NHS Orkney Board
14 December 2017

Purpose of Meeting

NHS Orkney Board’s purpose is simple, as a Board we aim to optimise health, care and cost.

Our vision is to ‘Be the best remote and rural care provider in the UK’

Our Corporate Aims are:

- Improve the Health and Wellbeing of the people of Orkney and reduce health inequities
- Pioneer ways of working to meet local health needs and reduce inequality
- Value and develop our people
- Nurture a culture of excellence, continuous improvement and organisational learning
- Demonstrate best value using our resources
- Improve the delivery of safe, effective and person centred care and our services
- Demonstrate behaviours that are consistent with our values and operating principles

Quorum:

Five members of whom two are Non-Executive Members (one must be chair or vice-chair) and one Executive Member.
There will be a meeting of Orkney NHS Board in the Saltire Room, Balfour Hospital, Kirkwall on Thursday 14 December 2017 at 10:00 am

Ian Kinniburgh
Chair

**Agenda**

**Presentation**
Tackling Inequalities in Orkney - Derek Cox, Consultant in Public Health

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<td>Head of Finance / Head of Hospital and Support Services</td>
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<td>Director of Public Health</td>
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<td>To review the content of the report and consider the range of actions it can take to improve health and reduce inequalities.</td>
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<td>Chief Officer</td>
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<td>Chief Executive</td>
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<td>To note the current position in relation to corporate and high operational risks</td>
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<td>Board Secretary</td>
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**Open Forum –** Public Questions and Answers Session

*A Press Briefing will follow the conclusion of Board Business*
By Standing Invitation:

Senior Management Team

Christina Bichan, Head of Transformational Change and Improvement
Ashley Catto, Human Resources Manager
Malcolm Colquhoun, Head of Hospital and Support Services
Maureen Firth, Head of Primary Care
Derek Lonsdale, Head of Finance
Wendy Lycett, Principal Pharmacist
Julie Nicol, Head of Organisational Development and Learning
Maureen Swannie, Interim Head of Children’s Health Services / Service Manager of Children’s Services
John Trainor, Head of Health and Community Care
Declaring interests flowchart – Questions to ask yourself

What matters are being discussed at the meeting?

Do any relate to my interests?

Yes

Do a particular matter close to me?

Does it affect:
- Me
- My partner
- My relatives
- My friends
- My job or my employer
- Companies where I am a director of where I have a shareholding of more than £25,000 (face value) or 1/100th of the capital
- My partnerships
- My entries in the register of interests

More than other people in the area?

You can participate in the meeting and vote

NO

NO

You may have a personal interest

Declare your interest in the matter

NO

NO

Withdraw from the meeting by leaving the room. Do not try to improperly influence the decision

Personal Interest

Prejudicial Interest

You may have a prejudicial interest

Would a member of the public – if he or she knew all the facts – reasonably think that the personal interest was so important that my decision on the matter would be affected by it

YES

YES

YES
Orkney NHS Board

Minute of meeting of Orkney NHS Board held in the John Rae Room, Stromness Library, Kirkwall on Thursday 26 October 2017 at 10:00am

Present

Gillian Skuse, Vice Chair
Naomi Bremner, Non Executive Board Member
Cathie Cowan, Chief Executive
David Drever, Non Executive Board Member
Steven Johnston, Non Executive Board Member
Fiona MacKellar, Employee Director
Jeremy Richardson, Non Executive Director
Marthinus Roos, Medical Director
Louise Wilson, Director of Public Health

In Attendance

Jean Aim, Board Secretary
Christina Bichan, Head of Transformational Change and Improvement
Malcolm Colquhoun, Head of Hospital and Support Services
Maureen Firth, Head of Primary Care Services
Julie Nicol, Head of Organisational Development and Learning
Caroline Sinclair, Chief Officer
Emma West, Senior Committee Clerk (minute taker)

586 Apologies

Apologies had been received from A Ingram, R Johnson, I Kinniburgh, D Lonsdale, D McArthur, H Robertson, J Stockan and J Trainor.

G Skuse chaired the meeting.

587 Declarations of interests

No interests were declared.

588 Minutes of previous meetings held on 24 August 2017

The minute of the meeting held on 24 August 2017 was accepted as an accurate record of the meeting, subject to the amendment noted below, and was approved.

- Page 8, 416, penultimate paragraph add ‘as a development tool and a means to learn from rare and unusual cases.’
- Page 12, 422, 5th paragraph, amend ‘Local Authority Regulations’ to ‘Care Authorities Regulations.

589 Matters Arising

690 - Community Mental Health event

This event facilitated by the Blide Trust would be held on the 20 November 2017 in the Pickaquoy Centre, the agenda was currently being developed.

86 – Orthopaedics outpatients waiting list

As of today there were 112 new patients on the orthopaedic waiting list.
Additional capacity (outpatient, day and inpatient procedures) has been created in Orkney by the Medical Director doing additional activity in his Orthopaedic Surgeon role. Capacity has also been sought from the Western Isles and weekend clinics/day surgery is being progressed with start dates in November. Joint replacements remain an issue and again additional capacity from neighbouring NHS Boards is being explored, this would require people to travel to another NHS Board in the Region and it was unlikely this would be Aberdeen given their capacity issues.

310 – Air travel

The Head of Finance would continue to progress with all options being reviewed; it was agreed that this would remain on the action log for review as appropriate.

411 – Property Asset Management Strategy

The Chief Executive confirmed a further paper would be provided to the December meeting of the Board, with the Hoy and Eday properties being put forward for sale.

590 Board Action Log

The action log was reviewed and corrective action agreed on outstanding issues. (see action log for details). It was noted that there would be an update on the children’s autism pathway to provide greater clarity on referral route/pathway.

Strategy

591 Orkney Community Plan – Integrating Orkney’s Local Outcomes Improvement Plan 2017-2020 – OHB1718-42

The Chief Executive presented the Local Outcomes Improvement Plan for 2017-2020 advising that the Plan reiterates the strategic direction and priorities by which the Community Planning Partnership will deliver improved outcomes.

N Bremner noted the following which could be considered for review in future versions

- The vision did not directly refer to all of Orkney
- Within supporting remote and rural housing development it needed to be captured that this should be within the right locations
- She would be keen to see the travel scheme extended to community transport,
- Scottish Ambulance Service was not included as a partner
- The Road Equivalent Tariff scheme should be considered for all ferry services

The Employee Director noted the lack of childcare provision out of hours and the effect that this had on staff who were shift workers. Traditionally family members had taken on this childcare support role but this was not a possibility for many staff with people working longer and families being more dispersed. The Chief Executive confirmed that this was being progressed within the Healthy & Sustainable Communities Delivery Group led by Orkney Island Council’s Principal Teacher for Early Years.
J Richardson noted that people with a limiting long term illness and unpaid carers combined made up over 25% of the population, it was confirmed that this was still lower than the Scottish average.

G Skuse noted that there were no views recorded on transport to the isles. The Chief Executive advised that there had been a consultation process on this matter. The Chief Officer added that people had made comment on transport to and from the islands as part of this process but acknowledged that there was no direct reference to this in the document.

J Richardson noted that the employment rates did not consider the contribution that people over the age of 65 may provide through employment or productive activity.

**Decision / Conclusion**

The Board noted the Improvement Plan and agreed that the comments noted should be fed back to the Partnership through the Chief Executive.

**Orkney’s Winter Plan 2017/18 – OHB1718-43**

The Head of Transformational Change and Improvement presented the winter plan advising that this had been submitted to Scottish Government with no changes required.

Members were advised that comments received from the Integration Joint Board had been accommodated where possible and two areas around strengthening references to islands and resilience and detailed numbers for contact points would be finalised and appended.

The Employee Director clarified that there was no physiotherapy service provided out of hours and that this should be corrected in the document.

M Roos joined the meeting.

J Richardson noted that flu vaccinations were not being made available to the public by some practices until November, which seemed very late in the year. The Director of Public Health noted that this could be related to how the vaccines were distributed and there was no specific reason for this.

G Skuse noted that the admissions to Balfour had reduced to rates seen in 2006/7, this was a positive move but she questioned the reasons behind this. The Chief Executive confirmed that this was total admissions (planned and unplanned) so changes to day surgery or admission on same day of surgery would reduce the admission rate. Our length of stay in comparison to Scotland also needs to reduce and this would impact on bed days saved. The Chief Officer added that this would be due to a mix of efforts across services.

**Decision / Conclusion**

The Board approved the final Winter Plan 2017/18 with the noted amendments to be added.
Corporate Governance

Clinical Governance and Safety – OHB1718-44

The Chief Executive presented the report confirming that a number of changes in how the Board reports, manages and learns from incidents using Datix had been implemented. These changes had also incorporated complaints including legal claims management within the recently established Quality Improvement Hub managed by the Head of Transformational Change and Improvement and led jointly by the Medical Director and Director of Nursing, Midwifery and Allied Health Professions.

This had led to a review of structures and systems to support quality and safety and the report provided outlined the Terms of Reference of the Quality and Safety Group including reporting and governance arrangements.

G Skuse advised that the meetings of the Quality and Safety Group would be on a monthly basis starting in November 2017.

J Richardson questioned how the open attendance to Integration Joint Board members would be publicised and was advised that dates would be forwarded and papers made available; it was noted that Non Executive Board members would also be welcome.

It was agreed that the Public Health Manager would be added as a member of the group and the members would be encouraged to send a deputy in their absence.

Decision / Conclusion

The Board approved the Quality and Safety Group Terms of Reference that would support clinical arrangements across NHS Orkney services.

Board and Governance Committees – future arrangements – OHB1718-45

The Board Secretary presented the proposal to discuss and agree a way forward with regard to Board and Governance Committee meeting arrangements. The paper includes two considerations: one is to hold assurance committee meetings in public and the other is to consider holding Board meetings out with Board premises.

Holding Assurance Committee meetings in public

Members were advised that, currently all agendas and minutes were made available to the public on the website and that any confidential items would need to be taken In Committee if the proposal was accepted.

S Johnston noted the additional importance of confidentiality in a small community and that this would always need to be a consideration.

The Director of Public Health noted that many committees would require to hold additional in committee sessions and raised concerns as to whether some of the openness of discussion would be lost or happen elsewhere, practical steps would need to be taken to address this.

The Chief Executive acknowledged that this would create additional work for the
Board. She noted that the Board made available all agendas and minutes to the public and considered that this transparency was good and should continue. She added she had reservations with the proposal in that it could limit discussion given some of the sensitivities spoken about.

J Richardson agreed that this would create additional work and reduce the richness of conversation and as such needed careful consideration.

The Board Secretary advised that NHS Tayside currently held all its Governance/Assurance Committee meetings in public. They reported that they had no public attendance at these meetings.

N Bremner was supportive of the idea and had no issues with holding conversations in public but noted that this would create additional work and there was not the capacity to accommodate this in either the Board Secretariat or the Executives and Lead Officers workloads. She suggested that this was not unrelated to the idea of holding Board meetings elsewhere and questioned whether this should be the priority.

D Drever noted that if people were not fully informed it did not lead to transparency and inviting members of the public to meetings was not the way to do this.

**Venues for Future Board meetings**

S Johnston noted that a similar proposal had been reviewed by the Strategic Planning Group but there had been cost implications and the lack of equipment such as Video Conferencing made this harder.

N Bremner suggested that the Board meeting could be held on a different day of the week so that news was reported more timely, members from the press explained that this would be an issue due to deadlines and a Thursday would remain the best day for them.

The Chief Executive suggested that there was a need to engage with communities more through facilitated events rather than meetings with attention to listening and responding to the outcomes from these events.

Live Streaming had been suggested and would be possible in the new build facility but investment to support this now was not insignificant in money and staff capacity terms.

N Bremner suggested that the Board meeting could be broadcast via Facebook live and the Board Secretary agreed to take this forward.

The Head of Organisational Development and Learning advised that the proposed equipment for the new Hospital and Healthcare Facility would allow live streaming and should be progressed then.

J Richardson questioned whether having clinical directors away from the hospital site created a patient safety risk. The Medical Director advised that there was no clinical risk from this but that travel time needed to be taken into consideration if there was an immediate need for him to return.

**Evening meetings**
It was noted the holding meetings in the evening was not a suitable option as staff had families and other commitments and would have already worked a full day.

The Chief Officer advised that there were around 12-30 people listening to Council meetings that were publicly broadcast but noted that some of these would be staff members with an interest in the papers being considered, however, it was still a positive number of public engaging with meetings.

**Decision / Conclusion**

The Board agreed to continue to hold Board meetings in Board premises, the Governance Committee meetings would not be made public but the agendas and minutes would continue to remain available via the website.

Live streaming or recording Board meetings would be further explored as part of the new build and the proposal would be brought back to the Board if there were any significant changes to accelerate this earlier.

Wider public engagement with the Board would also be considered through facilitated community events.

**Schedule of Meeting dates 2018-19 – OHB1718-46**

The Board Secretary presented the report seeking approval of the schedule of dates of meetings for the next financial year 1 April 2018 to 31 March 2019.

J Richardson questioned the date of the December Integration Joint Board meeting and whether this was achievable. The Chief Officer confirmed that the scheduling was to avoid the Christmas period.

S Johnston advised that Area Clinical Forum met on the first Friday of the month and alternated between formal meetings and development sessions, Non Executive Directors were invited to attend on a rotational basis.

**Decision / Conclusion**

The Board approved the schedule of meeting dates for 2018/19.

**Clinical Quality and Safety**

**Infection Prevention and Control Report and Education Strategy – OHB1718-47**

The Medical Director presented the report updating members of the current status of Healthcare Associated Infections and infection control measures, with particular reference to performance against the Local Delivery Plan Standards and cleanliness monitoring.

The Director of Public Health advised that the Board had six C.difficile infections to date with a limit of three and sought assurance that no link had been detected.

The Medical Director acknowledged that the limit had been exceeded but there were no links detected; there had been one patient with a reoccurrence.
The Board members were also provided with the Infection Prevention and Control Education Strategy as recommended by the Clinical and Care Governance Committee for approval.

J Richardson noted that reference to Safe and Effective Care Group need to be amended to Quality and Safety Group.

The Head of Organisational Development and Learning was keen that the Strategy was shared through the Area Partnership Forum, Staff Governance Committee and Education Steering Group to ensure consistency with the statutory and mandatory training review.

Decision / Conclusion

The Board noted the report against the requirement of national mandatory requirement for a Healthcare Associated Infection Control report to be presented to the Board on a bi-monthly basis.

The Board approved the Infection Prevention and Control Education Strategy in principle subject to the suggested further consultation and any material changes being brought back to a future meeting with assurance that this had taken place.

597 Chairs Report – Clinical and Care Governance Committee and minute of meeting held on 21 August and 11 October 2017

Gillian Skuse, Chair of the Clinical and Care Governance Committee, provided members with an update highlighting the following:

- The Committee had requested that a report on falls be progressed through the Audit Committee to provided assurance, followed by review and regular monitoring through the Clinical and Care Governance Committee
- Compliance with the Adults with Incapacity Act would continue to be a standing agenda item.

Decision / Conclusion

Members noted the chair’s report and minutes of the meetings held.

598 Chairs Report – Area Clinical Forum and minute of meeting held on 6 October 2017

Steven Johnston, Chair of the Area Clinical Forum, provided members with an update highlighting the following:

Concerns had been raised over the local autism diagnostic pathway for children around staff involvement, content and delivery and input into any further review would be welcomed. The Chief Executive advised that clarity would be sought on the paediatric pathway and this would be reported back through the Board once finalised.

There had been a recent development session held with discussion around strengthening the Area Clinical Forum and engagement with the professional
advisory committees.

The ongoing issues around duplicate clinical documentation on the blog had again been raised as members felt that this created a clinical risk, it had been agreed that any specific examples would be highlighted to the Head of Transformational Change and Improvement.

The Chief Executive advised that an alternative solution for storing and accessing clinical information was being progressed and that there would be a tender out to replace the blog in this financial year.

J Richardson noted that multiple versions of files was an ongoing issue and noted that the Board had previously been advised that there was a member of staff appointed to address this. He was advised that the member of staff in post had now moved on but had completed a significant amount of work to reduce this risk.

The issue of Clinical Director capacity to attend these meetings was raised and the Chief Executive suggested that due to the small Executive Team members of the Senior Management Team could share this workload.

Decision / Conclusion

Members noted the chair’s report and minute of the meeting.

Person Centred

Ombudsman Report – OHB1718-48

The Medical Director informed the Board of the Ombudsman’s report, sharing the current action plan and its implementation.

He gave background to the report, advising that a patient had attended the hospital following a road traffic accident and had been treated for a limb injury including being taken to theatre for a cleaning operation before transferral to Aberdeen Royal Infirmary. It had later been established that the patient had suffered a fracture to the spine which had not been diagnosed. The family had complained about this issue which had been investigated locally, but as they were not satisfied with the outcome this had been referred to the ombudsman.

It was agreed that this had been a major trauma case which should have been further investigation on admission; the recommendations had been addressed and included additional training for staff which was being arranged and progressed.

The Head of Organisational Development and Learning confirmed that Advanced Trauma Life Support (ATLS) training places were not available until early 2018 but training programmes for December had been put in place for nurses and a trainer would deliver further sessions locally until the ATLS places were available. A multi agency exercise would be held in the future to address further and would include the Scottish Ambulance Service.

The Medical Director added that new paperwork had also been implemented in the department and he was confident that a similar situation would not happen again. The issue around the previous handling and investigation of the complaint had also been addressed with the lessons learnt having positive outcomes on
future major trauma cases.

S Johnston noted that this had been discussed in detail at the Clinical and Care Governance Committee meeting and assurance provided that a trauma team would be mobilised as soon as NHS Orkney was aware that an accident had occurred.

The Chief Executive reported that subsequent cases had been adequately handled and again apologised to the patient and family.

N Bremner welcomed Scottish Ambulance Service involvement going forward as the ombudsman report did not consider the journey to hospital or handover which she felt was an omission. The Chief Executive clarified that the complainant had focused on hospital services and this was what the ombudsman report addressed.

The Medical Director confirmed that although the patient had been exposed to risk there had been no additional harm.

**Decision / Conclusion**

The Board noted the report, scrutinised the action plan, and took assurance that the actions had been implemented as recommended.

**Workforce**

**Chairs Report – Staff Governance Committee and minute of meeting held on 28 October 2017**

David Drever, Chair of the Staff Governance Committee, provided members with an update highlighting the following:

- Members had welcomed the redesigned workforce report
- iMatter and eKSF engagement continued to improve
- Compliance with ongoing medical appraisal and revalidation had been positively reported
- An organisational wide Training Needs Analysis was continuing

S Johnston questioned whether there was an update on the implementation of Duty of Candour. The Chief Executive confirmed that this had been reviewed by the Board with input from the Central Legal Office, feedback had been provided following this but there had been no further response.

**Decision / Conclusion**

Members noted the chair’s report and minute of the meeting held on 28 October 2017.

**Organisational Performance**

**Financial Management Performance Report – OHB1718-49**

The Chief Executive presented the report to inform members of the financial position for the period 1 April to 30 September 2017. Information was provided relating to resource limits, actual expenditure and variance against plan. NHS
Orkney was currently over spent against Core Resource Limit of £327,000 which was a 19% favourable movement on month 5. This was still a very challenging position for the Board and involved using reserves to offset expenditure.

Medical locum spend was a challenging area but it was a similar position across the UK. Creative ideas were being used to fill vacancies with regular locums used where possible to provide consistency and continuity. Senior locum consultants were also using their skills and expertise to support outpatient clinics.

The non consultant rota was fully staffed with past trainees having a very positive experience and this was influencing the number of trainees wanting to work in Orkney.

In regard to changes in service delivery the Chief Executive asked for a progress report on dermatology. The Head of Hospital and Support Services advised that he had met with Dounby Practice regarding the Dermatology Service which would utilise capital funds. The room was currently being renovated to meet requirements and equipment being progressed through the Medical Equipment Group. These changes would establish a phototherapy service to limit off island travel with a GP led dermatology service with consultant oversight.

The Chief Executive advised that additional funding to support training and equipment was being provided through the Scottish Government for a forensic service.

S Johnston questioned the training of staff to carry out this forensic work and maintaining those skills due to the small numbers involved. The Chief Executive advised that a training course led by NES was to be piloted in Shetland and Orkney would link in with this having been supported by the Scottish Government.

Members were advised that the savings target would be delivered but with a greater reliance on non recurring savings than had been planned for.

The Chief Executive advised that she would lead a cost improvement time out session to be held in early November to inform a three year improvement plan.

**Decision / Conclusion**

Members reviewed the in year financial position and noted the year to date position of £327,000 deficit.

602 **Performance Management Exception Report – OHB1718-50**

The Chief Executive provided a verbal update advising that the paper and presentation would be circulated following the meeting. She highlighted the following:

- Accident and Emergency compliance continued to be positive although there had been a small number of 4 hour breaches
- There were currently 5 delayed discharges and 112 bed days had been lost in August 2017
- 19% of patients had breached the Treatment Times Guarantee in August; and the main areas struggling with outpatient 12 week capacity was orthopaedics, dermatology, rheumatology and ophthalmology. Solutions
and mitigation plans were being developed locally to reduce the reliance on visiting services

- There had been 100% compliance with the 30 day cancer standard and 86.4% with the 62 day standard. Work would continue on improving the pathways and standards at a regional level.

The Medical Director noted that some Accident and Emergency timescale breaches were due to local circumstances and were clinically appropriate.

C Sinclair advised that Orkney Islands Council was undertaking a homecare recruitment campaign with a number of videos including staff and service users being made. There had been over 2,800 views to date on the Facebook page.

J Richardson questioned if local figures were available for wasted use of theatre time. It was confirmed that utilisation rates were available.

Decision / Conclusion

Members noted the verbal update and welcomed the paper and presentation being distributed following the meeting.

603 Annual Review – 24 October 2017 – outcome

The Chief Executive in the absence of the Chairman gave a verbal update following the Annual Review which had been held on the 24 October 2017.

The meeting had been very positive with a good turnout of public, staff and Board members. The questions from the floor had been welcomed and captured key outcomes and challenges. The recommendations letter would be shared once received.

604 Chair’s Report – Finance and Performance Committee and minutes of meetings held on 21 September and 13 October 2017

G Skuse, in the absence of the Chair of the Finance and Performance Committee, presented the report highlighting that the Committee had:

- Taken reassurance around the child health data
- Reviewed the cost reduction plan, with the financial review completed confirming that the plan was robust and achievable and providing assurance to the Audit Committee that this would continue to be monitored.
- The Laboratory Contract would be concluded by the end of October 2017, delays had been caused by workload and capacity issues that were being addressed by colleagues in NHS Shetland.

Decision / Conclusion

The Board noted the Chair’s report and the minute of the meeting held on 21 September and 13 October 2017.

Risk and Assurance
The Head of Transformational Change and Improvement presented the report which provided a summary of the overall risk register and listed corporate and high operational risks. There were 55 active risks, which was a reduction of 4 from the previous meeting. There was one very high risk and this was being reviewed due to the mitigation in place.

**Decision / Conclusion**

Members noted the summary update on risk registers as at 9 October 2017 and the current position in relation to corporate and high operational risks.

N Bremner, Chair of the Audit Committee presented the report for information highlighting that:

- The Committee had received a very positive Internal Audit report on the New Hospital and Healthcare Facility Project.
- It had been agreed that the Clinical and Care Governance Committee would continue to review performance and improvements against compliance with the Adults with Incapacity Act requirements and report back to the Audit Committee with any further concerns.
- The findings from the Digital Medical Records Audit Report would be discussed at a future Board Development Session.

**Decision / Conclusion**

The Board noted the Chair’s report and the minute of the meeting held on 5 September 2017.

N Bremner, in her role as Authority Observer, provided assurance to Board members that project governance and management arrangements in respect of the new build facility project were robust and that the project was progressing.

She advised that the next meeting of Project Co. would be held on 29 November 2017 when further information would be available. The role of the authority observer had been attached to the report, as previously requested.

**Decision/Conclusion**

The Board noted the contents of this report including the project progress to date and the minutes of the meetings held.

No other competent business was raised.
**Items for information**

609 **Key Legislation**

Members noted the key legislation that had been published since the last meeting of the Board.

610 **Orkney Partnership Board draft minute of meeting held on 22 September 2017**

Members noted the minutes of the meeting of the Orkney Partnership Board.

611 **Board reporting Timetable 2017/2018**

Members noted the reporting timetable.

612 **Record of Attendance**

Members noted the record of attendance.

613 **Reflection on meeting**

Members noted that it had been a positive meeting.

614 **Open Forum**

- Xandra Shearer acknowledged the delay in orthopaedics and ophthalmology but advised that there were also long delays in other specialities resulting in extended waiting times for patients.

  She was working with Aberdeen airport as part of a group representing disabled patients in Orkney and Shetland to make improvements and she would forward reports from these meetings.

  J Richardson questioned if issues at Kirkwall Airport including disabled parking and toilet facilities could be addressed and N Bremner agreed that this could be followed up.

- Sarah Sutherland from the Orcadian noted that they would be keen to attend and report on the Mental Health event being facilitated by the Blide Trust on 20 November 2017, the Chief Executive welcomed the offer of press attendance.
### NHS Orkney Board Action Log Updated 6 December 2017

**Purpose:** The purpose of the action log is to capture short term actions to enable NHS Orkney Board members to assure themselves that decisions have been implemented appropriately.

<table>
<thead>
<tr>
<th>No</th>
<th>Action</th>
<th>Source</th>
<th>Target date</th>
<th>Owner</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>06-2017/18</td>
<td>Holding Committee meetings in public How to embrace the proposal whilst complying with confidentiality plus review of Clinical and Care Governance Committee and governance structure</td>
<td>External Audit</td>
<td>October 2017</td>
<td>Chair/Chief Executive</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>07-2017/18</td>
<td>Spiritual Care Lead To be progressed by DONMAHP once in post</td>
<td>Meeting 24 August 2017</td>
<td>October 2017</td>
<td>Director of Nursing, Midwifery and AHPs</td>
<td>Verbal update to continue to be provided as part of Action Log</td>
</tr>
<tr>
<td>09-2017/18</td>
<td>Property and Asset Management Strategy Detailed report including options for premises to be brought to the Board</td>
<td>Meeting 24 August 2017</td>
<td></td>
<td>Chief Executive</td>
<td>On December agenda</td>
</tr>
<tr>
<td>10-2017/18</td>
<td>Regional Delivery Plan Focus as part of a Board Development Session to capture progress Draft being considered In Committee</td>
<td>Meeting 24 August 2017</td>
<td>October 2017</td>
<td>Board Secretary/Chair/Chief Executive</td>
<td>Feedback on consultation submission to be provided at December meeting</td>
</tr>
<tr>
<td>11-2017/18</td>
<td>Autism pathways Update paper to be provided to the Board once new pathways embedded. 26.10.17 – updated pathways to be brought to December meeting</td>
<td>Meeting 24 August 2017</td>
<td>August 2018</td>
<td>Medical Director</td>
<td>On agenda</td>
</tr>
<tr>
<td>No</td>
<td>Action</td>
<td>Source</td>
<td>Target date</td>
<td>Owner</td>
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<td>------------</td>
</tr>
<tr>
<td>12-2017/18</td>
<td>Community Mental Health Team&lt;br&gt;Final framework to be presented for approval</td>
<td>Meeting 24 August 2017</td>
<td>December 2017</td>
<td>Chief Executive</td>
<td>On agenda</td>
</tr>
<tr>
<td>14-207/18</td>
<td>Air Travel Negotiations&lt;br&gt;Verbal update to be provided as appropriate.</td>
<td>Meeting 24 August 2017</td>
<td>December 2017</td>
<td>Head of Finance</td>
<td>Ongoing</td>
</tr>
<tr>
<td>15-2017/18</td>
<td>Infection Prevention &amp; Control Education Strategy&lt;br&gt;assurance of consultation through the APF, Education Steering Group and Staff Governance Committee</td>
<td>Meeting 26 October 2017</td>
<td>December 2017</td>
<td>Head of Organisational Development &amp; Learning</td>
<td>Ongoing</td>
</tr>
<tr>
<td>16-2017/18</td>
<td>Annual Review&lt;br&gt;Outcome letter to be provided to the Board once received</td>
<td>Annual Review 2017</td>
<td>December 2017</td>
<td>Chair</td>
<td>Due</td>
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</tbody>
</table>

Completed actions deleted after being noted at following meeting
NHS Orkney Board Meeting

Date of Meeting: 14 December 2017
Paper No. : OHB1718-52

Subject: eHealth and IT strategic priorities

Executive Summary

This paper highlights key national, regional and local eHealth initiatives and how NHS Orkney intends to achieve them through national and regional collaboration.

Purpose

The purpose of this paper is;
- To update members on the national Digital Health and Care Strategy
- To inform members on eHealth North of Scotland Regional working
- To provide assurance that issues of importance are being progressed
- To seek the Board’s approval on the recommendations contained in the paper

Recommendation

The Board is invited to note the report, seek assurance on performance and approve the recommendations contained in this paper

1. Agenda Items

1.1. National Digital Health and Care Strategy

The national Digital Health and Care Strategy was due to be published by the end of December 2017 however the timescale has been revised and the strategy is due to be published in spring 2018. The strategy, which will include a costed implementation plan, builds on the previous national eHealth Strategy 2014-2017 and is likely to focus on the following key objectives:

- Enable more effective collaboration and coordination of care
- Empower people to manage their own health and wellbeing
- Develop leadership and digital skills across the workforce
- Support continually improving services, research and public health outcomes
- Establish the digital foundations for improvement and innovation
The use of the term 'digital' means any technology that connects people and machines with each other or with information, and at its core is the premise that services should be accessible, simple to use and convenient.

Following the publication of the national Digital Health and Care Strategy NHS Orkney’s the local eHealth strategy will be reviewed.

1.2. North of Scotland Regional working
North of Scotland (NoS) eHealth Leads meet on a regular basis to discuss how the digital infrastructure across the region can be improved to support a wide range of community and clinical service improvements. This infrastructure is needed to support the integration of health and social care and it is essential that partners in the NoS collaborate effectively on the eHealth/digital agenda. The following broad actions will be taken forward:

- NHS Boards will work together to integrate and standardize their core technologies so that NoS staff can access systems and services across the region seamlessly regardless of location.
- The NHS Boards will work together to integrate their core systems to allow regional working this will include clinical systems as well as management and administration systems.
- The NHS Boards will work together to deliver an integrated regional clinical portal that will support efficient management of patients across Board boundaries and support the movement of staff to work in regional services.
- The NHS Boards will build on the delivery of the regional clinical portal and the national work being undertaken in the West of Scotland to deliver a patients portal that will not only provide patients access to information on their care but also allows patients to interact with the health care services (note a patients portal may be delivered on a national basis rather than regional).
- The NHS Boards will work together to deliver the best solutions to support national initiatives e.g. HEPMA (Hospital Electronic Prescribing and Medicines Administration)
- NHS Boards and the Health and Social Care Partnerships will explore the development of common digital health initiatives to support patients to manage their own conditions and to be cared for in their own homes for as long as possible
- Initiatives will be put in place which will create a revolution in the decentralisation of access to services by patients at home and in their communities removing the need to travel to acute hospitals for treatment and care
- The NHS Boards will develop links between their eHealth teams to provide a virtual support network on a regional basis.

1.3. North of Scotland Regional Clinical Portal
Chief Executives recently supported the development of a NoS regional clinical portal. This project will be delivered in a number of phases:

- Phase 1 will consists of creating the core clinical portal environment; linking Highland, Grampian, Shetland and Orkney SCI Stores (SCI Store is the clinical repository used in all Boards), linking Highland and Grampian Trakcare, PACS (i.e. X-ray & CT scan images), Emergency Care Summary, Linking Shetland
Clinical Portal (which is currently in proof of concept stage), and a connection to the Greater Glasgow and Clyde clinical portal.

- Phase 2 will consist of linking the clinical portal to Primary Care Systems, Health and Social Care Systems, Document Stores (e.g. CCube) and linking to the Western Isles portal, West of Scotland Portal and Tayside portal.

Alongside the development of the regional clinical portal NoS Boards Information Governance and IT Security Policies will need to be standardised to ensure that barriers do not get in the way of staff working across the region.

One-off and recurring costs are indicative at this stage but are expected to be in the region of £4.6M across the NoS over five years. NHS Grampian will provide the hosted environment for the portal and NHS Highland will fund phase 1 implementation costs. Apportionment is expected to be based on Board NRAC allocations.

1.4. Hospital Electronic Prescribing and Medicines Administration (HEPMA)
HEPMA implementation across NHS Scotland remains a key objective. The majority of NoS Boards, including NHS Orkney, use the JAC Pharmacy system which is the system of choice for a single instance HEPMA implementation across NoS Boards.

Substantial national funding of £20M over seven years has been allocated to Boards for the HEPMA implementation with NoS Boards funding £2M over the same period. An initial Project Implementation Board meeting to take HEPMA forward is being arranged for early 2018. Indicative timescales are for HEPMA to be implemented in NHS Orkney during 2020/21.

1.5. Electronic Patient Record (EPR)
An EPR goes beyond simply storing patients’ paper notes in digital format; it contains patients’ medical histories and treatments, treatment plans, alerts, laboratory tests and results, radiography images and reports, referrals and clinical letters and documentation. It allows clinicians to enter information directly into the system and enables workflow processes to be standardised.

Trakcare is the NHS Scotland Patient Management (PMS) system of choice and has been implemented in most Boards. NHS Orkney and NHS Shetland are hosted on NHS Grampian Trakcare.

NHS Grampian eHealth staff visited Orkney in August and met a wide range of staff and gave a demonstration of EPR to the Area Clinical Forum. The proposed EPR programme will be reviewed and a business case to take this forward with NHS Grampian, including priorities, timescales and resources will be delivered by April 2018.

NHS Orkney has recently revised its SLA with NHS Grampian and has allocated £100K capital funding to NHS Grampian in 2017/18 and in 2018/19 to support the ongoing development and implementation of Trakcare/ EPR, including a Trakcare upgrade in early 2018.

1.6. Digital Medical Records (DMR)
Following an Internal Audit report in August 2017 the DMR project was assessed with regards to readiness to recommence scanning of paper records, readiness for the Community Mental Health team “go live” and readiness to authorise the
destruction of scanned records.

In order to give executive directors assurance on the above project resources have been increased, documentation has been reviewed, hospital medical records and community mental health team (CMHT) records scanned to date have been inspected to ensure they are of a sufficient standard to be acceptable as a clinical record, test scripts have been developed to certify the system functions as expected and procedures for the in-house scanning of loose paper casenotes have been developed.

In addition some hospital medical records and physiotherapy casenotes have been boxed ready to be sent for off-site scanning, and an out of hours service has been established so that clinical staff can continue to access casenotes which have been boxed or have been scanned and are available in digital format.

If approved the scanning of paper hospital medical casenotes will recommence in early 2018, hospital and CMHT and “go live” dates will be determined, and the resources required for the scanning of other casenotes such as AHP (Allied Health Professionals), community nursing, etc will be assessed before the project continues for the remainder of 2017/18 and into 2018/19.

1.7. GP Order Communications (GP Ordercomms)
NHS Scotland commissioned Deloittes during 2017 to undertake an assessment of primary care IT across NHS Scotland.

Order communications, which allows GPs to request tests, and receive results, electronically instead of using paper request forms was identified among a number of priority areas with the result that we committed to the Sunquest ICE system which is currently being implemented across Orkney GP Practices.

The first phase of the implementation will enable GPs to request tests electronically from Orkney laboratory and a second phase will assess the viability of requesting tests from Aberdeen laboratories.

1.8. National eHealth/ IT programmes

1.8.1 CHI/Child Health Systems
CHI/Child Health systems are hosted on a legacy mainframe computer system and consist of three main systems; the CHI system which holds demographic information on Scottish residents, the Child Health systems which are used for pre-school and school age children and a GP Registration service which allocates a unique patient identifier to each Scottish resident.

The costs of maintaining the current mainframe-based CHI system are becoming prohibitively expensive and the CHI and Child Health systems will be replaced by modern systems during 2018/19 and 2019/20. These replacement systems will provide additional functionality and enable easier integration between CHI/Child systems and other systems.

In preparation for the replacement Child Health system the Public Health Department is addressing significant gaps and concerns which were identified in their existing data quality, procedures and training.

1.8.2 GP IT
A re-tendering exercise is currently underway to replace the existing GP IT systems. The replacement systems will align with the new GP contract and will
offer increased functionality and integration with existing systems.

The IT delivery model is expected to move to a centrally hosted model and we are moving the majority of Orkney GP practices to a centrally hosted model in preparation for the new system being available.

The timescales for the project have been extended to allow more dialogue on bidder submissions and it is expected the contract will be awarded in Autumn 2018 with implementation taking place in 2018/19 to 2020/21.

A national funding shortfall in the project has been identified which Boards are expected to meet to enable the procurement to proceed.

1.8.3 PACS (Picture Archiving and Communications System)
The national PACS contract with Carestream has been extended to 2023 to allow a technical refresh of existing PACS implementations to take place and to allow options for future PACS data centre hosting, which will enable greater cross-border reporting and alignment with other objectives such as the National Radiology Model to be considered.

Recurring costs are estimated at £12K pa over the period 2017/18 to 2022/23 with a one-off cost of £86K in 2019/20.

1.8.4 Community system
An initial Outline Business Case for procurement of a national Community system was produced in 2017 however it was recognised that to realise efficiencies the procurement should be closely aligned with the GP IT and CHI/Child Health procurements and the Health and Social Care Delivery Board recommended that a more joined up approach with Social Work should be taken.

An options analysis has been undertaken and has identified costs of £102M over eight years across NHS Scotland to cover implementation costs and mobile devices/service to support remote working and enable a number of the expected benefits. No sources of funding were identified within the OBC, with national discussions required to determine where this funding would be provided from.

