Board

NHS Orkney
Thursday, 22 August 2024 at 10:00 BST to Thursday, 22 August 2024 at 16:00 BST

Agenda

1. Welcome and Apologies
Presenter: Chair

To welcome members and receive apologies

2. Declarations of Interest
Presenter: Chair

To receive any declarations of interest in terms of any agenda items

3. Minutes of Previous Meeting
Presenter: Chair

To approve the minute from the meeting held on 18 July 2024

4. Matters Arising
Presenter: Chair

To discuss any matters not covered on the action log

5. Action and Escalation Log
Presenter: Chair

To discuss the and agree any corrective actions

6. Board Chair and Chief Executive Report to the Board
Presenter: Chair

To receive an update on key external and internal events and activities during July and August 2024

7. Corporate Risk Register
Presenter: Medical Director

To review and scrutinise the Corporate Risks
Corporate Risk Register - click on the link and download in excel to view

8. CHAIRS ASSURANCE REPORTS

8.1. Joint Clinical and Care Governance Committee
Presenter: Rona Gold, Chair of Joint Clinical and Care Committee

To discuss the key items discussed at the Committee

8.2. Finance and Performance Committee
Presenter: Des Creasey, Chair of Finance and Performance Commitee

To discuss the key items discussed at the Committee

8.3. Staff Governance Committee
Presenter: Joanna Kenny, Chair of Staff Governance Commitee

To receive the key items discussed at the Committee

8.4. Audit and Risk Committee
Presenter: Jason Taylor, Chair of Audit and Risk Committee

To receive the key items discussed at the Commitee

8.5. Senior Leadership Team
Presenter: Chief Executive, Chair of the Senior Leadership Team

To receive the key items discussed

8.6. Area Clinical Forum
Presenter: Kirsty Cole, Chair of the Area Clinical Forum

To receive the key items discussed

9. STRATEGIC OBJECTIVE 1 - PEOPLE

9.1. iMatter Organisational Response
Presenter: Director of People and Culture

To receive assurance on action plan and progress

9.2. Board Walkarounds
Presenter: Chief Executive

To note the update provided

10. STRATEGIC OBJECTIVE 2 - PATIENT SAFETY, QUALITY AND EXPERIENCE

10.1. Clinical Governance Structure
Presenter: Medical Director

To understand and receive assurance in relation to the new structure

10.2. Quality Impact Assessments
Presenter: Medical Director

To receive a progress report

10.3. Safety, Quality and Experience Report Quarter 1
Presenter: Medical Director

To receive assurance

10.4. HIART Report
Presenter: Director of Nursing, Midwifery, AHP and Chief Officer Acute

To receive assurance and any items requiring escalation

11. STRATEGIC OBJECTIVE 3 - PERFORMANCE

11.1. Finance Report - Quarter 1
Presenter: Recovery Director

To receive assurance on the position against the Financial Plan

11.2. Integrated Performance Report

To receive and scrutinise Junes IPR
To seek assurance on delivery and implications of current performance levels
To note the proposed changes as per item 12.3

11.3. Integrated Performance Report by exception
Presenter: Chief Executive

To receive, discuss and approve the IPR and exception reporting process

11.4. Performance Management Framework
Presenter: Director of Improvement

To approve the proposal from Senior Leadership Team to introduce quarterly performance review meetings terms of reference
To discuss the Draft Terms of Reference

11.5. Improving Together Report
Presenter: Director of Improvement

To receive assurance on the progress made

11.6. Digital Delivery Plan - Quarter 1 Report
Presenter: Head of Improvement

To receive assurance on progress against plan
Digital Delivery Plan - click on link and open in Excel to view

12. STRATEGIC OBJECTIVE 4 - POTENTIAL

12.1. Future Proposal for the Improvement Team
Presenter: Director of Improvement

To approve the proposal

12.2. Quality Improvement Methodology and Training Programme
Presenter: Director of Improvement

To approve the new QI Methodology

13. STRATEGIC OBJECTIVE 5 - PLACE

13.1. Planning with People Guidance Update
Presenter: Chief Executive

To provide the Board with an update on the National Guidance published 29 May 2024

13.2. Population Health and Prevention Integrated Performance Report
Presenter: Director of Public Health

To scrutinise the report and seek assurance on delivery

13.3. Population Health and Prevention - proposal for future reporting
Presenter: Director of Public Health

To approve the proposal

14. ANY OTHER COMPETENT BUSINESS

15. MINUTES FROM GOVERNANCE COMMITTEE MEETINGS

To note the minutes from:

- Joint Clinical and Care Governance Committee - 14 June 2024
- Staff Governance Committee - 9 May 2024
- Area Clinical Forum - 4 June 2024

16. ITEMS FOR INFORMATION

Board Minutes

NHS Orkney
Thursday, 18 July 2024 at 09:30 BST

Present:
Members: Stephen Brown, Davie Campbell, Kirsty Cole, Paul Corlass, Des Creasey, Rona Gold, Issy Grieve, Joanna Kenny, Anna Lamont, Meghan McEwen, Ryan McLaughlin, Laura Skaife-Knight, Jason Taylor, Sam Thomas, Phil Tydeman, Louise Wilson

In attendance: Director of People and Culture, Head of Corporate Governance

1. Apologies

Apologies received from Jean Stevenson

2. Declaration of Interests

No declarations were made.

3. Minutes of previous meeting held on 27 June 2024

The Minutes were approved as an accurate record subject to some changes from J Taylor.

4. Matters Arising

No additional items were raised.

5. Action Log

No recorded actions to follow up

6. Chair and Chief Executive Report

The Chief Executive presented key items for noting from June and July:

1. The Board will receive the first of scheduled quarterly reports, reporting today on the Quarter 1 progress against the Corporate Strategy, with a suite of comms ready to issue following the meeting.
2. The relaunch of the long service awards celebrating and recognising colleagues in the organisation, along with staff awards earlier in the year, one of the highlights of the year.
3. Extended Senior Leadership Team where over 40 members of our senior leadership community came together to discuss key areas and number of non-execs attended
4. Developments in the Financial and Performance leadership space
5. Agreeing our digital priorities

The Chair echoed the comments about the long service awards acknowledging the powerful conversations that were had with colleagues and loved ones who gathered for the awards. She went on to advise members that regular briefings have been scheduled regular briefings with MP's and MSP's to go through agendas and build relationships.

Members **noted** the update and detail in the paper.

7. CHAIRS ASSURANCE REPORTS

7.1. Senior Leadership Team

The Chief Executive presented key points from the Senior Leadership Team on 4 July

- MRI scanner service funding to be withdrawn from 31 March 2025 which is a cause for concern, members heard that a letter has been sent to John Burns, Chief Officer for NHS Scotland, raising concerns in terms of impact on patient experience.
- Risks with progressing with only three digital priorities in 2024/25 - noting the need to be aware of those projects that are not being taken forward and associated risks
- Very out-of-date policies remains a challenge and gaps in governance arrangements for policies/documentation added as a new risk, members noted that there has been some additional senior resource in this space with strengthened governance

Members **noted** the items escalated.

8. STRATEGY QUARTER 1 UPDATE

8.1. Corporate Strategy and Annual Delivery Plan Delivery Update versus KPIs

The Chief Executive presented to Board the first quarterly update by means of a Scorecard, having work with each of the delivery leads on the key performance indicators across the 5 p's, advised members of the good progress with 68 action on track. She went on to go into more detail on the areas that were showing as adrift, with 3 showing as Red (significantly delayed) and 6 rated Amber (partially delayed);

1. Appraisals - the target is set at 40% but we have not moved beyond 32% -
2. Operational governance continued work in this space, clear reporting lines to SLT,
3. Board Assurance framework, clear plan to move that work forward starting with engagement with the Senior Leadership Team and Executive Team.

The Chair acknowledged the hard work that had gone into developing the scorecard.

The Head of Improvement referred members to those indicators that were reported as amber advising members that in the main there is additional engagement required on each of them to ensure that staff are involved and that the right thing is done. Members were asked to give feedback on the content of the report, noting that it the report to Board will only show those areas that are off track, as the Governance Committees will receive the detail and discuss in full.

The Chair asked whether there were any themes to those areas that are reported as off track.

The Chief Executive advised that in the case of appraisals is around accountability and managers performing in their areas, but acknowledged there are some areas where there are capacity issues with Heads of Service off sick and delays in getting the right project managers in place.

Non-Executive members acknowledged the report was detail that has not been to the Board before, and welcomed the presentation of information, offering suggestions on some additional information that would improve the level of information for them:

- dates added to the RAG
- early warning system
- quarter by quarter tracking
- improve the mitigations

The Chief Executive welcomed the helpful feedback which will enable the team to refine things further. She acknowledged that this is a very different way of working, and as a Board there are 3 things that we need to see as we mature as a Board:

1. Integrated performance report by exception only
2. Corporate Strategy and ADP metrics by exception
3. New performance review meetings due to be introduced where colleagues will be held to account for their metrics.

Members asked for clarity on what steps are taken in the event there is no progress on one of the indicators across the quarterly reports, suggesting there may be opportunity to trigger internal audit to carry out further work.

The Chief Executive noted that the Board have received reports on integrated improvement, integrated performance and integrated governance for the first time.

Members **received** and were **assured** by the mitigations for those indicators off track.

9. **Healthcare Associated Infection Reporting Template**

The Director of Nursing, Midwifery, AHPs and Chief Officer Acute presented the key messages from the report, commending the team for meeting the targets and continued progress across the sites with the training and positive feedback that is received.

The Team were recognised for their work. K Cole asked about colour coding which it was agreed would be clarified by a post meeting note.

POST MEETING NOTE:

The graph represents the percentage scores which is sent back to Boards from ARHAI and contains both local and national scores for CRA completion for Methicillin Resistant Staphylococcus aureus *(MRSA) and carbapenemase producing* Enterobacteriaceae *(CPE).*

Dark green – represents local MRSA CRA screening scores.

Mid Green – represents the collated Scottish Board scores/national MRSA CRA screening scores.

Light green – represents local CPE scores.

Turquoise – represents the collated Scottish Board score/ national CPE CRA scores.

Pink – Target

Presenting the data over time enables the Board to see that, despite having some improvement to make, overall NHSO is performing

10. Digital Priorities

The Chief Executive introduced the paper, presented to the Board for information, reminding colleagues that the Digital Strategy that had been agreed was quite ambitious. She went on to say that there had been a challenging discussion at the Finance and Performance Committee in this regard and the Digital and Information Operational Group were asked to carry out a prioritisation exercise.

The Chief Executive advised members that for those projects that were prioritised they are in the process of setting up the project teams and work is currently being done to look at the impact assessment of not proceeding with the other projects. She suggested that the approach taken demonstrates real maturity, accepting it cannot all be done, pausing and taking the time to prioritise, which came with some challenging conversations.

The Head of Improvement advised members that all of these priorities have been matched to a risk on the corporate risk register, she referred members to the GPIT project, which is showing as Amber in the Corporate Strategy scorecard, advising this is one of the national programmes that the Board do not have a lot of control of the national roll out.

D Creasey acknowledged the report which sets out very clearly why the priorities are what they are. J Taylor agreed and went on to ask about those projects that will not progress. The Head of Improvement advised that what is not taken forward this year, will remain on the Digital Roadmap. She went on to refer specifically to the text messaging capability of the Community EPR which is something that has been an ask from the Non-Executives for some time. D Campbell noted the maturity in the decision making, and the maturity in the challenge from the Finance Performance Committee, suggesting that it feels like the dial is turning.

There was discussion about the need to increase the use of Near Me consultations which members heard is part of the Outpatients Improvement Workstream.

Members **received** the report noting that progress reporting will be through the Finance and Performance Committee.

11. ANY OTHER COMPETENT BUSINESS

Concerns were raised about the social media activity in terms of the Daisyvilla GP Practice. The Chief Officer of the IJB advised that the Board are in a procurement process at the moment limiting what can be said, acknowledging that the biggest concern being raised is patients having to travel to Kirkwall to collect prescriptions. He went on to say that there is not a plan for this to change but recognising that we are in a process at the moment, with interested parties asking questions, further information will be provided over the coming weeks.

The Chief Executive, building on colleagues concerns, advised that the continuity of this service is important to the community, acknowledging that if there are lessons to learn or things we could have done better from a communication or engagement perspective that can be taken forward.

NHS Orkney Board Action Log

(Last Updated: 14/08/2024)

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.

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ITEM No	ESCALATED FROM	MEETING DATE	ACTION	LEAD	COMMENTS/UPDATE	DUE DATE

NHS Orkney Board Escalation Log

(Last Updated: 14/08/2024)

Purpose: The purpose of the escalation log is to capture items escalated from the Governance Committees to provide assurance on actions taken as a result of escalation.

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ITEM No	ESCALATED FROM	MEETING DATE	ITEM ESCALATED	LEAD	FOLLOW UP ACTIONS	DATE
01-2024/25	Senior Leadership Team	04/07/2025	MRI scanner service funding to be withdrawn from 31 March 2025 – with options under development for discussion with Scottish Government (paper will go onward to Finance and Performance Committee in July 2024).	Medical Director		
02-2024/25	Senior Leadership Team	04/07/2025	Risks with progressing with only three digital priorities in 2024/25 in addressing our overall 'digital deficit'.	Head of Improvement		
03-2024/25	Senior Leadership Team	04/07/2025	Very out-of-date policies remains a challenge and gaps in governance arrangements for policies/documentation added as a new risk.	Head of Improvement		
04-2024/25	Finance and Performance Committee	18/04/2024	We still do not have a paper on the financial assumptions relating to digital investment in the 24/25.	Recovery Director		
05-2024/25	Finance and Performance Committee	30/05/2024	A number of items are taken to committee due to the absence of a delegated budget to enable approvals to be made in the right place	Recovery Director	**Finance and Performance Committee**	**26 September 2024**
06-2024/25	Finance and Performance Committee	30/05/2024	There are a number of large digital projects that have come to Committee in isolation from one another, and without a full implementation plan there is a risk that the capacity will not be there to successfully implement any of them.	Head of Improvement		

07-2024/25	Finance and Performance Committee	30/05/2024	GP IT project is at risk due to capacity within the team	Head of Improvement		
08-2024/25	Staff Governance Committee	09/05/2025	Disappointing uptake of specific mandatory training elements in certain teams.	Director of People and Culture	**On Staff Governance Committee Agenda**	**14/07/2024**
09-2024/25	Staff Governance Committee	09/05/2025	Members acknowledged that the spiritual care framework was important to staff, and would be added to the staff governance action plan with a progress update at the next meeting	Director of People and Culture	**On Staff Governance Committee Agenda**	**14/07/2024**
10-2024/25	Staff Governance Committee	09/05/2025	Agenda for Change non-pay amendments – Finance and Performance Committee need to be cited on a potential cost pressure if there was a slippage in traction	Recovery Director		
11-2024/25	Staff Governance Committee	09/05/2025	Consultant job plans need to be brought up to date	Medical Director	**Staff Governance Committee**	**October 2024**
12-2024/25	Joint Clinical and Care Governance Committee	14/06/2024	Lack of specific data for complaints data for Acute services to be able to review the feedback re specific departments, not assured that if there are themes, we can see or address them.	Medical Director		
13-2024/25	Joint Clinical and Care Governance Committee	14/06/2024	Health Complaints annual report contains KPI's that are expected to be required for reporting to Scottish Government (SG) in September 2024. As KPI's are still to be confirmed the report may require adjustment for SG return	Medical Director		
14-2024/25	Joint Clinical and Care Governance Committee	14/06/2024	Committee requested 'closing of the loop' on improvements from patient complaints to ensure actions undertaken in set timescales and learning and improvement evidenced.	Medical Director		

NHS Orkney

Meeting:	**NHS Orkney Board Meeting**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Board Chair and Chief Executive Report**
Responsible Executive/Non-Executive:	**Meghan McEwen, Board Chair and Laura Skaife-Knight, Chief Executive**
Report Author:	**Meghan McEwen, Board Chair, and Laura Skaife-Knight, Chief Executive**

1 Purpose

This is presented to the Board for:

- Awareness

2 Report summary

2.1 Situation

This report has been provided to update the Board on key external/internal events and activities from July-August 2024, including:

- A summary of our operational performance
- An overview of our Quarter One financial performance
- Cabinet Secretary for NHS Reform, Health and Social Care visits NHS Orkney
- Six organisational priorities in response to staff feedback to further improve people's experience of working here
- Chair and Chief Executives' diaries – including meetings with external stakeholders and partners
- Looking ahead to August and September 2024

2.2 Background

2.2.1 A summary of our operational performance

NHS Orkney remains a top three performing Health Board in Scotland for this national standard, which is an important indicator of quality and experience. Our four-hour emergency access standard performance decreased slightly at the end of June 2024 to 92% against the national 95% standard (compared to 93.48% for NHS Orkney at the end of May 2024).

Performance against the 18-week Referral to Treatment standard has improved slightly during May 2024 to 82% compared to 81% in April and 74% in March 2024. The national standard is 90%. There are specialties where improvements are required, including Ear, Nose and Throat (60%), Trauma and Orthopaedics (66%) and Oral Surgery (67%). Actions will be put in place to improve performance as part of the work being overseen by our new Planned Care Board.

A total of 317 patients were waiting for diagnostic tests/scans at the end of June 2024 (compared to 327 patients in May 2024 and 366 patients in April 2024). 76 patients have waited over six weeks compared to 79 patients in May 2024. There has been a noted decrease in patients waiting for non-obstetric ultrasound scans and endoscopic procedures.

Our performance remains consistently above the national 31-day cancer standard at 100% versus the 95% national standard.

Waiting lists and backlogs

We continue to focus on areas which have the longest wait times. Performance against the 12-week standard remains disappointingly at 42%, showing a slight decrease in performance compared to the end of April 2024 position when our performance was 46%. Waiting lists and backlogs are a key priority for our new Planned Care Board. This Board's first meeting was on 17 July 2024.

Performance against the Treatment Time Guarantee for June 2024 for inpatients (patients who will not wait longer than 12-weeks) has improved. However, 150 people are still waiting more than 12 weeks out of a total of 277 patients compared to the end of April 2024 which showed a similar picture with 185 breaching 12-weeks out of 303 on the waiting list.

287 operations were scheduled during June 2024 with 80 (29%) being cancelled. The reasons for cancellation include patients being unwell or not fit for surgery on the day of procedure. Additional capacity has been identified to support pre-op assessments, to ensure patients are well prepared before the day of surgery to avoid on the day cancellations. No patients were cancelled due to inpatient bed capacity.

2.2.2 An overview of our Quarter One (April-June) financial performance

Thanks to an organisation-wide focus and strengthened discipline and grip, we have got off to a good start to 2024/25, meeting our financial and savings requirements for Quarter One. These are the headlines.

- Planned deficit of £1.73m at the end of Quarter One (April-June) - based on the Financial Plan we submitted to Scottish Government
- Actual financial deficit £1.71m, and therefore our Quarter One position shows a slightly favourable position to this plan of £23k
- We are still forecasting to achieve our year-end planned deficit of £5.8m at this stage but our run rate needs to reduce for the remainder of the year
- Overall savings delivered at the end of Quarter One of £780k which was £380k better than the £400k we planned to deliver (£262k delivered recurrently (broadly in line with the recurrent savings level required in our plan), £518k delivered non-recurrently)
- £3.1m savings forecast to be delivered full year (£2.5m recurrent forecast which is higher than the 3% requirement but short of the overall £4m requirement)
- £1m in the pipeline which if implemented will get us to £4.2m in the year
- The reliance on agency supply is much lower when compared to the first quarter of the 2023/24 financial period

2.2.3 Cabinet Secretary for NHS Reform, Health and Social Care visits NHS Orkney

On 1 August 2024, we welcomed the Cabinet Secretary for NHS Recovery, Health and Social Care, Mr Neil Gray, and shared the exciting journey of improvement we are on, and the steps we are taking to further improve patient care and services, and the experience of our staff.

During the visit, the Cabinet Secretary met patients and staff to hear about the developments and improvements we are making in theatres (including how we are reducing waiting times), radiology (including digital innovations to support the delivery of care in rural and island settings), how we are working to improve access to services, such as dentistry, and how as the first net zero hospital in Scotland we continue to lead the way with sustainability.

The Cabinet Secretary is committed to ensuring remote and rural areas are at the forefront of cutting-edge innovation and technology.

We also shared the work we are doing in response to staff feedback to value, recognise and support our staff, via investments in health and wellbeing and valuing and recognising people, as part of our work to improve our organisational culture, leadership and staff experience and engagement.

The visit also included a stakeholder meeting, with the Cabinet Secretary, NHS Orkney, Scottish Ambulance Service, Loganair, Orkney Islands Council, and Scottish Fire and Rescue Service to discuss how we can work together to improve inter-isles air services for those with mobility issues to ensure access to health care and treatment.

2.2.3 Six organisational priorities in response to staff feedback to further improve people's experience of working here

In addition to the improved iMatter results in 2024 compared to 2023, across NHS Orkney, 62 out of 90 teams (69%) completed their action plans within the iMatter system. This is an 11% increase from last year and a 40% increase from the 2022 results.

120 staff responded to our follow-up iMatter survey where we asked Team Orkney for more information about what matters to them to ensure that we focus on the right areas in the year ahead to further improve people's experience of working here.

This further survey was a really important way to collect people's stories and feedback so we could put context to our iMatter scores. We heard from staff our priorities remain:

- Health and wellbeing
- Valuing and recognising people
- Being involved in decisions that affect you
- Listening to, and acting on your feedback (and closing the loop)
- Leading with kindness

This year there was also an additional priority area:

- Being able to confidently raise concerns, including those about safety

These six areas are our organisational priorities for the next year, in response to feedback from staff regarding where people most want to see improvements.

2.2.4 CEO and Chair diaries – including meetings with external stakeholders and partners

Chair

Meghan travelled with Des Creasey, one of our Non-Executive Board Members to meet colleagues at the Westray Surgery. This visit provided an opportunity to hear how primary care on a ferry-linked island can present unique and complex challenges, and how valued these practitioners are in their communities. We also heard that there is further work to do to ensure we understand and respond to those challenges and work as NHS Orkney for all our communities.

Meghan met with the other Board Chairs from the North of Scotland to share best practice, and also to develop a shared understanding of the pressures within our region. There was a discussion about the mobile MRI scanner, recruitment and retention challenges and also work to reduce the number of Delayed Transfers of Care.

Our Board Development session in July 2024 was fully in-person which offered a very welcome opportunity to build our relationships with one another and allow conversations to take place off screen. Hybrid meetings will be the default in future, but these face-to-face opportunities are essential for us to continue our development as a Board.

Meghan also met with colleagues from our Improvement Team to learn about the great work taking place to develop our Performance Management Framework within the organisation. This multi-faceted approach will ensure we are doing all we can to deliver high quality care for our patients and is a key facet of our Corporate Strategy. Excellent progress is being made.

Chief Executive

Laura and Stephen Brown, Chief Officer for the Integration Joint Board, visited North Ronaldsay to meet Inga Martin, Advanced Nurse Practitioner, Heather Woodbridge, the Leader of Orkney Islands Council, and members of the North Ronaldsay Trust and North Ronaldsay Community Council. It was an opportunity to hear firsthand the experience of living and working on the most northerly of the Orkney Islands and to listen to feedback about what we can do to improve and better support staff and our community living and working in the north isles.

Laura joined Oliver Reid, the Chief Executive of Orkney Islands Council and Scott Robertson, Chief Inspector Orkney Police for a meeting with Police Scotland's Chief Constable, Jo Farrell at the end of July 2024 in Orkney. A range of discussion points were covered in this helpful meeting, including partnership working in rural and island areas, recruitment, relationships with unions, organisational culture and leadership challenges.

