an incapable patient.
-

19.2 The Director of Finance shall provide written procedures for all staff whose duty it is to administer the property.

19.3 This shall include instructions for accepting, recording, safekeeping, continuing management and disposal of (both discharge and a death of a patient) the property.

19.4 Interest bearing bank account(s) shall be opened, under the arrangement of the Director of Finance, solely for the management of patients' funds.

19.5 In summary, the procedure shall require:

19.5.1 Patients, relatives, carers and guardians, as appropriate, to be informed before or at any time of the patient's admission, that the Board shall not take responsibility or liability for property brought to the Board's premises unless it is handed in for safe keeping and an official receipt obtained. This will be done by:

- Notices and leaflets;
- Hospital admission documents
- Verbal advice of administrative and nursing staff

19.5.2 Systems for:

- Collection and banking of funds, pension and other income belonging to patients;
- For paying to patients' pocket money, or paying creditors on their behalf;
- Recording intromissions on behalf of patients;
- Recording, holding and maintaining where appropriate, patients' property;

- To ensure patients' pension and allowances are dealt with in accordance with NHS Circular 1981 (GEN) 42 and the Social Security Contributions and Benefits Act 1992;
- Returning to the patient their money and property on discharge;
- Disposal of a deceased patient's estate;
- Reporting financial information (Form 19).

19.5.3 Compliance with the Adults with Incapacity (Scotland) Act (Part 4) (thereafter referred to as the 'Act').

The procedure shall include instruction to Authorised Managers of their roles under the Act:

- Principles of intervention;
- Method of intervention;
- What can and cannot be managed;
- Authority limits;
- Record keeping and reporting;
- Use of patients' funds;
- Sale of assets;
- Reviewing and revoking certificates;
- Variation of authority;
- Supervisory body requirements.

19.5.4 Staff Training

Managers are t**o ensure that** nursing staff, in their areas of responsibility:

- Are trained in handling patients' funds and property and are conversant with the procedure on this
- Are given the opportunity to read the procedure and confirm that they have read and understood the appropriate sections of the procedure.

## Section 20

### Audit

20.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference, which will consider:

20.1.1 Internal control and Corporate Governance;
20.1.2 Internal Audit;
20.1.3 External Audit;
20.1.4 Code of Corporate Governance;
20.1.5 Accounting Policies;
20.1.6 Annual Accounts (including the schedules of losses and compensations);
20.1.7 Risk Management.

20.2 Where the Audit Committee feels there is evidence of ultra vires i.e. illegal or unauthorised transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Audit Committee should refer the matter to a full meeting of the Tayside NHS Board. Exceptionally, the matter may need to be referred to the Scottish Government Health Directorates.

20.3 It is the responsibility of the Audit Committee to regularly review the operational effectiveness of the internal audit service. The Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

**Director of Finance**

20.4 The Director of Finance is responsible for:

20.4.1 Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function;

20.4.2 Ensuring that Internal Audit is adequate and meets the NHS mandatory audit standards;

20.4.3 Deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities;

20.4.4 Ensuring that the Chief Internal Auditor prepares the following plans for approval by the Audit Committee:

- Strategic audit plan covering the coming five years;
- A detailed operational plan for the coming year.

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

20.5.1 A clear statement on the effectiveness of internal control;
20.5.2 Major internal control weakness discovered;
20.5.3 Internal control evaluation;
20.5.4 Progress against plan over the previous year.

20.6 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

20.6.1 Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

20.6.2 Access at all reasonable time to any land, premises or employee of each organisation;

20.6.3 The production of any cash, stores or other property of each organisation under an employee's control; and

20.6.4 Explanations concerning any matter under investigation.

**Role of Internal Audit**

20.7 The role, objectives and scope of Internal Audit are set out in the mandatory NHS Internal Audit Manual.

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

20.7.2 Minor deviations from the Government Internal Audit Standards (GIAS) should be reported to the Audit Committee. More significant deviations should be considered for inclusion in the Statement of Internal Control (SIC), with appropriate justification;

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

20.7.4 The extent to which NHS Tayside's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

a) Fraud and other offences;
b) Waste, extravagance, inefficient administration;
c) Poor value for money or other causes.

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

**External Audit**

20.9 The External Auditor is concerned with providing an independent assurance of each organisation's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of the Board rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000.

20.10 The appointed auditor has a general duty to satisfy himself that:

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

20.10.2 Proper accounting practices have been observed in the preparation of the accounts;

20.10.3 The organisation has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

20.11 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the appointed auditor to consider:

20.11.1 Whether the statement of accounts presents a true and fair view of the financial position of the organisation.

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

## Section 21

### Information Management and Technology

21.1 The Director of Finance shall be responsible for the accuracy and security of the financial data of the Board.

21.2 The Director of Finance shall devise and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of any financial or other informat**ion held on** computer files for which he has responsibility and shall take account of the provisions of the Data Protection Act 1998

21.3 The Director of Finance shall satisfy themselves that such computer audit checks and reviews as they may consider necessary, are being carried out.

21.4 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by an organisation outwith NHS Tayside, assurances of adequacy will be obtained from them prior to implementation.

21.5 The Director of Finance shall ensure that contracts or agreements for computer services for financial applications with the Board or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing and storage. The contract or agreement should also ensure rights of access for audit purposes.

21.6 Where the Board or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

21.7 Where computer systems have an impact on corporate financial systems the Director of Finance shall ensure that:

a) Systems acquisition, development and maintenance are in line with corporate policies such as Information Management and Technology Strategy;
b) Data produced for use with financial systems is adequate, accurate, complete and timely and that a management (audit) trail exits;
c) The Director of Finance staff have access to such data.

## Section 22

### Fixed Assets

22.1 The Chief Executive shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the financial plans for each organisation.

22.2 The Director of Finance shall ensure that every capital expenditure proposal meets the following criteria:

22.2.1 Potential benefits have been evaluated and compared with known costs;
22.2.2 Potential purchasing authorities should be able and (as far as can be ascertained) willing to meet cost consequences of the development as reflected in prices; and

22.2.3 Complies with the guidance in the NHS in Scotland Scottish Government Scottish Capital Investment Manual

22.3 Consideration should be given to the use of Private Finance or Operating Leases where appropriate.

22.4 Each division shall maintain a system for assessing whether leases or PFI/PPP/NPD contracts should be accounted for as on or off balance sheet in the context of SSAP21, FRS5 and any other relevant guidance advice received.

22.5 Refinancing of PPP/PFI/NPD projects may be undertaken, however, guidance issued by the Scottish Government in January 2009 must be followed in order to facilitate appropriate Scottish Government approval. Refinancing is often undertaken once a PPP/PFI/NPD project has been completed and it is essentially the substitution of new debt on more attractive terms.

22.6 In the case of large capital schemes a system shall be established for progressing the scheme and authorising necessary payments up to completion. Provision should be made for regular reporting of actual expenditure against authorisation of capital expenditure.

22.7 It is mandatory that Post Project Evaluations are undertaken for all schemes greater than £1.5 million and for a management review to be carried our on schemes of between £100,000 and £1.5 million with the degree of review dependent on the materiality of the scheme. All Post Project Evaluations carried out relating to capital projects greater than £1.5 million, will be reported to the Finance and Resources Committee. The Board will be kept informed through the receipt of the minutes from Finance and Resources Committee containing details of the Post Project Evaluation carried out. Post Project Evaluation on major capital projects of £5 million or more (£4 million or more for ICT capital projects), will be presented to the Board prior to consideration by the Capital Investment Group. It is mandatory to complete Post Occupancy Evaluations for projects above the £1.5 million threshold.

22.8 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Where land and property is disposed of, the requirements set out in the latest version of the NHS Scotland Property Transactions Handbook, together with any subsequent amendments, shall be followed.

22.9 There is a requirement to achieve best value when disposing of assets belonging to each organisation. Competitive tendering should normally be undertaken in line with the requirements of each organisation's tendering procedure.

22.10 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

22.10.1 Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer

22.10.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Board Items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed annually;

22.10.3 Capital expenditure purchases which fall into the following categories should be included as fixed assets:

- Intangible assets such as computer software licence which can be valued and are capable of being used within NHS activities for more than one year and have a replacement cost equal to or greater than £5,000;
- Tangible assets which are capable of being used for a period which could exceed one year and have a cost equal to or greater than £5,000;
- Tangible assets which are capable of being used for a period which could exceed one year and have a cost equal to or greater than £5,000;
- Assets of lesser value than £5,000 which may be included as fixed assets where they form part of a networked computer system purchased at approximately the same time and cost over £5,000 in total, or where they are part of the initial cost of equipping a new development and total over £5,000.

22.10.4 Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

22.10.5 Land or buildings concerning which Scottish Office Guidance has been issued but subject to compliance with such guidance.

22.11 Managers must ensure that:

22.11.1 All assets are to be disposed of in accordance with MEL (1996) 7 'Sale of Surplus and Obsolete Goods and Equipment';
22.11.2 The Director of Finance is notified of the disposal of any fixed assets;
22.11.3 All proceeds from the disposal of fixed assets are notified to the Director of Finance.

22.12 The overall control of fixed assets shall be the responsibility of the Chief Executive, advised by the Director of Finance.

22.13 The Board shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual (Section 10) as issued by the Scottish Government Health Directorates.

22.14 The organisation shall maintain a register of assets held under operating leases or Private Finance Initiative contracts.

22.15 The Director of Finance shall approve fixed asset control procedures. This procedure shall make provision for:

22.15.1 Recording managerial responsibility for each asset;
22.15.2 Identification of additions and disposals and transfers between departments;
22.15.3 Identification of all repairs and maintenance expenses;
22.15.4 Physical security of assets;

22.15.5 Periodic (annual or continuous rolling ) verification of the existence of, condition of and title to assets recorded;

22.15.6 Identification and reporting of all costs associated with the retention of an asset.

22.16 Additions to fixed asset registers must be clearly attributed to an appropriate asset holder and be validated by reference to:

22.16.1 Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

22.16.2 Store requisitions for own materials and wages records for labour including appropriate overheads;

22.16.3 Lease agreements in respect of assets held under a finance lease and capitalised.

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

22.18 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

22.19 The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual (Section 4).

22.20 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual.

22.21 The Director of Finance shall approve procedures for the calculation of capital charges as specified in the Capital Accounting Manual.

## Section 23

### Risk Management and Insurance

23.1 The Chief Executive shall ensure that NHS Tayside has a programme of risk management that will be approved and monitored by the Board.

The programme of risk management shall include, amongst other things

a) A process for identifying and quantifying risks and potential liabilities;
b) Engendering among all levels of staff a positive attitude to the control of risk;
c) The implementation of a programme of risk awareness training;
d) Management processes to ensure that all significant risks and potential liabilities are addressed, including effective systems o internal control, cost effective insurance cover, and decisions on

the acceptable level of retained risk. All significant risks and action taken to manage the risks will be reported to the Board;

e) The maintenance of an organisation-wide risk register (Risk Control Plan);
f) Contingency plans to offset the impact of adverse events;
g) Audit arrangements, including internal audit, clinical audit, health and safety review;
h) Arrangements to review the risk management programme;
i) A process whereby the risk management plans are measured against compliance with CNORIS standards.

23.2 The existence, integration and evaluation of the above elements will provide a basis for the Risk Management Group to make a statement to the appropriate Committee of the Board on the effectiveness of risk management arrangements in the organisation.

23.3 In the case of Partnership Working with other agencies, the NHS Tayside risk management framework will be shared to identify and quantify the individual risks, particularly where responsibility cannot be assigned to an individual partner.

23.4 The Director of Operations and Director of Finance shall ensure that insurance arrangements exist in accordance with the risk management programme.

## Section 24. Joint Ventures and Consortia

24.1 Prior to entering into a joint venture/consortium the Board will conduct due diligence to identify whether the joint venture/consortium has or will have in place anti-bribery policies and procedures that are consistent with its own.

24.2 Where the Board has overall control of the joint venture/consortium it should ensure that the joint venture/consortium has anti-bribery controls in place that are consistent with the Board's own policies and procedures.

24.3 Where the Board does not have overall control of the joint venture/consortium it will inform the joint venture/consortium organisations of its policy and procedures and encourage them to adopt these for the venture.

24.4 Where due diligence shows that the joint venture/consortium does not have appropriate anti-bribery policies and procedures in place consistent with its own, the Board should ensure that it is protected from litigation arising from acts of bribery by the partner organisations in the wording of any contract or agreement. Central Legal Office advice and guidance should be obtained to ensure that the Board is fully protected.

24.5 The Board should monitor the programmes and performance of its joint venture/consortium partners in respect of anti-bribery. Anti-bribery should be a standing agenda item on joint venture/consortium meetings and reports should be tabled demonstrating adherence to policy and procedures, identification of any acts of bribery or potential bribery and management actions taken and proposed.

24.6 Where the Board determines that the joint venture/consortium policies and practices are inconsistent with its own, the Board will take appropriate action. This may involve insistence by the Board of adoption of appropriate policy and procedures by the joint venture/consortium, putting in place legal protection for the Board, where the partners indemnify the Board against acts of bribery or ultimately withdrawal of the Board from the joint venture/consortium.

24.7 Where the Board is unable to ensure that a joint venture/consortium has anti-bribery policy and procedures consistent with its own, it will ensure that it has a plan to exit from the arrangement if bribery occurs or may be reasonably thought to have occurred. Central Legal Office advice and guidance should be sought to ensure that such arrangements are in place in any legal documentation.

**Annex 1**
**Tendering Procedure**

## 1. Invitation to Tender

1.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted as follows:

1.1.1 Plain, sealed package bearing a pre-printed label supplied by NHS Tayside (or bearing the word 'Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender); or

1.1.2 In a special envelope supplied by NHS Tayside to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender; or

1.1.3 By electronic means that identifies the date and time of receipt and keeps the contents 'closed' prior to the agreed opening, as set out below. Such facilities must be approved by the Chief Executive in advance.

1.2 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate.

1.3 Every tender for building and engineering works, except for maintenance work only where guidance set out in the Code of Practice of Estate Management within the NHS – ESTMANCODE – should be followed, shall embody, or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) standard forms of contract amended to comply with the current version of the Property Procurement Guidance for NHSScotland – PROCODE. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the institution of Civil Engineers. The standard documents should be amended to comply with the current version of PROCODE and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the Scottish Government Health Directorates.

1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Conditions as far as this practical. The advice of NHS Tayside Supplies, Scottish Healthcare Supplies or the Central Legal Office must be sought where alternative contract conditions are used. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

## 2. Receipt, Safe Custody and Record of Formal Tenders

2.1 Formal competitive tenders shall be addressed to the Chief Executive.

2.2 The officer designated by the Chief Executive will endorse the date and time of receipt of each tender on the unopened tender envelope/package and shall print and sign their name accordingly as means of proof of receipt. Individual's hand delivering tenders may witness the endorsement. A secure electronic recording system shall be in place for tenders received electronically.

2.3 Tenders must be stored either in a safe or other locked facility, to which only designated officers/key holders have access, from the time they are received until opening.

## 3. Opening Formal Tenders

3.1 As soon as possible after the date and time stated as being the latest time for the receipt of tenders, they shall be opened, either manually or electronically, in the presence of a senior officer from each of the originating department and another department, one of whom must be from the Finance Department.

3.2 Tenders for the provision of services where an in-house tender is also being invited shall be opened, either manually or electronically, as soon as practicable after the date and time stated as being the latest time for the receipt of tenders in the presence of a Non-Executive Member of the Board and the Chief Executive or Executive Director who has not been party to the preparation of any of the said tenders and neither of whom shall have pecuniary interest in the contract for which the tenders have been received.

3.3 The envelope/package/electronic record, or such part as may reasonably evidence receipt endorsement, shall be retained by the designated officer(s) along with the tender documents and in accordance with the NHS Tayside Record Retention Schedules.

3.4 Every tender received shall be stamped with the date of opening and initialled by two of those present at the opening. The date stamp may be manual or electronic.

3.5 A permanent record shall be maintained, manually or electronically, to show for each set of competitive tender invitations despatched:

3.5.1 The names of firms/individuals invited;
3.5.2 The names of and the number of firms/individuals from which tenders have been received;
3.5.3 The total price(s) tendered;
3.5.4 Closing date and time;
3.5.5 Date and time of opening;

and the record shall be signed manually by the persons present at the opening or acknowledged electronically by a secure means.

3.6 Except as in Section 3.7 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialled by two of those present at the opening of manual tenders. The audit trail shall include the identity of the person making the change and be date and time stamped.

3.7 A report shall be made in the record if, on any one tender, price alterations are not numerous as to render the procedure Section 3.5 unreasonable.

## 4. Admissibility and Acceptance of Formal Tenders

4.1 In considering which tender to accept, if any, the designated officers shall have regard to whether best value will be obtained and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

4.2 In exceptional circumstances and with the approval of the Chief Executive, a tender may be received and accepted after the closing date, provided that none of the tenders available for opening at the appointed time have been opened. Where the available tenders have been opened, a late tender shall be opened solely to identify the sender and returned with a letter of explanation. Tenders received after the due time and date may be considered only if the Chief Executive or nominated officers decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned.

The Chief Executive or nominated officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonable in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

4.3 In the event of an extension of time for receipt of tenders being approved by the Chief Executive or nominated officer, all invited tenderers shall be advised of the extension and the revised closing date.

4.4 Incomplete tenders (I.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 4.2.

4.5 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing the offer.

4.6 Necessary discussions with a tenderer of the contents of their tender, in order to clarify technical points, etc, before the award of a contract, need not disqualify the tender.

4.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safe keeping by an officer designated by the Chief Executive.

4.8 Where only one tender/quotation is received, NHS Tayside must ensure, as far as practicable, that the price to be paid is fair and reasonable.

4.9 A tender other than the lowest (if payment is to be made by the Board), or other than the highest (if payment is to be received by the Board) shall not be accepted unless for good and sufficient reason the Board, or the Chief Executive acting with the Director of Finance within limits delegated to them (see Section E paragraph 2.2.4), or the nominated Operational Director acting with the Associate Director of Finance – Financial Services and Governance, Fraud Liaison Officer with limits delegated to them (see Section E paragraph 2.4.4), decide otherwise and report the reason for their decision in accordance with the reporting requirements specified within Section E paragraphs 2.2.4 and 2.4.4.

4.10 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.

4.11 Access to all tender documentation will be managed in accordance with the requirements of the Freedom of Information (Scotland) Act 2002. Any relevant exemptions specified in the Act will be applied, taking account of both commercial and public interest. The documentation will be retained in accordance with the NHS Tayside records retention schedules.

## 5. Lists of Approved Firms

5.1 NHS Tayside shall compile and maintain, and the Director of Finance shall keep, lists of approved firms and individuals from whom tenders may be invited and shall keep these under review. The lists shall be selected from all firms which have applied for permission to tender provided that:

5.1.1 In the case of building, engineering and maintenance works, the Chief Executive is satisfied of their capacity, conditions of labour, etc and that the Director of Finance is satisfied that their financial standing is adequate;

5.1.2 In the case of the supply of goods, materials and related services, and consultancy services, the Chief Executive or the nominated officer is satisfied as to their technical competence, etc, and that the Director of Finance is satisfied that their financial standing is adequate;

5.1.3 In the case of the provision of healthcare services by a private sector provider, the Director of Finance is satisfied as to their financial standing and the Medical Director is satisfied as to their technical/medical competence.

5.2 NHS Tayside shall arrange for advertisements to be issued as may be necessary, and not less frequently than every third year. In trade journals and national newspapers, inviting applications from firms for inclusion in the prescribed lists. Applications from firms or individuals wishing to be admitted to the list may also be considered at any time.

5.3 If in the opinion of the Chief Executive or the Director of Finance, it is impractical to use a list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), the Chief Executive or nominated officer should ensure that appropriate checks are carried out as to the technical and financial capability of firms invited to tender or quote.

5.4 A permanent record should be made of the reasons for inviting a tender or quote other than from an approved list.

## 6. Post-Tender Negotiations

6.1 It is acceptable to enter into post-tender negotiations only with those tenderers who have been granted 'preferred supplier' status in any particular tendering exercise or who have a reasonable chance of gaining the contract. The negotiations must be fully documented and clearly indicate:

6.1.1 The justification for the use of post-tender negotiation;
6.1.2 The aim of the negotiations and the methods used;
6.1.3 A precise record of all exchanges, both written and verbal;
6.1.4 Management approval for the award of contract;
6.1.5 The approval of the Chief Executive.

## 7. Unsuccessful Tenders

7.1 Following completion of the tender acceptance, and having obtained confirmation from the successful tenderer of acceptance of the contract, the unsuccessful tenderers should be advised in writing that the contract has been awarded and that they have not been successful.

In advising the unsuccessful tenderers, it should be drawn to their attention that their tender documentation will be retained in accordance with the time limits set out in the policy on culling and retention. However, they should also be advised that they may collect additional copies of the documentation.

## Annex 2

## Common Seal

The common Seal shall be kept by the Board Secretary in a secure place and they shall be responsible for its safe custody and use.

The Seal shall be affixed in the presence of the Chair and the Chief Executive. If the Chair cannot be present the Vice Chair or a Non-Executive Member nominated by the Chair must be present.

The Board Secretary shall keep a register which shall record the sealing of every document. Every such entry shall be signed by those present when the document is sealed. The entries in the register shall be consecutively numbered.

**Annex 3**

**BUDGETARY CONTROL FRAMEWORK**
**Role and Responsibilities of Budget Holders / Finance Staff**
**Within the Budgetary Control Framework**

Sound Financial management is a fundamental building block of a successful, high quality health service. It is not just about recording and monitoring expenditure, but about planning to meet new developments, knowing how money is spent, whether it is giving good value and how extra investment can be best used to improve services.

NHS Tayside has a responsibility to prepare and submit financial plans in accordance with the requirements of the Scottish Government ensuring that budgets reconcile to such plans. NHS Tayside will perform its functions within the total funds allocated by Scottish Ministers and through the contractual framework and all plans, financial approvals and control systems will be designed to meet this obligation.

NHS Tayside must remain in financial balance whilst delivering the level of services required by the local population. Savings targets are used as a means of reducing baseline expenditure to meet financial targets and fund service developments. Effective planning, monitoring and reporting of achievement against savings targets is important in ensuring that NHS Tayside meets financial targets and releases sufficient funding to meet the requirements of service modernisation.

NHS Tayside's financial allocation consists of two elements:

- General Allocation
- Specific ring-fenced funding

NHS Tayside's budget cycle in respect of the general allocation will be coordinated with the business planning arrangements and timetables as approved by the Board. The financial plans will be submitted to the Board for approval at the March Board meeting prior to the start of the financial year to which the plan relates. This will include specific ring-fenced funding.

## 1. SCHEME OF BUDGET DELEGATION

Overall responsibility for budgetary control rests with the Chief Executive. The Chief Executive will, in turn delegate the responsibility for overall budgets to the Board Director of Finance who is accountable to the Chief Executive and the Board for the financial performance of NHS Tayside. The Chief Executive, in accordance with NHS Tayside's Standing Financial Instructions within the Code of Corporate Governance, will delegate responsibility of a budget to Budget Holders within NHS Tayside, to permit the performance of defined activities. The delegated first line responsibility for the control of a budget or part of a budget therefore lies with the Budget Holder.

In carrying out duties:

20 The Chief Executive shall not exceed the budgetary or virement limits set by the Board;
21 The Chief Executive may vary the budgetary limit of an officer within the Chief Executive's own budgetary limit.

## 1.1 RESPONSIBILITY OF THE BUDGET HOLDER

**Budget Holders are responsible for ensuring that:**

1.1.1 Expenditure is contained within the budgets allocated, within the terms of Schemes of Delegation and within the agreed application of virement (transfer of budget funds);

1.1.2 Expenditure is only incurred relating to the terms for which the budget was approved (subject to approved virement);

1.1.3 Employees are only appointed within the constraints of the budgeted establishment;

1.1.4 The procedures for ordering goods and services or committing NHS Tayside to expenditure are tightly controlled and are in accordance with NHS Tayside's Standing Orders and Standing Financial Instructions within the Code of Corporate Governance;

1.1.5 Budget variances arising as a result of an overspend position (either through an excess of expenditure or a shortfall in income) are investigated and corrective action is taken promptly;

1.1.6 Budgets are used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert back to the immediate control of NHS Tayside, unless covered by delegated powers of virement;

1.1.7 Any substantial slippage of funds arising from delays in the implementation of projects are reported to the appropriate Committee;

1.1.8 Expenditure for which no provision has been made in an approved budget and not subject to funding under the delegated powers of virement, shall only be incurred after authorisation by the appropriate Committee;

1.1.9 Budgetary limits are not exceeded and control procedures set by the Chief Executive, are strictly observed;

1.1.10 Non-recurring budgets are not used to finance recurring expenditure without prior authorisation from the appropriate Committee

1.1.11 The application of substantial funds arising from planned or fortuitous savings are subject to approval by the Chief Executive after consultation with the Director of Finance.

1.2 Budget Holders have delegated authority to:

1.2.1 Manage a budget or part of a budget, to permit the performance of defined activities. The terms of delegation include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of service and the provision of regular reports upon the discharge of those delegated functions to the Chief Executive.

1.2.2 Vire (transfer) recurring budget within a main budgetary heading up to the value of £50,000. The following conditions apply:

1.3 A formal record must be held by the management accounting staff, of all recurring budget virements made together with the reasons for making the virement;

1.4 The virement must not create an additional recurring cost;

1.5 Budget Holders do not have the power to transfer funding from one main budgetary heading to another even if both are within the Budget Holder's remit. A main budgetary heading in this context is any of the following headings:

- Hospital and Community Services
- Family Health Services (unified budgets)
- Voluntary Sector/Resource Transfer to Local Authorities
- Board Corporate Services
- Reserves and Earmarks

If a transfer of funds is required between main budgetary headings, authorisation is required by the Chief Executive/Director of Finance or if over £100,000,000 by the Finance and Resources Committee.

1.6 Funds cannot be vired from ring-fenced budgets under any circumstances.

Examples of ring-fenced budgets are:

- Blood Borne Virus Prevention
- Drugs Treatment & Rehabilitation
- Alcohol Action Plan
- Dental Action Plan

Authority to vire funds means the re-allocation of budget authority and involves the transfer of budget funding from one budget heading to another within the Budget Holder's area of responsibility or from/to another Budget Holder within a main budgetary heading up to the delegated limit set.

If Budget Holders are unsure of their powers of virement, they should check with management accounting staff prior to implementing a re-allocation of budget funds.

There is an over-riding requirement on NHS Tayside to contain expenditure within the Revenue Resource Limit (RRL); it may therefore be necessary in certain circumstances for the Chief Executive to impose virement and vary the budget of an individual Budget Holder.

Virements above £50,000 will require to be approved by the appropriate Officers, as specified within the 'Scheme of Delegation' and 'Local Scheme of Delegation', contained in Section E, sub-sections 3 of the Code of Corporate Governance.

## 2. RESPONSIBILITY OF FINANCE STAFF

The Director of Finance and/or his finance staff are responsible for assisting Budget Holders in monitoring budgets through the provision of management accountancy support and providing Budget Holders with detailed financial information and advice.

Whilst the Director of Finance and/or his staff will provide information and financial advice, the first line responsibility for the control of the budget clearly rests with the Budget Holder.

The Director of Finance and/or his finance staff will:

2.1.1 Meet with Budget Holders on a regular basis (to be agreed with each Budget Holder) to discuss budget reports, commentaries and any relevant financial issues, with the purpose of ensuring that resources are used for their intended purpose and are properly accounted for. Particular emphasis should be made on corrective action required as a result of significant variances. It is incumbent on both parties to ensure that these meetings take place. A record of the meetings held including formal note of the action points raised and actions taken to address the points raised should be kept and filed.

2.1.2 Provide timely and accurate budget monitoring information with financial commitments recognised as soon as possible and reflected in budget reports to ensure that Budget Holders can properly control costs.

2.1.3 Be expected to provide Budget Holders with detailed monthly budget reports before the 15th of each month, showing:

2.1.3.1 Current year budgets for income and expenditure;
2.1.3.2 Recurring budgets for future years;
2.1.3.3 Income and expenditure to date against budget to date, the variances being the difference between actual and budgeted amounts to date (for expenditure, a positive variance indicates an overspend compared to budgeted expenditure and a negative variance, an underspend. For income, a positive variance indicates an income

shortfall compared to budgeted income and a negative variance, excess income) and projected financial year end outturns.

2.1.4 Provide Budget Holders with explanations for any changes in the approved budget.

2.1.5 Provide accurate and timely information to provide 'early warning' of problems so that prompt corrective action can be taken where necessary.

2.1.6 Provide budget reports in sufficient detail to ensure that all significant variances are identified so that any necessary corrective action can be properly identified.

2.1.7 Assist Budget Holders in monitoring budgets through the provision of management accountancy support and the provision of detailed financial information, where appropriate.

2.1.8 Provide monthly commentaries on each Budget Holder's financial position identifying, as far as is reasonably possible, areas for investigation by budget holders, trends etc.