1.8.5 Microsoft Office
MS Office 2007 (i.e Word, Excel, Outlook, PowerPoint, etc) used in NHS Orkney and in the majority of Boards went out of extended support in October 2017. The product is stable however security updates are no longer available and there are issues around MS Office 2007 compatibility with newer versions of MS Windows.

An options appraisal for an updated version of MS Office has recommended a move to a national cloud based solution known as Office365 (O365). The benefits of a national solution are that NHS Boards would be able to work more collaboratively, local file storage requirements would be greatly reduced, and integration with social care and third parties would be more robust. Cloud solutions are annual subscription based and the estimated annual cost to NHS Orkney would be in the region of £30K per annum ex VAT.

1.8.6 Cybersecurity
Following the Wannacry malware incident in May 2017 the Scottish Government produced a Public Sector Cybersecurity Action Plan under which all NHS Boards must achieve the following:
• NHS Boards Have in place minimum cyber risk governance arrangements by end June 2018.

• Ensure that public bodies that manage their own networks become active members of the NCSC’s Cybersecurity Information Sharing Partnership (CiSP), in order to promote sharing of cyber threat intelligence, by end June 2018.

• Achieve Cyber Essentials/Plus cyber security certification on an appropriate basis by end October 2018. To support this, funding will be made available for all public bodies to undergo Cyber Essentials “pre-assessments” by end March 2018.

• Implement as appropriate the NCSC’s Active Cyber Defence Programme, which aims to make internet-based products and services safer to use, by end June 2018.

• Have in place appropriate cyber resilience training and awareness-raising arrangements for individuals at all levels of the organisation by end June 2018.

• Have in place appropriate cyber incident response plans as part of wider response arrangements, and ensure these align with central incident reporting and coordination mechanisms by end June 2018.

eHealth Leads are seeking SG funding to deploy a standard product set across NHS Scotland which will standardise firewall, antivirus, patch management, device management, account management, etc across Boards with specialist support being available from central support team. The NHS Orkney IT Security policy is currently being revised to align with the recommendations contained in the Cybersecurity Action Plan.

2. Risks

2.1. The primary risks to this programme relate to resourcing. The programme is extensive and we devolve ownership for projects to managers who have busy day jobs.

2.2. A further resourcing risk is clinical engagement. Project staff and project team members work hard to secure clinical engagement but it can be very challenging with the turnover of medical staff. Additionally we need to find ways to encourage staff to become involved.

2.3. There is a risk that it may not be possible to take eHealth and IT forward to the new hospital and/or incur duplicate costs/activities. All eHealth and IT developments must be aligned to the new hospital and healthcare facility.

3. Recommendations

The Board is asked to approve:

• The replacement of the NHS Orkney eHealth Strategy with a local Digital Health and Social Care Strategy closely aligned with the national strategy.

• Regional working with NoS Boards; Standardise Technologies, Regional Clinical Portal, HEPMA, Social Care integration and caring for people at home

• EPR; continuation of £100K capital funding to Grampian in 2018/19 to progress EPR
• DMR; continuation of the DMR project on the understanding that sufficient assurance is given to allow the system to go-live and off-site scanning of paper casenotes to recommence

• GP Ordercomms; Progressing to phase 2 of the project, i.e. interfacing Sunquest ICE with Grampian laboratories, once GP Ordercomms has been implemented with Orkney laboratory

• National eHealth/IT programmes; Engagement with national programmes CHI/Child Health, GP IT, PACS including funding of £86K in 2019/20, Community system, MS Office including recurring revenue funding of £30K and Cybersecurity.

Executive Sponsor: Cathie Cowan, Chief Executive
Author: Tom Gilmour, Head of eHealth and IT
Contact details: tom.gilmour@nhs.net
Date: 08 December 2017
NHS Orkney Board

Date of Meeting: 14 December 2017

Paper number: OHB1718-53

Subject: Property Asset Management Strategy

Executive Summary

The Board of NHS Orkney at its meeting in August approved the Property Asset Management Strategy (PAMS) and requested that a report (options) be presented to the December meeting.

Purpose of Report

The purpose of this report is to update NHS Board members on the implementation of the PAMS thus far and to specifically deal with properties and present options for those properties that have highlighted suitability and functionality issues that require to be addressed.

Recommendations

Members are invited to:

- consider the progress to date and the options presented
- approve the disposals as outlined
- request a future update on progress and plans being undertaken

Executive Sponsor/Author

Cathie Cowan, Chief Executive

Contributing Authors

Malcolm Colquhoun, Head of Hospital and Support Services
David Cowan, IT Manager
Maureen Firth, Head of Primary Care Services
Derek Lonsdale, Head of Finance

Contact details

derek.lonsdale@nhs.net

Date

6 December 2017
1. **Background**

The overall aim of our PAMs is to ensure that NHS Orkney’s asset base is the right size, suitable for purpose whilst positively contributing to enhancing service delivery and patient experience. In this regard our property portfolio will change as we look to demonstrate best value through enhancing, maintaining or disposing of surplus estate.

Investment in equipment to support our ambitious repatriation agenda will be required to support the delivery of more people centred, safe and effective care closer to home through an integrated service and workforce model that takes account of our health and care economy in an Island context.

The opportunities to work with partners notably Orkney Islands Council (OIC) that go beyond health and social care integration is a key feature of how we intend working within our local community planning arrangements. A short life working group proposed by NHS Orkney Chief Executive involving community planning partners was established. Gillian Morrison, Director of Corporate Services, OIC took on the role of chair. Members of the Group submitted details of all their properties. A spreadsheet and a geographical map listing properties throughout Orkney have been created. The Group has since been disbanded but will meet annually to discuss capital projects and opportunities for greater collaboration.

The Property Asset and Management Strategy was approved by the NHS Board in August 2017.

The physical condition of the estate was assessed in four categories:

- Category A: Very good
- Category B: Good
- Category C: Requiring investment
- Category D: Unsatisfactory and requiring major investment, replacement (and/or disposal)

NHS Orkney has a range of primary care premises that currently score a category C or D rating. In addition, the backlog maintenance liability of the physical estate was assessed under the following definitions:

- Low Risk
- Moderate Risk
- Significant Risk
- High Risk

The Balfour Hospital makes up for over 80% of the backlog maintenance in NHS Orkney’s estate, this will be addressed by the new Hospital and Healthcare Facility scheduled to open in the Spring of 2019.

NHS Orkney has 16 Health Centres and/or community GP facilities across Orkney and the Isles. The following table provides an overview of the physical condition of NHS Orkney’s property assets.
It shows that the majority are in poor physical condition which reflects the refurbishment and new build currently underway.

<table>
<thead>
<tr>
<th>Area</th>
<th>Physical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
</tr>
<tr>
<td>Balfour Hospital</td>
<td>7,871</td>
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<tr>
<td>Primary &amp; Community Care</td>
<td>5,747</td>
</tr>
<tr>
<td>Office Use</td>
<td>487</td>
</tr>
<tr>
<td>Residential</td>
<td>1,028</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>15,133</strong></td>
</tr>
</tbody>
</table>

2. **Progress, Proposals and Discussion**

Progress has been made on the strategy of NHS Orkney asset base, including:

**Surplus Assets**

A review of assets is underway, in line with best value and any asset deemed to not be Value for Money will be presented to the NHS Board for investment and/or disposal. Two properties have currently been identified and have a category “D” rating and were subject to discussion in August. The following assets have now been deemed surplus to requirements releasing £11,000 running costs and £73,000 back log maintenance requirements:

- Bayview, Hoy
- Heatherlea, Eday

The Scottish Government have confirmed that the profit element on the disposal can be with held and reinvested and once the properties have been valued this return will be built into the 2018/2019 Local Delivery Plan.

In addition, the Evie Surgery as previously reported is not fit for purpose. Consideration to replace this at Tingwall has been discounted due to cost (estimated at £350,000 this would not include any equipment required). It is proposed a full option appraisal be developed. The preferred option may be subject to public consultation and will be reported back to the NHS Board by April 2018.

On the back of the property asset management group being officially recognised as a committee structure it is proposed that Malcolm Colquhoun and Maureen Firth engage with the Director of Education at OIC to see if there are any joined up ways of using property in Papa Westray and Flotta going forward in the next financial year. The outcome of these discussions will be reported to a future NHS Board meeting.

**Property Maintenance**

Repairs and Maintenance have been carried out on the Primary care properties to keep them safe and reliable; Flotta, North Ronaldsay, Westray, Sanday, Stronsay, Stronness and St Margaret’s Hope, including roof repairs, drafts, damp, electrical wiring, potholes. The estates department were given a budget of £150,000 for these primary care properties and by the end of this financial year it is expected that this budget will be used in full to invest in these
6.2

premises. This spend is over and above the revenue budget required for the mandatory and statutory compliance annual testing of approximately £100,000.

Vehicle Fleet

Over the last two financial years NHS Orkney has invested approximately £120,000 in new vehicles for the Isles. At this time there are no charging points available to NHS Orkney on these islands and so the Scottish Government announcement on electric vehicles to maximise funding was not an option open to the NHS Board to pursue. On the Mainland of Orkney the new hospital and healthcare facility due to open in 2019 has 10 charging points and it would be our intention as a NHS Board to look to invest in electric cars as our mainland vehicles require replacing.

IM&T Assets

Investment in IM&T has continued into 2017/18, with progress in the following programmes:-

- Windows 7 migration is nearing completion with three remote Isles and Garson dental surgery remaining.
- Digital Medical Records programme is continuing with a scoping exercise on the requirements for both primary care and the school health records.
- The pharmacy JAC system went live in July and continues to deliver benefits.
- The Immediate Discharge Letters went live in September.
- Electronic Patient Records programme commenced in August with NHS Grampian visiting Orkney. Priorities, timescales and resources are to be agreed.
- The Dental IT system (R4) requires to be upgraded by the end of December 2017 to comply with changes to PSD’s claims submission system. This is on track to be completed in early January 2018.

3. Next Steps

The opportunities to work with partners notably OIC and local communities are ongoing.

On completion of the New Hospital and Healthcare facilities the leased Garden House property may become surplus to requirements, but will still have approximately 3 years left on the lease with Orkney Islands Council. We are reviewing our accommodation needs and may wish to pursue early severance. Discussions involving the Director of Corporate Services, OIC and Chief Executive of NHS Orkney supported by the Head of Hospital and Support Services are ongoing.

Other opportunities being considered include: -

Reprovision of service at Garson including an option to sell these premises given the progress achieved in moving from a reliance on the Public Dental Service to a new independent model and the underutilisation of this space.

We are also considering the potential to use different facilities on the Isles. Each of the Isles, with exception of Papa Westray, have a school and/or a community centre, therefore potentially providing space to relocate NHS Orkney surgeries. If
this was an option the NHS Board would consider disposing of the existing buildings whilst working collaboratively with communities and our community planning partners, notably OIC in line with the Community Empowerment Act. On the bigger Isles this may require building or extending onto existing buildings and on the smaller islands perhaps the use of existing space with modifications. The opportunity to close Daisy Villa if space became available in the Braeburn centre is also an area for discussion with colleagues in Orkney Islands Council
Executive Summary

This document describes our workforce strategy covering 2017 to 2019, informed by NHS Orkney’s Everyone Matters Action Plan, in response to NHS Scotland’s Workforce 2020 vision and our full business case for our new hospital and health care facility.

The Staff Governance Committee reviewed the Strategy on 27 November 2017 and agreed to recommend Board approval.

Purpose
To submit the Workforce Strategy to the Board for approval

Recommendation
That the Board review and approve the Workforce Strategy as recommended by the Staff Governance Committee

Lead Director
Chief Executive

Author
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Date
1 November 2017

Supporting Documents
Workforce Strategy 2017-2019
WORKFORCE STRATEGY
2017 - 2019

Sustainable

Capable

Engaged
Introduction

Our Workforce Strategy ensures that by having the “right number of people, in the right places, with the right skill mix, attitudes and behaviours, motivated and managed to perform their best and engaged on patient safety”, then we will, as an organisation, be contributing to becoming a high performing exemplar employer.

This document describes our workforce strategy covering 2017 to 2019, informed by NHS Orkneys Everyone Matters Action Plan, in response to NHS Scotlands Workforce 2020 vision and our full business case for our new hospital and health care facility.

The commitments described are intended to be concise, clear and meaningful to everyone in the organisation.

Context

Our Local Delivery Plan outlines a very different future than at present for Orkney’s health and care with primary care and community services playing an increasingly central part with greater integration of services that are built around patients and citizens rather than services that they have to fit into. Prevention and early intervention will become a key feature in our everyday interactions as a means to incorporating health improvement into our everyday activities to change behaviours especially amongst those people at greatest risk. Care in the community in line with NHS Scotland's 2020 vision will also need to change to address an ageing population who often raise concerns about isolation and a lack of support for their informal carers.

People living with more than one long term condition should be offered more life style interventions to help them change their behaviours in regard to smoking, alcohol consumption, obesity and physical activity. Low level intervention to support people’s health and wellbeing will require greater engagement with our community planning partners.

The newly established Integration Joint Board – Orkney Health & Care as part of its key commissioning role will be required to work more closely with communities to build greater capacity and resilience to enable people to live at home or in their communities. End of life care is also something people wish and our ability to support people die at home again will require a different approach using different staff and people.

Our vision, corporate objectives and values

Our Vision is ‘to be the best remote and rural health care provider in the UK. Our Corporate Objectives include:

- Improve the Health and Wellbeing of the people of Orkney and reduce health inequities
- Pioneer ways of working to meet local health needs
- Value and develop our people
- Nurture a culture of excellence and continuous improvement
- Demonstrate best value using our resources
- Improve the delivery of safe, effective and person centred care and our services
- Demonstrate behaviours that are consistent with our values and operating principles

As we strive to be the best remote and rural provider we will use the new build transition to move at pace in preparation for anticipated new ways of working. But, with new ways of working there is an expectation to see behaviours consistent with our values, values that support care and service delivery whilst at the same values that support how we engage with each other.
In support of these values and in an effort to move towards a continuous improvement culture staff have defined operating principles these are detailed at Appendix 1. We also recognise the skills that we will need to develop and build on to enable people to live by these operating principles. NHS Orkney as part of its commitment to developing people will expect all staff to have a PDP to reflect their ongoing personal growth and development.

**Looking forward**

As we get ready to move into a new hospital and healthcare facility, we will need to create a **sustainable, capable and engaged** workforce that is able to work in and across our primary, community and hospital settings that will become more and more multidisciplinary in nature.

We are moving from an ageing building to a state of the art facility, presenting opportunities as well as challenges as staff get used to working in a new environment.

Almost 19% of our workforce are aged 55 and above, and are all eligible for retirement see Chart 2. If we do nothing to succession plan, develop our existing workforce or if we stopped our youth employment strategy, we will find ourselves with a staffing deficit, see Chart 1.

Nationally there are well rehearsed reasons to describe the hard to fill posts. To date, our approach has been to take a more innovative approach to filling vacancies. However we also need to look at succession planning approaches, growing our own and encouraging those who have been out of the professional groupings to return to practice.

For those who choose to work beyond retirement age, we need to be supportive of their health and wellbeing needs, enabling them to stay with us for longer, working with them to retain their skills and knowledge as they prepare for retirement.
The move to single rooms in the new hospital and healthcare facility will require nurses who are currently working within specialisms to be more general to flex across, depending on needs of patient. It will also require additional hotel service staff to meet the cleanliness
standards across a larger footprint.

**Sustainable**

**Induction and first year in post**

We will provide a welcoming on-boarding experience to new recruits. We will clearly demonstrate through our corporate and departmental induction programmes “what is expected”, as well as “what you can expect” as per our staff governance standards.

**Youth Recruitment**

We will recruit youth to counteract the gap that retirement will leave, giving us fresh talent for the long term. **Chart 2** shows 25% of the workforce are approaching retirement age. We have 11 people confirming their intention to retire in the next 2 years (source Workforce Development and Succession Planning questionnaire, April 2017).

**Chart 2** shows that our youth employment strategy to date has been successful as we sit well above the Scottish Average in our 25 – 29 year olds age group, however as we see the 55+ within the workforce start to retire, if we do nothing we are going to see a staff shortfall.

We will continue with our Modern Apprenticeship programme which has brought in 11 new starts within the 19 – 24 year old age bracket, in the last 2 years.

We will continue to offer opportunities ranging from work experience placements through shadowing and secondment opportunities.

We will target, for recruitment, Orkney Students due to graduate, making NHS Orkney an early and attractive proposition for their careers.

We will develop a new approach, recruiting to posts we predict will become available, rather than waiting for the vacancy.

This will help increase the percentage of the workforce aged 16 – 29, additionally benefiting the community, keeping the younger generation in the islands.

**Growing our Own**

We aim to open more doors to training within employment, which will develop an environment in which people will flourish.

We will create opportunities for our own staff to develop through shadowing or internal secondments, enabling staff to learn new skills and extend their knowledge base.

Where career pathways are Nationally modelled, implement them. The Pathways look at the different roles in a range of services, at how they build on each other and the learning staff need to complete to get from one stage to the next. Pathways are currently available for Estates and Facilities staff and Admin and Support Services staff.
We will identify and develop leaders of the future through effective appraisal and talent spotting process. While the process is to be developed, we envisage this as being a pro-forma capturing career aspirations which we will use to create opportunities.

We have 30 employees who have expressed a desire to develop their careers within NHS Orkney in the next 2 years, we will use this data to test aspirations with 2 temporary improvement roles.

**Capable**

We are developing and will deliver a clinical skills training programme focussing on eight priority areas.

The clinical training needs analysis work in progress based on the four pillars of practice, will inform and further develop our clinical capability development.

Employees are currently asked to complete a number of mandatory training programmes that are not adding any real value to their roles.

We will reduce the number of statutory and mandatory training programmes, from 16 to 9, in line with National drive for consistent application of training across NHS Scotland.

This will:

- free up time for more value added training
- enable easier transition for staff from within the NHS to transition to another board by way of a statutory and mandatory passport.
- Increase compliance with the 9 statutory and mandatory training programmes from x - y

We will build the capabilities of our leaders to transform and incrementally improve services.

We will support leaders to identify and resource priority projects aligned to corporate objectives, through strategy deployment.

To be the best provider of rural and remote healthcare, we must first know how well we are currently delivering our services. As part of a quality planning development programme, managers and leaders will be supported to develop/enhance the success measures of their services, making these measures visible in the area where services are delivered.
Therefore, managers and leaders will be supported to develop an understanding of the demands and capacities of their service as part of quality planning development programme.

We have already begun working towards targeted levels of quality improvement capability. 43 of the targeted 318 have completed the level 1 training, and 3 are accredited at level 3. We are starting the level 2 training in September 2017, and will introduce an accreditation process to ensure learned skills are being applied to our services.

Whilst this framework will give them the skills they want to apply, we recognise the need for incentives to help make improvement part of the day job and offer opportunities for career progression.

To do this we propose making quality improvement skills part of the essential criteria in middle and senior management level job descriptions.

We recognise that once people have the necessary skills and incentives, they will need the support and encouragement of their immediate line managers to implement their improvement ideas, with a need to move to a position where we are less frequently seeking permission in line with our operating principle of standardising where possible, and customising where it adds value, all teams will move towards a position of having standard operating procedures (SOPs) in place for key processes. A standard template has been agreed and staff will be developed in the writing of effective SOPs.

A key enabler to improving a service is to ensure we have the necessary capacity to cope with the demands we are receiving.

In line with our operating principle of standardising where possible, and customising where it adds value, all teams will move towards a position of having standard operating procedures (SOPs) in place for key processes. A standard template has been agreed and staff will be developed in the writing of effective SOPs.

We will implement a management development programme to ensure that all staff members have the opportunity to maximise their potential by refreshing their management skills, learning new management and leadership skills and techniques, and stretching...
themselves in their current role and for future career progression.

We will conduct an IT training needs analysis and implement a training programme to support our other capability building ambitions.

**Engaged**

Only 76% of our workforce agree that we provide them with a continuously improving and safe working environment that promotes health and wellbeing.

![Chart 3](image)

**Chart 3** shows that the most challenging areas are: displaying appropriate behaviours, developing supportive relationships and employee health & wellbeing.

We will behave in accordance with our professional Codes of Conduct, our Staff Governance Standards, our Values and Operating Principles.

We will work with managers and supervisors to develop their skills to support them with performance management and team development.

We will maintain our Healthy Working Lives Gold status, by meeting the strategic goals outlined in our Staff Health and Wellbeing Strategy. We will issue a staff health and wellbeing survey and act on the results.

We will achieve the 4% absence target, aiming to maintain or reduce, by focussing on stress related and musculo-skeletal problems. In 2016/2017, 7,297.7 hours, (140 hours a week) were lost as a result of stress, **(Chart 4)** we aim to reduce the amount of hours lost by 25% over the next 2 years. It is important to note, this is not necessarily work related stress, and however we would aim to be able to support our staff to deal with any personal stressors that may be impacting on their ability to fulfil their role.
Chart 4 shows that we have exceeded the 4% sickness target 75% of the time in the last 12 months, with a monthly average of 4.48% absence.

Chart 5 shows that we have exceeded the 4% sickness target 75% of the time in the last 12 months, with a monthly average of 4.48% absence.

We will review all musco-skeletal related absences, ensuring appropriate workplace adjustments are in place and that our moving and handling policy is being applied where necessary. **Chart 6** shows that in 2016/2017 we lost 8,277.54 hours to back or musculoskeletal related absences. We aim to ensure our staff are appropriately trained to move and handle objects and people with a view to reducing these type of absences from the workplace, or by enabling people to return to work to alternative roles until such time as they are fit to fulfil their substantive role.
We will co-ordinate the launch of a new Dignity at Work Survey, in November 2017. Staff who are subject to bullying or who work within a culture of intimidation are more likely to suffer from work related stress, more likely to take time off work sick and as a result less likely to work to their full potential. Our survey results will enable us to take a proactive approach to managing any issues identified within the organisation.

We will achieve 80% completion of appraisals, to support those conducting appraisals we will deliver appraisal skills training, to enable managers to conduct high quality, informative and constructive appraisals. Looking back at the last 12 months, looking ahead to the next 12 months and beyond, capturing career aspirations in support of our talent management strategy. Chart 7 shows that over the last 6 months we have seen real progress with the annual appraisal process. We will support managers to ensure engagement levels continue.

We will have 100% of i-Matter action plans complete on an annual basis, with an annual Board “You said, we did” Newsletter. Our iMatter Employee Engagement Index is currently 74%, we would like to see this increase by 3% in the next 2 years. Managers are encouraged to display their team story boards in their work area as a reminder of the celebrations and the actions agreed to in their action plans. We will run an annual staff conference and awards ceremony, staff feedback via the iMatter process, is very positive, in that staff say the conference and the awards makes them feel valued, recognised and rewarded for the great work they are doing.
We will run an annual staff conference and awards ceremony, staff feedback via the iMatter process, is very positive; staff say the conference and the awards makes them feel valued, recognised and rewarded for the great work they are doing.

**What we are asking of you**

We are looking for managers to support the iMatter process, encourage staff to complete our surveys, make staff available for the development opportunities, engage in the strategy deployment process, engage in annual staff appraisals and ensure that all employees are familiar with this workforce strategy.

We expect employees to become familiar with the operating principles and values and live these as part of your daily working lives.
Work together

Create a workplace that works for staff and those who use our services

Reduce waste, using people’s experiences to define what adds value

Make good decisions, based on data, which are aligned with our corporate objectives

Raise issues with positivity and address them at the right level

Ensure projects are sufficiently resourced and aligned to our long term vision

Standardise where possible and customise where it adds value

Appreciate others, welcome positive challenge and respect diversity

Promote professionalism and high quality standards

Reflect, learn and develop
Executive Summary

Health inequalities exist in Orkney and are mainly associated with deprivation. Deprivation is scattered throughout the community, with 75% of people living in deprived circumstances located in our three least deprived areas, meaning that resources should be targeted at people, not places.

The link between deprivation and physical illness is mediated through low levels of wellbeing.

The paper proposes a pilot programme within the NHS to target people with low levels of wellbeing and to offer them a ‘health coaching’ intervention designed to improve their wellbeing and give them a sense of control over their lives.

Purpose  
To explore the possibilities for tackling health inequalities using targeted health coaching

Recommendation  
To agree funding of up to £52,000 for the pilot project

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Date  
15th November 2017

Attachments  
Paper “Proposal for a new way forward to address health inequalities”
Proposal for a new way forward to address health inequalities

Introduction
At a previous Board Development Day in October 2017 evidence was presented to support the following conclusions.

- Behaviour change programmes delivered to a whole population widen health inequalities due to differential uptake by less deprived people.
- Health inequalities exist in Orkney, with significantly higher hospital discharge rates for major illness groups in the most deprived post code areas in comparison to the least deprived areas (based on SIMD data)
- Around 75% of income and/or employment deprived people do not live in these deprived areas, making geographical targeting of health-enhancing resources an ineffective method of reducing inequalities. Targeting of resources needs to be to people, not places.
- The psycho-social risk factors for ill health and illness are at least as important, and probably more important, than the physiological (high blood pressure, raised serum cholesterol, obesity) or the lifestyle (smoking, poor diet, lack of exercise) risk factors.
- The psycho-social risk factors can be conveniently captured in the concept of low wellbeing.
- Wellbeing can be measured.
- People living in deprived circumstances have low levels of wellbeing, and can be identified.
- Levels of wellbeing can be significantly improved using ‘health coaching’, an intervention based on an empowering model of cognitive behavioural therapy (CBT)

Subsequent discussions have let to this current proposal, which is to pilot a new project approach to health and wellbeing within the NHS in the first instance.

The Proposal
The suggested project would offer staff within the health service in Orkney a ‘health check’ based loosely on the ‘Keep Well’ check, but with a different approach to the check, a longer appointment time and, crucially, with the inclusion of the measurement of wellbeing, using a variety of measurement tools. The ethos of the health check and any subsequent discussion of the findings would be based on allowing the individual to retain control. Whilst signposting to other services (e.g. ‘Smoking Matters’) would be available it would be offered in a non-directive way. Those individuals found to have low levels of wellbeing would be offered the opportunity to participate in the health coaching part of the project. The health coaching part of the project would be for as short or as long a period of time as determined by the ‘client’. Whilst no staff member would be excluded from the offer of a health check, the actual target group would be those staff on the lowest salary grades.
The planning phase

If the Board approves this proposal the Public Health Manager would have to do the following.

- Select an appropriate member of the current Public Health team to take on the role of health check nurse.
- Appoint a health coach.
- Train the staff in their new roles. This can largely be done by the Public Health Manager who has been trained in the training role, and who has previously provided this training, but some additional input from an experienced health coach would be desirable, if possible.
- Purchase the necessary equipment for the health check.
- Purchase the necessary resources to support the health coaching. These are small ‘self help’ booklets written and published by Dr Chris Williams, a consultant psychiatrist from Glasgow.
- Arrange the printing of the questionnaires used in the health check.
- Develop, with IT support, the database to support management and evaluation.
- Liaise with management, human resources and trade unions so that all are agreed with the practical steps to allow the project to go ahead.
- Liaise with local GPs to establish proper communication channels and possible follow-up (e.g. if significant and previously unknown high blood pressure was detected)
- Set up a system of clinical and managerial supervision for the staff involved.

It is expected that this phase would last for approximately three months.

The pilot

All going well the pilot should start at the beginning of April 2018, and should run for one year. Lessons learned will be incorporated into the project as it develops, and will use feedback from staff, managers, trade unions, GPs and others.

Evaluation

The mainstay of evaluation will be a quantitative measure of change in wellbeing following health coaching. In addition there will be a qualitative aspect to evaluation by providing feedback questionnaires to clients.

Costs

The current Vaccination Coordinator based in Public Health previously delivered the Keep Well Health Checks (although she is no longer employed in this role). Out with the vaccination timetable her role will be developed to deliver the Health Checks in the pilot. This will not incur additional cost.

There is no current capacity within the Health Improvement team to deliver the health coaching service. A Health Coach post at a band 5 would be required (0.5 WTE) at a cost of £18,193 (costed at top of the band) for the year.

There are considerable administrative tasks associated with the project including, but not restricted to, making appointments, booking rooms, arranging travel and entering data and clinical information into the database (which is crucial for the evaluation). The department has recently absorbed the
work associated with SIRS and the Child Health systems and this has put a considerable strain on the administration capacity of the department. This additional work cannot now be absorbed, and so an additional clerical post at Band 3 will be required, costing £23,836 (costed at top of the band) for the year.

Non-recurring costs are for clinical equipment (blood pressure and other measuring instruments etc) and for the CBT self-help booklets. There may be additional travel costs where clients want to be seen at home or some other non-health board premises. For the period of the pilot the costs will not exceed £10,000.

The costs are based on an assumption that 50% of staff will accept a health check, and that 20% of these will require health coaching

**The future**

If the pilot evaluates well, the Board may consider extending this service to selected groups in the general population, but a further business case would have to be produced. In order to reduce potential costs and to make the project sustainable it is suggested that the health coaching model could be trained out to other staff within the statutory agencies (e.g. health visitors, community nurses, social workers etc.) and within the third sector organisations that engage with people living in deprived circumstances. This could become “The way we work in Orkney”.

Dr Derek Cox  
Consultant in Public Health Medicine

Carol Stewart  
Public Health Manager

Dr Louise Wilson  
Director of Public Health

14th November 2017
NHS Orkney Board

Date of Meeting: 14 December 2017

Paper No.: OHB1718-56

Subject: Proposed New GP Contract

Purpose
To give a brief summary of the changes proposed within the newly published GP Contract

Recommendation
To add to the Board action log to ensure the Board has clear sight going forward.

Lead Director
Chief Officer

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Date
2 December 2017

Supporting Documents
http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract
A proposed new GP contract has been published with members of the BMA having the right to vote for acceptance of this. The voting system is open from 7 December through to 4 January with the results due to be published in mid January. The contract will be introduced in 2 phases. The first phase will be implemented from 1 April 2018 to 31 March 2021 and this is the phase that currently members are voting on. The second phase will require a further vote to be taken in advance of any additional implementation of change on 1 April 2021.

If the vote for the first phase is accepted then this contract is to be put in place by NHS Boards commencing from 1 April 2018 and Integrated Joint Boards are to ensure that changes and implementation plans are included in their strategic commissioning processes.

Essential services as stipulated under the current contract will remain the same whilst some of the additional services will reduce where it is safe to do so.

Expansion of enhanced services will cease. The current enhanced services around vaccination programmes will transfer from GPs to Boards. Currently local enhanced service funding will continue whist transition of services is occurring between 2018 and 2021 as it is seen as important that there is no destabilising of income to practices.

Out of hours provision will continue as is and the core daytime hours of GP Practices will remain the same. There will however be a national enhanced service developed which will allow GP Practices to deliver out of hours services should they wish to do so.

Financial aspects of the contract will change. There will be new funding formula (The GP Workforce Formula) introduced from 1 April 2018. Previously there were 4 funding streams that came into practices and these will now be combined into one payment. All practices have been reassured that they will not lose any money as a result of this new contract and any practices who are adversely affected by this new formula will have an additional income guarantee attached to them. This affects mainly rural practices and will affect all our Practices at the current time.

From 1 April 2019 the government will introduce a GP Partner whole time equivalent earning expectations based on an income of £80,430 which includes pension contribution.

Phase 2 of the contract will introduce an income range that is comparable with consultants, and also which will directly reimburse practice expenses. Data will be based on an average of how many GPs are required for population areas, it has been acknowledged that remote and rural areas require additional numbers of GPs to cover their unique circumstances. There will be a second national vote at this point around whether GPs want to accept what is being offered.

There will be a need to develop a Primary Care Improvement Plan. These plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. To support that aim HSCPs will collaborate on the planning, recruitment and deployment of staff.

Some services which are currently provided under general medical services contracts will be reconfigured in the future. Services or functions which are key priorities for the first 3
The expectation is that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Additional ring fenced money is to be invested and is intended to provide additional MDT staff, which should, where appropriate, be aligned to GP practices to provide direct support to these practices under the oversight of GPs as senior clinicians. GPs will continue to work to their responsibility to ensure that their premises remain fit for purpose, services remain accessible to patients, that they are responsive to local needs and can maintain continuity of care; all of which will allow GPs to deliver an effective, integrated service as part of the MDT.

The HSCP Primary Care Improvement Plans will be considered alongside the NHS Board arrangements for the delivery of the GMS contract in Scotland in line with the requirements of the Scottish contract offer document.

The Primary Care Development Plan should also consider how the new MDT model will align and work with community based and where relevant acute services.

Key Requirements of the Primary Care Improvement Plan:

To be developed collaboratively with HSCPs, GPs, NHS Boards and the stakeholders detailed below
- Patients, their families and carers
- Local communities
- SAS and NHS 24
- Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees)
- Primary care providers
- Primary care staff who are not healthcare professionals
- Third sector bodies carrying out activities related to the provision of primary care

To detail and plan the implementation of services and functions listed as key priorities listed below, with reference to agreed milestones over a 3 year time period

To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.

To provide detail on available resources and spending plans (including workforce and infrastructure);

To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.

Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018

Key Priority changes within the new contract are:

*Premises:* The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. Premises and location of
the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan. This should allow GPs to more easily enter into independent practice partnerships as it will reduce the associated risk of taking on any premises liability. Currently no practices within Orkney own their own premises so this change does not directly affect us.

*Information Sharing Arrangements:* The Information Commissioner’s Office (ICO) has issued a statement that whilst they had previously considered GPs to be sole data controllers of their patient records; they now accept that GPs and their contracting Health Boards have joint data controller processing responsibilities towards the GP patient record. These contractual changes will support ICO’s position that GPs are not the sole data controllers of the GP patient records but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GPs’ responsibilities and GPs will not be exposed to liabilities relating to data outwith their meaningful control.

The new contractual provisions will lay the foundations for increased lawful, proactive and appropriate sharing of information amongst professionals working within the health and social care system for the purposes of patient care. In effect this opens the way for increased joint multidisciplinary working and removes the concerns some GP Practices may have had about allowing access other health care professionals access to their patient data.

*Workforce:* The national health and social care workforce plan published on 28 June 2017 noted that Part 3 of the Plan, which would determine the Scottish Government’s thinking on the primary care workforce, would be published in early 2018 following the conclusion of the Scottish GMS contract negotiations. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

GPs are to become expert medical generalists who will concentrate on undifferentiated presentations, complex care, local and whole system quality improvement, local clinical leadership for the delivery of GMS services.

GP practices will in the future become more multi disciplinary teams with the additional team members being attached to the practice but employed by NHS Boards or local authorities. Examples of include pharmacists who will become responsible for delivering services in a three tier approach reviewing and authorising acute and repeat prescriptions.

*The Vaccination Transformation Programme (VTP)* was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations. In the period to 2021, HSCPs will deliver phased service change based on a locally agreed plan as part of the HSCP Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting of work to other appropriate professionals and away from GPs. This has already happened in many parts of the NHS system across Scotland for Childhood Immunisations and Vaccinations. This change needs to be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up.

*Pharmacotherapy services* – These services are in three tiers divided into core and additional activities, to be implemented in a phased approach. By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the HSCP Primary Care Improvement Plan. This is to be followed by
phases two (advanced) and three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role.

**Community Treatment and Care Services** - These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan. This change needs to be managed to ensure, by 2021 in collaboration with NHS Boards, a safe and sustainable service delivery model, based on appropriate local service design.

**Urgent care (advanced practitioners)** - These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resource such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients, allowing GPs to better manage and free up their time. By 2021, in collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

**Additional Professional roles** - Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT); this would be determined by local needs as part of the HSCP Primary Care Improvement Plan. For example, but not limited to:

- Musculoskeletal focused physiotherapy services
- Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

**Community Links Worker (CLW)** is a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services. As part of the Primary Care Improvement Plan HSCPs will develop CLW roles in line with the Scottish Government’s manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.

**Workforce** As part of their role as EMGs, GPs will act as senior clinical leaders within the extended MDT. Most of the MDT staff deployed to work in the GP Practices will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans. Most existing staff will remain employed by their GP
Practice but there may be a need to enter in joint discussion between GP Practices and NHS Boards around the need to TUPE some staff where service changes are occurring ie treatment room services.

GP IT Reprovision. There is currently a reprovision process being undertaken around the need to reprovision the GP IT databases that will also take into account the need to closed MDT working and part of this will include community worker based modules.

In summary

The above is a summary of the proposed changes. I have attached a link on the front page for those who wish to read the contract in fuller detail.

At the current time most of the contract updates have taken place at Director level and with the GP professional and practice manager bodies. There was a Scottish Government Roadshow which was held in Orkney on 29 November where question and answer sessions were held.

Scottish Government sources have indicated that if and once the vote has been accepted then a wide range of events will be held for Primary Care Leads and HSCPs to help them fully understand all the contract implications including the financial aspects, the primary care transitional planning, what paperwork is required for practices to sign up to new contract etc etc. It will be vital that we have representation at these initial events to allow us to fully understand the change agenda that lies ahead.

We cannot underestimate the work and change of systems required around implementing some of these changes and commencement of planning will be required at an early stage including reviewing premises and practice capacity for changes in MDT working. We will require closer working with the Local medical committee who need to approve changes and cluster working is seen as a vital component going forward.

I will give the Board a further update once the vote has been declared and we have further information around the next steps we are required to take.
NHS Orkney Board

Date of Meeting: 14 December 2017

Paper No. : OHB1718-57

Subject: Public Health Annual Report 2016-17

Executive Summary

The Director of Public Health’s annual report outlines the state of the health of the population of the people of Orkney and reports on key activities undertaken by staff, including those outwith of the public health team, to improve and protect the health of the population over the year. It highlights key actions that NHS Orkney can undertake to further improve health and reduce avoidable inequalities.