Laura and Meghan both met with the team from the Mental Welfare Commission during the annual visit to NHS Orkney and shared what they have heard from staff who work in our Mental Health Service in recent months and work underway to make improvements in response to this feedback and that which is needed for our patients and community.

Laura and Meghan did a great Board walkabout where they spent time with our Travel Administration Team to hear about the vital work this team do for our patients in supporting their travel needs, which has a very significant impact on the experience of our patients.

Laura joined members of the Macmillan Team to say thank you to Anne Gregg, Macmillan Specialist Nurse, who has retired after 34 years' service to the NHS and NHS Orkney. It was a pleasure to join Anne and her colleagues and friends to thank her for all she has done over the last three plus decades and the positive difference she has made to our community and patients.

Laura and Meghan, at separate events, said thank you to Moira Sinclair, Clinical Nurse Specialist, for her 40 years' service to NHS and NHS Orkney, and Marie Wylie, Accounts Payable Manager, who also marks 40 years' service to the NHS and NHS Orkney this year. It is clear that these events mean so much to colleagues, their friends, colleagues and families.

Laura also presented Wendy Lycett, Director of Pharmacy, with her badge and certificate for her 38 years' service to the NHS and NHS Orkney.

Laura had her regular meeting with Ryan McLaughlin, Employee Director, to discuss a wide range of issues relating to staff experience and engagement and the Area Partnership Forum.

Laura and Meghan met Rhoda Grant, MSP for the Highlands and Islands, at The Balfour to update on our progress, challenges and future ambition, and Laura had her latest meeting with Liam McArthur, MSP for Orkney, to discuss and update on a number of matters, including a continued focus on reducing waiting times in specialties such as pain and ophthalmology. She

also hosted the visit from the Cabinet Secretary early August 2024 and updated the Cabinet Secretary, with Meghan, on our improvement journey, progress and challenges and response to these.

2.2.4 Looking ahead to August and September 2024

The priorities in the next few months, many of which will be discussed at August's public Board meeting, include:

- Developing a future proposal for our in-house Improvement Team
- Agreeing a Quality Improvement methodology and training programme what works for NHS Orkney so we have a 'way of doing change' here to get consistency across the organisation and to upskill our staff
- Agreeing a new Performance Management Framework for the organisation
- Preparing to move to exception reporting for our Integrated Performance Report at Board and Senior Leadership Team from October 2024
- Preparing to introduce Performance Review Meetings from October 2024 for corporate and clinical services so that teams can be held to account for performance and delivery of our strategic objectives and supported to make improvements where this is necessary
- A continued focus on improving our waiting times for our patients and community
- A sustained focus on financial discipline and grip so we remain on track for delivery against our financial plan and savings requirements for the year and attending our Quarter One review meeting with Scottish Government at the end of August 2024

NHS Orkney

Meeting:	**NHSO Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Corporate Risks aligned with the Staff Governance Committee**
Responsible Executive/Non-Executive:	**Anna Lamont, Medical Director**
Report Author:	**Kat Jenkin, Head of Patient Safety, Quality and Risk**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Annual Operation Plan
- Emerging issue
- Government policy/directive
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Presentation of the Corporate risk register has undergone significant changes to support clarity, oversight, and scrutiny. The risk register report cover has similarly been revised to improve visibility of changes and enhance scrutiny of the organisation.

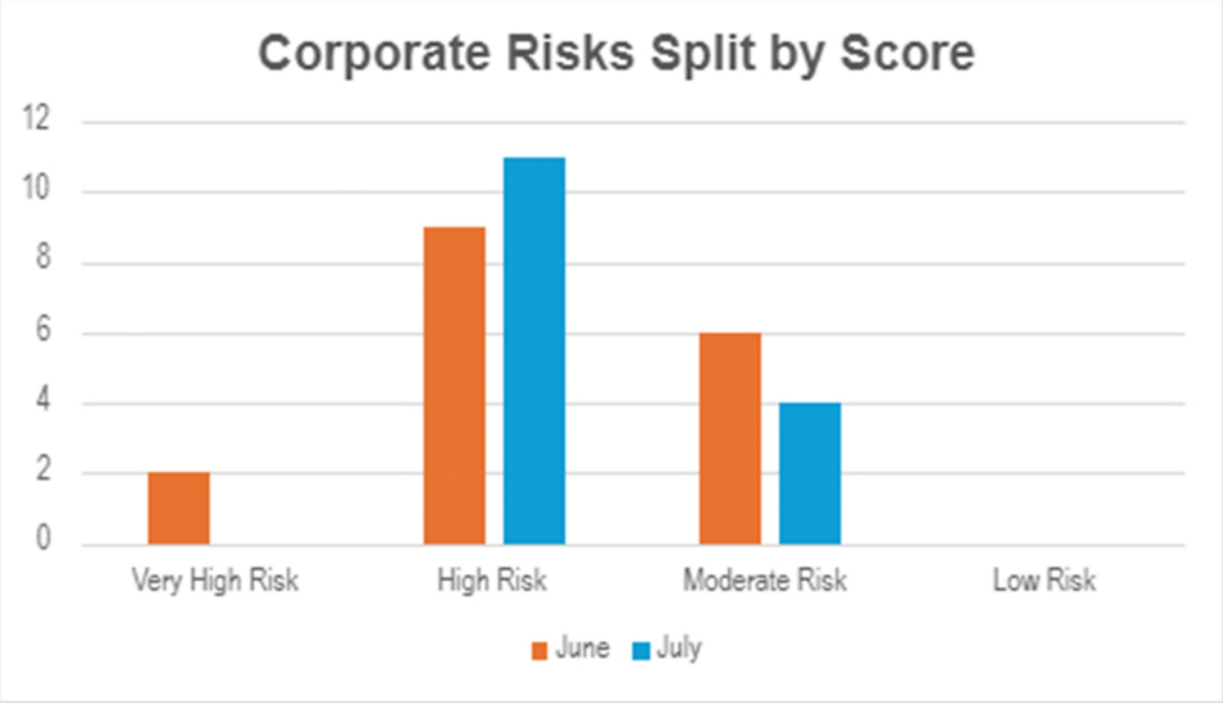
This is the first revised cover page to Board, having been shared at the Staff Governance Committee on 14th August. The Board members are asked to consider and discuss the risks which can be seen in the attached corporate risk register.

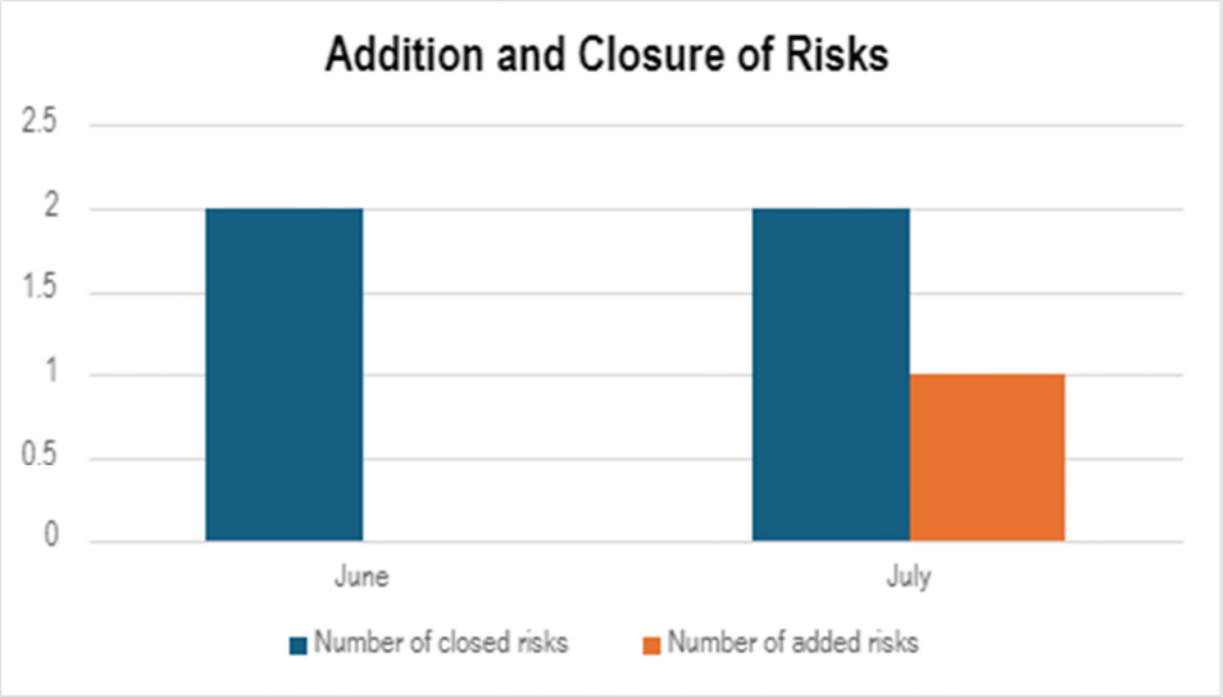
2.2 Background

The corporate risk register is a live document, which has been previously difficult to present as the report becomes out of date as soon as the register is exported for review at committee or Board. The revised style of presentation provides an at a glance view of what has changed over two months, to note that the risks split by score aligned with each committee is a new addition to the data and added to the risk register in July, therefore for August 2024 there is only one month displayed. Some of this information will be copied into each cover paper, however the Excel risk report will now also include an at a glance summary.

2.3 Assessment

The corporate risk register with overview is attached as appendix one. In future the aim is to present a single version of the live document in meetings to ensure that the most up to date information is shared.





2.3.5 Equality and Diversity, including health inequalities
There are no identified impacts identified through this report.

2.3.6 Climate Change Sustainability
There are no identified impacts identified through this report.

2.3.9 Route to the Meeting
The corporate risk register is reviewed at the senior leadership team meetings and risks aligned with each Board committee at the corresponding meetings.

2.4 Recommendation

- **Discuss** – NHSO Board are asked to review and scrutinise the corporate risk register. Committee members are asked to critically consider the register, and raise any recommended changes or clarifications beyond those noted in the cover report
-

2 List of appendices

The following appendices are included with this report:

- Appendix one: Corporate Risk Register

Joint Clinical and Care Governance Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Joint Clinical and Care Governance Committee	**Date of Meeting: 22 August 2024**
Prepared By:	Julie Colquhoun, Corporate Governance Lead	
Approved By:	Rona Gold, Committee Chair	
Presented By:	Rona Gold, Committee Chair	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the committee at its meeting on 30 July 2024		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Concern around getting information on colonoscopy, and an ask for this to be tested around how that information would work within the clinical governance system • Concerns raised about lack of clarity in terms of the Clinical Governance Structure and meetings being held with no approved terms of reference. • Concern raised about the number of components, action plans and reports around Mental Health, with no clear route for all the reporting. • Medical Directors report contained breadth of new information and it was not clear the implications of some matters highlighted or where these would be addressed.	• Medical Directors Report – welcomed this initial report and the work to bring together breadth of information. Feedback included purpose of some information for Committee and whether it should be a Clinical Director Report due to the items covered being wider than the Medical Directors portfolio • Psychiatric Mental Welfare Plan to come to the October JCCGC as part of action plan from Mental Welfare Commission Report. • Chair and Executive Lead are working together to approve the agenda setting of the meeting • Significant work underway in terms of the mental health bed ensuring the safety and care of patients • Unscheduled Care funding allocation – to be reported to Finance and Performance Committee and back to JCCG Committee in October.
Positive Assurances to Provide	**Decisions Made**
• Positive assurances given in terms of the Childrens Health Review and engagement with staff on the learning • Assurance taken from the Social Work and Social Care Service User Experience Report • Positive feedback on the role of the Confidential Contacts from the Whistleblowing Report • Public Health and Population Health planning influencing the Community Planning Partnership work. • Positive developments in terms of the improvements on the risk register and presentation of the report.	• Approved the Social Work and Social Care Service User Experience Report.

Finance and Performance Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Finance and Performance Committee	**Date of Meeting: 22 August 2024**
Prepared By:	Julie Colquhoun	
Approved By:	Des Creasey	
Presented By:	Des Creasey	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee at its meeting on 11 July 2024		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• MRI service provision to cease 31 March 2025 as the North Imaging Alliance has been disbanded and funding withdrawn. • Concerns raised about lack of preparedness for the Island Games	• Digital Maturity corporate risk to be reviewed and updated to incorporate the range of digital related risks. • Finance Team to meet with budget holders to carry out budget cleansing exercise • Outpatients Improvement workstream focussing on increasing the number of near me clinics and maximising clinics and clinic templates. • NIS Improvement plan evidence to be submitted by 7 October 2024 • Members received the Terms of Reference for the Planned Care Programme Board • Corporate Strategy and ADP metrics presented in one performance management framework
Positive Assurances to Provide	**Decisions Made**
• Difficult choices return that had been submitted was acknowledged by the Scottish Government • Financial position reported at Month 2 is in line with the financial plan • Annual Delivery Plan approval letter received	• Agreed to review the Financial sustainability corporate risk given the range of mitigation that is in place. • Members received the Digital Budgets and Prioritisation for 2024/25: o cCube o MORSE – EPR o GPIT reprovisioning
Comments on Effectiveness of the Meeting	
•	

Finance and Performance Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Finance and Performance Committee	**Date of Meeting: 22 August 2024**
Prepared By:	Julie Colquhoun	
Approved By:	Des Creasey	
Presented By:	Des Creasey	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee at its meeting on 11 July 2024		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• MRI service provision to cease 31 March 2025 as the North Imaging Alliance has been disbanded and funding withdrawn. • Concerns raised about lack of preparedness for the Island Games	• Digital Maturity corporate risk to be reviewed and updated to incorporate the range of digital related risks. • Finance Team to meet with budget holders to carry out budget cleansing exercise • Outpatients Improvement workstream focussing on increasing the number of near me clinics and maximising clinics and clinic templates. • NIS Improvement plan evidence to be submitted by 7 October 2024 • Members received the Terms of Reference for the Planned Care Programme Board • Corporate Strategy and ADP metrics presented in one performance management framework
Positive Assurances to Provide	**Decisions Made**
• Difficult choices return that had been submitted was acknowledged by the Scottish Government • Financial position reported at Month 2 is in line with the financial plan • Annual Delivery Plan approval letter received	• Agreed to review the Financial sustainability corporate risk given the range of mitigation that is in place. • Members received the Digital Budgets and Prioritisation for 2024/25: o cCube o MORSE – EPR o GPIT reprovisioning
Comments on Effectiveness of the Meeting	
•	

Staff Governance Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report to Board	**Date of Meeting 14 August 2024**
Prepared By:	Rachel Ratter	
Approved By:	Joanna Kenny	
Presented By:	Joanna Kenny	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Staff Governance Committee at its meeting on 14 August 2024		

Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**
• The Medical Director did not submit the requested report on consultant job planning. Members were therefore unable to take any assurance on the matter. The committee have requested a written report at the November meeting • Occupational Health, Safety and Wellbeing Committee had not met since April 2024, as a consequence the committee were unable to take any assurance on operational matters delegated to the committee. • The Health and Care (Staffing Scotland) Act report highlighted significant lack of progress and engagement from the organisation. The committee was unable to take assurance that there were adequate mitigations in place and particularly concerned that the Programme Board had not met since March 2024. • Members requested that a Corporate Risk was raised regarding the compliance and data quality issues of mandatory training	• Further support and communications are required with regards to the Band 5 nursing review component of the agenda for change non pay elements. • Work had progressed regarding the review of people of culture, the recommendations would be presented at the next meeting.
Positive Assurances to Provide	**Decisions Made**
• Members welcomed the proposals for Spiritual Care • Positive assurance on culture programme plans, there had been significant progress • There was positive assurance around face to face manual handling • JLNC had met and provided a positive chairs assurance report	• Members approved the colleague experience programme. • The iMatter actions were approved
Comments on Effectiveness of the Meeting	
• One meeting paper was carried forward to the next meeting due to timing constraints	

Audit and Risk Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Audit & Risk Committee	**Date of Meeting: 27 June 2024**
Prepared By:	Rachel Ratter	
Approved By:	Jason Taylor	
Presented By:	Jason Taylor	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Audit & Risk Committee at its meeting on 27/06/24		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• No matters of concern or key risks to escalate were raised	•
Positive Assurances to Provide	**Decisions Made**
• Positive relationship improvements and flow of information during the annual accounts process • Gratitude to the finance team for their work preparing the annual accounts, recognising the staffing challenges • Positive assurance taken from the external audit report and recommendations • Assurance taken from the service audit reports	• Reviewed and approved the recommendation of approval of the annual report and accounts 2023/24 onwards to Board • Approved the draft significant issues letter which has been submitted to the Scottish Government • Authorised Chief Executive to sign annual report, accounts and representation letter
Comments on Effectiveness of the Meeting	
Scrutiny and Challenge of subject matter.	

Senior Leadership Team (SLT) Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Senior Leadership Team	**Date of Meeting:** 5 August 2024
Prepared By:	Laura Skaife-Knight, Chief Executive	
Approved By:	SLT	
Presented By:	Laura Skaife-Knight, Chief Executive	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on 5 June 2024.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Integrated Performance Report (June's performance) – SLT focused on areas in which a different response is needed due to deteriorating performance/where improvements are needed, including: staff sickness due to stress (>30%), pre-noon in-week discharges and waiting times. SLT agreed to focus on sickness absence/stress and to discuss solutions together at September's SLT, and to provide more improvement support to improving pre-noon discharges, consistent with our approach re: planned care/reducing waiting times 2. Preparedness for the Island Games – to be a monthly standing agenda item at SLT and a request for visibility of the full plan to return ASAP to SLT for scrutiny and familiarity given the concerns raised re: lack of preparedness 3. Internal Audit recommendations 2023/24 progress report – 7 actions are overdue (spanning: clinical governance/complaints, business continuity and cyber security). Mitigating actions will be shared at September's Audit and Risk Committee	1. Consideration of compassionate conversations training (and to prioritise clinical colleagues for this training in 2024/25 and return with a proposal re: in-house versus external training). Consideration to be given re: complaints/patient experience training for 2025/26 so that we look at training by staff group in the rounds with Quality Improvement and other training needs. It was not supported that complaints training should be mandated for all staff, recognising the statutory and mandatory training priorities and challenge that already exists 2. Consideration of moving from a three to a two tier risk management process was deferred to the September 2024 meeting as the paper was not circulated to SLT to enable this discussion to take place. Agreement that early conversations will happen with the Board and Audit and Risk Committee Chair and an update shared at August's In Committee Board 3. Visibility of planned care funding for 2024/25 shared with SLT for the first time, with more detail re: funding spent to date and activity to date to be overseen by the new Planned Care Board and a paper to come to September's Finance and Performance Committee 4. New in-house Improvement Team and Quality Improvement methodology proposals supported by SLT, with some additions to be made prior to submission to Board 5. Strengthened Performance Management arrangements welcomed by SLT – including Performance Management Framework, Performance Review Meetings (from October) and Integrated Performance Report by exception

Positive Assurances to Provide	Decisions Made
1. Month 3 and Quarter 1 financial and savings results on track against plan 2. Internal Audit is now a quarterly agenda item at SLT – and we welcomed Azets in attendance for this item, which included updates on 3 audit reports ahead of a discussion at September's Audit and Risk Committee: - Significant Adverse Events Management - Recruitment Staff Records - Health and Safety Risk Assessments 3. Risk Jotter test of change – agreed to continue using simplified version of the jotter for Corporate Risks 4. 2 key national returns discussed: - 15 box grid self assessment (will go to September's Finance and Performance Committee) - Supplementary Staffing AHP submission – monthly spend is declining, all spend at framework levels and in line with national practice (to be shared with Staff Governance Committee) 5. Improving Together Programme - £3.8m in-year savings identified - £0.6m increase since May, which have been risk-adjusted. Recurrent savings £2.6m (6.9%), which is in line with plan submitted to the Scottish Government. Quality Impact Assessment Panel now in place, and reporting to the Improvement Board and Joint Clinical and Care Governance Committee. To close the £0.25m gap, 7 key opportunities are being 'run to ground' by the Executive Team and workstream leads	1. Decision to close risks 350 and 722 – Urgent Cancer Referrals Pathway risk (as risk is about cancer pathways not having timings and standards of milestones defined) and Control of Substances Hazardous to Health Regulations 2002 (COSGG 2002) – mitigations are all in place and target risk score has been met 2. Financial Choices return (for submission to Scottish Government by 9 August) 3. Unscheduled Care national funding allocation of £166K for NHS Orkney – a proposal for how we will spend the monies was approved by SLT for submission to Scottish Government by 7 August 4. Approved the updated new style report re: Corporate Risk Register 5. Refreshed Smoke Free Site Policy approved – subject to a plan for brief interventions training and an organisation-wide communications plan being agreed to relaunch 6. 11 x IT policies approved as follows: - Freedom of Information Policy - IT Security Framework Policy - Access Control Policy - Malicious Software Policy - Password Policy - Remote Access Policy - Removeable Media Policy - Sending Data to Third Parties Policy - Use of Email Policy - Use of Personal Devices of Work Purposes Policy - Proposal for in-house and new Improvement Team approved – ahead of going onward to Board - Proposal for approach to developing Quality Improvement methodology approved – ahead of going onward to Board

Feedback about meeting:

- Good discussions
- More challenge and scrutiny is needed
- Papers difficult this month – were issued late, due to late submission from some colleagues, making preparation for the meeting difficult
- Meeting length a challenge – long and tiring (3 hours and 45 minutes)
- Inclusive meeting
- At September's meeting we will have a refresh and reset – re: expectations when it comes to agendas, papers, preparing for SLT and contributing to the meeting itself. We will also discuss and come to an agreement whether we continue with monthly meetings or have a meeting every 2 weeks.

Chair's Assurance Report to Board

Title of Report:	**Chair's Assurance report - ACF**	**Date of Board Meeting: 22 August 2024**
Prepared By:	Julie Colquhoun, Corporate Governance	
Approved By:	Kirsty Cole	
Presented By:	Kirsty Cole	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the ACF Committee at its meeting on 2 August 2024		

Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**
1. Concerns raised about the lack of financial information forthcoming from Primary Care to the GPSub committee relating to the PCIF resulting in limited ability of that committee to perform its advisory and stakeholder roles with relation to the PCIP. 2. Concern raised regarding struggles to achieve a quorum at APC often related to independent contractor attendance. 3. Neurodevelopmental pathway not progressed causing concern and confusion across services and schools. 4. Restaurant queuing times continues to be a challenge for staff to get their lunch and eat it within their allocated breaks.	1. Island Games – the Medical Plan from the Island Games Committee has been received, further updates to be provided once the report has been scrutinised. 2. Discussions continue, led by the Medical Director, in relation to the private phlebotomy service offered in a local salon in the Community. 3. Work is ongoing in relation to: a. ED review b. Psychiatric Emergency Plan c. Medical Staffing establishment
Positive Assurances to Provide	**Decisions Made**
1. Positive feedback from the Chair of NAMAC in relation to their last meeting.	1. Aim for future focus of ACF meetings to be the Chair's Assurance Reports of the clinical advisory committees and for this to support a broader piece of work relating to increased clinical engagement.
Comments on Effectiveness of the Meeting	
•	

NHS Orkney

Meeting:	**Board Meeting**
Meeting date:	**Thursday, 22 August 2024**
Title:	**2024 iMatter – Update and Next Steps**
Responsible Executive/Non-Executive:	**Jarrard O'Brien, Director of People and Culture**
Report Author:	**Steven Phillips, Head of People and Culture**

1 Purpose

Please select one item in each section and delete the others.