2.1.9 Determine the phasing of budgets, allocated to Budget Holders, prior to the commencement of the financial year and ensure that financial reports are produced on the appropriately phased basis. If necessary budgets will be re-phased, in year, after discussion with Budget Holders.

2.1.10 Provide advice on all aspects of budgetary control and training where required.

2.1.11 Submit monthly financial reports to Senior Management Teams/Committees. The reporting of performance against budget and the corrective taken as a result is an essential element of financial management in NHS Tayside.

## 3. SETTING OF BUDGETS AT BUDGET HOLDER LEVEL

3.1.1 NHS Tayside uses an incremental approach to budget setting where existing budgets are rolled forward year on year and adjusted for new developments, inflation and efficiency savings. Each year, the Director of Finance agrees the level of pay awards and price inflation to be applied to budgets and the policy on cost pressures and efficiency saving targets.

3.1.2 Budgets for each financial year are prepared in the four-month period to the commencement of the financial year in question. The steps involved in the process are as follows:

3 Total funding available, including allowances for inflation, pay awards etc. for each main budget heading;

4 Detailed calculations of pay and non-pay budgets are undertaken by management accounting staff on the basis of the current staff in post and current supplies expenditure trends and also taking into account other known factors affecting the following year's financial position e.g. changes to employers' national insurance rates. A comparison of the current year's budget with the proposed budget for the following year is prepared with explanations for any significant changes;

5 Management accounting staff will discuss draft budgets with Budget Holders and amend as necessary. Developments requested by Budget Managers are not included at this stage as these require to be approved by the Board's Executive Team and, if necessary, by the Finance and Resources Committee.

Following completion of the process, individual budgets are then set and will include anticipated monthly phasing. The detailed budgets will be monitored within the budgetary control monitoring system to ensure that the resources are used for their intended purposes and are properly accounted for. Monthly budget reports are prepared from May onwards. The reporting of performance against budget and the corrective action taken as a result is an essential element of financial management in NHS Tayside.

# CAPITAL APPROVALS PROCESS
# AND
# BUSINESS CASE GUIDE

CAPITAL APPROVALS PROJECTS AND
BUSINESS CASE GUIDE EFFECTIVE APRIL 2011


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**Appendix 1 – NHS Tayside Project Management Guide**

**Appendix 2 – Capital Plan Review Cycle**

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## 1. Purpose of this Guidance

This guide is intended to cover the approvals process for all capital projects and is intended to act as guidance for those NHS Tayside employees, who may become involved in a project at some point in their career, of the logical and progressive steps to be taken in terms of the appropriate form of business case and the approval gateways that a project has to progress through. Being asked to take forward a potential capital project can be a daunting task, especially if you haven't been involved in the process previously.

The guidance covers investment in buildings, major equipment, I.T., business systems, etc and should be read in conjunction with the NHS Tayside Project Management Guide. Copies of this can be obtained from the Project Support Office of the Capital Projects Department.

To ensure that a project starts up correctly and follows appropriate approval routes it is crucial that initial advice is sought from the start as this will avoid unnecessary and unproductive work that may have to be redone at a later stage

If you cannot find the information that you need in this document or if you require any further support you should contact NHS Tayside's Head of Capital Projects, who will be able to provide you with the necessary advice on how to take the specific project forward and the procedures that will have to be followed.

## 2 Definition of a Capital Project?

A capital project is a project that will require capital (exchequer) funds and applies to projects, which will significantly alter and, usually increase, the value of an NHS asset.

A capital project will cover the list below where the lifespan is 5 years or more and the estimated value is more than £100,000

- **Equipment Purchase (replacement or new)**
- **IT System or Equipment (replacement or new)**
- **Building, either alteration or new**
- **Engineering Works (Infra-structure Improvements)**

This can cover the purchase of a single item of equipment up to a new build hospital building.

Any projects which have a capital value of less than £100,000 will normally be dealt with by the Estates Department, although there may be occasions when this guidance will be amended depending on the specific project.

## 3 The Role of the Capital Projects Department

The Capital Projects Department role within NHS Tayside is twofold. To ensure that required project management processes and procedures are undertaken in relation to all projects and that all technical aspects of construction and refurbishment work for capital projects are carried out within the agreed timescales, within the agreed cost, provide the appropriate quality and design and comply with all necessary health and safety and building regulations. The combination of these elements will ensure that NHS Tayside provide fit for purpose environments and services for both patients and staff and that when approvals are sought at relevant stages, Committee and Board members can be assured that proposals are robust, well documented and that the decisions arrived at are based on informed thought and information.

3.1 Project Management

Project management processes are structured to provide an environment of control to a project to ensure that the project objectives are well defined, have a start and end date and that financial, time and quality parameters are met. The Capital Projects Department will support and assist with these processes and structures and have developed a standard set of documents and tools to support project teams. The complete Project Management Guide is attached in Appendix 1.

**Standard processes include:**

- **Project Initiation and Start Up**
- **Definition of project objectives, scope and success criteria**
- **Identification and Management of relevant stakeholders**
- **Involvement, Engaging and Informing with relevant stakeholders**
- **Risk and Issue Management**
- **Change Control**
- **Post Project Evaluation**
- **Post Occupancy Evaluation**

Support and assistance with development of all relevant Approval Documents including Project Initiation Document, Initial Agreement, Standard or Outline Business Case and Full Business Case can be given where required, or downloaded from
**http://www.nhstayside.scot.nhs.uk/cap_projects/index.shtml**

All projects will require project management to some degree but it should be noted that for any higher value project (> £1m), a project manager who holds an industry recognised qualification must be appointed as a requirement of the Scottish Government.

3.2 Technical Management

Technical management associated with the design and construction of the new build and refurbishment projects will ensure that detailed output specifications are developed and agreed with relevant stakeholders. As part of an ongoing dialogue process project specific workshops will take place with the design team and the end users plus internal NHS advisors (infection control, fire and maintenance).

The management process adopted will provide the control over all subsequent methodologies including management of any contract with external contractors and consultants, construction cost monitoring and reporting.

3.3 Capital Accounting

The Capital Accounting Team, led by the Assistant Director of Finance Governance, Service Development & Modernisation reporting directly to the Director of Finance, will assist in the production of the financial sections to be included in approval documents such as the Initial Agreement and Business Cases. The extent and detail of the information required will vary depending on which document or stage of the project has been reached.

Any bid for funds must reflect estimated total costs based on the stage reached. Costing information must refer to three elements which are:

**Capital Cost**

To identify the one off cost of the physical refurbishment or new build or new piece of equipment. This cost should also show any associated costs for VAT, medical equipment, IT, voice communications, fixtures such as curtain/ track, plus fees for professional services (e.g. Architect, Engineering, QS, CDM Co-ordinator) where external consultants are providing these services.

Capital costs provided by the Capital Projects Department will be prepared using the appropriate NHS Guidance and based on the level of detail available at the particular point in the project cycle.

The costing methodology will be carried out in accordance with the guidance and procedures contained in the Scottish Capital Investment Manual (SCIM). The guidance recognises that the accuracy of the estimated costs are likely to change from the feasibility stage to the full detailed/ designed stage reflecting the level of information that emerges from the progression of the design process. Costs may therefore increase or decrease. This detailed cost planning process allows issues to be highlighted and action taken to ensure the project will address the clinical needs and provide NHS Tayside with value for money.

**Revenue Cost**

To identify any recurring revenue savings or additional recurring revenue cost and any non recurring revenue cost (Non Added Value Capital Cost) that will be required as a result of the successful completion of the project.

It is important to remember that all capital expenditure has a revenue consequence in the form of depreciation of an asset, currently categorised as items over £5,000 and with a life greater than 1 year.

A project may also include a service redesign element that will require additional staff and additional revenue to support those staff.

If medical equipment is being purchased there may be a recurring maintenance charge or installation cost associated with it. Likewise if an additional engineering plant is required (boilers, ventilation plant, controls etc) there will also be a recurring maintenance charge.

**Bridging Costs**

To identify any bridging money that may be required, over a time limited period to support the transition from the current service to the new service. This could be to cover double running costs of two services or buildings during the changeover period.

Other financial costs, which may require to be added depending on the estimated overall cost of the project will include:

Optimism Bias **– an allowance for unknown cost elements at the early stages of a project which will be reduced as clarity is achieved over accommodation requirements and design issues. Optimism Bias is also added to the project timescale, and likewise reviewed during the life of the project.**

Quantified Cost of Risk **– an allowance, based on the overall capital value, that recognises that some risks will carry a financial penalty and may or may not occur up to and including during the period of construction.**

Contingency **– an allowance made to cover any unforeseen difficulties during the construction period, usually site or design specific.**

Guidance on these costs and processes should be sought, at an early stage of the project, from the Capital Accounting Team and Capital Projects Department.

## 4 The Strategic Planning and Approvals Process

Every year NHS Tayside spends in the region of £30 million of central funds on capital projects. The total capital expenditure is often higher than this when projects funded by other means are taken account of, e.g. through private/third party finance, Tayside Health Fund grants and revenue budgets.

Sometimes these alternative funding strategies represent an appropriate way to finance specific capital projects and should be considered. For major projects (over £20 million) there is a requirement for NHS bodies to consider private finance as an alternative to the use of capital funding.

There are also specific circumstances where alternative funding strategies may be considered or required and specific advice about this is available through the Head of Capital Projects.

However this guidance is primarily aimed at those projects that require capital funding and sets out the process that must be undertaken to have this funding approved and committed via NHS Tayside's Capital Plan.

### 4.1 The Capital Plan

All NHS Boards are required to prepare a 5-year Capital Investment Plan as part of the Local Delivery Plan. The Local Delivery Plan sets out objectives for NHS Tayside over a five year period and includes sections on Health Improvement targets and measures to achieve these and also includes targets on capital expenditure and how these will be achieved. It sets out the proposed capital profile over the future of the strategy.

All projects that NHS Tayside have approved to move forward within the five year time frame must be shown on the capital plan as individual projects with the capital value shown and any revenue consequences identified in the five year financial Revenue Plan or, for smaller projects, may be grouped under a single heading of Minor Works.

Minor works have been defined locally as capital schemes that have a total capital requirement of less than £100,000 (inclusive of VAT and professional fees) in order to separate them from more significant (expensive) schemes. These projects also require a level of approval that is appropriate to the level of funding being accessed. Scheduling and implementation of these smaller projects requires flexibility that takes account of the large value of projects at this level. Guidance for Minor Works is provided in section 6 of this guidance.

The capital plan is under constant scrutiny, specifically to compare actual and planned activity/expenditure, but is also formally reviewed/updated annually to ensure that new projects are considered for addition and that projects already in the plan are still viable and have committed funding.

New projects are primarily considered by the Joint Executive Team (JET) and subsequently by a representative group under the Chairmanship of the Medical Director, or designated deputy, known as the Clinical Service Advisory Group

(CSAG) and (if approved) will be prioritised, along with existing schemes, using an agreed objective scoring and prioritisation system. A template for this can be obtained from the Project Support Office of the Capital Projects Department. Both the Capital Scrutiny Group (CSG) and Clinical Service Advisory Group (CSAG) review this scoring system annually to ensure that it appropriately reflects those many factors that can determine the relative priority of a capital project. Only those projects that have been approved through the appropriate committees will appear on the Capital Plan.

Existing approved schemes are also reviewed at this time to establish if their relative priority has changed and ultimately to ensure that available capital and revenue resources are used optimally within a continually changing environment.

This prioritised list of schemes is then scheduled into an overall capital and revenue investment programme that is deemed to be affordable and deliverable under the auspices of the CSG.

The draft Capital Plan will be compiled taking account of many issues, including but not limited to clinical priority, impact on existing or interfaced services, legislative requirements and affordability (both capital and revenue) and proposed strategic objectives and developments over the next 5 years. This means that any project appearing on this list must have been developed to a stage where the estimated costs and timescales can be accurately reflected in the plan, particularly for those projects expected to start in years 1 & 2 of the plan. However years 3 - 5 remain flexible at this time as a project may require to be reprioritised based on any one of a number of issues including those noted above.

The draft Capital Plan is presented to CSAG, CSG, Joint Executive Team (JET), Finance and Resources Committee (F&R) and NHS Tayside Board. The F&R Committee ultimately considers the detail in the plan prior to making a recommendation to the Board in terms of final approval prior to submission to the Scottish Government Health Department (SGHD).

Every effort is made to ensure that effective clinical prioritisation remains at the core of capital planning specifically through the following stages:

- **The key role of the clinically representative CSAG in formally scoring/prioritising projects**

- **CSAG's role in agreeing the draft Capital Plan prior to presentation to F & R and ultimately the Board**

- **Tayside NHS Board's role in approving the draft capital plan prior to presentation to the Scottish Government for final approval.**

Project requests will be received continually throughout the year and the inclusion and prioritisation of these into the capital plan will be dealt with between meetings by the Medical Director as Chair of the CSAG in discussion with finance colleagues to ensure availability of funding.

4.2 Approval Stages

The capital approvals process is designed to ensure that all investments represent Value for Money and this is demonstrated through the development of a Business Case, which, as the project progresses, will become increasingly detailed and will show that designs and costs are robustly defined to support the case for change.

The type of business case required and process to follow varies depending upon a number of factors, most importantly the total amount of exchequer funding required. Capital developments with a high cost require a higher level of justification through more detailed business cases, which in turn ensures that the process for these projects is robust and normally takes longer to achieve.

The majority of projects undertaken will fall below the £3m delegated authority threshold, effective from 1 April 2011, set by the Scottish Government Health Department and confirmed in CEL 32 2010. This means that Tayside NHS Board or one of its Standing Committees can approve these projects.

Projects with a capital cost in excess of £3m will require to be approved by Tayside NHS Board and subsequently by the Capital Investment Group (CIG) of the Scottish Government. This approval will be required for all documents and must be given at each stage before the project can move forward. Submissions to the Scottish Government are assessed and scored using a standard assessment tool, Appendix 3. This is undertaken at each stage to ensure that service requirements remain unchanged and that no substantial changes in cost have occurred. For example if the capital cost between Outline Business Case and Full Business Case varies by more than 10%, allowing for inflation, the Scottish Government can request that the project Outline Business Case be redone.

Section 5 of this document outlines the difference in the business case process relative to the ultimate capital cost of each project. This information is supplemented by the charts contained in Section 10.

4.3 Local and National Procedures

In taking forward projects there is a requirement to be consistent with local and national procedures and guidance (see useful references in Appendix 6).

Specific procedures that must be taken account of, particularly for larger projects are detailed in NHS Tayside's "Code of Corporate Governance" and Scottish Government Health Department "The Scottish Capital Investment Manual" (SCIM).

Projects that will make changes to the property portfolio and its configuration must be referred to the NHS Tayside Property Strategy Management Group (TPSMG). If this is the case consultation should be made with either the Head of Capital Projects or Head of Estates as early as possible.

4.4 Informing, Engaging & Consulting

NHS Tayside as a publicly funded organisation has a duty and is highly committed to inform, engage and consult the public and its own staff around all aspects of developing health and community care policies and service changes, particularly where changes are proposed to service design and provision or physical location.

NHS Tayside, the Scottish Health Council and the Scottish Government have issued guidance in a number of areas and these include:

- **Informing, Engaging and Consulting the Public in Developing Health and Community Policies and Services issued through CEL4 (2010)**

- **NHS Tayside – Communication and Engagement Strategy, Participation Standards, Communities Scotland – Community Engagement Standards**

The early involvement of all relevant stakeholders is an important factor in the success of any project and suitable scheduling for this activity must be considered in the initial stages of planning. A useful reference and further guidance to this is:

"Six Steps to Involving Patients, Carers and the Public in Service Change and Improvement" available on Staffnet.

All projects, and particularly projects that directly affect staff, should also be highlighted to staff side representatives, who can assist in ensuring appropriate communication and representation at all stages of the project.

4.5 Openness in Public Contracting

NHS organisations are obliged under HDL (2005)19 'Freedom of Information (Scotland) Act 2002: Publication of PPP Contracts and Capital Business Cases' to be open and transparent in relation to the publication of contracts and other key documents and to make available to the public, copies, irrespective of capital value, of contracts and the following key documents:

**Initial Agreements**
**Standard Business Cases**
**Outline Business Cases**
**Full Business Cases (Including addendums in the case of PPP/PFI projects)**

It should be noted that, at various stages throughout the process, financially sensitive information that is commercially confidential may be excluded from publication.

It is also important to note that Ministerial Approval is required where significant service change or hospital closure is proposed. Property Disposal also requires compliance with the Property Transaction handbook http://www.sehd.scot.nhs.uk/propertymatters/nhsa.pdf Where this approval is required the process should be considered at an early stage, with further advice available through the Head of Capital Projects.

5 The Business Case Process

5.1 Documentation

Some service redesign or building projects that are single elements of a larger strategic change may be required, in the first instance, to submit a strategic direction document to Tayside NHS Board for initial approval of the overall service development. Approval of a Strategic Policy is not part of the formal Business Case Approval Process but can be an initial stage that then facilitates the formal process to begin with the development of an Initial Agreement or Standard Business Case.

**The SCIM sets out the following documentation requirements based on total project cost:**

- **Less than £1.5m : Standard Business Case**
- **£1.5m - £5m : Initial Agreement and Standard Business Case**
- **£5m+ : Initial Agreement, Outline Business Case, Full Business Case**

**The documents can be summarised as follows:**

5.1.1 Project Initiation Document (PID) **– required for all projects**

**The key document to be developed in the initial phase is the Project Initiation Document (PID), which typically contains:**

- **Project Aim/Scope**
- **Key Objectives**
- **Project Organisation, Roles and Responsibilities**
- **Stakeholder Analysis**
- **Assumptions**
- **Constraints**
- **Methodology, Monitoring and Control System**

This core PID document will require to be further supported by a working Communication Plan and Risk Plan. This document, which must be approved by the Programme/Project Board, aims to give an effective and clear picture of the project and can also form a concise project overview that is readily communicable to everyone involved in the project, including new project team personnel.

This core document will also form the basis of and transfer into the Project Execution plan once the Full Business Case has been approved.

5.1.2 Initial Agreement (IA) **(establishes the need for change and sets out the proposal in the context of the NHS Board's strategy)**

- **Sets out the strategic reasons for change**
- **Defines estimated capital and revenue implications including inflation relative to the estimated mid point of construction, vat, professional fees, contingency and optimism bias**
- **Notes major risk factors.**
- **Design Guide Statement (for projects over £5m)**

5.1.3 Standard Business Case (SBC) **(outlines how the project measures up against key criteria)**

- **Sets out detailed strategic reasons for change**
- **Sets out implications of failure to meet the need for change**
- **Looks at potential options and identifies preferred option within a decision making framework**
- **Contains detailed capital costings for new build/refurbishment of the preferred option**
- **Contains detailed revenue costings to support the change**
- **Contains a description for the project management arrangements for the project**

5.1.4 Outline Business Case (OBC) **(detailed document which identifies the preferred option and supports and justifies the case for investment)**

**All of the Standard Business Case requirements but must also provide:**

- **Analysis of potential procurement routes i.e. Capital (exchequer) funding or PPP**
- **Demonstrate Value for Money of preferred option including 30 year life cycle costing in a Public Sector Comparator**
- **Explore, detail and include all calculations for Optimism Bias and Quantified Risk**
- **Detailed exemplar drawings of preferred option at 1:200**

5.1.5 Full Business Case (FBC) **(explains how the preferred option (from the OBC) would be implemented and how it can best be delivered)**

- **To be completed for any project with a capital value in excess of £5m and for all PPP projects, with details of the final agreed costs and to demonstrate that value for money has been achieved**

- **Contains details of how post project evaluation will be undertaken and note where the resultant report will be presented and how the report will be logged and made available for future use**

Due to differing levels of delegated authority to NHS Tayside to approve expenditure, the table below notes which committees the relevant document should be submitted to, dependent upon its capital value. However all projects will be submitted in the first instance to the Joint Executive Team and the Capital Scrutiny Group.

| | Project up to a value of[1] | | | |
|---|---|---|---|---|
| Committee or Board | Less than £1m | £1m to £1.5m | £1.5m to £3m | Over £3m |
| | | | | |
| **Joint Executive Team** | • | • | • | • |
| **Capital Scrutiny Group** | • | • | • | • |
| **Nominated Operational Director /Chief Executive and Director of Finance** | • | | | |
| **Finance and Resources Committee** | | | • | • |
| **Tayside NHS Board** | | | | • |
| **Scottish Government Capital Investment Group** | | | | • |

**Capital Value should be derived after application of contingency, fees, vat, optimism bias and inflation to midpoint of construction**

5.2 Initial Agreement – Projects over £1.5m

Every capital investment proposal starts with an idea, with these ideas requiring a level of development and work-up of estimated cost before they can be formally

considered as potential future projects ready to be prioritised by the wider organisation.
Therefore, at this early stage, it lies with the local clinical/departmental manager to develop the idea and case for change to a level where it has the documented support of the local management team. The local management team can be defined as one of NHS Tayside's major operating units and will include bodies such as a CHP Committee, Clinical Group Management Team, Operational Management Team etc as appropriate. It is only after this level of local support has been confirmed that the formal submission of an IA can be made.

In taking forward an idea it is necessary for the team developing the IA to seek appropriate general advice from representatives within the various departments who will support or be impacted upon by the project e.gg Capital Projects, Finance Directorate, IT, Support Services, Estate Maintenance, Fire Safety, Control of Infection, Risk Management, Human Resources and Procurement Departments. It is also important that they identify and gain the support of other stakeholder groups who may be affected by the specific proposal, e.g. Patient groups, any service in a physically adjacent area, any related clinical services, any partnership bodies such as Local Authorities, any Decanting requirements of the project. Where the proposed project will have a major impact on service delivery or location, it is crucial that all relevant stakeholders are identified and appropriate involvement, engagement and informing is undertaken.

It is essential that the proposed outcomes, strategic objectives, benefits realisation, timescales and broad financial implications (both capital and revenue) be identified in the IA although at this preliminary stage this is in "broad brush" terms and detailed input is not required. It is important, however, that all information provided reflects the full scope and complexity of the proposed project, is evidence-based, and presents a long list of all possible options and any other relevant information that will aid prioritisation and scheduling.

Capital costs will normally be provided by the Capital Projects Department and will include Contingency, Design Risk, Professional Fees, Optimism Bias, Vat and inflation to mid construction.

The IA should be submitted to the Joint Executive Team in the first instance for consideration of capital affordability prior to a business case being developed. If funding is identified, the IA is then recommended for submission to the JET. The table at 5.1 details the approval route for projects based on estimated value.

A model for an Initial Agreement is contained in SCIM Business Case Guide and examples can be obtained from the Project Support Office of the Capital Projects Department.

It is important to note that no project over £1.5m will be considered for, or appear in, the capital plan until this document has been appropriately completed, considered and received the necessary approvals. It should also be further noted that significant changes to any factor within the IA that affects its integrity will require its re-consideration and perhaps re-submission, eg a fundamental change to the proposal or predicted costs.

Following acceptance of an IA the next stage in the approvals process for projects above £1.5m is to develop a business case. The nature of the business case(s) required is dependent upon the total capital value of the project.

Projects with a capital value of less than £5 million require submission of a Standard Business Case, whereas projects with a capital value of more than £5 million involve a more complex approvals route, requiring submission of an

Outline Business Case (OBC) and Full Business Case (FBC). Templates for these documents can be found in SCIM Business Case Guide.

5.3 Standard Business Case (For projects of less than £1.5m capital)

The Standard Business Case is a document outlining how the project measures up against key criteria. It is the only document required in respect of projects under £1.5m capital. It will set out the strategic objectives of the project in relation to the clinical needs and proposed patient benefits.

The SBC should set out the options that have been considered, identify the preferred option and provide a detailed financial breakdown of its associated capital and revenue costs.

A model for a Standard Business Case is contained in SCIM Business Case Guide.

5.4 Standard Business Case (For projects of more than £1.5m capital)

The Standard Business Case for projects of more than £1.5m capital follows on from the submission and approval of the Initial Agreement.

Building upon the objectives and information from the IA, the SBC must refine this information, in particular short listing options to viable solutions, and assessing these against the benefits the project aims to realise to identify a preferred option. Cost and planning information must be sufficiently developed to ensure certainty and risk mitigation, and must reflect the input of development partners (PSCP and HUB Co.).

A model for a Standard Business Case is contained in SCIM Business Case Guide, and on the NHS Tayside Capital Projects website:

5.5 Outline Business Case (Only applies to projects greater than £5million capital)

The Outline Business Case is a detailed document, which builds on the IA, identifying the preferred option and supporting and justifying the case for capital investment. The emphasis is on what has to be done to meet the strategic objectives identified in the IA and will also include the benefits to be achieved and the consequences of not delivering these. The OBC must demonstrate that the project will provide value for money in terms of the capital and revenue outlay over a twenty five year period.

Within the OBC, the full list of options will be reduced to a short list of those that meet agreed criteria. An analysis of the costs, benefits and risks of the short listed options will be prepared. A preferred option will be determined based on the outcome of a benefits-scoring analysis; a risk analysis, and a financial and economic appraisal.

The preferred option is developed to ensure that best value for money is secured. Part of this exercise will be to consider the possible procurement routes available which could include either exchequer funding or a Public Private Partnership (PPP).
If the preferred procurement route is through PPP, the preferred option is refined to produce a robust public sector comparator, which is used as a comparison against the best PPP option.

Proposed Project Management arrangements must be fully detailed within the OBC and show the resource and funding to support the project. It should note the appointed Project Sponsor and Project Manager.
For projects over £5m the Scottish Government require the Project Manager to hold an industry recognised project management qualification.

An important component of the process around developing the OBC is the involvement, engagement with and informing of all relevant stakeholder groups including patients, staff and the wider public.

A model for an Outline Business Case is contained in SCIM Business Case Guide OBC Section.

5.6 Full Business Case (Only applies to projects greater than £5million capital)

The Full Business Case will detail the final financial structure of the project, and any funding arrangements. It will also demonstrate that there have been no significant increases in the capital sums involved (allowing for inflation) of more than 10% (if this has occurred a revised OBC will be required). It details the final timetable for construction and the expected delivery of the project objectives.

The FBC should also detail the Post Project Evaluation arrangements. The FBC should also provide details of what monitoring arrangements have been developed to evaluate the eventual Benefits to be Realised following implementation of the project outcomes.

A model for a Full Business Case is contained in SCIM Business Case Guide FBC Section.

5.7 Full Business Case Addendum (Applies only to PPP projects)

After financial close, an addendum to the Full Business Case should be prepared. The Addendum should set out any changes in the project following Full Business Case approval and will detail relevant final unitary charges following financial close and summarise the commercial contract in plain English**.**

For comprehensive details of the required contents of all Business Cases refer to SCIM Business Case Guide.

5.8 Post Project Evaluation (PPE) (applies to all projects)

For all projects over £1.5m it is mandatory to prepare a project plan for monitoring the progress, completion and commissioning of the project and for evaluating the outcome following implementation.

A Post Project Evaluation is recommended for all projects and is a mandatory requirement by the Scottish Government for any project with a capital value in excess of £5m, as it will provide valuable lessons for the future, which the Capital Projects Department will incorporate into a process of continuous improvement of overall project management procedures. Guidance on the content of a PPE can be found in the Scottish Capital Investment Manual and the Capital Projects Department will be able to assist with this.

Post Project Evaluations will be presented to the same committees as the approval stages for the IA, SBC and OBC, where relevant, for information and should subsequently be lodged with the Project Support Office of the Capital Projects Department.

5.9 Post Occupancy Evaluation (POE) (applies to all projects)

For all projects over £1.5m it is mandatory to prepare a project plan for monitoring the evaluation of the delivered asset against the benefits and activity it was designed to achieve.

A Post Occupancy Evaluation is recommended for all projects and is a mandatory requirement by the Scottish Government for any project with a capital value in excess of £5m, as it will provide valuable lessons for the future, which the Capital Projects Department will incorporate into a process of continuous improvement of overall project procedures and facility design. Guidance on the content of a POE can be found in the Scottish Capital Investment Manual and the Capital Projects Department will be able to assist with this.

Post Occupancy Evaluations will be presented to the same committees as the approval stages for the IA, SBC and OBC, where relevant, for information and should subsequently be lodged with the Project Support Office of the Capital Projects Department.

5.10 Surplus property

Some projects will result in property becoming surplus to operational requirements. Where this is likely to be the case this should be identified in the IA or SBC and reported to the Capital Projects Department. They will take the necessary steps to evaluate the surplus property against other local needs and if appropriate to seek authority to have it formally declared surplus to operational requirements and dispose of it in accordance with NHS Property Transaction Procedures. The service proposing this may be required to undertake consultation with local stakeholders regarding any potential closure. If the property is declared surplus the vacating service must comply with the guidance set out by NHS Tayside in the Site Closure & Clearance Policy, and any sale of an asset must be transacted according to the Property Transaction Handbook. http://www.pfcu.scot.nhs.uk/PDFs/PropertyHanbook.pdf

5.11 Audit

For all projects all process, documentations, cost estimates and contracting, from inception to completion, is subject to internal audit review – irrespective of project value. In particular for all projects over £5m, advice on audit requirements will be required and will be addressed by the senior Finance Officers involved.