Purpose

The purpose of this report is to provide the Board with an overview of the health of the population of Orkney for the period 2016-2017. The report highlights key aspects of public health work including performance of screening and vaccination programmes, as well as providing information on work undertaken in the health promotion areas particularly around alcohol, tobacco and obesity.

Recommendation

The Board is invited to:

Review the content of the report and consider the range of actions it can take to improve health and reduce inequalities.

1. Background

Overall the people of Orkney have better health than the Scottish average, as indicated by life expectancy and the low rate of premature mortality. However, the good health is not evenly distributed across our community and one of the key objectives of NHS Orkney is to improve health and reduce avoidable health inequalities. Whilst many of the usual indicators of deprivation may have some limitations in the more rural setting, where deprivation may be more scattered than in some urban areas, nevertheless gradients in health based on geographical areas are found in Orkney. We also know that in general those unable to gain employment or in low paid employment, with poor educational attainment, mental health, chronic ill health or substance misuse issues, looked after children and those in low income households require a more focused approach to enable them to achieve their maximum health and life potential. Addressing lifestyle factors is not sufficient to reduce health inequalities, and a stronger focus on the fundamental causes rather than just mitigating the effects is required.
There are significant changes planned in the delivery of public health in Scotland, and NHS Orkney must ensure that it both shapes and utilises these opportunities to enable the needs of the population to be met. The “once for Scotland” agenda which includes workstreams around screening and out of hours public health will support new ways of working. The regional agenda offers further opportunities for shared working, from polices to approaches and staff.

As NHS Orkney reviews its strategic direction, flowing on from Our Orkney Our Health, ensuring actions to improve population health and reduce inequalities must remain strongly embedded. The use of health impact assessments can strengthen approaches to decision making. The upcoming review of the strategic priorities of the community planning partnership offers an opportunity to ensure the community planning partnership priorities and actions to deliver are firmly focused on reducing inequalities. The integration authority, Orkney Health and Care’s refreshed strategic commissioning plan needs to align with key health issues to maximise health benefits.

The board will wish to ensure that The Health and Social Care Delivery Plan (2016) public health imperatives are followed through at a local level. The national public health priorities developed with SOLACE and COSLA are awaited and will need to be utilised to strengthen local public health activity. By 2020 local joint public health partnerships need to be established between local authorities, NHS Scotland and others to drive these priorities and again this will be key for NHS Orkney.

As transformation of clinical services occurs in preparation for moving to the new hospital and healthcare facility ensuring public health activity remains embedded and is enhanced will be important. Utilising this period of change to drive improvement in clinical and preventative services is important and the organisational use of strategy deployment matrices provides a way of ensuring line of sight of action to key objectives.

If the new GP contract is approved there will be significant changes in delivery of primary care functions. A focus on the management of chronic conditions should be welcomed, and the vaccination transformation programme will be a substantial local change in the delivery of vaccinations. This change will be a key workstream in public health over the next 3 years. Working closely with the GP cluster will be important to maximise the public health impact of primary care. Supporting people to improve their own health and wellbeing enabling them to live in good health for longer is important, particularly with our aging population with multiple morbidities. Further work is required around data management of both vaccinations and child health surveillance data in preparation for the introduction of new national systems in 2018.

For the coming year the NHS Board can play a key role in reducing inequalities by focusing on the quality of services and plans, our role as an employer and procurer, and how we work in partnership and advocate for action.

1.1 Linkage to Corporate Objectives / Strategic Aims

The paper is focused on how we can improve population health and focus on avoidable health inequalities and links to corporate objectives:
6.6

- Improve the Health and Wellbeing of the people of Orkney and reduce health inequities
- Pioneer ways of working to meet local health needs

1.2 Contribution to Quality

Please indicate which of the 2020 vision / quality ambitions are supported in this report by ticking the relevant dimension

- **Safe:** avoiding injuries to patients from healthcare that is intended to help them

- **Effective:** providing services based on scientific knowledge

- **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy

1.3 Compliance with Board Policy on Equality and Diversity

No equality impact assessment has been undertaken, but the paper draws attention to inequalities.

2. Resource Implications and Identified Source of Funding

No specific resource implications, however, it is important that resources are allocated to achieve public health outcomes.

3. Fit with Best Value Criteria

Activity focused on preventing ill-health can reduce spend on treatment costs.

4. Risk Assessment and Mitigation

A formal risk assessment has not been undertaken

5. Consultation and Engagement

Sections of the report have been contributed to by a range of staff.

6. Conclusion

The substantial changes in service delivery planned over the next two years both nationally and locally, and the local persistence of ill-health for segments of the population means that a substantial refocus of activity within the public health department and with partners needs to occur to achieve local and national health outcomes.

**Executive Sponsor**
Dr Louise Wilson

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<table>
<thead>
<tr>
<th>Date</th>
<th>4/12/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Documents</td>
<td>Public health annual report</td>
</tr>
</tbody>
</table>
Public Health Report 2016-17
Public Health Report 2015-16

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1.0 Introduction

In Scotland and in Orkney there are significant challenges with regard to the health of the population – alcohol misuse, obesity, and smoking are consistent challenges. It is, however, a time of great opportunity for public health in Scotland and in Orkney. Nationally the public health reform group is considering the creation of a new national public health body, and the development of national priorities for public health in Scotland. Other changes include health boards working together on a once for Scotland basis – with a focus on out of hours public health cover and how best to deliver screening services. Locally there are opportunities to improve population health through partnership working with community planning partners and although much good work is already occurring a greater pace and spread of activity is required.

The annual report provides a snapshot overview of work undertaken and performance achieved – but also highlights where we need to do more, together. Working with other agencies at local and regional and national level will be imperative.

My thanks go to everyone who has contributed to the report and the work undertaken by colleagues not only within NHS Orkney but across Orkney Islands Council and the Community Planning Partnership. I hope you find the report useful and welcome any comments.

Dr Louise Wilson
Director of Public Health
2.0 The health of the county

This section provides an overview of some of the key statistics in relation to the changing population and health in the county. The trend in an ageing population is well known, and the general health of the population as measured by life expectancy and premature mortality is good compared with Scotland.

The population of Orkney was estimated to be 21,850 in 2016, an increase of under 0.1% from 2015. The trend, within Orkney as elsewhere in the Scotland, is currently towards an ageing population with an estimated 23% of the population over the age of 65, and 16% under 16 (Figure 2.1).

Figure 2.1 Age structure of NHS Board areas mid-2016

Source: National Records of Scotland 2017

Migration within Orkney and Migration to and from Orkney

The number of residents in Orkney is partially determined by the number of people who leave or move to the islands. The most recent figures from the National Records Scotland on migration based on council areas for 2015-16 show 858 people migrated in to the islands and 635 migrated away from the islands.
Population projections
In the long-term the population of Orkney is projected to increase by 2.4% due to the impact of in-migration, whereas the population of Scotland is projected to increase by 6.6% over the period 2014-2039. Figure 2.2 shows the expected change in population by age from 2014 to 2039.

Figure 2.2 Population pyramid for Orkney Islands 2014 and 2039

Orkney Islands, 2014 (solid) and 2039 (line)

It can be seen that in general the number of children and working age adults is projected to decrease in contrast to the increase in older people. This shift in age distribution is well known locally and being factored in to how services will need to change for future health needs.

Births
In 2016 there were 178 live births recorded for Orkney, a drop of 6.8% from 2015. The number of births in Scotland, 54,488, fell by 1.1 % over the same
period. The fertility rate decreased to 51.1 (from 54.3 in 2014) births per 1000 women aged 15-44 and was below the Scottish rate of 52.6 births per 1000 women. In 2016 Orkney had an equal number of boys and girls born.

Life expectancy

The latest life expectancy data is from 2015. Life expectancy at birth in Orkney is greater for females (82.8 years) than males (78.8 years), and both were greater than the Scottish average (females 81.1 males 77.1 years) (Figure 2.3). Life expectancy in Orkney at age 65 is greater for females (21.2 years) than males (18.7 years).

Figure 2.3 Life expectancy at birth in Orkney Islands and Scotland, 2013-15

Source: National Records of Scotland 2017

Premature mortality

In 2016 there were 223 deaths at all ages recorded for Orkney. One quality indicators for the NHS focuses on addressing premature mortality. This is usually measured by looking at the death rates for people aged under 75. For the last 8 years of reported data the under 75 age-standardized death rate for all causes of death in Orkney has been lower than the Scottish rate (Table 2.1).
Table 2.1 Death rates (All causes) under 75 (per 100,000 population): age-standardised using the 2013 European Standard Population

<table>
<thead>
<tr>
<th>Year</th>
<th>Orkney</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>558.1</td>
<td>516.8</td>
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<td>2008</td>
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<td>2011</td>
<td>346.7</td>
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<td>341.2</td>
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</tr>
<tr>
<td>2013</td>
<td>345.9</td>
<td>437.5</td>
</tr>
<tr>
<td>2014</td>
<td>336.5</td>
<td>423.2</td>
</tr>
<tr>
<td>2015</td>
<td>378.5</td>
<td>440.5</td>
</tr>
</tbody>
</table>

Source Scottish Government 2017

When we look at mortality for under 75 year olds for specific diseases we can see that in general the mortality rate from all heart disease in Orkney is lower than the Scottish rate (Table 2.2).

Table 2.2 Circulatory Death rates under 75 (per 100,000 population): age-standardised using the 2013 European Standard Population

<table>
<thead>
<tr>
<th>Year</th>
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</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>2009</td>
<td>81</td>
<td>117.2</td>
</tr>
<tr>
<td>2010</td>
<td>61.7</td>
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</tr>
<tr>
<td>2011</td>
<td>77.5</td>
<td>106.7</td>
</tr>
<tr>
<td>2012</td>
<td>83.6</td>
<td>104.2</td>
</tr>
<tr>
<td>2013</td>
<td>50.5</td>
<td>101.5</td>
</tr>
<tr>
<td>2014</td>
<td>95.7</td>
<td>94</td>
</tr>
<tr>
<td>2015</td>
<td>82.1</td>
<td>98.5</td>
</tr>
</tbody>
</table>

Source Scottish Government 2017

When we look at the mortality rate from all types of cancer we see a year to year variability for Orkney in recent years, but with the rate below the Scottish rate (Table 2.3).
Table 2.3 Cancer Death rates under 75 (per 100,000 population): age-standardised using the 2013 European Standard Population

<table>
<thead>
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<tbody>
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<td>231.3</td>
<td>186.8</td>
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<td>2008</td>
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<td>2009</td>
<td>108.9</td>
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<td>2010</td>
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<td>2011</td>
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<td>2012</td>
<td>104.1</td>
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<tr>
<td>2013</td>
<td>123.0</td>
<td>170.2</td>
</tr>
<tr>
<td>2014</td>
<td>114.4</td>
<td>165.8</td>
</tr>
<tr>
<td>2015</td>
<td>132.5</td>
<td>167.1</td>
</tr>
</tbody>
</table>

Source Scottish Government 2017

When we look at the mortality rate from respiratory system disease we see a year to year variability for Orkney with the rate generally below the Scottish rate (Table 2.4).

Table 2.4 Respiratory System Death rates under 75 (per 100,000 population): age-standardised using the 2013 European Standard Population

<table>
<thead>
<tr>
<th>Year</th>
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</tr>
</thead>
<tbody>
<tr>
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<td>45.4</td>
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<tr>
<td>2008</td>
<td>49.8</td>
<td>45.5</td>
</tr>
<tr>
<td>2009</td>
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<td>45.2</td>
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<tr>
<td>2010</td>
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<td>2013</td>
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<td>41.5</td>
</tr>
<tr>
<td>2014</td>
<td>17.7</td>
<td>40</td>
</tr>
<tr>
<td>2015</td>
<td>25.2</td>
<td>42.5</td>
</tr>
</tbody>
</table>

Source Scottish Government 2017
3.0 Health Improvement

Improving the health of the population and reducing health inequalities is a key objective of NHS Orkney. In order to achieve this we need to understand some of the key influencers – or social determinants on our health. One model of this, the psychosocial model of health, is shown in Figure 3.1. It links these broad social determinants with individual and community level adverse and protective psychosocial factors influencing how we think and feel. This, along with how we act and behave, and how our body reacts, results in the distribution of health in our population. This approach supports both an upstream approach to tackle health issues but also integrates that with work to support the individual.

Figure 3.1 The psychosocial model of health

Source Public Health England

There are opportunities locally to utilize the health and social care commissioning plan to further drive improvements in preventative approaches, and with the primary care cluster to focus on variation and quality improvement in the management of long term conditions. The Board must also capitalize on opportunities offered
through regional and national working practices. The work below is reported around specific topics primarily related to health related lifestyles.

It is important for NHS Orkney to utilize health inequality impact assessments as it introduces new policies to ensure that any unintended consequences are mitigated and we do not inadvertently widen health inequalities.

3.1 Promoting Healthy attitudes to substances

Alcohol brief interventions

To support effective implementation of the Quality Principles, the Scottish Government commissioned the Care Inspectorate to undertake a programme of validated self-evaluation across Alcohol and Drugs Partnerships in Scotland. Orkney ADP participated in this in 2016. Some of the key strengths in the findings included:

* Services worked well together to improve outcomes for individuals accessing services across communities.
* Individuals had access to a wide range of recovery treatments and therapies that helped them improve different areas of their life including harm reduction advice, tools and techniques.
* Highly committed staff made individuals feel valued, respected and well supported in their recovery. Staff worked extremely hard to ensure most individuals were seen within waiting times targets.
* A creative and early intervention process had been developed via a local community response, combining strong multi-agency connections and response using local knowledge and initiative.
* Individuals were meaningfully included and sufficiently involved in their assessment and reviews. Collaborative goal setting ensured individuals fully engaged in developing and reviewing their recovery plan.
* The ADP demonstrated strong cohesiveness and connectedness and worked effectively together to improve outcomes for individuals accessing services within their community.
NHS Orkney should ensure that an evidence based approach to interventions continues to drive ADP work and that prevention of ill health remains a key strand.

Having previously been an area of good performance, performance on delivery of alcohol brief interventions in key areas including primary care fell with overall 118 interventions against a target of 249. As a result of this public health have developed an action plan to improve the focus on and delivery in this area.

Keen to be an exemplar of “every healthcare contact is a health improvement opportunity” NHS Orkney continues to develop a health promoting culture, incorporating health improvement into everyday practice and supporting health behavior change amongst patients, visitors and staff alike. This includes work on alcohol brief interventions as well as other health improvement activities under the banner of the Health Promoting Health Service. NHS Orkney should ensure that the Health Promoting Health Service becomes further embedded in the activities of the organization.

3.2 Smoking Cessation

To improve health locally the Public Health department is committed to work, in line with the Scottish Government policy, toward a Smoke-free environment where less than 5% of the population smoke tobacco by 2034. In Orkney the percentage of the population smoking at around 19% is slightly lower that the Scottish percentage.

The Scottish Government HEAT standard set Orkney’s Smoking Cessation Services a target of supporting 31 quits from the 60% most deprived areas in the county between the 1st April 2016 and the 31st March 2017, with a successful quit being defined as a person not smoking for 12 weeks following their quit date.

The majority of attempts to stop smoking do not involve Specialist cessation services, and the increasing accessibility of stop smoking aids and use of electronic smoking devices has changed quitting behaviours and reduced service footfall nationally.
At the end of March 2017, 72 people across Orkney had made an attempt to quit with support from Smoking Matters Orkney (58 attempts) and Community pharmacy (14 attempts).

Of these attempts, 31 people were still not smoking 12 weeks after their quit date. This 43% success rate at 12-week follow up exceeds NICE 2013 guidance which suggests services should aim for at least 35% success at 4-week follow up. Of these successful quits, 16 lived in the 60% most deprived areas had achieved a successful 12 week quit (14 with support from Smoking Matters Orkney and 2 from Community Pharmacy). Overall this meant that 51.6% of the target was achieved; a 16.6% improvement on last year’s target performance.

To improve performance further, more people need to approach the services for support to stop smoking. In 2017 a 3-month programme is underway to raise the profile of the service in order to increase signposting to the service and the number of referrals received from NHS colleagues and partner agencies.

Responding to local feedback, Smoking Matters Orkney offers appointments at a variety of times (including two evenings per week) and locations. To increase access, support can also be delivered via more flexible methods such as telephone, text and email. Community pharmacies continue to offer support and increase reach through availability in different geographic locations and ease of access. Efforts are in place to generate shared working opportunities between these support services and to address recording issues on the national database.

From 1st April 2015, it became a requirement that all Health Boards become smoke-free meaning that staff, patients and visitors can no longer smoke in any NHS grounds or premises. To support this, Smoking Matters Orkney are available to help people who do not wish to stop smoking but would like some support for times when they cannot smoke. All patients who have a planned admission to the Balfour Hospital receive a leaflet explaining the Smoke-free policy and offering them help.
and support to cope with not being able to smoke whilst they are in hospital. Similar information is available in clinical areas for those who have an unplanned hospital admission. An opt-out referral system to the cessation service is in place and referrals made by hospital wards and services are monitored through reporting for the Health Promoting Health Service programme. Staff members who smoke continue to be offered support through Smoking Matters Orkney and can attend sessions in work time following agreement with their Line managers.

3.3. Obesity and Physical Activity

Maintaining a healthy weight is important and in Orkney, as in Scotland, the proportion of the population with an unhealthy weight is of concern. Obesity is linked with a wide range of diseases (Figure 3.2). It is recognized that a wide range of interventions are required to tackle obesity in Scotland and that consumer education and personal responsibility and physical activity whilst important will not by themselves achieve what is required – changes in the wider environment also need to occur in order to support healthier choices.

Figure 3.2 Health problems associated with obesity

Source Public Health England
Maternal and Infant Nutrition

Actions from the Maternal and Infant Nutrition Framework have continued during 2016 and 2017, successes have included health visiting staff successfully being re-accredited with Stage 3 Unicef Baby Friendly status. The Maternity Department has also continued efforts working to maintain their Stage 3 accreditation.

Maternity ward staff run five volunteer led breastfeeding cafes which offer breastfeeding support and encourage visibility of breastfeeding in wider community settings across Orkney mainland. Efforts are underway to establish a peer support buddy scheme, once trained the peers supporters will offer social and breastfeeding support through phone, text and home visits. Wheelie walks recommenced in July 2017 for mums and dads with babies and young children. These walks take place one lunch time per week and are planned to run until later in the year.

Efforts to increase local uptake of the Healthy Start Scheme have utilised service improvement approaches. This has involved awareness raising at various educational settings and with a wide range of services and organisations who are likely to meet with eligible families. A scoping exercise was also carried out with parents to support increased accessibility and effectiveness of efforts. All pregnant mums are now supplied with healthy start vitamins at their first maternity appointment, and a consistent supply of children’s vitamin drops are now available at the Public Health Department.

The public health department purchased access to online training to support early years practitioners in using Setting the Table guidelines. Of the 29 local registered childminders, 15 signed up to and completed this training course. The course has also been widely publicised through relevant partner organisations.

Work is carried out in line with national treatment guidance and local referral pathways for women who are overweight or obese in pregnancy. Maternity staff will be working with Dietetics and Health Promotion to improve communication with
parents in order to increase engagement with programmes and services available to prevent and reduce harms associated with poor nutrition and weight concerns pre-conception, during pregnancy and post natal period.

A number of options are being explored and discussed between maternity staff, Pickaquoy centre and the Health Promotion Department to increase availability and access to appropriate physical activity options for pregnant mums and families with young children.

Healthy weight in childhood

Orkney continues to have a high proportion of children at risk of overweight or obesity. In 2014 the Scottish Government decided to review the national target for Child Healthy weight but work continues locally to address this sensitive issue.

The “Go for It!” school-based programme aims to give children and their parents an increased understanding of healthier choices which can lead to a healthier weight. Six sessions were delivered by a range of professionals to children in one north island school, all pupils between primary three and second year in High school took part in classes and interactive learning opportunities on topics such as the portion sizes, hidden sugars and the importance of good hydration and sleep. The programme was well received and evaluated well with school staff and the pupils themselves. Support was given for teachers in one mainland primary school to increase their capacity to deliver the programme. Two primary 5 classes took part in the 6 week programme which was led by teachers and some health professionals.

A number of educational packs have been purchased between NHS Orkney and Orkney Islands Council Education Department for initial roll out across 8 schools in Orkney. Offering cumulative learning across the primary school years, it is planned that this programme will be rolled out to imbed delivery of the curriculum for all pupils in Orkney, increasing sustainability and subsequent impact upon child health. The
JIGSAW programme (www.jigsawpshe.com) is a whole system approach to delivering the range of health and wellbeing aspects of Curriculum for Excellence.

Following feedback from parents and schools, and upon reflection with other Scottish Health boards, the School Nursing team identified an opportunity to improve the letter and communication process with parents following Primary One school surveillance. As well as school-based programmes, one to one programmes for children who are overweight or obese have been available. These programmes are delivered by specially trained dietitians and can be based around the child healthy weight programmes ‘SCOTT’ and ‘SCOTTlite’.

Health promotion staff and the Oral Health team have attended events in various primary and pre-school locations and parents events throughout the year to promote topics relating to hidden sugars, nutrition and healthy weight, and raise awareness of the national “Eat Better, Feel Better” campaign.

The “Keep Healthy Keep Hydrated” team has continued efforts to raise awareness in the wider public of the importance of hydration. Providing education for children and young people has been an important priority for the team over the year. Working within and out with the classroom, the group has promoted the importance of hydration for maximizing educational attainment and general health. The team has provided free water at ranging community sporting events, encouraging children to “drink before, during and after sport” to improve their performance and overall health through competitions and display materials. The Keep Healthy Keep Hydrated Team work continues to develop.

For young people, Personal, Social Health and Education (PSHE) sessions were carried out with school leavers to increase nutritional awareness and explore concepts surrounding healthy weight and body esteem. House Parents at Papdale Halls of Residence were trained to deliver confidence to cook programmes for young people in school care accommodation. These programmes aim to increase participants’ capacity and nutritional health literacy through increased knowledge and practical skills. Young people also used supported study sessions to create ideas and designs from which new healthy weight resources have been developed. These
are now being used to increase reach and engagement with young people through social media as well as traditional printed leaflets.

Healthy weight for adults

Dietetic and Health Promotion staff have continued working together to offer healthy weight group programmes. These programmes were reviewed and extended from 6 to 12 weeks in line with existing evidence that 12 weeks is considered the optimum duration. Additional checks were introduced to enable exploration of a wider range of health benefits and changes in lifestyle choices including waist circumference, BP and cholesterol. This new programme has been delivered twice in geographically distinct towns on the Orkney mainland, the groups were well attended and achieved positive results and evaluation. However, we need to ensure these programmes are focused on those with greatest need.

Dietetic services offer the Counterweight programme which includes physical activity, dietary change and behavioural change components. This one-to-one programme is also made available within Board administered practices on the outer Isles thereby ensuring ease of access for people who live more remotely and are unable to access mainland services. Dietetic staff have continued to offer Counterweight Plus as an alternative to bariatric surgery, this approach has been found to be just as effective but without the associated risks and costs.

Confidence to Cook training for trainer courses aim to increase nutritional health literacy, food safety and practical cooking skills on a budget. Three of these courses were provided this financial year to a range of staff in third sector and other agencies, all of whom work with vulnerable individuals and / or groups. To offer a more accessible and appropriate route to engagement and improved self-care for harder to reach individuals and groups (e.g. marginalised groups and inter-pregnancy), a member of the Health Promotion team was trained to be a ‘Well Now’ facilitator. Well Now courses focus on health and well being and offer a different approach in to issues around healthy weight.
Physical Activity across the ages

In May 2016, 12 schools reported that they were participating in the daily mile with the introduction of a whole school approach on one island school. Health promotion staff have attended a wide variety of community events including Nursery fun days, school and college Transition events, the Growing up in Orkney Conference and weight management groups to raise awareness of the importance of physical activity as well as national physical activity guidelines. These opportunities have also been used to identify and encourage fun and affordable ways of keeping active across the life course.

Active Schools’ staff continue their work across the county to increase activity levels of school-aged children. Alongside these efforts, the Health and Wellbeing Officer has worked with colleagues in education to raise the quality of physical education in pre-school, primary and junior high schools.

Efforts to raise NHS staff capacity in encouraging increased physical activity have involved wide promotion of links to ‘Get Active’ MOOC, and Health Scotland’s ‘Raising the Issue of Physical Activity’ e-learning module. Confidence to Cook training for trainers this year explored local opportunities for accessible, affordable physical activity as well as national guidelines, and this supports partner agencies who work with vulnerable individuals, families and groups to promote the importance of and encourage increased physical activity.

Introduction of Active Life memberships has made a wide range of services and recreational facilities more affordable and accessible for individuals and families. The Public Health Department have worked with Orkney Islands Council and the Pickaquoy Centre to pilot 6-month Active Life memberships being offered for free to individuals who see the Diabetic Specialist Nurse and who attended a weight management group programme.

Regular health walks led by volunteer walk leaders are held in Kirkwall, St. Margaret’s Hope and Stromness. Two “Walk Weeks” were also held this year which involved walks in a wide range of locations including isles.
Keep Well

The Keep Well program is a national program focusing on reducing inequalities by identifying people at risk of cardiovascular disease. Keep Well is targeted at people between 40 and 64 years of age who are at risk of preventable ill health because of their life circumstances. In Orkney certain groups of people may be more at risk than others and as a result health checks are being offered to specific groups of people who at present have no disease symptoms but if some lifestyle choices go undetected and unchanged have a high risk of developing heart disease or stroke in the future. Many of the risk factors related to heart disease are lifestyle choices that can be changed such as diet, physical activity, smoking and alcohol consumption.

The Keep Well check gives the participant an ASSIGN score. The ASSIGN score is a cardiovascular risk score developed in 2006 by Dundee University, Scotland which takes into account social deprivation (through postcode), family history of cardiovascular disease along with other risk factors (smoking, cholesterol and blood pressure) to give a score. People who do not have a diagnosis of cardiovascular disease are assessed using the tool and it can identify people who are most likely to develop the disease over a ten year period. A Low risk is a risk under 10%, Medium risk is 10% to under 20%, and a High risk is 20% or more. A ‘High risk’ (score 20 or more) suggests that risk-lowering medication and/or other medical help is indicated. This is the tool has been chosen for use by SIGN (Scottish Intercollegiate Guidelines Network) and Scottish Government Health Directorates.

The Scottish Index of Multiple Deprivation (SIMD) a consistent way of identifying areas of multiple deprivation across all of Scotland. The SIMD ranks small areas (called datazones) from most deprived (ranked 1) to least deprived (ranked 6,505). People using the SIMD will often focus on the datazones below a certain rank, for example, the 20% (SIMD 1) most deprived data zones in Scotland. The breakdown of these datazones is important for allowing effective policies and funding to be allocated to try to tackle or of make a difference in these small area concentrations of multiple deprivation. However, in rural areas it is recognised that these geographical measures of deprivation have their limitations, and other approaches may be required to tackle inequalities.
For 2016/2017 within NHS Orkney, the approach taken was a targeted approach. Keep Well Health Checks were performed at Women’s Aid, Orkney Blide Trust, Orkney Fishermen’s Association, NHS Orkney for staff, The Living Skills centre and more recently in Men’s Sheds.

Figure 3.3 shows how the Keep Well checks that have been undertaken break down by SIMD Quintile area throughout Orkney. As can be seen over 50% of the checks were for those in the most deprived zones in Orkney SIMD 2 (Orkney has no SIMD 1 areas).

![Figure 3.3 Keep Well checks by SIMD deprivation area](image)

The ASSIGN Score is the percentage risk of the person suffering cardiovascular disease in the next ten years based on the data gathered by the checks if they were to choose not to change their lifestyle habits. Figure 3.4 shows the breakdown of the Keep Well checks into High Risk Assign. The national reporting system for Keep Well only specifically asked for NHS Boards to report on the High risk assign Scores identified through Keep Well Health Checks.
3.4 Detect Cancer Early

In February 2012 the Detect Cancer Early (DCE) programme was launched in Scotland. One aim of the DCE programme is to increase the percentage of people who are diagnosed early in the disease process (with stage 1 disease). The programme is now in year 5. Table 3.1 (page 23) shows the number and percentage of patients by stage of diagnosis with breast, colorectal and lung cancer in Orkney for the years 2015 and 2016 combined. The NOSCAN data refers to the North of Scotland cancer network data of which NHS Orkney is a member.

Note that Orkney has a high percentage of cancers where the stage is not known at 16.2%, and this relates in part to the way staging for breast cancer in particular is carried out in NHS Grampian. This is a data issue rather than a clinical staging issue. Work is being undertaken to align the recording of staging to that used elsewhere in Scotland. Overall around 1 in 4 cancers in Scotland are detected at Stage 1. Due to the small numbers involved there can be marked year to year fluctuation in the data for Orkney.

Breast cancer: For the two-year period, 2015-16 the most common stage of disease at diagnosis for breast cancer in Scotland was stage 2 which accounted for 53.8% of all patients. During this period the percentage of patients in Scotland with breast
cancer diagnosed as stage 1 disease was 41.0% and in Orkney 32.7% (Table 3.2, page 23).

Colorectal cancer: For the two-year period, 2015-16, the most common stage of disease at diagnosis for colorectal cancer in Scotland was stage 2 which accounted for 26.0% of all patients. During this period the percentage of patients in Scotland, with colorectal cancer diagnosed with stage 1 disease was 15.1% and in Orkney 7.7% (Table 3.3, page 23). Note the small numbers diagnosed in Orkney can have significant impact on percentages diagnosed at each stage.

Lung cancer: For the two-year period, 2015-16, the most common stage of disease at diagnosis for lung cancer in Scotland was stage 4 which accounted for 45.7% of all patients. During this period the percentage of patients in Scotland, with lung cancer diagnosed with stage 1 disease was 18.3% and in Orkney 19.0% (Table 3.4, page 23).
Table 3.1 Number and percentage of patients by stage at diagnosis for breast, colorectal and lung cancer for Orkney, the North of Scotland cancer network and Scotland for 2015 and 2016 combined.

<table>
<thead>
<tr>
<th>Area of Residence</th>
<th>Stage 1</th>
<th></th>
<th>Stage 2</th>
<th></th>
<th>Stage 3</th>
<th></th>
<th>Stage 4</th>
<th></th>
<th>Stage Not Known</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>NHS SCOTLAND</td>
<td>6,202</td>
<td>25.5%</td>
<td>6,317</td>
<td>26.0%</td>
<td>4,293</td>
<td>17.6%</td>
<td>6,230</td>
<td>25.6%</td>
<td>1,300</td>
<td>5.3%</td>
<td>24,342</td>
<td>100.0%</td>
</tr>
<tr>
<td>NOSCAN</td>
<td>1,476</td>
<td>23.7%</td>
<td>1,690</td>
<td>27.1%</td>
<td>1,026</td>
<td>16.4%</td>
<td>1,625</td>
<td>26.0%</td>
<td>422</td>
<td>6.8%</td>
<td>6,239</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>23</td>
<td>23.2%</td>
<td>34</td>
<td>34.3%</td>
<td>9</td>
<td>9.1%</td>
<td>17</td>
<td>17.2%</td>
<td>16</td>
<td>16.2%</td>
<td>99</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 3.2 Number and percentage of patients by stage at diagnosis for breast cancer for Orkney, the North of Scotland cancer network and Scotland for 2015 and 2016 combined.

<table>
<thead>
<tr>
<th>Area of Residence</th>
<th>Stage 1</th>
<th></th>
<th>Stage 2</th>
<th></th>
<th>Stage 3</th>
<th></th>
<th>Stage 4</th>
<th></th>
<th>Stage Not Known</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>NHS SCOTLAND</td>
<td>3,527</td>
<td>41.0%</td>
<td>3,815</td>
<td>44.4%</td>
<td>653</td>
<td>7.6%</td>
<td>490</td>
<td>5.7%</td>
<td>107</td>
<td>1.2%</td>
<td>8,592</td>
<td>100.0%</td>
</tr>
<tr>
<td>NOSCAN</td>
<td>926</td>
<td>40.2%</td>
<td>1,048</td>
<td>45.4%</td>
<td>157</td>
<td>6.8%</td>
<td>119</td>
<td>5.2%</td>
<td>56</td>
<td>2.4%</td>
<td>2,306</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>17</td>
<td>32.7%</td>
<td>28</td>
<td>53.8%</td>
<td>1</td>
<td>1.9%</td>
<td>2</td>
<td>3.8%</td>
<td>4</td>
<td>7.7%</td>
<td>52</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 3.3 Number and percentage of patients by stage at diagnosis for colorectal cancer for Orkney, the North of Scotland cancer network and Scotland for 2015 and 2016 combined.

<table>
<thead>
<tr>
<th>Area of Residence</th>
<th>Stage 1</th>
<th></th>
<th>Stage 2</th>
<th></th>
<th>Stage 3</th>
<th></th>
<th>Stage 4</th>
<th></th>
<th>Stage Not Known</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>NHS SCOTLAND</td>
<td>991</td>
<td>15.1%</td>
<td>1,704</td>
<td>26.0%</td>
<td>1,646</td>
<td>25.1%</td>
<td>1,542</td>
<td>23.5%</td>
<td>675</td>
<td>10.3%</td>
<td>6,558</td>
<td>100.0%</td>
</tr>
<tr>
<td>NOSCAN</td>
<td>239</td>
<td>12.9%</td>
<td>498</td>
<td>27.0%</td>
<td>430</td>
<td>23.3%</td>
<td>424</td>
<td>23.0%</td>
<td>255</td>
<td>13.8%</td>
<td>1,846</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>2</td>
<td>7.7%</td>
<td>6</td>
<td>22.1%</td>
<td>5</td>
<td>19.2%</td>
<td>6</td>
<td>23.1%</td>
<td>7</td>
<td>26.9%</td>
<td>26</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 3.4 Number and percentage of patients by stage at diagnosis for lung cancer for Orkney, the North of Scotland cancer network and Scotland for 2015 and 2016 combined.

<table>
<thead>
<tr>
<th>Area of Residence</th>
<th>Stage 1</th>
<th></th>
<th>Stage 2</th>
<th></th>
<th>Stage 3</th>
<th></th>
<th>Stage 4</th>
<th></th>
<th>Stage Not Known</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>NHS SCOTLAND</td>
<td>1,664</td>
<td>18.3%</td>
<td>798</td>
<td>8.7%</td>
<td>1,994</td>
<td>21.7%</td>
<td>4,198</td>
<td>45.7%</td>
<td>518</td>
<td>5.6%</td>
<td>9,192</td>
<td>100.0%</td>
</tr>
<tr>
<td>NOSCAN</td>
<td>311</td>
<td>14.9%</td>
<td>144</td>
<td>6.9%</td>
<td>439</td>
<td>21.0%</td>
<td>1,082</td>
<td>51.9%</td>
<td>111</td>
<td>5.3%</td>
<td>2,067</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>4</td>
<td>19.0%</td>
<td>3</td>
<td>14.3%</td>
<td>3</td>
<td>14.3%</td>
<td>9</td>
<td>42.9%</td>
<td>5</td>
<td>23.8%</td>
<td>21</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Detect Cancer Early baseline data and Year 2015-16 comparison.

In Scotland, there was a 9.2% increase in the percentage of people diagnosed at stage 1 for breast, colorectal and lung cancer (combined) between the baseline and years 2015-16. A 17.9% increase in stage 1 diagnosis has occurred in Orkney (Table 3.5). Note, however, the small number of individuals involved.

Table 3.5 Number and percentage of stage 1 patients for breast, colorectal and lung cancer by NHS Board of residence and region, with percentage change from baseline 2010-11 to year 2015-16.

<table>
<thead>
<tr>
<th>Area of Residence</th>
<th>Baseline</th>
<th>Year 2015-16</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Scotland</td>
<td>5,550</td>
<td>23.2</td>
<td>6,202</td>
</tr>
<tr>
<td>NOSCAN</td>
<td>1,299</td>
<td>22.2</td>
<td>1,476</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>13</td>
<td>19.7</td>
<td>23</td>
</tr>
</tbody>
</table>

A number of health promotion activities aligned to the detect cancer early programme ran locally.

3.5 Sexual Health

The sexual health work in Orkney has continued in 2016-17 to work towards the five outcomes of the Sexual Health and Blood Borne Virus Framework for 2015-2020, which are:

- Fewer newly acquired blood borne viruses and sexually transmitted infections; fewer unintended pregnancies.
- A reduction in the health inequalities gap in sexual health and blood borne viruses.
- People affected by blood borne viruses lead longer, healthier lives, with a good quality of life.
- Sexual relationships are free from coercion and harm.
- A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and blood borne viruses are positive, non-stigmatising and supportive.
The Nordhaven Clinic, Orkney’s sexual health service, continues to offer STI testing, access to contraception, including emergency contraception, pregnancy testing, sexual health related advice and information. This year showed the highest level of attendances at this clinic since it started in 2010, which hopefully reflects improved local knowledge and acceptability of the service. The Nordhaven Clinic maintains a website and Facebook page which communicates up to date and reliable information on sexual health related topics to the public.

Orkney’s needle exchange service is accessed through the Nordhaven Clinic, guaranteeing good access to health advice and testing through this service. The condom by post service continues to be available through the Nordhaven Clinic website. When condoms are ordered through this service, they can be delivered free of charge to any Orkney residential address in a plain envelope with no NHS markings. This is to allow equitable access for condoms across Orkney in a discrete and confidential manner.

Information in regards to sexual health, local campaigns and national developments or news in relation to sexual health has been cascaded throughout this year to statutory and third sector bodies via a monthly e-mail newsletter. This aims to maintain communication and promote services locally.

During 2016-17, work has continued to promote positive sexual health and well-being across the county. Sexual health and relationships education have been delivered to young people across Orkney in a range of settings including through the Public Health department developed ‘Lovebug’ programme. This seeks to provide a bespoke programme tailored to young people’s needs. This year, the programme has continued to develop with local area trainers being trained to deliver the programme and more accessible packs in the process of being designed for delivery.