This is presented to the Board for:

- Awareness
- Discussion

This report relates to a:

- Government policy/directive
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The iMatter survey was open from Monday 13 May to Monday 3 June 2024. During this period, colleagues were encouraged to take part in the annual survey through multiple communication channels. The board, directorates, and teams received their results and engaged in the action planning phase. Managers were supported to convert local outputs into meaningful actions by Tuesday 30 July, by doing the following:

- Conduct manager iMatter sessions to support the process.

- The iMatter lead provides assistance to managers and teams, including a toolbox for managers to use in creating action plans and following up with the team.
- Focus areas on the one or two key actions that will make a difference.
- External facilitation
- Provide the organisation with regular updates on iMatter action planning and plan review data.

Across NHS Orkney, 62 out of 90 teams (69%) have completed their action plans within the iMatter system. This shows an 11% increase from last year and a 40% increase from the 2022 results. While the national deadline was set for Tuesday 30 July, teams can still create and submit their action plans at a later date. As of the time of writing this report, we have received an additional 5 action plans, bringing the total number of action plans to 67 out of 90 teams (74%).

To support and enhance the organisational response to the entire iMatter initiative, colleagues have been given an opportunity to provide qualitative feedback through an anonymous surveying tool operated by Webropol (the same company that runs iMatter nationally). The surveying tool was used to gather feedback on the same 5 priority areas identified as those for the 2023 survey, as well as understanding more about how colleagues feel raising concerns.

The questions asked to colleagues were:

1. What does it mean to you?
2. What changes should we make, and what difference would you expect to see?

The analysis (Appendix 7) has been shared organisation-wide, and collaborative partnership work will continue to develop a meaningful action plan for colleagues. A summary of key themes was presented at APF on Tuesday 16 July. Union Representatives were asked to gather feedback from their members on the 6 focus areas and the suggested actions.

2.2 Background

The iMatter questionnaire allows colleagues to share their personal experiences, provide feedback on team dynamics, and offer input about the organisation in real time. The results are reported at various levels - team, directorate, and organisation. Once the team receives the results, they work together to create an action plan within 8 weeks. Progress is monitored throughout the year. Teams gather to review the results, exchange ideas, and develop and implement action plans. The process is documented by sharing team stories, making it an integral part of the iMatter process. The iMatter program is monitored nationally and a benchmarking report will be released later in the year.

2.3 Assessment

The paper attached details the Board's outcome in relation to iMatter.

2.3.1 Quality/ Patient Care

iMatter is a valuable tool for continuous improvement that enhances patient care and improves colleagues experience when used appropriately.

2.3.2 Workforce

The iMatter tool is a national development utilised by all NHS Scotland Boards. Its purpose is to assist individuals, teams, Directorates, and Boards in understanding and improving colleague experience.

2.3.3 Financial

None Identified

2.3.4 Risk Assessment/Management

No process-related issues have been identified. However, failing to engage in action planning may have negative consequences for colleagues in terms of a lack of positive change and disengagement if feedback is not seen to proactively drive change. National benchmarking may also generate risk and opportunities for NHS Orkney.

2.3.5 Equality and Diversity, including health inequalities

None identified – this is a nationally procured took that has been impact assessed.

2.3.6 Climate Change Sustainability

None Identified

2.3.7 Other impacts

None Identified

2.3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

State how this has been carried out and note any meetings that have taken place.

- Area Partnership Forum
- All staff briefing and email

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Area Partnership Forum 16 July 2024.
- Staff Governance Committee on 14 August 2024.

2.4 Recommendation

- **Awareness** – For Members' information only.

2 List of appendices

The following appendices are included with this report:

- Appendix 1, iMatter 2024 overview.
- Appendix 2, Board Report 2024
- Appendix 3, Board Yearly Components Reports
- Appendix 4, Raising Concerns Report
- Appendix 5, Yearly response rates
- Appendix 6, Yearly EEI
- Appendix 7, Imatter Survey Summary Results July 2024

iMatter 2024

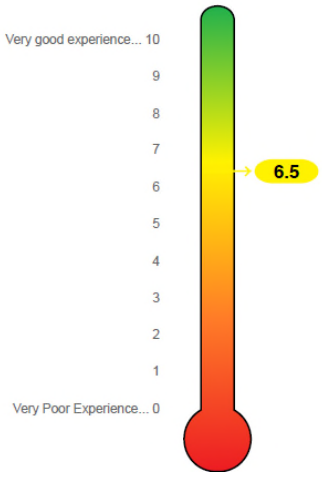
The iMatter survey was circulated to NHS Orkney staff throughout May/June 2024. The overarching Board report is attached at (Appendix 1). The response rate for 2024 has increased by 10% from 59% in 2023 to 69% in 2024.

There are a number of positives to take from the outputs:

- The employee engagement score has, for the third year in a row, increased 72% (2022), 74% (2023) and 75% (2024) (Figure 1)
- Across all the strand scores, aligned to the five pillars of Staff Governance, our weighted index value has remained the same or increased by up to 2% points (Appendix 2)
- Out of the 28 questions asked of staff, we continue to see 24 of the responses are in Strive and Celebrate. In addition, 17 questions showed an increase of 1 to 8% points.
- Our overall experience score increased to 6.5 out of 10. (Figure 2)

Figure 1

Figure 2



17 of the iMatter staff experience components have increased this year. However, 6 saw no change to the response, and 5 saw a reduction of 1-3% points.

Although there was an increase of 1-8% points the areas highlighted from the organisation's feedback to 'monitor to further improve' remain the same as last year:

1. I am confident performance is managed well within my organisation (+1%).
2. I have confidence and trust in Board members who are responsible for my organisation (+4%).
3. I feel sufficiently involved in decisions relating to my organisation (+4%).
4. I feel that board members who are responsible for my organisation are sufficiently visible (+8%).

There were no 'improve to monitor' or 'focus to improve areas' at the Board level. However, there were a number of teams within the 'monitor to further improve' area that will be offered support and assistance from the iMatter team where necessary. (See Figure 3)

Figure 3

EEI number for teams in the same Board

EEI Threshold	(67-100)	(51-66)	(34-50)	(0-33)	No report	Total
Number of Teams	68	13	0	0	9	90
Percentage of Teams	75.6%	14.4%	0.0%	0.0%	10%	100%

Raising Concerns

The iMatter survey introduced two additional questions in 2023 to collect feedback on colleagues' experiences in raising concerns. This year, we have observed both an increase and a decrease in our scores when compared to last year.

- I am confident that can safely raise concerns about issues in my workplace – 74% (-1%)

- I am confident that my concerns will be followed up and responded to – 65 (+1%)

Action Planning:

The action planning window opened on June 4th and will remain open until July 30th. The Scottish government has set this 8-week timeframe to allow managers to upload their plans into the system. The organisation has shared training sessions and launched a Turas Learn module to assist managers.

Action planning data will be available from July 31st.

Summary

The iMatter Report has highlighted several areas of achievement to celebrate and some areas that require attention. This year, the EEI score has increased by 1 point, and 24 out of 28 questions remain within the strive and celebrate parameters.

It is essential for teams to complete their action-planning process to fully benefit from the iMatter outcomes.

Board Report 2024

NHS Orkney

Total number of respondents: 617

Response rate

69%

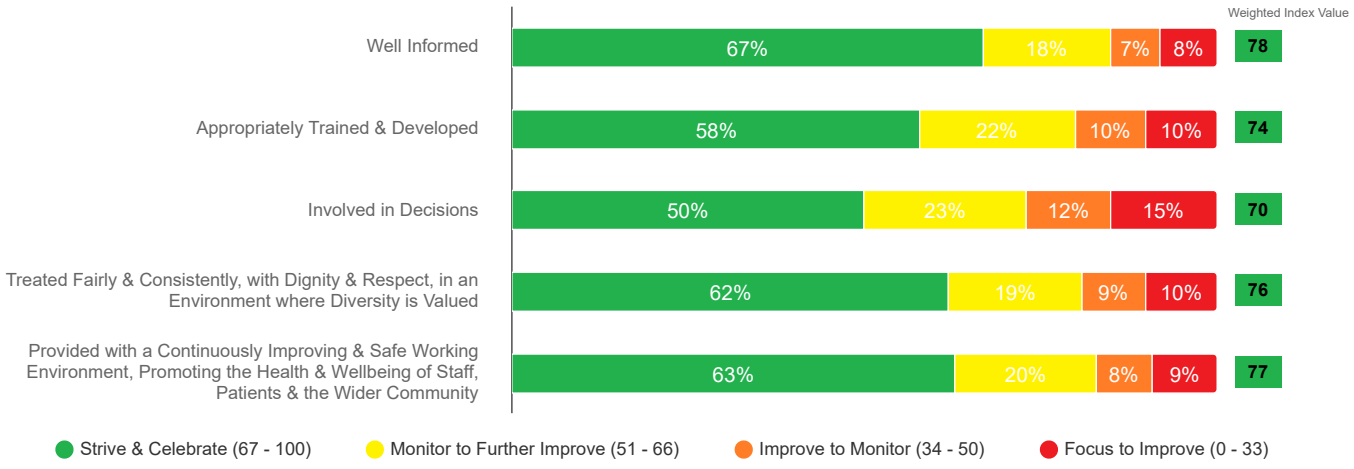
Respondents: 617
Recipients : 895

EEI

75

Employee Engagement Index

Staff Governance Standards - Strand Score Index



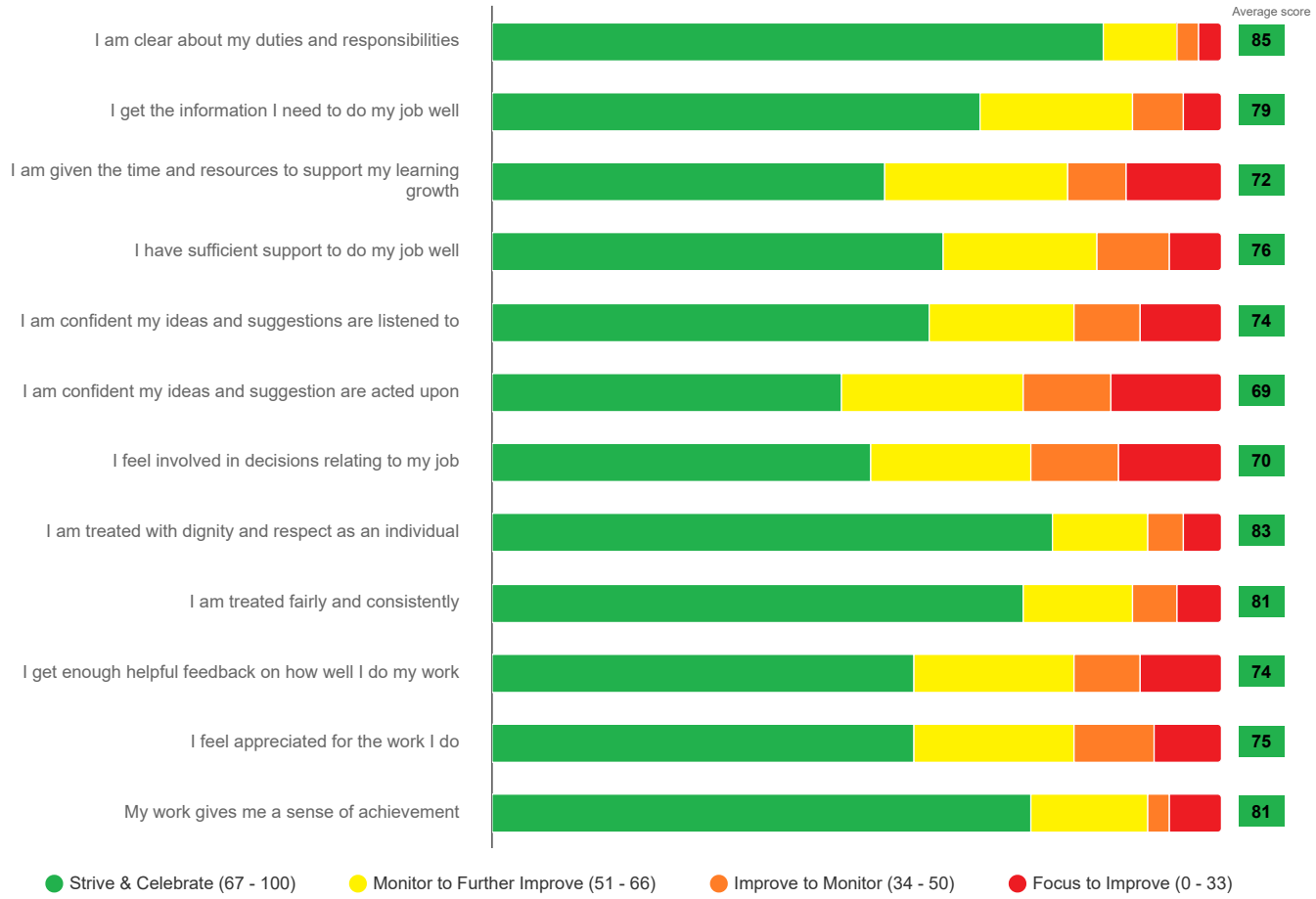
Calculating the Average Score

The number of responses for each point on the scale (Strongly Agree – Strongly Disagree) is multiplied by its number value (6-1) (see right). These scores are then added together and divided by the overall number of responses to the question.

6	Strongly Agree
5	Agree
4	Slightly Agree
3	Slightly Disagree
2	Disagree
1	Strongly Disagree

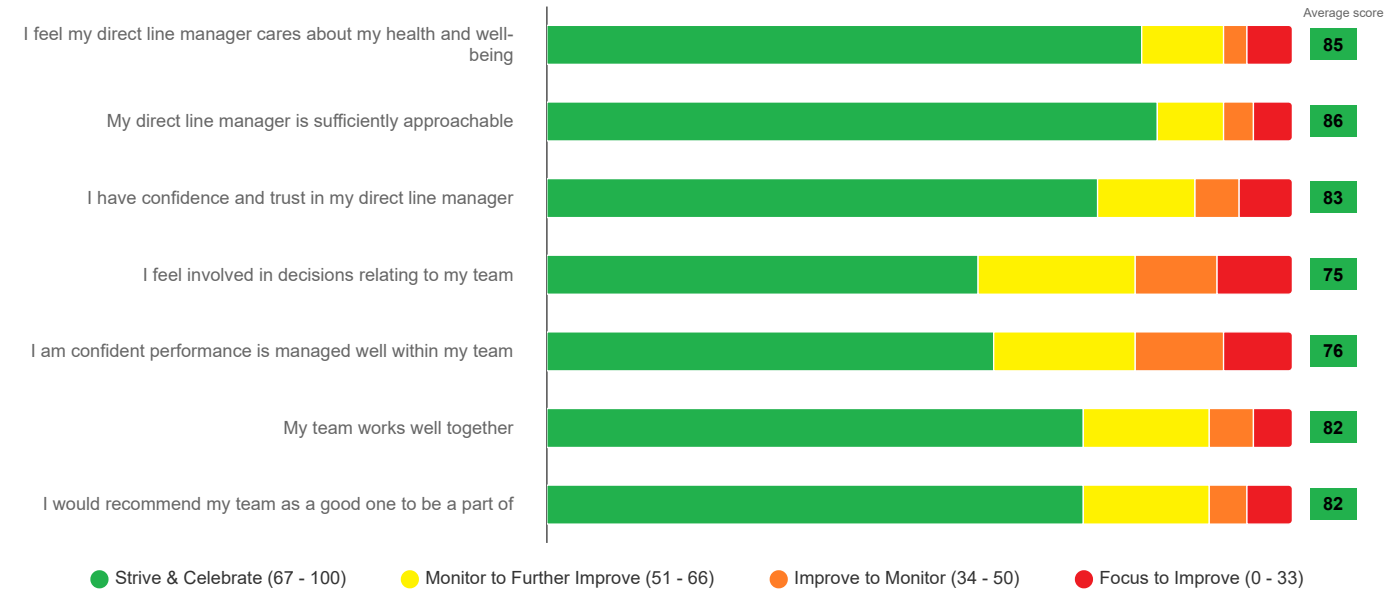
Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements:

Number of respondents: 617



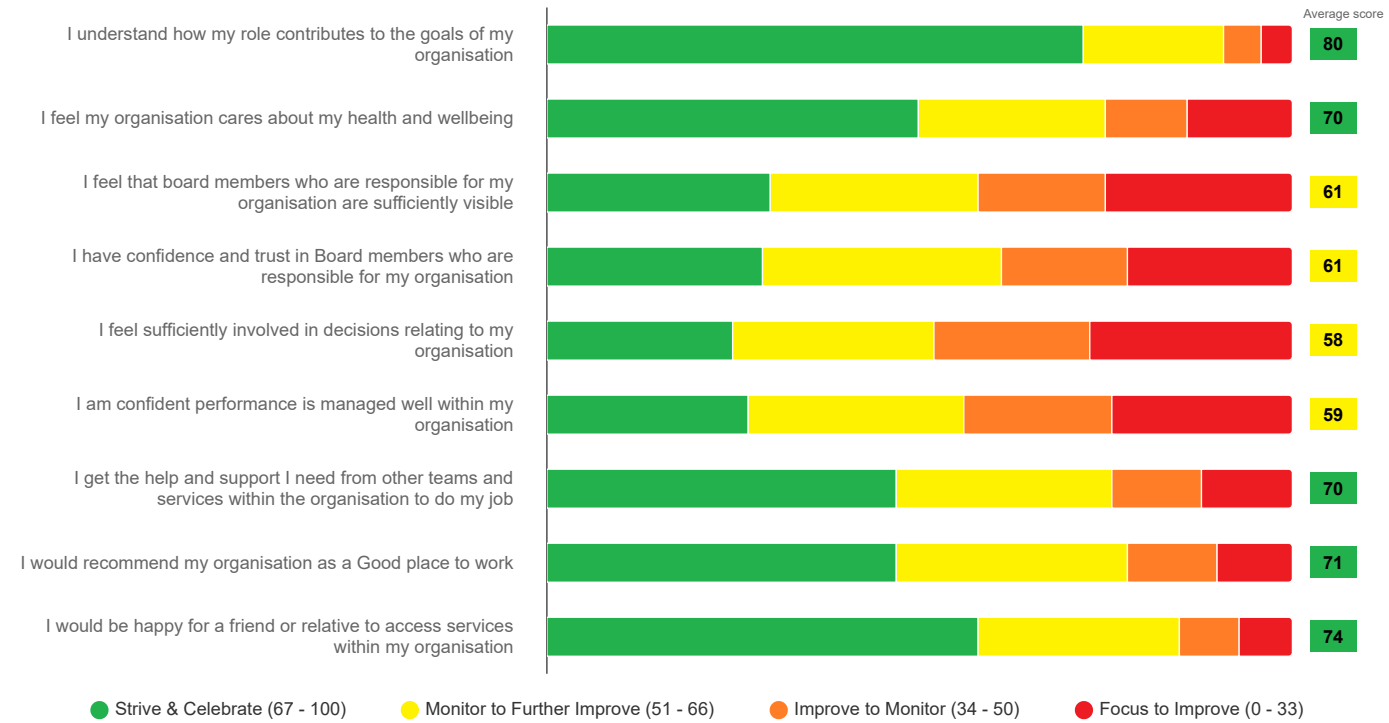
Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements relating to your team and direct line manager:

Number of respondents: 617



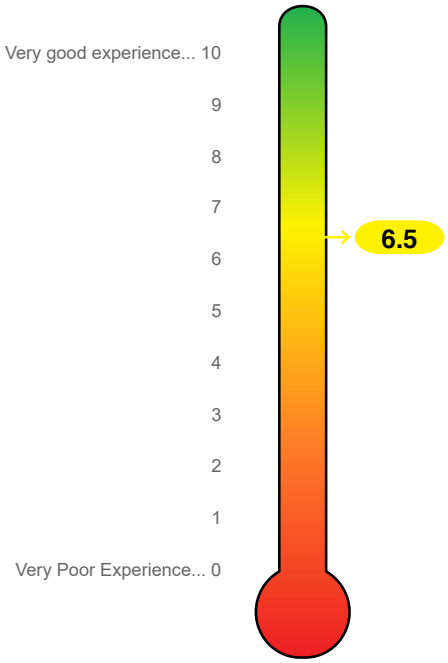
Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements relating to your Organisation:

Number of respondents: 617



Please tell us how you feel about your overall experience of working for your organisation from a scale of 0 to 10 (where 0 = very poor and 10 = very good):

Number of respondents: 617



EEI number for teams in the same Board

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Number of Teams	68	13	0	0	9	90
Percentage of Teams	75.6%	14.4%	0.0%	0.0%	10%	100%

Board Yearly Components Report

NHS Orkney

Total number of respondents: 617

iMatter Components

iMatter Questions	Staff Experience Employee Engagement Components	Average Response			
		2021	2022	2023	2024
My direct line manager is sufficiently approachable	Visible & Consistent Leadership	82	83	84	86
I feel my direct line manager cares about my health and well-being	Assessing risk & monitoring work stress and workload	81	81	82	85
I am clear about my duties and responsibilities	Role Clarity	81	84	85	85
I have confidence and trust in my direct line manager	Confidence & trust in management	78	80	80	83
I am treated with dignity and respect as an individual	Valued as an Individual	79	80	82	83
I would recommend my team as a good one to be a part of	Additional Question	78	80	81	82
My team works well together	Effective team working	78	80	80	82
I am treated fairly and consistently	Consistent application of employment policies and procedures	76	77	80	81
My work gives me a sense of achievement	Job Satisfaction	77	81	82	81
I understand how my role contributes to the goals of my organisation	Sense of Vision, Purpose & Values	77	80	81	80
I get the information I need to do my job well	Clear, appropriate and timeously communication	73	76	78	79
I have sufficient support to do my job well	Access to time and resources	71	74	76	76
I am confident performance is managed well within my team	Performance management	69	72	74	76
I feel involved in decisions relating to my team	Empowered to Influence	70	73	75	75
I feel appreciated for the work I do	Recognition & Reward	71	72	75	75
I would be happy for a friend or relative to access services within my organisation	Additional Question	72	73	72	74
I am confident my ideas and suggestions are listened to	Listened to & acted upon	70	73	75	74
I get enough helpful feedback on how well I do my work	Performance development & review	69	71	74	74
I am given the time and resources to support my learning growth	Learning & Growth	68	71	72	72
I would recommend my organisation as a Good place to work	Additional Question	67	69	70	71
I get the help and support I need from other teams and services within the organisation to do my job	Appropriate behaviours & supportive relationships	67	67	69	70
I feel involved in decisions relating to my job	Empowered to Influence	66	68	71	70
I feel my organisation cares about my health and wellbeing	Health & Wellbeing Support	66	67	69	70
I am confident my ideas and suggestion are acted upon	Listened to & acted upon	66	68	71	69
I have confidence and trust in Board members who are responsible for my organisation	Confidence & trust in management	57	57	57	61
I feel that board members who are responsible for my organisation are sufficiently visible	Visible & Consistent Leadership	52	52	53	61
I am confident performance is managed well within my organisation	Performance management	53	57	58	59
I feel sufficiently involved in decisions relating to my organisation	Partnership Working	50	53	54	58

67 - 100 Strive & Celebrate | 51 - 66 Monitor to Further Improve | 34 - 50 Improve to Monitor | 0 - 33 Focus to Improve

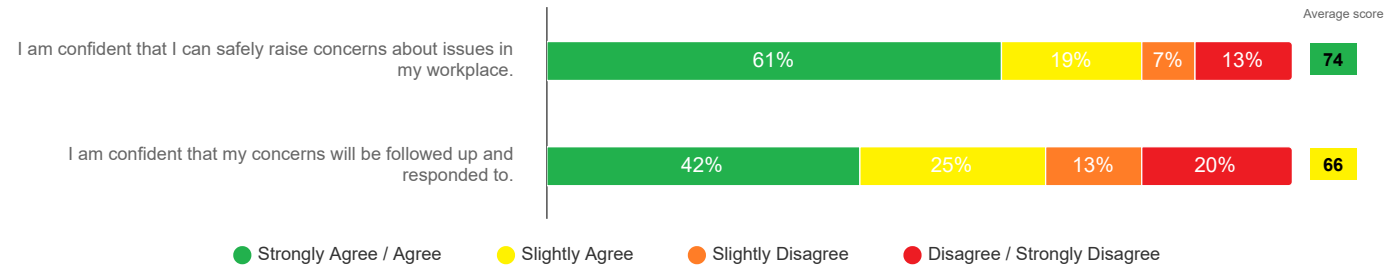
Raising Concerns Report

NHS Orkney

Total number of respondents: 617

Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements:

Number of respondents: 608



Yearly Response Rates

NHS Orkney

	Response rate	Response rate		Response rate		Response rate	
Organisation	**2021**	**Improvement**	**2022**	**Improvement**	**2023**	**Improvement**	**2024**
HSCP NHS Orkney (Chief Officer)	-		47%	→	47%		-
NHS Orkney (SMT Directorate)	65%	↑	66%	↑	70%	↓	69%
NHS Orkney (SMT Directorate)	100%		-		-		-
NHS Orkney Board Members	77%	↑	82%	↑	89%	↑	93%
NHS Orkney	**65%**	↓	**58%**	↑	**59%**	↑	**69%**

Yearly EEI

NHS Orkney

EEI numbers and improvements from last year

Organisation	2021	Improvement	2022	Improvement	2023	Improvement	2024
HSCP NHS Orkney (Chief Officer)	-		72	↑	73		-
NHS Orkney (SMT Directorate)	70	↑	72	↑	74	↑	75
NHS Orkney (SMT Directorate)	70		-		-		-
NHS Orkney Board Members	86	↓	83	↑	84	→	84
NHS Orkney	**70**	↑	**72**	↑	**74**	↑	**75**

67 - 100 Strive & Celebrate | 51 - 66 Monitor to Further Improve | 34 - 50 Improve to Monitor | 0 - 33 Focus to Improve

iMatter Free Text Survey Results
July 2024
Responses =120

1. What does health and wellbeing mean to you?

A genuine sense of support, care and respect, with workloads that are manageable.