5.12 Design & Art

Effective high quality design is a key benefit of almost all capital projects. NHS Tayside “Design Quality Action Plan” document outlines the importance of effective healthcare design and its clear contribution to both patient care and staff well being. In addition, effective integration of art and design is a main component of delivery of NHS Tayside’s Design Guide, and support for this can be gained from the services of Tayside Health Arts Trust (THAT).

Projects over £5m in value must include a “design statement” document and submit this to Architecture and Design Scotland (ADS http://www.healthierplaces.org/ ) prior to the approval of the Initial Agreement by the national Capital Investment Group.

# 6 Minor Works Guidance

## 6.1 Introduction

This section presents a transparent process to manage those smaller schemes that do not require the same level of approval as full Capital Projects, known locally as “minor capital” works. This process is designed to:

- Demonstrate that all available resources (both financial and non-financial) allocated to minor capital works are being expended appropriately
- Satisfy NHST governance requirements
- Strike an appropriate balance between financial governance and efficient process by recognising that the relevant value of schemes should determine the extent and complexity of the approvals required
- Document the single approved means of identifying and taking forward “minor capital” schemes across NHST however they are funded. (Thereby complementing those processes already in place for larger schemes)

## 6.2 Minor Capital Schemes

NHST’s Business Case Guide identifies that “minor capital” schemes have been recognised locally as those that have a total cost (inclusive of VAT, fees and any other considerations, e.g. optimism bias) of less than £100k.

These schemes have traditionally been funded from three main sources:

- The “minor capital” budget, a component of NHST’s capital allocation delegated to the Director of Operations
- Service revenue budgets
- Other (non-exchequer) sources such as Tayside Health Funds or private financing.

## 6.3 The Process For Approving, Prioritising and Undertaking “Minor Capital” Schemes

The process for taking forward minor capital schemes, reflecting the nature of the funding issues identified, is two-fold:

1)That component related to approving/prioritising funding requests for an allocation from the minor capital budget.

2) The process for allocating the technical staff/resources required to progress funded schemes (whatever the source of funding).

## 6.4 Approving/Prioritising Expenditure from the Minor Capital Budget

The minor capital budget is a component of NHST’s capital allocation that is delegated to the Director of Operations. This delegation recognises that the schemes funded from within this budget are generally very small in financial terms and do not therefore require the protracted approval of the committee structure.

The approval/prioritisation of schemes to be funded from the minor capital budget is the responsibility of the Director of Operations who makes relevant decisions in consultation with The Head of Estates, Head of Capital Projects and Senior Capital Accountant.

In addition, where specific clinical expertise/consideration is required, this will also involve the Medical Director (who chairs the overarching Clinical Services Advisory Group) and/or Director of Nursing in the decision making process.

In order to ensure that all requests for funding are considered fairly and equitably they require to be submitted in the form of Standard Business Case for a number of reasons including:

- This is the established means of seeking approval in principle for larger projects
- The template is recognised nationally and now well established throughout Tayside as a result of the work of the CSAG
- The template is not onerous to complete but does require the service to have considered the need for and implications of those works proposed
- This will allow smaller developments presented to CSG for funding to be passed to the Director of Operations for funding from minor works if deemed appropriate without the need for additional paperwork
- It will provide a clear audit trail related to minor works expenditure that will support the financial data already reported upon

The only exception to the requirement to submit an IA will be for those schemes of less than £10,000 when a Minor Works Approval Request Form should be completed and submitted to the Director of Operations for consideration. The standard form is attached at Appendix 5.

In some circumstances, following initial discussions with senior Estates and Capital Projects Department, it may be possible to progress a minor works project using the standard form only, even if the value is over £10,000. It is recommended that early discussions take place to establish an appropriate approval route.

The elimination of capital to revenue transfers and limited availability of funding overall has placed an additional strain upon the minor capital budget, as the nature of most of the schemes that it supports mean that they actually require revenue funding, e.g. Minor refurbishments and other “non-value adding” works. This also places further emphasis on the need for effective prioritisation and inevitably the need to recognise affordability (both of capital and revenue) as a fundamental consideration.

It is also noted that the nature of minor capital requests is that they are continual throughout the year and that this process must remain flexible enough to manage this situation appropriately. In particular, it must reflect upon the total capital and revenue allocation available within the minor works budget in any given year in the context of a continual stream of un-coordinated requests for varying levels of funding with varying degrees of urgency.

Where a request is made for funding from the minor capital budget that is not deemed to be appropriate, the SBC submitted may instead be submitted by either the Director of Operations or its original sponsor to CSG for consideration of funding from the balance of NHST’s capital allocation.

A high-level schematic of this process is presented in Appendix 2.

6.5 Prioritising Technical Resources to Undertake Minor Schemes

Depending on the nature of a minor capital scheme, in order to make best use of the resources available and recognise specific skill-sets required, it may be progressed by either the Estates or Capital Projects Department.

In summary:

- All schemes that are of less than £10,000 in value will normally be progressed by the Estates Dept, with the support of Capital Projects to make submission for a building warrant where this is required
- All schemes that are between £10,000 and £100,000 in value that do not require a building warrant will normally be progressed by the Estates Department
- All schemes over £10,000 that require a building warrant will normally be progressed by the Capital Projects Department

- In recognition of the specific intricacies of individual schemes these indications are for guidance only with decisions ultimately taken through dialogue between the Estates Department and Capital Projects Department
- Clients of both the Estates and Capital Projects Departments should see no difference in how a scheme is progressed, irrespective of who is progressing it, as this guidance is for those skill-mix reasons noted previously.

Although the prioritisation of funding is clearly essential to the effective management of all minor capital schemes, the prioritisation of the technical resources (primarily staff) required to action them is also absolutely critical. This is particularly important given that both the Capital Projects and Estates Departments are required to take forward many schemes that will have fallen wholly out with any formal prioritisation process. (Most notably the smallest schemes that are funded from revenue allocations or other means).

Given the small nature of these schemes, their volume (in number) and the requirement to make the best use of all of the staff resources available, these scheduling decisions will be taken by the Head of Estates and/or Head of Capital Projects in reflection of all the relevant considerations.

These considerations will include, but are not limited to:

- The priority allocated to schemes funded from minor capital by the Director of Operations
- Their assessment of the relative priority of the works in question
- Those resources available at any given time

Where they deem it necessary, the Head of Estates and/or Head of Capital Projects may also seek specific advice over the relative scheduling of project activity from relevant staff, including the Medical Director and/or Director of Nursing via the Director of Operations.

In summary:

- Minor works budget is delegated to the Director of Operations
- Funding from this budget based on submissions received and resource availability
- IA's submitted directly by services or may be re-directed by CSG
- IA's received directly from services may be re-directed to CSG if minor capital is not deemed to be an appropriate funding source

- For sums less than £5k, Director of Operations may waiver the requirement for an IA depending on sufficient written information to make an informed decision
- Allocation of technical staff to progress these developments will be devolved to the Head of Estates and Head of Capital Projects
- Formal feedback will be provided around those decisions taken to the services involved

# PROJECT MANAGEMENT GUIDE

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## 1 Aim of this Guide

The aim of this guide is to assist you when undertaking a project by outlining the basic project management processes. The application of such processes, when carried out effectively, will help ensure the success of a project. This guide is aimed primarily for those undertaking projects, which have a requirement for capital investment. However the general project management principles outlined in this guide can be applied to any project.

## 2 What is a Project?

A project may be defined as: a “unique” piece of work with a definable beginning and end, which requires to be managed.

Typical NHS projects may include procuring new buildings and/or equipment, introducing a new service development.

## 3 What is Project Management?

Project management may be defined as:

> “the overall planning, control and co-ordination of a project from inception to completion, aimed at meeting a client’s requirements ensuring completion on time, within budget and to the required quality standards.”

Project management brings a systematic common sense logical approach to planning and delivering a product or service. It differs from functional or line management. It is time limited and may cross existing functional boundaries. It is expected to bring about change.

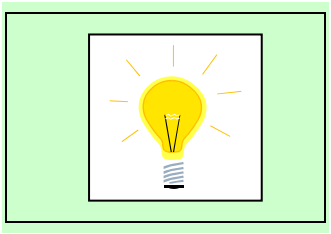
Successful projects that deliver their stated benefits require the deployment of project specific skills. This deployment relies on the availability of staff who possess these skills. These skills are generally in short supply and high demand. Recognising this, NHST has put in place arrangements to provide NHS specific project management training for those staff who are to manage or be closely involved in a major capital project. The training is organised by the Capital Projects Dept in association with the NHST Training & Development Dept.

## 4 Project Phases

Every project has five main phases. For those wishing to know more about the content of these phases further information is contained in section 5 of this guide. In addition, the Capital Projects Department will provide professional project management input to capital projects and will be pleased to provide informal advice and assistance at any time relating to the management of your project.

Every project has 5 main phases. Each of the phases are explained in more detail later but here is the basic process:

**1. INITIATING**



The Idea!
What?
Why?

**2. PLANNING**

Formalising the idea

**How? When? Who?**

Getting approval

Business Case process

**3. EXECUTING**

Getting up and running

Operational PM processes

**4. CONTROLLING**

Acquiring / Developing

Implementing

Procurement Processes

**5. COMPLETING**

Evaluating

Post-project evaluation

## 5.1 PHASE 1 - Initiating

The following guidance is aimed at giving a general overview and wider understanding of the main project phases. It is not a definitive guide to project management. The Capital Projects Department will be pleased to assist you in developing your project management arrangements.

Once the initial idea for a project has been established, the person, team or department that wishes to develop the project is required to describe the project in a prescribed framework.

In the initiating phase of a project there requires to be a clear description of what the project is about and why the project should be implemented.

The following check list is aimed at ensuring that the project documentation at the initiating stage contains the relevant information:

### 5.1.1 Objectives and Milestones

What is the objective of the project?
What are the main milestones within the project?
Have the success criteria for the project been stated?
It is important to explain what benefits the project will deliver.

### 5.1.2 Scope

The scope of the project outlines what the project will do and the areas it will cover. The scope also sets out what the project will not cover in order that there is no ambiguity.

### 5.1.3 Constraints

Have the constraints applying to the project been clearly stated within the initiating documentation? Constraints can include limits to the project that have been prescribed or conditions that have to be implemented by a given date.

### 5.1.4 Risks

It is vital at this stage that all major risks to the project are highlighted.

**Have the risks been identified, documented and appropriately allocated on a Risk Register or recorded on the NHS Tayside SMART Risk System?**

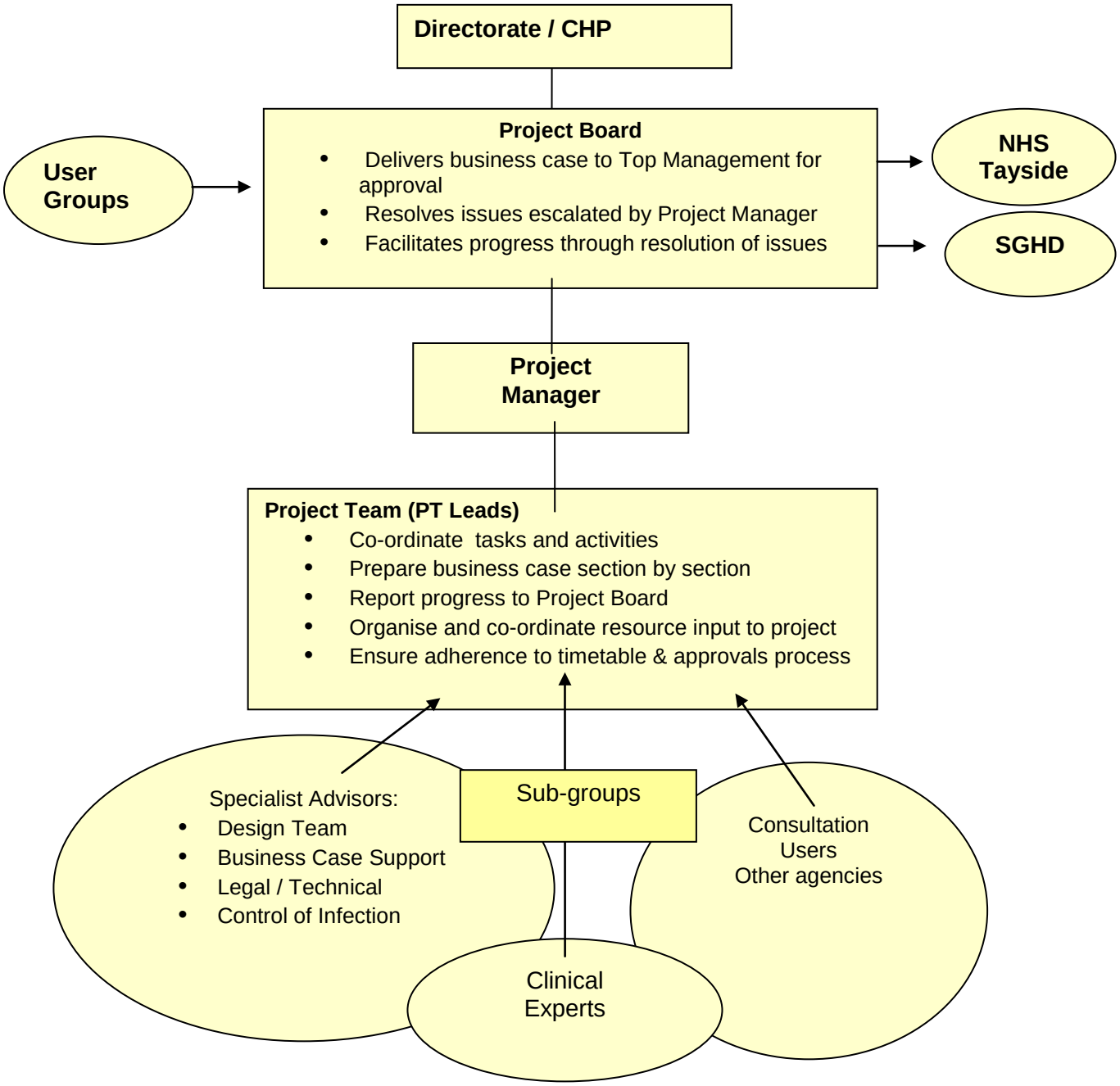
### 5.1.5 Project Organisation

A typical organisational structure for a major project is shown in section 5.1.6. below.

The following checklist points are relevant to the organisation of such projects:-

Have the Project Board members been identified?
Have the Project Team members been identified?
Does the Project Initiation Document (PID) explain what people resources and skills will be required to take the project forward?
Does the PID clearly explain who is the Project Sponsor? (the role of the project sponsor is described in the PID)
Has the change control process been identified and included in the PID?

5.1.6 Typical Project Organisational Structure




5.1.7 Approvals Process

As different projects will have different approval processes, it is worth having a discussion during the Initiation Phase to ensure that project team and board members understand the processes that will be followed as the project develops in order to secure appropriate approvals at each phase and to ensure that monies to support the project overall are available and committed.

The chart below shows a simplified version of the process and further assistance with this can be obtained by contacting the Head of Capital Projects.

| Projects greater than £5m | Projects between £1.5 and £5m | Projects below £1.5m |
|---|---|---|
| **Project Initiation Document** | **Project Initiation Document** | **Project Initiation Document** |
| **Initial Agreement** | **Initial Agreement** | **Standard Business Case** |
| **Outline Business Case** | **Standard Business Case** | |
| **Full Business Case** | | |

5.2 PHASE 2 – Planning

Once the PID and the Initial Agreement (IA) or Standard Business Case (SBC) have been approved in principle, the project will be allowed to proceed through this gateway to the development of the project plan.

The planning phase of a project looks at the how, when and who questions and defines the project activities in detail, such as deliverables, timescales, people resources, costs, benefits, dependencies etc.

Project plans can be constructed on project management software or can readily be documented on a spreadsheet.

The plan is divided into logical phases and within each phase a number of tasks are identified. The number of tasks will vary with the size and complexity of the project.

Within each phase of a project there will be a series of tasks that require to be completed to ensure that each particular phase is completed. Each task within a project will have a target date for completion and will have a person assigned to complete each task.

The Project Manager is required to secure the appropriate resources including people to complete the tasks having regard to the skills required and the timescales associated with the tasks.

A vital aspect of the project plan phase is to identify those risks that may have an adverse impact on the project. Failure to identify, assess and manage potential risks may cause a project to fail in terms of completion date, budget, benefit realisation and may have wider implications for the service.

It is important therefore that the risks should be ranked in order of their individual ability to affect the project and that strategies to manage the risks are put in place so that they do not adversely affect the success of the project. A Risk Register should be compiled and maintained.

The completion of this phase will result in an approved project plan. This plan will act as a baseline for monitoring the progress of the project.

5.2.1 Checklist – Planning Stage

Have the project phases been identified?
Have tasks within each phase been identified?
Have resources been allocated to each task?
Are target dates in place for each task and phase?
Are target dates, people resources sensible? Are they achievable, ie are there enough people to do the work and has enough time been allowed for the tasks?
Have project risks been identified, management strategies put in place and contingencies identified?
Is the funding allocated for the project still sufficient to deliver the project?
Have project dependencies been identified and communicated?
Is the Project Plan aligned to the overall objective and scope of the project?
Has the Communications Plan been completed?
Has the project plan been approved and signed off by the Project Board / Sponsor?
Have appropriate persons been involved in the planning phase? e.g. IT, Capital Projects Dept, Clinicians, Infection Control, Fire Safety, etc.
Please note that at this point the plan is frozen and any changes to the project after this point must go through the formal Change Control process and be signed-off by the Project Board/Sponsor.

## 5.3 PHASE 3 - Executing

The purpose of this phase is to ensure that everyone involved in the project knows what is required of them, i.e. who is doing what, why and when.

This phase normally starts with a formal project 'kick-off' workshop to outline the project, communicate what the objective is, how long it will take and what tasks are assigned to whom etc. The Capital Projects Department can facilitate such workshops if required.

The objective of this phase is to ensure that the project has a smooth start, avoiding delay or disruption.

It is important that the project team is composed of key individuals with the requisite expertise, e.g. a project team may involve representatives from Clinical Services, IT, Site Management, the Capital Projects Department, Infection Control, Finance, or other specialist advisers. It is important to identify all who need to be involved to make the project successful.

The following checklist contains points for the project workshop agenda. They will assist in securing an effective start to the project.

5.3.1 Project Owner/Sponsor

The project owner (sometimes called the project sponsor) is the senior representative for the service who has primary responsibility, and sets the strategic theme for the project

5.3.2 Project Manager

Communicates the project plan and sets out how the project will be run

- Ensures all Project Team members are clear re roles and responsibilities
- Explains the Risk Management procedures applicable to the project
- Explains how issues will be managed, i.e. the Issue Management Procedure (see Phase 4 below)
- Explains the Change Control procedure applicable to the project
- Outlines the reporting procedures and lines of communication
- Invites questions and answers and double check that everyone is clear on their individual roles.

PHASE 4 - Controlling

The purpose of this phase is to ensure that each task within the project is delivered on time, within budget and that the overall project is similarly successfully completed. The control phase is an important part of the project, and must be well managed.

The control phase of a project requires the Project Manager to regularly review progress and the action required at any stage to keep the project on target and to issue status reports to the project stakeholders.

Progress reviews take the form of project team meetings and an important aspect of the meeting is the review of 'issues' that have arisen, the review of project 'risks' and to review the overall 'progress to plan'.

'Issues' are events that have taken place or will take place that will affect the progress of the project. An 'Issues Log' should be created at the start of the project so that each issue can be recorded and assigned to a Project Team member(s) to resolve by an agreed date.

The Status Report is a method of reporting progress to the Project Board / Sponsor and others having an interest in the project, on a regular basis. The frequency of reporting is normally monthly but may increase in frequency as the project reaches critical stages.

The following checklist consists of the major elements, which require to be addressed within the control phase:

Checklist – Controlling Stage

- Are stakeholders aware of how they will be kept informed? i.e. meetings, reports etc
- Are project status reporting procedures in place?
- Is the issue management procedure and issue log in place?
- Consider the escalation procedure that requires to be in place, e.g. a project team member raises an issue with the project manager, the project manager assess the need to escalate, the project manager decides to raise issue with the project board having regard to the assessed impact of the issue
- Is the risk management procedure and risk management log in place?
- Is the change control process and change control log in place?

PHASE 5 - Completing

The purpose of the completing phase is to check that the key objectives of the project have been achieved and to assess the quality of the project in overall terms.

The main vehicle for this is a Post-Project Evaluation (PPE) and is normally led or facilitated by person(s) not directly related to the project but in conjunction with the Project Team e.g. another project manager.

The purpose of the PPE is to identify the aspects of the project that went well and those aspects of the project that could have been better. The knowledge gained from PPE will be used to improve future projects. A PPE is recommended for all capital projects and mandatory for capital projects over £1.5m and where Scottish Government approval was required for the project.

After occupation of the new building of over 18 months, a Post Occupancy Evaluation can be carried out, to assess how well the delivered project is addressing the objectives set out in its original business case. This can assess the quality of the built environment, and the activity it is supporting.

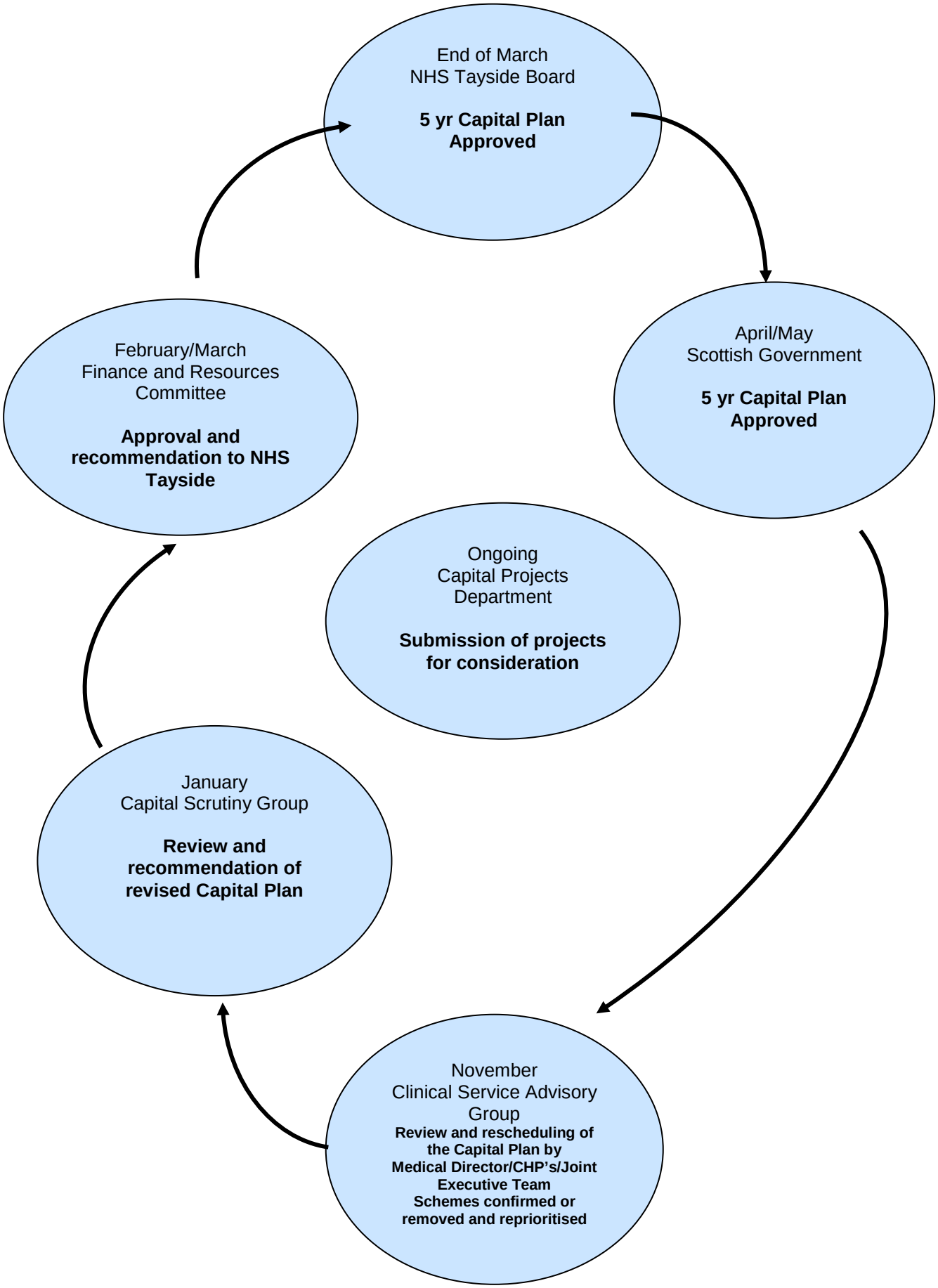
The Head of the Capital Projects Department will be pleased to provide guidance on post project evaluation and post occupancy evaluation methodology.

The following checklist contains the major elements needed to ensure a successful completion and closure of the project:-

5.5.1 Checklist – Completing Stage

- Have the benefits set out in the Business Case been realised?
- Have all tasks in each phase been completed?
- Has the project been signed off as completed by the Project Board/Sponsor?
- Is the project documentation up to date?
- Has date been arranged for the PPE & POE? This date is after the project has been completed minimum of 6 months for PPE and 18 months for POE in normal circumstances
- Have lessons learned been documented and communicated?
- Can Project Team be disbanded?