In July 2016, the Nordhaven Clinic launched a HIV self test kit by post service. These kits are ordered and delivered in a similar way to the condoms by post service meaning that Orkney residents can access free HIV self testing from home. World Aids Day 2016 was utilised to advertise this service with the St. Magnus Cathedral ‘Going Red’ to mark the day.
Towards the end of 2016, a multi-agency sexual consent training was developed. The training drew on the knowledge and experience of the Orkney Alcohol and Drugs partnership (ADP), Health Improvement (NHS Orkney) and Orkney Rape Crisis. The training was delivered twice to a range of professionals in Orkney covering topics of the law around sex, the effect of alcohol on consent, the judicial process for victims of rape and sexual assault and the support services available for victims.

3.6 Mental Health
There is no health without mental health and the importance of mental health is recognized within the department and work on mental health promotion has continued throughout 2016-17.

There are many pressures on young people, not least the pressures of studying and exams. Recognising this and the impact that this can have on mental health and exam performance, the Health Improvement Department provided all S4 pupils in Orkney sitting exams in 2017 an exam stress survival pack. This had positive messages to encourage appropriate breaks, hydration and preparation for the exam period. These packs had a copy of the ‘cool heads’ pamphlet which give a lot of
information, including signposting of services, to young people in regards to mental health and wellbeing. Coping with exam stress sessions were delivered alongside the packs being given to Stromness Academy and Kirkwall grammar school S4 pupils

NHS Orkney Health Improvement staff worked alongside our community partners in the Orkney Choose Life Group and the Blide Trust to mark Suicide Awareness Day in September and deliver a campaign based on encouraging the community to talk about when things go wrong and seek help before it escalates. Orkney Blide Trust supported the department to empower local business fronts on the main streets in Kirkwall to place an electric candle in their window to mark suicide awareness day. The poster for the ‘There is no Shame in saying I’m not Fine’ which was developed based on a campaign in Shetland, was then distributed and displayed across Orkney with a successful social media campaign supporting this. The poster featured local prominent community members from a range of professions, many of which are traditionally male dominated professions. The campaign attracted a high response on social media and prompted discussions around mental health, thus achieving the aim of the campaign.

In December, the Public Health Department participated in the local ‘BID’ Christmas tree event, decorating the tree with woolly hats which reflected our ‘Keep Your Heid’ campaign. This campaign focussed on positive activities to participate in which protect and improve mental health.

Healthy Working Lives (HWL), the key national programme in relation to health in the work place, has evolved into a more centralised service with a website and helpline to support companies to achieve HWL awards. NHS Orkney contracted with NHS Highland for additional specialist support in 2016/17. A HWL advisor from NHS Highland provided one to one support to local companies as required but in 2017 much of the Healthy Working Lives programme will be delivered from Orkney by the public health team.
Figure 3.5 is the World Health Organization’s 12 tips to be healthy. Whilst recognizing the wider social determinants and the impact of community factors as shown in Figure 3.1, this advice to the population of the world resonates locally.
4.0 Health Protection

Health Protection is a term used to encompass a set of activities within public health. It can be defined as protecting individuals, groups and populations from single cases of infectious disease, incidents or outbreaks, and non-infectious environmental hazards such as chemicals and radiation. As such it includes responsibility for immunisation programmes and for some aspects of resilience planning. It encompasses everything from dealing with the spread of cases of Influenza to dealing with the possible health consequences of a chemical spillage. It often needs to be working alongside colleagues in Environmental Services, Police, Fire and Rescue Service, Scottish Water, and occasionally with other agencies such as the Maritime and Coastguard Agency. So protecting the public’s health is often achieved through a multi-agency response, but always led by Public Health.

In Orkney this presents a challenge in providing a robust 24 hour per day/7 day a week on call rota to allow for dealing with incidents which, in their nature, cannot be left to the next working day. This has been solved by innovative working across the island health boards. A national review around out of hours working in public health is currently being undertaken, and lessons learned from the model have been shared.

4.1 Communicable diseases

The microbiology laboratories in the Balfour Hospital and in Aberdeen and Glasgow that deal with Orkney patients automatically report positive results to Public Health for a number of infectious diseases. Not all of these reports require specific action from Public Health, but many of them do require to be followed up in some fashion. In this reporting period there were 58 such notifications (Table 4.1).
Table 4.1 Laboratory reports to public health

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campylobacter</td>
<td>19</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>11</td>
</tr>
<tr>
<td>Cryptosporidium</td>
<td>10</td>
</tr>
<tr>
<td>Escherichia coli O157</td>
<td>2</td>
</tr>
<tr>
<td>Clostridium perfringens</td>
<td>1</td>
</tr>
<tr>
<td>Giardiasis</td>
<td>3</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>1</td>
</tr>
<tr>
<td>Influenza</td>
<td>2</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis E</td>
<td>1</td>
</tr>
<tr>
<td>Mumps</td>
<td>1</td>
</tr>
<tr>
<td>Norovirus</td>
<td>1</td>
</tr>
<tr>
<td>Salmonella</td>
<td>1</td>
</tr>
<tr>
<td>Streptococcus Group A</td>
<td>1</td>
</tr>
<tr>
<td>Streptococcal Infection</td>
<td>2</td>
</tr>
<tr>
<td>Mycobacterium</td>
<td>1</td>
</tr>
</tbody>
</table>

The common infections

- Campylobacter is the commonest cause of food poisoning in the UK, and whilst it is usually a relatively mild illness it is associated with around 100 deaths per year in the UK. 80% of cases are caused by eating undercooked contaminated chicken, but the organism is also easily transferred from contaminated chicken to other foods.

- *Clostridium difficile* (C.diff) causes diarrhoea. It most commonly occurs in unwell, often older adults who require the prescription of broad spectrum antibiotics. These sometimes deplete the gut of its normal bacterial flora, and allow an overgrowth of the C.diff organism. The group of drugs called Proton Pump Inhibitors (PPIs), which significantly suppress the production of gastric acid, are also a significantly aggravating factor in the cause of a C.diff infection. PPIs are amongst the most commonly prescribed drugs worldwide and are commonly mis-prescribed for people with mild or temporary symptoms. Reducing the incidence of C.diff infections requires a much more thoughtful use of broad spectrum antibiotics and PPIs. It is possible to spread C.diff from patient to patient in the presence of poor infection control practice, and so this too is important in its control. It is a serious illness with around 6% of cases
resulting in death. Not all reports to public health are toxin producing C.diff the cases which are of most concern.

- Cryptosporidium is a protozoan, not a bacterium, and so it is entirely unaffected by antibiotics. It is a cause of diarrhoea and sometimes respiratory symptoms. Since it is commonly associated with otherwise normal cattle, it is not surprising that the infection is seen from time to time in Orkney, where most cases are sporadic and associated with farming activities. If outbreaks of Cryptosporidium infection occur they are often caused by contaminated drinking water. Since the organism is highly resistant to chlorine disinfection of the water supply, Scottish Water go to considerable lengths to ensure adequate filtration of water so as to avoid contamination of drinking water, which is a particular risk in farming communities such as Orkney.

An outbreak can be defined as an incident in which two or more linked cases experience the same illness, or when the observed number of cases unaccountably exceeds the expected number. On the basis of this definition the following outbreaks were dealt with by Public Health during this reporting period (Table 4.2).

Table 4.2 Types of incidents dealt with over the year

<table>
<thead>
<tr>
<th>Type</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhoea and vomiting onboard Cruise Liner</td>
<td>June 2016</td>
</tr>
<tr>
<td>Influenza A onboard Cruise Liner</td>
<td>June 2016</td>
</tr>
<tr>
<td>Gastroenteritis onboard Cruise Liner</td>
<td>June 2016</td>
</tr>
<tr>
<td>Chickenpox onboard Cruise Liner</td>
<td>June 2016</td>
</tr>
<tr>
<td>Sickness Bug at a School</td>
<td>Nov 2016</td>
</tr>
<tr>
<td>Norovirus illness at an institution</td>
<td>Dec 2016</td>
</tr>
<tr>
<td>Sickness Bug at a School</td>
<td>Dec 2016</td>
</tr>
<tr>
<td>Diarrhoea and vomiting in an institution</td>
<td>Jan 2017</td>
</tr>
<tr>
<td>Increase in absence at School</td>
<td>Jan 2017</td>
</tr>
<tr>
<td>Salmonella on property</td>
<td>Feb 2017</td>
</tr>
<tr>
<td>Sickness Bug at a School</td>
<td>Mar 2017</td>
</tr>
</tbody>
</table>

As can be seen the significant numbers of cruise ships carrying many thousands of people to the Islands is emerging as a significant challenge to Public Health and our colleagues in Environmental Services in Orkney Islands Council.
4.2 Vaccination Programmes

Childhood programme

Over many years the childhood immunisation programme has grown in complexity and the number of diseases targeted. It currently provides protection against the following illnesses:

- Diphtheria
- Pertussis (Whooping cough)
- Tetanus
- Polio
- Haemophilus influenza
- Meningitis B
- Meningitis C
- Measles
- Mumps
- Rotavirus
- Rubella

The following tables (Table 4.3, 4.4, 4.5) show the reported immunisation uptake rates for the childhood immunisation programme.

Table 4.3 Primary immunisation uptake rates (%) by 12 months of age, by financial year

<table>
<thead>
<tr>
<th></th>
<th>Year to March 16</th>
<th>Year to March 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP/Pol/Hib</td>
<td>88.9</td>
<td>92.3</td>
</tr>
<tr>
<td>Men C</td>
<td>91.5</td>
<td>91.8</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>89.4</td>
<td>92.9</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>87.3</td>
<td>86.2</td>
</tr>
</tbody>
</table>

Table 4.4 12/13 Month booster immunisation uptake rates (%) by 24 months of age, by financial year

<table>
<thead>
<tr>
<th></th>
<th>Year to March 16</th>
<th>Year to March 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR 1</td>
<td>97.4</td>
<td>90.4</td>
</tr>
<tr>
<td>Hib/MenC</td>
<td>95.8</td>
<td>90.4</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>96.3</td>
<td>90.9</td>
</tr>
</tbody>
</table>

Table 4.5 Pre-school booster immunisation uptake rates (%) by 5 years of age, by financial year

<table>
<thead>
<tr>
<th></th>
<th>Year to March 16</th>
<th>Year to March 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT/Pol</td>
<td>88.3</td>
<td>88.9</td>
</tr>
<tr>
<td>MMR2</td>
<td>87.4</td>
<td>85.8</td>
</tr>
</tbody>
</table>

Although some of these figures suggest that immunisation uptake is not as high as it might have been, further analysis locally shows that some data is missing or
misrecorded on the Scottish Immunisation Recall System (SIRS) and so it is highly likely that actual uptake rates were higher than these recorded figures would suggest. A key action in 2017 is the improvement of recording so that reported figures more accurately reflect local performance.

However, the very success of the immunisation programme means that today all of the diseases targeted by the programme have become a rarity, and consequently young parents have no experience of witnessing the devastating and sometimes fatal consequences of them. This false sense of security leads some parents to refuse to have their children immunised at all. These parents are putting their children at significant risk today, although their children gain some protection from living in a community with high levels of immunisation in the other children. As adults these children will be at greatly increased risk if travelling to countries without these high levels of immunisation. As children and adults they are at considerable risk of contracting the terrifying disease of tetanus from some relatively minor injury. Everything needs to be done to convince these parents that, far from protecting their children, they are actually putting their children at serious risk.

**Teenage programme**

Teenage girls are offered two doses of Human Papilloma Virus (HPV) vaccine in school, although the scheduling of this varies – for example in Secondary 3 in Orkney rather than Secondary 2 and this can make comparison with national uptake figures difficult. The HPV vaccine protects them from the common viruses that are the cause of cervical cancer.

In this reporting period the uptake of the first dose of HPV vaccine in S1 was 76.1%, below the Scottish average of 85.6%. At the end of the school year the HPV uptake rate for the first dose for girls in S2 was 88.9, slightly below the Scottish average of 91%. In S3 the percentage uptake was 77.8% below the Scottish average of 88.8% and further work is required to understand why this has occurred. The data shows that uptake is 85.7% in the SIMD least deprived category falling to 66.7% in the most deprived category.
In Secondary 3 all school pupils are offered a booster dose of Diphtheria/Pertussis/Tetanus vaccine and a vaccine against the meningitis types A, C, W and Y. Uptake rate in this reporting period was 83.3%.

The ‘flu programme

The increasingly complex ‘flu programme now offers immunisation against several varieties of influenza virus to the following groups. The percentage uptake rate is in brackets after each group.

- Pre-school children aged 2 – 5 years (67.8%)
- All primary school children (69.7%)
- All people aged 65 years and older (73.8%)
- Adults and children aged six months or older with chronic heart disease, kidney disease, liver disease, neurological disease or diabetes (43.3: 52.5: 36.1: 48.6: 61.4% respectively)
- Adults and children aged six months or older who are immunosuppressed either because of a disease or because of medication (60.3%)
- People with no spleen or with a dysfunctional spleen (35.3%)
- Pregnant women (No risk 39.5: At risk 62.5%)
- Unpaid carers and young carers (53.6)
- People with morbid obesity (27.9%)
- Health and social care staff (40.5%)

Some of these uptake rates seem low, but are generally in line with experience across Scotland. There are also some problems with correctly coding these immunisations in GP practice systems which are the source of the data. Work in 2017 is required to ensure immunization in, for example, pregnant women is being appropriately coded.

Pregnant women

As well as ‘flu immunisation, pregnant women are also offered pertussis (whooping cough) vaccination between 16 and 32 weeks of pregnancy. This is to offer protection to the baby in its early weeks before the childhood immunisation programme commences. The published data for Orkney suggest that the uptake
rate was 61.5%, which would be the lowest in Scotland, but it would appear that there is an issue with the recording of the data in GP systems and work is underway to improve recording.

**Shingles vaccination**

For shingles vaccination in 2016/17, vaccination coverage in the 70 years old routine group of patients was 59.5% the highest in Scotland. It was 63.1% for the new 76 years old group of individuals, again the highest in Scotland.

In conclusion, the very complex immunisation programmes would appear to be well delivered, but there are several issues concerning accurate data recording, and the Board and General Practices will need to work to resolve these issues so that reliable reporting can be achieved.

In 2017 the Scottish Immunisation call and recall system will be moved in to public health for administration, followed by the child health information systems. Work will be undertaken to improve data quality locally in these systems which are due to be replaced nationally in 2018.

There are national proposals to transfer responsibility for the delivery of vaccinations from GPs to NHS Boards. Locally it will be important to ensure that whatever delivery arrangement is agreed meets the needs of the local population and that vaccination rates do not drop as a result of any change in the delivery programme.

**4.3 Screening Programmes**

Screening is the process of identifying healthy people who may be at increased risk of a disease or condition. The screening provider then offers information, further tests and treatment as appropriate.

**Abdominal aortic aneurysm**

An Abdominal Aortic Aneurysm (AAA) is a swelling of the aorta, the main artery in the body, as it passes through the abdomen. As some people get older, the wall of
the aorta in the abdomen can become weak and balloon out to form an aneurysm. The condition is most common in men aged 65 and over and usually there are no symptoms.

The Scottish AAA screening programme aims to reduce deaths associated with the risk of aneurysm rupture in men aged 65 and over by identifying aneurysms early so that they can be monitored or treated. The screening test is a simple ultrasound scan of the abdomen which takes around 10 minutes. Men aged 65 are invited to attend AAA screening and men aged over 65 who have not previously been screened can self-refer into the screening programme. Most men have a normal result and are discharged from the screening programme. Men with detected small or medium sized aneurysms are invited for regular surveillance screening to check the size of the aneurysm. Men with large aneurysms are referred to vascular specialist services. NHS Orkney joined the Grampian, Orkney and Shetland Collaborative Abdominal Aortic Aneurysm (AAA) Screening Programme at its inception in October 2012.

The latest data for March 2017 shows that 100% of the eligible population were sent an initial offer to screening before the age of 66. The percentage of those offered screening who were tested before the age of 66 and 3 months was 86.7 (Scotland 84.4%). Uptake in Orkney was 88.9% in the SIMD most deprived area and 93.8% in the least deprived area, with a low of 82.9% in the second most deprived area. Although deprivation may be more widely dispersed in rural areas and the SIMD a less useful measure it can still demonstrate an inequalities gradient for some measures.

Only 1 of 3 individuals with an aneurysm \(\geq 5.5\) cm were seen by a vascular specialist within two weeks of screening compared with 74.6% in Scotland. Further focused work by the collaborative is required in 2017/18 to ensure those with an aneurysm detected by screening are promptly seen by the vascular specialists.

**Diabetic Retinopathy Screening**

Diabetes can affect the small blood vessels in the body like those found in the retina of the eye. When this happens it can affect sight, resulting in diabetic retinopathy, the most common cause of blindness in the working age population.
In order to minimise risk of sight loss, systematic diabetic retinopathy screening (DRS) is offered to all of the eligible diabetic population (aged 12 years and over) in Orkney. This involves digital photography of the back of the eye, and if changes are identified treatment is initiated if appropriate. In general the programme performs well in Orkney and the release of 2016 data is due in December 2017.

**Bowel (Colorectal) Cancer Screening**

The NHS Bowel Cancer Screening Programme offers screening every 2 years to all men and women aged 50-74 who are registered with a GP. People aged 75 or over can request a screening kit. Initial screening is via a faecal occult blood test undertaken at home, and samples of a bowel motion are put on a special card and posted safe, secure and free of charge to the Bowel Screening Centre laboratory for testing. (Those with a normal result will be re invited into the screening programme in 2 years if they fall within the age range. Patients with an abnormal test will be offered an appointment with a Specialist Screening Practitioner who will assess them for suitability to have a colonoscopy.

In the 2014-16 period NHS Orkney achieved an overall screening uptake of 62.3%, above the standard of 60%. There is a difference in uptake by sex with females having an uptake of 67.1% compared with 57.6% for males. Overall for Scotland the performance was 56.4%, with 59.5% uptake for females and 53.3% for males.

Using the Scottish Index of Multiple Deprivation shows an increased uptake rate for males and females in the least deprived areas of Orkney (70.5%) compared with the most deprived (57.2%) (Figure 4.1).
Figure 4.1 Uptake of bowel screen by sex and deprivation category for Orkney

Breast Cancer Screening

In Orkney, like the rest of Scotland, women aged 50-70 years are invited for a routine screen once every three years. Women over 70 years are also screened three-yearly but on request.

Over the last five years (2011-16) the uptake of Breast Screening in Orkney (83.8%) has not only exceeded the desired standards of 80% uptake, but has done so consistently (Table 4.6).

Table 4.6 Uptake rate by NHS Board of Residence (2011-2016, three-year periods)

<table>
<thead>
<tr>
<th></th>
<th>2010-13</th>
<th>2011-14</th>
<th>2012-15</th>
<th>2013-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orkney</td>
<td>84.7</td>
<td>84.7</td>
<td>84.6</td>
<td>83.8</td>
</tr>
<tr>
<td>Shetland</td>
<td>86.0</td>
<td>84.4</td>
<td>84.4</td>
<td>84.4</td>
</tr>
<tr>
<td>Western Isles</td>
<td>79.8</td>
<td>80.2</td>
<td>80.6</td>
<td>80.5</td>
</tr>
<tr>
<td>Scotland</td>
<td>73.5</td>
<td>72.9</td>
<td>72.5</td>
<td>71.9</td>
</tr>
</tbody>
</table>

However, and like in many other screening programmes, the screening programme does not reach every stratum of society with due equity, and although we do not have currently a specific picture for Orkney, that of Scotland shows a clear decline of uptake for those living in the most deprived areas. This emphasises the need to
ensure not only breast screening and other screening programmes but also other
health promotion programmes are working to reduce health inequalities.

Cervical Screening

All women aged 25 to 49 in Orkney are offered a smear test every three years, in
line with the national programme. Women aged 50 to 64 are invited every five years.
Women, under the age of 25, who have already been invited for screening, may be
invited again before they reach 25. Some women are also offered screening more
frequently, up to the age of 70 years.

Over the years there has been a steady decline in the uptake of cervical smears
everywhere in the UK. Whilst Scotland is not different, the downward trends in the
northern isles (Orkney and Shetland) have been less marked with uptake over the
75% mark. Performance for Orkney for 2016-2017 was 79% compared with 73.4%
for Scotland. Again we see that uptake is higher in those areas categorized as least
deprived using SIMD (Table 4.7).

Table 4.7 Cervical screening uptake by national SIMD category

<table>
<thead>
<tr>
<th>SIMD</th>
<th>Orkney</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 (least deprived)</td>
<td>83.7</td>
<td>78.3</td>
</tr>
<tr>
<td>4</td>
<td>81.1</td>
<td>76.5</td>
</tr>
<tr>
<td>3</td>
<td>77.4</td>
<td>73.8</td>
</tr>
<tr>
<td>2</td>
<td>72.7</td>
<td>71.2</td>
</tr>
<tr>
<td>1 (most deprived)</td>
<td>-</td>
<td>67.4</td>
</tr>
</tbody>
</table>

Data source: ISD October 2017 (Orkney has no area classified national SIMD 1)

Antenatal and Newborn Screening

These tests are offered to all pregnant women to assess the ‘chance’ of them or their
baby having a particular health problem or disability. They do not provide a definite
diagnosis but help the pregnant woman and her midwife decide whether further tests
are required to make a diagnosis. The screening programme for communicable
diseases in pregnancy is designed to offer women the opportunity for early
identification of hepatitis B, HIV and syphilis thus allowing management interventions to be offered to the mother and to prevent mother to child transmission.

**Newborn Blood Screening**

Newborn blood spot screening identifies babies who may have rare but serious conditions. Most babies screened will not have any of the conditions, but for the small number reported, screening can point the way to early treatment which can improve their health or prevent severe disability.

Blood spot results are analysed and interpreted by the Scottish Newborn Screening Laboratory (SNSL). Results are usually sent to the Community Child Health Departments for input to the database. In 2017 the management of the databases locally will be taken over by the Public Health department.

The system supports the recording of newborn bloodspot screening; currently providing for up to 5 blood spot tests:

- Phenylketonuria – PKU
- Congenital Hypothyroidism – CHT
- Cystic Fibrosis – CF
- Medium Chain Acyl-CoA Dehydrogenase Deficiency – MCD
- Haemoglobinopathy – HBO (Sickle Cell Disorder - SCD)

**Newborn Hearing Screening Programme (NHSP)**

One to two babies in every 1,000 are born with permanent hearing loss in one or both ears. This increases to about 1 in every 100 babies who have spent more than 48 hours in intensive care. Permanent hearing loss will significantly affect a baby’s development.

As most of these babies are born into families with no history of permanent hearing loss, finding out early can give these babies a better chance of developing language,
speech, and communication skills. The hearing test is a simple test done in the first few weeks after birth, ideally when the mother is still in the maternity unit.

In Orkney during 2016, the number of babies screened was 139. Overall two babies were referred for diagnostic testing and no children were identified with hearing loss.

4.4 Port Health

Orkney is now a popular cruise ship destination. In 2017 140 cruise ships docked, an increase on the 116 seen in the 2016 season. In season 2018 there are currently over 140 vessels booked with an estimated 134,600 passengers (Figure 4.2).

Figure 4.2 Cruise liner visitors

Some of the visiting vessels booked are larger and will accommodate more passengers hence increase the passenger numbers. Marine Services within Orkney Islands Council seek to limit passenger numbers to 4,500 per day to reduce the
impact of such a large influx of visits on Kirkwall town centre and surrounding visitor attractions.

The great majority of cruisers visiting Orkney have a UK port as the origin, and a few have international itineraries. Normally the cruisers, before docking, send a Maritime Declaration of Health to both Port Health Authority and Environmental Health, who pass on any concerns to the Public Health department when necessary. Close partner working is an important element of Port Health.

The cruise liner season 2016/17 saw three declarations to Public Health which included norovirus, influenza, and diarrhoea and vomiting which resulted in Problem Assessment Groups and notifications to Health Protection Scotland.

The ongoing rise in cruise ships will require appropriate resource planning by stakeholders involved, to balance financial and environmental impacts.

4.5 Emergency Planning, Resilience and Business Continuity

Significant work including a tabletop exercise was carried out on the Major Incident Plan for NHS Orkney. Over 2017 further testing occurred as part of a national exercise. Business continuity planning templates were redesigned to be simple to use for all staff members and focused on department and service specific risks. An action card system has been incorporated as part of risk identification process so that any staff member picking up the business continuity plan will have a detailed series of actions to follow relative to the risk that they are facing.

The Battle of Jutland Commemorations took place on the 31st May 2016. Given the number of visiting dignitaries including members of the Royal Family and the Prime Minister a Protected Persons Plan was developed for the Balfour Hospital which covered the actions for the Board should any Protected Person require hospital admission. This original document has now formed the basis of the new Protected Persons Plan.
A significant amount of work has been undertaken throughout the period under review in relation to the Government's Counter Terrorism Strategy in compliance with the Counter Terrorism Security Act 2015. A Prevent Delivery Group has been set up chaired by the resilience officer and supported by the Director of Public Health as the executive lead for Prevent. This has resulted in the development of a Prevent Policy and ratification of an Information Sharing protocol between Police Scotland, Orkney Islands Council and NHS Orkney. WRAP is a workshop to raise the awareness of prevent training. A number of WRAP trainers have been trained and WRAP sessions are now being delivered on a two weekly basis at staff induction and as part of a rolling programme to existing staff. The resilience officer regularly attends the Prevent Working Group, Prevent and Contest Boards.

As part of compliance with the 41 Standards of Organisational Resilience published by the Scottish Government Health Resilience Unit, Police Scotland Architectural Liaison Officers undertook surveys of NHS Orkney Estate from a crime prevention and security perspective. This was followed up with the Counter Terrorism and Security Advisors undertaking a review of the new hospital plans with recommendations passed to the project team.

In addition to the prevent meetings, the Public Health Department has participated in regular multi-agency meetings such as the Orkney Local Emergency Co-ordinating Group, (OLECG), Highland and Islands Local Resilience Partnership, and the North of Scotland Regional Resilience Partnership (NoSRRP) as well as attending the Scottish Government Health Resilience Unit Forum. This has ensured that national guidance and planning has been considered when the organisation has been fulfilling its role as a Category 1 Responder.

The Winter Plan 2016/17 was updated to ensure that planning was in place for the winter weather. This linked into the re-draft of the Pandemic Flu Plan and the Mass Prophylaxis Plan all of which will be tested in the coming year.

During the year 2016-17, NHS Orkney participated in a range of training at a local, regional and national level. Table 4.8 is a resume of some of the key events that were attended.
Table 4.8 Participation in training events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2016</td>
<td>Safe Hands 1 at the Royal College of Surgeons in Edinburgh examining the learning from the multi-agency response to events in Paris. This was attended by the resilience officer.</td>
<td>The resilience officer.</td>
</tr>
<tr>
<td>October 2016</td>
<td>Safe Hands 2, designed to test Board responses to a mass casualty incident against the Mass Casualty Plan March 2015 and the setting up of the Strategic Health Group. This was attended by the Chief Executive and members of the executive team.</td>
<td>The Chief Executive and members of the executive team.</td>
</tr>
<tr>
<td>November 2016</td>
<td>Local training for loggists attended by executive PAs and administrative staff.</td>
<td>Executive PAs and administrative staff.</td>
</tr>
<tr>
<td>December 2016</td>
<td>Exercise Silver Swan 2 at the Scottish Police College Tulliallan, examining the national response to a flu pandemic and focusing on local issues was attended by the resilience officer.</td>
<td>The resilience officer.</td>
</tr>
<tr>
<td>February 2017</td>
<td>Extreme Right Wing Awareness Training delivered by Rewind UK on behalf of Police Scotland looking at the role of Interventors. This was attended by members of Primary Care, WRAP 3 trainers and the resilience officer.</td>
<td>Members of Primary Care, WRAP 3 trainers and the resilience officer.</td>
</tr>
</tbody>
</table>

In addition to this, the 5 north isles airport plans have been exercised with NHS staff in attendance subject to other medical duties.

Finally, the Board suffered a number of disruptive events which included the severing of the fibre optic cable providing internet access to the Balfour Hospital IT infrastructure.

On the 17th of November 2016, there was a lightning strike to the main communications mast on Sanday. This resulted in the loss of IT, telephony, mobile phone signal, emergency services airwave system and coastguard VHF radio systems to some of the north isles. The local emergency multiagency co-ordinating group, OLECG, stood up and multi-agency meetings took place until communication systems were fully restored.
OIC and NHS Orkney in collaboration with the local community councils, Scottish Government and National Centre for Resilience Unit are looking at solutions to limit the impact of such events in the future. Both the broadband and communications outage were the subject of structured debriefs run by the Scottish Resilience Development Service (ScoRDS).
Acknowledgements

I would like to thank everyone who has worked in the public health department and the rest of the organisation for their contribution to this annual report, which provides a snap shot of just some of the work being undertaken. In particular I would like to thank Suzanne Baird and Carol Stewart for their help in compiling the report and Rose Rendall for formatting the final report. Cindy Marsh and Dr Derek Cox have worked with the department as locum consultants in public health and some of the work they undertook is also reflected in this report.
Executive Summary

Cathie Cowan has been appointed as Chief Executive Officer, NHS Forth Valley and will take up her new post with effect from 1 January 2018. Negotiations have been ongoing between the NHS Orkney Board Chairman and the Scottish Government to agree future arrangements for recruitment to the Chief Executive post.

Purpose

The purpose of this report is to update the Board on the interim Chief Executive arrangement

Recommendation

The Board is invited to:

- Note the arrangements.

1. Background

Cathie Cowan, Chief Executive, is leaving the employment of NHS Orkney to lead NHS Forth Valley. Gerry O’Brien, Director of Finance and Logistics with the Scottish Ambulance Service, has been appointed as the interim Chief Executive of NHS Orkney. G O’Brien previously served as Director of Finance with NHS Orkney. His appointment to this interim role will provide continuity while plans for a permanent appointment are progressed.

1.1 Linkage to Corporate Objectives / Strategic Aims

The interim arrangements will provide continuity in meeting all corporate objectives and strategic aims.

1.2 Contribution to Quality

Please indicate which of the 2020 vision / quality ambitions are supported in this report by ticking the relevant dimension

- **Safe**: avoiding injuries to patients from healthcare that is intended to help them  
  - 
- **Effective**: providing services based on scientific knowledge  
  - 
- **Efficient**: avoiding waste, including waste of equipment  
  - 

- 
- 
-
1.3 Compliance with Board Policy on Equality and Diversity

Not applicable.

2. Resource Implications and Identified Source of Funding

All costs will be met from within existing budget.

3. Fit with Best Value Criteria

The interim arrangement will result in the Chief Executive being replaced by someone who has an extensive knowledge of NHS Orkney and its business and previously was appointed as NHS Orkney's Deputy Chief Executive.

4. Risk Assessment and Mitigation

Any risks associated with the Chief Executive vacancy will be mitigated by this interim appointment and will provide time for the recruitment process of a substantive Chief Executive.

5. Consultation and Engagement

The interim arrangements were approved by the Remuneration Committee on 4 December 2017.

6. Conclusion

The Board members are asked to note the interim arrangements.

Executive Sponsor -

Author Ian Kinniburgh
NHS Orkney Board chairman

Contact details ian.kinniburgh@nhs.net
888271

Date 28 November 2017

Supporting Documents -
Executive Summary

This is a mandatory requirement for a Healthcare Associated Infection Control report to be presented to the Board on a bi-monthly basis utilising the template below.

Purpose

The purpose of this paper is to update Board Members of the current status of Healthcare Associated Infections (HAI) and infection Control measures, with particular reference to performance against the Local Delivery Plan Standards and cleanliness monitoring.

Key issues will include

- Staphylococcus aureus Bacteraemias
- Clostridium difficile
- Hand Hygiene compliance
- Cleanliness monitoring
- Antimicrobial prescribing
- Outbreaks/Incidents

Other HAI activity such as surgical site surveillance will also feature.

Recommendation

To note the report against the requirement of national mandatory requirement for a Healthcare Associated Infection Control report to be presented to the Board on a bi-monthly basis. The Board is asked to note this report

Executive Sponsor

Marthinus Roos
Medical Director
HAI Executive Lead

Author

Rosemary Wood
Infection Control Manager

Contact details

01856888046
rosemary.wood@nhs.net

Date

1/12/2017
Healthcare Associated Infection Reporting Template (HAIRT)
Section 1 – Board Wide Issues

Key Healthcare Associated Infection Headlines for December 2017

HPS HAI Digest 17 November 2017

The latest figures on norovirus reported to HPS by NHS Boards show increased norovirus activity http://www.hps.scot.nhs.uk/giz/norovirusdashboard.html. Therefore NHS boards should now begin to implement their active plans.

The Stay at Home campaign materials including digital social media toolkit can be found at http://www.healthscotland.com/resources/campaigns/norovirus.aspx.

Further information on Norovirus including link to the Top Tips for Preventing Infection and Norovirus Guidance and tools can be found at http://www.hps.scot.nhs.uk/giz/norovirus.aspx?subjectid=125

Norovirus is very much part of everyday business as it tends to be all year round not just focused to winter months. Staff remain vigilant of all patients presenting with sudden onset of vomiting and or diarrhoea. Strict standard infection prevention and control measures are adhered to along with isolation of patient where possible. Staff abide by the 48 hr rule for not returning to work until 48hrs clear of last episode of either vomiting and or diarrhoea.

NHS Orkney has had no ward or bay closures due to norovirus since February 2012.

World Antibiotic Awareness Week 13th-19th November 2017

Poster displays where placed throughout NHS Orkney and to Community Pharmacists. Also information provided on the role of Infection Prevention and Control in preventing antibiotic resistance in Health Care.

LDP Standard 1st April 2017 to 31st March 2018

- NHS Orkney has had 1 Staphylococcus aureus Bacteraemia (SAB) case(s) for Q3 calendar year (Jul-Sept ), the same 1 case is still to be declared at time of report for Q2 (Jul-Sept) for LDP. NHS Orkney is within the LDP Standard of 3 cases. The next update will be in February 2018 for Q4 end of calendar year and Q3 for LDP.

- NHS Orkney has 3 confirmed cases Clostridium difficile infection (CDI) case(s) for Q3 calendar year (Jul-Sept 2017) by Health Protection Scotland, the same 3 case(s) to be declared at time of report for Q2 (Jul-Sept 2017) for LDP. NHS Orkney is 2 cases over the LDP Standard. Reporting 5 confirmed cases in total to date. The next update will be in February 2018 for Q4 end of calendar year and Q3 for LDP.

Staphylococcus aureus bacteraemia (SAB)
See Appendix A for definition.

Figure 1 shows SABs by location and cause for Q2 (Jul-Sep 2017) LDP

![Total Staphylococcus aureus Bacteraemia (SAB) 2017](chart)

**Current Board Performance for Calendar Year January - December 2017**

<table>
<thead>
<tr>
<th>Quarter 1.</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – March</td>
<td>April – June</td>
<td>July - to September</td>
<td>October - December</td>
</tr>
<tr>
<td>0</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**LDP Standard 1st April 2017 -31st March 2018**

<table>
<thead>
<tr>
<th>Quarter 1.</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>April – June</td>
<td>July - September</td>
<td>October - December</td>
<td>January - March 2018</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Next report Feb 2018</td>
<td></td>
</tr>
</tbody>
</table>

For Q2 LDP there were no Meticillin-resistant *Staphylococcus aureus* (MRSA) cases. All 3 cases reported were Meticillin-sensitive *Staphylococcus aureus* (MSSA).

Every SAB is reported through DATIX and is subject to a rigorous review involving clinician involved in patient care. The latest case being a Peripheral Vascular Cannula (PVC) related Hospital Acquired Infection.

At the request of the HAI Executive Lead this case will be presented to the Clinicians for further discussion and lesson learned for any ongoing improvement work.

**Clostridium difficile infection (CDI)**

See Appendix A for definition.

Figure 1 shows CDI by location and cause for Q2 (Jul-Sep 2017) LDP

![Total Clostridium Difficile infection (CDI) 2017](chart)
Current Board performance for calendar year Jan - Dec 2017

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Jan – March</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 2</td>
<td>April – June</td>
<td>2</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>July-September</td>
<td>3</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>October - December</td>
<td>Next report Feb 2018</td>
</tr>
</tbody>
</table>

LDP Standard 1st April 2017 - 31st March 2018

<table>
<thead>
<tr>
<th>Quarter</th>
<th>April-June</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 2</td>
<td>July-September</td>
<td>3</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>October-December</td>
<td>Next report Feb 2018</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>January- March</td>
<td></td>
</tr>
</tbody>
</table>

Our aim is to continue to work towards maintaining a low number of cases.

NHS Orkney continues to report to Health Protection Scotland (HPS) symptomatic patients that were treated, even if this was not necessarily fully confirmed by the laboratory result. Therefore treatment of CDI has been based on clinical presentation as well as lab reporting. It was noted this was over and above reporting as national reporting requirements. National requirements only stipulate that we must report symptomatic toxin positive cases.

As with every SAB case(s), every Clostridium difficile infection (CDI) case is subject to a rigorous review which includes a feedback and inclusion of the clinician caring for patient.

Local Enhanced CDI Surveillance in NHSO : Definition of Origin

*Hospital acquired CDI* is defined as when a CDI patient has had onset of symptoms at least 48 hours following admission to a hospital.

*Healthcare associated CDI* is defined as when a CDI patient has had onset of symptoms up to four weeks after discharge from a hospital.

*Indeterminate cases of CDI* is defined as a CDI patient who was discharged from a hospital 4-12 weeks before the onset of symptoms.