Summary
Staff health and wellbeing means feeling supported, respected, and valued within the workplace, both physically and mentally. It includes manageable workloads, effective communication, and genuine care from management. Staff should have opportunities for development, recognition for hard work, and access to support services. A healthy work environment promotes good mental and physical health, allowing colleagues to perform at their best without stress or burnout. Ultimately, it's about creating a balanced, positive, and inclusive atmosphere where staff can thrive both professionally and personally.

What changes should we make to better support staff wellbeing and what differences would you expect to see?

- Recruit and retain skilled staff to cover all roles and reduce workload.
- Provide direct access to support services and act on staff feedback.
- Encourage breaks and physical activity, and offer mental health resources.
- Recognise contributions, ensure fair HR practices, and create a supportive work environment.

2. What does valuing and recognising staff mean to you?

Genuine appreciation and acknowledgement of hard work, in an inclusive environment.

Summary
Recognising and respecting people for their contributions and efforts. Listening to colleagues, acknowledging their work, showing appreciation through simple gestures like saying “thank you”, and fostering a respectful and supportive work environment where everyone feels valued and recognized. It highlights the significance of genuine appreciation, fair treatment, and involving staff in decision-making processes. The overall message is about creating a workplace culture that values and respects all colleagues.

What changes should we make to ensure that we are valuing and recognising staff throughout the organisation and what difference would you expect to see?

- Recognition and appreciation: implementing a colleague of the month award, regular acknowledgment and thank you, including smaller actions of

recognition. Restoring Christmas and staff parties to bring all colleagues together.
- Communication and engagement: encouraging open dialogue and transparency, holding regular face-to-face meetings to listen to concerns, and demonstrating visibility.
- Equality and fairness: ensure equal treatment and recognition for all staff, irrespective of position or department, and eliminate nepotism.

3. What does being involved in decisions mean to you?

Multiple channels to engage people as early as possible in decisions that affect them or their services.

Summary
Involving all relevant stakeholders (recognising that not everyone needs to be involved in every decision) as early as possible in decision-making and change processes. People need to see the rationale for decisions and action in direct response to their feedback and suggestions. Some recognition of communication improving and a reminder to continue to use multiple channels to keep people informed and seek ideas. Several mentions of engaging staff “at the coalface”/”on the shop floor”. Note that clinical staff in particular are not always able to attend meetings, webinars etc.

What changes should we make to ensure that you are involved in decision-making across the organisation and what difference would you expect to see?
- More face-to-face engagement to inform, involve people including senior leaders attending team meetings.
- Much more involvement of staff (all those impacted by a change/decision) and evidence of listening and understanding through actions not words.
- Communication has improved e.g. bulletin email and all-staff sessions, so we need to sustain these and offer other ways for people to be informed and involved.

4. What does listening and acting on staff feedback mean to you?

Actively listening to staff and taking appropriate action in response.

Summary
“Listen to hear, not just to respond”. Actively listening to staff and ensuring that everyone’s views are equally respected. Take the time to meet people in small groups so that they can share ideas, concerns and feedback, and involve people in the actions that follow. Seeing positive change in response to feedback is critical and an important part of people feeling valued. Also, people will understand if things are not possible as long as they are given feedback and clear reasons why ideas cannot be implemented. It was also noted that we need robust systems for routinely collecting and responding to staff feedback.

What changes should we make to ensure we are listening to and acting on staff feedback and what difference would you expect to see?

- Acknowledgement that listening and closing the loop have improved. Encouraged to continue with current channels of communication, including listening sessions and Bright Ideas, but continue to evaluate to make sure everyone is able to access these/participate.
- Have robust systems for people to give regular feedback/share ideas with clear evidence of change in response to feedback, or explanations about why things might not be possible. “We will SEE the differences”.
- Implement changes in response to feedback as quickly as possible and close the loop to help build trust and engagement. “You said, we did”.
- More meeting with people in teams/small groups face-to-face

5. What does leading with kindness and living our values mean to you?

Acting with kindness and respect for one another. Visible and compassionate leadership.

Summary
Emphasis on the importance of kindness, respect, and empathy within the organisation, particularly in a healthcare setting. Treating colleagues and patients with dignity, understanding individual challenges, fostering teamwork, and promoting a culture of compassion and support. Eliminate behaviours such as bullying, lack of empathy, and insincerity in leadership. Overall, the recurring theme is that kindness should not be just a superficial gesture but should be integrated into actions and the organisational culture, starting from leadership and extending to all staff members.

What changes should we make to ensure we are leading with kindness and living our values and what difference would you expect to see?

- Implement fair and equitable recognition practices by establishing clear and consistent methods to recognise and reward employees across the organisation. This includes initiatives such as Employee of the Month awards and day-to-day acknowledgements for smaller achievements.
- Foster a culture of transparency and inclusivity. This means promoting open communication channels where staff feel comfortable sharing their opinions and concerns. It involves regular meetings, feedback sessions, and ensuring that decisions are explained and discussed openly.
- Enhance visibility and accessibility of managers. Encourage managers to be present on the floor, interact with staff, and listen to their feedback. This includes visiting work areas, observing work firsthand, and being available for discussions.
- Improve working conditions and provide career development opportunities. This includes addressing concerns about working conditions, ensuring sufficient resources, and offering training, personal and professional development.

6. What does confidently raising concerns mean to you?

Systems for anyone to raise concerns safely, confidentially and have trust that their concerns will be acted on appropriately.

Summary
Listening to concerns respectfully, acting appropriately, and maintaining confidentiality. Assurance that raising issues won't lead to retribution or labelling. Clear processes and trust that managers will take things seriously. Some express frustration with existing systems that don't effectively address concerns, especially in environments where confidentiality and trust are lacking.

What changes should we make to ensure staff are confident raising concerns within the workplace and what difference would you expect to see?

- Promote open communication. Encourage all staff to freely raise concerns and suggestions without fear of punishment.
- Enhance confidential reporting. Implement a confidential email system for reporting concerns anonymously, ensuring privacy and feedback on investigations.
- Ensure accountability by setting clear procedures for investigating and addressing all reported concerns, followed up by designated individuals.
- Training and support. Offer managers training on confidentiality, and cultivating a supportive environment to make staff feel heard and appreciated.

NHS Orkney

Meeting:	**NHS Orkney Board Meeting**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Themes from Team Orkney feedback**
Responsible Executive/Non-Executive:	**Meghan McEwen, Board Chair and Laura Skaife-Knight**
Report Author:	**Laura Skaife-Knight, Chief Executive**

1 Purpose

This is presented to the Board for:

- Awareness

2 Report summary

This paper summarises the main themes from the Board walkarounds between June and August 2024.

2.1 Situation

In May 2023, Board walkarounds were introduced at NHS Orkney to improve the visibility of Board members and to ensure staff across the organisation felt heard and relationships strengthened.

This new approach was introduced in response to staff feedback, notably following low 2023 iMatter staff survey scores for Board visibility and specifically to recognise that as Board members we would find it helpful to gain an insight/deeper understanding into the work of our teams/different area of work.

Our Board walkarounds are part of a wider package of changes that were introduced in 2023/24 to further improve staff engagement, Board visibility and organisational culture.

Since the last update to the Board, the iMatter scores for 2024 have been received and provide evidence that scores have improved significantly in this area, which should be noticed. See below for more information.

Improvements to iMatter results - 2024

Our results tell us we are moving in the right direction and that the changes we made in 2023/24 are making a positive difference. Among the positive movements we have seen in the 2024 iMatter survey results are:

- Many more staff feel Board members are sufficiently visible (highest score increase of any question 2024 v 2023 - by 8 points from 53 to 61 score)
- Many more staff having confidence and trust in Board members (score 61 in 2004 compared to 57 in 2023)

2.2 Background

Board walkarounds were introduced in May 2023.

They involve an Executive Director and a Non-Executive visiting different teams and departments across NHS Orkney and listening to how it feels working here.

The walkarounds are an opportunity to listen, get to know each other and build relationships and hear firsthand what staff are proud of and any challenges they face, leading to how Board members can support to resolve and unblock issues.

The areas we cover in our conversations with staff are:

1) What is going well in your team/service at the moment?
    - What are you most proud of working in this area?

2) What do you consider to be the main challenges you face on a daily basis?
    - What feedback do people using this service give you?
    - If you could change one thing, what would it be?
    - what do you wish you had more time to do?

3) How can the Board help?
    - Is there anything that you would find helpful to raise to the Board?

4) What does patient safety look like in your area? (new question added in 2024/25 in Year 2 of our Board walkarounds)
    - Do you feel confident in reporting incidents or near misses?
    - Do you get enough feedback when you report incidents/near misses?
    - Do you feel there is enough support for you if you are involved in a patient safety incident?

5) Staff wellbeing: are colleagues aware of support available and have they been able to access that for staff as necessary?

There have been 22 Board walkaround between May 2023-August 2024 – including:

- Stromness Surgery
- Sanday GP Practice
- Maternity
- Peedie Sea Centre
- Pharmacy
- Community Mental Health
- Theatres
- Health Visitors and School Nursing
- Primary Care
- Dental
- Vaccination Centre
- Specialist Nurses
- Infection, Prevention and Control
- Macmillan
- Catering
- Public Health
- Finance and Procurement
- People and Culture
- Heilendi GP Practice
- Westray GP Practice
- Radiology
- Travel Administration Team

There have been three Board walkarounds between July and August 2024 – to Westray Surgery, Radiology and to our Travel Administration Team. Below is a summary of the feedback.

Main themes from these visits

Positive:

- Teamworking
- Excellent peer support network
- Successful recruitment
- A real focus on patients, patient care and patient experience
- Great examples of career development pathways

Areas for improvement:

- Challenging workloads
- Better discharge communication and understanding of the island context
- Poor connection with professional leadership structures
- Often a lack of clarity about how changes are decided, and how they will impact on teams
- Some processes, forms, and approvals are overly bureaucratic

- Lack of regular/dedicated Radiologist support
- Ongoing work around MRI provision

Next steps

In 2024/25, we will build further develop our Board walkabouts as follows:

- Will continue to be a standing agenda item at each public Board meeting
- In addition to Board walkabouts, (1) Executive Directors do informal visits in pairs as part of business as usual arrangements and (2) the Chair and CEO do monthly informal walkabouts
- There is a forward plan of Board walkarounds for the remainder of 2024/25 covering all clinical and non-clinical areas
- Better triangulation of feedback with wider staff experience metrics
- Ensuring that there is a distinction between strategic matters that need to be resolved and taken forward and quick wins that need to be followed through on and the appropriate routes are followed for each
- To ensure there is feedback to every team after the visit which captures the actions that have been taken/issues that have been resolved/unblocked to build confidence that Board members are listening to and acting on staff feedback throughout the year and that it is how we do things (ie closing the loop). The Corporate Governance Team lead on this process
- Expanding the focus of Board walkabouts to include conversations about patient safety (as described above)

2.3 Recommendation

- Awareness – For information only.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**NHSO Clinical Governance structure**
Responsible Executive/Non-Executive:	**Medical Director: Anna Lamont**
Report Author:	**Anna Lamont**

1 Purpose

This is presented for:

- Awareness
- Discussion

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Following the development of the Clinical Strategy in 2021 a revised Healthcare Assurance and Governance Quality Improvement Framework (HAGQIF) was proposed to formalise the operational and assurance roles of Clinical Governance. The HAGQIF was not subsequently developed and in the intervening years operational clinical governance was addressed through multiple groups, including the quality forum, professional advisory groups, incident review group, risk management forum, Senior Leadership Team (SLT) and the Joint Clinical and Care Governance Committee (JCCGC). The scheme of delegation for such groups under the SLT and JCCGC remained

unclear, and from February 2024, changes to the clinical governance and quality improvement were set out to the JCCGC and SLT to provide clear routes for operational clinical governance and to ensure each board committee received sufficient detail to enable critical scrutiny while ensuring transparency in the threshold for escalation for assurance.

Following consultation with stakeholders, the quality forum was moved to a quarterly clinical governance meeting to approve clinical processes and compile a summary clinical governance report for scrutiny by the JCCGC. The monthly quality forum meetings would continue to focus on quality improvement and receive recommendations from the risk management group and professional advisory groups. Population Health clinical governance issues have also been presented to the quality forum and will continue to be presented at the quality group.

Alongside the changes to the quality forum to formalise its operational clinical governance role, there have been changes to how risks are presented and scrutinised at a corporate level, with similar scrutiny being brought to operational risk management.

This paper summarises the current clinical governance roles and structure.

2.2 Background

Operational clinical governance and board assurance clinical governance represent two distinct levels of oversight and responsibility within a health board, each with its own focus and function. The following summarises the groups currently operating in NHSO to provide each function.

2.2.1 Operational Clinical Governance

Operational clinical governance is concerned with the day-to-day management and implementation of clinical governance processes at the service delivery level. This involves ensuring that clinical standards are consistently met and that patient care is delivered safely, effectively, and efficiently. Operational clinical governance requires that clinical governance processes are integrated into everyday practice, with a focus on immediate and practical application.

Key activities under operational clinical governance include:

1) **Monitoring and Managing Clinical Performance:** Regular review of clinical outcomes, population health, incidents, and audits to ensure that services are performing to expected standards.
    a) Weekly Incident Review Group (WIRG). Due to poor attendance at the meeting through 2024 the WIRG was frequently not quorate. Incidents are currently being reported and monitored through the monthly Clinical Quality group while the WIRG role and membership is reviewed. The weekly reports that were for the group to review are to be reinstated for sharing with SLT members for visibility.

b) Clinical Quality Group and Quarterly Clinical Governance Committee: Approval of clinical policies and Serious Adverse Event Reviews (SAER) reports. Quarterly reporting of clinical governance from services and wards to JCCGC.
c) Planned Care Programme Board: Scrutiny and delegated decision making from SLT for planned care and diagnostic imaging. While not solely a clinical governance group, this is referenced for completeness.
d) Waiting times review meeting: Consultant led weekly review of waiting lists.

2) **Risk Management:** Identifying, assessing, and mitigating risks in clinical practice to prevent harm to patients.
   a) Risk management group: Monthly review of operational risks and delegated risk registers, reporting to Audit and Risk Committee for scrutiny, and recommending escalation of operational risks to the Clinical Governance Committee.
   b) SLT: Operational management of the Corporate risk register.
   c) Local operational risk management groups, scrutinise local risks to report quarterly to the Risk management group.
3) **Staff Development and Support:** Ensuring that clinical staff are appropriately trained, supervised, and supported in their roles.
   a) Responsibility for approving what training, development and support is required in each role remains at the individual director level.
   b) Staff Governance Committee: Receives assurance through reports.
4) **Patient and Public Involvement:** Incorporating feedback from patients and the public into clinical service improvement initiatives.
   a) Feedback both positive and negative is managed within the patient safety, quality, and risk team. Reporting to SLT and the JCCGC
   b) Duty of Candour is applied by default to all Serious Adverse Event Reviews to include patient involvement, reporting to the Clinical Governance Committee.
   c) Improvement hub: Receiving, giving feedback, and developing on from suggestions for improvement from staff, patients and the community.
5) **Quality Improvement:** Implementing and overseeing quality improvement initiatives at the service level to enhance patient care.
   a) Clinical Quality Group to review and approve quality improvement reports.
   b) Improvement Hub: Operationally support quality improvement projects.

c) Planned Care board: to provide oversight and summary reporting to Audit and Risk Committee, and SLT.

6) **External Reporting:** Compiling, reviewing, and submitting required data and reports to external organisations including Scottish Government.
   a) Individual executives informed by professional advisory groups.
   b) Visibility of reporting to SLT, summary and approval structures require improvement.

2.2.2 Assurance Clinical Governance

Board assurance clinical governance operates at a strategic level for oversight and scrutiny that the organisation's clinical governance arrangements are robust and effective. The NHSO board is responsible for ensuring that the organisation has effective systems in place to manage clinical risks and deliver high-quality care. Key activities under board assurance clinical governance include:

1. **Strategic Oversight:** The board ensures that clinical governance strategies align with organisational goals and regulatory requirements.
2. **Assurance Processes:** Establishing frameworks, internal audit and reporting mechanisms that allows the board to monitor and review the effectiveness of clinical governance across the organisation.
3. **Risk Management and Mitigation:** The board assesses and oversees the organisation's approach to and appetite for clinical risks, ensuring that there are strategies in place to manage these risks at a systemic level.
4. **Accountability:** Holding senior management to account for the implementation of clinical governance and for addressing areas of concern identified through assurance processes.
5. **External Reporting:** Ensuring compliance with external regulatory requirements and standards.

These roles are delivered through the Committees chaired by non-executives delegated by the NHSO Board and IJB, primarily the JCCGC and Audit & Risk Committees.

2.3 Assessment

The revised operational Clinical Governance and quality improvement reporting structure was shared with JCCGC on 3rd April 2024, approved at the Audit and Risk Committee on 28th May, and presented to the board on 7th June 2024.

Reporting to the JCCGC now includes a summary clinical governance report from the Clinical Governance Committee. Following initial feedback and revision of the template for quarterly returns, the request to wards and departments was delayed from May till July 2024. Feedback from this first report presented in July will inform subsequent quarterly reports.

The summary report provides an update on areas of NHSO strategic, enabling, and underpinning activity of particular clinical relevance which the JCCGC should be sighted on, including:

- Where there is a new clinically related role, requirement, or risk for NHSO.
- Where there may be public or media interest.
- Where a major milestone has been achieved in relation to a strategic clinically- related programme.
- Providing assurance out-with annual reporting routes in relation to clinical executive responsibilities and the clinical workforce.

This aims to facilitate the roles of the Board and delegated Non-Executive committees to review and scrutinise reports on NHSO programmes in support of clinical services; and assure that advice is provided, as required, to the Board on the clinical impacts of any major new service developments or changes proposed for adoption by NHSO.

The diagram at Appendix 1 illustrates the core operational clinical governance structure for accountability, delegation and reporting of clinical governance. This was shared with the board in June and is included here for reference. Clinical advisory groups report into and advise the ACF but are not shown. The clinical advisory groups include GP Sub Committee, NAMAC (Nursing and Midwifery), TRADAC (AHP's), Hospital sub Committee, Area Medical Committee, and Area Dental Committee. Not all the clinical advisory groups are active at present, and review of participation and activity of the groups is scheduled for Q2-Q3 24 to inform

2.3.1 Quality/ Patient Care

The revised approach is intended to enhance quality, population health, and patient care, including sharing of best practice and clear approval routes for change.

2.3.2 Workforce

It is essential that the Clinical Governance structure empowers staff and does not unnecessarily add to the administrative burden.

2.3.3 Financial

Escalation and reporting of Clinical Governance concerns will indirectly reduce the financial risks of improvement/change programmes.

2.3.4 Risk Assessment/Management

Following initial feedback on the template for quarterly CG return, the request to wards and departments was delayed from the April JCCGC for reporting in July. Feedback from that meeting will inform the next quarterly report.

2.3.5 Equality and Diversity, including health inequalities

No equality or diversity impacts are anticipated.

2.3.6 Climate Change Sustainability

No anticipated impact on climate change or environmental sustainability

2.3.8 Communication, involvement, engagement and consultation

The revised schedule of reporting and structure was initially shared at the February JCCGC. Members of the Clinical Quality Group have supported revision of the group. The revised operational Clinical Governance and quality improvement reporting structure was shared with JCCGC on 3rd April 2024, approved at the Audit and Risk Committee on 28th May 2024, and presented to the board on 7th June.

2.4 Recommendation

To note the reporting structure for clinical governance.