Capital Investment Plan Review Cycle
Example Timetable



The chart below is an extract of the Scottish Government CIG Assessment Tool used to determine whether a Business Case fulfils all relevant criteria and accurately sets out the NHS Board current position and future proposals and that all relevant clinical and financial issues have been addressed. The complete questionnaire can be found in HDL (2002) 87, Appendix D

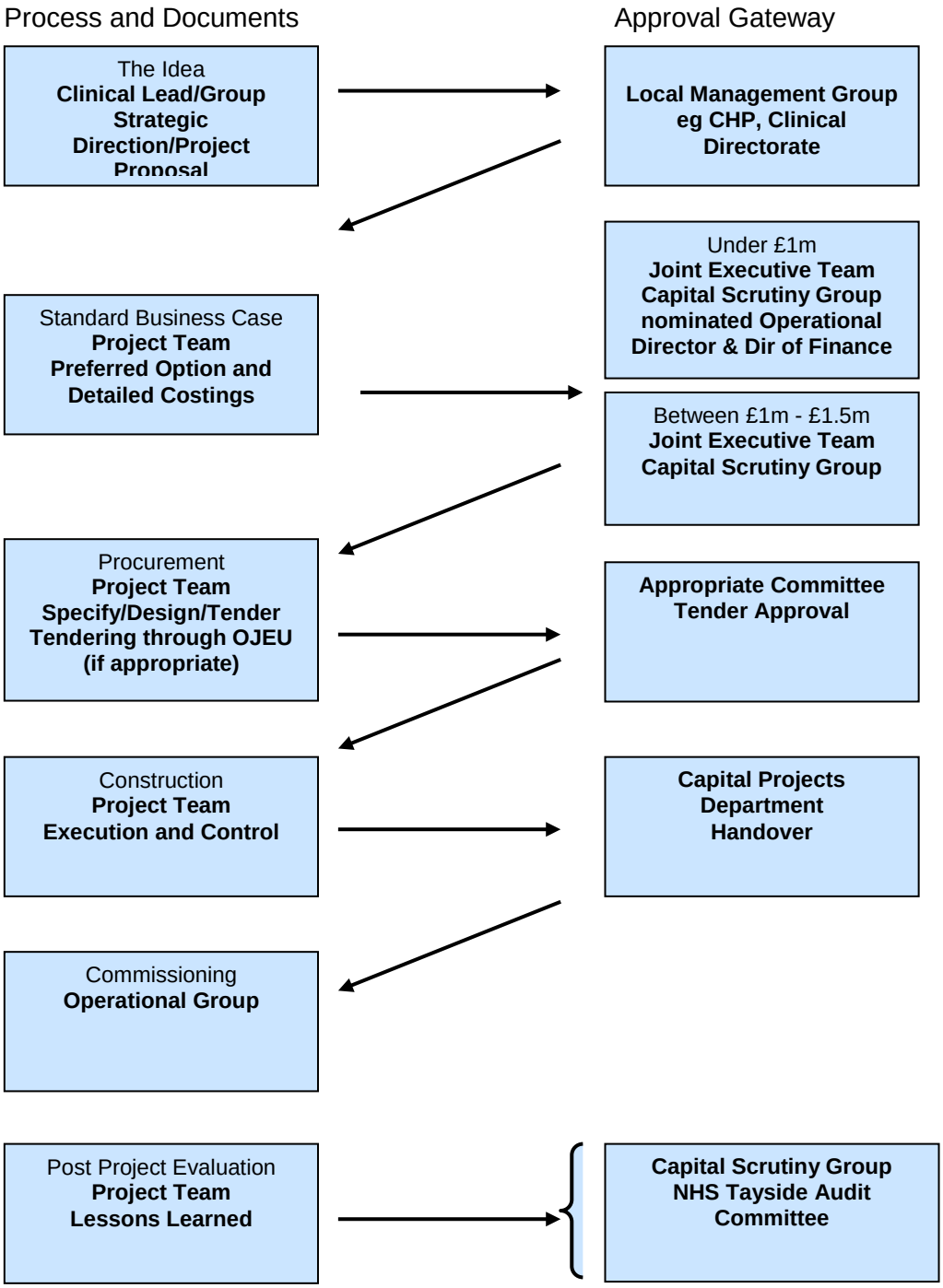
Scottish Government Health Department
Capital Investment Group

Assessment of Standard Business Case

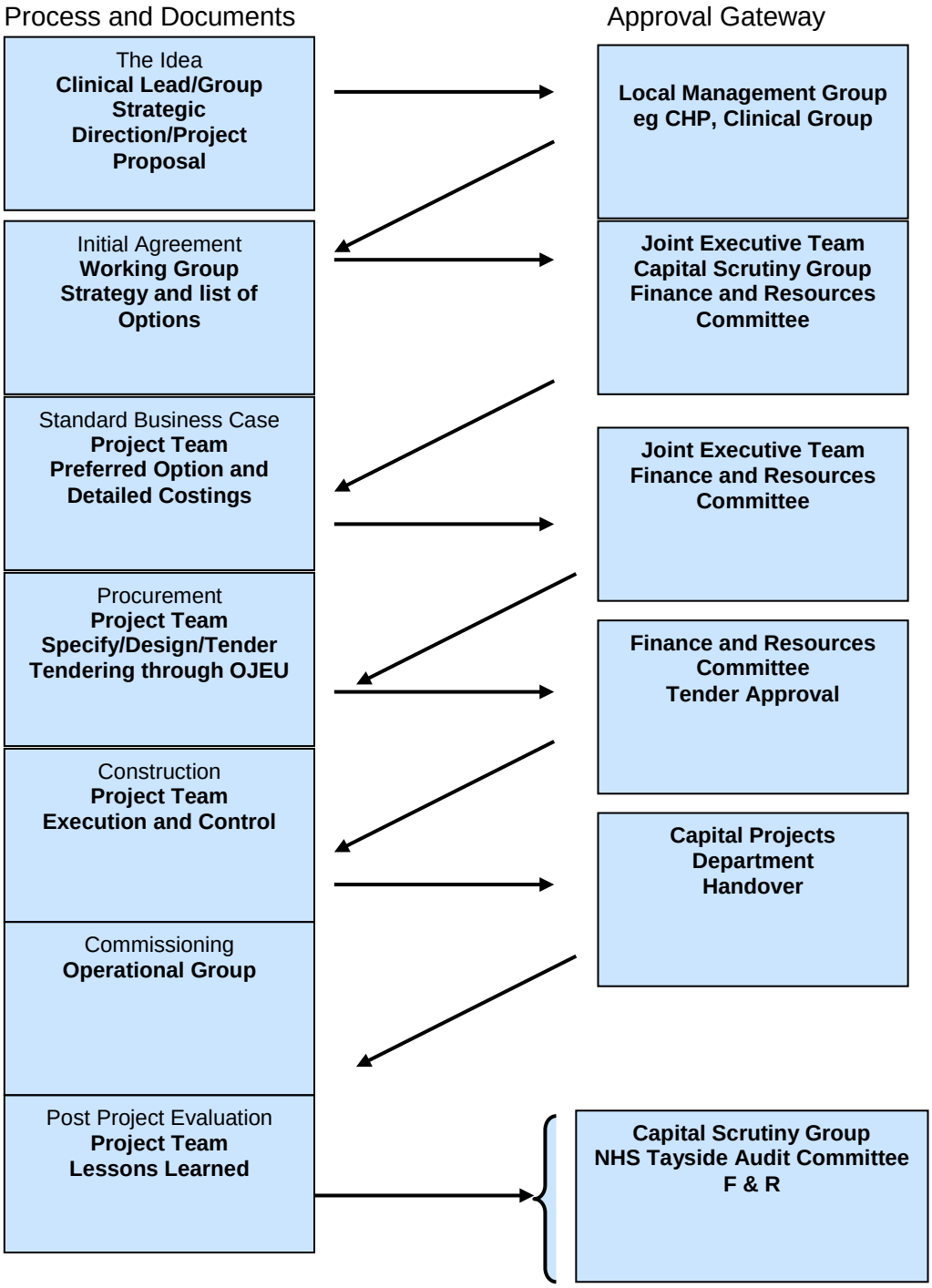
Submitting NHS body……..
Project Name……..
Approximate capital value……
PFCU reference number……
Date received by PFCU……
Date of Assessment……..

| Contents checklist | | | | Criteria to Assess Quality of Submission | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Yes | No | | Yes | No | N/A | Section Score | Section Weight | Score x Weight |
| 1 | Scheme Title (PFCU) | | | **Title clear and consistent with capital plan** | | | | | | |
| | | | | | | | | | 1 | |
| 2 | Introduction/ Background (PM) | | | | | | | | | |
| | **Strategic direction and objectives** | | | **Strategy and objectives clearly defined** | | | | | | |
| | **Explanation of clinical and other needs** | | | **Clear explanation of need** | | | | | | |
| | **Implications of not meeting need** | | | **Implications of not meeting need are persuasive and consistent with local health plan** | | | | | | |
| | **Brief explanation of services required** | | | **Clear and brief explanation provided** | | | | | | |
| | **Brief statement of proposed outcomes and benefits to patients** | | | **Outcomes and benefits are clear and consistent with strategy** | | | | | | |
| | | | | | | | | | 5 | |
| 3 | Description of the service concerned (PM) | | | | | | | | | |
| | **Description of Trust/NHS body and partners as appropriate** | | | **Development context is clear and an up to date profile of services has been provided** | | | | | | |
| | **Description of current service** | | | **A current service description has been provided along with activity levels** | | | | | | |
| | **Description of proposed service** | | | **Model of service is well explained**<br>**Evidence of whole system planning**<br>**Required service levels and quality specification well described**<br>**Objectives are clear, deliverable and ranked in priority order**<br>**Benefits are clearly set out and widely drawn**<br>**Clinical benefits are shown**<br>**Reasons why benefits cannot be delivered within existing estate are demonstrated** | | | | | | |
| | | | | | | | | | 10 | |

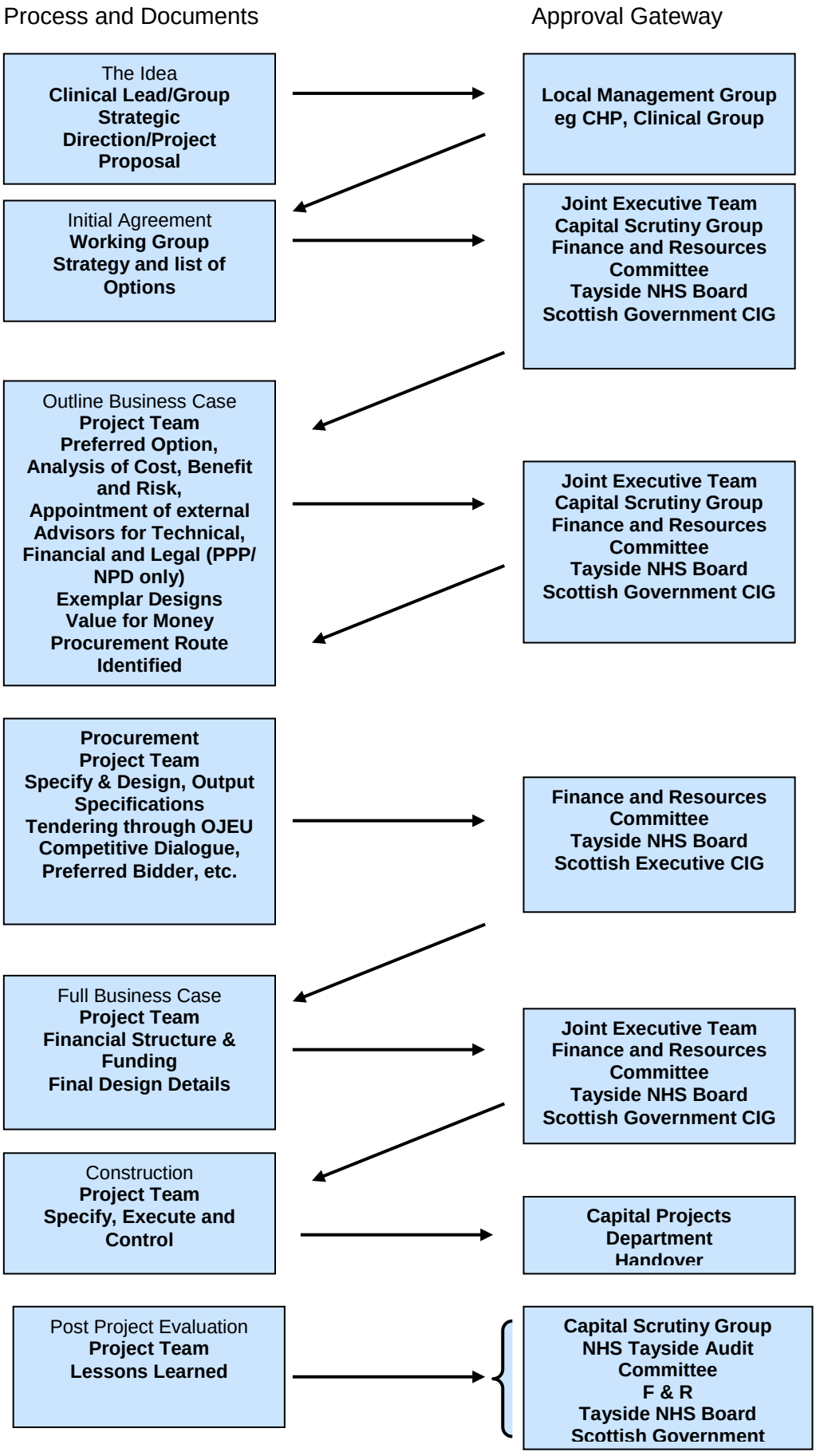
1.1 Projects up to £1.5m



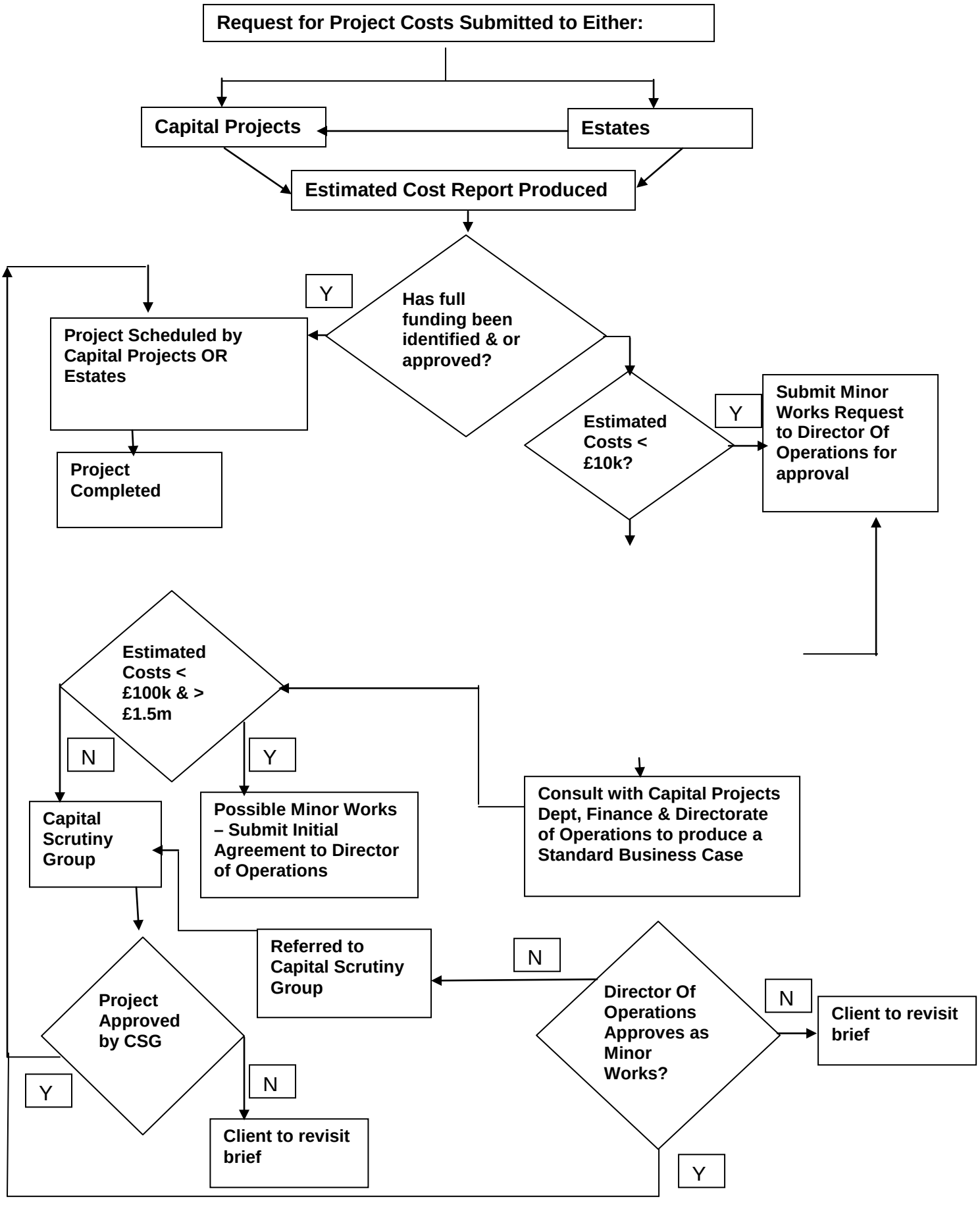
1.2 Projects between £1.5m and £3m



1.3 Projects over £3m



1.4 Minor Works Process



On completion this document should be submitted to the Director of Operations, for consideration and allocation of Finance Code if approval given

*1

| | |
|---|---|
| **Project Ref/Title** | |
| **Project Requested By** | |
| **Project Description** | |
| **Project Objectives** | |
| **Clinical/Legislative Requirement:** | |
| **Strategic Aim:** | |
| **Costs Provided By** | |
| **Cost Breakdown** | |

*2

| | |
|---|---|
| **Authorised By** | |
| **Authorised Date** | |
| **Financial Code** | |

*1 = to be completed by requesting officer * 2 – to be completed by D of O and Finance

Useful Web Links

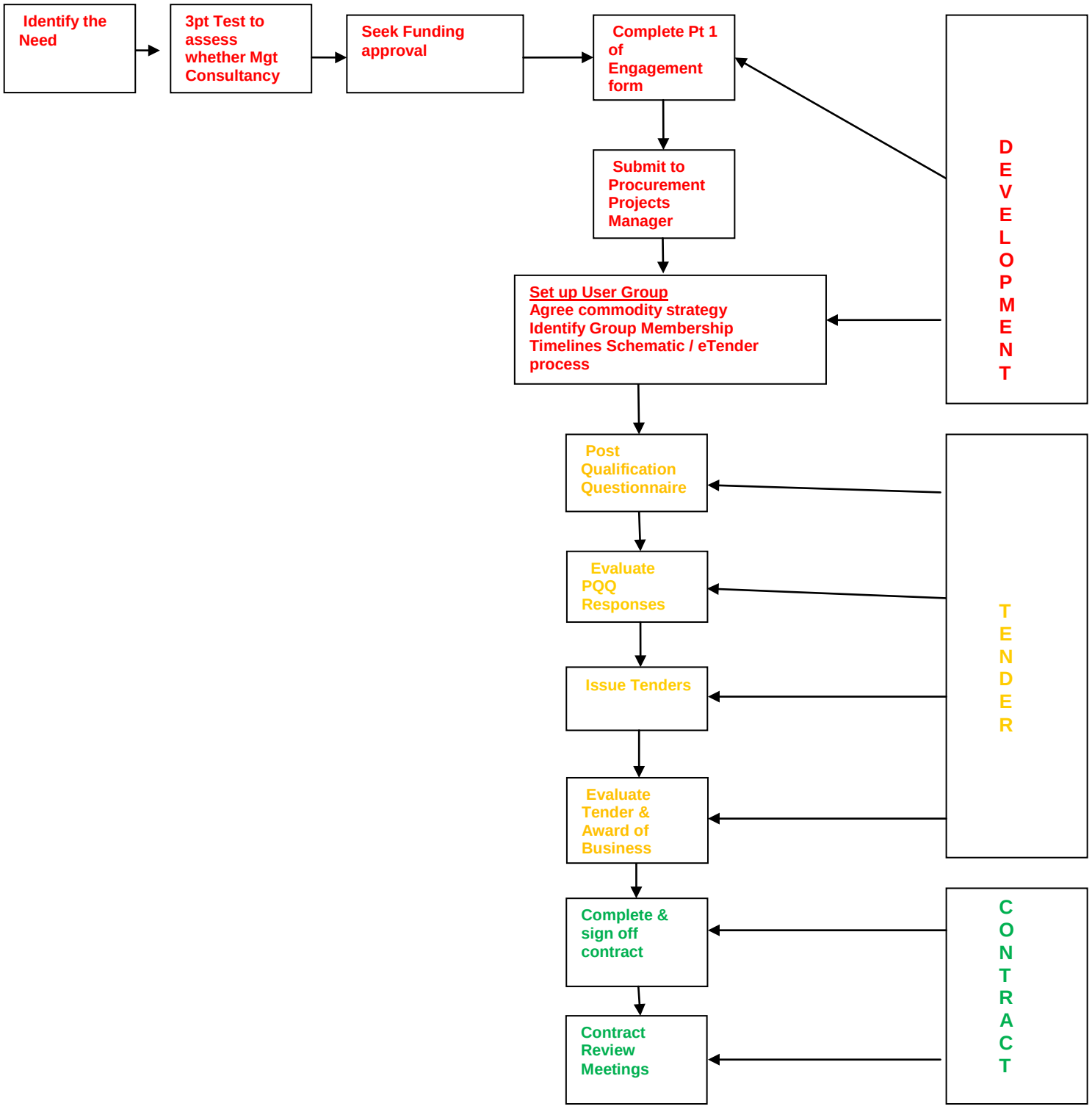
**The Scottish Capital Investment Manual (Business Case Guide) provides essential guidance on projects. It can be accessed through the Capital Projects Dept or on the Scottish Government web site at** http://www.scim.scot.nhs.uk/

- **NHS Tayside Capital Projects Dept Website -** http://www.nhstayside.scot.nhs.uk/cap_projects/index.shtml
- **NHS Scotland Property Transaction Handbook describes the processes for buying, selling and leasing property for the NHS. It can be accessed through the Capital Projects Dept or be found at on the SGHD website –** http://www.pfcu.scot.nhs.uk/PDFs/PropertyHanbook.pdf
- **NHS Scotland Capital Accounting Manual.** http://www.pfcu.scot.nhs.uk/index.htm
- **Proactive Risk Management -** NHS Tayside Intranet, search under Advanced Search, *Risk Management Guidance*
- **SGHD Capital Planning & Investment** http://www.show.scot.nhs.uk/pfcu/
- **Openness: Publication of PPP Contracts and Capital Business Cases** *HDL* (2002) 49 http://www.show.scot.nhs.uk/sehd/mels/HDL2002_49.pdf

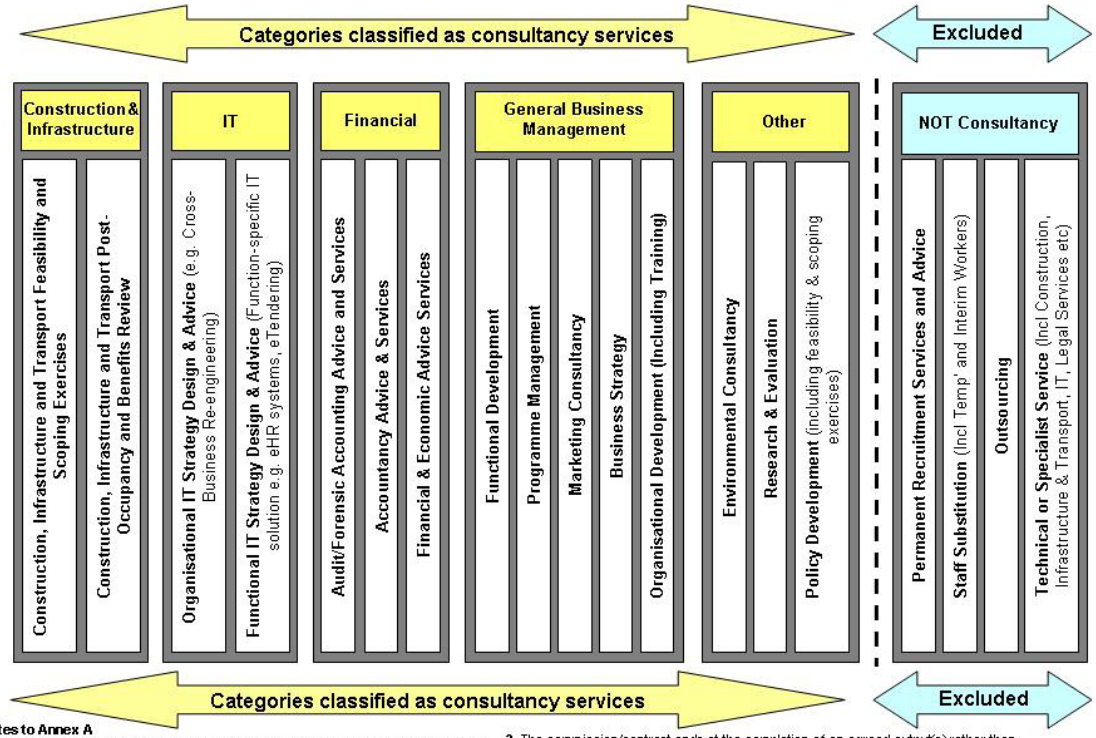
If you have any problems with obtaining the required documents contact the Head of Capital Projects Department on 01382 423101 or ext. 24020 who will be pleased to help.

Note: IT investment has slightly different financial thresholds, which are detailed in the SCIM. This guidance document is aimed at assisting staff in ensuring that their proposal is given due consideration towards a place in the Capital Plan through following the guidance on business case preparation, by understanding the approvals process and through the application of project management.

# PROCESS FOR THE ENGAGEMENT OF A MANAGEMENT CONSULTANT



# Annex A: Consultancy Categories and Three Part Test




**Notes to Annex A**

It is Annex A in conjunction with all of the Three Part Test that determines whether a service is defined as consultancy. The three tests are:

1. There must be an ongoing exchange of intellectual or professional information concerning the planning and/or delivery of the project or objectives between the Scottish Government and the supplier; and

**2.** The commission/contract ends at the completion of an agreed output(s) rather than the end of a set period of time (subject to the required project timescales); and

**3.** The day-to-day task management remains with the supplier. However, a regular reporting arrangement should be agreed with the Scottish Government contact to ensure that progress is recorded, that issues/risks are identified early, and that resolutions are agreed and delivered, where necessary.

**NHS TAYSIDE REGISTER OF ENGAGEMENT OF MANAGEMENT CONSULTANTS (v1. 0414)**

**SECTION 1 – PRE ENGAGEMENT REVIEW**

**PLEASE COMPLETE ALL SECTIONS BELOW. YOU WILL BE SENT SECTION 2 FOR COMPLETION AFTER THE ASSIGNMENT.**

**Description of Assignment**

| |
|---|
| |

**Estimated Cost**

| |
|---|
| £ |

**Basis of Decision to appoint a Management Consultant**

| |
|---|
| |

| | |
|---|---|
| **Project Manager:** | **Directorate:** |

**Budget Approved by**

| | |
|---|---|
| **By:** | **Finance Code: 4806** |

**Please confirm level of risk is acceptable**

| |
|---|
| |

**Has Intellectual Property Rights been considered**

| |
|---|
| |

**Please detail clear exit strategy**

**Financial Code to be charged (Detail Code 4806 must be used)**

_ _ _ _ _ _ /4806

**Proposed Period of Engagement**

**Please provide detail of assessment of whether internal resources can be used instead?**

**Please provide names of potential Management Consultants**

**Is the work to be competitively tendered? If not please give reasons.**

**Provide an assessment that benefit will accrue to NHS Tayside**.

**Who has approved the engagement? Please state Standing Committee**

| |
|---|
| Committee:<br><br>Date approved: |

**Please provide a capability assessment (references/experience you will seek).**

| |
|---|
| |

**What criteria will be applied to evaluate value for money?**

| |
|---|
| |

**This Schedule has been completed by (name and designation): -**

| | |
|---|---|
| **Name:** | **Designation:** |

**Date: -**

| |
|---|
| |

**FOR PROCUREMENT TEAM USE ONLY**

| **Project Ref No:** |
|---|

| **PECOS Order No:** |
|---|

**Contract completed and signed off**

| |
|---|

**Post Assignment Review Date: -**

| |
|---|

**PLEASE COMPLETE AND RETURN TO PROCUREMENT PROJECTS MANAGER**

**NHS TAYSIDE REGISTER OF ENGAGEMENT OF MANAGEMENT CONSULTANTS (rev 14)**

**SECTION 2 – POST ENGAGEMENT REVIEW**

**PLEASE COMPLETE ALL SECTIONS BELOW**

## Description of Assignment

| |
|---|
| |

| | |
|---|---|
| Project Manager: | Directorate: |

## Original Estimate of Costs/ Final Overall Costs

| | |
|---|---|
| **OEC £** | **FOC £** |

**Were costs contained within original estimate? If not please provide detail.**

| |
|---|
| |

**Name of Management Consultant**

| |
|---|
| |

**Period of Engagement**

**Was assignment completed on time?**

**What were the reasons for delay in completion?**

**Please detail any additional benefits delivered**

**Are there any other business areas who might benefit from outputs of the work?**

**Did the engagement recommend what was already suspected or planned?**

**Will the recommendations be implemented?**

**What were the key critical success factors that enabled this project to be a success?**

**What were the key lessons to be taken on board if repeating this exercise?**

**Will internal staff now be able to carry out this work in future?**

**SCHEDULE SIGN-OFF**

This Schedule has been completed by (name and designation): -

**Name:** **Designation:**

**Date: -**

**Outcome reported to Standing Committee**

**Committee:** **Date:**

**FOR PROCUREMENT TEAM USE ONLY**

**Order Number:-**

**Project Ref:-**

**PLEASE COMPLETE AND RETURN TO PROCUREMENT PROJECTS MANAGER**

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

**Item 21**

**BOARD09/2017**
**Tayside NHS Board**
**23 February 2017**

**NHS TAYSIDE ANNUAL REPORT AND ACCOUNTS 2015/16**

## 1. SITUATION AND BACKGROUND

NHS Tayside is required to publish an Annual Report. This is available at this link

http://www.nhstayside.scot.nhs.uk/Publications/PROD_208162/index.htm

The report must include standard information as directed by the Scottish Government Health Department. This includes NHS Tayside's annual accounts, activity data and annual feedback report for the year 2015/2016 as well as the outcomes from the Annual Review.

Tayside NHS Board approved NHS Tayside's annual accounts at its meeting on 23 June 2016.

## 2. ASSESSMENT

NHS Tayside is required to publish the Annual Report. The Board is asked to approve the NHS Tayside Annual Report and Accounts 2015/16.

## 3. RECOMMENDATIONS

The Board is asked to approve the NHS Tayside Annual Report and Accounts.

## 4. REPORT SIGN OFF

The Lead Officer is the Board Secretary.