*Community associated CDI* is defined as a CDI patient with onset of symptoms while outside a hospital and without discharge from a hospital within the previous 12 weeks; or with onset of symptoms within 48 hours following admission to a hospital without stay in a hospital within the previous 12 weeks

Hand Hygiene

For supplementary information please see Appendix A

Hand hygiene continues to be monitored by each clinical area through their departmental Standard Infection Control Precautions (SICPs). The Infection Prevention and Control team follow up with any area which either fail to submit results or which fall below 90% for two consecutive months. The Infection Prevention & Control team carryout bi-monthly Quality Assurance (QA) audits. This information is reported to the Senior Charge Nurse (SCN) at time of audit and through the Infection Prevention and Control Team, Infection Control Committee and Safe & Effective Care Group.
103 observations undertaken during November 2017

Overall results for hand hygiene

<table>
<thead>
<tr>
<th>Staff Groups</th>
<th>Number Observed</th>
<th>Opportunities taken</th>
<th>Percentage for opportunity</th>
<th>Percentages for techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>62</td>
<td>60</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Medics</td>
<td>15</td>
<td>13</td>
<td>93%</td>
<td>87%</td>
</tr>
<tr>
<td>AHPs</td>
<td>22</td>
<td>4</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Low scoring for Medics was the result of non dress code compliance - the wearing of wrist watches and Fitbits.
MRSA Clinical Risk Assessments

The current Key Performance Indicator has been developed in order to measure compliance at a Scottish level on an annual basis. The minimum number of records that require to be submitted each quarter by boards reflects the sample size required to measure this precisely. As part of the MRSA Screening Programme at HPS, quarterly compliance is reviewed by the team to provide assurance that CRA compliance is at or above 90%.

Below is current data for the 4 most recent quarters within your board and for Scotland 25/10/2017

**Quarter 1  2017/18 Audit data results for Quarter 2**

<table>
<thead>
<tr>
<th>Health Board</th>
<th>2016_17 Q3</th>
<th>2016_17 Q4</th>
<th>2017_18 Q1</th>
<th>2017_18 Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orkney</td>
<td>93%</td>
<td>100%</td>
<td>97%</td>
<td><strong>94%</strong></td>
</tr>
</tbody>
</table>
The IPCT are continuing to monitor this very closely due to changes within documentation throughout all clinical areas. This is done by vetting 5 case notes per week. The IPCT are also targeting inter-hospital transfers to ensure the CRA is undertaken and followed up.

**Cleaning and the Healthcare Environment**

For supplementary information please see Appendix A

<table>
<thead>
<tr>
<th>Traffic light System</th>
<th>RED</th>
<th>AMBER</th>
<th>GREEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scores</td>
<td>&lt;70%</td>
<td>70-90%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Overall Compliance</td>
<td></td>
<td></td>
<td>Domestic 97%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Estates 98%</td>
</tr>
</tbody>
</table>

The National Target is to maintain compliance with standards above 90%

<table>
<thead>
<tr>
<th>Division</th>
<th>Domestic</th>
<th>Domestic rectifications</th>
<th>Estates</th>
<th>Estates rectifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Ward</td>
<td>☑️ 97%</td>
<td>5</td>
<td>99%</td>
<td>2</td>
</tr>
<tr>
<td>Macmillan</td>
<td>☑️ 95%</td>
<td>5</td>
<td>98%</td>
<td>2</td>
</tr>
<tr>
<td>Theatre</td>
<td>☑️ 98%</td>
<td>1</td>
<td>98%</td>
<td>3</td>
</tr>
<tr>
<td>Laboratory</td>
<td>☑️ 97%</td>
<td>4</td>
<td>98%</td>
<td>1</td>
</tr>
<tr>
<td>Assessment &amp; Rehabilitation</td>
<td>☑️ 95%</td>
<td>4</td>
<td>99%</td>
<td>1</td>
</tr>
</tbody>
</table>
The NHS Scotland National Cleaning Services Specification for NHS Orkney for period 30th November 2017 was Domestic 97% and Estates 98% which remains above the National target of 90%.

Outbreaks
Since the last Board update paper, there have been no outbreaks of diarrhoea and vomiting. There have been none declared since February 2012.

NHS Orkney Surgical Site Infection (SSI) Surveillance
NHS Orkney participates in a national infection surveillance programme relating to specific surgical procedures such as Caesarean sections, hip fractures and large bowel surgery. This is coordinated by Health Protection Scotland (HPS) and the national definitions and methodology which enable comparison with overall NHS Scotland infection rates. These results are now being fed through NSS Discovery for Boards to view.

Standard Infection Control Precautions (SICPs) – Departmental and Quality Assurance audits update.
Next audit update will be February 2018 HAIRT as next audits due are in December 2017 and January 2018.

Education update
Launch of Scottish Infection Prevention & Control Education Pathway (SIPCEPS) 21st June 2017 by Shona Robinson, Cabinet Secretary for Health and Sport.

What is it? A staged pathway of infection prevention and control education.

Who is it for? All Scottish health & social care staff and students.

What is the aim? To enable staff and students to continuously improve their knowledge and skills around infection prevention and control as part of their role.

The Infection Prevention and Control team have promoted this learning across NHS teams through corporate induction, staff meetings, and facilitated training days in July, August and September 2017 and more latterly through Compulsory training days.

A snapshot for the last 5 months is encouraging to see the number of staff across primary and secondary care having undertaken this learning opportunity.

<table>
<thead>
<tr>
<th>SIPCEP Modules</th>
<th>No of staff having completed each module</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Why Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>2</td>
<td>Breaking the Chain of Infection</td>
</tr>
<tr>
<td>3</td>
<td>Placement Placement/Assessment for infection Risk</td>
</tr>
<tr>
<td>4</td>
<td>Hand Hygiene</td>
</tr>
<tr>
<td>5</td>
<td>Respiratory and Cough Hygiene</td>
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<tr>
<td></td>
<td>Course Title</td>
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<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6</td>
<td>Personal Protective Equipment (PPE)</td>
</tr>
<tr>
<td>7</td>
<td>Safe Management of Care Equipment</td>
</tr>
<tr>
<td>8</td>
<td>Safe Management of Care Environment</td>
</tr>
<tr>
<td>9</td>
<td>Safe Management of Linen</td>
</tr>
<tr>
<td>10</td>
<td>Safe Management of Blood and Body Fluids Spillages</td>
</tr>
<tr>
<td>11</td>
<td>Safe Disposal of Waste (Including Sharps)</td>
</tr>
<tr>
<td>12</td>
<td>Prevention and management of occupational Exposure (Including Sharps)</td>
</tr>
<tr>
<td>13</td>
<td>Prevention &amp; Control of Infection Clostridium difficile</td>
</tr>
<tr>
<td>14</td>
<td>Infection prevention and Control: Refresher for Non-clinical Staff</td>
</tr>
<tr>
<td>15</td>
<td>Infection Prevention and Control: Refresher for Clinical staff</td>
</tr>
<tr>
<td>26</td>
<td>1,262 modules completed</td>
</tr>
</tbody>
</table>

Decontamination Lead: Roles and Responsibilities

An accredited City & Guilds programme was delivered by Eastwood Park and hosted in NHS Orkney on 8th - 10th November 2017. NHS Orkney shared this learning event with the Infection Control Manager from Western Isles and Shetland plus two other staff members from Shetland. Local participants were Gary Drever CDU Manager, Sarah Walker Infection Prevention and Control Nurse Specialist and Rosemary Wood Infection Control Manager.

The programme provided the baseline knowledge and required skills to perform the role of Decontamination Lead within a healthcare environment. The Infection Control Manager is the named Decontamination Lead for NHS Orkney with deputies as named above. The programme highlighted the number of areas this role covered in both primary and secondary care. There is a great deal of work to be undertaken by teams to ensure as an organisation we are meeting all standards.

This training provided excellent networking across all 3 island boards establishing relationships, sharing of best practice and providing support to one another. Our visitors had enjoyed their time and thank us for our hospitality.

Compulsory training – previously known as Boxset training. Introduced in March 2017 a set programme for two days where staff can sign up for dedicated time to allow training on specific areas, ekf, Fire, Prevent, LearnPro and Infection Prevention and Control. It has been slow to take off but last session in November saw 4 staff sign up and all said how valuable the session had been and that they would go back to their areas and share with their colleagues about the sessions. Looking forward to seeing more staff engage with this learning opportunity in the future.

Standard infection prevention

As with the departmental SICPs audits the quality assurance (QA) SICPs audits are undertaken in line with section 2 of the Infection Prevention & Control Audit Algorithm (for local Guidelines & Policies, Audit Algorithm).

The audits frequency is dictated by the RAG score for each SICP. It should be recognised that the QA tool is a far more detailed audit tool, in comparison with the departmental tool and therefore some differences between the audit scores will be evident.

Additionally there have been several “walk around spot checks” which aim to target some improvements on an ad hoc basis. This is fed back on the day informally and discussed with staff.
Appendix A

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 out with 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 Methicillin Sensitive *Staphylococcus aureus* (MSSA) and Methicillin Resistant *Staphylococcus aureus* (MRSA).

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.diff 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
Hospitals carry out regular audits of how well their staff is complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

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.

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. 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 HOSPITAL

**Staphylococcus aureus** bacteraemia monthly case numbers

**LDP Standard identified** 48 hrs after admission therefore Hospital acquired.

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<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
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<td>TOTAL</td>
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</table>

**Staphylococcus aureus** bacteraemia monthly case numbers **LDP Standard Out of Hospital including Healthcare associated**

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</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>MSSA</td>
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</tr>
</tbody>
</table>

**Clostridium difficile** infection monthly case numbers **LDP Standard Hospital**

| Ages   | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 15-64  | 0      | 1      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| 65+    | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| 15+    | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 1      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 2      |

**Clostridium difficile** infection monthly case numbers **LDP Standard Out of Hospital**

| Ages   | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 15-64  | 0      | 1      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| 65+    | 0      | 0      | 0      | 0      | 0      | 1      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| 15+    | 0      | 1      | 1      | 0      | 0      | 1      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |

**Cleaning Compliance (%)** Domestic

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</tr>
</thead>
<tbody>
<tr>
<td>Board</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
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13
NHS Orkney Board

Date of Meeting: 14 December 2017

Subject: Chair’s Report – Area Clinical Forum

Executive Summary

This report highlights key agenda items that were discussed at the Area Clinical Forum meeting on 1 December 2017 and it was agreed that these should be reported to the NHS Orkney Board.

Purpose

The purpose of this report is;

- to update Board Members on the current business of the Area Clinical Forum; and
- to provide assurance to the Board that issues of importance are being progressed.

Recommendation

The Board is invited to note the report and seek assurance on performance.

1. Agenda Item

1.1 Autism Diagnostic Pathway

Members had agreed that the pathway should be clinically robust and provide children with the service that they needed in a timely manner. This should be a multidisciplinary approach and it was acknowledged that this would be different for every child. Members agreed that a single pathway for children would be more beneficial, rather than the two which currently exist. It was agreed that there should be a single point of referral and it has been suggested that this be the GP.

It was recommended that a short life working group be established, including all relevant clinicians and members as to enable the finalisation of the pathway.

1.2 Secondary Care Investigation Results

It had been noted from the minute of the Area Medical Committee that there was a current issue around the responsibility of acting upon results of investigations which were requested in secondary care. The robustness of the system in secondary care was questioned, which carried a risk that the results of test were missed or not acted upon. The Area Medical Committee had made a request that this was escalated to the Area Clinical Forum.
2 Items to be brought to the attention of the Clinical and Care Governance

2.1 Clinical Documentation on the Blog

It was noted that Clinical Governance and the Advisory Committees would work together to improve current Clinical Documentation issues.

2.2 Clinical and Care Governance Committee

Members welcomed the changes to the Clinical and Care Governance Committee and work around DATIX, the Quality Improvement Hub and the establishment of the Quality and Safety Group and looked forward to working more closely with the Head of Transformational Change and Improvement and her team.

Steven Johnston
Area Clinical Forum Chair
6 December 2017
8.2.1

Orkney NHS Board

Minute of meeting of Area Clinical Forum of Orkney NHS Board held in the Saltire Room, Balfour Hospital on Friday 1 December 2017 at 12.15pm.

Present: Steven Johnston, Chair (ADC)
Nigel Pendrey, Secretary (ADC)
Penny Martin (TRADAC)
Moraig Rollo (TRADAC)
Sylvia Tomison (NAMAC) by VC

In Attendance: Christina Bichan, Head of Transformational Change and Improvement (Item number 97)
Caroline Sinclair, Chief Officer (Item number 94 & 95)
Fyona Stout, Committee Clerk (Minutes)
John Trainor, Head of Health and Community Care (Item number 95)

83 Apologies

Apologies were received from J Sinclair, L Wilson, N Bremner and C Siderfin.

84 Declaration of interest – Agenda items

No interests were declared.

85 Minute of meeting held on 6 October 2017

The minute from the meeting held on the 6 October 2017 was accepted as an accurate record of the meeting, subject to the amendments noted below and was approved on the motion of P Martin seconded by N Pendrey.

- Numbering of pages to be added

86 Matters Arising

43 - Informed consent

The Chair informed members that this was on hold for the moment as the Medical Director was awaiting further national guidelines from the General Medical Council before proceeding with new local work.

65 – Development Session

It was noted that P Martin and D McArthur had been added to the ACF Yammer group.

87 Area Clinical Forum Action Log/ Recurring Agenda Items for Area Clinical Forum

The Action Log was reviewed and corrective action agreed on outstanding issues (see action log for details).

88 Chairman’s report from the Board and Annual Review

The Chair provided members with an update from the October Board meeting highlighting the
following:

- The Infection Control Education Strategy for mandatory and continuing education had been seen by the Board, but was still pending approval from the Clinical and Care Governance Committee.
- It was noted that many positive learning outcomes had come from the Ombudsman Report.
- Issues surrounding the Blog and the Autism Diagnosis Pathway had been discussed with a request for further input from the advisory committees and the ACF to go back to the Board in December.

The Chair provided members with an update from the 2017 Annual Review highlighting the following:

- The joint Area Clinical Forum and Area Partnership Forum session had received full commitment from the Board that help and support would be given to improve attendance at the advisory committee meetings.
- Issues had been raised with regards to the Orthopaedic waiting times.
- There had been concerns around Children’s services and the transition from children to adult services.
- The Scapa Court residents had felt well informed with regards to the build of the new hospital.
- Compliments were paid by patients to audiology and radiology services and the introduction of the new phototherapy service in Dounby was also welcomed.
- The continued to be issues around Cardiology waiting times.
- There had been no successful applicants as yet to the post of a Heart failure speciality nurse. An option could be to up skill a current member of staff as a development opportunity.

89 Advisory Committee Reports:

The Chair advised that he would be attending meetings of the Professional Advisory groups to gain a better understanding of their business and format.

NAMAC

S Tomison advised that NAMAC had met on the 29 November 2017 and highlighted the following:

- A discussion had taken place on the attendance of the meetings.
- J Sinclair had given an update on the Excellence of Care.
- The new forensic service was still under discussion with regards to sexual assault and rape.
- The previous NAMAC chair had recently taken up post with another Board. S Tomison remained Vice Chair and J Sinclair Secretary.
- Distributing a questionnaire to NAMAC members to try to find out things the group could do to improve attendance was considered.
- The next meeting would be held on the 31 January 2018.

AMC
There were no representatives for AMC at the meeting.

S Johnston noted from the minute that there had been an issue around the responsibility of acting upon results of investigations which were requested in secondary care. There may not to be a robust system in secondary care to ensure this happens which carried a risk that the results of test were missed or not acted upon. The AMC had made a request that this was escalated to the ACF.

S Johnston had noted from the AMC minute that Dr C Taylor, GP Prescriber for the drugs and rehabilitation service would leave Orkney and there would need to be discussions held to ensure a replacement service would be provided.

APC

There had been no recent meetings of the APC and no members were present at the meeting.

ADC

There had been no recent meetings of the ADC.

TRADAC

M Rollo and P Martin advised that TRADAC had met on the 30 November 2017 for a development session and highlighted the following:

- Two key members of staff had recently left NHS Orkney; therefore TRADAC now lacked representation from Physiotherapy.
- AILIP priority areas had been discussed, covering Radiography reporting, Work Force and Work Force planning.
- The next meeting would be held on 29 January 2018.

89 Development Sessions

November Development Session Outcomes – ACF response on Regional Delivery Plan

The Chair delivered an update on the November development session. A response had been compiled to the Regional Delivery plan. All members had agreed that this had been a good review and had covered all the necessary areas and would be submitted.

90 Topic for Future Sessions

Members discussed topics for future sessions, clinical supervision which had been planned for November was postponed to allow for a response to the regional deliverly plan and would be the topic for next session in March.

It was noted that the Allied Health Professions had completed a national strategy for supervision and that a new model was required for Midwifery supervision and this would be reviewed nationally.

91 Development Session Output

Members noted that there had been an session of the Area Partnership Forum with ACF invite
Area Clinical Forum – Terms of Reference

The members approved the updated Terms of Reference.

ACF Representative for the Endowment Fund Sub Committee

The Endowment Fund Sub Committee required an additional representative from ACF. M Rollo was a current representative. There were no volunteers so S Johnston would email all the ACF members to seek a volunteer.

M Rollo gave members an update of the most recent Endowment Sub Committee stating that the committee worked hard to ensure endowment money was being spent wisely. The process of bidding had been made much more open. This was a publicly held meeting now and decisions would be made during the meeting and the people would be informed immediately. The meetings were held quarterly.

Engaging the ACF in IJB work

C Sinclair, Chief Officer, discussed with members the relationship between the Integration Joint Board and the Advisory Groups, the following were agreed:

- Members would like to be informed of upcoming agendas to decide whether they would need to be involved or not.
- Members would like an insight into strategic planning.
- This would be trialed for the next 12 months.

Autism Diagnostic Protocol

J Trainor, Head of Health and Community Care, delivered the report on the Autism Diagnostic Protocol. There had been concerns raised around the policy, which had already been to TRADAC, NAMAC and AMC.

C Sinclair noted that there were currently three pathways; The Adult Pathway, the CAMHS Pathway and the non CAMHS Pathway. The Adult Pathway was currently suitable.

The Medical Director had taken forward a piece of work with Ann-Marie Gallagher, a specialist in autism. This would help produce one robust child pathway that would be recommended by Health Education Scotland.

All members of the groups agreed that they would prefer one Child pathway instead of two with clinical input into this essential.

P Martin had highlighted many concerns with the pathway that had been provided to the Board.

The majority of children who meets the CAMHS criteria would not be seen by CAMHS. The process so far had not run smoothly. The Allied Health Professionals would be essential in the early stages of the pathway.

C Sinclair appreciated that this has been a long process and welcomed any feedback from
members, acknowledging that current issues should be addressed.

J Trainor emphasised that the Board were in a unique position. There would be a need for a pathway that was clinically robust and provided the children with the service that they need as soon as possible. It would need to be a multidisciplinary approach that would be different for every child. There would need to be a single point of referral. Everything would be funneled through the General Practitioner and then referred out to a multi disciplinary team framework.

N Pendrey stressed the value of having the GP acting as the “gatekeeper” at the front and centre of any referral pathway.

NHS Orkney had currently employed an adult consultant psychologist and interviewing would be taking place soon to appoint another psychologist who would have capacity to see children. This news was welcomed by members.

C Sinclair would take on board all of the comments from this meeting and previous meetings regarding the pathway and write up a new pathway.

P Martin would gather remaining comments and responses from staff on any of the pathways and get the responses to J Trainor and C Sinclair before the Board meeting on the 14 December 2017.

S Johnston would recommend to the Board that a team would be put together of all the relevant members around to finalise the pathway before passing back through the advisory committees for approval.

C Sinclair agreed to take the principles to the board and then it would be finalised through a Short Life Working Group.

96 Risk Register Report

Members noted the Risk register report provided and acknowledged that there were new ways of reporting this information being progressed.

Clinical Governance

97 Quality Improvement Hub, Clinical Governance and Datix

The Head of Transformational Change and Improvement delivered an update on the Quality Improvement Hub, informing members that the Hub had been produced to incorporate Health Intelligence, Clinical Governance and Quality Improvement.

R Dijkhuizen had recently been appointed as a Quality Improvement Advisor on a permanent part time contract and would provide clinical guidance.

The Complaints and Claims Department had been brought into governance due to a learning point that had come from the recent Ombudsman Report. The Datix tool had now been used to record a lot of the complaints. Further learning had been provided at the weekly Morbidity and Mortality meetings. These meetings had fantastic attendance and were covered by all areas of clinical staffing. Any information would be shared through the Quality and Safety Group.

There had been five Significant Adverse Events between April and September 2017. Four of these had been Clinical Incidents. R Dijkhuizen had investigated the clinical incidents and C
Bichan had investigated the non clinical incident. R Dijkhuizen had since drafted a Standard Operating Procedure for clinical incidents to go through process.

The Safe and Effective Care group, Patient Centered Care and Population Health had now been combined into the Quality and Safety Group. This group would meet on a monthly basis and report into the Clinical and Care Governance Committee. There would be an advert going to the press for two patient representatives for the Quality and Safety Group.

There was now a management of clinical incidents policy in place. All stage two complaints would now go straight to the Head of Service to be dealt with. A weekly meeting would cover complaints, comments, queries, compliments and feedback. Attendance to this meeting includes the Head of Transformational Change and Improvement, Patient Experience Officer, Quality Improvement Advisor, Medical Director and the Clinical Governance Facilitator. A report would be provided Bi-monthly for the Quality and Safety Group. C Bichan advised that she was reviewing the Clinical Governance strategy and the Risk strategy. Work with the Board and Quality Improvement around governance was ongoing. A Strategy Deployment Matrix would be provided for the Board by January 2018.

S. Johnston questioned if there had been any developments in the recording and learning from where things have gone well. C Bichan replied that the staff conference was a good example of sharing good news.

All of the members agreed that this update had been helpful and useful. It would be more robust and it was very welcomed.

It was noted that all of the concerns regarding this that had been raised at the ACF development session “How to become a learning organisation” back in May 2017 had been addressed providing very positive outcomes.

**For information and noting**

98 Key legislation issued

Members noted the key legislation issued since the last meeting.

99 Correspondence

100 Area Partnership Forum minutes:

Members noted the minutes from 19 September and 17 October 2017.

101 Learning and Education Steering Group

Members noted the minutes from 28 September 2017.

102 Quality and Safety Group minutes

Members noted the minutes from 13 November 2017

103 Transformational Implementation Programme Board minutes

Members noted the minutes from 18 September 2017
S Johnston gave members an update from the most recent meeting held, including the following information:

- The build of the new hospital and healthcare facility was 6 weeks ahead of progress.
- The radiology department had put in an early equipment request on the grounds that staff would need to become familiar with it before moving. It was felt that other departments would possibly be facing the same issues so any equipment requests would need to be clinically justified.
- Two thirds of the operation brief templates had been put out. So far the support and feedback on this had been positive.
- The Immediate Discharge Letter was already in place and up and running in some teams and being rolled out further.

104 Learning and Education Plan

Members noted the Learning and Education plan. M Rollo had noted that it did not include the Allied Health Professionals and would feed this back to J Nicol.

Members recognised that the layout of this plan may need to be slightly different, acknowledging that this would be difficult to do.

105 Agree any items for onward reporting:

Board

- The Autism Diagnosis Pathway.
- The issue surrounding secondary care investigation results

Clinical and Care Governance Committee

- Members wanted to note that they had welcomed the changes to Clinical and Care Governance Committee, Datix, Quality Improvement Hub and the Quality and Safety Group and looked forward to working with C Bichan and her team.
- Clinical Governance and the Advisory Committees would work together to improve Clinical documentation.

Executive Team Management

There were no items to be brought to Executive Team Management

ACF Chair’s Group

There were no items to be brought to the ACF Chair’s group.

106 Any other competent business

M Rollo had requested an update on the Digital Medical Records progress and CCube. S Johnston responded by stating that A McComish had given an update at the most recent Transformational Implementation Programme Board meeting. This project had been on hold to allow a robust project set up around this. CCube had assured NHS Orkney that it was their priority. The Community Mental Health records are due to go live soon.

S Johnston informed members that there had been requests from non ACF members to join
the ACF Yammer group. Members agreed this would be a good idea.

- **NHSO IT Security Policy**

  There had not been enough time to review and discuss this policy; therefore it would be circulated to all Advisory groups for comment.

107 **Schedule of Meetings 2017/18**

  Members noted the schedule of meetings for 2017/18.

108 **Record of Attendance**

  Members noted the record of attendance.

109 **Committee Evaluation**

  No comments were made.
NHS Orkney Board

Date of Meeting: 14 December 2017

Paper No. : OHB1718-

Subject: Autism Diagnosis Pathways

Executive Summary

NHSO has been working to clearly set out pathways for diagnosis of autism for children and adults. This paper updates on the development of those pathways and provides assurance that work is progressing to clearly set out appropriate pathways for the diagnosis of autism of children and adults.

Purpose

The purpose of this report is to update Board members on development work underway to ensure refreshed and updated pathways for diagnosis of autism for children and adults are in place.

Recommendation

The Board is invited to note the contents of this report.

1. Background

1.1 Locally a multi-disciplinary working group met to review and refresh pathways and consider the training needs of involved staff. This group has been supported by input from a recognised autism specialist practitioner.

1.2 Children and young people in Orkney have traditionally been able to access a diagnosis of autism informed by multi-disciplinary assessment led by Orkney Islands Council’s Educational Psychology Service. Work has been undertaken to refresh that pathway to ensure that it is up to date in terms of the inclusion of general psychology services for children and young people which are available locally through the Child and Adolescent Mental Health Team, in addition to educational psychology services. A refreshed pathway for diagnosis for children and young people has now been developed and consulted on through NHSO’s professional advisory committees for consideration prior to being finalised.

1.3 Historically the pathway for diagnosis for adults has been less clear due to the lack of availability in Orkney of an appropriately qualified professional to lead this diagnosis role, order to mirror the arrangement in place for children. After extensive consideration and consultation it has been established that the most appropriate diagnostic pathway for adults is for assessment to be sought from an identified autism specialist practitioner on
an as and when required basis through the non-commissioned activity panel process, triggered by a GP referral, in line with SIGN guidelines, to that route. To provide local support to the process work has been underway to ensure appropriate training is in place for relevant professionals to contribute to the multi-agency aspect of the assessment process. This training has been commissioned delivered.

1.4 Following concerns raised via the Area Clinical Forum (ACF) the board requested the pathway was looked at again. This has now happened and the new pathways revised and consulted with the ACF in December 2017.

1.5 Feedback from the Area medical Committee (AMC) and the ACF created a principle that required a single children’s pathway. Feedback on the adult pathway was that this was satisfactory.

1.6 The outcome of the review of the process is a single pathway into the service channelled via the G.P. as generalist experts, through the SCI gateway to the Psychology service. An MDT team of relevantly trained professionals will then be convened to oversee the progress of the pathway. This will include all those professionals seen as relevant to the individual case. Main professional groups will be Clinical Psychology, Psychiatry, Nursing, Paediatrics, Educational Psychology, Speech and language Therapy and occupational Therapy.

1.7 The advantages to this pathway are a single point of entry for GP referral for all suspected neurodevelopmental assessments whether adult or child. The ability to interrogate data from the SCI referral route and TRAK care. Assurance that the pathway followed is clinically robust and meets the SIGN guidance. Confidence in a multi-disciplinary diagnosis.

1.8 Whilst the fine detail of the final pathway may be amended in an iterative process of service improvement the general principles of:

- a clinically driven process,
- a single point of entry for GPs to refer in using SCI gateway, (point of entry the same whether adult or child),
- a multi-disciplinary assessment process,
- this multi-disciplinary process will involve all professionals who need to be involved and,
- that there is a route for seeking outside expertise as required for more complex cases through the NCAP process.

has been agreed and can be communicated to referrers.

2. **Linkage to Corporate Objectives / Strategic Aims**

This paper supports the Board’s Corporate Objectives, notably:

- Improve the health and wellbeing of the people of Orkney, including our own staff, and reduce inequalities
- Improve the individual experience of care and our services
- Make best use of our available resources by
pioneering ways of working jointly with partners

The paper also supports delivery of NHS Orkney’s Corporate Parenting responsibilities.

3. Contribution to Quality

Please indicate which of the 2020 vision / quality ambitions are supported in this report by ticking the relevant dimension

- **Safe**: avoiding injuries to patients from healthcare that is intended to help them [✓]
- **Effective**: providing services based on scientific knowledge [✓]
- **Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy [✓]

4. Compliance with Board Policy on Equality and Diversity

An Equalities Impact Assessment is not required.

5. Resource Implications and Identified Source of Funding

The resource and staffing implications arising directly from the revised and new pathways for diagnosis must be managed within the existing resources of NHS Orkney.

6. Fit with Best Value Criteria

6.1 The paper refers to all of the four generic themes, notably effective:

- partnership working
- governance and accountability
- use of resources
- performance management

7. Risk Assessment and Mitigation

There are no risks associated directly with the recommendations of this noting report.

8. Conclusion

This report updates Board members on progress to refresh and put in place appropriate diagnostic pathways for people with autism.
Executive Sponsor Marthinus Roos, Medical Director

Author Caroline Sinclair, Chief Officer

Contact details caroline.sinclair@orkney.gov.uk

Date 04/12/2017
NHS Orkney Board  
Date of Meeting: 14 December 2017  
Paper No. : OHB1718-61  
Subject: Community Mental Health Services Framework Development

Executive Summary

This report updates on work to design and implement the Community Mental Health Services Framework, a draft of which was presented to the Board of NHS Orkney on 24 August 2017.

Purpose

The purpose of this report is to update Board members on progress in relation to the framework.

Recommendation

The Board is invited to:

- consider the progress made since the meeting of 24 August 2017

Attachments:

Appendix 1 - Mental Health Event Agenda
Appendix 2 – Framework Update

Sponsor and Author: Cathie Cowan, Chief Executive
Contributing Authors: Caroline Sinclair, Chief Officer
Contact details: caroline.sinclair@orkney.gov.uk

1. Background

The CMHS Framework was developed and presented to the Board on 24 August 2017. It built on service reviews that were undertaken and development work in response to these within the Community Mental Health Team, as well as the Scottish Government’s Mental Health Strategy 2017 – 2027, and the recent National Rural Mental Health Survey Scotland: Report of Key Findings.

2. Linkage to Corporate Objectives / Strategic Aims

This paper supports the Board’s Corporate Objectives, notably:

- Improve the Health and Wellbeing of the people of Orkney and reduce health inequities
- Improve the delivery of safe, effective and person centred care and our
services

- Pioneer ways of working to meet local health needs (with our partners)
- Value and develop our people
- Demonstrate best value using our resources

3. **Contribution to Quality**

Please indicate which of the 2020 vision / quality ambitions are supported in this report by ticking the relevant dimension

- **Safe** (avoiding injuries to patients from healthcare that is intended to help them) √
- **Effective** (providing services based on scientific knowledge) √
- **Efficient** (avoiding waste, including waste of equipment, supplies, ideas, and energy) √

4. **Compliance with Board Policy on Equality and Diversity**

An Equalities Impact Assessment is not required.

5. **Progress on Implementing the Framework (attached at Appendix 2)**

There has been significant work, and progress in relation to the framework.

The Blide Trust facilitated a public engagement event on 20 November 2017 attended by around 70 people. The priority theme emerging from the feedback was the need for good communication between all involved. The full write up from the event is being developed at present and will be available in due course, which will further inform the finalising of the framework.

The Primary Care Mental Health Transformation Action Plan, developed by the Community Mental Health Service in response to Dr Gask’s review, is being delivered.

The Community Mental Health Service has been able to recruit to all locally based posts with the exception of one. This increased nursing capacity has had a positive impact on service delivery. Arrangements have also been put in place to provide business support to the service to work on updating policies, procedures and protocols. This will have a positive impact on work flow. Changes are being considered to the leadership of the service to ensure a strong clinical lead role.

Similarly, the arrangement for the leadership of the psychology service is being redesigned to provide strong clinical leadership working alongside, but no longer directly within, the Community Mental Health Service. Opportunities are being explored for collaborative or regional working around psychology services which could see Orkney offering leadership or services to other areas, with reciprocal arrangements in other areas where Orkney is less well provided for.

Work continues on options to develop an appropriate model for the provision of psychiatry services, in collaboration with other Boards including NHS Highland.
In patient bed day usage is down by more than 50% in comparison with 2016 / 2017 figures. NHS Orkney has entered negotiation with NHS Grampian in relation to reducing the costs paid through the Service Level Agreement as a result of this.

Agreement has been reached with NHS Grampian to provide support to the local dementia service mirroring the successful service delivery model in place in Shetland. NHS Grampian are now working to identify a consultant to undertake the role.

The Community Mental Health Service and the GP Cluster has met on a number of occasions to support the development of the closer working relationship between mental health services and primary care.

The Community Mental Health Services files have now all successfully transitioned to an electronic format through the Digital Medical Records project.

6. **Resource Implications**

The framework to date is being progressed within existing resources with the exception of the additional support to dementia diagnosis which was highlighted and subsequently approved by the Board on 24 August 2017. Any further resource implications will be considered in line with the development of the options.

7. **Fit with Best Value Criteria**

The paper refers to all of the four generic themes, notably effective:

- partnership working
- governance and accountability
- use of resources
- performance management

8. **Risk Assessment and Mitigation**

The report updates on work being undertaken to addresses a number of risks captured in our risk register that relate to staffing and our ability to recruit to vacancies when competing with national recruitment/workforce supply challenges in mental health. The opportunity to foster stronger alliances with the Third Sector is also a key feature when it comes to addressing issues such as isolation and making it easier for people to talk to each other.

9. **Conclusion**

Good progress has been made in implementing the framework and work continues in this area. A final version of the framework will be made available once the feedback from the public event has been received.
Agenda

Mental Health Services Consultation 20th November 2017

1300 – 1330: Registration – tea/coffee and scones etc

1330 – 1335: Opening address – Frazer Campbell, Orkney Blide Trust and Liam McArthur MSP

1335 – 1350: Island networks: John Trainor and Angela Colborn-Veitch, Community Mental Health Team

1350 – 1405: NHS Board CMHS Framework report: Linda Gask – summary of main points (Recommendations as a handout for each workshop)

1405 – 1505: Workshop 1
  - Main points of the framework
  - Discuss existing pathway suggestions for the new care pathway
  - How everyone can be involved in joint working, shared training, shared assessment tools etc

1505 – 1520: Break, tea/coffee and biscuits

1520 – 1530: Collaborative Approaches – Presentation on Complementary Therapies, Orkney Blide Trust

1530 – 1600: Workshop 2
  - How to make use of complementary therapies alongside medication & Psychological interventions

1600 – 1615: Emerging themes from Workshop 1
  - Prioritising the themes

1620 – 1645: Question time, chaired Liam McArthur MSP

1645 – 1700: Summary of the day and what will happen next - Cathie Cowan, Chief Executive NHS Orkney
## Our Framework - Key Actions

**Our Vision:** ‘To be the best remote and rural community mental health service provider in the UK’

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| Improving the mental health and wellbeing of the population of Orkney | - Focusing on prevention and early intervention for infants, children and young people  
- Focusing on prevention and early intervention for pregnant women and new mums | Work initiated with education colleagues to develop a collaborative process for early identification of children and young people on the edges of requiring support.  
Delivering the perinatal mental health plan. | Maureen Swannie / OIC Education  
Michelle Mackie / Angela Colborn-Veitch | Green |
| Improving the experience for people using mental health services in Orkney | - Invite key stakeholders and service users to inform and review our work  
- Support mental health nurse alignment with primary care based on a duty worker model and reissue Community Mental Health Team referral criteria a part of GP liaison | NHS Orkney invited and supported the Blide Trust facilitate a mental health stakeholder event, this took place on 20 November 2017. Around 70 delegates participated in the event and the write up/output from this will further inform the Framework implementation.  
The Mental Health Primary Care engagement plan developed following receipt of Dr Gask’s review report is being delivered. The service is engaging with the GP Cluster Group to address common themes and issues such as the development of shared care protocols, | C Cowan  
Angela Colborn-Veitch | Green |
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<tr>
<th>worker role</th>
<th>supported by the policy input now available to the service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Develop care pathways for dementia care, (expand on 5 care pathways)</td>
<td>A full time resource to progress the five development pathways is in place and work is progressing.</td>
</tr>
<tr>
<td>- Develop and agree multi service crisis plans to support proactive case management for people with enduring mental illness and ensure mechanisms are in place to share these with staff who need them in order to provide appropriate care</td>
<td>As part of the pathway development work is planned to create multiservice crisis plans to support proactive case management. Care needs to be taken in the development process to ensure data protection rights are correctly attended to therefore the timeframe has been extended.</td>
</tr>
<tr>
<td>- Revisit the out of hours and hospital care mental health nurse input to better understand roles of all clinicians, to be captured in multiservice crisis care plan</td>
<td>Work has been undertaken to respond to the findings of clinical reviews involving hospital staff. As a result, work has progressed to develop collaborative training sessions on key themes such as managing self hard and responding to psychiatric emergencies. This will be delivered by CMHT members to hospital staff.</td>
</tr>
<tr>
<td>- Update the Psychiatric Emergency Plan with specific reference to the place of safety as the Balfour hospital (Section 297 and use of police station to be included) and its function supported by hospital staff in the accident and emergency department</td>
<td>The Psychiatric Emergency Plan is being updated and following work with Orkney Islands Council to clarify arrangements for inter isles transfers for detained patients. The plan includes reference to Section 297 - the ‘place of safety’ and use of the police station.</td>
</tr>
<tr>
<td>- Establish a Psychology Department led by the Consultant Psychologist reporting to the Chief Officer within the auspices of the Mental Health Directorate</td>
<td>A Psychology Department led by the Consultant Psychologist reporting under the Chief Officer within the auspices of the Mental Health Directorate has now been agreed and is in the process of being</td>
</tr>
<tr>
<td>Value and develop our staff</td>
<td>Demonstrate best value using</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>

- Explore ways to provide specialist Consultant Psychiatry support for older people to improve diagnosis and treatment support for people with dementia

The NHS Board in August 2017 approved funding to provide specialist Consultant Psychiatry support for older people to improve diagnosis and treatment support for people with dementia, the service is ready to become operational as soon as NHS Grampian identify a consultant for the role.