2 List of appendices

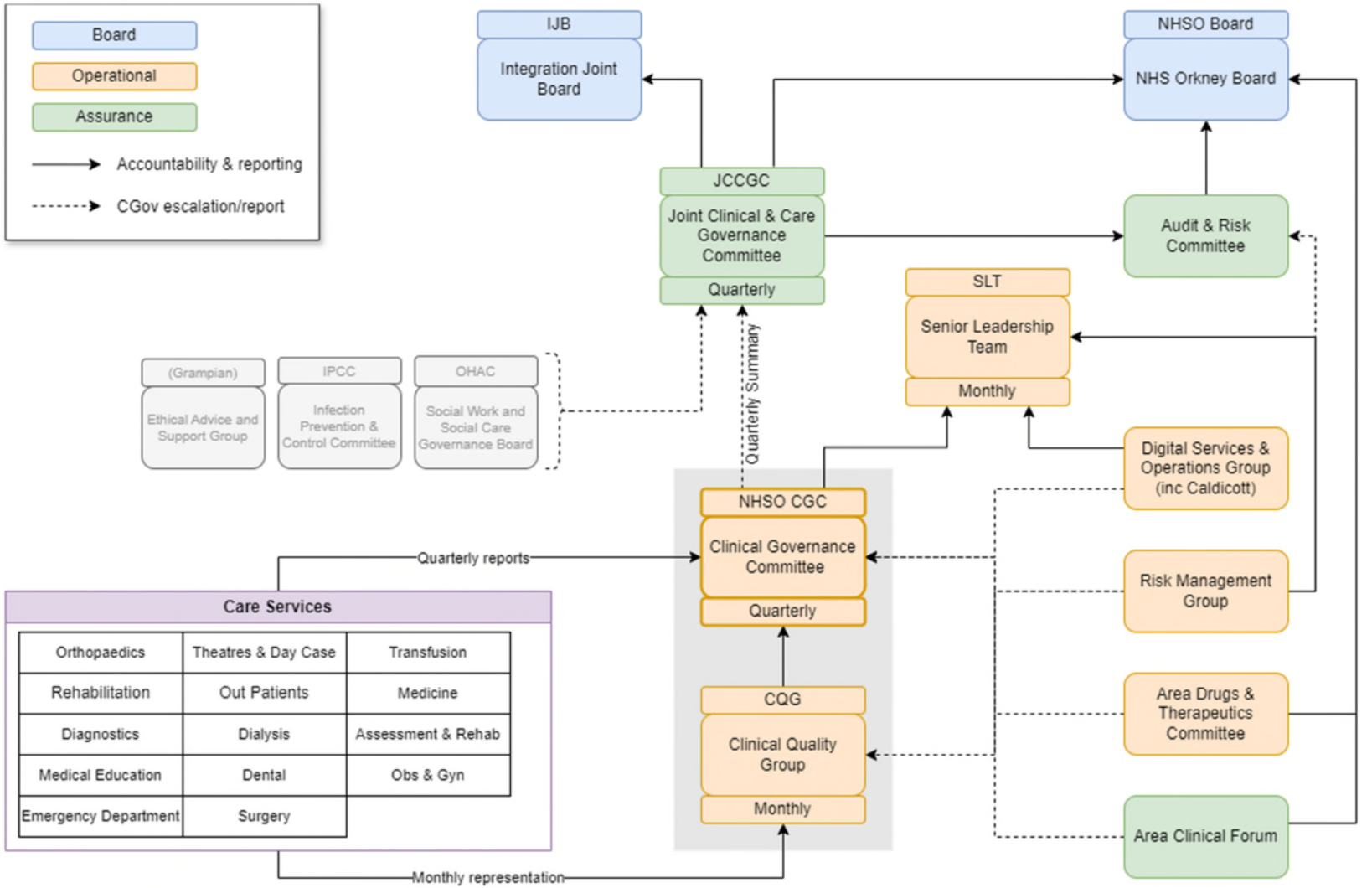
The following appendices are included with this report:

- Appendix 1. Core operational Clinical Governance reporting chart.
    - The version number of the chart has been updated from that shared with the board in June 2024 as the title has been changed and reference to the previous Quality Forum has been removed.
- Appendix 1. Clinical Governance Quarterly Return Template
    - This was previously shared with the board in June and is included here as part of the summary of reporting.

Appendix 1.

Operational Clinical Governance Reporting

v1.09



Appendix 2

Clinical Governance Quarterly Return Template

V1.2 23-5-24

Introduction

This template is for reporting on the clinical governance and strategic activities within NHS Orkney (NHSO), from each speciality and activity area. The aim is to give insight into ongoing efforts, challenges, and planned initiatives to advance healthcare quality and patient safety across the organisation. This return should be completed quarterly and sent to the clinical governance mailbox. The reports will be discussed at the Clinical Governance Committee (previously Quality Forum) with agreement reached on what parts of the returns will be included in the quarterly report to the Joint Clinical & Care Governance Committee (Joint CCGC).

Completing the form

- Focus on clinical governance activities requiring board-level awareness and assurance.
- Include critical issues, **positive achievements**, and planned initiatives for informed oversight.
- Use bullet points and brief notes, the additional information page is optional to expand on points raised.
- The text and headings in the boxes are for guidance only
- **Please return completed reports to ork.clinicalgovernance@nhs.scot**

Throughout this return, the NHS Scotland quality dimensions should be considered:

- Safe: Ensuring that clinical environments are safe for patients, families, and staff.
- Effective: Providing evidence-based care with optimal outcomes for patients.
- Person Centred: Delivering clinical services that are equitable and responsive to individual patient preferences, needs, and values.
- Sustainable: Promoting financial and environmental sustainability and efficiency in the delivery of healthcare services.

By adhering to this structured approach, we aim to maintain high standards of clinical care, address any areas of concern promptly, and plan effectively for future improvements in line with the NHS Scotland quality ambitions. Feedback is also welcomed on the template and suggested improvements. Thank you.

Date		Completed by: Name	
Department/Area		Role	

Awareness

Public/Media Interests:
Description of any clinical governance matters that have or may in future attract public or media attention during the quarter.
Actions taken in response to public/media interest and outcomes achieved.

Assurance:
Summary of audits, inspections, and reviews conducted in the quarter, including key findings.
Overview of compliance with national standards and regulations.
Assurance statements on the integration and effectiveness of clinical governance practices across NHSO.

Any Other Business:
Highlight any additional information not covered in other sections that the Medical Director should be aware of.

Do Next

Upcoming Key Initiatives:
Outline of initiatives planned for the next quarter that support the NHS Scotland quality dimensions (safe, effective, person centred, sustainable).
Expected outcomes and impact on patient care and service delivery.

Actions and Dependencies:
Actions required to implement the key initiatives, including responsible teams or individuals. Include Dates.
Identification of any dependencies or support needed from other parts of the organisation or external partners

Concerns / Risks / Issues

Local Risks and Issues:
Outline new or ongoing risks and issues impacting clinical governance and patient safety.
Mitigation strategies and actions taken to address these risks and issues.

Additional information

Optional – for additional information not included or additional detail

NHS Orkney

Meeting:	**NHS Orkney Health Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Quality Impact Assessment (QIA) Progress Report**
Responsible Executive/Non-Executive:	**Anna Lamont, Medical Director**
Report Author:	**Anna Lamont, Medical Director** **Phil Tydeman, Director of Improvement**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to provide the Board with a progress update on the work of the Quality Impact Assessment (QIA) panel as well as the findings from the panel assessment held on 01 July 2024.

NHS Orkney is required to deliver £4m (6%) in-year efficiency savings as part of its commitment to return to financial balance and achieve a model of financial sustainability. NHS Orkney submitted a plan to the Scottish Government to deliver £2.9m recurrently (72%) and £1.1m (28%) non-recurrently this financial year.

Maintaining the safety and quality of services alongside the delivery of cost improvement schemes is a core requirement of the programme. While it is entirely possible to protect and enhance quality while reducing costs, this cannot be assumed. Processes must be in place to ensure that planned service or efficiency changes do not have unintended or adverse consequences on quality of care. This is crucial in a hospital system, where decisions in one part of the service can impact another, with many co-dependencies that are not always easy to predict or assess.

A QIA Panel and set of processes was therefore designed to maintain and support the safety and quality of services. This report outlines the key findings of the QIA panel and details the ongoing efforts to effectively monitor the potential impact of the efficiency programme on patient care.

The Board is asked to note:

(a) the findings of the QIA Panel Assessment held on 01 July 2024, and the next planned QIA panel on 10 September.

2.2 Background

A total of 10 workstreams comprise the efficiency programme which has identified productivity and efficiency savings of £3.75M in-year savings and £3.9M full-year savings by Month 4.

On 01 July 2024, the QIA Panel reviewed 27 schemes: 11 required a pre-QIA review, and 16 required a full-QIA review. Each scheme had validated savings and categorised as shown in Table 1.

Table 1: CIP schemes reviewed by the QIA Panel

CIP Category	Total Number of 'pre-QIA reviews'	Total Number of 'full-QIA reviews'	Total No. of QIA Reviews
Budget Releasing	11	7	18
Run-rate Reduction	0	9	9
Total	**11**	**16**	**27**

Table 2 shows the number of CIP schemes currently pending QIA review, which will be assessed by the QIA Panel on 10 September 2024.

Table 2: CIP schemes currently pending QIA review

CIP Category	Pending QIA Review
Budget Releasing	6
Run-rate Reduction	1
Total	**7**

Schemes designated as ‘pipeline’ have not been included however these are captured on the programme tracker. As schemes move from pipeline to pending QIA review, these will be included in future reports.

2.3 QIA Methodology

A set of core principles were agreed as part of the QIA process and methodology.

(a) All CIPs were subject to a full QIA where they were patient-focused and had a direct impact on the delivery of a clinical service or on workforce numbers.
(b) Each CIP scheme had a Senior Responsible Officer, Delivery Lead, and, where clinical, a Clinical Lead who completed the QIA.
(c) The QIA template was issued to the Delivery Lead and Clinical Lead responsible for each workstream for completion and sign off.
(d) All eligible proposed schemes were assessed for their potential effect on patient care and are risk assessed against the three domains of quality below:

(i) **Safe** *Outline the risks/s the scheme may impact on current safety systems in place which safeguard patients and harm, including infections)*

(ii) **Effective** *(Could the scheme impact on evidenced based practice, clinical engagement, clinical leadership, patient outcomes, regulatory requirements, or care standards)*

(iii) **Person Centred** *(Does the scheme have the potential to negatively impact on Person Centred Care?)*

(e) All schemes were required to complete a pre-QIA. Those with an overall risk score below 9 were deemed unlikely to have a material negative impact and did not require a full QIA. Pre-QIAs with an overall risk score above 9 necessitated a full-QIA.
(f) Final sign-off of the CIPs and associated workforce plans is the responsibility of the Medical Director and Director of Nursing, Midwifery, AHPs, and Chief Officer - Acute.
(g) Schemes can only progress into implementation and delivery once approved by the QIA Panel to safeguard against unwarranted and negative impacts on staff, clinical delivery, and patient care.

The pre-QIAs and full-QIA’s were then collated and presented to the Medical Director and Director of Nursing, Midwifery, AHPs, and Chief Officer Acute to review and consider the individual impact of workstreams on clinical service, patient experience, or workforce; as well as the impact of the totality of schemes on the organization, recognising the implicit interdependencies across the recovery programme.

2.4 Assessment

A total of 27 schemes were reviewed by the panel, with 19 signed off for implementation, 5 requiring additional information, and 3 schemes removed from the programme. This reflects the level of rigour and challenge applied through the panel and the time and consideration given to patient care and clinical safety.

The panel requested additional information on the following schemes shown in Table 3 below.

Table 3: Schemes requiring additional information

Workstream	Schemes requiring additional information	Information to return to QIA Panel
Estates & Facilities	Accommodation Charges & Policy Review	Agreed with CIP increase, in principle. However, this should be a loss mitigation scheme as accommodation is funded by NHSO, except for students.
Workforce Workstream	Reduction of Agency Spend & Temporary Staffing – Nursing (Acute)	Approved in theory, but POAP and QIA documents are required to formally approve the scheme.
	Reduction of Agency Spend & Temporary Staffing – (Health Science)	Figures and narrative need to be cross-checked as this may cover nurses rather than Health Science.
	Reduction of Overtime – Clinical (Acute)	A combined QIA exists for Clinical and Non-clinical Overtime, separate QIAs are required.
	Reduction of Overtime – Non-clinical (Acute)	There is a combined QIA for Clinical and Non-clinical Overtime. However, separate QIAs are required.

The schemes listed in Table 4 were not approved by the Panel and were removed from the programme due to a lack of realisable savings for 2024/25.

Table 4: Schemes removed from the Programme

Workstream	Schemes removed from programme	Reason for removal
Diagnostics	2023/24 CF – Repatriation of MRI Patient Radiology	The savings for 2023/24 were taken from the 2023/24 efficiency programme. No savings for 2024/25.
Workforce	Posts removed / delayed as part of the Cost Pressures exercise Feb 24 (Non-recurrent) (1) Chaplain and Spiritual Care (Bank Band 6 (2) Chaplain and Spiritual Care (Band 7)	The budget is currently allocated to a Band 7 temporary staff member covering this position. The Spiritual Care Policy is being redrafted and the job description will be reviewed thereafter. No savings anticipated.

Monitoring and Performance

Monitoring the quality impact of the CIPs will be maintained throughout the year as part of general performance framework. The next QIA Panel is scheduled for 10 September

2024, with 7 CIP schemes currently pending QIA review. A QIA progress report will be presented quarterly to the Joint Clinical and Care Governance Committee (JCCGC).

2.5.1 Quality/ Patient Care

The QIA template includes quality and patient care measures and includes scoring on the principles of realistic medicine. The QIA process helps to identify potential risks and unintended consequences of changes in service delivery, ensuring these risks are mitigated before implementation.

By assessing the impact of CIPs or service changes on patient care, QIAs help ensure that safety standards are upheld and that any negative effects on patient safety are addressed.

2.5.2 Workforce

The workforce impact is considered as part of the QIA process.

2.5.3 Financial

The Improving Together Efficiency Programme is a key part of improving NHS Orkney's financial position and achieving financial balance. The QIA process is fundamental in supporting this programme by ensuring CIP schemes are thoroughly assessed and approved before implementation.

2.5.4 Risk Assessment/Management

The QIA process helps to identify potential risks and unintended consequences of changes in service delivery, ensuring these risks are mitigated before implementation. Each QIA includes a risk assessment on the individual schemes.

2.5.5 Equality and Diversity, including health inequalities

Equality and Diversity implications are considered as part of the QIA scoring. Dignity and respect of staff groups, patients, and existing services needs to be considered in all decision making.

2.5.6 Climate Change Sustainability

The impacts of climate change and sustainability are considered as part of the QIA scoring.

2.5.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

All QIAs involved engagement with the following staff groups:

- Workstream Senior Responsible Officers
- Delivery Leads
- Clinical Leads
- Workforce Leads
- Finance Leads

There was strong evidence of engagement with clinical teams in the development of CIP schemes.

2.4.7 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Improving Together Delivery Group, 16 July 2024
- Improving Together Programme Board, 29 July 2024

3. Recommendation

The Board is asked to note:

(a) the findings of the QIA Panel Assessment held on 01 July 2024, and the next planned QIA panel on 10 September.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Table 5: Breakdown of Pre-QIA Schemes
  Table 6: Breakdown of Full-QIA Schemes

Appendix 1

Table 5: Approved Pre QIA-Schemes

Workstream	Scheme	24/25 IY Savings	24/25 FY Effect Savings	QIA Comments
Estates & Facilities	Disposable Food Containers	£2,699	£3,598	Approved, pending liaison and agreement with Infection, Prevention & Control regarding the cleaning of reusable containers on the wards.
Pharmacy	Proprietary switch to generic medicines 24/25 – Apixaban (Acute)	£4,500	£4,500	Approved.
Pharmacy	Community Dressings – Improvement Initiative	£10,500	£10,500	Approved.
Procurement	Reducing Stock Levels – Budget Checker in Pecos	£150,000	£180,000	Approved. Some issues have arisen so need to ensure all mitigations are covered.
Procurement	Streamlining Stock Management – Ward Top-up Amendments	£17,250	£20,700	Approved. Ensure all sign-off processes are covered.
Procurement	Streamlining Stock Management – Stores Levels Reduction	£28,600	£31,200	Approved. Ensure all sign-off processes are covered.
Procurement	Quarterly No-buy Week for the NDC	£30,000	£30,000	Approved. Ensure all sign-off processes are covered.
Social Care & Community (IJB)	Ayr Clinic SLA	£116,667	£200,000	Approved. Ensure all contingencies are covered.
Social Care & Community (IJB)	Reserves Contribution Towards Non-Recurring Savings 2024/25	£500,000	£500,000	Approved under non-recurrent and reflects the shortfall in services, but concerns raised that many projects are delayed rather than underspent.

Table 6: Approved Full-QIA Schemes:

Workstream	Scheme	24/25 IY Savings	24/25 FY Effect Savings	QIA Comments
Cancer	Endoscopy: Introduction of nurse led Capsule Sponge-on-a-String OGD Service	£108,248	£144,431	Approved. Implementation funding has ceased. An agreement will be reached on training and developing staff to conduct clinics. An implementation plan needs to be developed.
Diagnostics	Repatriation of MRI Patients	£277,618	£277,618	Approved.
Diagnostics	Expansion of Echocardiogram Service	£138,345	£237,163	Approved.
Estates & Facilities	Estates & CDU Redesign	£0 – (TBC)	£0 – (TBC)	Approved.
Pharmacy	Poly-Pharmacy Reviews	£21,000	£21,000	Approved.
Pharmacy	Script switches (Medicine Switches)	£10,000	£40,000	Approved.
Social Care & Community (IJB)	Reduction of Agency Spend & Temporary Staffing)	£125,000	£125,000	Approved.
Workforce	Reduction of Agency Spend & Temporary Staffing – Medical (Acute)	£300,000	£300,000	Approved. The establishment will be reviewed in July, with recruitment plans and expressions of interest to proceed as soon as possible.
Workforce	Consultant in Public Health (Band 8D) removed – Cost Pressures Exercise	£28,579	£28,579	Approved. Contingency plan required for population health requirements.
Workforce	Vacancy Control Panel Target 24/25	£400,000	£400,000	Approved. Part of BAU and correct processes in place and followed appropriately.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Safety, Quality and Experience Report**
Responsible Executive/Non-Executive:	**Anna Lamont, Medical Director**
Report Author:	**Kat Jenkin, Head of Patient Safety, Quality and Risk**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This is a new report to support the organisational aim of focusing on patient safety, experience, and quality of care. The report looks at incidents, serious adverse events (SAE), patient feedback and quality related to these as well as projects across the organisation. The report will develop and as it matures the aim is to be able to provide much richer information around quality improvement in relation to incidents and themes and trends, as well as work around Excellence in Care (EiC) and the Scottish Patient Safety Programme (SPSP).

This report is intended to be quarterly and therefore, future reports will be presented a quarter in arrears to allow time for response and investigation time limits to be met.

The aim is to collate themes and trends across all aspects of safety, quality, and experience, but due to the current issues with the integrated incident, risk management and patient safety system (IIRMPS), currently this is not possible.

This partial report has been presented to SLT for review and discussion and SLT have supported this report being presented quarterly as set out above. The fully quarter one report will go to SLT in September 2024 and then on to JCCGC in October 2024 as per the quarter in arrears.

The Board are asked to review the attached partial report and discuss and give feedback on the report.

2.2 Background

Historically there has been several different reports looking at different aspects of safety, quality and experience, separately. This report is designed to bring these together, highlight and provide oversight of areas of excellence and learning as well as areas for improvement. Currently the patient experience and complaints report has been presented as a separate report, this will now make up part of this report, this report was also presented a quarter in arrears.

2.3 Assessment

The presented report is not complete as the quarter wasn't complete at the time of submission to SLT and to ensure good governance the full report will go through SLT and JCCGC prior to coming to the Board; therefore, the first two months of the year have been presented.

As part of the work to ensure that learning is shared and that action plans are completed this report will include information about SAE including learning summaries from closed SAE and an update on action plans. This is not included in this report as they are currently going through the internal clinical governance structure.

2.3.1 Quality/ Patient Care

The aim of this report is to evidence and provide assurance of areas of excellence supporting quality and good patient care. The report will also highlight areas that are being reviewed and plans to improve the quality and standards of care.

2.3.2 Workforce

The report will celebrate where our workforce is demonstrating good practice and supporting positive patient experiences, but also highlights areas where support is needed to improve care.

2.3.3 Financial

There are no financial impacts identified with this report.

2.3.4 Risk Assessment/Management

Through the identification of themes and trends and review of incidents and complaints, the organisation is enabled to identify areas of increased risk and to formulate mitigating actions to address these. This report supports this process.

2.3.5 Equality and Diversity, including health inequalities

There is no identified impact with this report.

2.3.6 Climate Change Sustainability

There is no identified impact with this report.

2.3.7 Other impacts

There is no identified impact with this report.

2.3.7 Communication, involvement, engagement and consultation

This report has been prepared in consultation with the Safety, Quality and Risk team and areas of quality improvement have been discussed with the service responsible for the project.

2.3.9 Route to the Meeting

This report has been prepared for this meeting only, once agreed the full quarterly report will be brought back for review and discussion and will then be presented to the committees with responsibility for safety, quality and experience.

2.4 Recommendation

It is asked that the Board receive this report and discuss the content and layout. They members are asked to provide feedback in terms of this.

- **Discussion** – To discuss the attached report and feedback comments to support the development and improvement of the quarterly report.

3 List of appendices

The following appendices are included with this report:

- Appendix one: Safety, Quality and Experience Report – April and May 2024

Safety, Quality and Experience Report

Safety Quality and Risk Team

April and May 2024

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Serious Adverse Events (SAE) 6
Themes and Trends from SAE Recommendations 7
Analysis 8
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Conclusion 14

Introduction

Patient safety, the quality of our services and the experience of our service users is fundamental to the work that the Safety, Quality and Risk team undertake. This report is a new report which brings together a number of aspects to provide the organisation with information to stimulate discussion, provide guidance on areas of good practice and quality, and celebrate these, as well as identify areas for improvement.

This report will be a quarterly report to fit with the reporting requirements, and to provide meaningful data. This first report however will be two months covering the first two months of this financial year, April and May 2024, to demonstrate how the information will be laid out.

Previously the complaints and feedback report has been submitted separately to safety and quality reports. The quarterly reporting is a requirement from Scottish Government, this will now be collated into this report, so that we can look at themes and trends across all aspects of safety, quality, and experience to give the organisation a richer narrative and to identify areas of concern.

There are some difficulties looking at themes and trends for several reasons. These include the categorisation for incidents, feedback and complaints being different, so often, the categories cannot be matched. It has also been noted that the initial categorisation may change as an incident is investigated and therefore when looking at themes and trends, this may not be accurate until the time of closure and final checking has been completed.

Over the coming months this report will be revised, and the information provided and the format of this may change. This will be done through the clinical governance groups and with feedback from the these and the committees this paper will be presented to.

Safety

The organisation records and manages its incidents through an Integrated Incident, Risk Management and Patient Safety system (IIRMPS). This allows us to look at trends and themes in incidents across the organisation. We are working on looking at themes collated from different areas including incidents, complaints, and risk. We have not achieved this yet but are looking at ways that we can do this in the future.