**Ms M Dunning**
**Board Secretary**

**Ms L McLay**
**Chief Executive**

**February 2017**

**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 | 27 Oct 2016 | 1 December 2016 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| **Member** | | | | | | | | | | |
| Prof J Connell | Chairman | Present | Present | Present | Present | Present | Present | Present | Present | |
| Mrs G Costello | Nurse Director | Present | Apologies | Present | Present | Present | Apologies | Present | Present | |
| Dr A Cowie | Non Executive Member | Present | Present | Present | Present | Present | Apologies | Apologies | Present | |
| Mr D Cross | Non Executive Member | Present | Present | Present | Present | Present | Present | Present | Present | |
| Councillor D Doogan | Non Executive Member | Present | Apologies | Apologies | Present | Present | Present | Present | Present | |
| Mrs L Dunion | Non Executive Member | Present | Present | Present | Present | Present | Apologies | Present | Present | |
| Mrs J Golden | Non Executive Member | Present | Present | Present | Present | Present | Present | Present | Present | |
| Mr S Hay | Non Executive Member | Present | Present | Present | Present | Present | Apologies | Present | Present | |
| Mr M Hussain | Non Executive Member | Present | Present | Present | Present | Present | Present | Apologies | Present | |
| Councillor K Lynn | Non Executive Member | Apologies | Apologies | Present | Present | Present | Present | Present | Present | |
| Councillor G Middleton | Non Executive Member | Present | Present | Present | Present | Present | Apologies | Apologies | Present | |
| Ms L McLay | Chief Executive | Present | Present | Present | Present | Present | Apologies | Present | Present | |
| Dr R Peat | Non Executive Member | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | |
| Mr H Robertson | Non Executive Member | Present | Present | Present | Present | Present | Apologies | Present | Present | |
| Mrs A Rogers | Non Executive Member | Present | Present | Present | Present | Present | Present | Present | Present | |

**Tayside NHS Board 1 April 2016– 31 March 2017**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Dr A Russell | Executive Member | Present | Present | Present | Present | Present | Apologies | Present | Present | |
| Prof M Smith | Non Executive Member | Present | Apologies | Present | Present | Present | Apologies | Present | Apologies | |
| Mrs S Tunstall-James | Non Executive Member | Present | Present | Present | Present | Present | Present | Present | Present | |
| Dr D Walker | Executive Member | Apologies | Apologies | Apologies | Present | Present | Apologies | Present | Apologies | |
| **Attendees** | | | | | | | | | | |
| Mrs J Alexander | Partnership Representative | Present | Apologies | Present | Apologies | Present | Apologies | Apologies | Present | |
| Mr L Bedford | Interim Director of Finance | Present | Present | Present | Present | Present | Present | Present | Present | |
| Dr A Cook | Medical Director – Operational Services | Present | Apologies | Apologies | Apologies | Present | Apologies | Present | Present | |
| Mr G Doherty | Director of Human Resources | Present | Present | Present | Present | Present | Present | Present | Present | |
| Ms M Dunning | Board Secretary | Present | Present | Present | Present | Apologies | Present | Present | Present | |
| Mr T Gaskin | Chief Internal Auditor | Present | Apologies | Apologies | Apologies | Present | Apologies | Present | Present | |

## STAFF GOVERNANCE COMMITTEE

Minute of the above meeting held at 2:00pm on **Tuesday 27 September 2016** in the Board Room, Kings Cross, Hospital.

**Present**
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
Mr Munwar Hussain, Non Executive Member, Tayside NHS Board
Mr Raymond Marshall, Staff Side Representative, NHS Tayside
Mrs Alison Rogers, Non Executive Member, Tayside NHS Board
Professor Margaret Smith, Non Executive Member, Tayside NHS Board
Mrs Sheila Tunstall-James, Non Executive Member, Tayside NHS Board

**Apologies**
Ms Jenny Alexander, Co-Chair Workforce and Governance Committee, NHS Tayside
Dr Andrew Cowie, Area Clinical Forum Chair, NHS Tayside
Ms Lesley McLay, Chief Executive, NHS Tayside
Mrs Jennifer Mudie, Associate Director of HR – Resourcing, NHS Tayside
Mr Hugh Robertson, Non Executive Member, Tayside NHS Board

**In Attendance**
Ms Debbie Balsham, Family Nurse Partnership, NHS Tayside (Observer)
Ms Margaret Dunning, Board Secretary, NHS Tayside
Ms Jenni Jones, Associate Director - Development, NHS Tayside
Mrs Pat Millar, Head of Knowledge and Skills, NHS Tayside
Mr Iain McEachan, HR Business Lead
Mr Ian McLaren, Head of HR - Resourcing (Planning and Information)
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 to the meeting especially Ms Balsham who would be observing the meeting as part of her development.

**2. Apologies**

The apologies were as noted above.

**3. Minute of Previous Meeting**

**3.1 Minute of Meeting held on 21 June 2016**

The Staff Governance Committee Minute of the meeting held on 21 June 2016 was approved on the motion of Mrs Sheila Tunstall-James and seconded by Mrs Alison Rogers.

**3.2 Committee Chair's Assurance Report – Staff Governance Committee Minute – 21 June 2016**

The Committee Chair's Assurance Report – Staff Governance Committee Minute (21 June 2016) was noted and had been submitted to the Board**.**

- The Local Partnership Fora Chairs had met to discuss issues, roles, remit and responsibilities.
- Work would be undertaken to provide clear links and align the Local Partnership Fora, Area Partnership Forum and Staff Governance Committee together.
- A report had been written by Mr Marshall and Mr Smith looking at the reporting structures for the Partnership Fora. This was still to be agreed by the Area Partnership Forum.

The Staff Governance Committee:-

- **Noted the Committee Chair's Assurance Report 21 June 2016**

**3.3 Action Points Update**

The following was discussed:-

- **Item 6.1 Supporting Staff Who Are Carers** – an information pack had been produced for staff. The Organisation has received an award from Carers Scotland for the work carried out by Rev. Gillian Munro and Ms Jackie Bayne.
- Mrs Golden and Mr Doherty were to discuss finding the placing of a pop up sign on Level 7 signposting Staff who are Carers to areas where they could discuss Welfare Rights.
- **Item 7.1 Safe & Improved Working Environment** – it was unsure whether this action was completed. Comparative Data was not available from other Boards. Discussions following on from the Staff Survey had shown an increased concern from staff in relation to public aggression towards them by generic users and members of the public. Health & Safety now sat as a responsibility of the Chief Operating Officer and an update would be provided to the December 2016 or March 2017 meeting. **L Wiggin**

**4. Matters Arising**

Discussion centred on the Influenza Immunisation programme. The Organisation was looking at pragmatic solutions to increase the uptake within the Organisation. An action plan for a test of change would be available October 2016

**5. Declaration of Interests**

There were no declarations of interest.

**6 Presentations**

**6.1 Staff Appreciation and Recognition Awards**

Mrs Rogers advised that the Quality Awards had run for 4 years with an honest and developed process however there were a number of reasons why it fell into abeyance.

The Star Awards were being developed with Ms. Wiggin, Mrs Tunstall-James, Mrs Golden and Mrs J Jones. This would be introduced to ensure staff felt valued and ensure the ethos and culture of the Organisations was taken

forward. The Star Awards were meant to provide a tangible effect for the Organisation. There was a need to recognise staff work and the Awards were to be open to all. A new system would be developed which would see the benefit and recognition in place for staff to feel valued every day.

There were categories for individuals, teams, clinical and non-clinical with work concentrating on care, compassion for patients and carers. The Awards were inclusive as anyone could nominate and ensure recognition was received for every day work in making a difference for patients.

An award ceremony would be arranged for April/May 2017 with nominations being received in January 2017. A shortlist would be produced in February 2017 with judging taking place in March 2017. Judges would be required and the Group were requesting nominees from the Local Partnership Foras, Integrated Joint Boards, Spiritual Care, Area Partnership Forum and Area Clinical Forum. Various groups would take ownership and promote the awards

Mrs Rogers was asking the Committee to disseminate the knowledge of the Star Awards widely.

The following was discussed:-

- Nominations would be made electronically from Primary and Secondary Care
- Concerns were highlighted that Support Services did not have access to electronic equipment. The Group were looking at utilising a "hotline".
- Engagement should be made through the media and public. A communications plan would be implemented at the meeting taking place within the next 4 weeks. The Dundee Courier & Advertiser had declined to provide sponsorship. Other avenues were being explored.
- An update report would be provided to the December 2016 meeting **A Rogers**

The Staff Governance Committee:-

- **Noted the update**
- **Supported the Star Awards and the work being undertaken**
- **Agreed to receive an update to the December 2016 meeting** **A Rogers**

**7. Staff Governance Standards**

**7.1 Taking Root – Our Collaborative Leadership Commitment**

This item was deferred until December 2016 **N Owen**

**7.2 Statutory Mandatory Training (SGC/2016/43)**

Mrs Millar was seeking support to align reporting of compliance with statutory and mandatory training activity to Staff Governance, Area Partnership Forum and Local Partnership Fora's.

Work was developing around 9 core topics which were:-

1. Equality, Diversity and Human Rights
2. Health, Safety and Welfare
3. Fire Safety

4. Infection Prevention and Control
5. Manual Handling
6. Violence and Aggression (Personal Safety Awareness)
7. Information Governance
8. Public Protection (includes Adult and child Protection)
9. Resuscitation (summoning clinical assistance)

The Staff Governance Committee highlighted:-

- Strong support for the work being carried out however there were issues in relation to uptake from staff i.e. NHS Tayside had the lowest uptake of the flu vaccination
- Concerns were noted in relation to Health & Safety training and the programmes currently running and the ongoing recording of training activity. There are 6 core training elements with the Knowledge Skills Framework (KSF) and queries were raised as to whether they were all reflected in the training. Mrs Millar reassured the committee that they were, however it is important to note that not all staff are covered by the KSF.. Appraisals should increase the percentage of those completing KSF, and reporting would move forward in the coming years. Mrs Tunstall-James requested assurance that improvements and training were being carried out at all levels. Mr Doherty highlighted that the Framework being developed would provide comprehensive detailed information. The Framework would be presented to the March 2017 meeting.

The Staff Governance Committee:-

- **Agreed to realign reporting requests via the Area Partnership Forum for Statutory Mandatory Training Compliance, KSF and iMatter.**
- **Approved the 9 core Statutory Mandatory Training Modules as priority focus for NHS Tayside.**
- **The Framework for Statutory/Mandatory Training would be provided to the March 2017 Staff Governance Committee** **P Millar**

**7.3 NHS Tayside Board Members Input into Programme of "Welcome Events" for New Employees (SGC/2016/44)**

Mrs Jones advised that discussions had taken place at Board Level to explore the potential for developing "Welcome Events" for Medical, Nursing, Allied Health Professionals, students and new recruits joining the Organisation with Board Membership participation.

Work would centre on supporting individuals during the early stages of their career. This would create a shared understanding of the Organisations vision, values and expectations.

The Staff Governance Committee:-

- **Approved the adoption of Developing Our Culture discovery phase**
- **A report regarding Board Member involvement to "Welcoming New Starts" is provided the Staff Governance Committee March 2017** **JJones**

**8. Governance Risks**

**8.1 Strategic Risks Board Assurance Framework**

- **Medical Workforce – Strategic Risk 95 (SGC/2016/46)**

The risks have been reviewed and template has been framed for Doctors in training. Section 5 of the report provides information relating to further action being taken to mitigate risks. Risk would be reframed for the wider Organisation as all areas were looking to reshape the workforce.

The Staff Governance Committee noted the following steps which had become or were being implemented to mitigate the risk:-

- **New Deal Monitoring for each rota twice per year, with support to Lead Clinicians, managers and doctors in training in relation to the understanding, management and individual responsibilities to comply with the regulations, e.g. monitoring guidelines for each rota for each Trainee pre-monitoring talks to all trainees, non-compliance rotas reported to Rota master and an identified consultant.**
- **Local Workforce Plans developed by General Managers and Lead Clinicians to redesign models of service delivery to reduce the reliance on doctors in training**
- **The Corporate Workforce Plan and Projections to inform Scottish Government in relation to training numbers.**
- **Intelligence gained through and contribution to influencing power of the North of Scotland Medical Workforce Planning Group.**
- **Adjustment of consultant on-call rota to ensure adequate senior clinician decision making is available when the more ST grades are unified.**
- **Employing Speciality Doctors and Locums without training numbers to minimise gaps in service delivery as well as Agency Doctors**
- **Piloting the introduction of Physicians Associates to gauge impact on rostering compliance.**
- **Engagement in social media, media network advertising to target the passive talent market.**

**8.2 Strategic Risks Board Assurance Framework**

- **Workforce Optimisation – Strategic Risk 58 (SGC/2016/47)**

Mr Doherty highlighted that risk reporting was due to be refreshed in December 2015. Page 2 of the report provide information mitigating the steps being taken for future reporting. Concerns were highlighted in relation to the shortage in training doctors.

The Staff Governance Committee:-

- **Noted the contents of the report**

**8.3 Strategic Risks Board Assurance Framework**
**Nursing & Midwifery Workforce – Strategic Risk 58 (SGC/2016/48)**

Mr Doherty advised the report had not been received and would discuss this with the Nurse Director to ensure reporting was received for each meeting.

The Staff Governance Committee:-

- **Noted no update report had been received**
- **Agreed the approach for future reporting**

**9. Monitoring Reports**

**9.1 Workforce Information Quarter 1**

- **Future Assurance Reporting (SGC/2016/49)**

It was noted that information being mapped would provide a comprehensive insight in future years using job families.

Concerns were highlighted that there had been significant increase in the number of whole time equivalents (WTE) for the Integrated Joint Boards. However, this could be attributed to recoding.

A meeting has been undertaken with Staff Side representatives in relation to the concerns around the accuracy of reporting regarding disciplinary cases, grievances, bullying and harassment. The Local Partnership Fora would be provided information to discuss this at a local level. Further discussion on supporting the Local Fora around this work would take place out with the meeting.

The Board had requested information on how future assurance would be achieved. A methodology would be developed and future reports would be shared with the Board.

Mr Rogers advised that Whistleblowing reporting has changed. Communications and engagement had to be meaningful.

The Staff Governance Committee:-

- **Noted the content of the report**

**9.2 Promoting Attendance at Work (SGC/2016/50)**

The following was discussed:-

- Queries were raised as to how to manage the rate drops shown in Quarter 1 across the year. Possible seasonality monitoring could provide positive news for the Organisation.
- Stress, Anxiety and Depression was highlighted as an area of concern. Questions were asked as to how NHS Tayside compared to other Boards. Mr Smith advised that work was being carried out to combat stress in the workplace however so mar no significant inroads had been made.

- A report would be provided in March 2017 on how the Organisation approach supporting individuals with stress/anxiety. This would be part of the work of the Wellbeing.
  Work on ensuring Policies were being applied carefully across different Directorates. Mr Doherty advised that this work could be taken forward by the Local Partnership. Mr Doherty and Mrs Golden would discuss out with the meeting and take matters forward.
- Did not Attend rates within Occupational Health appeared high and a report looking into this would be provided in December 2016. Work was being undertaken by Dr Lethwaite to remind managers on the referral system.

The Staff Governance Committee:-

- **Noted the progress and seek reassurance through the Area Partnership Forum and Local Partnership Fora that the iMatter issues highlighted in the paper are considered and reported.**

**9.3 Recruitment Activity (SGC/2016/51)**

Mr Doherty advised that the overall staff turnover rate for the period had dropped. Vacancies within Mental Health were noted and a report requested for December 2016 meeting. A recruitment strategy refresh was underway and would also be provided to a future meeting of the Committee.

All available newly qualitified practitioners from Dunde University had been offered posts. Work was being undertaken to improve the process for NHS Tayside. Recruitment undertaken in other Boards was being reviewed to assess learning. It was highlighted that other Boards did not undertake similar interview processes. Work would be done to actively recruit from other Universities such as Edinburgh and Glasgow. Mrs Mudie and Ms Wiggin were currently looking at the recruitment process. Mr Marshall would link into this as lead partnership representative. There was also a meeting with the Chief Executive to discuss planning around student numbers and recruitment.

There were concerns around Mental Health recruitment and this would be included in future reporting.

The Staff Governance Committee:-

- **Noted the content of the report**
- **Agreed Mental Health recruitment would form part of future reporting**

**9.4 Staff Experience & Engagement – Embedding iMatter as a Vehicle to Underpin an Improvement Culture (SGC/2016/52)**

Mrs Jones highlighted that from January 2017 implementation of iMatter across the Organisation would be complete with Directors, Chief Officers and the Chairman being responsible for continuous improvement within their Directorates. Local Partnership Forums would have overall governance around the continuous improvement.

Positive evidence of engagement had been through the rates of returns received

from Support Services which was around 51%. This was a significant increase from the National Staff Survey responses.

The Staff Governance Committee:-

- **Noted the content of the report**
- **Noted the comparison with the national report**
- **Noted the support available to Directorates**
- **Noted the strategic group encourage and support the message**
- **Noted the role of the Local Partnership Forum**
- **Noted the consideration of the requirement of the Local Partnership Forums Progress Reports**
- **Celebrated the achievements to date**
- **Noted the exit strategy for "business as usual"**

**9.5 Equality & Diversity Employment Measures Update (SGC/2016/53)**

Mr Smith highlighted the measures for monitoring previously agreed:-

1. Equality & Diversity Learnpro Module
2. Percentage of panels which have a panel member who attended Certificate to Recruit Training
3. Change the percentage of staff who indicate "declined" or "Unknown" against protected characteristics information

Mr Smith told the Committee that there had been an increase in the number of staff completing the Learnpro Module. The numbers of staff completing the training for the Certificate to Recruit was excellent in Angus, Perth & Kinross however figures for Dundee indicated a need for further work.

The Organisation had to recruit fairly across all areas. Areas of risk required a focused approach which had been carried out; for example within the Medicine Directorate where current uptake figures showed an improvement.

A decision would be made in December 2016 to decide whether recruitment panels could be undertaken without a member holding a Certificate to Recruit being on the Panel. **C Smith**

A strategy for improvement would be presented to the December 2016 meeting.

The Staff Governance Committee:-

- **Noted the work of the Public Sector Equalities Group and endorsed the improvement measures detailed in the Report**
- **Agreed a Strategy of improvement be provided to the December 2016 meeting** **C Smith**

**9.6 Exit Questionnaire (SGC/2016/54)**

Mr Doherty advised that an electronic version of the exit questionnaire had been developed to provide better understanding of why staff were leaving the Organisation.

A number of areas were of concern such as 2.9% of the total completed forms indicating they were leaving the Organisation due to bullying and harassment issues. Further work would continue to be carried out to better understand the emerging trends and improve exit questionnaire response rates.

The Staff Governance Committee:-

- **Noted the information outlined in the Exit Questionnaire Report**

**10. Annual Reports/Work Plans/Plans**

**10.1 Staff Governance Committee Terms of Reference and Workplan (SGC/2016/55)**

Mr Doherty advised:-

- The Terms of Reference were to be further re-aligned to the current priorities
- A full review was to be undertaken with a full discussion to be held at the December 2016 meeting.
- A Sub-Group would be set up to discuss "People Matter" which would provide a more informed discussions

The Staff Governance Committee:-

- **Noted the updated Terms of Reference**
- **Mrs Rogers would provide amendments to Mrs Owen** **A Rogers/N Owen**

***11. *For Noting* - If Items Required Discussion Please Raise with the Chair**

**11.1 Area Partnership Forum Board Report 25 May 2016 (SGC/2016/56)**

The Staff Governance Committee:-

- **Noted the Area Partnership Forum Board Report 25 May 2016**

**11.2 Area Partnership Forum Board Report 27 July 2016 (SGC/2016/57)**

The Staff Governance Committee:-

- **Noted the Area Partnership Forum Board Report 27 July 2016**

**11.3 Internal Audit Review (SGC/2016/58)**

The Staff Governance Committee:-

- **Noted the Internal Audit Review**

**12. Items for Adoption**

**12.1 HR Policies (SGC/2016/59)**

- **Fixed Term Policy**

The Staff Governance Committee:-

- **Endorsed the Fixed Term Policy**

**13. Items for Information**

**13.1 Area Partnership Forum Minute 25 May 2016**

The Staff Governance Committee:-

- **Noted the Area Partnership Forum Minute 25 May 2016**

**13.2 Area Partnership Forum Minute 27 July 2016**

The Staff Governance Committee:-

- **Noted the Area Partnership Forum Minute 27 July 2016**

**13.3 Joint Negotiating Committee Minute 6 April 2016**

The Staff Governance Committee:-

- **Noted the Joint Negotiating Committee Minute 6 April 2016**

**13.4 Workforce & Governance Forum Minute 4 May 2016**

The Staff Governance Committee:-

- **Noted the Workforce & Governance Forum Minute 4 May 2016**

**13.5 Record of Attendance**

The Staff Governance Committee:-

- **Noted the Record of Attendance for information**

**14. Any Other Competent Business**

Mrs Tunstall-James highlighted the length of time taken in relation to disciplinary hearings in relation to Medical staff. Mr Doherty advised that strict terms and conditions had to be adhered to however Mr Christopher Smith would discuss any concerns relating to specific cases with Mrs Tunstall-James outside of the meeting.

**C Smith/S Tunstall James**

**15. Date and time of the next meeting**

The next meeting of the Staff Governance Committee will take place on Tuesday 13 December 2016 at 2pm in the Board Room, Kings Cross.

**16. 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)**

**16.1 Reserved Minute of the Staff Governance Committee 21 June 2016**

The Staff Governance Committee Minute of the meeting held on 21 June 2016 was approved on the motion of Mrs Sheila Tunstall-James and seconded by Mrs Alison Rogers subject to the following amendments:-

**Corporate Workforce Plan 2016 Workforce Projections – Page 3 Paragraph 9 3rd line should read:-** //...Employee Director and the workforce plan and projections had not been agreed in partnership.

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 27 September 2016 and was approved by the Committee at its meeting held on Tuesday 13 December 2016.

……. ……..

Chair Date

# Minute

# NHS Tayside

UNIVERSITY STRATEGIC LIAISON COMMITTEE

Minute of the Universities Strategic Liaison Committee meeting held at 1400 on 1 November 2016 in Board Room, Level 10, Ninewells Hospital, Dundee.

| Present | |
|---|---|
| Professor John Connell | Vice Principal, University of Dundee |
| Dr Andrew Cowie | Non Executive Member, Chairman Area Clinical Forum (Chair) |
| Professor Pete Downes | Principal, University of Dundee |
| Dr Jacob George | Research & Development Director, NHS Tayside |
| Mr Robin Ion | Divisional Leader, Division of Nursing and Counselling, Abertay University |
| Professor Gary Mires | Dean & Professor of Obstetrics, Co-Director Academic Health Sciences Partnership |
| Dr Janice Rattray | Dean's Representative for the School of Nursing and Midwifery, University of Dundee |
| Professor Andrew Russell | Medical Director, Tayside NHS Board |
| Professor Margaret Smith | Non Executive Member, Tayside NHS Board |

| In Attendance | |
|---|---|
| Mr Lindsay Bedford | Director of Finance, NHS Tayside |
| Mrs Nicki Owen | Committee Support Officer, NHS Tayside |
| Dr Norman Pratt | Area Clinical Forum Representative, NHS Tayside |

| Apologies | |
|---|---|
| Mr Allan Burns | Chairman, Fife NHS Board |
| Mrs Gillian Costello | Nurse Director, NHS Tayside |
| Mr Doug Cross | Non Executive Member, Vice Chairman, NHS Tayside |
| Professor David Crossman | Dean of Medicine, St Andrews University |
| Ms Margaret Dunning | Board Secretary, NHS Tayside |
| Professor Simon Guild | Nominee for Professor Hugh MacDougall, St Andrews University |
| Professor Mark Hector | Dean of the Dental School, University of Dundee |
| Mr David Howie | Area Clinical Forum Representative, NHS Tayside |
| Mrs Judith Golden | Employee Director, Tayside NHS Board |
| Professor Ray Lloyd | Head of School, Social and Health Sciences (Principal's nominee), Abertay University |
| Professor Clare McKenzie | Postgraduate Dean, NHS Education Scotland |
| Ms Lesley McLay | Chief Executive, NHS Tayside |
| Mrs Jennifer Mudie | Associate Director of Human Resources – Resourcing, NHS Tayside |
| Professor Dilip Nathwani | Director of Undergraduate Teaching, NHS Tayside |
| Professor Nigel Seaton | Principal, Abertay University (left meeting at 1030) |
| Professor Morwenna Wood | Director of Medical Education, NHS Fife |

Dr Andrew Cowie in the Chair

1 **CHAIRMAN'S WELCOME AND INTRODUCTION**

Dr Cowie welcomed all to the meeting. He advised that discussion would centre on shaping strategic thinking for the future of services.

2 **APOLOGIES**

Apologies were noted as above.

3 **MINUTE OF PREVIOUS MEETING**

3.1 **MINUTE OF PREVIOUS MEETING – 17 September 2015**

The Minute of the Meeting of the Universities Strategic Liaison Committee held on 17 September 2015 was accepted as an accurate.

3.2 **MATTERS ARISING**

There were no matters arising.

4. **DECLARATION OF INTERESTS**

4.1 **Declaration of Interests – Agenda Items and Any Updates to the Register**

There were no declarations of interests.

5 **STRATEGIC DIRECTION**

**5.1 Academic Health Science Partnership in Tayside (AHSP)**

Professor Mires provided an update to the Committee and advised that Professor Nathwani was unable to attend the meeting.

He highlighted:-

- Professor Mires and Professor Nathwani shared the Co-Directorship of the Academic Health Science Partnership (AHSCP).
- His thanks were expressed to Professor Jill Belch who set up the AHSP however she had now retired.
- A review had been undertaken of the Executive Group and a number of executives had been invited to manage and direct ongoing/future projects.
- Discussions were ongoing with Medtronic regarding partnership working on health skills. The Partnership was looking to develop an electronic training centre for skills such as laparoscopic techniques.
- St Andrews and the University of Dundee were working together on the Scottish General Graduate Programme over four years from 2018 to develop working within Primary Care. Tayside Academic Science Centre (TASC) was linking in as currently there were no fellowship grants for non-medical staff. All projects had to be undertaken in a clinical environment.
- Discussions were ongoing between NHS Fife, St Andrews and the University of Dundee for the potential of partnership working. Robert Gordon University were also interested in furthering links.
- A bid proposal from AHSP has been submitted for product development.

The Committee discussed:-

- Working in partnership would drive the international brand and enhance services and NHS Fife would be included with AHSP.
- The similarities of the model to that used for Healthcare UK. It was noted that the AHSP model was similar to others in the UK; however this current model would be used by the Scottish Government to take forward through other Boards. A funding meeting with the Scottish Government was to take place.
- Discussions with the Scottish Government were underway around the new regional structure. NHS Tayside was currently lobbying NHS Scotland to become a tertiary centre within the region.
- Concerns around insufficient medical graduates in the future, and currently NHS Education Scotland (NES) were looking for direction from the Scottish Government around the ongoing workforce and funding issues.
- AHSP were pulling together a business case to secure sustainable funding for a Masters Programme and discussions in this regard were ongoing.
- Professor Ions advised a meeting was taking place with the Scottish Government this week around undergraduate numbers and work would be undertaken around local allocations based on customer practice. Allocations for 16/17 have not been finalised. Currently there was no long term plan from the Scottish Government around trainee numbers. It was noted the Scottish Government had advised that Physicians Associates were lower priority as the workforce had Advanced Nurse Practitioners. Those who became Post Graduate Nurses were self funded and numbers were not planned. Graduates could come from other areas and could be cross trained. Currently it was unclear if there was a funding portfolio.
- The Chief Nursing Officer (CNO) has changed its stance over the past few years indicating that both Physicians Associates and Advanced Nurse Practitioners were required within the workforce. There are concerns that nurses would have less exposure to the acute setting. Professor Connell advise he would discuss concerns with the CNO
- Dr Cowie indicated that the information from the Scottish Government around undergraduate numbers was rather vague. This was a concern as the numbers influenced Health Board planning. The current numbers of 2600 for Scotland was based on affordability.
- Professor Russell advised that NHSScotland needed to commit to numbers at scale and therefore a number of graduates would stay within the area of their training.
- Professor Connell added that as a Health Board clearer information should be available for work plans. He would invite the CNO through the Dean of Nursing to attend the next meeting to discuss local models. Professor Connell, Mrs Costello and Professor Smith would discuss this out with the meeting.
- In relation to surgical robotics, work was undertaken to develop skills and the environment to move forward with training. NHS Tayside did not provide this service locally.
- There are three areas within Scotland which met current requirements for robotic surgery. NHS Tayside had the skills and ambition, however had to be mindful of the cost pressures. It was highlighted that NHS Grampian charged £10k per use of their robot. Capital costs were prohibitive as this was in the region of £1M. Lease arrangements were being looked into, however a business case had not been produced outlining the clinical care benefits. Discussion around supporting this were taking place with “Medtronic”, AHSP and NHS Tayside. Support from the Committee was agreed and work would be undertaken.

The Universities Strategic Liaison Committee:-

- **Noted the verbal update on AHSP**

**5.2 University Updates**

**University of Dundee**

The University had been re-structured and was working well. There were a number of projects being worked on and proving to be more efficient and capitalising on shared resources.

Russell Petty has led a bid for the University to gain its CL status. An interview had been conducted and feedback would be available at the end of November 2016.

The McKenzie building was being released by the University back to NHS Tayside from summer 2017.

Preparation was underway for a GMC visit in 2017. There have been pressures balancing service delivery and training in areas such as ENT.