- Implement NHSO staff appraisal and Continuing Professional Development processes using corporate objectives and eksf system

The NHSO staff appraisal and CPD processes using our approved corporate objectives and eksf is in place. Performance for this area is currently 0%. Appraisals are now scheduled and have begun at the start of December 2017.

- Develop a comprehensive supervision plan and audit its application

A comprehensive supervision plan is under development. There have been improvements in this area with supervision arrangements now in place for all staff.

- Use the iMatter process to seek feedback from the team and develop an improvement focused team action plan

The Mental Health Team in common with other Teams in NHS Orkney have completed their iMatter questionnaire and J Nicol, Head of OD & Learning supported the Team develop their Action Plan. The Plan focused on

- Improving efficiency and effectiveness in decision making supported by up to date policy and procedures.
- Embedding clinical supervision across the team.

- National mental health service performance indicators are under Work to commence when in receipt of national indicators.

Angela Colborn-Veitch
<table>
<thead>
<tr>
<th>our resources</th>
<th>development and the local service will work to implement the locally relevant ones once the final version is known</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Make best use of our staff resources by maximising the use of online and virtual methods of engagement with patients</td>
<td></td>
</tr>
<tr>
<td>- Make best use of our staff and building based assets by exploring options for joined up / collaborative working</td>
<td></td>
</tr>
<tr>
<td>The service has implemented VC options for consultations and actively promotes the use of online early intervention options such as Beating the Blues – an online cognitive behavioural therapy.</td>
<td></td>
</tr>
<tr>
<td>Options to sharing GP reception facilities at Kirkwall health centre have been considered however did not prove viable therefore the CMHT is now providing reception duties for the service.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Create a culture of excellence and continuous improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- NHS Orkney has been working to develop mental health faculty with other remote and rural communities/NHS Boards.</td>
</tr>
<tr>
<td>- Explore clinical/academia initiatives with the University of the Highlands and Islands</td>
</tr>
<tr>
<td>- Increase Quality Improvement capacity and capability within the team</td>
</tr>
<tr>
<td>VC discussions have taken place with regional partners. Good engagement. Practical options to share and support across the region being actively considered. Early effective example is the development of a joint working approach to the delivery of an alternative prescribing and review clinic for substance misuse with NHS Shetland.</td>
</tr>
<tr>
<td>Developed a Mental Health Service Strategy Deployment Matrix, delivery of matrix last reviewed in November – slippage in some areas due to staff absences but progress in others.</td>
</tr>
<tr>
<td>Policy Support provided to the team and prioritised approach being taken to developing policy, SOPs and other workflow reviews.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Veitch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angela Colborn-Veitch</td>
</tr>
</tbody>
</table>
Executive Summary

This report highlights key agenda items that were discussed at the Staff Governance Committee meeting on 27 November 2017 and it was agreed that these should be reported to the NHS Orkney Board.

Purpose

The purpose of this report is;

- to update Board Members on the current business of the Staff Governance Committee; and
- to provide assurance to the Board that issues of importance are being progressed.

Recommendation

The Board is invited to note the report and seek assurance on performance.

1. Agenda Items

1.1 Workforce Strategy 2017-2019

The Committee had considered and recommended Board approval of the Workforce Strategy 2017-2019. Feedback from Area Partnership Forum had been that this was a very engaging document.

1.2 Clinical Development Fellows Programme

As part of the discussions around the workforce plan members were advised of the developments with Clinical Development Fellows roles that were being developed across Scotland and the positive evaluations of these.

1.3 iMatter update

Members were advised that work continued with managers in progressing and implementing action plans for their departments. The technical issues with the Dignity at Work survey had been raised as a concern and would be fed back through the national Employee Directors Group.

1.4 Infection Prevention and Control Education Strategy

Members had received the report, as approved by the Board for information and noting. It was agreed that this item would be withdrawn from the agenda as it required further input from the Education Steering Group and Area Partnership Forum. This had been requested by the 8 December 2017 with any material...
changes reported back to a future meeting.

It was questioned whether this should be a standalone document or covered within the overall strategy. This would be agreed through the Area Partnership Forum and reported back to the staff Governance Committee and Board as appropriate.

1.5 Staff Governance Standards 2017/18 and beyond

The Committee were advised of changes to future monitoring with interim arrangements in place for 2017/18. There was a view that wider input would be beneficial and this would be discussed further at the joint Area Clinical Forum and Area Partnership Forum development day to agree the achievements in year and how these would be measured and taken forward.

2. Risks

No risks had been identified

3. Cross Committee Assurance

The Committee agreed to raise the following issue:

Finance and Performance Committee:

Pay as if at work

The Pay as if at work short life working group had met following the survey results which showed inconsistencies in this area. This was being resolved prospectively and retrospectively. There would be a financial cost implication to this, the extent of this was not yet known. There was pressure to resolve this within the financial year and the retrospective process should be the same as other Boards with one solution for all.

Author David Drever
Staff Governance Committee Chair

Contact details david.drever@nhs.net

Date 1 December 2017
Orkney NHS Board

Minute of meeting of the Staff Governance Committee of Orkney NHS Board held in the Saltire Room, Balfour Hospital, Kirkwall on Monday 27 November 2017 at 10.30 am.

Present: David Drever, Chair
Fiona MacKellar, Vice Chair
Cathie Cowan, Chief Executive
Annie Ingram, Director of Workforce
Steven Johnston, Non Executive Board Member
James Robertson, Staff Representative

In Attendance: Ashley Catto, Human Resources Manager
Julie Nicol, Head of Organisational Development and Learning
Emma West, Senior Committee Clerk (minute taker)

645 Apologies

Apologies had been received from K Smith and K Spence, J Robertson deputised.

646 Declaration of Interests – Agenda Items

There were no declarations of interest in relation to agenda items.

647 Minute of meeting held on 28 August 2017

The minute of the Staff Governance Committee meeting held on 28 August 2017 was accepted as an accurate record of the meeting, subject to the below amendments, and was approved.

- Page 3, 455, amend penultimate sentence to, ‘... agreement to use hospital staff 24/7 in Macmillan’
- 463 – amend ‘Director of Workforce’ to ‘Human Resources Manager’

648 Matters Arising

455 – Report from the Board Autism Diagnosis pathway

This was being reviewed by the Professional Advisory committees and Area Clinical Forum with feedback to be provided to the December Board.

457 - Duty of Candour

The Board response had been sent with no further correspondence received.

649 Action Log

The Action Log was reviewed and corrective action agreed on outstanding issues (see Action Log for details).

650 Chairman’s Report from the Board

The Chair provided members with an update from the Board meetings held on the 26 October 2017, in Stromness, highlighting the following:
There had been a proposal to hold governance committee meetings in public and also consideration as to whether meetings should be held out with the Board premises in Kirkwall. It was agreed that due to practical reasons and lack of demand this would not be taken forward. The Director of Workforce added that in NHS Grampian, members of staff were welcome to attend the Staff Governance Committee if they wished and suggested that the same could occur in NHS Orkney.

J Nicol noted that audio recording of meetings would be possible with the equipment in the new hospital and healthcare facility but consideration of the resource implications to do this would need to be a requirement. The Director of Workforce suggested that the added benefit provided would need to be considered as the minutes were a full record of the meeting and already openly available to the public.

Members had also been informed of the Terms of Reference and reporting arrangements for the new Quality and Safety Group. The Chief Executive added that the group had since met, with members agreeing that the Chief Executive chairing this group was of benefit. The group would aim to streamline business and would also ensure cross reference and learning through the Quality Improvement Hub.

Members were advised that R Dijkhuizen had been formally appointed as Quality Improvement Advisor following interview which would strengthen the quality and safety agenda.

The Board had also reviewed the Health and Social Care Delivery plan and Winter plan.

**Decision / Conclusion**

The Committee noted the Chairs reported highlights from the Board meeting.

### Feedback on issues raised to Board by Committee

The Board had received the Staff Governance Committee Chair’s report at the October meeting and had noted the following issues raised:

- Workforce Report
- iMatter and eKSF
- Medical appraisals and revalidation
- Training needs analysis
- DL (2017) 7 – Safety and protection of patients, staff and volunteers in Scotland

**Decision / Conclusion**

The Committee noted the feedback on issues raised to the Board.

**Governance**

### Staff Governance Standards 2017/18 and beyond – SGC1718-14

The Human Resources Manager presented the paper to agree the process by which NHS Orkney reviewed the achievements of Staff Governance Standards during the
financial year to enable reporting as required by the Scottish Government.

It had been indicated that there would be changes to future monitoring with interim arrangements in place for 2017/18. There was a view that wider input would be beneficial and this would be discussed further at the joint Area Clinical Forum and Area Partnership Forum development day to agree the achievements in year and how these would be measured and taken forward.

The Director of Workforce welcomed this approach and acknowledged the value in joint discussion and ownership to ensure engagement in the process. She noted that the reporting requirements were set but the Staff Governance Committee should want to know for its own assurance the achievements in year.

**Decision / Conclusion**

The Committee noted the report and supported the proposed way forward.

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653 **Workforce Strategy 2017-2019 – SGC1718-15**

The Head of Organisational Development and Learning presented the report seeking a recommendation of Board approval of the Workforce Strategy for 2017-19. Feedback from Area Partnership Forum had been that this was a very engaging document. The strategy focused around 3 themes sustainable, capable and engaged and the document was structured around this.

The Director of Workforce noted that 19% of the workforce was aged over 55, there would be a need to start considering the extended retirement age of 67 for many of these staff and the challenge that this would create. There would be a need to think differently about this group of staff as the reality was that many would not be able to physically continue in the same roles up to the age of 67.

The Head of Organisational Development and Learning noted that the staff health and well being strategy incorporated some of this work and although there was cross over this was a standalone document. The FIT2 group reviewed this document and there would be a real focus on this area for 2020 and onwards. The Chair agreed that this should be monitored and reviewed.

The Director of Workforce noted that if older staff remained in roles this also limited the opportunities for younger employees to start with the organisation.

The Employee Director advised that this had been discussed through the Area Partnership Forum with concerns that some staff groups may not have the physical ability to carry out their roles into their late 60s. The organisation would need to support these staff and implement initiatives to keep staff at work.

**Decision / Conclusion**

The Committee reviewed the Workforce Strategy and recommended Board approval.

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654 **Workforce Plan 2017-18 – SGC1718-16**

The Head of Organisational Development and Learning presented the Workforce Plan 2017-18 for review and approval. The report highlighted the workforce profile and the links to strategy moving forward along with the workforce projections
submitted to the Scottish Government in June.

The Chair noted that the Medical and Dental appraisal programme had been highly successful and questioned if any lessons could be taken from this and applied elsewhere. The Head of Organisational Development and Learning advised that Emma Watson as Director of Medical Education had done work raising the profile of NHS Orkney along with Paul Cooper as Medical lead for students and electives with positive feedback from these groups.

The Director of Workforce noted that Clinical Development Fellows (CDF) were being developed across Scotland and the positive evaluations of these roles suggested that this needed to be considered further in the training pathways.

The Chief Executive added that CDF often felt that they were not at stage in their career to decide on final outcomes and this was an opportunity to pause and also gave more work life balance. There was a need to respond to this demand and ensure that new contracts support this ethos.

S Johnston noted the recruitment consultant and GP vacancies and was advised that the paper had been written earlier in year, there had been very positive interest in the last consultant post advertised.

The Director of Workforce added that there was a supply issue rather than a recruitment issue. Advances in technology was also allowing attend anywhere appointments through internet access which was positive for patients and clinicians.

**Decision / Conclusion**

The Committee approved the Workforce Plan 2017-18.

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**National Health and Social Care Workforce Plan – SGC1718-17**

Members had been provided with the National Health and Social Care Plan for information and noting. The document set out the framework and broad direction around national work along with the requirement to consider a regional workforce plan.

**Decision / Conclusion**

The Committee noted the National Health and Social Care Workforce Plan.

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**Communications and Engagement Group – Terms of Reference – SGC1718-18**

The Chief Executive presented the Communication and Engagement Group Terms of Reference for information. The Group would lead on the tender process for the replacement of the Blog and would report through the TIPB to the Board. The minute would also be provided to the Staff Governance Committee for information.

**Decision / Conclusion**

The Committee noted the Terms of Reference.
Members had received the report, as approved by the Board for information and noting. It was agreed that this item would be withdrawn from the agenda as it required further input from the Education Steering Group and Area Partnership Forum. This had been requested by the 8 December 2017 with any material changes reported back to a future meeting.

It was questioned whether this should be a standalone document or covered within the overall strategy. This would be agreed through the Area Partnership Forum.

**Decision/Conclusion**

The Committee deferred this item to allow further discussion and input through the Area Partnership Forum.

The Head of Organisational Development and Learning presented the draft Learning and Education Plan for 2017 – 2019. She advised that a training needs analysis had been completed in the Estates Department and others were ongoing in hospital nursing and midwifery. This had caused some apprehension in the system around the new skills required for the move to the new hospital and healthcare facility. Work continued with staff to develop this positively with more skills and opportunities.

The Director of Workforce suggested that the layout of the document could be improved to make it easier to read, this was acknowledged and had been a challenge, the document had been broken down by career pathways but any suggestions on how to improve this would be welcomed.

**Decision/Conclusion**

The Committee noted the Learning and Education Plan 2017-2019 and welcomed input from Grampian workforce to improve the format.

Members noted the minutes provided.

**Involved in Decisions that Affect them**

The Employee Director, Co-Chair of the Area Partnership Forum, presented the Chair’s report highlighting the key agenda items that were discussed at meetings. It had been agreed that these issues should be reported to the NHS Orkney Staff Governance Committee:

The development session in August had been well attended, positive meeting with
outcomes to be further developed at the December session.

The Pay as if at work (PAIAW) short life working group had met following the survey results which showed inconsistencies in this area. This was being resolved prospectively and retrospectively. There would be a financial cost implication to this, the extent of this was not yet known. There was pressure to resolve this within the financial year and the retrospective process should be the same as other Boards with one solution for all.

The Human Resources Manager advised that the solution would be in line with terms and conditions. There was an SSTS module that could be switched on to protect the Board going forward and as an automatic calculation retrospectively, this would have a financial implication and this risk needed to be identified. It was suggested that virtual agreement to switching on this module should be sought and ratified at the meeting on the 19 December 2017.

Partnership Membership of Central Hub Project Team had been discussed with feedback well received by staff who felt engaged in the process. This was not organisational change but relocation which would not require the same level of consultation but staff would be involved and engaged.

S Johnston noted the risk around catering staff and that no there was no risk register report with the papers this month.

Decision / Conclusion

The Committee reviewed the report from the co-chair of the Area Partnership Forum and took assurance that matters of importance were being progressed.

661 Minute of Area Partnership Forum meeting held on 15 August, 19 September and 17 October 2017

The Committee noted the minutes of the Area Partnership Forum meetings.

Treated Fairly and Consistently

662 Workforce Report – SGC1718-21

The Human Resources Manager presented the report highlighted the following:

- There had been a slight increase in headcount, taking the Whole Time Equivalent to 523.3
- There had been a increase in nursing and midwifery bank usage in correlation with vacancies
- There had also been an increase in medical and dental bank usage but there were a number of consultant vacancies in this area with interviews scheduled for December
- Sickness absence had reduced to 3.63% as at the end of August 2017
- From 1 October 2016 to 30 September 2017 there had been 66 starters (114 including bank) and 53 leavers (87 including bank).
- 26 vacancies had been submitted for approval between July and September 2017.
- 1 staff member had been removed from the displacement register.
• There was a continuing shortage of Hepatitis B vaccine
• There had been an increase in the number of referrals to occupational health.

The Director of Workforce added that the Occupational Health issues were due to a turn over of staff in the wider service which had caused capacity issues within this team. Some pre employment screening was not being completed as quickly as previously and this was being addressed where possible. NHS Orkney staff were being prioritised due to smaller numbers.

S Johnston noted that although the Medical Education OMEP sessions timetable had been refreshed he was aware that attendance at these sessions had been very low. J Nicol acknowledged that staff capacity and having the time to be released from day to day duties could be an issue in many areas and OMEP would be reviewed in light of this. Any development would continue to be reported to the committee through standard reporting.

Decision/Conclusion

Members noted the workforce report and took assurance on performance.

663 Facilities Time off for accredited representatives – SGC1718-22

The Human Resources Manager presented the report which provided details of the Facilities Arrangements Time-off which the Accredited Representatives had during the year from 1 April 2016 to 31 March 2017. She advised that the data was based on what had been reported but that this was possibly an under reporting as it was only based on the returns submitted.

Decision/Conclusion

Members noted the findings from the report, the support provided by the unions and professional organisations and continued to support time off for accredited representatives.

664 Policies and Procedures - SGC1718-23

Members had received the following policy for approval.

a) Electrical Safety Policy

Members were advised that this had been reviewed through the Occupational Health and Safety Committee with minor changes that were highlighted in the document.

Decision/Conclusion

Members approved the Electrical Safety Policy

Provided with a Safe and Improved working environment

665 iMatter update

The Head of Organisational Development and Learning presented an iMatter update advising that work continued with managers to follow up on action plans. The recent focus had been on the dignity at work survey but focus on iMatter would continue.
The Employee Director expressed concerns that the data from the dignity at work survey would not be a true picture due to the technical issues staff had experienced. It was suggested that this be fed back through national employee directors group to the Scottish Government.

The Head of Organisational Development and Learning advised that the iMatter cycle would start again in April 2018.

The Chair questioned the steps being taken to reassure staff and was advised that every manager had an action plan within iMatter and engagement around this would also be an opportunity to raise the profile.

The Head of Organisational Development and Learning advised that the Board newsletter would be finalised along with the agreement as a Board on actions going forward.

**Decision / Conclusion**

The Staff Governance Committee noted the verbal update on iMatter.

666 **Occupational Health and Safety minute 5 and 26 September 2017**

The Committee noted the minutes of the Occupational Health and Safety meetings.

**2020 Workforce Vision**

No agenda items this meeting.

**Risks**

No agenda items this meeting.

667 **Issues Raised from Governance Committees**

There had been no reports from the Chairs of the Governance Committees regarding cross committee assurance.

668 **Agree any issues to be raised to Board/ Governance Committees**

The Committee agreed that the following items should be reported to the Finance and Performance Committee

- Pay as if at work

669 **Any Other Competent Business**

No other competent business was raised.

670 **Schedule of meetings**

The schedule of meetings for 2017/18 was noted. Meeting dates had been set for 2018/19 and the staff Governance Committee would be held on a Wednesday due to
9.1.1

member availability.

671 **Record of Attendance**

The record of attendance was noted.

672 **Committee Evaluation**

No comments were made.
NHS Orkney Board

Date of Meeting: 14 December 2017

Paper number – OHB1718-62

Subject: Financial Management Performance Report

Executive Summary

The report provides analysis of the financial position for the period up to 31 October 2017. Information is provided relating to resource limits, actual expenditure and variance against plan. NHS Orkney is currently over spent against Core Resource Limit of £0.307m which is a 6% favourable movement on month 6.

Purpose of Report

The purpose of this report is to inform the Board of the financial position for the period 1 April 2017 to 31 October 2017.

Recommendations

The Board are invited to:

- **review** the in year financial position
- **note** the year to date position of £0.307m overspend and forecast for breakeven at the year end

Executive Sponsor

Cathie Cowan, Chief Executive

Author

Derek Lonsdale
Head of Finance

Contact details

derek.lonsdale@nhs.net

Date

11 November 2017

Supporting Documents

Financial management performance report
1 Background

All Boards have financial targets to meet, every year:

- Live within the Revenue Resource limit
- Live within the Capital Resource limit
- Achieve the target level of savings (which may be comprised of cash releasing savings and productivity gains)

The financial strategy for 2017/18 is to deliver cash releasing cost reductions of £1.307m (2% of baseline) and achieve a recurring surplus of £0.428m. After allowing for non recurring income and expenditure, this will deliver an overall surplus of £0.086m, which will be carried forward. 2019/20 will be the year when the recurring surplus ceases and the new hospital and healthcare facility (£1.2 million commitment) comes into effect, where we plan to maintain a recurring breakeven position.

2 Executive Summary

NHS Orkney is £307,000 over spent against Core Revenue Resource Limit which is a 6% favourable movement from the position in September and ahead of schedule against the LDP trajectory, however, it utilises 25% of the reserves.

![2017/18 Revenue Outturn trajectory against actual](image-url)
There are three significant factors of concern:-

- Spend on medical locums continues to cover consultant vacancies in three of our specialties: anaesthesia, medicine and surgery. Interviews for each of the specialties listed are planned to take place in December and the likely outcome is to appoint to all three areas given the calibre of the applicants. This will impact favourably going into 2018/2019.
- Excess costs on service level agreements with NHS Grampian for mental health services continue.
- Slow progress on identification of recurring savings.

Expenditure in labs remains high and is due to a combination of locum cover to cover vacancies and consumables costs. Once the labs contract is signed we will be able to recover the remaining VAT on the managed service of £16,000.

3 Proposals and discussion

3.1 Revenue allocations

NHS Orkney’s base allocation for 2017/18 is £46.984m.

Additional allocations were assumed as part of the financial plan. Appendix 1 provides full details of the anticipated £8.242m allocations and how these compare to the financial plan.

Unanticipated allocations of £0.266m recurring and £0.911m non-recurring have been received. The most significant new allocation is £180k for the Health Visitor funding and £164,800 for new medicines.

Any unused allocations during the year may be used to support the cost reductions plan or alternatively will be held in reserves to offset over spends.

3.2 Year to Date Revenue Performance

The revenue over spend has decreased by 6% on last month to an over spend of £0.307m.

Main components are noted below:

<table>
<thead>
<tr>
<th>Area of spend</th>
<th>Prior Month Variance £000</th>
<th>Current Month Variance £000</th>
<th>Movement £000</th>
<th>Forecast Year End Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sla Hcp-Grampian Mental Health</td>
<td>(371)</td>
<td>(403)</td>
<td>(32)</td>
<td>(661)</td>
</tr>
<tr>
<td>Obstetrics Medical Staff</td>
<td>(199)</td>
<td>(229)</td>
<td>(29)</td>
<td>(392)</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>(188)</td>
<td>(198)</td>
<td>(10)</td>
<td>(333)</td>
</tr>
<tr>
<td>Laboratory</td>
<td>(91)</td>
<td>(112)</td>
<td>(21)</td>
<td>(181)</td>
</tr>
<tr>
<td>Pharmacy - Staff Costs</td>
<td></td>
<td>47</td>
<td>4</td>
<td>43</td>
</tr>
<tr>
<td>Other Areas of Spend</td>
<td></td>
<td>480</td>
<td>588</td>
<td>108</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(327)</td>
<td>(307)</td>
<td>20</td>
</tr>
</tbody>
</table>

(3)
A summary of budgeted against actual revenue expenditure by area to month 7 of 2017/18 is set out in the table below:

<table>
<thead>
<tr>
<th>Previous Month Variance</th>
<th>Annual Budget £000</th>
<th>Budget YTD £000</th>
<th>Spend YTD £000</th>
<th>YTD Variance £000</th>
<th>YTD Variance %</th>
<th>Forecast Year End Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(648) Hospital Services</td>
<td>10,895</td>
<td>6,398</td>
<td>7,164</td>
<td>(766)</td>
<td>(11.98)</td>
<td>(1,242)</td>
</tr>
<tr>
<td>(43) Pharmacy &amp; Drug costs</td>
<td>1,958</td>
<td>1,139</td>
<td>1,122</td>
<td>17</td>
<td>1.50</td>
<td>5</td>
</tr>
<tr>
<td>(249) Orkney Health and Care - IJB</td>
<td>21,987</td>
<td>13,340</td>
<td>13,590</td>
<td>(250)</td>
<td>(1.87)</td>
<td>(719)</td>
</tr>
<tr>
<td>(5) Orkney Health and Care - Non IJB</td>
<td>247</td>
<td>158</td>
<td>149</td>
<td>8</td>
<td>5.28</td>
<td>18</td>
</tr>
<tr>
<td>(281) External Commissioning</td>
<td>10,459</td>
<td>5,970</td>
<td>6,266</td>
<td>(296)</td>
<td>(4.96)</td>
<td>(313)</td>
</tr>
<tr>
<td>(30) Estates and Facilities</td>
<td>3,266</td>
<td>2,048</td>
<td>2,091</td>
<td>(43)</td>
<td>(2.11)</td>
<td>(76)</td>
</tr>
<tr>
<td>58 Support Services</td>
<td>5,448</td>
<td>2,889</td>
<td>2,890</td>
<td>(1)</td>
<td>(0.05)</td>
<td>194</td>
</tr>
<tr>
<td>460 Reserves</td>
<td>1,907</td>
<td>467</td>
<td>0</td>
<td>467</td>
<td>1.889</td>
<td></td>
</tr>
<tr>
<td>184 Reserves – Under spends</td>
<td>242</td>
<td>242</td>
<td>0</td>
<td>242</td>
<td>242</td>
<td></td>
</tr>
<tr>
<td>227 Savings Targets</td>
<td>(992)</td>
<td>315</td>
<td>0</td>
<td>315</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>(327) Total Core RRL</td>
<td>55,417</td>
<td>32,966</td>
<td>33,273</td>
<td>(307)</td>
<td>(0.93)</td>
<td>86</td>
</tr>
<tr>
<td>(0) Ophthalmic Services NCL</td>
<td>292</td>
<td>173</td>
<td>173</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
</tr>
<tr>
<td>0 Dental and Pharmacy NCL - IJB</td>
<td>1,189</td>
<td>781</td>
<td>781</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
</tr>
<tr>
<td>NON-CORE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 Annually Managed Expenditure</td>
<td>336</td>
<td>(73)</td>
<td>(73)</td>
<td>0</td>
<td>(0.41)</td>
<td>0</td>
</tr>
<tr>
<td>(0) Depreciation</td>
<td>1,235</td>
<td>713</td>
<td>714</td>
<td>(0)</td>
<td>(0.04)</td>
<td>0</td>
</tr>
<tr>
<td>(328) Total For Board</td>
<td>58,469</td>
<td>34,560</td>
<td>34,868</td>
<td>(307)</td>
<td>(0.89)</td>
<td>86</td>
</tr>
</tbody>
</table>

Non cash limited expenditure on Family Health Services is covered by a separate stream of funding.

Non-core expenditure is supported through non-core revenue allocations.

These two types of expenditure therefore are not part of the core revenue resource limit.
The requirement to use locums to support the safe delivery of clinical services continues to be the greatest pressure, with a projected annual budgetary deficit on Hospital Medical Staffing of £0.846m. Vacant posts and annual leave drive the financial pressures.

- The general medical budget has a month end deficit of £54,000. The changeover in staff in month 5 required induction courses completing hence dual running costs to allow cover on the wards for resilience. However, the over spend has increased by 25% on last month, it may be due to the locums co-ordinator being in post and reviewing outstanding commitments, however, the budget was increased based on the rota and requires further investigation. The yearend forecast currently shows an over spend of £85,000.

- Within the surgical team the cover for annual leave over the summer had resulted in an adverse variance of £43,000 last month. The variance has reduced by 14%.

- Anaesthetics and Obstetric teams are also under pressure with budget deficits of £197,000 and £228,000 respectively. Combined they amount to a forecast outturn of £725,000. Obstetrics variance has increased by 15%. This area is of high concern.

- Wards and Theatre staff are under pressure with a 14% increase in variance on use of bank nurses covering for annual leave and sickness, which £152,000 has been spent to date compared to £83,000 and £74,000 over the same period in 2015 and 2016.

- The variance in the laboratory is due to locum cover for maternity leave contributing £11,000 per month and consumables as a result of the requirement to keep the double systems calibrated and the additional point of care blood tests being carried out. When the contract has been signed additional VAT element can be reclaimed equating to £16,000.
The movement in Medical Records and Hospital Manager is due to £42,000 being given up as savings due to vacancies with a full year effect of £63,000.

Pharmacy and Drugs (under spend £17,000)

<table>
<thead>
<tr>
<th>Previous Month Variance</th>
<th>Annual Budget</th>
<th>Budget YTD</th>
<th>Spend YTD</th>
<th>YTD Variance</th>
<th>Forecast Year End Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>M06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Pharmacy Services
  - Pharmacy - Staff Costs: 519 300 253 47 43
  - Hospital Pharmacy Services: 485 283 315 (32) (48)
  - Community Pharmacy Services: 915 534 536 (57)
  - Prescribing: 39 23 18 4 6

(43) Total: 1,958 1,139 1,122 17 5

- Prescribing information to October has been extrapolated to produce the reported position. Drugs volumes are within the parameters established at budget setting.
- The staff vacancies within the department are off-setting against hospital drugs.
- The community pharmacy budget has been brought back into line with the addition of the anticipated new medicines allocation from Scottish Government of £165,000.

NHS Services – Primary & Community Care (Over spend £241,000)

<table>
<thead>
<tr>
<th>Previous Month Variance</th>
<th>Annual Budget</th>
<th>Budget YTD</th>
<th>Spend YTD</th>
<th>YTD Variance</th>
<th>Forecast Year End Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>M6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Resource Transfer and Commissioning: 3,798 2,687 2,764 (78) (441)
- Children's Services & Women's Health: 1,831 1,078 1,106 (29) (12)
- Primary Care, Dental & Specialist Nurses: 9,047 5,346 5,510 (164) (321)
- Health & Community Care: 3,332 1,941 1,852 90 177
- Pharmacy Services: 3,979 2,288 2,358 (69) (122)

(249) Total IJB: 21,987 13,340 13,590 (250) (719)

- Non IJB: 247 158 149 8 18

(254) TOTAL NHS Primary & Community Care: 22,234 13,498 13,739 (241) (701)

- Primary Care over spend is a continuation of staffing issues on the Isles. £100,000 cost pressure has been allocated as a result of cover required on Stronsay.
• The movement on resource transfer (allowed for in IJB delegated functions/budgets) is due to an ongoing pressure relating to a long term out of area service user which the liability lies with the council and is being reviewed.
• Women’s health over spend is due to staffing cover in the maternity ward and payment in lieu of notice due to ill health retirement.
• Health and community care under spend is attributable to Occupational Therapy and Community Nursing vacancies, in addition to Scottish Government psychology allocation which hasn’t been utilised.
• Pharmacy prescribing invoice submissions are 2 months in arrears. Previous invoices were slightly higher, therefore increasing the accrual. This is hopefully an anomaly which has occurred in previous years, but pharmacy are analysing the data to see if further reports can be provided to increase the accrual accuracies.

Healthcare Purchases / Commissioning (over spend £296,000)

<table>
<thead>
<tr>
<th>Previous Month Variance</th>
<th>Annual Budget</th>
<th>Budget YTD</th>
<th>Spend YTD</th>
<th>YTD Variance</th>
<th>YTD YTD</th>
<th>YTD Variance</th>
<th>Forecast Year End Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000 M06</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External Commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>(231) SLAs</td>
</tr>
<tr>
<td>7,571</td>
</tr>
<tr>
<td>4,341</td>
</tr>
<tr>
<td>4,582</td>
</tr>
<tr>
<td>(242)</td>
</tr>
<tr>
<td>(266)</td>
</tr>
<tr>
<td>(0) SLAs – SHS</td>
</tr>
<tr>
<td>524</td>
</tr>
<tr>
<td>233</td>
</tr>
<tr>
<td>233</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>104</td>
</tr>
<tr>
<td>(12) UNPACS – NCRs / OATS</td>
</tr>
<tr>
<td>33</td>
</tr>
<tr>
<td>33</td>
</tr>
<tr>
<td>36</td>
</tr>
<tr>
<td>(2)</td>
</tr>
<tr>
<td>(20)</td>
</tr>
<tr>
<td>(9) Visiting Services</td>
</tr>
<tr>
<td>215</td>
</tr>
<tr>
<td>129</td>
</tr>
<tr>
<td>133</td>
</tr>
<tr>
<td>(4)</td>
</tr>
<tr>
<td>(12)</td>
</tr>
<tr>
<td>(29) Patients Travel</td>
</tr>
<tr>
<td>2,115</td>
</tr>
<tr>
<td>1,234</td>
</tr>
<tr>
<td>1,283</td>
</tr>
<tr>
<td>(49)</td>
</tr>
<tr>
<td>(120)</td>
</tr>
<tr>
<td>(281) Total</td>
</tr>
<tr>
<td>10,459</td>
</tr>
<tr>
<td>5,970</td>
</tr>
<tr>
<td>6,266</td>
</tr>
<tr>
<td>(296)</td>
</tr>
<tr>
<td>(313)</td>
</tr>
</tbody>
</table>

• The increased movement in SLAs is due to the Mental Health SLA which is over spent by £403,000 due to increased activity in 2016/17 and 2017/18 increasing in cost. The reduced activity in the acute services in 2016/17 and 2017/18 has offset the over spend with reduced orthopaedic activity and gynaecology.
• Patients travel profile had assumed a downward trend over the summer period, but this hasn’t been the case and is being re-visited. Flights costs are up by 1% and the number of escorts have also increased by 2% on last year.

Estates and Facilities (over spend £43,000)

<table>
<thead>
<tr>
<th>Previous Month Variance</th>
<th>Annual Budget</th>
<th>Budget YTD</th>
<th>Spend YTD</th>
<th>YTD Variance</th>
<th>YTD YTD</th>
<th>YTD Variance</th>
<th>Forecast Year End Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000 M06</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estates and Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Estates and Facilities</td>
</tr>
<tr>
<td>1,919</td>
</tr>
<tr>
<td>1,230</td>
</tr>
<tr>
<td>1,236</td>
</tr>
<tr>
<td>(6)</td>
</tr>
<tr>
<td>(19)</td>
</tr>
<tr>
<td>(37) Hotel Services</td>
</tr>
<tr>
<td>1,347</td>
</tr>
<tr>
<td>818</td>
</tr>
<tr>
<td>855</td>
</tr>
<tr>
<td>(37)</td>
</tr>
<tr>
<td>(57)</td>
</tr>
<tr>
<td>(30) Total</td>
</tr>
<tr>
<td>3,266</td>
</tr>
<tr>
<td>2,048</td>
</tr>
<tr>
<td>2,091</td>
</tr>
<tr>
<td>(43)</td>
</tr>
<tr>
<td>(76)</td>
</tr>
</tbody>
</table>

• Within Hotel Services, cover for leave and sickness is causing over spending - domestic Services at £37,000 and switchboard of £14,000. Sickness has improved and benefits should start to be seen.
- Estates and Facilities are currently projecting an over spend of £19,000, mainly within energy. The consumption will be monitored over the next few months.
Within support services, £15,000 of under spends are due to vacant posts and have been removed to contribute to the savings target. Further analysis of the under spends are required by budget holders.

The over spend in Medical Director is due to staffing and software purchase.

Human Resources are over spent due to the relocation expenses, however, the 2 vacant posts will start offsetting until the posts are filled. Analysis on the pressure in this area is being monitored and relocation expenses quantified.

### In Year Challenges

The challenges are a continuation of the previous year, having to rely on locums, however the interviews scheduled in December may result in appointments to consultant vacancies with favourable impact in 2018/2019. SLA cost pressures continue.

The recurring cost reduction target needs to be progressed and achieved.

### Capital

The Board has an allocation of £42.963m; 32% has been utilised to date with a forecast outturn of break-even.

The main planned area of spend is £41.985m on construction of the new hospital and healthcare facility with periodic payments as progress is made, 32% of the budget has been spent.

The nature of the remaining IT and Estates allocations, although committed, the expenditure occurs within the final quarter of the year.

### Cost reductions

The cash releasing cost reduction target is set at £1.307m recurring and is assumed to be delivered in line with the LDP.
The Senior Management Team is taking a corporate approach to delivery supported by meetings with budget holders to press the need for progress; non recurring savings will be impacting on the financial position in the years to come.

A workshop took place with Senior Management teams and budget holders taking a longer term approach to savings and cost reductions a report will be presented to the Finance and Performance Committee on progress.

Production of the full recurring savings will be difficult given the period we are in, however, the balance of £1.307m will be achieved.

At month 7, £0.557m (43%) has been secured and removed from budgets, which is ahead of trajectory, however only 41% is recurring. The majority of the workforce savings has been achieved by revisiting vacancies.

A total of £1.907m is held in reserves, to meet in year pressures notably specialist drugs, provisions for national and regional issues yet to be agreed as part of SLA's; and investments that have not yet fully started. These provisions are being monitored by finance and slippages are forming part of year end planning to bring the Board towards a surplus position.

£0.450m is earmarked for approved investments, SMT are reviewing to revisit decisions in response to long term financial challenges.
8 Risks

The table below provides an update on the risk areas identified in the financial plan, and any new risks.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Rating and impact (per financial plan)</th>
<th>Rating and impact (current)</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to identify and deliver unidentified cost reductions</td>
<td>Medium Risk £250k</td>
<td>Medium Risk £250k</td>
<td>Potential for reductions to be non recurring</td>
</tr>
<tr>
<td>Locum costs over and above plan</td>
<td>High Risk £500k</td>
<td>High Risk £500k</td>
<td>Recruitment process complete with a number of appointable candidates (on paper) – interviews December. Impact on 2018/2019 budget. This will inform budget setting in our 4 specialties.</td>
</tr>
<tr>
<td>Drug costs</td>
<td>Low Risk Up to £100k</td>
<td>Low Risk £100k</td>
<td>Currently forecast breakeven</td>
</tr>
<tr>
<td>UNPACS</td>
<td>Medium Risk Up to £250k</td>
<td>Low Risk Negligible</td>
<td>Currently forecast breakeven</td>
</tr>
<tr>
<td>Service Level agreements</td>
<td>Medium Risk Up to £250k</td>
<td>Medium Risk Up to £250k</td>
<td>Forecasted activity level uncertain.</td>
</tr>
<tr>
<td>Potential future allocations</td>
<td>-</td>
<td>Low Risk</td>
<td>Unspent allocations to be held back</td>
</tr>
</tbody>
</table>

Similar to last year, it is intended to undertake an exercise with budget managers, looking at budgets which can be held back, to support the additional costs in relation to medical staffing.