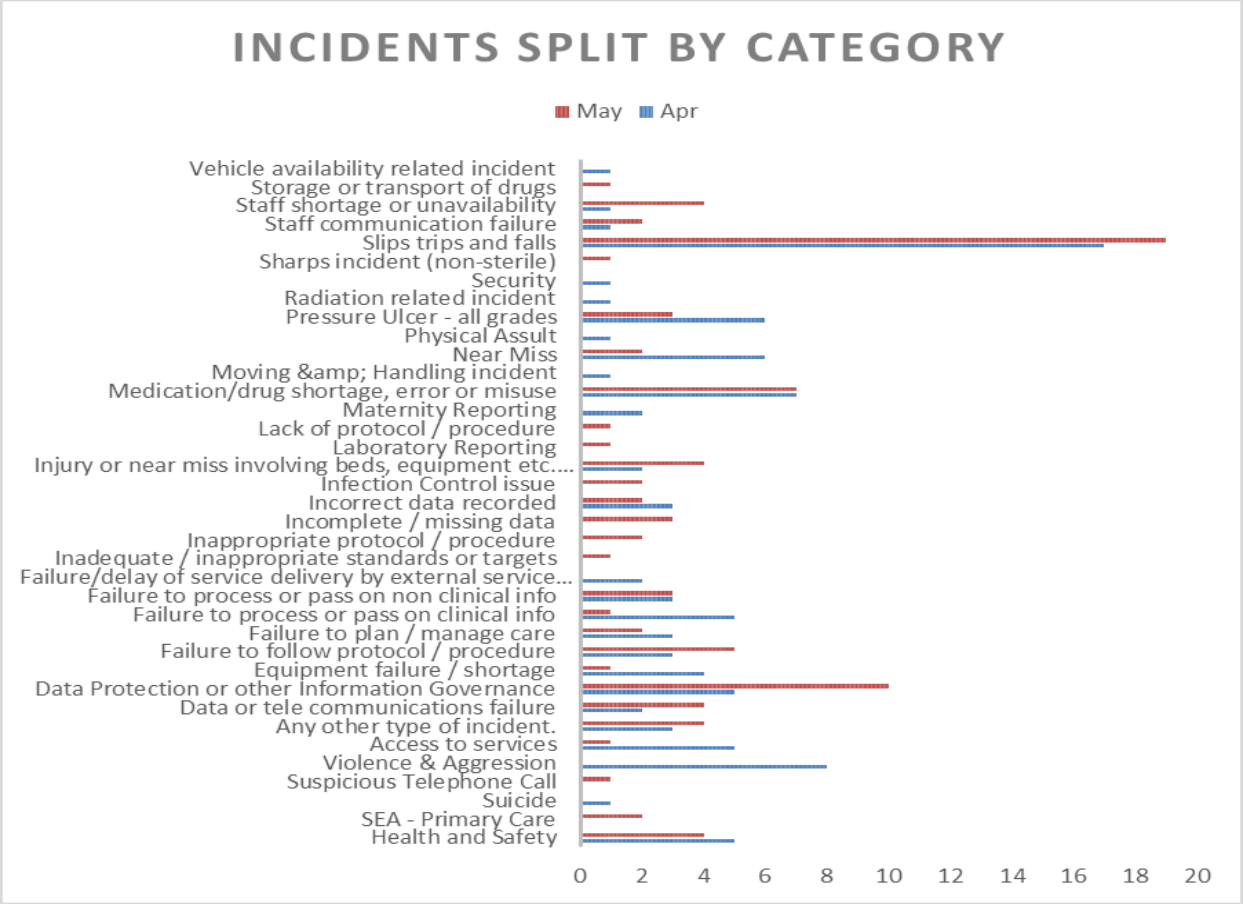
Incidents

Reporting of incidents and near misses help the organisation in learning, improving and maintaining patient safety. Themes and trends are reviewed to identify increases / decreases and reasons for this. We also look at what services the incidents and near misses occur in and what the trends of these are. This helps us identify areas that we

may need to look at in more detail. Serious adverse events are also identified through this system. These will be looked at in another section.

	April 2024	May 2024
Number of Incidents reported	99	93
Number of rejected Incidents	2	0
Number of Incidents closed	64	43
Total number of open Incidents	33	50
Number of overdue incidents for the month	31	40
Total number of overdue Incidents	337	377

We have been looking at options to reduce the numbers of overdue incidents. The discussions will continue to take place through the clinical governance groups and when an option is decided this will be escalated to SLT for agreement. The number has reduced over the last few months.


INCIDENTS SPLIT BY CATEGORY
May
Apr
Vehicle availability related incident
Storage or transport of drugs
Staff shortage or unavailability
Staff communication failure
Slips trips and falls
Sharps incident (non-sterile)
Security
Radiation related incident
Pressure Ulcer - all grades
Physical Assult
Near Miss
Moving & Handling incident
Medication/drug shortage, error or misuse
Maternity Reporting
Lack of protocol / procedure
Laboratory Reporting
Injury or near miss involving beds, equipment etc....
Infection Control issue
Incorrect data recorded
Incomplete / missing data
Inappropriate protocol / procedure
Inadequate / inappropriate standards or targets
Failure/delay of service delivery by external service...
Failure to process or pass on non clinical info
Failure to process or pass on clinical info
Failure to plan / manage care
Failure to follow protocol / procedure
Equipment failure / shortage
Data Protection or other Information Governance
Data or tele communications failure
Any other type of incident.
Access to services
Violence & Aggression
Suspicious Telephone Call
Suicide
SEA - Primary Care
Health and Safety
0
2
4
6
8
10
12
14
16
18
20

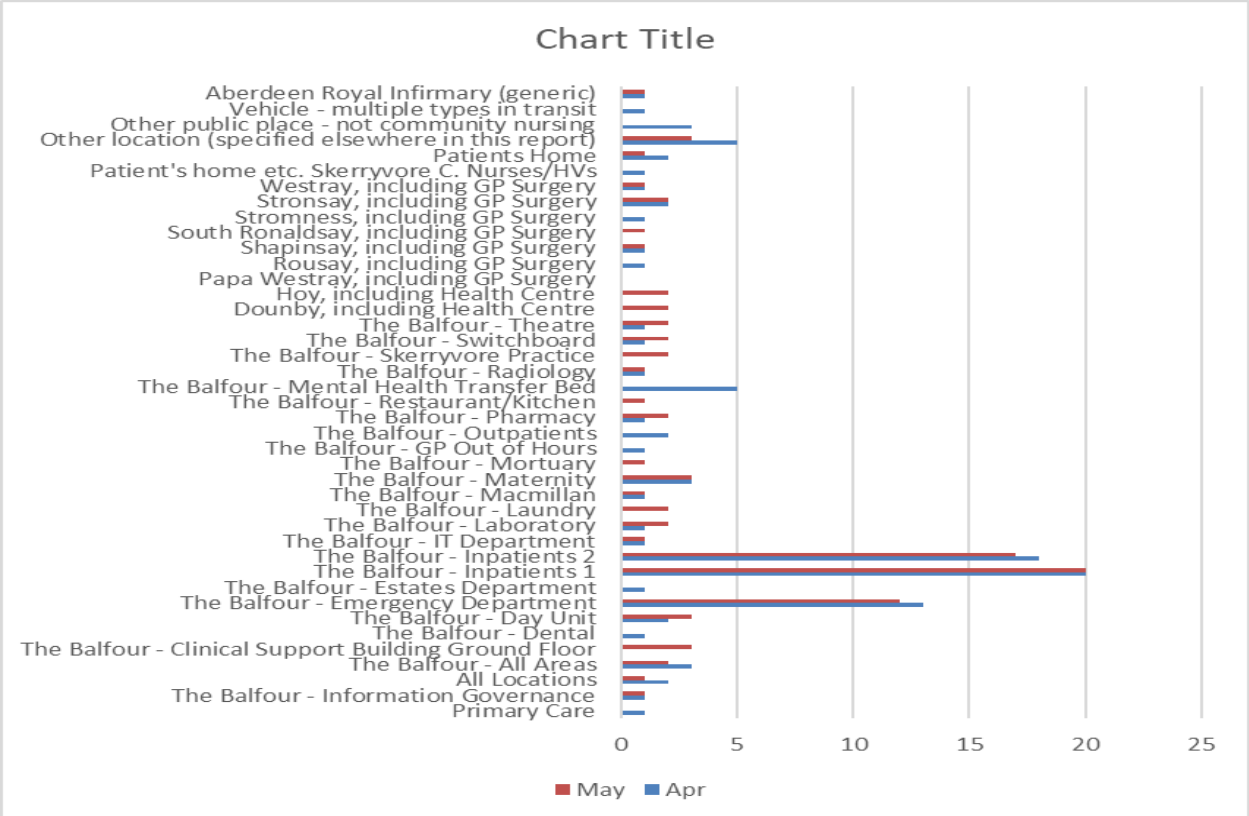


Chart Title
Aberdeen Royal Infirmary (generic)
Vehicle - multiple types in transit
Other public place - not community nursing
Other location (specified elsewhere in this report)
Patients Home
Patient's home etc. Skerryvore C. Nurses/HVs
Westray, including GP Surgery
Stronsay, including GP Surgery
Stromness, including GP Surgery
South Ronaldsay, including GP Surgery
Shapinsay, including GP Surgery
Rousay, including GP Surgery
Papa Westray, including GP Surgery
Hoy, including Health Centre
Dounby, including Health Centre
The Balfour - Theatre
The Balfour - Switchboard
The Balfour - Skerryvore Practice
The Balfour - Radiology
The Balfour - Mental Health Transfer Bed
The Balfour - Restaurant/Kitchen
The Balfour - Pharmacy
The Balfour - Outpatients
The Balfour - GP Out of Hours
The Balfour - Mortuary
The Balfour - Maternity
The Balfour - Macmillan
The Balfour - Laundry
The Balfour - Laboratory
The Balfour - IT Department
The Balfour - Inpatients 2
The Balfour - Inpatients 1
The Balfour - Estates Department
The Balfour - Emergency Department
The Balfour - Day Unit
The Balfour - Dental
The Balfour - Clinical Support Building Ground Floor
The Balfour - All Areas
All Locations
The Balfour - Information Governance
Primary Care
0
5
10
15
20
25
May
Apr

Analysis

Currently we are unable to pull the numbers of overdue incidents in the month as the system will not allow us to do this. We are speaking with RLDatix who design the system and they are looking at a way to do this.

There was a small decrease in the number of incidents reported in this reporting period. As the report progresses, we will be able to see trends across the year.

As would be expected there is a greater number of incidents reported in the inpatient acute areas. There was an increase in the mental health transfer bed, but these relate to one incident, completed by multiple people involved. Slips, Trips and Falls was the highest reported category for both months. Unfortunately, this category is used to report falls as well as assisted to chair or floor as well, to split these out would be difficult, but as part of the review of the IIRMPS this will be looked at. Medication incidents and information governance follow as the second highest reported incidents. None of the information governance incidents recorded were reportable under the General Data Protection Regulations (GDPR) and consisted of mostly internal emails being sent to the incorrect person. Medication incidents is a large category with no trend in the type of medicine incident reported.

Slips, trips and falls remains the highest reported category. There has been work looking at these and how to improve the identification of patients at risk of falls and how to manage these as well as managing care following a fall. This is also looked at within the section below.

Serious Adverse Events (SAE)

SAE are incidents that have resulted in serious harm or death. With all SAE, we manage them as if organisational duty of candour applies and offer an apology to the patient, invite them to be involved in the review of the incident and what a review entails. Once the review has concluded we offer an opportunity to meet with the team to go through the report and answer any questions they have and give them a copy of the report. It may be that once the review has concluded that organisational duty of candour is deemed not to apply, but that does not change the process as this supports us being open and honest.

The policy and processes for the management of SAE is being reviewed and revised to support reviewers in completing reviews in a timelier manner. We have reduced the numbers of overdue SAE and continue to work to complete and close these. The action plan template for SAE has been reviewed to ensure that all actions are SMART (specific, measurable, achievable, relevant and time-bound) and the process for the management of these, ensuring that they are reviewed and completed, has been revised to include oversight through the governance structure.

	April 2024	May 2024
Number of SAE reviews commissioned	2	0
Number of SAE reviews completed	1	0
Number of SAE reviews open	5	5
Number of SAE reviews overdue	3	3

Closed SAE reviews that meet the Duty of Candour (DoC) and the category of harm

	April 204	May2024
Number of closed SAE reviews that met DoC	1	0
Type of Harm		
A person died		
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions		
A person's treatment increased	1	
The structure of a person's body changed		
A person's life expectancy shortened		
A person's sensory, motor or intellectual functions were impaired for 28 days or more		
A person experienced pain or psychological harm for 28 days or more		
A person needed health treatment in order to prevent them from dying		
A person needing health treatment in order to prevent other injuries as listed above		

Themes and Trends from SAE Recommendations

SAE reports are presented along with learning summaries and the action plans to the Clinical Quality Group (CQG) and Clinical Governance Committee (CGC). The learning summaries will also be shared with the Senior Leadership Team (SLT) as part of this

report. The action plans are followed up through the CQG and CGC to ensure that actions are completed, and assurance is provided to the Board through the Medical Directors report.

The following are themes through the SAE closed in this reporting period:

- Poor record keeping
    - Illegible writing
    - Incomplete records/lack of documentation
- Need for clinical pathways and engagement with specialist services external to NHS Orkney
- Need for robust follow-up and signoff of clinical investigations
- Need for clearer processes to contact Locum/bank staff members when no longer working within NHS Orkney

Analysis

Within the SAE a consistent concern (including previous SAE) is documentation. This is across the multidisciplinary team (MDT), with illegible writing, lack of dates and times, missing signatures, and countersignatures – inability to put a clinician to an entry. There were also incidences where care had been undertaken and could be described verbally but had not been written in to the notes. A clinical audit will be undertaken to look at what areas need to be improved within record keeping, so a plan to address these areas can be formulated.

The organisation follows best practice clinical guidance, but in some areas where the speciality does not sit without the Board, the referral and lines of communication need to be reviewed and tightened to support swift referral if required.

Quality

Learning does not stop at the completion of an action plan. Learning shows implementation and improvement. The evidence of quality and quality improvement is an ongoing process that may involve continuing clinical audits and recognising trends in incident and near miss reporting as well as patient feedback.

As this report matures this section will include more information around quality within the organisation. This first report will be looking at areas of quality improvement and how this has linked to safety above and the experience section following. We will be including the EiC and SPSP work in future as well as improvement that has come from reviews.

Learning from Incidents and SAE

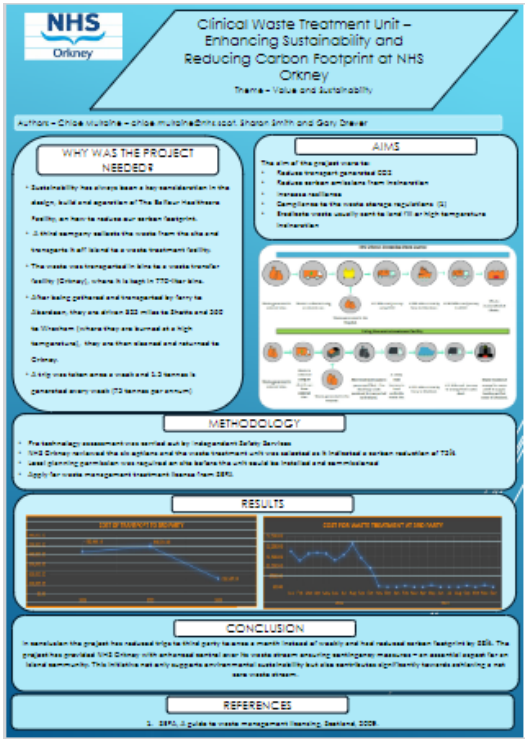
Falls

An area that has come up repeatedly within incidents and has been the reason for a couple of SAE reviews is falls. The recommendations were around training for our workforce to support them in decision-making around recognition of risk, assessing the fallen patient and using the appropriate equipment to assist the patient. Work has taken place around manual handling and using the correct equipment to transfer a fallen patient to their bed.

Quality Improvement Projects

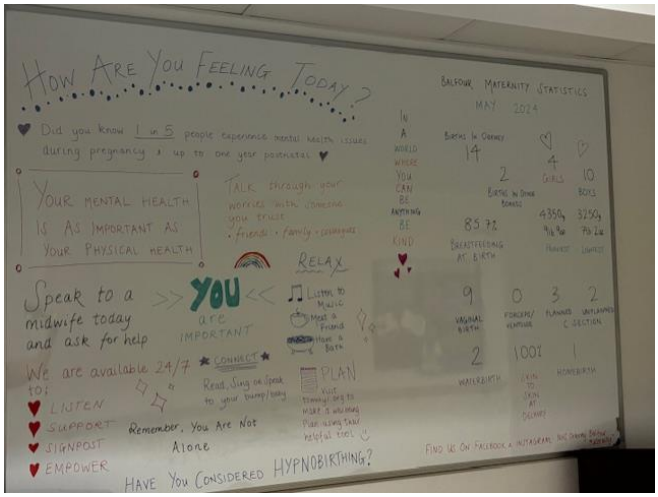
The NHS Scotland Event 2024 took place in Glasgow on 10 June 2024. As part of this there was an opportunity for organisations to submit posters showcasing some of the areas of quality improvement. There were multiple categories for this, with NHS Orkney submitting a poster to the value and sustainability category. We were selected to participate in the final of this and the poster, designed by Chloe Mulraine with Sharon Smith and Gary Drever being part of the authoring team. The poster they designed is below and a link to all the posters and further information is here:

Learning Toolbox (ltb.io)



There are several projects that are underway to support the sharing of information with staff and service users. Two examples of these are below.

The Maternity Service have updated their bulletin board to include information to service users and guidance on where they can seek further support and they have increased the infographics that were already in place.



Within the inpatient acute areas care boards have been put up, to enable staff to record Excellence in Care (EiC) data. The EiC Lead is currently working on inputting this data into the care dashboards, so that each inpatient area will be able to see what their fall rate and pressure ulcer rate is. This will be expanded to include all the EiC data so that each area can see their areas of excellence and where they need to review their current processes.

Experience

Previously complaints and experience has been reported quarterly as a separate report. This has now been combined into this report. Due to the timing of this report we are unable to give the same amount of information as some data is not available monthly and the quarter has not completed at time of submission.

Currently patient experience is recorded within the IIRMPS (Datix), but due to difficulties and constraints with this system, themes and trends are pulled manually. Due to the challenges with the IIRMPS, it is not possible to drill down further on themes, trends, areas etc. The system does not allow us to collate themes with other modules, so presently we cannot present themes across incidents, SAE and complaints. We are looking at how we can do this for future reports.

Training uptake is gathered quarterly, so will be presented in future reports.

Complaints

Complaints Received	April 2024	May 2024
Total Number of Complaints Received	15	8
Total Number of Primary Care Contractor Complaints	Not available – received from practices quarterly	Not available – received from practices quarterly
Total Number of Complaints Closed	14	8
Total Number of Complaints Open	1	0
Total Number of Complaints withdrawn/no consent	0	0
Stage 1 Complaints Received	12	8
Stage 2 Complaints Received	3	0
Stage 2 Escalated Complaints Received	0	0

The expected response times for responding and closing complaints is five working days for stage one complaints and 20 working days for stage two complaints.

Response Times	April 2024	May 2024
Stage 1 Complaints Closed in <5 working days	6 (50%)	4 (50%)
Stage 2 Complaints Closed in <20 workings days	0 (0%)	n/a
Stage 2 Escalated Complaints closed in <20 working days	n/a	n/a
Authorised Extensions		
Stage 1 Complaints	4	2
Stage 2 Complaints	3	n/a

Outcomes	April 2024	May 2024
Stage 1 Complaints		
Upheld	4	1
Partially Upheld	6	4
Not Upheld	2	3

Stage 2 Complaints		
Upheld	0	n/a
Partially Upheld	1	n/a
Not Upheld	1	n/a
Stage 2 Escalated Complaints		
Upheld	n/a	n/a
Partially Upheld	n/a	n/a
Not Upheld	n/a	n/a

Analysis

In April and May 2024, themes for complaints related to issues such as care and treatment, access to services and communication issues.

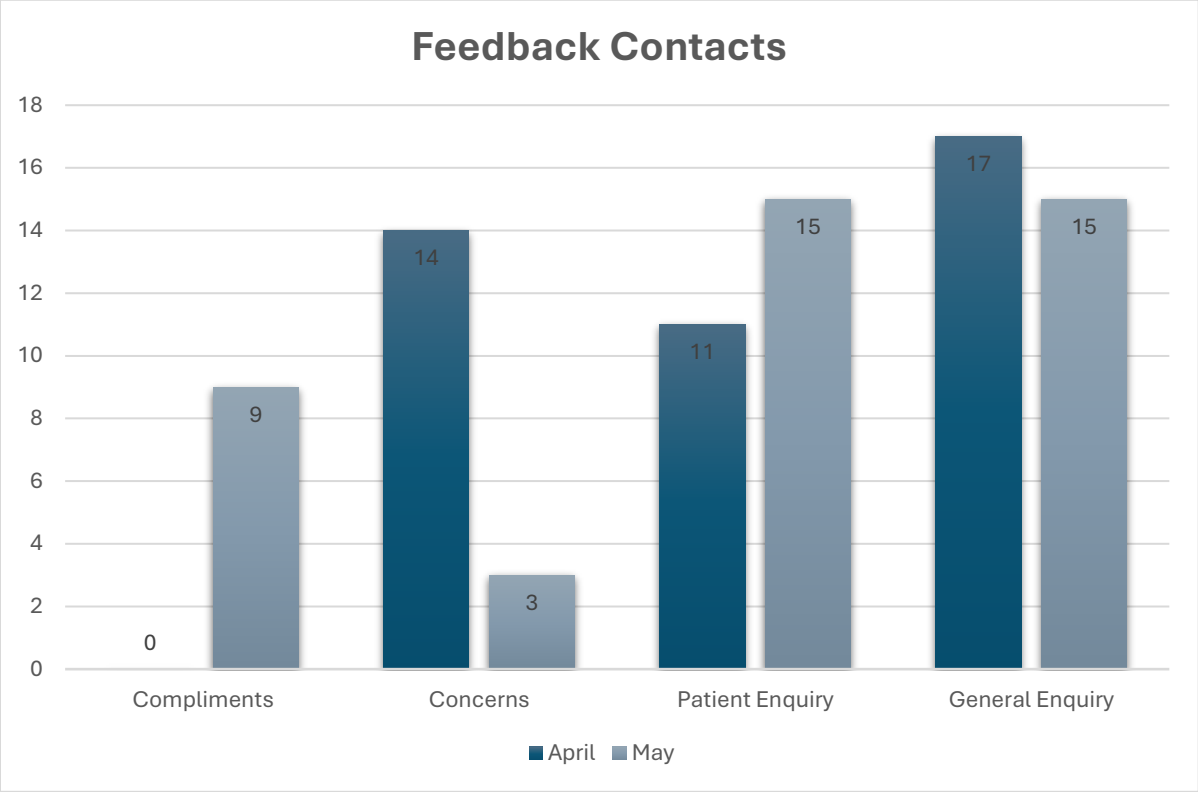
The top-level subjects by which we record complaints such as communication, staff and care and treatment, show that 26% of April and May's complaints relate to issues raised about care and treatment. 22% relates to accessing our services and 17% relate to procedural issues. These were mainly regarding changes to the escort travel policy. All three of the Stage 2 complaints received related to care and treatment.

We have not met the timescales on any of the Stage two complaints with all three passing the 20-working day threshold for response. 50% of Stage one complaints in both April and May were responded to within five working days.

Feedback

Different forms of feedback are received from service users. People are also able to informally raise concerns where they do not wish to formally complain. We also receive enquiries where patients want to change appointment dates and times and are unsure who to contact. General enquiries can relate to anything across the organisation.

Compliments are often received by services directly in the form of thank you cards and letters. Although some areas do send a copy of these to the team, we often do not get oversight of them. We are trying to encourage areas and teams to send us copies or inform us of these, so that we can better represent compliments across the organisation.



	April 2024	May 2024
Patient Feedback Contacts	42	42

Main Patient Feedback Themes	April 2024	May 2024
Compliments	-	Thanks to all staff for Care and Treatment in ED
Concerns	Travel/Escort Travel policy decisions	Escort Travel policy decisions
Patient Enquiries	No theme identified	Subject Access Requests
General Enquiries	No theme identified	No theme identified

Analysis

The main theme identified from feedback concerns has been around the change in policy for authorising travel escorts. Subject Access Requests (SAR) have been the highest request in May 2024 for patient enquiries, this is where a patient requests a copy of all or part of information that we hold related to them, such as inpatient notes. The general enquiries have been varied and therefore, no theme has been identified.

Conclusion

Reporting of incidents and near misses remains high. The IIRMPS has historically been used for recording notification information as well as incidents, which does mean that it is difficult to extract some information as the data is mixed and would require manual review.

The number of overdue SAE reviews is reducing. The process for managing SAE is under review to try and support more timely completion of these and the completion of action plans.

Numbers of stage two complaints remains low. Response times to complaints are not met 100% of the time due to the complexity of the complaints, constraints of allocating investigators and capacity issues to undertake thorough investigations. Care Opinion is being fully implemented into the organisation over the coming months and this will be included in future reports.

Over the coming months the report will be developed to meet the needs of the organisation. We aim to collate information in to one report to focus on areas that may require further review and areas of excellence, as well as highlight work that is ongoing around improving and maintaining quality, this includes Excellence in Care and Scottish Patient Safety Programmes.