The Committee discussed:-

- How to ensure that Dundee was a prestigious option for Consultants to work in.
- The use of 9:1 contracts has been removed with new 8:2 contracts being the standard for all new Consultants. The University and NHS Tayside were aware of the competitive market
- For the GMC visit it was thought that Health Boards associated with Medical Schools would be visited - however there was no guarantee this would take place.
- A regional review was also underway by the Taskforce Quality Medical Education team (TQME). NHS Tayside and The University of Dundee both sit on this team. From a Health Board perspective, NHS Tayside was looking education at all levels.
- Education has become part of the agenda for the Clinical Care Governance Committee reporting into the Board on undergraduate nursing and medical training.
- A matrix was being developed to put information into the workforce performance review which would provide oversight on clinical care. Professor Connell would be discussing this with NES.
- A Performance Review mechanism would be implemented to triangulate data which would red flag issues of performance with Junior Doctors. There was an opportunity for members of the Committee to be invited. Professor Russell would extend an invitation.
- Whistleblowing policy for those who wish to raise concerns must be clear and robust. NHS Tayside has an accountable officer and it was agreed that Professor Russell would discuss whistleblowing for Junior Doctors with her.
- It was agreed an integrated approach was required for performance management.
- Clinical issues were being raised through the Clinical Care Governance Committee with work being undertaken in relation to clinical risks
- An overall refresh of the University strategy would be undertaken during the 2017 academic year along with consultation with key partners.

**Abertay University**

The following was noted:-

- The NMC were holding a monitoring event with the University
- Discussions were underway around a Memorandum of Understanding between the Health Boards and Abertay University as the current agreement was not fit for purpose. The National Memorandum of Understanding has not been completely worked out as yet. The local Memorandum of Understanding will include joint responsibility. Once completed this will be sent to the Council of Deans
- The National Strategic Practitioners Group have completed a Memorandum of Understanding
- Currently there is no written agreement in relation to the placement of students. It was agreed a discussion would take place out with the meeting to look at sharing Service Level Agreements.
- The University were struggling to engage students around psychiatry. It was further noted that NHS Tayside currently had 11 locums from 44 posts within NHS Tayside.
- There were concerns that Tayside was not seen as an attractive area with issues of retention in regards to Psychiatry

The Universities Strategic Liaison Committee:-

- Thanked the Universities for their updates
- Noted the verbal updates

## 6. GOVERNANCE ISSUES

### 6.1 2020 Vision for Clinical Strategy

Professor Russell highlighted the following:-

- A service focused clinical strategy had been pulled together
- Provision for midwifery services has been commissioned
- Older People's services were now commissioned through the Integrated Joint Boards
- Inequalities would be targeted in community paediatric services
- Surgical services would be transformed with Ninewells providing acute care and Perth Royal Infirmary providing elective surgery
- Mental Health services required rationalising and a contemporary model of care was looking to be implemented in March 2017
- A medical model of care was being discussed in relation to stroke and cardiac services.
- A cancer strategy was being brought forward between NHS Tayside and the University of Dundee.

The Universities Strategic Liaison Committee:-

- **Noted the verbal update from Professor Russell**

### 6.2 Universities Strategic Liaison Committee Annual Report 2015 – 2016

It was noted that an electronic copy of the Annual Report had been circulated for

approval and then presented to the Audit Committee.

The Universities Strategic Liaison Committee:-

- **Approved the Annual Report formally**

**6.3 Universities Strategic Liaison Committee Terms of Reference 2016 - 2017**

There were a number of changes discussed and it was agreed that these would be made and a further copy circulated to members for final approval.

The Universities Strategic Liaison Committee:-

- **Agreed amendments to be made and then circulated for final approval** **NJO**

**7. ITEMS FOR INFORMATION**

**7.1 Record of Attendance**

The Record of Attendance was noted

**8. AOCB**

There was no other competent business.

**9. DATE OF NEXT MEETING**

The date of the next Universities Strategic Liaison Committee was Tuesday 7 March 2017 at 1400 in the Board Room, Ninewells Hospital.

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 Universities Strategic Liaison Committee held on 1 November 2016 and was approved by the Committee at its meeting held on 7 March 2017.

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 10 November 2016** in the Board Room, King's Cross, Dundee.

**Present**

| | |
|---|---|
| Professor John Connell | Chair, Tayside NHS Board |
| Mrs Gillian Costello | Nurse Director, Tayside NHS Board (joined the meeting at Item 8) |
| Mrs Linda Dunion | Non-Executive Member, Tayside NHS Board |
| Mr Stephen Hay | 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**

| | |
|---|---|
| Dr Andrew Cowie | Non-Executive Member, Tayside NHS Board |
| Ms Margaret Dunning | Board Secretary, NHS Tayside |
| Mrs Judith Golden | Non-Executive Member, Tayside NHS Board |
| Professor Clare McKenzie | Postgraduate Dean, NHS Education for Scotland |
| Ms Lesley McLay | Chief Executive, NHS Tayside |

**In Attendance**

| | |
|---|---|
| Mr Alan Cook | Medical Director - Operational Unit and Consultant, NHS Tayside |
| Mrs Alison Hodge | Committee Support Officer, NHS Tayside |
| Ms Arlene Napier | Associate Director, Clinical Governance and Risk, NHS Tayside |

**Mrs Alison Rogers in the Chair**

**1 APOLOGIES** **ACTION**

The apologies were noted as above.

**2 WELCOME AND INTRODUCTION**

Mrs Rogers welcomed everyone to the meeting.

She extended a welcome to Ms Caroline McLean who was a member of the Clinical Governance and Risk department and Ms Vicky Stewart who would be presenting the Non-Medical Prescribing Policy.

Mrs Rogers proposed the following changes to the agenda:
Item 7.1 Maternity Risk would be discussed in Reserved section of the meeting.

The following items would be taken together:

- Item 7.6 - Section 23 legal Agreement between Tayside Health Board and the Equality and Human Rights Commission
- Item 10.7 - Specific Duties Action Plan 2013-2017
- Item 10.8 - Equality and Diversity Workplan March 2016 – March 2017

The Committee were in agreement.

## 3 MINUTE OF PREVIOUS MEETING

**Open Business**

### 3.1 Minute of the Clinical and Care Governance Committee 11 August 2016 Open Business

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 11 August 2016 was approved as an accurate record on the motion of Ms Linda Dunion and Professor John Connell.

**The Committee:**

- Approved the minute of the Open Business of the Clinical and Care Governance Committee held on Thursday 11 August 2016

### 3.2 Action Points Update Clinical and Care Governance Committee 10 November 2016 Open Business

The Medical Director provided a verbal update as follows:

**1. Update on the implementation of the Safety and Flow Huddle**

Noted that this update would come to the next meeting in February 2017.

**2. Strategic Risks - Provide a cover report showing the monthly position and trends**

Action complete.

**3. Out of Hours Service Update**

Noted that this update would come to the next meeting in February 2017

**4. Duty of Candour**

Noted that NHS Tayside had representation on the Duty of Candour Implementation Advisory Group. Locally work has commenced regarding the Implementation Plan for training ahead of 2018.

**The Committee:**

- Noted the verbal update

### 3.4 Matters Arising

There were no matters arising.

**Reserved Business**

### 3.5 Minute of the Clinical and Care Governance Committee 11 August 2016 Reserved Business

An amendment to the minute was requested as follows:

Page 10, bullet point 3
'Health and Safety Executive (HSE) action plan to be taken forward by **NHS Tayside.**

There were no further comments in relation to this minute. The minute of the Reserved Business of the Clinical and Care Governance Committee held on Thursday 11 August 2016 was approved as an accurate record subject to the amendment described above on the motion of Ms Linda Dunion and Professor John Connell.

**The Committee:**

- Approved the minute of the Reserved Business of the Clinical and Care Governance Committee held on Thursday 11 August 2016 subject to the amendment above

**3.6 Action Points Update Clinical and Care Governance Committee 10 November 2016 Reserved Business**

The Medical Director advised that all action points would be discussed during Reserved Business.

**The Committee:**

- Noted the verbal update

**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 had no questions in relation to the Workplan 2016-17.

**The Committee:**

- Noted the Clinical and Care Governance Committee Workplan 2016-17 Open and Reserved Business

**6. Developmental**

No items.

**7 Assurance**

**7.1 Summary – Strategic Clinical Risks (CCGC/2016/65)**

Ms Napier was in attendance for this report. She advised that the summary report had been requested by the Committee at the last meeting and had been provided today as a 'test of change'.

The Committee noted that the summary report contained information that was reported to the Tayside NHS Board in October 2016.

Mrs Rogers highlighted that information in the summary report differed from the individual risk assurance reports. The Committee noted that the individual risk reports

were dynamic reports and were updated on regular basis by the risk managers.

There was short discussion on Risk Appetite. The Committee agreed that it would be helpful for another Board Development Session to be held on strategic risk and risk management.

There was a discussion on the template which had been approved by the Board for use when providing assurance reports to Committees on strategic risks. It was agreed that the template should include a section where emerging issues could be highlighted.

Ms Napier provided a brief update on each of the strategic clinical risks.

**15 Delivering Care for Older People (CCGC/2016/63)**

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

This risk was discussed by the Clinical Quality Forum (CQF) on 12 September 2016.

Comments on the assurance report were noted as:

- There were references to the Improvement and Quality Committee which required to be updated
- The forms of assurances were external and that internal assurances should be sought

It was noted from the report that completion of documentation that demonstrated quality of care was a challenge.

There was a short discussion on the quality of care for older people within the Health and Social Care Partnerships.

Regarding the assurance report the Committee agreed that the complexities of patient discharge had not been captured and detail in relation to re admission rates for older people was also not included.

**16 Clinical Governance (CCGC/2016/48)**

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

This risk was discussed by the Clinical Quality Forum (CQF) on 12 September 2016.

Regarding gaps in assurance, Ms Napier confirmed that staffing levels had been reduced but there was still resource within the area that could be drawn on.

**22 Health Protection of Children and Young People (CCGC/2016/50)**

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

This risk was discussed by the Clinical Quality Forum (CQF) on 12 September 2016.

The Committee noted that the risk manager was now Ms Joan Wilson following the retirement of Ms Kay Fowlie. Noted that the report at the next meeting would provide more accurate information in relation to this the risk.

**121 Person Centredness (CCGC/2016/49)**

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

This risk was discussed by the Clinical Quality Forum (CQF) on 12 September 2016.

There were no comments relating to this assurance report.

**144 Maternity Services (CCGC/2016/52)**

| | |
|---|---|
| Owner – Gillian Costello | Amber Risk |
| No change to the owner | No change to the scoring of this risk |

This item was discussed in Reserved Business.

**302 PRI Patient Flow (CCGC/2016/70)**

| | |
|---|---|
| Owner – Alan Cook | Amber Risk |
| No change to the owner | A change to the scoring of this risk |

This risk was discussed by the Clinical Quality Forum (CQF) on 12 September 2016.

There was a short discussion on actions taken in PRI regarding the number of delayed discharge patients.

The Committee noted that at any given time there were between 10 - 14 delay discharge patients in the wards in PRI and elective surgery and this did not affect the elective surgery workload.

Recently there has been up to 34 delayed discharge patients in PRI. At this level the PRI hospital site was compromised, the level the patient flow was significantly affected and consideration was given to diverting patients.

There was a discussion on the shortage of Community and Social Care Nursing staff and the following points were noted:

- Within rural settings the Health and Social Care Partnerships were not able to offer these as posts
- Recruitment and retention of social care staff was a challenge despite funding being available
- That in some areas external organisations were being encouraged to provide care in rural areas
- It was acknowledged that providing care in rural areas was more complex.
- Delayed discharge is high on the Health and Social Care Partnership agenda
- It was hoped that the introduction of the living wage would address these concerns

The Medical Director advised that going forward an escalation plan (Plan 'B'), an alternative approach to the winter plan, would be developed and that he would be meeting with the Chief Officers and the Chief Operating Officer for Acute Services to progress this. The Medical Director acknowledged that during periods of unscheduled admissions NHS Tayside has struggled in the past to cope with the increased demand.

This report would come to Tayside NHS Board in the first instance. The Committee agreed that it would be beneficial for the Health and Social Care Partnerships to have input into the development of this plan.

The Medical Director described the actions taken by the Medical Director, Operational Unit when it was not appropriate for delayed discharge patients to remain in acute beds during the recent period of high demand for these beds. Patients were transferred to a more appropriate healthcare setting pending their discharge from PRI.

The Committee noted that there were other issues that could influence delayed discharge e.g. patient's complex needs and delays due to the Guardianship process.

**395 Mental Health Services – Sustainability of Safe and Effective Services**

This risk was discussed by the Clinical Quality Forum (CQF) on 12 September 2016. The update was provided in Item 13.3 in Reserved Business.

**414 Managed/ 2C Practices (CCGC/2016/66)**

This risk was discussed by the Clinical Quality Forum (CQF) on 12 September 2016.

The Committee acknowledged the considerable progress and team work to achieve a satisfactory outcome in Brechin.

The Committee discussed new ways of working within GP practices and noted the following:

- There the triage model operating in Blairgowrie
- NHS 24 can also provide a triage service for doctors
- Advanced Nurse Practitioners (ANPs) undertake a number of duties on behalf of GPs
- A considerable amount of money has been invested in the training of Advance Nurse Practitioners however there are retention issues and that significant investment in the form of training and backfill would be required to increase the supply

**The Committee:**

- Noted the Risk Assurance reports
- Were advised that the risk assurance reports were dynamic reports that were continually updated by managers and the information on these would be differ from the Strategic Risk Summary Profile and the BAF
- Requested Board Development Session on strategic risk and risk appetite
- Requested that consideration be given to updating the report template to include a section on emerging issues

**7.2 Clinical Governance and Risk Management Update (CCGC/2016/62)**

Ms Arlene Napier was in attendance for this report and introduced Ms Caroline McLean, Clinical Governance and Risk Coordinator who prepared the report.

The report was positively received specifically the section in the report which contained information from the Public Partners.

There was a short discussion on patient feedback and the questions that were being used and asked by NHS Tayside. Regarding the survey concern was raised regarding

the how feedback was being captured in Primary Care. Ms Napier advised that GP practices were required to capture feedback as part of their General Medical Services (GMS) contract.

The Committee agreed it would be beneficial to receive a report on the systems and processes that were being utilised to collect patient feedback across NHS Tayside including Primary Care and the Health and Social Care Partnerships. A Napier

**The Committee:**

- Noted the report
- Noted that a report on how patient feedback is collected across NHS Tayside would come to a future meeting

**7.4 Better Blood Transfusion NHS Tayside Update Report: April 2015 – March 2015 (CCGC/2016/53)**

Ms Eleanor Hazra, Blood Transfusion Practitioner was in attendance for this report.

Ms Hazra advised that during the reporting period the Tayside Transfusion Team (TTT) and the Hospital Transfusion Committee (HTC) have continued to engage in collaborative activities to promote the safe and appropriate use of blood and blood components within NHS Tayside.

Ms Hazra advised that within the 2015-16 indicators the number of rejected samples continued to be a challenge. There was a short discussion on the impact of incorrectly labelled samples. Ms Hazra advised that this was a challenge and currently within NHS Tayside 5.8% of samples were rejected due to incorrect labelling by staff. Ms Hazra advised that the zero tolerance approach by the laboratory teams continued. The Committee noted that rejected samples continued to be a national issue.

Ms Hazra advised that there had been a successful national awareness campaign that took place three years ago. This had resulted in a decrease in rejected samples.

There was a short discussion regarding the benefits to patient safety of using barcoded wristbands and associated technology. It was acknowledged that the Scottish National Blood Transfusion Service had no financial influence to introduce barcodes within NHS Tayside. The Committee noted that barcode wristbands were currently in use within Stracathro and that Ward 7 in Ninewells Hospital were using thermal coated wristbands.

There was a short discussion and it was agreed that barcoded wristbands would greatly improve safety in relation to blood samples and transfusion however; the introduction within NHS Tayside would have considerable financial and IT implications. The introduction of a national system would have to consider that NHS Boards use different IT systems.

The Committee encouraged Ms Hazra to progress a cost benefit analysis in relation to rejected samples and articulate the information within a business case.

The Medical Director advised that the introduction of barcoded technology was not on a prioritised list at present for NHS Tayside.

**The Committee:**

- Noted the report
- Supported the implementation of a sustainable improvement plan across NHS

Tayside
- Acknowledged that there was a compelling case for the introduction of wristband barcode technology for cost and patient safety reasons
- Noted that there was a compelling case that change is required for cost and patient safety reasons
- Encouraged the development of a business case and cost benefit analysis to support this

**7.3 Maternity and Child Quality Improvement Collaborative (MCQIC) (CCGC/2016/51)**

The Medical Director spoke to this report.

The Maternity and Child Quality Improvement Collaborative (MCQIC) was launched in March 2013 and encompasses activity of the Scottish Patient Safety Programme's Maternity, Neonatal and Paediatric strands. The overall aim of MCQIC is to improve outcomes and reduce inequalities by providing a safe, high quality care experience for all women, babies and families in Scotland. The original aims of the three programmes were to be met by December 2015 these have been extended for a further three years until March 2019, subject to annual review and the availability of funding.

The report detailed the key objectives and challenges with the Scottish Patient Safety Programme (SPSP) activities in relation to Maternity Care, Neonatal Care and Paediatric Care.

The Medical Director highlighted the graph on page 10 of the report. The graph 'Paediatric Serious Harm Index'. This graph showed a small increase in neonatal fatalities. These were due to recognised medical conditions and that there was an existing structured process to investigate these events.

There was a short discussion on the seconded Patient Safety Champion post which ceased in September 2016. This post had been funded by endowments. The Committee suggested that another application should be made to the Board of Trustees (Tayside Health Fund) for funding for this post. The application should articulate the benefits to patient safety.

**The Committee:**
- Acknowledged the above progress, achievement and challenges by each of the MCQIC programmes
- Encouraged another application to the Board of Trustees for funding for the seconded Patient Safety Champion post

**10.6 Equality and Diversity Steering Group Minute 20 April 2016**

**The Committee:**
- Noted the Equality and Diversity Steering Group Minute 20 April 2016

**10.7 Specific Duties Action Plan 2013-2017 CCGC/2016/60**

Ms Santosh Chima was in attendance for this report.

The Committee noted that there were nine specific duties that NHS Tayside were required to comply with. In addition to this NHS Tayside is required to ensure that there are systems and processes in place to progress the implementation of the statutory specific duties

The Committee noted that NHS Tayside had achieved the required duties and that there were sections within the Action Plan that represented continuous work.

The Specific Duties Action Plan (2013-2017) was approved by the Improvement and Quality Committee in October 2014.

**The Committee:**

- Noted the progress with the Statutory Specific Duties Action Plan 2013-2017
- Noted that Tayside Health Board had met its legal obligations in relation to Equality and Diversity

**10.8 Equality and Diversity Workplan March 2016 - March 2017 (CCGC/2016/61)**

Ms Santosh Chima was in attendance for this report. The Committee noted that the workplan described what work had to be carried out and the reports that were required to ensure that NHS Tayside will meet the required legal obligations and duties as set out in the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.

Ms Chima advised that the NHS Tayside Staff Governance Committee also received assurance regarding employer duties. The Committee had no questions in relation to this report.

**The Committee:**

- Approved the Equality and Diversity Workplan March 2016 - March 2017

**7.6 Section 23 Legal Agreement between Tayside Health Board and the Equality and Human Rights Commission (CCGC/2016/59)**

Ms Santosh Chima was in attendance for this report. Ms Chima provided the Committee with a summary of the events which had led to the Equality and Human Rights Commission entering a legal agreement with Tayside NHS Board. This agreement was dated 7 October 2014, was made pursuant to Section 23 of the Equality Act 2006 and was legally binding on both parties.

During the past two years Tayside Health Board has worked closely with the Equality and Human Rights Commission and the two-year piece of work ended on 7 October 2016. Ms Chima advised that the final report presented to the Committee today was for assurance that NHS Tayside had met the requirements of the Section 23 agreement. From the report the Committee noted that these requirements were:

Tayside Health Board will create an Improvement Plan ("the improvement plan"), describing the steps that the Health Board will take to meet the overall aims of The Agreement. The Improvement Plan will clearly identify who will be responsible for each action and will include detailed proposals with a clear timetable to ensure that:

1. All reasonable steps are taken to make all medical staff, managers and other relevant staff aware of their legal requirements under the Equality Act 2010 and responsibilities in relation to identifying and meeting the reasonable adjustment needs of patients within agreed timescales;

2. The obligation of staff to meet the needs of relevant patients as set out under 1 above and consequences for failure to do so are embedded in working practice and staffs' appraisal systems;

3. Tayside Health Board's senior management team provide high-level leadership for this work; approve all reports sent to the Commission; and take note of any lessons learned to identify any further steps required to meet the overall aims of this agreement;

4. Tayside Health Board will carry out a full review of the effectiveness of improvements made for all patients with additional communication requirements, one year after the implementation of the Improvement Plan;

5. Tayside Health Board will provide reports once every three months starting from the date of the Agreement (7 October 2014), to the Equality and Human Rights Commission.

The Commission is working with NHS Tayside to ensure we have met our legal obligations as set out in the Equality Act 2010 and to ensure that NHS Tayside is complying with the General Duty to:

- **Eliminate** discrimination, harassment, victimisation or any other prohibited conduct
- **Advance** equality of opportunity between people who share a relevant protected characteristic and those who do not
- **Foster** good relations between people who share a protected characteristic and those who do not

There was a short discussion on methods of communication for visually impaired patients for outpatient appointments.

Ms Chima advised that work was ongoing to establish the method of communication best suited to the recipient. The Committee noted that often there was reluctance by the individual to advise health services of impairments and that information held by Primary Care Services was not always communicated to Secondary Care. Work was taking place with the Medical Records Team regarding identifying the preferred method of communication for individuals who have visual or hearing impairments.

Ms Napier advised that the NHS Tayside Deaf and Health Action Group had been established and it was anticipated that this group would continue to monitor the achievements of the Interpretation and Translation Section 23 Improvement Plan. The group has been looking at applications at local level and have highlighted that there are challenges as the current telephony system within NHS Tayside is unable to send text messages.

Ms Napier advised that there are plans to attend the GP Sub Group to highlight these and other issues.

The Committee noted that NHS Tayside could not complacent and that would continue with the improvement work.

**The Committee:**

- Noted the report and the work that has been progressed by NHS Tayside to meet its legal obligations and compliance with the requirements of the Section 23 Legal Agreement
- Agreed that the report should now be submitted to Tayside NHS Board on 1 December 2016

- Agreed that the Section 23 Agreement Governance and Leadership Team would no longer be required to meet as all obligations had been fulfilled

**7.7 Revised Clinical Quality Forum Terms of Reference and Workplan 2016/17 (CCGC/2016/68)**

The Medial Director advised that the Clinical Quality Forum Terms of Reference membership of had been revised. The business section of the meeting would become more focussed and a participatory learning session will follow the meeting. Clinical Governance Leads will be invited to attend these sessions and the invitation list will be extended to clinicians, nurses etc. depending on the topic.

The first participatory learning session would include a presentation led by a relative of an inpatient who was in the care of NHS Tayside.

**The Committee:**

- Noted the revised meeting arrangements and the inclusion of a participatory learning session
- Approved the Revised Clinical Quality Forum Terms of Reference and Workplan 2016/17

**8 Local and National Reports**

**8.1 Health Improvement Scotland (HIS) Care of Older People in Acute Care Unannounced Inspection: Improvement Action Plan Update (CCGC/2016/72)**

Dr Cesar Rodriguez was in attendance for this report. He advised of the unannounced inspection on the care of older people in acute areas to NHS Tayside 7 – 9 June 2016.

During this inspection, the following wards were visited: Wards 3, 4, 5, 6, 7, Acute Medical Unit (AMU), Wards 17, 18 and 33. Only two of these wards were specialist wards for older people. During the inspection, the inspectors noted that older people were treated with dignity and respect and that there was evidence of good practice.

The Report (published) highlighted seven areas of good practice within Ninewells Hospital and fifteen areas for improvement related to HIS outcomes. The majority of the improvements related to:

- Multi disciplinary documented assessments
- Evaluations of patient safety related care
- Demonstrating a person-centred approach to care planning

The Committee noted that the care was rated as good both in the informal feedback and the formal report.

Following the inspection, a meeting took place on 17 August 2016 which included the Nurse Director and members of the Older People Clinical Board (OPCB) and an Improvement Action Plan was created. This Improvement Action Plan has 15 areas for improvement. Dr Rodriguez advised that these areas were similar to reports from other Health Boards in Scotland.

Further meetings were held with Clinical Directors and Associate Nurse Directors.

Dr Rodriguez discussed the importance of the improvements being owned by the whole clinical team so that all specialties were involved. There would be a tight reporting

mechanism with the clinical teams reporting on improvement through the Heads of Nursing to the Older People Clinical Board.

The Nurse Director informed the Committee that the group have set a target to develop specific documentation for older people. This is being aligned with the Silver Book for older people and NHS Tayside will tailor documentation for older people and work towards the HIS requirements.

There is work on going with the Audit Tool and it is being tested by qualified nurses and has been received positively.

**The Committee:**

- Noted that this was a positive report
- Noted the progress of the Improvement Action Plan to date
- Considered and agreed the proposed model of scrutiny and improvement at multidisciplinary team level and reporting mechanisms
- Noted that areas identified for improvement were being progressed and that there were good governance arrangements in place

## 9 Policies and Guidance

### 9.1 NHS Tayside Child Protection Clinical/ Case Supervision Policy (CCGC/2016/54)

The Committee had no questions in relation to this policy.

**The Committee:**

- Adopted the NHS Tayside Child Protection Clinical/ Case Supervision Policy

### 9.2 Review of the Infant Feeding Policy (CCGC/2016/55)

The Committee had no questions in relation to this policy.

**The Committee:**

- Adopted the Infant Feeding Policy

### 9.3 Revision of the Non-Medical Prescribing Policy (CCGC/2016/69)

The Nurse Director declared an interest in this item advising that she was the Chair of the Non-Medical Prescribing Leads Group.

The Nurse Director introduced Ms Vicky Stewart, Non-Medical Prescribing Lead for Dundee who provided the Committee with a brief overview of the revised policy.

She advised that there had been a revision of the policy framework and feedback from the Area Clinical Forum (ACF), Professional Advisory Groups and Non-Medical Prescribing Network Leads had been incorporated.

Ms Stewart advised that the principals of the policy were unchanged. The policy had been updated to:

- Incorporate all professional groups that were now non-medical prescribers following recent changes in legislation e.g. optometrists, pharmacists and some Allied Health Professionals
- Refine appendices to make the policy easy to use
- Include an audit tool

The Policy applies to all NHS Tayside Non-Medical Registered Prescribers, potential Non-Medical Prescribers, Designated Medical Practitioners and Managers responsible for services. The Nurse Director outlined the application process which included obtaining sponsorship from the University of Dundee and the identification of a designated medical practitioner to supervise practice through learning. Once qualified most individuals have a peer supervisor or coach. Within the policy there is a requirement for the individual to participate in an audit of practice a minimum of once per year.

Ms Stewart described the review register and that this would be made available to managers to form part of the appraisal process. The Nurse Director added that NMP would feature in future Job Descriptions to evidence fitness to practice.

**The Committee:**

- Noted the Area Clinical Forum and Area Nursing and Midwifery Advisory Committee have considered the policy content changes and their feedback has been received
- Adopted the Non-Medical Prescribing Policy

**7.5 Quality Assurance and Improvement (QAI) Arrangements for Child Protection in Tayside (CCGC2016/67)**

The Nurse Director spoke to this report. She advised the Committee that she was chair of the Child Protection Executive Group and this report had been considered by this group.

The Committee noted that the information in the report illustrated performance against each standard for the year ending March 2016. Where the minimum levels had not been achieved actions have been identified by the service area.

The Nurse Director advised that the Child Protection Executive Group had multi professional membership that allowed discussed both NHS and Non-NHS issues.

The Committee requested that the Nurse Director conveyed their thanks to the Child Protection Team and all involved in Child Protection.

One change requested in relation to the reference of a ‘named person’ in the improvement plan. The Committee requested that this was changed to ‘responsible person’.

**The Committee:**

- Noted the report
- Noted the progress to date with the collation of data
- Noted the performance of each service area against the standards, which are applicable to them
- Note the actions and timescales that service areas have identified to improve performance against the standard
- Noted that there was ongoing work to move towards electronic reporting

**10 Items for information and action as required**

**10.1** This Item was removed from the agenda. The Committee were advised that the report would now come to the next meeting on 9 February 2016.

**10.2 Health Improvement Scotland - National Care Standards Flash Report July 2016 (CCGC/2016/46)**

The Committee had no questions in relation to this report.

**The Committee:**

- Noted the Health Improvement Scotland - National Care Standards Flash Report July 2016

**10.3 NHS Tayside Spiritual Healthcare Committee Minute 15 March 2016**

**The Committee:**

- Noted the NHS Tayside Spiritual Healthcare Committee Minute 15 March 2016

**10.4 Spiritual Healthcare Committee Annual Report 2015/16 (CCGC/2016/56)**

The Committee had no questions in relation to this report.