9 Conclusion and forecast outturn

The financial position is challenging due to the level of locum expenditure required to cover vacancies and annual leave and the need to achieve savings targets.

The forecast outturn position is indicating a slight surplus in line with the Local Delivery Plan, but utilises 98% of its reserves and reflects the full delivery of savings with no further increase in medical locums or increased activity in SLA’s beyond that already forecast.

Forecasting is closely monitored and emerging pressures highlighted to budget holders, Board Members and Scottish Government.
A cost reduction plan is being collated for a longer term strategy, working closely with budget holders and holding under spends where possible to achieve the 2017/18 target.

Derek Lonsdale
Head of Finance
11 November 2017
# APPENDIX 1

## REVENUE RESOURCE LIMIT
### ALLOCATIONS ANTICIPATED AND NEW ALLOCATIONS

<table>
<thead>
<tr>
<th>Item</th>
<th>Included in Original LDP £</th>
<th>Received in RRL to 31/10/17 £</th>
<th>Variance £</th>
<th>Outstanding at 31/10/17 £</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMS</td>
<td>4,630,174</td>
<td>4,728,000</td>
<td>97,826</td>
<td></td>
</tr>
<tr>
<td>Salaried GDS</td>
<td>1,791,000</td>
<td>1,791,000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Outcomes Framework</td>
<td>1,084,562</td>
<td>1,047,743</td>
<td>(36,819)</td>
<td></td>
</tr>
<tr>
<td>PMS Enhanced Services</td>
<td>100,079</td>
<td>100,079</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mental Health Bundle</td>
<td>165,500</td>
<td>165,500</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Partnership Working</td>
<td>250,000</td>
<td>250,000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>NSD Risk Share</td>
<td>(172,472)</td>
<td>(186,225)</td>
<td>(13,753)</td>
<td></td>
</tr>
</tbody>
</table>

**Total:** 8,242,404  7,896,097  47,254  393,561

### Allocations awaited
- PET Scan adjustment: (28,716)
- NDC Top Slicing: (32,448)
- Community Pharmacy Practitioners Champions: 5,000
- Carers Information Strategy: 22,681
- Alcohol Funding: 427,044

**Total:** 8,242,404  7,896,097  47,254  393,561
## New RRL allocations

<table>
<thead>
<tr>
<th>Description</th>
<th>Recurring</th>
<th>Non-recurring</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSD - Selective Dorsal Rhizotomy</td>
<td>(634)</td>
<td></td>
</tr>
<tr>
<td>NSD - Chest Wall Deformity</td>
<td>(888)</td>
<td></td>
</tr>
<tr>
<td>NSD - Deep Brain Stimulation</td>
<td>(7,731)</td>
<td></td>
</tr>
<tr>
<td>NSD - Adult Bone Marrow</td>
<td>(1,107)</td>
<td></td>
</tr>
<tr>
<td>NSD - Renal Transplant</td>
<td>(3,148)</td>
<td></td>
</tr>
<tr>
<td>Sustainability Awareness Campaign</td>
<td>(506)</td>
<td></td>
</tr>
<tr>
<td>Insulin pumps for adults/CGMs</td>
<td></td>
<td>16,276</td>
</tr>
<tr>
<td>Cancer - Improvement Plan</td>
<td></td>
<td>14,000</td>
</tr>
<tr>
<td>GP Digital services</td>
<td></td>
<td>25,000</td>
</tr>
<tr>
<td>Primary Care - Pharmacists in GP practices</td>
<td></td>
<td>75,000</td>
</tr>
<tr>
<td>Open University Nursing Students</td>
<td></td>
<td>30,000</td>
</tr>
<tr>
<td>Access Support Waiting Times delivery</td>
<td></td>
<td>180,000</td>
</tr>
<tr>
<td>Veterans/Carers</td>
<td></td>
<td>30,000</td>
</tr>
<tr>
<td>Choice and medical web portal</td>
<td>(155)</td>
<td></td>
</tr>
<tr>
<td>NSD - Biochemistry Test</td>
<td>(680)</td>
<td></td>
</tr>
<tr>
<td>Health Visitor funding</td>
<td></td>
<td>180,910</td>
</tr>
<tr>
<td>healthy Start vitamin scheme</td>
<td></td>
<td>736</td>
</tr>
<tr>
<td>6EA to improving unscheduled care</td>
<td></td>
<td>33,634</td>
</tr>
<tr>
<td>excellence in care</td>
<td></td>
<td>30,000</td>
</tr>
<tr>
<td>SLA - Children’s Hospices Area Scotland (CHAS)</td>
<td>(27,508)</td>
<td></td>
</tr>
<tr>
<td>Primary Care Transformation, OOH and mental Health</td>
<td></td>
<td>106,753</td>
</tr>
<tr>
<td>Carer Information Strategy</td>
<td></td>
<td>24,640</td>
</tr>
<tr>
<td>BSRIA Membership</td>
<td>(660)</td>
<td></td>
</tr>
<tr>
<td>Yr1 Vaccination Transformation Programme</td>
<td></td>
<td>108,133</td>
</tr>
<tr>
<td>Completion of Non Medical Prescribing Course</td>
<td></td>
<td>8,500</td>
</tr>
<tr>
<td>Carry Forward</td>
<td></td>
<td>89,000</td>
</tr>
<tr>
<td>Winter Pressures</td>
<td></td>
<td>24,000</td>
</tr>
<tr>
<td>Primary Care Transformation - Pharmacy First</td>
<td></td>
<td>3,400</td>
</tr>
<tr>
<td>Daily Dynamic Discharge</td>
<td></td>
<td>5,000</td>
</tr>
<tr>
<td>New Medicines</td>
<td></td>
<td>164,800</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>266,207</strong></td>
<td><strong>910,558</strong></td>
</tr>
</tbody>
</table>
### APPENDIX 2
CASH RELEASING SAVINGS ANALYSIS

<table>
<thead>
<tr>
<th>SAVINGS ANALYSIS 2017-2018</th>
<th>Target</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rec (425,000) NR (425,000)</td>
<td>Rec (425,000) NR (425,000)</td>
</tr>
<tr>
<td>SERVICE PRODUCTIVITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLA</td>
<td>50,000</td>
<td>50,000</td>
</tr>
<tr>
<td>IT</td>
<td>30,000</td>
<td>30,000</td>
</tr>
<tr>
<td>Misc Income</td>
<td>82,000</td>
<td>82,000</td>
</tr>
<tr>
<td>Public health</td>
<td>2,500</td>
<td>2,500</td>
</tr>
<tr>
<td>Health Improvement</td>
<td>15,000</td>
<td>15,000</td>
</tr>
<tr>
<td>Finance</td>
<td>24,000</td>
<td>24,000</td>
</tr>
<tr>
<td>Organisational Development &amp; learning</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>Nursing &amp; AHPs</td>
<td>6,500</td>
<td>6,500</td>
</tr>
<tr>
<td><strong>SERVICE PRODUCTIVITY</strong></td>
<td>(425,000)</td>
<td>0 (425,000)</td>
</tr>
<tr>
<td></td>
<td>162,000</td>
<td>58,000</td>
</tr>
<tr>
<td></td>
<td>220,000</td>
<td>51.8%</td>
</tr>
<tr>
<td>DRUGS AND PRESCRIBING</td>
<td>(200,000)</td>
<td>(200,000)</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>WORKFORCE</td>
<td>(200,000)</td>
<td>(200,000)</td>
</tr>
<tr>
<td>OHAC H&amp;CC</td>
<td>42,000</td>
<td>42,000</td>
</tr>
<tr>
<td>Medical records</td>
<td>23,000</td>
<td>23,000</td>
</tr>
<tr>
<td>Balfour General</td>
<td>16,076</td>
<td>16,076</td>
</tr>
<tr>
<td>Chaplaincy</td>
<td>22,255</td>
<td>22,255</td>
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<tr>
<td>DoNAHP</td>
<td>38,726</td>
<td>38,726</td>
</tr>
<tr>
<td>Macmillan Medical staff</td>
<td>30,582</td>
<td>30,582</td>
</tr>
<tr>
<td>HI&amp;CG</td>
<td>67,328</td>
<td>67,328</td>
</tr>
<tr>
<td>HR</td>
<td>5,770</td>
<td>6,500</td>
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<tr>
<td>Practice Education Facilitator</td>
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</tr>
<tr>
<td>Board Secretariat</td>
<td>10,000</td>
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</tr>
<tr>
<td>OD&amp;L (OU)</td>
<td>7,500</td>
<td>7,500</td>
</tr>
<tr>
<td><strong>WORKFORCE</strong></td>
<td>(200,000)</td>
<td>0 (200,000)</td>
</tr>
<tr>
<td></td>
<td>36,352</td>
<td>240,385</td>
</tr>
<tr>
<td></td>
<td>276,737</td>
<td>138.4%</td>
</tr>
<tr>
<td>ESTATES AND FACILITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4,500</td>
<td>32,000</td>
</tr>
<tr>
<td></td>
<td>36,500</td>
<td>0.0%</td>
</tr>
<tr>
<td>H&amp;S HR SLA</td>
<td>24,105</td>
<td>24,105</td>
</tr>
<tr>
<td><strong>ESTATES AND FACILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>240,385</td>
<td>24105</td>
</tr>
<tr>
<td></td>
<td>557,342</td>
<td>6.0%</td>
</tr>
<tr>
<td>SUPPORT SERVICES</td>
<td>(400,000)</td>
<td>(400,000)</td>
</tr>
<tr>
<td></td>
<td>24,105</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>24,105</td>
<td>0.0%</td>
</tr>
<tr>
<td>PROCUREMENT</td>
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</tr>
<tr>
<td></td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.0%</td>
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<tr>
<td>UNIDENTIFIED</td>
<td>(82,000)</td>
<td>(82,000)</td>
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<tr>
<td></td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>TOTAL CRES</td>
<td>(1,307,000)</td>
<td>(1,307,000)</td>
</tr>
<tr>
<td>Less achieved (CRES)</td>
<td>226,957</td>
<td>330,385</td>
</tr>
<tr>
<td></td>
<td>557,342</td>
<td>42.6%</td>
</tr>
<tr>
<td>CRES BALANCE TO BE FOUND</td>
<td>(1,080,043)</td>
<td>330,385</td>
</tr>
<tr>
<td></td>
<td>749,658</td>
<td>0.0%</td>
</tr>
<tr>
<td>% ACHIEVED</td>
<td>17.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>42.6%</td>
<td></td>
</tr>
</tbody>
</table>
NHS Orkney Board

Date of Meeting: 14 December 2017

Paper No. : OHB1718-63

Subject: Performance Management Report

Executive Summary

A process of updating performance reporting to the NHS Board is underway led by the Head of Transformational Change & Improvement. It is intended to use the Health Foundation Framework for Measuring and Monitoring Safety. In the meantime the NHS Board will receive a shortened report covering health improvement, patient experience and access and treatment standards.

Infection control measures will continue to be reported to the NHS by the Medical Director in his lead infection control and prevention Director role to the NHS Board. Staff related measures will continue to be reported through the staff governance committee. Other measures will be reported by exception.

Purpose: The purpose of this report is to inform the NHS Board of performance and in particular exceptions.

Recommendation: The Board is invited to:

- **review** the report
- **seek further information** on any areas of concern
- **consider** assurances given about performance

Attachments: Appendix 1 – Performance Report

Author: Cathie Cowan, Chief Executive

Contact details: cathiecowan@nhs.net
1. **Background**

The NHS Board agreed to update its approach to performance reporting and agreed to adopt the Health Foundation Framework for Measuring and Monitoring Safety. The Framework is described in diagram 1.

Diagram 1

![Diagram 1](image)

Work is underway to populate the Framework and this will be further explored with Board members at a future Board Development session.

1.1 **Linkage to Corporate Objectives / Strategic Aims**

Performance Management is a critical function of the Board and supports the Board’s commitment to continuous improvement using data to inform decision making and delivery of its Corporate Objectives.

1.2 **Contribution to Quality**

Please indicate which of the 2020 vision / quality ambitions are supported in this report by ticking the relevant dimension

- **Safe**: avoiding injuries to patients from healthcare that is intended to help them

Supports delivery of all ambitions
• √ **Effective:** providing services based on scientific knowledge through inclusion of relevant measures

• √ **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy

1.3 **Compliance with Board Policy on Equality and Diversity**

Performance management and adherence to legislation including the Equalities Act 2010 is evident in Board papers and where appropriate EQIA are completed.

2. **Resource Implications and Identified Source of Funding**

No resource implications.

3. **Fit with Best Value Criteria**

Performance management is a key contributor to achieving ‘best value’ and a review will ensure the Board is able to support a culture of continuous improvement.

4. **Risk Assessment and Mitigation**

Any major risks to achievement of corporate objectives and standards are identified on the corporate risk register, along with mitigating actions.

5. **Consultation and Engagement**

Accountability for key measures is assigned to Senior Management Team members. The roll out of the Strategy Deployment Matrix approach is engaging wider teams in the delivery of the NHS Board’s corporate objectives. This work is also helping to assign accountability for results to the lowest practical level and so enhance performance.

6. **Resource Implications**

Additional resources are required to support waiting time reductions. A funding submission to Scottish Government is being prepared and will be sent to the Access Team for consideration.

7. **Conclusion**

Members are asked to consider the appended performance report and seek assurance in relation to any areas of concern.
Health Improvement, Patient Experience and Access & Treatment Standards

- Health Improvement Standards

**Alcohol Brief Interventions (ABIs)**

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Delivered</th>
<th>% in priority settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 1 to June 17</td>
<td>59</td>
<td>24</td>
<td>37.5</td>
</tr>
<tr>
<td>Q2 to Sept 17</td>
<td>59</td>
<td>27</td>
<td>55.6</td>
</tr>
</tbody>
</table>

*Q3 figures are not available until January 2018*

Virtually no-one accepts an ABI in either maternity or in Accident and Emergency priority settings, making it challenging to reach either target numbers or to meet the 80% priority settings requirement.

**Smoking Cessation**

<table>
<thead>
<tr>
<th></th>
<th>Target in 'deprived' areas*</th>
<th>12 week quits</th>
<th>No in 'deprived' areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 to end March 17</td>
<td>8</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Q1 to end June 17</td>
<td>8</td>
<td>12</td>
<td>6</td>
</tr>
</tbody>
</table>

*Full validated data for Q2 not available until Dec 17*

*The concept of Orkney’s 60% most deprived areas is difficult to reconcile with rural deprivation. Successful quits at 12 weeks are achieved both in community pharmacies and in the specialist service Smoking Matters Orkney (SMO), which has the third highest successful quit rate of all specialist services in Scotland.

**Weight**

<table>
<thead>
<tr>
<th></th>
<th>% adults overweight/obese</th>
<th>% adults obese</th>
<th>% 5/day fruit &amp; veg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>64.6</td>
<td>27.4</td>
<td>22</td>
</tr>
<tr>
<td>Orkney</td>
<td>72.6</td>
<td>32.9</td>
<td>28</td>
</tr>
</tbody>
</table>

Data are from Scottish Health survey for 2008–11

Weight problems are being tackled in a tiered approach.

**Tier One:** 3 training for trainer courses to deliver community based cooking skills programmes, with additional funding secured to support roll out of these programmes by third sector agencies, 12 primary schools have utilised a new approach to the delivery of the health and wellbeing curriculum.

**Tier Two:** 35 participants commenced attending group weight management programmes. Of the 26 participants who completed attendance, 17 participants achieved ≥5% weight loss and 5 of these went on to achieve ≥ 10% weight loss over the 12 weeks. Improvements were evidenced in other health parameters including an average loss of 8.4cm from their waist circumference (ranging from 2 - 20cms, and reductions in HbA1c for all participants with diabetes.
**Tier Three:** of the 41 adults who have attended one to one sessions with dietetic staff 23 have achieved ≥5% weight loss, 7 of these participants have gone on to achieve ≥10% weight loss.

**Tier Four:** five patients enrolled on the counterweight plus programme, the three patients who committed to and attended the full programme achieved successful weight loss.

- **Patient Experience**

  NHS Orkney in regard to complaint response time (standard 100%) for the first two quarters has improved significantly from previous reports and are as follows:

  Q1 - Early Resolution – 87.5% answered within timescales  
  Investigation – 85.3% answered within timescales

  Q2 - Early Resolution – 84% answered within timescales  
  Investigation – 80% answered within timescales

  Quarter three is currently being collated and will be reported in February 2018.

- **Access & Treatment Standards**

  **Accident and Emergency**

  Accident & Emergency performance continues in the most part to exceed the required standard although performance has dipped on occasion. At 26 November 2017 our performance remained virtually unchanged at 94.7% (previous reporting period (94.6%) (patient numbers attending rose to 113 from 93 patients) and 6 patients (previously 5) waited more the 4 hours with no patients waiting more than 8 or 12 hours.

  **Diagnostics**

  As reported at September 2017, the percentage of patients waiting less than 6 weeks for one or more of the eight key diagnostic tests (updated quarterly) was 97.1% (previously reported at 94.9% in June 2017) compared to 81.6% in Scotland.

  **Cancer**

  As at September 2017 NHS Orkney met the 31 and 62 day cancer standard.

  **Outpatients**

  Outpatient performance continues to be challenging with 26.7% of patients waiting over 12 weeks to be seen for a first new appointment as of 5th December 2017. The specialities with the longest waits are Cardiology, Ophthalmology and Orthopaedics and Table 1 below provides an overview of the number of patient waits breaching the 12 week target between 26/09/17 and 05/12/17. As can be seen there has been an improvement in access in both Orthopaedics and Dermatology during this time. Additionally, across the totality of outpatient services, 90% of patients were seen within 148 days during the July-September 2017 quarter which is an improvement over the past two quarters performance (Jan to March 2017 – 179 days and April to June – 189 days).
Table 1

Number of patient waits breaching the 12 week target for new outpatients 26/09/17-05/12/17. Most recent data is at 5 Dec 2017 (highlighted)

<table>
<thead>
<tr>
<th>Specialty/Date</th>
<th>05/12</th>
<th>27/11</th>
<th>20/11</th>
<th>06/11</th>
<th>23/10</th>
<th>17/10</th>
<th>09/10</th>
<th>02/10</th>
<th>26/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>135</td>
<td>127</td>
<td>118</td>
<td>142</td>
<td>134</td>
<td>129</td>
<td>125</td>
<td>129</td>
<td>127</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>64</td>
<td>102</td>
<td>116</td>
<td>117</td>
<td>111</td>
<td>153</td>
<td>153</td>
<td>141</td>
<td>130</td>
</tr>
<tr>
<td>Dermatology</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>0</td>
<td>52</td>
<td>52</td>
<td>51</td>
<td>50</td>
</tr>
<tr>
<td>Cardiology</td>
<td>57</td>
<td>56</td>
<td>56</td>
<td>51</td>
<td>54</td>
<td>48</td>
<td>48</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>21</td>
<td>20</td>
<td>20</td>
<td>18</td>
<td>17</td>
<td>32</td>
<td>32</td>
<td>31</td>
<td>28</td>
</tr>
</tbody>
</table>

Local initiatives are being progressed to improve the NHS Board's performance. In ophthalmology we have established outpatient/day surgery programme supported by a named consultant from NHS Highland. Outpatient capacity has increased both at a consultant and nurse level to support the changes in service model. Two nurses have now been trained in diagnostics through the University of Leeds Teaching Hospital with a further identified two nurses to be trained in intravitreal injections (procedure previously undertaken by medical staff); the nurses will complete their training in early January 2018 and will begin nurse led clinics thereafter.

In dermatology a GP led service including phototherapy is in the final stages of development with oversight from NHS Tayside. A Service Level Agreement which includes 4 visiting clinics in year has been agreed in principle with contractual negotiations at a developed stage. A clinic was held in November to address the waiting list and long waits with the waiting list position as at 5th December showing a marked improvement. At present there are 19 people on the waiting list with 10 to breach before the end of January although a date for a January clinic is being confirmed.

In rheumatology 6 clinics are booked for 2018 and discussions to invite a GP with a specialist interest have begun.

In cardiology we are yet to reach agreement on the use of a regular NHS locum cardiologist however a joint meeting with colleagues from NHS Grampian is scheduled for January to agree the shape of future service provision.

In orthopaedics we have monthly clinics from NHS Grampian and funding for Western Isles until end of the financial year.

**In Patient and Day Case Waiting Times**

As reported for the period July to September 2017 the average number of days waited for an inpatient or day case admission was 26 days (compared to 34 reported previously) during the last quarter with 90% of patients admitted within 65 days (compared to 114 days reported previously).

**18 week Referral to Treatment (RTT)**

For the month of September 2017 the percentage of patient journeys completed within 18 weeks from GP referral to OPD appointment and/or treatment (updated quarterly) was 97.5% compared to 81.4% Scotland.

**Cancelled Operations**

In October 2017 (updated monthly) 11% (previously 5.6%) of planned operations were cancelled (24) compared to a Scottish average of 8.5%. The percentage of planned
operations cancelled for non clinical reasons was 0.5% (1) compared to a Scottish average of 1.9%. The majority of cancellations in October were by patient request.

**TTG Compliance – Patients waiting over 12 weeks for treatment (ongoing waits)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 17</td>
<td>22</td>
</tr>
<tr>
<td>Aug 17</td>
<td>23</td>
</tr>
<tr>
<td>Sep 17</td>
<td>36</td>
</tr>
<tr>
<td>Nov 17</td>
<td>8 (unpublished data)</td>
</tr>
</tbody>
</table>

Due to the nature of our visiting services programme there is significant variation each month in the number of patients who receive treatment. At 5th December 2017 there were 8 people who had been waiting over 12 weeks – 6.3% of the current list total. All of these waits are associated with ophthalmology but with investment in increased operating capacity this number will reduce in December.

**Delayed Discharges**

The number of delayed discharges at census date (October 2017) was 3 (previous reporting period was 2). The number of bed days lost to delayed discharges within the Balfour Hospital during October was 64 compared with 134 days the previous month.

![Delayed Discharges Chart]

Cathie Cowan  
**Chief Executive**  
6 December 2017
NHS Orkney Board

Date of meeting: 14 December 2017

Subject: Chair’s Report – Finance and Performance Committee

Executive Summary

This report highlights key agenda items that were discussed at the Finance and Performance Committee meeting on 28 November 2017 and it was agreed that these should be reported to the NHS Orkney Board.

Purpose

The purpose of this report is;

- to update Board Members on the current business of the Finance and Performance Committee; and to provide assurance to the Board that issues of importance are being progressed.

Recommendation

The Board is invited to note the report and seek assurance on performance

1. Agenda Items

The following three items were discussed by the committee and it was agreed that more detailed discussions and updates would be provided to the In Committee meeting of the Board due to the commercial nature of these reports.

- Cost Reduction plan
- Laboratory Managed Service Contract
- Dental Grant Recovery

2. Risks

There were no risks to be escalated to the Audit Committee

3. Cross Committee Assurance

There were no items requiring Cross Committee assurance

Author

Rognvald Johnson
Finance and Performance Committee Chair

Contact details

rognvald.johnson@nhs.net

Date

6 December 2017
Orkney NHS Board

Minute of meeting of **Finance and Performance Committee of Orkney NHS Board** held in the **Saltire Room, Balfour Hospital, Kirkwall** on **Tuesday 28 November 2017** at **9:30 am**

**Present:**
- Rognvald Johnson, Chair
- James Stockan, Vice Chair
- Cathie Cowan, Chief Executive
- Ian Kinniburgh, Board Chair
- Gillian Skuse, Non Executive Board Member

**In Attendance:**
- Derek Lonsdale, Head of Finance
- Anne Mccomish, Clinical Administration and Outpatient Manager (item 681)
- Louise Wilson, Director of Public Health
- Emma West, Senior Committee Clerk (minute taker)

673 **Apologies**

Apologies had been noted from D McArthur, H Robertson and P Robinson.

674 **Declarations of Interests – agenda items**

No declarations of interest were raised with regard to agenda items.

675 **Minutes of Meetings held on 21 September and 13 October 2017**

The minute of the meeting held on 21 September was accepted as an accurate record of the meeting and was approved on the motion of D Lonsdale seconded by J Stockan.

The minute of the meeting held on 13 October 2017 was accepted as an accurate record of the meeting and was approved on the motion of I Kinniburgh seconded by D Lonsdale.

676 **Matters Arising**

**21 September 2017**

166 – **Strategy Deployment Matrix (SDM) session**

The Non Executive Board members would welcome further invites to a focused SDM session to gain further understanding around this.

327 - **Heart Failure Nurse**

The team had been encouraged to consider this as a development post following a number of unsuccessful recruitment attempts. However, on the advice of the Specialist Nurse and Lead Nurse it was agreed to re-advertise this post again externally. The Committee requested that both proposals be progressed simultaneously to build resilience into the service.

523 – **Sickness absence rates**

The Chief Executive advised that whilst organisational performance as last reported
to the Staff Governance Committee was below the national 4% standard it did fluctuate and was higher in some area of the hospital including the acute ward. Assurance was given on sickness/absence management processes.

13 October 2017

583 – Grampian Service Level Agreement (SLA)

Members were advised that the 2016-17 position had been finalised with a credit note for £43,000 agreed, more recent activity levels would be received in December 2017.

583 - Patient travel

The Head of Finance confirmed that discussions with Loganair were being progressed and an update would be provided to the January 2018 meeting.

It was clarified that Loganair was the NHS Board’s first choice provider (contract in place) but patients could request to use Flybe if there was an adequate reason for this, e.g. flight times to match appointments.

677 Action Log

The action log was reviewed and members were provided with an update on outstanding issues. (see action log for detail)

Financial Management and Control

678 Financial Management Performance Report to 31 October 2017 - FPC1718-46

The Head of Finance presented the financial position for the period up to 31 October 2017 including information relating to resource limits, actual expenditure and variance against plan. NHS Orkney were currently over spent against Core Resource Limit by £0.307m which was a favourable movement of 6% on month 6.

Members were provided with further information around the areas of concern. This included medical locum cover; the Board was currently out to advert with a positive response that could lead to vacancies in the Consultant workforce being filled. The Chief Executive advised that the Lead Hospital Doctor and Medical Director were working hard to promote Orkney along with the Director of Medical Education. The reputation of the Board was also good with those working reporting having positive experiences.

J Stockan noted that an island innovation centre was being discussed with Robert Gordon University and suggested that health research could be built into this to provide further opportunities.

I Kinniburgh noted that as there were a number of very good candidates this could be an opportunity to do things differently and make the service more resilient.

The Head of Finance advised that there had been an overspend in the Mental Health SLA but this was being offset by the reduced activity in acute.

I Kinniburgh questioned the mental health activity and was advised by the Chief
Executive that there was a new locum consultant in post and it was hoped that a more permanent solution could be agreed.

J Stockan noted the vacancies in the Orkney Islands Council (OIC) mental health team and questioned how this affected the NHS. The Chief Executive confirmed that staff vacancies could impact on performance notably if there were a lack of mental health officer posts (specific LA posts in MH services) to adequately provide statutory requirements.

The additional medical and nursing cover in Stronsay presented a cost pressure with an additional £100,000 funding to cover this overspend.

**Decision / Conclusion**

The Finance and Performance Committee noted the Financial Management Report including the year to date position of £0.307m overspent and a forecast for breakeven at year end.

*J Stockan withdrew from the meeting.*

679 **Cost Reduction Plan – Outcome from Senior management team session**

The Chief Executive advised that two sessions had been held with the Senior Management Team with invitations to both the Area Clinical Forum and Area Partnership Forum. The outcomes from these sessions would be shared with the Board at their December In Committee meeting to allow for sign off on the cost reduction plan for the next 3 years.

**Decision / Conclusion**

The Committee agreed that this report would be presented for discussion at the Board meeting, in Committee on the 14 December 2017.

680 **Performance Management**

680 **Access and Treatment Standard Performance Report – FPC1718-48**

The Chief Executive presented the report which informed the Committee of access and treatment performance compared to NHS Scotland. She highlighted that much of the information was the same as the previous report due to how and when official data was received and reported. She highlighted the following advising that any movements in the data would be reviewed for the December Board meeting:

- There had recently been a number of breaches within Accident and Emergency department, each breach would be individually reviewed along with processes in this area.
- Capital was being spent to create a room in the Dounby practice for the phototherapy service which would be ready to start shortly and reduce patient travel for those requiring this treatment.
- The number of Rheumatology clinics had been increased with work also ongoing to recruit a GP with specialist interest in this area.
- Consultants from the Western Isles were undertaking Orthopaedic clinics to the end of the year. This did not cover hip and knee replacements, capacity
to do additional joint replacement surgery was being pursued with the Western Isles. The CEO confirmed she was seeking funding to support this work from the Scottish Government.

- Nurses were due to be trained to carry out some ophthalmology procedures (post meeting – date for training confirmed as 8 Jan 2018) with a dedicated consultant in this area. It was predicted that waiting lists would reduce in the next 4 to 6 months as there was now stability in this service.

G Skuse asked for clarity around the bed numbers and delayed discharges. The Chief Executive advised that the bed days lost due to delayed discharges was a better measure than a point in time measure (census date provided an number). G Skuse noted that there was a need to know when the delayed discharges had affected the running of the hospital.

I Kinniburgh agreed that if the hospital kept managing delayed discharges in this way it would never be addressed as a serious issue. G Skuse advised that the Integration Joint Board (IJB) did not have a full understanding around this issue, there was a need to maintain focus on delayed discharge numbers and lost bed days along with a community focus.

The Chief Executive suggested that the number of red alerts in the hospital and other measures could give an indication that would help to further understand the position.

G Skuse agreed that conversation together with IJB members around lost bed days and delayed discharges should be held to understand this at a patient level and further educate members.

**Decision / Conclusion**

The Committee noted the information provided, took assurance around current performance and requested further data be added to future versions of the report.

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**NHS Orkney Typing and Coding November 2017 – FPC1718-49**

The Clinical Administration and Outpatient Manager joined the meeting informing the committee of performance against typing and coding of medical records as at the 13 November 2017.

Members were advised that the Coding data was received from Information Services Division (ISD) who rated NHS Orkney as 100% compliant every 6 weeks. Due to the small numbers 100% was not met every month, but this was always completed within the 6 weeks. The department was in a good position with no outstanding coding being carried forward on a month to month basis.

With regards to typing the average backlog had been reduced from 18.5 days in 2015 to 7 days in 2017 with further improvement envisaged. Additional clinics had been completed by consultants from the Western Isles (orthopaedics) and MEDINET (dermatology) to reduce waiting lists and this had created additional work for the team.

I Kinniburgh questioned how performance could be 100% if there were 340 outstanding records and was advised that from the point of discharge coding should
be completed within 6 weeks, the 340 records were not outstanding over this timescale, but were the number in the system still to be coded.

D Lonsdale questioned why the data was submitted by NHS Grampian not NHS Orkney and was advised that this was part of Trackcare.

**Decision / Conclusion**

The Finance and Performance Committee reviewed the performance for the period to date and took assurance that actions were being taken to ensure delivery against agreed national targets.

It was agreed that coding and typing compliance would reported at every other meeting if the position remained stable.

**Laboratory Managed Service Contract**

The Chief Executive had circulated a paper that morning having only received feedback from the Lab staff in NHS Shetland (due to annual leave) and members advised that they had not had adequate time to fully read this information.

It was agreed that this report would be taken at the Board meeting on the 14 December 2017, to allow members additional time to read the information provided.

I Kinniburgh questioned if the Chief Executive had concerns around the laboratories position and if so, would these be addressed before taking the paper to the Board.

The Chief Executive advised that her concerns were around the length of time taken for the contract to be signed and whether there were issues associated with this. In hindsight regular reporting to the Board should have been requested when the business case was agreed and to document decisions being made.

G Skuse requested that it be referenced within the paper that Non Executives had questioned and sought assurance on numerous occasions. There was a need to understand why this situation had arose, see transparency around the conversations held and note the lessons learnt.

The Chief Executive agreed that she had challenged the number of point of care testing locations/kit through the PIB and now TIPB. This had resulted in the number being reduced. It was noted that the TIPB minutes are presented to Board as part of the Authority Observer report.

The Director of Public Health noted that the improved project documentation in response to the DMR internal audit would help all projects going forward. Given the number of projects it was important in governance terms to have good supporting project documentation.

**Decision / Conclusion**

The Finance and Performance Committee agreed that this paper would be taken at the Board meeting on the 14 December 2017, with a future update and lessons learnt included.

**Dental Grant Recovery – FPC1718-51**
The Chief Executive presented the report which had been shared with colleagues in Dental to ensure that this was an accurate reflection of views. The paper contained background information on the ratification of both grants, one of which had been breached.

It was noted that there had been a challenge in regard to the professional advice supporting bulk transfer however the Chief Executive as confirmed by those directly involved had not been proactive in attracting patients on receipt of the Grant.

Lessons had been learnt but the strategic direction had been good and savings had been made on the ring fenced allocation. It was noted that the use of an action log to track progress would have been a positive addition from a governance and performance management perspective.

It was also noted that the Scottish Dental Access Initiative (SDAI) template had been used to capture the capital grant and that this on reflection had been inadequate. It had been agreed that the Central Legal Office (CLO) would be used in the future to draft Heads of Terms and although this would involve a cost it provided potentially greater protection to the Board.

The Chair welcomed the Scottish Government support around this issue and also that the lessons learnt had been detailed and acknowledged. G Skuse suggested that the NHS, as well as OHAC, losing sight of the terms of agreement and the lack of action planning should also be added. The Chief Executive reminded colleagues that OHAC (concurrent committees of NHSO and OIC meeting at same time, same location to work in partnership using a common agenda) at that time was a Board Assurance Committee and should not be confused with the IJB as operating now.

The Chief Executive acknowledged that future grants be paid on receipts received and evidence of work and/or purchase of equipment.

**Decision / Conclusion**

The committee considered the lessons learnt and the grant recovery progress underway. It was agreed to include this paper on the In Committee agenda as means to inform all Board members.

**Service Development and Review**

**Regional Delivery Plan – FPC1718-52**

The Chief Executive presented the report which had also been provided to the Area Clinical Forum for comment.

The Chief Executive advised that clinicians were very supportive of regional working and the ways that this could help with cost reduction and collaborative solutions.

G Skuse noted that the Area Clinical Forum response was very good and should form the basis of the Board response.

I Kinniburgh questioned whether there was enough reference in the document to working between the island boards and the opportunities this provided. He also questioned the language in the document around health and social care integration.
There was also a need to tease out more around the uniqueness of Orkney, the positive dialogue with partners and the tone of the document needed to reflect this. It was noted that there was a balance to be struck between local, regional and national service delivery.

The Chair noted that the question of what happens next also needed to be addressed.

The Director of Public Health reminded members that the governance around regional working and joint board solutions had been raised by the auditors in their partnership audit and there was a need to be mindful of having good terms of reference to support work going forward.

**Decision / Conclusion**

The Finance and Performance Committee reviewed the draft report and agreed that a submission would be made on behalf of the Board.

**Governance**

**IT and eHealth Chairs report**

Members had received the IT and eHealth Chairs report for information and noting.

G Skuse questioned the project manager for the Digital Medical Records (DMR) and was advised that A McOmish had been seconded to this post, supported by A McCarlie in an oversight role and reporting through the Project Board for DMR which was chaired by N Bremner.

Members were advised that Immediate Discharge letters had now gone live and the GP Ordercomms was progressing.

The Director of Public Health noted that the General Data Protection Regulations (GDPR) came into effect in May 2018 and the Board didn’t currently have the information governance structure to move forward with this. The Chief Executive suggested that a once for Scotland solution with local review could be the way forward to help support this significant piece of work.

**Minutes of Information Governance meetings held on 3 August and 2 November 2017**

Members noted the minutes.

**Minute of eHealth Project Board meeting held on 18 October 2017**

Members noted the minute.

**Risk Register Report – FPC1718-53**

The Head of Finance presented the Risk Register Report for discussion and noting of the current status in relation to risks assigned to Committee.

A new risk around the failure of pager systems in hospital had been added. There were some pager black spots that had been highlighted to both the IT and Hospital
managers. The Chief Executive agreed that the pager issue needed to be resolved but that if there was not an IT solution the public address system could be used as a fallback position in situations such as cardiac arrest. I Kinniburgh suggested that if the black spots were known they should be highlighted by signage.

It was noted that the HAI surveillance system risk assessment was being reviewed. The Director of Public Health confirmed that this issue was being mitigated and was part of wider concerns re access to medical support and advice. The Chief Executive confirmed this advice was available through the Medical Directors network.

**Decision / Conclusion**

The Finance and Performance Committee noted the updated summary of risk registers.

689 **Agree risks to escalate to Audit Committee**

There were no risks to be highlighted to the Audit Committee.

690 **Issues raised from Governance Committees/ Cross Committee Assurance**

The Chair provided a verbal update from the Staff Governance Committee around Pay as if at Work (PAIAW) and the financial implication of this.

691 **Key items to be brought to Board or other Governance Committees attention**

Members agreed to bring the following items to the attention of the

**In Committee Board:**

- The Dental Grant paper, update on the Laboratories Contract and cost reduction plan would be discussed further at the in committee session of the Board on the 14 December 2017 due to the commercial nature of these items.