Areas of difficulty in collating information is being looked at and updates around this will be shared in future reports.

NHS Orkney

Meeting:	NHS Orkney Board
Meeting date:	Thursday, 22 August 2024
Title:	Infection Prevention HAIRT
Responsible Executive/Non-Executive:	Sam Thomas, Executive Director of Nursing Midwifery and AHPs & Chief Officer Acute
Report Author:	Sarah Walker Infection Prevention Manager

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):

- Safe

2 Report summary

2.1 Situation

This report provides the Board with infection prevention & control surveillance of infection and provides an update of Infection Prevention & Control and wider team activity and progress for June to July 2024. The data is set at real time and includes all fully investigated cases and findings.

2.2 Background

The Healthcare Associated Infection Reporting Template has been devised as a national guide for reporting to Boards on Infection Prevention & Control activities and surveillance of infection and nationally driven standards and infection prevention activities.

2.3 Assessment

The LDP Standards for 2024-25 are still yet to be confirmed.
Currently the team continue surveillance based on the previous LDP standards, with an emphasis of focus on infections that are considered preventable. These infections are few. An infection incident is currently being investigated within one of the departments and an exceedance report was sent through to ARHAI Scotland to inform them. This incident is ongoing, and an outbreak report will be formulated once the incident is closed outlining any learning that has been identified.
The Domestic Monitoring Tool has been malfunctioning and therefore there is no data for July within the HAIRT. The IT team are assisting to resolve the issue.
On the 1st August 2024, ARHAI updated the National Infection Prevention & Control Manual (NIPCM) to align with the UKHSA guidance for hospitalised Covid -19 positive patients. The isolation period has now been reduced to 5 days for patients (with risk assessment), for those who are not severely immunocompromised.
Additionally, the NIPCM has been updated within Chapter 4 – Infection Control in the Built Environment and Decontamination, to include water safety and management.

2.3.1 Quality/ Patient Care

The team aim to provide any learning from all cases investigations or incidents that would impact/improve patient care.

2.3.2 Workforce

The Infection Prevention Workforce Strategic Plan 2022-24, issued initially in December 2022 and followed with a DL (2024)11 outlining roles and responsibilities, the work on the team descriptor is ongoing.

2.3.3 Financial

N/A.

2.3.4 Risk Assessment/Management

Risk assessment is core to the IP&C service.

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Climate Change Sustainability

IP&C are involved in year 2 of the decarbonisation project.

2.3.7 Other impacts

N/A

2.3.8 Communication, involvement, engagement, and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- Infection Prevention & Control Committee is not due to meet until 25th September.

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- N/A – mandatory report

2.4 Recommendation

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- None

NHS Orkney
Infection Prevention & Control HAIRT Report
August 2024

Created by:

Sarah Walker

Infection Control Manager

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2 Report Summary

2.1 Situation

This report provides an update of Infection Prevention & Control and wider team activity and progress for June to July 2024. The data is set at real time and includes all fully investigated cases and findings.

2.2 Background

It is a requirement of the Infection Prevention & Control Manager to present a bi-monthly report to the Board on the surveillance of infection, incidents and learning and any emerging issues.

2.3 Assessment

The LDP Standards for 2024-25 are still yet to be confirmed.

Currently the team continue surveillance based on the previous LDP standards, with an emphasis of focus on infections that are considered preventable. These infections are few.

An infection incident is currently being investigated within one of the departments and an exceedance report was sent through to ARHAI Scotland to inform them. This incident is ongoing and an outbreak report will be formulated once the incident is closed outlining any learning that has been identified.

The Domestic Monitoring Tool has been malfunctioning and therefore there is no data for July within the HAIRT. The IT team are assisting to resolve the issue.

On the 1st August 2024, ARHAI updated the National Infection Prevention & Control Manual (NIPCM) to align with the UKHSA guidance for hospitalised Covid -19 positive patients. The isolation period has now been reduced to 5 days for patients (with risk assessment), for those who are not severely immunocompromised.

Additionally, the NIPCM has been updated within Chapter 4 – Infection Control in the Built Environment and Decontamination, to include water safety and management.

2.4 Recommendations

The Board is asked to note the report and the Infection Prevention team continue to support and facilitate improvement on a daily basis, by monitoring and updating staff on the management of infections, updating staff to changes within the National Infection Prevention and Control Manual, changes in the evidence bases and providing information and rationale for areas where improvement can be made. The team also ensure that feedback is given in real time.

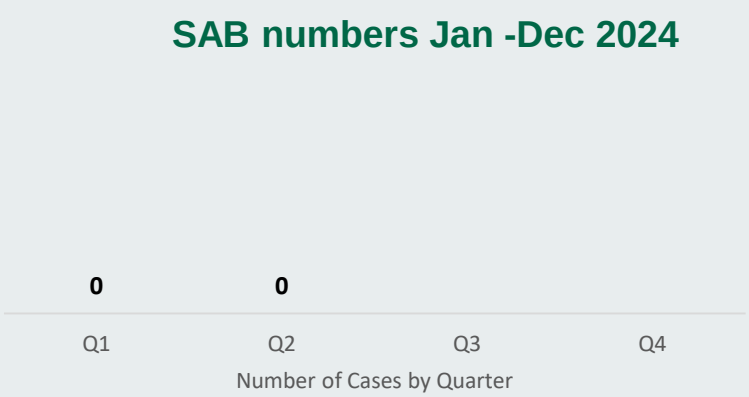
Staphylococcus aureus bacteraemia (SAB)

Surveillance is in combination with the Leading Clinician to identify the underlying cause and any risk factors. The LDP standard reduction is set at 10% for Orkney, the aim is to achieve zero preventable cases.

As our cases are small, the focus is on the preventable cases where learning can be shared, to prevent further cases, and the last case where learning and changes in practice was needed was several years ago. Therefore, meeting a 10% reduction standard is likely not achievable, so NHSO aim for zero preventable. **There are zero cases to date for Quarter 1 and Quarter 2 2024.**

Dashboard

Calendar year 1st Jan 2024 to 31st Dec 2024 for *Staphylococcus aureus* bacteraemia (SAB) – LDP Standard 10%



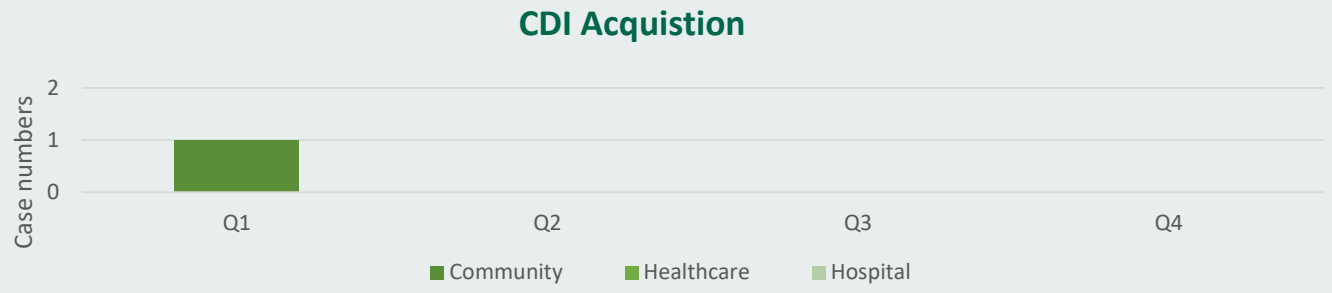
***Clostridioides difficile* Infection**

Clostridioides difficile Infection Surveillance is undertaken routinely along with the Leading Clinician or GP to identify cause and any risk factors. The standard (April to March) is based on rate per 100,000 bed days.

This does prove problematic for NHSO, with swings in data for small numbers. We continue to report cases and look at the preventable infections where identified, for improvement.

Zero cases for Q2

Calendar year 1st Jan - 31st Dec 2024 for *Clostridioides difficile* Infection– LDP Standard 10% reduction



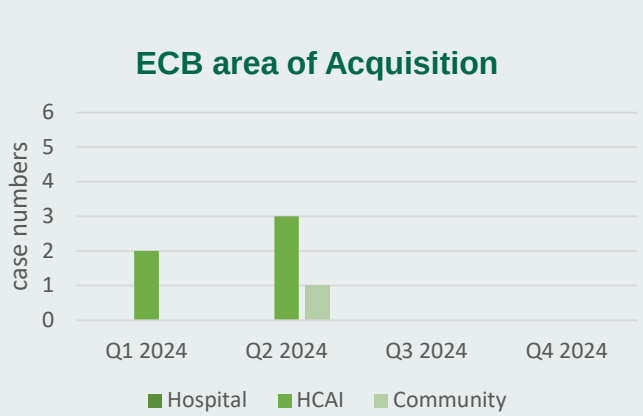
***E. Coli* Bacteraemia**

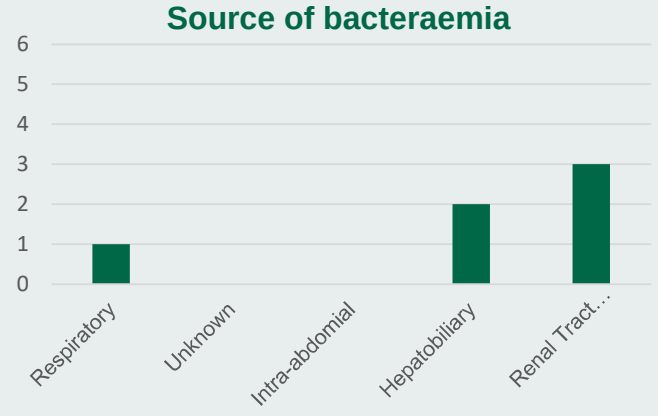
National surveillance of *E. Coli* bacteraemia continues, and this year's standard is still awaited. The standard rate is set on per 100,000 TOBDs (April-March).

As mentioned above, this does prove problematic for NHSO with swings in data for small numbers. We continue to report cases and look at the preventable infections where required for improvement.

4 cases confirmed for Q2.

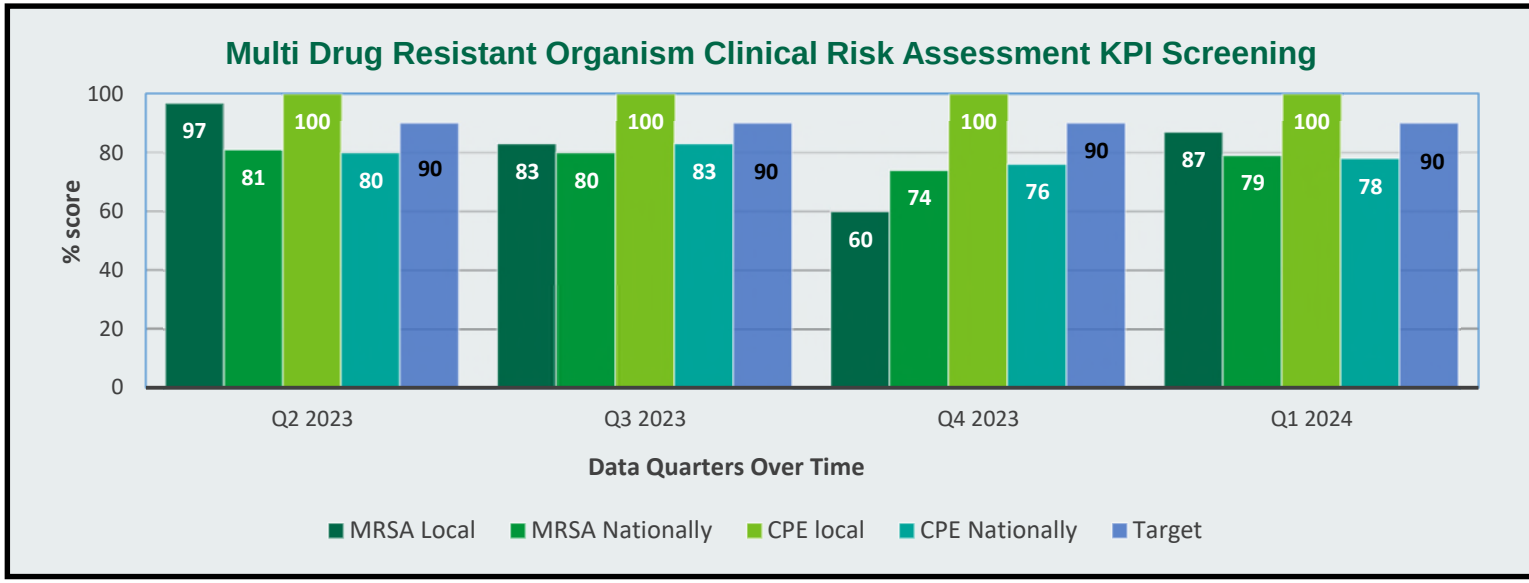
Calendar year 1st Jan 2024 to 31st Dec 2024 for *E.Coli* bacteraemia (ECB) – LDP Standard 25%





Multi Drug Resistant Organism (MDRO) Clinical Risk Assessment National Screening

Q2 information is yet to be received from ARHAI.



Additional MDRO CRA Information

The multidrug resistant organism (MDRO) Clinical Risk Assessment (CRA) is a national KPI. This is based on two multi drug resistant pathogens and the KPI target is set at 90%.

Each quarter the Board are required to submit 10 patient MDRO screens, however the IP&C team collect data on 30 patients per quarter. This ensures that patients are being screened appropriately at time of admission or transfer and assists with maintaining patient safety, by risk assessing those patients who potentially are at a higher risk of being colonised with MRSA or CPE (criteria has been set nationally by ARHAI). It also helps to prevent huge variation in data, that may occur when only 10 are collected.

The KPI is based on the clinical risk assessment being undertaken for all new admissions and transfers, within the specified timeframe and completeness of the documentation. For every CRA that has a 'YES' response the appropriate follow-on lab samples require to be taken, again this is based on a specified timeframe.

The graph represents the percentage scores which is sent back to Boards from ARHAI and contains both local and national scores for CRA completion for Methicillin Resistant *Staphylococcus aureus* (MRSA) and carbapenemase producing *Enterobacteriaceae* (CPE).

Dark Green – represents local MRSA CRA screening scores.

Mid Green – represents the collated Scottish Board scores/national MRSA CRA screening scores.

Light Green – represents local CPE scores.

Turquoise – represents the collated Scottish Board score/ national CPE CRA scores.

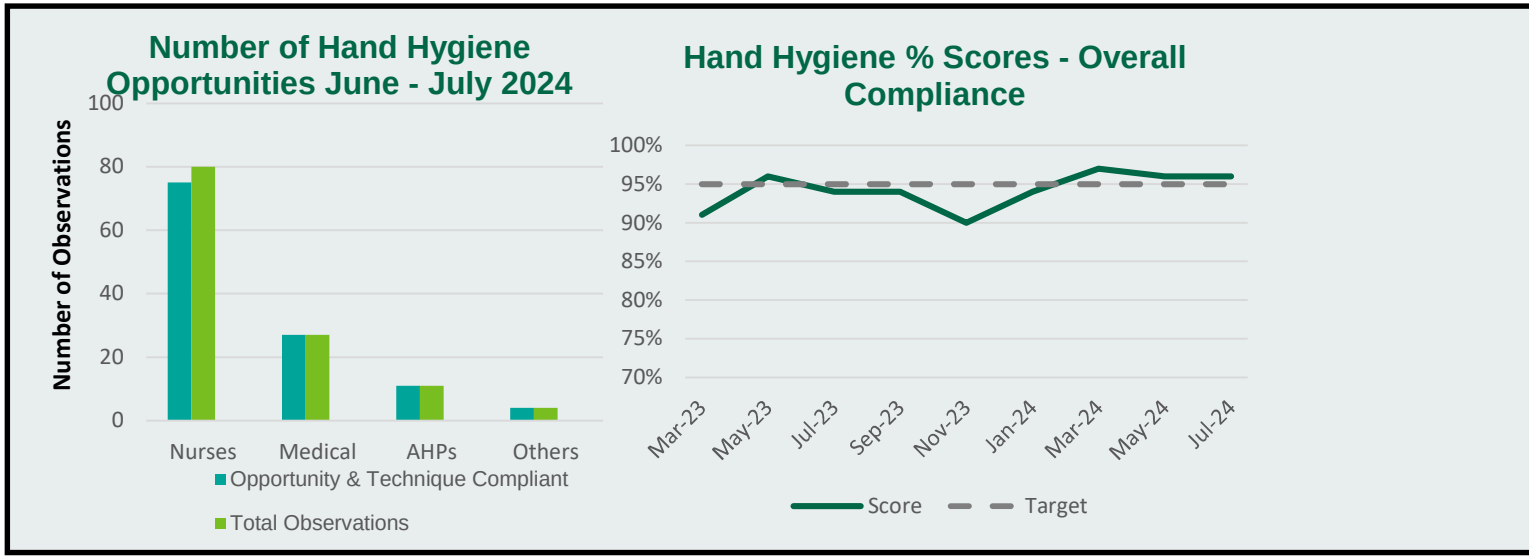
Blue – Target

Presenting the data over time enables the Board to see that, despite having some improvement to make, overall NHSO is performing above other boards nationally.

Hand Hygiene

The hand hygiene score for June through to **July is 96%** for opportunity taken and 99% for correct technique. A total of 122 hand opportunities were observed, 5 of these failed to take the opportunity, resulting in 117 being observed for hand hygiene technique.

All aspects of noncompliance, such as dress code & PPE use continue to be addressed on an individual basis with all staff groups.



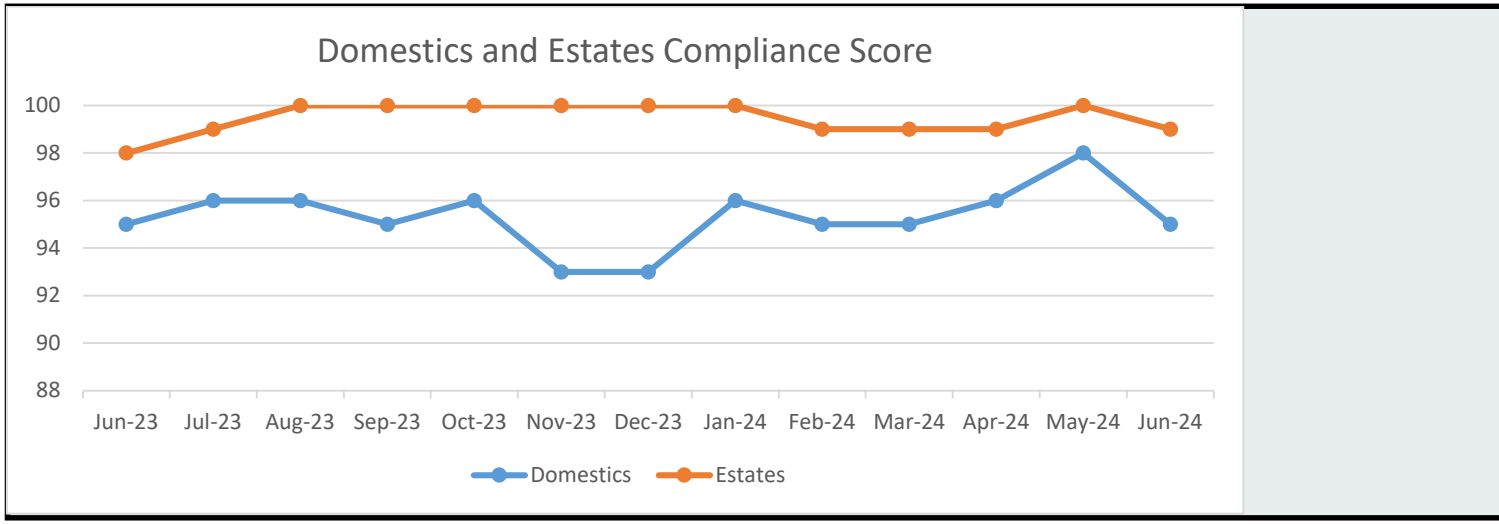
NHS Orkney

Local Domestic and Estates

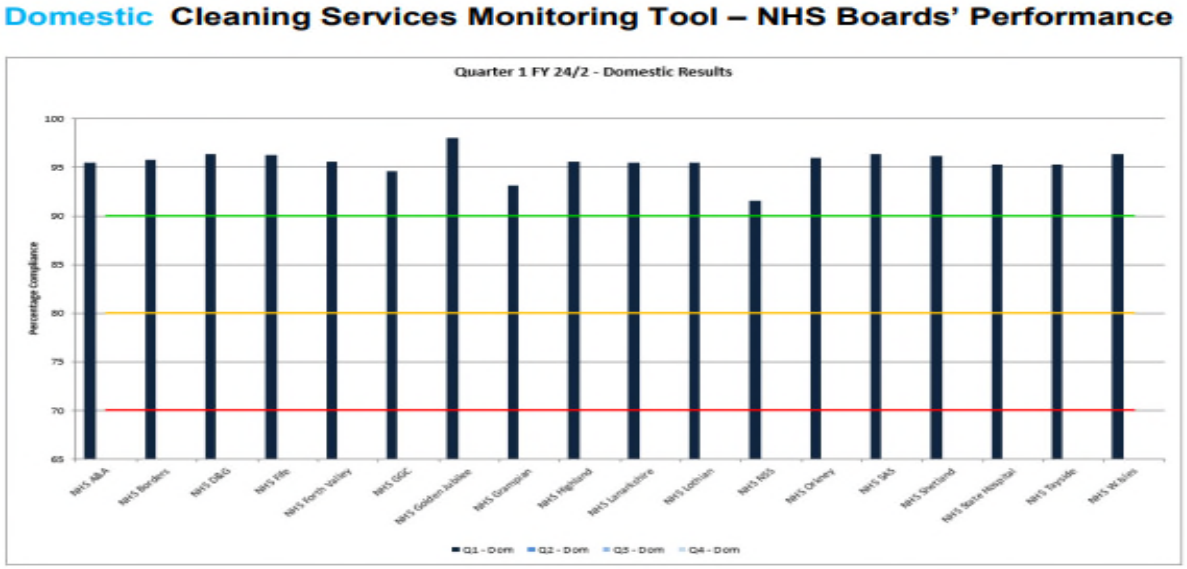
Environmental Scores

The environment is crucial to prevention/transmission of infection. and both Domestic Teams and Estates/RFM have maintained an outstanding level of cleanliness within care settings.

Locally reported scores attached. There are no scores for July as the auditing tool is down. The IT department are attempting to resolve this issue.