**The Committee:**

- Approved the Spiritual Healthcare Committee Annual Report 2015/16
- Approved the Spiritual Healthcare Committee Terms of Reference
- Approved the Spiritual Healthcare Committee Work plan

**10.5 Spiritual Healthcare Department Annual Report 2015/16 (CCGC/2016/57)**

The Committee had no questions in relation to this report.

**The Committee:**

- Approved the Spiritual Healthcare Department Annual Report 2015/16

**10.9 Record of Attendance**

**The Committee:**

- Noted the record of attendance

**11 Items for internal and external communication**

- No Items

**12 AOCB**

**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 Items for Discussion**

**13.1 Chair's Assurance Report for the Clinical Quality Forum (CQF) meeting held on 23 May 2016 (CCGC/2016/64)**

**The Committee:**

- Noted the Chairs Assurance Report for the Clinical Quality Forum (CQF) Action

Note 18 July 2016

**14.2 Perth Royal Infirmary update on key measures**

**The Committee:**

- Noted the update
- Noted the interim measures that had been put in place as a result of the high numbers of delayed discharges in PRI

**13.3 Murray Royal Hospital Adult Mental Health Inpatient Care: Update on Health and Safety Executive Investigation and Improvement Notice (CCGC/2016/71)**

**The Committee:**

- Thanked Dr Ozden for the comprehensive report
- Noted the report and were content with the level of assurance
- Noted that the risks associated with the Improvement Notices were
    - Being actively mitigated and managed or controlled
    - Agreed that the approach being taken in respect of a longer term, but best option/ minimal risk solution for the en suite shower room doors and bedroom doors is acceptable given that the ongoing risk is not able to be wholly managed
- Noted that a report would go to the Finance and Resources Committee in January 2017 outlining the cost of the replacement windows

**In accordance with the Freedom of Information (Scotland) Act 2002 Section 36(2), Section 38**

**14 Items for Discussion**

**14.1 Scottish Public Services Ombudsman Reports (CCGC/2016/58)**

**The Committee:**

- Noted the report and the learning outcomes for NHS Tayside
- Noted that the Nurse and Medical Director would progress the report being made available in the Open Business section of the meeting

**14.2 Public Health - Performance Review Framework (CCGC/2016/47)**

**The Committee:**

- Noted the report and approved the Public Health – Performance Management Framework

**15 Items for information and action as required**

- No items

**16 AOCB**

- There were no items.

**17 DATE OF NEXT MEETING**

The next meeting of the Clinical and Care Governance Committee will take place on Thursday 9 February 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 10 November 2016 and was approved by the Clinical and Care Governance Committee at its meeting held on 9 February 2017.

**CHAIR** **DATE**

# 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 10:46 am on **Thursday 17 November 2016** in the Board Room, Kings Cross, Dundee

**Present:**
Prof J Connell, Chair, Tayside NHS Board
Dr A Cowie, Non Executive Member & Chair of Area Clinical Forum, NHS Tayside
Mr D Cross, OBE, 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
Ms L McLay, Chief Executive, NHS Tayside
Prof A Russell, Medical Director, NHS Tayside
**Regular and Other Attendees**
Mr M Anderson, Head of Property, NHS Tayside
Mrs A Dailly, Information Governance Manager, NHS Tayside (for items 6.6 & 8.3)
Mr N Deuchar, Senior Property Manager, NHS Tayside
Mrs J Duncan, Head of Communications, NHS Tayside
Ms M Dunning, Board Secretary, NHS Tayside
Miss A Elder, Facilitator, Clinical Governance & Risk Management, 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
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 J Ruddy, Energy Officer, NHS Tayside (for item 6.4)
Mr M Valentine, Property Asset Manager, NHS Tayside (for item 6.7)
Mrs H Walker, Risk Manager, Clinical Governance & Risk Management, NHS Tayside
Mr P Wilde, Head of Environmental Management, NHS Tayside (for item 6.4)
**Apologies**
Mr G Doherty, Director of Human Resources, NHS Tayside
Councillor D Doogan, Non Executive Member, Tayside NHS Board
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside
Miss D Robertson, Representative Area Clinical Forum

**Mr D Cross in the Chair**

**1. CHAIRMAN'S WELCOME AND INTRODUCTION** **ACTION**

Mr Cross welcomed all to the meeting.

Mr Cross introduced Mrs Hilary Walker, Risk Manager and Miss Adele Elder Facilitator, Clinical Governance and Risk Management, Mr Mark Valentine, Property Asset Manager, in attendance for Item 6.7 on the Agenda alongside Mr Mark Anderson and Mr Niall Deuchar and Mr Philip Wilde, Head of Environmental Management and Mr John Ruddy, Energy Officer, in attendance for Item 6.4 on the Agenda.

It was noted Mrs Linda Dunion was joining the meeting by teleconference.

**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 – 18 August 2016

The Finance and Resources Committee Minute of the meeting held on 18 August 2016 was approved on the motion of Mrs Judith Golden and seconded by Mrs Linda Dunion.

### 4.2 Action Points Update

Mr Bedford spoke to the Action Points Update.

It was noted that both actions were items on the Agenda for this meeting.

### 4.3 Work Plan 2016/17

The Committee was asked to note the Work Plan 2016/17.

Mr Cross advised the Committee that the Work Plan 2016/17 was a working document and any suggestions or amendments from Members would be welcomed.

## 5. Matters Arising

There were no matters arising

## 6. GOVERNANCE ISSUES

### 6.1 Capital Report for the Period Ended 30 September 2016 (FRC61/2016)

Mrs Lyall advised the Committee of the report detailing the capital position of NHS Tayside for the period ended 30 September 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 £912k between the approved and forecast Capital Plan and advised the confirmed capital funding for 2016/17 from Capital Resource Limit (CRL) was £12.258m, which included £0.468m capital grants. The September SGHSCD allocation letter had confirmed CRL of £15.099m with further allocations and adjustments anticipated.

It was noted Table 2 of the report highlighted a reconciliation of the CRL at 30 September 2016 with the September 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 was currently estimated at £2.3m, comprising of current year completions at £2.115m and assets under construction completions at £0.185m.

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 £0.006m identified in respect of equipment disposals. The current forecast NBV of £2.878m would be returned to SGHSCD, however, discussions would continue with SGHSCD regarding the use of asset receipts, inclusive of NBV, to assist NHS Tayside's revenue position being retained by NHS Tayside.

There was a non core CRL of £5.253m anticipated in 2016/17 in relation to asset additions from the hub investment programme to recognise the value of Assets Under Construction of revenue financed projects. It was noted this addition was in relation to the NHS Scotland Pharmaceuticals 'Specials' Service project.

Mrs Lyall highlighted the gross capital expenditure to 30 September 2016 was reported at £3.741m, comprising CRL of £3.154m and NAV revenue of £0.588m. This was comparable with the gross expenditure of £3.059m 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 approved 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 £18.817m 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 20.2% and ring fenced Radiotherapy Equipment Replacement at 20.1%. It was noted EAMS funding had been allocated to tackle infrastructure, statutory compliance and backlog maintenance issues.

The overall budget increase at 30 September 2016 was £0.875m 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.

Mrs Lyall advised that due to other sources of funding becoming available there had been a budget increase in medical equipment. This would be managed within the overall 2016/17 CRL. It was noted other budget increases were in relation to IM&T and the recognition of the requirement for the eHealth Investment Programme in 2016/17 and Radiotherapy Replacement receiving an additional allocation from SGHSCD.

It was noted the slippage of £1.226m which had been returned to SGHSCD in 2015/16 had now been returned to NHS Tayside through allocation letters. There had been slippage of £0.45m identified in relation to the Critical Care Unit project in 2016/17 due to delays in the progression of an Initial Agreement. This slippage had been managed locally and would continue to be monitored in order to achieve a breakeven position.

Mrs Lyall advised 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.

Mrs Lyall advised the Committee that the current national contract of telephony services was 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. A review of the tender returns and NHS Tayside requirements had resulted in re-tendering with Invitation to Tender issued to bidders on 25 October 2016, with responses due back 25 November 2016. It was noted that confirmation of capital costs was awaited and had not been included within the Five Year Capital Plan.

It was noted that work was ongoing between all parties in relation to the NHS Scotland Pharmaceuticals 'Specials' Service project to ensure financial close on the revised target date of mid November 2016 was achieved and discussions continued in relation to Bridge of Earn Surgery with project team and Integrated Joint Boards (IJBs).

Professor Connell sought clarification regarding the suggestion in Appendix 3 of the report that there was no allocation of funds in relation to Bridge of Earn. Mrs Lyall advised that in terms of work slipped into following year this would reflect in that budget.

Mrs Lyall noted the request from Mr Cross that future reporting included more information in relation to the reference "other funding" as in Table 1 of the report and more narrative around risk.

**The Committee**

- **Noted the content of the report**

**6.2 Corporate Financial Report for the Period Ended 30 September 2016 (FRC51/2016)**

Mr Bedford advised the Committee this report had been submitted to Tayside NHS Board at its meeting on 27 October 2016 and was presented to the Committee to note the position as at 30 September 2016. An update on the current position would be provided further on the Agenda.

***11:00 Mrs Alison Dailly arrived.***

The September position showed an overspend of £7.751m, this was noted as being £6.165m as at August 2016. The unbalanced Local Delivery Plan (LDP) was represented through proportion to date of £5.825m showing in both Integrated Joint Board (IJB) and Core Operational Unit revenue positions.

It was noted efficiency savings remained below the initial expectations at close to £1.9m. A proportionate share of the Board Contingency had been released to reflect the impact of surge beds, hard to recruit to medical posts and non compliant rotas. The sum released totalled £1.5m.

Mr Bedford advised Table 2 of the report highlighted an overspend in relation to pay of c£1.3m, this was detailed within Table 3 of the report. It was noted Whole Time Equivalent (WTE) had again fallen in the month by 22 and again mainly within Nursing and Midwifery. The appointment of a significant cohort of Newly Qualified Practitioners had commenced. This was expected to fill a substantial element of vacancies and impact positively on the external agency and bank shift requests in the second half of the year, however their deployment required to be carefully managed in order to mitigate both agency costs and reducing the level of requests for bank cover.

It was noted that Table 5 of the report highlighted supplementary costs at £10.624m as at September 2016, a graphical format was contained within Appendix 1 of the report, this showed a reduction of £110k on the same period in the previous financial year. Nursing external agency costs also reflected a 10% reduction on the same period. Tayside NHS Board had benefitted financially from the reduction in WTE employed of 220 WTE since March 2016 and an average over six months of around 175 had contributed to a reduction of c£3.2m in spend patterns.

A level of winter surge beds had remained open with a number previously closed being reopened on the Perth Royal Infirmary site due to capacity and flow issues. This had added £0.6m to the financial position at the half year period.

Mr Bedford advised prescribing within the month saw an increase on the previous pattern of spend, particularly in relation to Hepatitis C and Rheumatology. The team responsible would remain within the patient numbers agreed at the beginning of the year and in line with targets set by Scottish Government Health and Social Care Directorate (SGHSCD). It was noted Tayside NHS Board had derived efficiencies in the year through the adoption of bio similar medicines with a forecast that it would deliver in excess of £1.0m by year end and with a greater Full Year Effect impact.

The FHS Prescribing position was noted as £3.161m and included £0.205m from 2015/16. It was noted that growth continued to exceed the Scottish average and continued to extend the variation from the Scottish average.

Mr Bedford advised work had commenced around knowledge sharing in collaboration with NHS Ayrshire and Arran and NHS Fife. It was noted a range of actions were being actively pursued and was expected to impact on the current spend pattern over the remaining four months of the financial year.

Mr Bedford highlighted the new style of reporting provided individual group positions contained within Section 3.7 of the report. The intention was to provide a greater level of understanding on each aspect of the organisation in terms of trends, particular areas of traction in containing costs and pressures faced. It was anticipated reporting would be enhanced further in future months to recognise forecast outturn position.

There was the intention to invite representation from specific areas to future Committee meetings to provide Members with a greater understanding of challenges faced.

Mr Bedford referred to pages 11 and 12 of the report under the heading Facilities and Operations. It was noted Property Services had commissioned an external consultant to review waste and variation within utility charges across Tayside. There was an indication that a claw back of c£0.5m would be obtained, along with a small recurring benefit.

The Efficiency Savings workstream programme position was detailed within Table 20 of the report and included the position of the IJBs. The current overall efficiency saving position was a shortfall of c£1.9m against the plan, of which £732k related to the IJBs.

Mr Bedford advised a review had taken place to assess the deliverability within the current year linked with group forecasts. There was also a range of accelerated proposals which were currently being considered and assessed. These would be addressed further on the Agenda for this meeting.

The Committee noted the importance of delivering a position that minimised the shortfall on resources at year end and should not exceed the unbalanced LDP submitted to SGHSCD in May 2016. It was noted activities over the remaining months of the financial year were critical in achieving this.

Ms McLay queried, from a governance perspective, financial recovery plans in relation to IJB overspends and the mechanism for requesting these from the IJBs. It was noted this would be a formal process in terms of integration schemes, with requests for recovery plans being sought by the Chief Executive and Chief Officers. This was not the responsibility of the Finance and Resources Committee.

Mr Cross advised he had met with the Board Secretary, Chief Internal Auditor and Team and the Interim Director of Performance with regards to Risk Management and the requirement to address risk and governance elements within IJBs. It was noted a session would be arranged to include the Chief Executive and Chief Officers. The Committee agreed there was a lack of clarity and assurance was required as a result of these discussions.

Mr Cross queried the significant overspend within clinical supplies, highlighted within Table 8 of the report, and whether the overspend was due to volume over cost. It was noted work was ongoing to highlight particular demand pressures, recovery of costs from other Health Boards and address the profile of clinical supply spends through the Procurement Workstream.

**The Committee**

- **Noted the current position and supported the actions being taken to contain spend**
- **Noted the decision taken by Tayside NHS Board on 27 September 2016 to approve the non recurring release of the Board Contingency on a proportionate basis each month, to recognise the range of cost pressures that were evident across the system**

**6.3 Reporting Requirement – Code of Corporate Governance (FRC52/2016)**

Mr Bedford advised the purpose of the report was to advise the Committee of the exercise of delegated authority and of waiver of competitive tendering. The Committee was asked to note the content of the report.

Mr Bedford advised there were two awards of contracts in excess of £150k. Cair Scotland had been awarded the contract in respect of Sexual Health and BBV. This was a three year contract with the option to extend for one further year and was funded by the Sexual Health and BBV allocation of the Outcomes Framework.

Menarini Diagnostics had been awarded the contract in respect of the provision of analytical systems for the measurement of HbA1c and Haemoglobinopathy screening. It was noted funding was through the existing revenue scheme. Mr Cross noted that Menarini Diagnostics scored higher than other tenders, albeit was not the lowest quote, therefore the report was unclear as to why this tender had been accepted. Mr Cross requested future reports provided more clarity around the decision in awarding of contracts.

It was noted there were a number of Single Tender Approvals which all recognised the specific circumstances noted with regard to the single tender status.

**The Committee**

- **Noted the content of the report**

**6.4 Sustainability and Environmental Management Update (FRC55/2016)**

Mr Wilde and Mr Ruddy were in attendance to present the report.

Mr Wilde advised the Committee the purpose of the report was to provide an annual update on NHS Tayside's Sustainability and Environmental Agenda. The Committee was asked to note the significant sustainability and environmental challenges faced by NHS Tayside and the progress made to date and future planned schemes.

It was noted the Sustainability and Environmental Agenda was designed to support the reduction of carbon emissions and included the following targets and initiatives:

- Carbon Reduction Commitment Scheme (CRC)
- Statutory Compliance Audit and Reporting Tool (SCART)
- Sustainable Development Strategy Policy for Scotland
- NHS Scotland CO2 Reduction Grant Scheme
- Carbon Energy Fund (CEF)

Mr Wilde advised that the CEF project was more than halfway through the construction phase of works. This was a 25 year partnership between NHS Tayside and Vital Energi. There was the expectation that works, upon completion, would significantly reduce energy consumption across the three acute sites resulting in considerable savings to NHS Tayside. It was noted that this work was also expected to significantly reduce NHS Tayside's carbon energy emissions and this would assist in meeting national environmental targets set by Scottish Government (SG).

Mr Wilde informed the Committee that a new non-clinical waste contractor, Biffa had been appointed through the national framework with effect from 1 October 2016. It was noted that food waste recycling was taking place at catering sites covered by Waste Regulations and included the installation of food waste dryers in Ninewells, Perth Royal Infirmary (PRI) and Royal Victoria Hospital (RVH). The funding for the food waste dryers had been approved by the Capital Scrutiny Group (CSG). It was noted three new waste compactors had also been installed at the Ninewells waste yard.

The Committee noted that Electric Vehicle dual and rapid chargers had been operational at Ninewells since August 2016 with a further six dual chargers, at no cost to NHS Tayside, to be installed by December 2016 at a number of sites as part of Dundee City Councils winning Office for Low Emission Vehicle (OLEV) bid. Mr Wilde advised that a report would be submitted to Tayside NHS Board to approve the transfer of 200 capital vehicles to leased vehicles over a five year period. It was noted subject to approval 2017/18 would see the replacement of 12 diesel vehicles with electric vehicle and 48 old/inefficient/not fit for purpose vehicles being replaced with 48 leased vehicles fit for purpose , fuel efficient and low in CO2 emissions.

The Committee noted a number of further planned schemes detailed within the report.

Mr Wilde highlighted Table 1 of the report detailed the impact of the cost of the Carbon Reduction Commitment (Energy Efficiency Scheme) (CRC). The scheme required NHS Tayside to participate by purchasing allowances for CO2 caused by the use of electricity and gas in NHS Tayside buildings. It was noted there was reduction in CRC allowances in 2015/16 due to NHS Tayside now being a permit holder under the EU Emissions Trading Scheme (ETS) and CO2 relating to electricity and gas use at the Ninewells site not be included under the CRC scheme.

Mr Cross queried the purpose and benefits of the food waste dryers and, in regards to future schemes which would make the most impact on savings. Mr Wilde advised the dryers enabled food waste to be captured and recycled. Mr Wilde further explained that food wasted collected in the dryers was broken down, dried out and collected in bins. It was then uplifted by a waste contractor for disposal where it was used to produce heat or electricity. It was noted food waste dryers had been implemented in the three larger sites, Ninewells, PRI and RVH with smaller sites using food waste bins.

Mr Ruddy advised in relation to future schemes, the installation of software to reduce energy consumption from IT equipment and Heat Recovery for Laundry waste water in Ninewells would impact greatly on the savings

Mr Cross sought further information around the information contained in Table 1 of the report. Mr Ruddy advised that the Ninewells site was included in an EU wide scheme, as opposed to CRC, which is a UK wide scheme for smaller businesses. There was an increase in the emissions in the EU scheme and as a result allowances were accounted for differently.

**The Committee**

- **Noted the significant agenda associated with the sustainability and environmental issues faced by NHS Tayside, the progress to date and further planned schemes**

***11:45 Mr Philip Wilde and Mr John Ruddy left the meeting***

**6.5 Forward Planning 2017/18**

Mr Bedford provided a verbal update to the Committee.

Mr Bedford advised that the Chancellor of the Exchequer Autumn Budget Statement was expected on 23 November 2016 followed by the initial announcement of the Draft Scottish Budget Statement by the Cabinet Secretary for Finance and the Constitution to the Holyrood Parliament around 15 December 2016. It was understood this would be a one year budget.

It was noted that Scottish Government (SG) provided a forecast uplift of 1.8% when developing the five year financial framework in 2015/16, however there was cognisance that in 2015/16 a number of further challenges, particularly in relation to funding towards alcohol and drugs, were made to NHS Boards as part of the settlement last year.

It was unclear at this stage if any further resource would be allocated towards the Health and Social Care Partnerships (HSCPs).

It was noted the existing Financial Framework set out a financial challenge for Tayside NHS Board for 2017/18 of c£42m. Tayside NHS Board would be further impacted in 2017/18 through the adoption of an Apprenticeship Levy with employers contributing 0.5% of their annual paybill. This was assessed as being c£1.8m for NHS Tayside. A rates revaluation was also expected to impact NHS Tayside by c£1.0m resulting in further challenges to the efficiency agenda.

***11:45 Professor John Connell left the meeting.***

The Committee noted a review of the Business Planning and Budget Process was considered at a Development Event in September 2016 with the intention for this to be extended at a future Board Development Event. It was noted a number of key dates were scheduled where further clarity would be sought.

Ms McLay advised the mid-year review letter confirming brokerage was awaited, however there was a commitment to focus on the in year balance and the repayment plan into 2017/18. It was noted there was the expectation that 5% would be the minimum, cognisance of pressures within local authorities and the need to focus on regional working and greater information sharing.

Mr Cross highlighted the importance of the brokerage repayment plan and the critical requirement for clarity around the governance of the Integrated Joint Boards (IJBs), noted as being referenced in Item 8.3 on the Agenda.

**The Committee**

- **Noted the verbal update**

**6.6 Information Governance Mid Year Update (FRC53/2016)**

Ms Dunning advised the Committee that Mrs Alison Dailly, Information Governance Manager and the Information Governance (IG) Team were currently working to address various areas to comply with policy frameworks and legislation received from Scottish Government (SG).

Mrs Dailly advised that the purpose of the report was to provide an update on NHS Tayside's performance in achieving and complying with national Information Governance Standards and the Committee was asked to note the recommendations set out in the report.

It was noted a benchmarking exercise had been carried out which identified issues around the lack of documentation, which was required for the purpose of audits. It found eHealth had identified controls and measures which were in place but had not been documented.

It was noted the recommendations from the Internal Audit Report T32/15 the Public Records (Scotland) Act 2011 – Preparation of the Records Management Plan formed the basis of NHS Tayside's PRSA Records Management Action Plan. Mrs Lynda Petrie, Corporate Web Manager, was leading on the Public Records (Scotland) Act 2011 – NHS Tayside Compliance Update and this would be presented to the next Committee meeting.

Mrs Dailly advised that other ongoing work within IG includes Freedom of Information (FOISA) requests, Caldicott applications, and general data protection queries.

Mrs Golden raised a query in relation to FairWarning, she advised that there had not been any recent discussions around FairWarning and there was the need for an update and discussions in regard to the implications for staff.

Mrs Dailly briefly explained to the Committee that the FairWarning system should automatically provide a functioning audit system and notifications of inappropriate access or breaches of confidentiality within NHS Tayside. It was noted that the process was currently dependant on manual input and output with no pro-active way of identifying incidents.

It was noted that investigations into FairWarning working alongside Trakcare were ongoing, however it was noted that as FairWarning was an 'off the shelf' system and was not part of the current contractual agreement, and that there may be a cost for InterSystems to be implemented.

The Committee agreed the FairWarning system was central to Information Governance and support was required in this being implemented along with further exploration of linking FairWarning with Trakcare.

Ms Dunning advised all issues regarding the FairWarning system had been discussed at the last IG meeting and offered assurance further discussions would continue with the eHealth with possible involvement from the Caldicott Guardian.

Mrs Dailly advised the Committee that NHS Tayside was not an outlier and other Health Boards were experiencing the same issues.

Ms Dunning advised that the Information Governance Information Security Policy Maturity Assessment 2015, included as Item 8.3 on the Agenda was submitted to the Committee for information. It was noted this was a status report which was continually updated. There were plans were in place to create a Short Life Working Group and the Committee would be further updated in due course.

**The Committee**

- **Noted progress reported on the NHS Tayside Information Governance and Security Improvement Plan 2015 – 17**
- **Noted the steps being taken to comply with Public Records (Scotland) Act 2011**
- **Noted the steps being taken to address strategic Data Quality policy and measurement**
- **Noted the outcome of Internal Audit T32/15 the Public Records (Scotland) Act 2011 – Preparation of the Records Management Plan with recommendations forming the basis of NHS Tayside's PRSA Records Management Plan**
- **Noted the IG contribution and commitment to national Public Benefit and Privacy Panel**

**6.7 Risk Assessment Methodology for Backlog Maintenance (FRC62/2016)**

Mr Anderson advised this report was in response to the request from the Committee at its last meeting for an update to the Property Asset Management Strategy Update 2016 regarding the risk assessment methodology for backlog maintenance.

Mr Anderson advised the process of risk assessment was straightforward, factual and technical and followed the processes identified within guidance from Health Facilities Scotland and gave assurance that there was a series of checks and balances carried out both locally and nationally with a system for continual reviews and assessments.

Mr Cross noted the processes in place were encouraging and the importance of the Committee being advised of any areas with an assessed risk score of major or catastrophic. Mr Anderson confirmed any areas which fell into these categories would be reported through the Committee.

**The Committee**

- **Noted the content of the report**

**6.8 Review of Finance and Resources Committee Updated Terms of Reference and Work Plan 2016/17 (FRC57/2016)**

Mr Bedford advised the Committee that a review of the Terms of Reference and Work Plan had been undertaken following recommendations included within the Interim Evaluation of the Internal Control Framework.

The Committee was asked to consider and approve the updated Terms of Reference and Work Plan with specific regard to the refreshed remit under Section 8 of the revised report.

Mr Bedford advised the remit provided greater detail and the Chairs of the Finance and Resources and Audit Committee and the Chief Internal Auditor had been consulted.

Mr Bedford informed the Committee the Corporate Finance Report had been re-developed and would continue to be developed at the request of Members and noted the Finance and Resources Committee It was noted the Chairs Assurance Report was also a standing item on the Tayside NHS Board Agenda.

Mr Cross noted the importance of the remit properly reflecting the aims of the Committee.

Mrs Golden welcomed the broader remit, however, requested that the Membership be updated to include Mr Raymond Marshall as a regular attendee in his capacity as a representative of the Area Partnership Forum. **LG**

**The Committee**

- **Considered and approved the updated Terms of Reference and Work Plan 2016/17**
- **Requested that the Membership be updated to include Mr Raymond Marshall as a regular attendee in his capacity as a representative of the Area Partnership Forum**

**6.9 Annual State of the Estate Report 2015 (FRC64/2016)**

Mrs Lyall advised the Committee that the Annual State of NHSScotland Assets and Facilities Report (SAFR) for 2015 was published on 5 August 2016. The report was available on the Scottish Government (SG) website and a link was also provided within the report.

It was noted there were no major issues identified in respect of NHS Tayside specific information contained within the 2015 SAFR report. The Property and Asset Management Strategy (PAMS) was a key strategic document in demonstrating NHS Tayside's performance in meeting requirements and work was ongoing in updating and verifying records on the Estate Asset Management System (EAMS). There was a requirement for the information contained within the EAMS to be accurate as this informed the national Capital Planning System used by SG to inform decision making.

It was noted that NHS Boards were provided with asset pro-forma returns to be completed and submitted to Scottish Government Health and Social Care Directorate (SGHSCD) on an annual basis. The information provided from NHS Boards was used to inform the SAFR.

Mrs Lyall advised that 2015 was the fifth year the SAFR had been published and was widely recognised as a key reference document used to inform decisions on the continuing investment in assets and facilities services to deliver the Scottish Government's "2020 Vision" for sustainable high quality in health.

The SAFR report provided a range of information to assist NHS Boards target limited resources on achieving maximum benefit and value for money and the following was highlighted:

- the quality of NHS Tayside properties was significantly higher than the NHS Scotland Board average - 92% of NHS Tayside properties were classified as Excellent or Satisfactory compared to 70% of NHS Scotland properties;
- 82% of NHS Tayside properties were classified as Excellent or Satisfactory in terms of Functional Suitability, compared to 72% of NHS Scotland properties;
- property maintenance costs for NHS Tayside properties were one of the lowest in NHS Scotland, and 17.5% lower than the NHS Scotland Board average;
- other operational costs that highlight good performance of NHS Tayside were energy costs, catering costs and waste costs, and
- space allocated for office accommodation in NHS Tayside is better than the NHS Scotland Board average, however, there was an opportunity to improve even further by implementing Smarter Offices initiative where appropriate

Mrs Lyall advised the SAFR highlights areas of improvements to NHSScotlands property asset performance in the last five years. This included reduction of backlog maintenance, utilisation of accommodation and provision of facilities that were functionally suitable to support effective health and care service delivery.

The key messages identified within the SAFR report for NHS Boards in terms of developing their future PAMS were noted as being:

- NHS Boards should continue to focus their investment strategies towards reducing high and significant backlog maintenance;
- estate rationalisation leading to disposal of surplus properties had the potential to reduce currently identified and future backlog, lower future operational running costs and reduce future investment requirements for estate replacement;
- 70% of annual recurring expenditure on assets was associated with the day to day operation and maintenance of the estate and the delivery of associated facilities services, therefore it was essential to focus on improving the performance on these services;
- estate replacement projects had the potential to bring about significant change to the way in which the existing estate is configured, and how it might continue to support the delivery of healthcare services, and
- investment plans should not ignore the requirements of the other assets, which need to be sufficient to ensure adequate replacement, but also for further investment in new medical equipment and technology that might introduce innovative solutions towards the 2020 vision for quality healthcare provision, and potentially reduce reliance on continued investment in property replacement.