692 **Any Other Competent Business**

The Chair advised that this would be the last meeting of the Finance and Performance Committee attended by Cathie Cowan. He paid tribute to her diligence, enthusiasm and contributions to the committee. It was noted that the financial situation of the Board had greatly improved due to this and was on a sound footing following the increase to NRAC funding which she had secured. He noted that she would be missed and wished her well in her new role in Forth Valley.

**Items for information and noting only**

693 **Minutes of Orkney Partnership Board held on 22 September 2017.**

Members noted the minutes of the Orkney Partnership Board.

694 **Schedule of Meetings 2017/2018**

Members noted the schedules of meetings.
695  **Record of attendance**

Members noted the record of attendance.

696  **Committee Evaluation**

Members noted that it had been a positive meeting with good debate.
Executive Summary

The Board has a corporate risk register and three supporting operational risk registers. Risk register processes are set out in the Risk Register Policy which was revised, and approved in March 2017.

This report is provided for information to the Board, and provides a summary on the overall risk register and lists corporate and very high / high operational risks. The report also provides some narrative on progress on mitigation plans.

Purpose

This report is for information.

Recommendation

The Committee is invited to note:

- The summary update on risk registers as at 15 November 2017
- The current position in relation to corporate and high operational risks

Executive Sponsor

Cathie Cowan, Chief Executive

Author

Derek Lonsdale, Head of Finance

Contact details

derek.lonsdale@nhs.net

Date

23 November 2017
1. Background

A risk is the possibility of loss, damage, missed opportunity, injury or failure to achieve objectives. It arises from a set of circumstances, which may lead to an event occurring, with a potential impact on NHS Orkney, its patients, staff or other resources. Crucially, uncertainty (positive or negative) may be able to be avoided through pre-emptive action.

Risk Management Strategy forms part of a wider framework for corporate governance and internal control as set out in our Code of Corporate Governance.

The Risk Management Strategy is due for review in 2017. This review has commenced with a search of current practice in other NHS bodies. Engagement on potential for change is commencing during August with a view to presenting a renewed Risk Management Strategy to the Board in December.

The Board has a corporate risk register and three supporting operational risk registers. Risk register processes are set out in the Risk Register Policy which was revised, and approved in March 2017. The Audit Committee is responsible for providing assurance on the application of risk management processes in line with Risk Management Strategy, Risk Register Policy and all risk related policies. Appendix 1 contains extracts from the policy, for information.

This report is provided to the Board for an overview of the registers and progress being made.

There are 50 active risks across all four registers (last report 59).

**CURRENT RISK LEVELS**

<table>
<thead>
<tr>
<th>Current levels (number of risks)</th>
<th>Very High</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
<th>Total</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>2</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>16</td>
<td>32.0%</td>
</tr>
<tr>
<td>OHAC</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>9</td>
<td>18.0%</td>
</tr>
<tr>
<td>Hospital</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>11</td>
<td>22.0%</td>
</tr>
<tr>
<td>Business and Support</td>
<td>0</td>
<td>3</td>
<td>10</td>
<td>1</td>
<td>14</td>
<td>28.0%</td>
</tr>
<tr>
<td>TOTAL RISK(S)</td>
<td>2</td>
<td>22</td>
<td>25</td>
<td>1</td>
<td>50</td>
<td>100%</td>
</tr>
<tr>
<td>% of total</td>
<td>4.0%</td>
<td>44.0%</td>
<td>50.0%</td>
<td>2.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Risk exposure (the aggregated value of the individual risk scores) is 528, which has decreased from 635 compared to the last report to the committee. Identification and assessment of new risks is to be encouraged, as good management practice, so that we can prioritise our responses and apply resources as required to address areas of most concern.
Effective management of mitigation plans can be seen in the mitigation of very high risks to high or lower, a reduction in the number of high risks, and the de-escalation of low risks to departmental level.

We continue to manage a small number of very high risks, and this reflects the heavy resource requirement to address these. Two risks remain rated very high (1 additional since last report).

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Total score</th>
<th>Very High</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
<th>Total</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>267 Healthcare Acquired Infection (HAI) system not able to support HAI standard 2015</td>
<td>139</td>
<td>40</td>
<td>131</td>
<td>29</td>
<td>0</td>
<td>200</td>
<td>37.9%</td>
</tr>
<tr>
<td>301 Failure of or inconsistent coverage of Pager systems in Hospital and/or Community (New Very High Risk)</td>
<td>110</td>
<td>0</td>
<td>43</td>
<td>61</td>
<td>0</td>
<td>104</td>
<td>19.7%</td>
</tr>
</tbody>
</table>

For all of these risks we are undertaking an in depth, team based multi-factoral review of the risk assessments. This will ascertain:
- the degree to which there is continuing uncertainty
- the extent to which control measures have already been effective,
- what resources we need to prioritise to reduce these to an acceptable level, in an acceptable timescale.

1.1 Linkage to Corporate Objectives / Strategic Aims

An effective risk management process underpins all of the Board’s corporate aims. Potential events which provide a threat to delivery of our corporate aims must be proactively identified, analysed and assessed, with appropriate mitigation plans developed, implemented and monitored. The existence of a visible and robust process of risk management will provide assurance to the Board, staff, patients and public that management, clinicians and staff are working together to deliver improved outcomes.

1.2 Contribution to Quality

Implementation of best practice risk management underpins all of the 2020 vision / quality ambitions

- **Safe**: avoiding injuries to patients from healthcare that is intended to help them
- **Effective**: providing services based on scientific knowledge
- **Efficient**: avoiding waste, including waste of equipment, supplies,
ideas, and energy

1.3 Compliance with Board Policy on Equality and Diversity

There are no implications for equality and diversity.

2. Resource Implications and Identified Source of Funding

There are no current financial implications to be considered.

3. Fit with Best Value Criteria

Effective risk management supports Commitment and Leadership, Accountability, and Sound Use of Resources.

4. Risk Assessment and Mitigation

Updates provided by managers are recorded on Datix. Outstanding updates are requested in line with the business cycle for reporting on risks. Mitigation plans for risks are reviewed by risk owners and by risk register owners. The Risk Review Group meets quarterly to horizon scan and provide an overview of risk management activity within NHS Orkney. Risk updates are reported to the assigned committees.

5. Consultation and Engagement

There is wide engagement in the risk management process through risk updates being provided to management team meetings, advisory groups and governance committees. Risk is everyone’s responsibility. Everyone has a duty for taking appropriate action on a risk.

6. Conclusion

Reinforcing best practice in relation to risk management is essential to support the effective use of resources, and to enable effective management of potential and actual threats to delivery of corporate objectives. Consistent application of the assessment of risks, and consideration of action required to mitigate their potential impact, will increase Board, staff, patient and public confidence.
### APPENDIX ONE  Extracts from NHS Orkney Risk Register Policy

Responses to risks should be proportionate to the level of risk exposure.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (1-3)</td>
<td>No additional controls are required but any existing risk controls or contingency plans should be documented. The line manager should periodically review whether these continue to be effective.</td>
<td>&lt; 3 Years</td>
<td>N/A</td>
<td>3 Years</td>
</tr>
<tr>
<td>Medium (4-9)</td>
<td>Further action shall be taken to reduce the risk but the cost of control will probably be modest. The line manager shall document that the risk controls or contingency plans are effective. The relevant Departmental Manager will periodically seek assurance that these continue to be effective.</td>
<td>&lt; 1 Year</td>
<td>1 Year</td>
<td>2 Years</td>
</tr>
<tr>
<td>High (10-16)</td>
<td>Further action must be taken to reduce risk, possibly urgently and possibly requiring significant resources. The line manager must document that the risk controls or contingency plans are effective. The relevant General Manager or Director will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more.</td>
<td>&lt; 3 Months</td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Very High (20-25)</td>
<td>Given the gravity of the risk, the Chief Executive and relevant stakeholders must be informed explicitly by the Director or General Manager. The Chief Executive must either urgently divert all possible resources to reduce the risk; suspend the situation presenting the risk until the risk can be reduced; abandon or significantly revise the threatened objective; or explicitly authorise that the risk is worth taking.</td>
<td>&lt; 1 Month</td>
<td>1 Month</td>
<td>2 Months</td>
</tr>
</tbody>
</table>

### Escalation and De-escalation

There may, on occasion, be the need to report a risk to the next level of management:
- Where the risk is unacceptable with current controls
- Where the risk is unable to be reduced with current resources
- Where the risk affects more than one area within the service

Very high risks must be escalated to the corporate risk register. High risks may be considered for escalation to the corporate risk register. Medium and low risks should be considered for de-escalation to operational register or department risk assessment.

Risks can be made inactive (possible re-occurrence) or closed (fully mitigated) but should not be removed from the register. A full audit trail must be maintained. Risks can recur if control measures are no longer satisfactory. Risks can be marked as tolerable and made inactive, rather than removed.
## APPENDIX TWO – ALL CORPORATE RISKS AND HIGH OPERATIONAL RISKS

### COMMITTEE REPORTING OF RISKS

<table>
<thead>
<tr>
<th>From Corporate Risk Register</th>
<th>Initial rating</th>
<th>Current rating</th>
<th>Board</th>
<th>F&amp;P / Audit</th>
<th>Clinical &amp; Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>267 Healthcare Acquired Infection (HAI) system not able to support HAI standard 2015</td>
<td>25</td>
<td>20</td>
<td>F&amp;P</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>301 Failure of or inconsistent coverage of Pager systems in Hospital and/or Community</td>
<td>20</td>
<td>20</td>
<td>Audit</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>210 Windows Desktop XP is no longer supported by Microsoft which may lead to security vulnerabilities compromising our network</td>
<td>20</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>199 Risk from uncontrolled clinical documentation of an adverse impact on safety and effectiveness.</td>
<td>16</td>
<td>16</td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>232 Lack of development of Electronic Patient Records prior to move to new build will negatively impact on provision of services</td>
<td>25</td>
<td>15</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>287 National Early Warning Score Compliance</td>
<td>20</td>
<td>15</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>238 Provision of Custody Health Care Services</td>
<td>15</td>
<td>15</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>229 Windows Server 2003 is no longer supported by Microsoft which may lead to security vulnerabilities compromising our network</td>
<td>20</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>251 Communication of laboratory results to Primary Care</td>
<td>20</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>227 A failure to safeguard information assets could cause an information breach with significant patient or regulatory impact</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>268 Risk of poor experience of care for people who require psychiatrist input due to unstable staffing arrangement</td>
<td>20</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>124 Failure to deliver financial plans &amp; manage impact of unforeseen costs will breach targets, and result in section22 report</td>
<td>15</td>
<td>9</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>242 Management of Children &amp; Neonates in the Balfour Hospital and INOC.</td>
<td>20</td>
<td>8</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>126 NHSO may suffer reputational damage due to inadequate planning associated with proposed organisational change / redesign</td>
<td>6</td>
<td>6</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>283 There is a risk that if the IT Server Room AC units fail staff will have no access to telephones or IT systems</td>
<td>25</td>
<td>6</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>281 NHSO staff based in OIC premises may be unable to access NHS administrative systems</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>From OHAC risk register</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84 Incomplete and unpredictable mobile phone coverage is preventing effective and efficient communication within Orkney</td>
<td>20</td>
<td>15</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>264 Risk of failure to meet Psychological Therapies waiting times standard due to</td>
<td>15</td>
<td>15</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>298 Lack of Short Term Cover of Community Nursing – Isles vs. Mainland</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>149 Risk of dispensing errors in isles dispensing practices</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>302 Care of diabetic foot ulceration/pressure ulceration</td>
<td>16</td>
<td>16</td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>From Hospital risk register</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>296 Hospital casenotes removed for offsite scanning may not be available to clinical staff</td>
<td>20</td>
<td>16</td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>291 Use of an out of date Patient Consent form may lead to Complaints/Claims, Financial implications and adverse publicity for NHSO</td>
<td>20</td>
<td>15</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>290 Provision of Chef service within Balfour</td>
<td>20</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>From Business and Support risk register</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>186 Inability to report on performance from ward to Board due to inadequate Dashboards</td>
<td>16</td>
<td>16</td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>85 Data and Telecommunications networks may fail resulting in total or major loss of communications within and outwith Orkney</td>
<td>20</td>
<td>15</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>123 NHSO may not be able to maintain its services/operations due to inadequate business continuity arrangements/plans</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>
NHS Orkney Board

Date of meeting: 14 December 2017

Subject: Chair’s Report – Audit Committee

Executive Summary

This report highlights key agenda items that were discussed at the Audit Committee meeting on 5 December 2017 and it was agreed that these should be reported to the NHS Orkney Board.

Purpose

The purpose of this report is;

- to update Board Members on the current business of the Audit Committee; and
- to provide assurance to the Board that issues of importance are being progressed

Recommendation

The Board is invited to note the report and seek assurance on performance

1. Agenda Items

1.1 The National NHS Overview report

The Committee had received the Audit Scotland National NHS overview report for information and noting. The report contained the checklist for NHS Non Executive Directors and this would be considered further at the next quarterly Non Executives meeting. The link to the document is provided below.


1.2 Internal Audit Reports

The Committee had received positive reports on Partnership working and Financial Ledger, with management actions being progressed as recommended.

1.3 Falls reporting

The Director of Nursing, Midwifery and AHP present the committee with a review of the intelligence gathering work which has previously been conducted regarding falls and the proposed format to provide consistency of reporting and to detail a series of preventative policy interventions to reduce the incidence of falls.

It was agreed that the proposals recommended and performance reporting
would be through the Clinical and Care Governance Committee.

2 Cross Committee Assurance

There were no items requiring cross committee assurance.

Author
Naomi Bremner
Chair of the Audit Committee

Contact details
Naomi.bremner@nhs.net

Date
6 December 2017
NHS Orkney Board

Date of Meeting: 14 December 2017

Subject: New Hospital and Healthcare Facility - Authority Observer Report

Executive Summary
The Board of NHS Orkney considered the construction phase of the new hospital and healthcare facility and supported the Terms of Reference and project arrangements including reporting to the NHS Board. The Transformation Implementation Programme Board (TIPB) has been established and is chaired by the Chief Executive. Membership of TIPB includes three non executive directors, one of which is the Authority Observer. The Authority Observer will regularly provide a progress report on the project which will be informed by her observations as a member of the TIPB and member of the Special Purpose Vehicle (SPV) Board established by Robertson Capital Projects.

Purpose of Report
The purpose of this report is to provide assurance to Board members that project governance and management arrangements in respect of the new build facility project are robust and that the project is progressing.

Recommendations
The Board is invited to note
- the contents of this report and
- project progress to date

Attachments
Summary of the Authority Observers Role – Appendix 1

Executive Sponsor
Chief Executive

Authors
N Bremner, Non Executive Director/Authority Observer
C Cowan, Chief Executive
A McCarlie, Project Director

Contact Details

cathiecowan@nhs.net
1. **Background**

1.1 The New Hospital and Healthcare Facility Project reached Financial Close on 24\textsuperscript{th} March 2017 when NHS Orkney entered into the formal contract with Robertson Capital Projects for the provision of the new hospital and healthcare facility.

1.2 Robertson Health (Orkney) Limited is the Special Purpose Vehicle (SPV) established by Robertson Capital Projects for the design, build, finance and maintenance of the new hospital and healthcare facility for NHS Orkney (the Authority). The Articles of Association of Robertson Health (Orkney) Limited entitle the Authority to appoint an individual, known as the Authority Observer, as its representative on the SPV Board. (A Summary of the Authority Observers Role is attached at Appendix 1 for reference.)

1.3 As part of the Board’s project governance arrangements the Authority Observer is also a member of the Transformation Implementation Programme Board (TIPB). NHS Orkney has appointed N Bremner, Non Executive Director to the role of Authority Observer (AO). It is intended the Authority Observer will provide a regular update to the Board on project progress and related matters.

2. **AO Project Update**

2.1 The 100 week construction programme started on site on 24\textsuperscript{th} April 2017. This Authority Observer’s report covers the 27 week construction period to 30\textsuperscript{th} October 2017.

2.2 Works on site are reported ahead of programme; this is verified by reports from the Independent Tester and the Authority Technical Advisor and further supported by the Clerk of Works.

2.3 The steel superstructure and the metal decking are now complete with the last of the concrete floors poured. The external envelope of the building is being progressed with the roof, secondary frame fixing, window installation and external blockwork making its way around the perimeter of the building. The external works have now moved onto the formation of the ring road in the car park and the construction of the car park itself. Internally the installation of the plasterboard partitions and electrical and mechanical installations has commenced. External to the site the storm outfall across Foreland Rd has been installed.

2.4 The cladding to be used in a limited area on the exterior of the building has been confirmed as non combustible. This has been verified by the NHSO fire advisor (CS Todd) and independently by the Head of Estates and Facilities, NHS Health Scotland. A risk assessment has been undertaken and reported to the TIPB. No further action is required in respect of this risk. The Chief Executive has updated colleagues at Scottish Government on the change to this position.
3. **Assurance**

3.1 Since commencement of the construction phase of the project TIPB has met on 4 occasions, 30\(^{th}\) May, 20\(^{th}\) July, 18\(^{th}\) September and 29\(^{th}\) November 2017. The SPV Board has met on 3 occasions, 22\(^{nd}\) May, 14\(^{th}\) August and 20\(^{th}\) November 2017.

3.2 The TIPB is supported by an extended Project Team chaired by the Chief Executive. The Project Director, with members of the Project Team, visits the site on a monthly basis. This is followed by a Site Progress meeting attended by representatives from Robertson, the Independent Tester, the Authority Technical Advisor and the Clerk of Works.

The Project Team has reported that the following matters have been concluded in the reporting period:-

- **External Cladding**
  The cladding to be used in a limited area on the exterior of the building has been confirmed as non combustible. This has been verified by the NHSO fire advisor (CS Todd) and independently by the Head of Estates and Facilities, NHS Health Scotland. A risk assessment has been undertaken and reported to TIPB. No further action is required in respect of this matter.

- **Discharge of Planning Conditions**
  Of the 19 Planning Conditions in respect of the new build, Conditions 1 to 8 required to be discharged prior to the commencement of the development. With the agreement of Orkney Islands Council the discharge of Condition 7 (External materials) was deferred awaiting the inspection of a sample panel by Planners. This inspection has now taken place and the Condition discharged. Condition 8 was also deferred awaiting the submission of further landscaping information, this Condition has now also been discharged.

- **Landscaping at the Boundary with Scapa Court Residents**
  A meeting took place on 14\(^{th}\) November to which all Scapa Court residents were invited. Those who attended took the opportunity to record their choice of landscape treatment at their boundary wall, from one of two options as illustrated in visualisations previously provided. Those not able to attend were invited by letter to indicate a choice from the 2 options (the visualisations, with a short explanation of each, was included in the letter) by contacting the Project Office by telephone, email or in writing by 1\(^{st}\) December. The invitation letter stated that if a resident did not have a preference they need take no further action, and the scheme adjacent to their garden wall will tie in to neighbouring schemes. At the time of writing this report all but two residents have confirmed their choice.

3.3 The Independent Tester records all points raised on monthly site visits on an “Inspections Issue Tracker”, updated on each visit. The Tracker is included in the Project Team Assurance Report to TIPB. In addition, the Authority Technical Advisor (ATA) provides a construction monitoring report following their monthly site visit. The ATA verifies site progress against contract. The Clerk of Works (CoW) visits the site weekly on 2 consecutive days. The CoW role is to observe progress on site ensuring that a high standard of building construction work is attained, the correct materials are used and that a good standard of workmanship is carried out, all commensurate with the Board’s specification.

3.4 Issues highlighted are considered and discussed in the TIPB and all exceptions are captured and progressed. Progress is managed through the extended project team.
3.5 In addition to the above Brian Swanson, Head of Estates and Facilities, NHS Scotland, has made a site visit in the reporting period. The visit included reviewing the Clerk of Works activities and recording and reporting methods, confirming that these are in line with good practice. He will maintain a watching brief on behalf of NHSO including oversight of the Clerk of Works activities, for the duration of the construction.

4. **Community Benefits**

4.1 The Project Agreement includes a range of community benefits to be achieved by Robertson during the construction phase of the project. Key Performance Indicators are monitored and reported to the TIPB and the SPV Board. Robertson continue to demonstrate good progress against targets. The project continues to generate local employment and training opportunities including offering apprenticeships and making good use of the local supply chain, including the 3rd Sector.

4.2 **Community Benefits Key Performance Indicators (KPI)**

The table below sets out KPI progress against target up to week 27 of the construction programme.

<table>
<thead>
<tr>
<th>EMPLOYMENT AND SKILLS AREA – CONSTRUCTION PHASE</th>
<th>KPI</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work Placements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work placement in education (persons)</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>Work placement not in education (persons)</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td><strong>Curriculum Support Activities (number)</strong></td>
<td>12</td>
<td>26</td>
</tr>
<tr>
<td>Graduate (persons)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Apprentices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New apprentices (persons)</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>Existing Apprentices (persons)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Jobs created on the project (persons)</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Qualifying the workforce – Qualifications (persons)</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Qualifying the workforce – short duration training</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Training Plans</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Considerate Constructors Score</strong></td>
<td>40/50</td>
<td>40/50</td>
</tr>
<tr>
<td><strong>SUPPLY CHAIN DEVELOPMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet the Buyer (number)</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Time Bank Offering (hours)</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>Quarterly reports (number)</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>
5. **Commissioning and Migration Planning**

5.1 The Commissioning Group has been renamed the ‘Construction, Transformation and Move Group’. Terms of Reference are in draft and under review. A review and refresh of the Hospital Project SDM is to be undertaken at the next meeting of the Group.

6. **Summary**

6.1 The 100 week construction programme to deliver the new hospital and healthcare facility started on site on 24th April 2017. The construction programme, as at 30th October 2017, (week 27) is running ahead of programme.

6.2 Activity on site and in respect of the procurement of design, sub contracts and work packages is regularly and consistently monitored and reported.

6.3 The delivery of Community Benefits is monitored against the targets set out in the Project Agreement.

6.4 Planning for the Board’s commissioning of and migration to the new building is at an early stage. This will be developed as part of the SMT cycle, aligned to the hospital Project SDM and construction timetable and will be overseen by TIPB.

6.5 As AO I am satisfied that the project is managed well. I have no issues to highlight in this report to the NHS Board.

7. **Naming the New Facility**

7.1 The Board will recall that at the 2017 County Show a suggestion box was provided to allow members of the public to suggest a name for the new facility. 192 suggestion slips were completed with 89% favouring “Balfour Hospital” or “The Balfour”. The suggestion box has also been placed in the Mock Up room and members of staff have been invited to provide their suggestions. A total of 32 slips had been completed by staff to the end of November with 78% favouring “Balfour Hospital” or “The Balfour”. Other suggestions were “The New Balfour” (12.5%) with 6% suggesting “Balfour Hospital Healthcare”. Appendix 2 sets out all suggested names received to date from both staff and the public.

7.2 The Board is invited to consider the approach to take in respect of naming the new facility, acknowledging the public and staff suggestions.
Role of the Authority Observer

Robertson Health (Orkney) Limited is the Special Purpose Vehicle (SPV) established by Robertson Capital Projects for the design, build, finance and maintenance of the new hospital and healthcare facilities for NHS Orkney (the Authority).

The Articles of Association of Robertson Health (Orkney) Limited entitle the Authority to appoint an individual, known as the Authority Observer, as its representative on the SPV Board. The Authority Observer is not a Director of the SPV and not entitled to exercise the powers of a Director.

The Authority Observer is entitled:-

- to be invited to all meetings of the SPV board,
- to receive the agenda and all supporting papers circulated to SPV Directors including 6 monthly management accounts, budgets and management reports and the statutory accounts in respect of each financial year,
- to attend and participate (but not vote) in all meetings of the SPV board,
- to receive copy minutes of meetings of the SPV board and all other documents circulated to Directors generally.

The Directors of the SPV are entitled to exclude the Authority Observer from any part of an SPV board meeting at which any of the following is discussed:-

- the exercise or possible exercise of contractual rights by the SPV against the Authority or vice versa,
- any claims or potential claims by the SPV against the Authority or vice versa,
- any matter of interpretation of the PA, the Pre Payment Agreement (PPA) and/or the Subordination Agreement.

The Directors of the SPV are entitled to withhold from the Authority Observer any supporting papers and information relating to the above items.

The Authority Observer must adhere to the requirements of the Project Agreement (PA) in respect of SPV commercially sensitive information as set out in the Articles of Association, (article 5.15.5 in the attached). In practice this generally means that SPV board papers are issued as “commercially sensitive” and while reports, minutes and other information may be (as “commercial in confidence”) discussed with and disclosed to NHSO Board members and other NHSO employees (or its advisors or other agents) as deemed necessary for the exercise of the Authorities rights and obligations under the PA and PPA, the papers (including their contents) should not be disclosed further and in particular should not be appended or annexed to any minutes or other Authority papers which will be taken into the public domain. Any request made to the Authority for information contained in SPV board papers should be treated as a Freedom of Information request and dealt with under Clause 62 of the PA.
Appendix 2

Public and Staff Suggestions for Naming the New Facility Received to November 2017

<table>
<thead>
<tr>
<th>Suggested Name</th>
<th>Balfour Hospital</th>
<th>Balfour or The Balfour New Balfour Hospital</th>
<th>Balfour Hospital Healthcare</th>
<th>(New) Scapa Hospital</th>
<th>John Rae Hospital</th>
<th>Orkney Hospital</th>
<th>Groundwater Hospital</th>
<th>Kirkuvar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>85</td>
<td>85</td>
<td>15</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>192</td>
</tr>
<tr>
<td>Staff</td>
<td>9</td>
<td>15</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100</td>
<td>19</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>224</td>
</tr>
</tbody>
</table>


NHS Orkney Board

Date of Meeting: 14 December 2017

Subject: Key Legislation

Executive Summary

This report contains a list of documents issued by the Scottish Government so that members are kept up to date with new requirements, regulations, standards and consultation documents.

Purpose

The purpose of this report is to provide the Board with a list of key legislation issued since the last meeting.

Recommendation

The Board is invited to note the list of documentation.

Executive Sponsor

Cathie Cowan
Chief Executive

Author

Jean Aim
Board Secretary

Contact details

jean.aim@nhs.net

Date

1 December 2017

Supporting Documents

List of Key Legislation
### Consultations

<table>
<thead>
<tr>
<th>Topic</th>
<th>Consultation dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>A healthier future - action and ambitions on diet, activity and healthy weight</td>
<td>Opened 26 October 2017</td>
</tr>
<tr>
<td></td>
<td>Closes 31 January 2018</td>
</tr>
<tr>
<td><img src="https://consult.gov.scot/health-and-social-care/a-healthier-future" alt="Link" /></td>
<td></td>
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<tr>
<td>Review of the Gender Recognition Act 2004</td>
<td>Opened 9 November 2017</td>
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### Publications

<table>
<thead>
<tr>
<th>Topic</th>
<th>Summary</th>
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</thead>
<tbody>
<tr>
<td>Help with health costs – a quick guide to help with health costs.</td>
<td>A Public information leaflet providing information on NHS dental charges, Optical Voucher values and help with health cost including Travel costs</td>
</tr>
<tr>
<td><img src="http://www.gov.scot/Publications/2017/10/8935" alt="Link" /></td>
<td></td>
</tr>
<tr>
<td>Scotland’s National Action Plan to prevent and eradicate Female Genital Mutilation (FGM)</td>
<td>This Year One Report provides and update on the initial work to deliver on the actions and objectives of the FGM National Action Plan.</td>
</tr>
<tr>
<td><img src="http://www.gov.scot/Publications/2017/10/8829" alt="Link" /></td>
<td></td>
</tr>
<tr>
<td>Consultation on the Continuing Care (Scotland) Amendment Order</td>
<td>Consultation on the Draft of The Continuing Care</td>
</tr>
<tr>
<td>Topic</td>
<td>Summary</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2018</td>
<td>(Scotland) Amendment Order 2018</td>
</tr>
<tr>
<td>Inpatient census 2017: Hospital Base Complex Clinical Care and Long Stay</td>
<td>Results from the Hospital Based Complex Clinical Care &amp; Long Stay Census, carried out by the Scottish Government and NHS Boards at midnight, 30 March 2017.</td>
</tr>
<tr>
<td>A Healthier Future: action and ambitions on diet, activity and healthy weight: consultation document.</td>
<td>An open consultation on the proposals for improving diet and weight in Scotland. Responses will be used to inform the development of the final strategy.</td>
</tr>
<tr>
<td>Pregnancy and Parenthood in Young People Strategy: National Progress Board</td>
<td>The National Progress Report sets out progress against the Strategy’s aims and actions for the period March 2016 to September 2017. It also sets out the next steps for the next period of implementation.</td>
</tr>
<tr>
<td>Approved medical practitioners: Section 22 update November 2017</td>
<td></td>
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<tr>
<td>COPD Best Practice Guide</td>
<td>COPD Best Practice Guide</td>
</tr>
<tr>
<td>The Scottish Approach: a case study of the Out of Hospital Cardiac Arrest Strategy</td>
<td>A case study of the Out of Hospital Cardiac Arrest Strategy which assesses the extent to which the Strategy embodies the ‘Scottish Approach’ to policy.</td>
</tr>
<tr>
<td>Topic</td>
<td>Summary</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LD CAMHS inpatient report</td>
<td>A report recommending improvements to respond better to the needs of children and young people with Learning Disability (LD) and/or autism</td>
</tr>
<tr>
<td>The National Code of Practice for GP Premises</td>
<td>This Code of Practice sets out the Scottish Government’s plan to facilitate the shift to a model which does not entail GPs providing their practice premises.</td>
</tr>
<tr>
<td>The 2018 GMS Contract in Scotland</td>
<td>The 2018 GMS Contract in Scotland</td>
</tr>
<tr>
<td>Obesity indicators: monitoring progress for the prevention of obesity route map: November 2017 Report</td>
<td>This publication reports the latest results for the indicators selected to monitor progress of the Scottish Government’s Prevention of Obesity Route Map. The data for most indicators have been updated to include 2016, although some are less recent than this. The indicator framework was informed by NHS Health Scotland’s healthy weight outcomes logic model, and by the Scottish Public Health Network’s Route Map engagement process.</td>
</tr>
<tr>
<td>Review of targets and indicators for health and social care in Scotland</td>
<td>This publication reports the latest results for the indicators selected to monitor progress of the Scottish Government’s Prevention of Obesity Route Map.</td>
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## Circulars

(Reports on circulars received and action taken are monitored by Information Governance Group)

<table>
<thead>
<tr>
<th>Reference:</th>
<th>Date of Issue:</th>
<th>Subject:</th>
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<tbody>
<tr>
<td>PCA(D)(2017)06 <a href="http://www.sehd.scot.nhs.uk/pca/PCA2017(D)06.pdf">http://www.sehd.scot.nhs.uk/pca/PCA2017(D)06.pdf</a></td>
<td>19/10/2017</td>
<td>This letter advises NHS Boards, Practitioner Services and NHS Education for Scotland (NES) of the introduction of the NHS (General Dental Services) (Scotland) Amendment Regulations 2017. It also advises of the publication of an amendment (Amendment No 136) to the Statement of Dental Remuneration (SDR).</td>
</tr>
<tr>
<td>PCA(D)(2017)07 <a href="http://www.sehd.scot.nhs.uk/pca/PCA2017(D)07.pdf">http://www.sehd.scot.nhs.uk/pca/PCA2017(D)07.pdf</a></td>
<td>25.10.2015</td>
<td>The Memorandum to this letter advises dentists and dental bodies corporate (DBCs) of IT hardware and software specification standards for working with NHS patient data.</td>
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<tr>
<td>Reference:</td>
<td>Date of Issue:</td>
<td>Subject:</td>
</tr>
<tr>
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<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>cmo/CMO(2017)15.pdf</td>
<td></td>
<td>This circular advises community pharmacy contractors and NHS Boards on the outcome of the negotiations for the community pharmacy funding envelope for 2017-18.</td>
</tr>
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</table>
**NHS ORKNEY BOARD**

Timetable for Submitting Agenda Items and Papers – 2017/2018

<table>
<thead>
<tr>
<th>Initial Agenda Planning Meeting with Chair, Chief Executive and Board Secretary</th>
<th>Final Agenda Planning Meeting with Chair, Chief Executive and Board Secretary</th>
<th>Papers in final form to be with Board Secretariat by 1200 hrs on</th>
<th>Agenda &amp; Papers to be issued no later than 1600 hrs on</th>
<th>Date of Meeting held in the Saltire Room Balfour Hospital (unless otherwise notified) at 10:00 am</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; two weeks after previous meeting &gt;</td>
<td>&lt;3 weeks before Date of Meeting&gt;</td>
<td>&lt; 13 days before Date of Meeting&gt;</td>
<td>&lt;1 week before Date of Meeting&gt;</td>
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</tr>
<tr>
<td>9 March 2017</td>
<td>6 April 2017</td>
<td>14 April 2017</td>
<td>20 April 2017</td>
<td>27 April 2017</td>
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<tr>
<td>11 May 2017</td>
<td>6 June 2017</td>
<td>14 June 2017</td>
<td>19 June 2017</td>
<td>26 June 2017 (Annual Accounts)</td>
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<td>7 September 2017</td>
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<td>13 October 2017</td>
<td>19 October 2017</td>
<td>26 October 2017</td>
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<tr>
<td>9 November 2017</td>
<td>23 November 2017</td>
<td>1 December 2017</td>
<td>7 December 2017</td>
<td>14 December 2017</td>
</tr>
<tr>
<td>28 December 2017</td>
<td>1 February 2018</td>
<td>9 February 2018</td>
<td>15 February 2018</td>
<td>22 February 2018</td>
</tr>
</tbody>
</table>

Chair: Ian Kinniburgh  
Vice Chair: Naomi Bremner  
Lead Officer: Cathie Cowan  
Board Secretary: Jean Aim  
Senior Committee Clerk: Emma West

1 draft minute of previous meeting, action log and business programme to be available  
2 draft agenda, minute and action log issued to Directors following meeting  
3 Any late papers will be placed on the agenda of the following meeting unless the Chair determines that they are urgent
### NHS ORKNEY BOARD

**Timetable for Submitting Agenda Items and Papers – 2018/2019**

<table>
<thead>
<tr>
<th>Initial Agenda Planning Meeting with Chair, Chief Executive and Board Secretary</th>
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<tbody>
<tr>
<td><strong>&lt; two weeks after previous meeting &gt;</strong></td>
<td><strong>&lt;3 weeks before Date of Meeting &gt;</strong></td>
<td><strong>&lt; 13 days before Date of Meeting &gt;</strong></td>
<td><strong>&lt;1 week before Date of Meeting &gt;</strong></td>
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<td>13 April 2018</td>
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<td>08 November 2018</td>
<td>22 November 2018</td>
<td>30 November 2018</td>
<td>06 December 2018</td>
<td>13 December 2018</td>
</tr>
</tbody>
</table>

- Chair: Ian Kinniburgh
- Board Secretary: Jean Aim
- Vice Chair: Gillian Skuse
- Senior Committee Clerk: Emma West
- Lead Officer: Chief Executive

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1. draft minute of previous meeting, action log and business programme to be available
2. draft agenda, minute and action log issued to Directors following meeting
3. Any late papers will be placed on the agenda of the following meeting unless the Chair determines that they are urgent
NHS Orkney - Board - Attendance Record - Year 1 April 2017 to 31 March 2018:

<table>
<thead>
<tr>
<th></th>
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<tr>
<td>I Kinniburgh</td>
<td>Chair</td>
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<td>Attending</td>
<td>Attending</td>
<td>Apologies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Bremner</td>
<td>Vice Chair (until 27 April 2017)</td>
<td>Attending</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>G Skuse</td>
<td>Vice Chair (from 21 June 2017)</td>
<td>Attending</td>
<td>Attending</td>
<td>Attending</td>
<td>Attending</td>
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<tr>
<td>N Bremner</td>
<td>Non Executive Board member</td>
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<td>Attending</td>
<td>Attending</td>
<td>Attending</td>
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<tr>
<td>D Drever</td>
<td>Non Executive Board member</td>
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<td>Attending</td>
<td>Attending</td>
<td>Attending</td>
<td></td>
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</tr>
<tr>
<td>S Heddle</td>
<td>Non Executive Board member (until 31 April 2017)</td>
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<td>R Johnson</td>
<td>Non Executive Board member</td>
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<td>Area Clinical Forum Chair</td>
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<td>F MacKellar</td>
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<td>J Richardson</td>
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<tr>
<td>J Stockan</td>
<td>Non Executive Board member (from 18 May 2017)</td>
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<tr>
<td>C Cowan</td>
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<tr>
<td>E Peace</td>
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<tr>
<td>H Robertson</td>
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<tr>
<td>M Roos</td>
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<tr>
<td>L Wilson</td>
<td>Director of Public Health</td>
<td>Attending</td>
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<tr>
<td>J Aim</td>
<td>Board Secretary</td>
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<td>A Ingram</td>
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<tr>
<td>C Sinclair</td>
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<tr>
<td>E West</td>
<td>Committee Clerk</td>
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<tr>
<td>C Bichan</td>
<td>Head of Transformational Change and Improvement</td>
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<tr>
<td>A Catto</td>
<td>Human Resources Manager</td>
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<tr>
<td>M Colquhoun</td>
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<td>M Firth</td>
<td>Head of Primary Care</td>
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<tr>
<td>D Lonsdale</td>
<td>Head of Finance</td>
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<tr>
<td>W Lycett</td>
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<tr>
<td>J Nicol</td>
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<tr>
<td>J Trainor</td>
<td>Head of Health and Community Care</td>
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<tr>
<td>J Sinclair</td>
<td>Lead Nurse</td>
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<tr>
<td>M Swannie</td>
<td>Interim Head of Children's Health Services/Service Manager of Children's Services</td>
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