The NHS Tayside Capital Forecast 2016/17 – 2020/21 had been developed taking cognisance of clinical strategies and risks. There was the expectation from SGHSCD that a proportion of the formula capital allocation should be spent addressing statutory compliance and backlog maintenance identified through the EAMS and PAMS.

Mrs Lyall advised ring fenced earmarks had been maintained within the Capital Plan to deliver projects identified under EAMS, Medical Equipment, Information Management and Technology and Primary Care premises. It was noted the draft Capital Forecast for 2017/18 – 2021/22 was currently under development.

It was noted NHS Boards were expected to submit a full PAMS in 2017 and correspondence from SGHSCD was expected in due course detailing requirements and timelines.

The Committee discussed difficulties in Tayside NHS Board fully understanding the risk element within the EAMS and as a result not being fully aware of the condition of the estate and the position of essential and non essential properties as well as their functionality. Mr Anderson advised that whilst the EAMS method and narrative could perhaps create confusion, the Ninewells Hospital Site for example was a functional site. It was noted that although there were issues around car parking and infrastructure, these issues could be identified within EAMS for investment or replacement, the site remains functional. It was noted that a non

essential property did not mean a surplus property and all sites were functional until declared surplus to requirements and would continue to receive the level of attention and investment required until then.

The Committee noted there was increasing recognition of the challenges around the NHS Tayside estate and recognised the work of the property department in achieving scores contained within the report.

**The Committee**

- **Noted the recommendations contained within the report**

***12:30 Mrs Judith Golden and Mr Raymond Marshall left the meeting.***

**7. ASSURANCE – Strategic Risks Aligned to the Finance and Resources Committee**

**7.1 Assurance Report on Strategic Financial Plan Risk (FRC58/2016)**

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.

Mr Bedford advised the Committee that this report and Item 7.2 Assurance Report on Reduction in Capital were both similar to reports which had be presented at the August 2016 Committee meeting.

It was noted this report had been enhanced with the inclusion of Operational Risks which support the Strategic Risk. It was noted the Strategic Financial Plan inherent risk exposure remained unchanged and was unlikely to change in the near future.

Mrs Walker advised the Committee of the recommendations from Internal Audit to ensure robust systems were in place and welcomed the inclusion of Operational Risks.

The Committee were advised comments on further control measures would be welcomed.

**The Committee**

- **Noted the content of the report**

**7.2 Assurance Report on Reduction in Capital Risk (FRC59/2016)**

Mr Bedford advised the Committee this report was in similar vein to Item 7.1 and was included in discussions under Item 7.1.

**The Committee**

- **Noted the content of the report**

**7.3 Assurance Report on Information Governance Risk (FRC54/2016)**

Ms Dunning presented the report to the Committee for noting.

Mrs Dailly advised the current risk exposure was due to ongoing work to comply with DL (2015) 17 Information Governance and Security Improvement Measures 2015-2017, including the new NHSS Information Security Policy Framework.

Mrs Walker advised the Committee that Mr Bedford and Ms Dunning had robust processes in place and risks were reviewed on a regular basis.

Dr Cowie disagreed with the current risk exposure score of (4x3) and suggested this should be amended to be (4X4). Ms Dunning agreed Dr Cowie's comments would be addressed at the next Information Governance Committee and reported in the next update to the Committee.

**The Committee**

- **Noted the content of the report**
- **Noted the current risk exposure score would be discussed at the next Information Governance Committee meeting and reported in the next update to the Committee**

**8. ITEMS FOR INFORMATION**

**8.1 Record of Attendance**

**The Committee**

- **Noted the Attendance Record**

**8.2 Finance and Resources Committee Schedule of Meetings 2017/18**

**The Committee**

- **Noted the Finance and Resources Committee Schedule of Meetings 2017/18**

**8.3 Information Governance Information Security Policy Maturity Assessment 2015**

**The Committee**

- **Noted the Information Governance Security Policy Maturity Assessment 2015**

**8.4 Information Governance Committee Minute – 27 July 2016**

**The Committee**

- **Noted the Information Governance Committee Minute – 27 July 2016**

**DATE OF NEXT MEETING**

**The next meeting of the Finance and Resources Committee will take place on Thursday 19 January 2017 at 9:30am in the Board Room, Kings Cross 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 17 November 2016, and approved by the Committee at its meeting held on 19 January 2017.

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**CHAIR** **DATE**

# 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 9:30 am on **Thursday 19 January 2017** in the Board Room, Kings Cross, Dundee

**Present:**
Prof J Connell, Chair, Tayside NHS Board
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
Cllr K Lynn, Non Executive Member, Tayside NHS Board
**Attending – Executive Directors**
Mr L Bedford, Director of Finance, NHS Tayside
Ms L McLay, Chief Executive, NHS Tayside
**Regular and Other Attendees**
Mrs G Culross, Senior Communications Manager, NHS Tayside
Mr A Gall, Interim Performance Director, NHS Tayside
Mrs F Gibson, Head of Financial Services, NHS Tayside
Mr A Graham, Head of Service – eHealth, NHS Tayside (for item 7.3)
Mrs L Green, Committee Support Officer, NHS Tayside
Mrs L Lyall, Capital Finance Manager, NHS Tayside
Mr S Lyall, Head of Finance, Operational Unit, NHS Tayside
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside
Mr R Marshall, Representative Area Partnership Forum
**Apologies**
Mr M Anderson, Head of Property, NHS Tayside
Mr N Deuchar, Senior Property Manager, NHS Tayside
Mr G Doherty, Director of Human Resources, NHS Tayside
Ms M Dunning, Board Secretary, NHS Tayside
Mrs J Golden, Non Executive Member, Tayside NHS Board
Miss D Robertson, Representative Area Clinical Forum

**Mr D Cross in the Chair**

**1. CHAIRMAN'S WELCOME AND INTRODUCTION** **ACTION**

Mr Cross welcomed all to the first meeting of 2017.

**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 – 17 November 2016

The Finance and Resources Committee Minute of the meeting held on 17 November 2016 was approved on the motion of Mrs Linda Dunion and seconded by Dr Andrew Cowie.

### 4.2 Action Points Update

Mr Bedford spoke to the Action Points Update.

It was noted the Committee membership had been updated to include Mr Raymond Marshall as a regular attendee in his capacity as a representative of the Area Partnership Forum.

### 4.3 Work Plan 2016/17

The Committee was asked to note the Work Plan 2016/17.

Mr Bedford advised the Work Plan 2016/17 had been updated to reflect the current and forthcoming reporting arrangements.

Mr Cross queried the expected submission date of the Procurement Annual Report to the Committee. Mr Bedford advised this would be confirmed and the Work Plan 2016/17 would be updated accordingly. **LB**

## 5. Matters Arising

There were no matters arising

## 6. GOVERNANCE ISSUES

### 6.1 Capital Report for the Period Ended 30 November 2016 (FRC02/2017)

Mrs Lyall advised the Committee of the report detailing the capital position of NHS Tayside for the period ended 30 November 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 advised the confirmed capital funding for 2016/17 from Capital Resource Limit (CRL) was £12.397m, which included £0.466m capital grants. Mrs Lyall highlighted the request from Mr Cross at the November 2016 Committee meeting that more information regarding donated and other funding be included within future reporting. It was noted the donated funding element of £0.592m within Table 1 of the report was in relation to jointly funded capital projects in 2016/17 between NHS Tayside and MacMillan Cancer Support. This had been incorporated into capital programme to highlight the full cost of projects. Table 1 of the report detailed £1.086m for other funding, this consisted of £0.741m, repayable to NHS Tayside at financial close, for early payment of Stage 1 and Interim Stage 2 design fees for the NHS Scotland Pharmaceutical 'Specials' Service (NHSS PSS) project in line with guidance issues by Scottish Futures Trust in May 2014, £0.288m in relation to anticipated transfer from revenue to capital in respect of NHSS PSS sub-debt funding to reverse the capital to revenue transfer that was actioned in 2015/16 and the remaining balance of other funding being in relation to specific items of equipment where funding had come through revenue.

The November SGHSCD allocation letter had confirmed CRL of £15.162m with further allocations and adjustments anticipated.

It was noted Table 2 of the report highlighted a reconciliation of the CRL at 30 November 2016 with the November 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 £1m for the year. This was a decrease of £1m from the approved capital plan and reflected the anticipated transfer of £1m back to revenue. Annually Managed Expenditure (AME) impairment was currently estimated at £2.452m, comprising of current year completions at £2.271m and assets under construction completions at £0.243m and £0.04m in impairment on disposals and assets for sale. It was noted following a review a number of properties had been removed from assets held for sale and had resulted in a reversal of impairment of £0.102m

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 £0.003m identified in respect of equipment disposals. The current forecast NBV of £2.568m would be returned to SGHSCD, however, discussions would continue with SGHSCD regarding the use of asset receipts, inclusive of NBV, to assist NHS Tayside's revenue position being retained by NHS Tayside.

Mrs Lyall advised the Committee that during 2016/17 sales had concluded for Dundonnachie House and Sunnyside Royal Hospital. The recommendations to accept the preferred offers for the Murray Royal and Little Cairnie site had been approved by Tayside NHS Board at its meeting on 25 August 2016 and work was ongoing to conclude the missives. It was noted offers had been received and were under consideration in relation to a number of smaller properties previously marketed and further properties identified surplus to requirements and available for sale were either being marketed or prepared for market. It was noted a review of the NHS Tayside Disposal Strategy was ongoing through the Property Workstream, which had been established under the NHS Tayside Transformation Programme.

There was a non core CRL of £4.909m anticipated in 2016/17 in relation to asset additions from the hub investment programme to recognise the value of Assets Under Construction of revenue financed projects. It was noted this addition was in relation to the NHS Scotland Pharmaceuticals 'Specials' Service project.

Mrs Lyall highlighted the gross capital expenditure to 30 November 2016 was reported at £5.395m, comprising CRL of £5.077m and NAV revenue of £0.319m. This was comparable with the gross expenditure of £4.837m 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 approved 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.

The gross forecast capital expenditure of £17.642m was detailed within a chart on page 4 of the report with the highest proportion of forecast gross expenditure expected ring fenced Radiotherapy Equipment Replacement at 20.3% and Medical Equipment at 19.8%. It was noted EAMS funding at 16.6% had been allocated to tackle infrastructure, statutory compliance and backlog maintenance issues.

The overall budget decrease at 30 November 2016 was £0.3m 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.

Mrs Lyall advised that due to other sources of funding becoming available there had been a budget increase in medical equipment. This would be managed within the overall 2016/17 CRL. It was noted other budget increases were in relation to IM&T and the recognition of the requirement for the eHealth Investment Programme in 2016/17

It was noted NHS Tayside had received funding of £0.798m for Energy Initiative projects in 2016/17 and slippage of £0.234m had been identified in relation to the proposed installation of a biomass boiler in Arbroath. The funding had been returned to SGHSCD through the November Financial Performance Return (FPR) with the assumption this would be returned to NHS Tayside in 2017/18.

It was noted a number of other schemes had been identified where the programme to completion had slipped or would be delayed, this would reduce the level of predominantly NAV funding required to support the capital programme in 2016/17. The NAV element of the capital programme was funded by the transfer from revenue to capital, with £2m being earmarked in the approved Financial Framework 2016/17. Mrs Lyall re-iterated this earmark had been

amended to £1m to reflect the reduced projected level of NAV within the 2016/17 capital programme.

The capital team would continue to monitor slippage in the capital programme to ensure a breakeven position was achieved.

Mrs Lyall advised 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.

Mrs Lyall advised the Committee that the current national contract of telephony services was 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. A review of the tender returns and NHS Tayside requirements had resulted in re-tendering with Invitation to Tender issued to bidders on 25 October 2016, with responses due back 25 November 2016. Mrs Lyall advised that further technical and financial clarifications had been issued to the suppliers with a deadline of 4 January 2017 for responses. Following receipt of the clarifications, interviews would be held with shortlisted suppliers. It was noted that there may be a requirement for capital funding to purchase hardware and software equipment and the enabling works to allow installation, however, this was dependant on the options provided by the successful bidder. It was noted confirmation of capital costs was awaited and had not been included within the Five Year Capital Plan.

It was noted that financial close had been achieved in relation to the NHSS PSS project on 22 December 2016 with further information being provided under Item 10.2 on the Agenda. Mrs Lyall advised with regard to Bridge of Earn, discussions with hubco Chief Executive continued around receipt of a formal response and the Project Team continue to review options available to deliver project objectives.

It was noted that Donated Asset Additions for 2016/17 were estimated at £0.250m.

Mrs Lyall informed the Committee that following the request by Mr Cross at the November 2016 Committee meeting, further narrative around risk had been included within the report. It was noted Appendix 1 of the report provided an update to the major risks.

Mr Cross thanked Mrs Lyall for the additional information regarding donated and other funding and enhanced narrative around risk.

***10:36am Cllr Ken Lynn arrived***

Prof Connell queried if there was any further information regarding Bridge of Earn Surgery and Kingsway Care Centre, noting the length of time these had been ongoing. Mrs Lyall advised that the Bridge of Earn Surgery project had been included within the HUB Initiative pipeline, however the project was no longer being progressed via this procurement route. Discussions were ongoing with the Perth and Kinross Integrated Joint Board (IJB) around a number of potential options. It was noted an update around Bridge of Earn, Kingsway Care Centre and Carse of Gowrie would be submitted to the Committee at its meeting in February 2017. The Committee discussed the lack of progress, in particular with the Bridge of Earn Surgery, and agreed that whilst the Draft Capital Plan would provide an update an interim action plan was required.

Mr Cross reminded the Committee that the report submitted was a finance report however, noted the need for clarity around Tayside NHS Boards intentions in relation to Bridge of Earn. The Committee agreed this was not within the remit of the Committee and suggested the need for progression through a separate forum. Ms McLay agreed to facilitate discussions with Prof John Connell, Tayside NHS Board Chairman and Mr Robert Packham, Chief Officer, Perth and Kinross Health and Social Care Partnership and noted a report would be submitted to a future Committee and Tayside NHS Board meeting. **LMcL**

Mrs Dunion sought clarification regarding the statement "There is, however, no identified sources of revenue funding for this essential IM&T equipment, and highlights the urgent need to identify an annual revenue funding earmark in future NHS Tayside Financial Plan". Mrs Lyall advised that capital funding allocated to IM&T for 2016/17 was £800k, in previous years this was £1m, however, the majority of equipment purchased was revenue not capital resulting in the expenditure being written off to revenue as NAV expenditure. It was noted IM&T did not have revenue funding to support such equipment purchases therefore they were being purchased through the capital programme. Mrs Lyall advised there was the need to review the allocation of earmarks between revenue and capital funding in relation to IM&T expenditure, and this would be considered when preparing the draft 5 year financial plans.

***10:45am Mr Alistair Graham arrived***

Dr Cowie sought clarification around the repayment of NAV, whether this was a year to year transfer, and asked for an explanation around NAV. Mrs Lyall advised that not all expenditure that is incurred through the capital programme can be capitalised and added to the fixed asset register, for example, each year Tayside NHS Board's external valuers will review the expenditure incurred in the capital programme and provide an opinion around the level of added value that will be capitalised on the Fixed Asset Register. Expenditure not capitalised requires to be written off as revenue expenditure i.e. NAV. A funding earmark was made annually within the Strategic Financial Plan for NAV expenditure. As a result of slippage in the Capital Programme during 2016/17 the anticipated level of NAV has reduced from £2m to £1m resulting in a reduction to the earmark within revenue.

**The Committee**

- **Noted the content of the report**
- **Noted a meeting would be arranged between the Chief Executive, Tayside NHS Board Chairman and Perth and Kinross Health and Social Care Partnership Chief Officer to discuss Bridge of Earn Surgery with a report being submitted to a future Committee meeting**

**6.2 Corporate Financial Report for the Period Ended 30 November 2016 (FRC06/2017)**

Mr Bedford advised the Committee this report had been submitted to the Transformation Programme Board (TPB) at its meeting December 2016 and was presented to the Committee to note the position as at 30 November 2016. An update on the December position would be provided further on the Agenda.

It was noted that whilst the in year monitoring continued to be a focus the year end forecast was now gaining prominence as the financial year end approaches. This would be discussed further on in the Agenda.

The current position showed an overspend of £9.981m for the eight months to 30 November 2016, this was noted as being £8.943m as at October 2016. The current position remained within the unbalanced Local Delivery Plan (LDP) trajectory submitted to Scottish Government Health and Social Care Directorate (SGHSCD) in May 2016.

There was however, recognition further actions to control spend were required in the remaining four months of the year to deliver on the submitted LDP position.

Mr Bedford advised two reports had been submitted to Tayside NHS Board at its meeting in December 2016 in relation to Nursing, reflecting on the impact of Newly Qualified Practitioners (NQPs) on the system with the explicit assumptions on the level of agency staff being secured over the remaining months of the year and Medicines Management and the actions being progressed. It was noted both these areas remained key for the final months of this financial year and moving forward into 2017/18.

It was noted this did not preclude the wide range of actions required by all to contain spends wherever legitimate and appropriate across the entire spectrum of the spend and income of Tayside NHS Board.

The November position reflected the accelerated initiatives and the reprofiling of savings targets over the remaining four months, in particular key areas of Workforce and Medicines. The Prescribing and Workforce elements remained integral in the drive to deliver operational efficiency.

It was noted the reporting of the £9.981m overspend as at November 2016 reflected the release of a proportionate share of Tayside NHS Board contingency as agreed by Tayside NHS Board at its meeting in October 2016 along with a proportionate share of the benefit from the Non Added Value (NAV) capital which was estimated as part of the further actions being taken.

The Committee noted of the £9.981m overspend, c£7.8m reflected the LDP submitted position and the position of Tayside NHS Board was demonstrated in both an organisational and subjective basis.

Mr Bedford advised Table 2 of the report highlighted an overspend in relation to pay of c£1.9m, this was detailed further within Table 3 of the report. The Committee was asked to note the increase in Whole Time Equivalent (WTE) principally reflected the expected final cohort of NQPs being engaged and orientated with Tayside NHS Board. It was noted due to an induction period of 2/3 weeks the ability to reduce supplementary costs was impacted. It was now anticipated that a natural level of attrition would be seen.

***10:10 Dr Baxter Millar arrived***

It was noted supplementary costs across all workforce areas were now higher than the same period last year, however, Nursing external agency costs at c£3m over the eight month period were 17% lower than the same period last year with the expectation this would grow over the remaining months of the year.

Mr Bedford advised Medical agency costs had increased in the month and as at November 2016 were approximately 40% higher than the previous year reflecting principally on the known hard to fill specialities. It was noted the managed service contract on medical agency was now live, giving Tayside NHS Board the ability to reclaim VAT which would be of benefit in the remaining months. It was noted that staffing levels overall however remained below the levels saw in the previous financial year.

The Prescribing position was noted as c£4.5m as at November with FHS Prescribing noted as being c£4.6 which was offset by an underspend on Secondary Care medicines of £0.1m. NHS Tayside's gap to the Scottish average on Primary Care prescribing was 9.2% with a financial assessment of £7m recognising this would incorporate both warranted and unwarranted variation.

It was noted the report submitted to Tayside NHS Board in December 2016 detailed the actions being taken. NHS Tayside was driving hard on the use of biosimilar medicines with two drugs identified showing a higher level of switching than the average across Scotland. This was expected to deliver an in year benefit of c£1.2m.

The Committee noted the NHS Tayside Financial Framework 2016/17, which was approved by Tayside NHS Board in March 2016, included the anticipated allocation in respect of High Cost Medicines. The forecasted share of £60m had since been revised down to £45m with the reductions in anticipated allocations now being c£1.5m. It was noted Section 3.7 of the report provided individual group positions highlighting key areas, challenges faced, particular areas of traction in containing spend and where pressures were evident.

The Efficiency Savings workstream programme position was detailed within Table 20 of the report and included the position of the IJBs. The current overall efficiency saving position was a shortfall of £3.764m against the plan.

Mr Bedford highlighted Tayside NHS Board had discussed actions required at its meeting in October 2016, with clear directives being integral to delivering initiatives at pace in the remaining months of this financial year and recognising focus was required in containing spend across all areas. The Committee noted a comment received at the Area Partnership Forum that small changes made by everyone could have a significant cumulative impact and the importance of getting that message across.

The Committee noted the Financial Framework 2016/17 set out a recurring savings target of 40%, the current assessment was that this at a minimum would be secured and recognised the importance of delivering a position that minimised the shortfall on resources at year end and not exceed the unbalanced LDP submitted to SGHSCD in May 2016.

Mr Cross thanked Mr Bedford for the report and noted the level of analysis now included in the reporting was helpful as was the expanded information regarding committed earmarks and deferred spend.

Mr Cross queried whether further traction and the mitigation of the impact of emerging cost pressures was reliant on the success of efficiency measures. Mr Bedford advised that this would be discussed in further detail under Item 9.4 of the Agenda however, noted a range of actions were flowing through from all initiatives and discussions continued across a broad spectrum.

Mr Bedford reinforced that individual Directors were holding meetings in January 2017 regarding specific actions required in all areas to achieve further traction in the remaining months.

The Committee agreed it was important to ensure the change in behaviours, improvements and cost efficiencies were carried over to 2017/18 and noted the purpose of this Committee was to ensure scrutiny was applied.

**The Committee**

- **Noted the current position and support the actions being taken to contain spend**

**6.3 Reporting Requirement – Code of Corporate Governance (FRC01/2017)**

Mr Bedford advised the purpose of the report was to advise the Committee of the exercise of delegated authority and waiver of competitive tendering.

The report detailed two Single Tender Waivers, noted as being the purchase of Philips Healthcare Avalon FM30 Intrapartum Foetal Monitors, which provided compatibility with the telemetry system, and the appointment of ARUP Structural Design Engineers to progress the detailed designs in respect of Electrical Infrastructure at Ninewells Hospital. It was noted ARUP Structural Design Engineers had previously involvement in Phase 1 of the Electrical Infrastructure of Ninewells Hospital which was beneficial to NHS Tayside.

**The Committee**

- **Noted the content of the report**

**7. ASSURANCE – Strategic Risks Aligned to the Finance and Resources Committee**

**7.1 Assurance Report on Strategic Financial Plan Risk (FRC07/2017)**

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 and identified the current risk profile and the current controls in place.

Mr Bedford advised that the magnitude of the risk presented was recognised and the report reflected on the unbalanced Local Delivery Plan (LDP) submitted to Scottish Government in May 2016.

It was noted the Strategic Risk remained in the outer extremity and in keeping with good practice, this report had been enhanced with the inclusion of Operational Risks which supported the Strategic Risk.

There was recognition of the scale of the programme being accelerated in order to return NHS Tayside in the medium term to a financially balanced position and the progression of the workstreams was integral to the recovery required. It was noted that whilst the work being advanced nationally was welcomed the need to ensure no double counting was paramount.

***10:30am Mr Mark Valentine arrived***

Mr Cross noted that it was unlikely that this risk would change and there was the need for the Committee to apply scrutiny. Mr Cross drew attention to the rationale of the current score in paragraph 2 of the report which the Committee agreed was a true reflection. It was agreed the Committee required to see what was being done in each of these risk areas or an action plan.

Mr Gall advised that assurance should be sought from the Transformation Programme Board (TPB). Mr Cross advised that the Committee needed to see the wider plan. The benchmarking exercise highlighted that NHS Tayside was an outlier in relation to spend patterns in comparison to other Health Boards across Scotland. It was noted two of the main outliers in spend related to Prescribing and Workforce which were being progressed through the TPB workstreams. It was agreed the Committee required evidence and assurance from the TPB work was being progressed in its totality. **LB**

Cllr Doogan sought clarification regarding the suggestion that NHS Tayside spend patterns were higher as better care was provided. It was noted that whilst NHS Tayside may be willing to spend more, reductions would be required elsewhere in order to find a balance.

The Committee discussed the standards of care provided and level of affordable spends. It was noted Clinicians and Tayside NHS Board both needed to work together to ensure a high level of patient care within the financial envelope.

Mr Cross agreed to liaise with Mr Bedford regarding emerging possibilities from benchmarking exercises and actions taken as a result of TPB workstreams. It was noted a report would be submitted to the February 2017 Committee meeting. **DC/LB**

Ms McLay noted that there was confidence cost containment would not affect quality. Mr Bedford highlighted the following components which would impact on the benchmarking exercise:

- Efficient and effective deployment of resource
- Productive opportunities
- Elements relating to Clinical Strategy

**The Committee**

- **Noted the content of the report**
- **Noted Committee requested evidence and assurance from the TPB work was being progressed in its totality**
- **Noted Mr Cross and Mr Bedford would discuss emerging possibilities from benchmarking exercise and actions taken as a result of TPB workstreams with a report being submitted to the February 2017 Committee meeting**

**7.2 Assurance Report on Reduction in Capital Risk (FRC08/2017)**

Mr Bedford advised the Committee this report was in similar vein to Item 7.1 and recognised the in year position. It was noted the current risk profile and current controls in place were detailed within the DATIX report.

It was noted there was an awareness of the current constraints nationally on Capital Resources and a clear Clinical Strategy would inform the future direction of both asset release and also asset investment.

Mr Bedford advised the Committee that 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 (CIG).

Mr Cross noted the rationale of the current score reflected failure in this area would impact on Tayside NHS Board's ability to support the Clinical Strategy and highlighted the importance of the Clinical Strategy becoming apparent.

The Committee noted the low level of capital and ring fenced capital would remain low. There was the need to continue to fight the case of NHS Tayside to support our infrastructure and ensure a robust financial plan.

It was noted the draft Strategic Financial Plan and Strategic Capital Forecast 2017/18 – 2021/22 would be submitted to the February 2017 Committee meeting followed by final reports to the March 2017 Committee meeting.

**The Committee**

- **Noted the content of the report**
- **Noted the draft Strategic Financial Plan and Strategic Capital Forecast 2017/18 – 2021/22 would be submitted to the February 2017 Committee meeting followed by final reports to the March 2017 Committee meeting**

**7.3 Assurance Report on Implementation of TrakCare (FRC03/2017)**

Mr Alistair Graham was in attendance to present this report.

Mr Graham advised the Committee the TrakCare system would replace the current TOPAS and Symphony systems and implementation of TrakCare would require complex service configuration and data transfer operations to take place in conjunction with changes to current operational service processes.

It was noted the expected service impact had been evaluated at a maximum of 20 hours downtime. Business Continuity Plans would be in place and shared across the service to mitigate the impact and all activities would be monitored and supported during the period of downtime.

Mr Graham advised the TrakCare programme was currently planned over two phases. The go live date for phase 1, all Patient Administration System (PAS) users and Emergency Department (ED) system users, was planned for 17 February 2017 with phase 2, Maternity users, planned for 19 May 2017. It was noted that the planned go live date for phase 2 would also impact on PAS and ED users, however, the second go live impact was dependent on Maternity services deciding on their data migration requirements.

The Committee noted the delivery of the programme was supported by a Communication and Engagement Strategy (CES) and both an Operational and Technical Steering Group. The purpose of CES was to support the implementation of the TrakCare application and support the changes to operating procedures and working methods necessary to allow the safe implementation of TrakCare to NHS Tayside.

The programme was structured into three stages, Operational Review, Build and Validation and Adoption. The Operational Review was now completed, the Build and Validation stage was due to conclude 27 January 2017 and the Adoption Stage continued to be progressed. It was noted training would provide operational support and would run from 9 January 2017 until the go live date.

Mr Graham advised the Committee a Go Live Matrix continued to be developed and was being reported to the programme board on a weekly basis. The matrix reflected measures required to ensure a safe go live position with patient safety remaining a key priority with regard to the implementation of TrakCare.

It was noted that whilst the overall progress of the programme had fallen behind resources and remedial actions had been identified to prioritise activities.

Mr Cross noted the delays experienced were due to internal and external resources and the supplier. Intersystems had been engaged in having to re-work the system to meet NHS Tayside's specific requirements. It was noted progress was at a critical point in reaching the February 2017 deadline and a meeting had been arranged for the following week to review progress and risks with a report being submitted to the Directors meeting.

Mr Cross highlighted the hard work of Mr Graham and the programme team with benefits expected to be seen following the implementation of the programme.

Ms McLay acknowledged the work which had been done and re-iterated the issues regarding IT systems and functionality. It was noted NHS Tayside was one of the last Health Boards to have TrakCare implemented.

**The Committee**

- **Noted the content of the report**

***11:15am Mr Graham left the meeting***

**8. ITEMS FOR INFORMATION**

**8.1 Record of Attendance**

**The Committee**

- **Noted the Attendance Record**

**8.4 Information Governance Committee Minute – 25 October 2016 (unapproved)**

**The Committee**

- **Noted the unapproved Information Governance Committee Minute – 25 October 2016**

**DATE OF NEXT MEETING**

**The next meeting of the Finance and Resources Committee will take place on Thursday 16 February 2017 at 10:15am in the Seminar Room, Kings Cross 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 19 January 2017, and approved by the Committee at its meeting held on 16 February 2017.

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**CHAIR** **DATE**