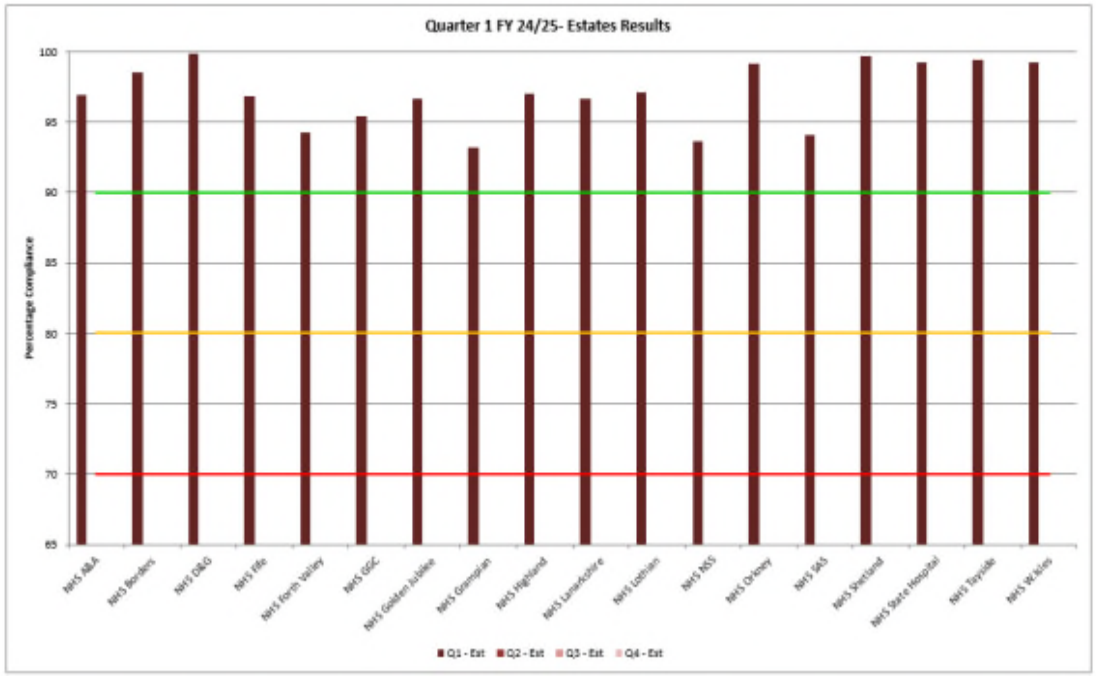


National Domestic and Estates Monitoring for Quarter 1



Health Board	1st Quarter Apr - June 2024/25
NHSSCOTLAND	**95.2**
NHS Ayrshire and Arran	95.5
NHS Borders	95.8
NHS Dumfries and Galloway	96.4
NHS Fife	96.3
NHS Forth Valley	95.6
NHS Greater Glasgow and Clyde	94.6
NHS Golden Jubilee	98.0
NHS Grampian	93.1
NHS Highland	95.6
NHS Lanarkshire	95.9
NHS Lothian	95.5
NHS NSS SNBTS	91.6
NHS Orkney	96.0
NHS Scottish Ambulance Service	96.4
NHS Shetland	96.2
NHS State Hospital	95.3
NHS Tayside	95.3
NHS Western Isles	96.4

Estates Fabric Monitoring Tool – NHS Boards' Performance



Health Board	1st Quarter Apr - June 2024/25
NHSSCOTLAND	**96.4**
NHS Ayrshire and Arran	96.9
NHS Borders	98.5
NHS Dumfries and Galloway	99.8
NHS Fife	96.8
NHS Forth Valley	94.2
NHS Greater Glasgow and Clyde	95.4
NHS Golden Jubilee	96.6
NHS Grampian	93.2
NHS Highland	97.0
NHS Lanarkshire	96.6
NHS Lothian	97.1
NHS NSS	93.6
NHS Orkney	99.1
NHS Scottish Ambulance Service	94.1
NHS Shetland	99.7
NHS State Hospital	99.2
NHS Tayside	99.4
NHS Western Isles	99.2

National Infection Prevention Updates

On the 1st of August ARHAI have adjusted the isolation period for SARS-CoV-2 hospitalised patients to 5 full days for most patients. Patients also need to have no fever without the use of antipyretics for 48hours prior to step down. There are additional recommendations for step down of patients with immunosuppression.

Chapter 4 of the National Infection Prevention & Control Manual now includes a section on water safety and management. This will be discussed at the Water Safety Group, to ensure NHS Orkney align to the information, although the NIPCM chapter update does align to all current guidance so it is anticipated that there will be little to no changes required.

Infection Prevention Quality Assurance Audits

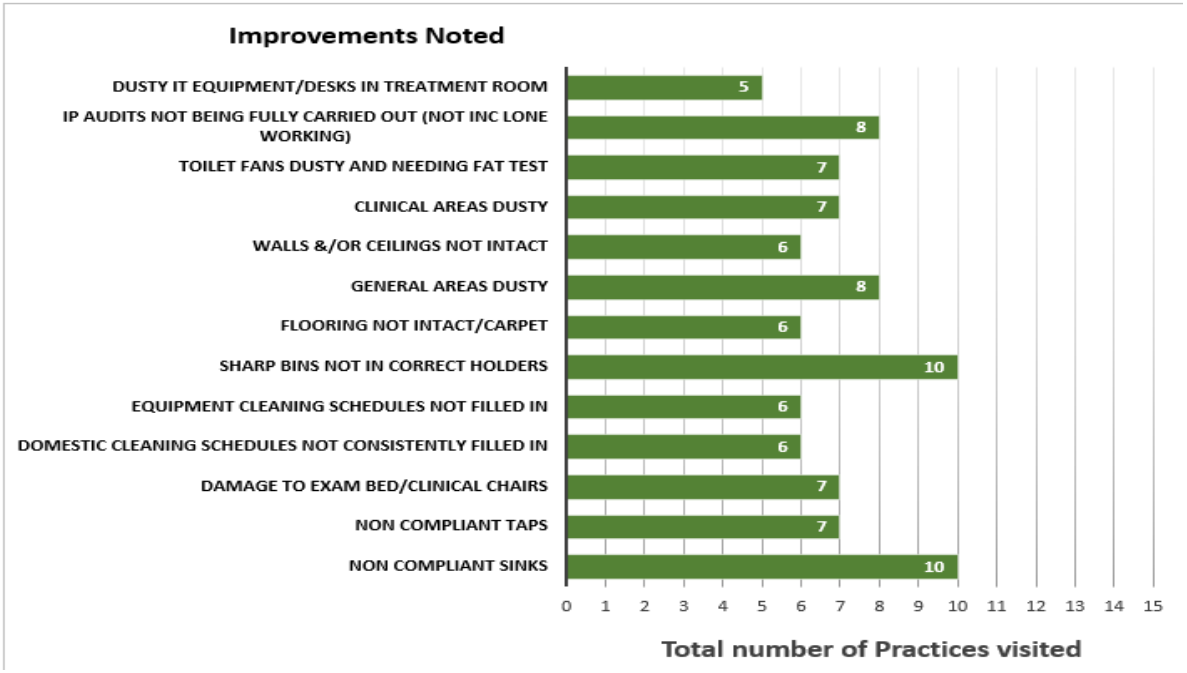
The quality assurance audits are ongoing, and most departments are due their 6 monthly revisits in September.
The IP team continue to work across all areas to support improvements.

As The Balfour is now into the fifth year of occupancy and some areas now require Estates support into upkeep and maintenance of the building. The Estates team are aware of the requirements and refurbishment discussions are taking place.

Overview of Community Practice Audits

In general, in all practices there is a vast improvement since the last visit. The main findings are around the environmental and patient care equipment cleaning, but these have also improved this year. Domestic staff employed by the practice are offered education by NHSO Facilities team, but it continues to present some challenges.

All the community and isles practices have had their annual visits and all but one of the practices has returned an improvement plan, escalation for non-return of the single improvement plan has been through the Head of Primary Care Services, and through Datix for noting, as per Standard Operating Procedure for IP&C Quality Assurance. Further discussion will take place at the next Infection Control Committee meeting.



Staff Education

Due to ward activity, clinical staff are unable to be released for face to face IP&C education/training. The team have been allocated a board in each of the inpatient areas to display information, for staff to read at a convenient time for them. This has been supported by the senior nurses in each area and has been very well received by staff.

Education has also been offered to the Pharmacy team in recent weeks.

Patient Surveys

In recent weeks, 11 patient surveys were completed within IP1. The survey consists of five questions, ranging from cleanliness of the patient's surroundings to hand hygiene related questions.

The data gathered from these surveys suggests that patients feel staff are good at cleaning their hands, either by washing or using hand gel. Almost all patients felt satisfied with the level of cleanliness in their room and ensuite bathroom. However, one patient felt that the furniture and objects in the room hindered efficient cleaning. This was acted on in the department immediately.

Patients report not needing to raise concerns about cleanliness of the ward but reassuringly all felt confident enough to raise concerns if they needed to. A large percentage of the patients said they are encouraged to clean their hands prior to mealtimes, often having a hand wipe left on their meal tray. The IP Team have requested that hand hygiene prior to meals is encouraged within the ward, including assistance to patients who are unable to use the hand wipes or wash their hands themselves. The SCNs will ensure this is taken forward in the wards and departments.

Care Home Support

Support to care homes continues and recent discussions have included waste management, particularly for residents who require transmission-based precautions. Support to staff is ongoing on a daily and as and when basis.

Exception Reporting to Scottish Government

An exception report remains open following a potential cross transmission event. This is standard practice for IP&C surveillance, once an 'infection trigger' is triggered in this case; two or more cases of the same infection within a set period.

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Quarter 1 – 2024/25 Financial Performance**
Responsible Executive/Non-Executive:	**Paul Corlass, Interim Recovery Director**
Report Author:	**Paul Corlass, Interim Recovery Director**

1 Purpose

This is presented to the Committee for:

- Awareness
- Discussion

This report relates to a:

- Annual Operation Plan
- Legal requirement
- NHS Board Strategy and Direction

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

The purpose of this report is to provide the Board with an update on financial performance at the end of the first quarter of the 2024/25 financial reporting period. The report is for noting and discussion and to outline the key headlines and risks.

2.2 Background

NHS Orkney remains at stage 3 of the NHS Scotland Support and Intervention Framework for finance. The Board submitted a financial plan for the 2024/25 financial period which forecasts a full year deficit of £5.778m against the Boards revenue resource limit. Whilst this plan was approved by the Board and submitted to Scottish Government, it remains a non-compliant plan.

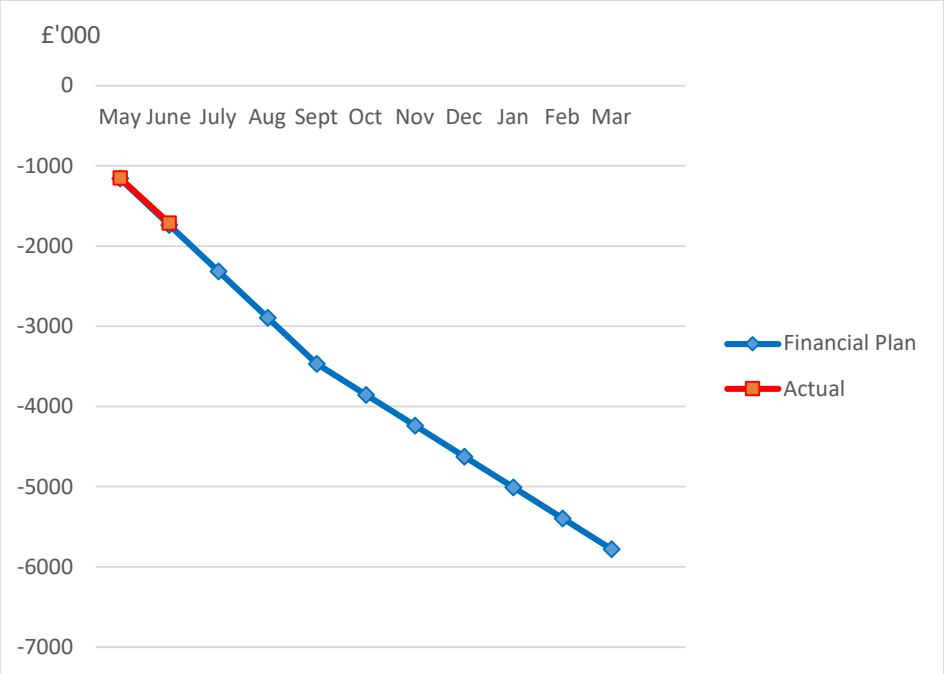
It is positive to note that the reported financial position at the end of quarter 1 is slightly favourable to plan and the Board is still forecasting to deliver the £5.778m original plan at the end of the year. However, it is important to note that the Board profiled the in-year deficit plan to be more challenging over the second half of the year as the efficiency programme develops, and therefore the run rate needs to reduce over the remainder of the financial year to achieve the financial plan. The Board is still anticipating full delivery of the £4.000m in-year savings programme and the minimum 3% full year recurrent delivery target.

2.3 Assessment

2.3.1 Year to Date Financial Position

The reported revenue position after 3 months of the 2024/25 reporting period reflects an overspend of £1.710m. This compares to a planned year-to-date overspend at month 3 of £1.733m and therefore the overall revenue position is £0.023m favourable to the original plan. Graph 1 shows the financial plan trajectory vs the actual monthly results after three months of the 2024/25 financial year.

Graph: Year to Date Run Rate vs Planned Run Rate



The most notable year-to-date overspends are noted in the table below and provided in further detail in Annex A

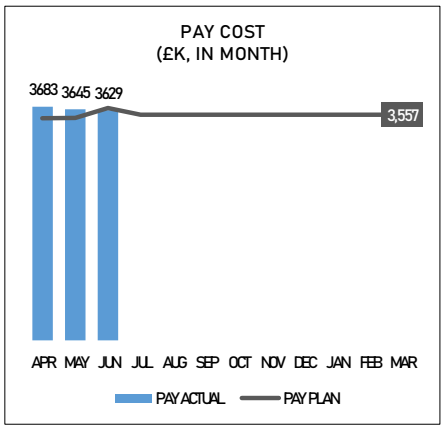
Area	Variance to RRL	Reason
Nursing and Acute Services	£0.696m	Supplementary staffing including nursing and medical agency as well as cost pressures within Junior Doctors.
Estates and Facilities	£0.073m	Unit price of energy being higher than forecast and cost pressures across staff accommodation. Continued staffing pressures across a number of areas including Portering, Domestic and Catering.
Unachieved Savings Target (Including IJB)	£1.945m	Savings includes the amount required to break even as well as the £4m of actual anticipated savings in 24/25.
Director of Human Resources	£0.102m	Recruitment and relocation costs have been higher than planned offset by departmental vacancies mainly within Organisational Development
Other	£0.009m	There are other smaller movements (see Annex A)
Reserves	£0.660m	This includes some cost pressure reserves, mainly temporary staffing excess costs, agreed through the annual planning process.
Integration Joint Board (operational areas)	£0.233m	Vacancies being higher than forecast which has reduced expenditure
Total Month 03 overspend	**£1.710m**	

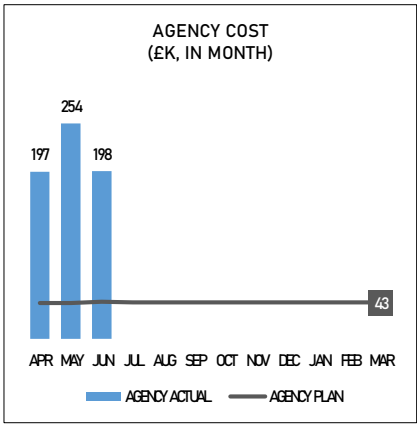
2.3.2 Allocations

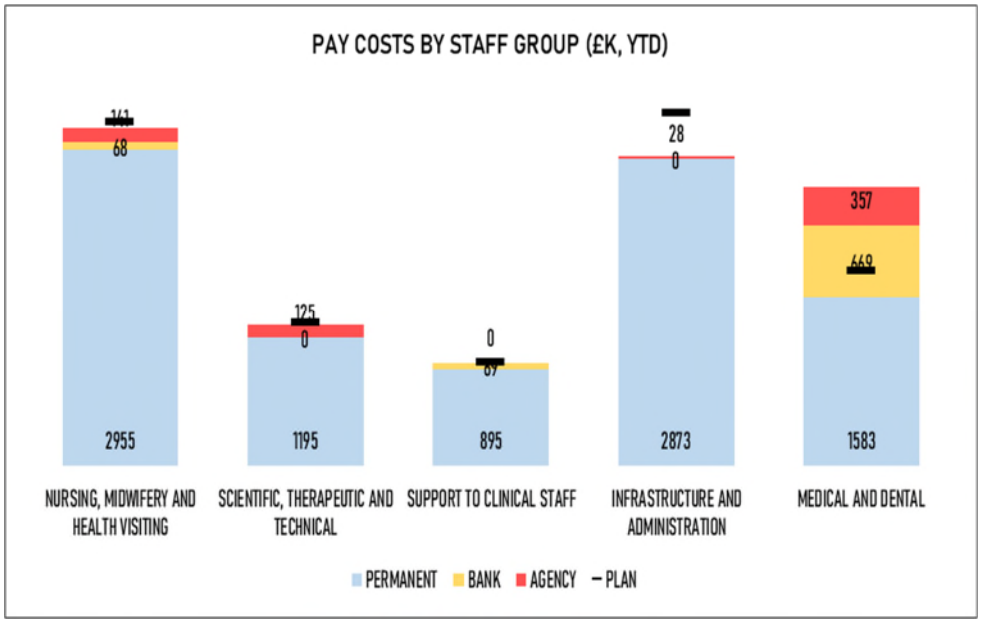
The Board have received confirmation from Scottish Government of £80.204m of in year core allocations. These allocations are included at Appendix 1 for information. Senior Leadership Team members are asked to review the allocation schedule and ensure any allocations relevant to their areas are appropriately aligned to budgets to ensure service delivery and budgetary control.

2.3.2 Pay Expenditure

The Boards overall workforce expenditure was £3.629m during June, £10.957m year-to-date which is approximately £0.287m higher than the revenue resource limit. The Boards agency expenditure during the period was £0.198m (£0.123m medical agency, £0.031m nursing agency) with cumulative agency spend to date of £0.650m.







2.3.2 Full Year Forecast Position

The Board is still forecasting to achieve the original £5.778m deficit plan for 2024/25 at this stage but the run rate needs to reduce over the remainder of the year in line with the expected profile of the Boards efficiency programme.

2.3.3 Savings Plan

NHS Orkney has an integrated improvement function which is responsible for driving savings within the organisation. £4.000m of savings are required to be achieved during 2024/25 to deliver the £5.778m deficit plan.

The Board has achieved £0.780 million after 3 months to 30th June 24, with the current programmes in implementation forecast to deliver £3.192m with an

additional £1.008m of savings in the pipeline being progressed to the implementation stage. The current recurrent savings forecast is £2.547m which is above the minimum 3% requirement during the year.

Savings delivery is a key focus, led through the Board's Improving Together Programme, with improved collaborative working relationships with Scottish Government colleagues, aligned to national improvement programme initiatives.

The Board is committed to support NHS Orkney's statutory responsibility to break even and operate within the resource allocation given. Work is ongoing across the organisation to return the best possible results in 2024/25 with extensive work underway to improve the future financial performance and sustainability.

2.3.3 Capital

The formula-based capital resources for 2024/25 are £1.027m. The planned areas for expenditure are broken down below which would bring the Board to a breakeven position:

Area	Value	Detail
Estates and Primary Care	£0.100m	This will be used for equipment purchases; property works and primary care priorities.
IT	£0.300m	This will be used to support our Digital Strategy.
Medical Equipment	£0.150m	Spending priorities will be decided by the Medical Equipment Group.
Digital	£0.155m	This will be used to support our Digital Strategy.
De-Carbonisation Shortfall	£0.188m	This will be used to fund Solar Panels that will help reduce future revenue costs.
Other	£0.134m	
Total spend	**£1.027m**	

The Boards capital expenditure at the end of the first quarter is broadly in line with plan.

2.3.4 Forecast Range

There are a number of key risks which may affect the year end outturn position. A detailed forecast exercise will be undertaken within Finance during the next month and the risk range below will be updated following this exercise. The following risks have been noted at this stage and will be validated as part of the detailed forecast exercise.

Area	Risk / opportunity detail	Best case	Worst Case
Savings delivery	There is a risk planned delivery of savings in the final part of the year are lower than planned	£0.100m	£0.250m
IJB outturn	There is a risk the IJB overspends and requires funding from the NHS Board	£0.300m	£0.200m
Inflation	There is a risk inflation remains above plan, however this could fall in the final quarter	£0.100m	£0.100m
SLA costs	All SLA costs are not yet confirmed	£0.200m	£0.350m
Prescribing costs	Data is behind on primary care prescribing therefore there is still a high degree of estimation in costs	£0.100m	£0.150m
Allocations from SG	There remain some allocations outstanding from SG and therefore a risk allocations could be lower than anticipated	£0.000m	£0.300m
Agenda for Change Reform	Funding is currently non-recurrent. The impact of the Band5/6 review and PLT likely to drive pressure against the funding	£0.000m	£0.300m
Total outturn reported	***Expected outturn***	***£5.778m***	
Adjusted for variables		**£4.978m**	**£7.428m**

2.4 Brokerage

The Board is required to report the level of cumulative brokerage received from Scottish Government as a proportion of the Boards total revenue resource limit. This is a key assessment criteria moving forward under the NHS Scotland Support and Intervention Framework. The Board received £5.156m of brokerage in the 2023/24 financial year which was 6.6% relative to the Boards revenue resource limit at M12 2023/24.

The Board will require a further £5.778m of brokerage this year in line with the forecast. This would be the second successive year that the Board would require brokerage in excess of 6% of the revenue resource limit. This would result in a score of 4 relative to the framework, as per the table below.

Board Financial Position	Indicative level
10% of core RRL in year brokerage in two consecutive years AND cumulative brokerage of over 25% core RRL	5
6% of core RRL in year brokerage in two consecutive years AND cumulative brokerage of over 15% core RRL	4
4% of core RRL in year brokerage AND cumulative brokerage of over 8% core RRL	3
2% of core RRL in year brokerage OR cumulative brokerage of over 4% core RRL	2
No brokerage or below criteria above	1

2.5 Conclusion and Next Steps

The year-to-date financial position reported after 3 months of the 2024/25 financial year is slightly favourable to plan at this stage which is positive.

The Board continues to focus on progressing the efficiency programme and pipeline to reduce the run rate into the second half of the financial year to ensure delivery of the overall annual financial plan and will strive to achieve a financial and savings position that is favourable to the initial plan submitted to Scottish Government to reduce the reliance on brokerage support.

2.6 List of appendices

The following appendices are included with this report:

- Appendix 1, Allocations Schedule
- Appendix 2, Month 3 Financial Position Detail

Appendix 1: Allocation Schedule

NHS Orkney Budget Movement Summary 2023/24 Allocatiions, anticipated v actual			M3 Jun £'s
BASELINE ALLOCATION	Baseline	Baseline Allocation	63,586,000
	Baseline	Recurring Allocation from 23/24	4,413,537
	Baseline	Waiting times	253,786
	Baseline	General Medical Services with pension increase	385,314
	Baseline	General Dental Services	18,068
	Baseline	EiC - NHS Board Leads and eHealth Support	49,771
	Baseline	District Nursing	55,000
	Baseline	Administration of the Child Death Review Process	3,969
	Baseline	Pension Uplift	689,095
	Baseline	SACT/Acute oncology	23,201
	Baseline	Adjustment to STN baselined allocations (NoS)	1,526
	Baseline	Cancer Waiting Times	57,000
	Baseline	Enhanced Mental Health Outcomes Framework	1,075,592
	Baseline	Digital Mental Health Programme Licences and Support	15,253
	Baseline	ADP / PfG AfC uplift /recurring	10,000
	Baseline	Test and Protect 24-25 baselined funding	12,300
	Baseline	Adult weight management services and Type 2 Diabetes Prevention Framew	131,600
	Baseline	Children and young people's weight management services	65,800
		BASELINE ALLOCATIONS	**70,846,812**
EARMARKED RECURRING	Earmarked	Primary Medical Services	5,622,278
	Earmarked	Primary Care Improvement Fund Tranche 1	591,748
	Earmarked	Out of Hours additional funding	25,379
	Earmarked	Scottish Vitamin Scheme - Healthy Start/Vitamin D	2,142
	Earmarked	Breastfeeding Projects	26,000
	Earmarked	Patient Advice and Support Service	(2,951)
	Earmarked	Urgent and Unscheduled Care Collaborative	166,000
	Earmarked	FVCV Delivery Allocation (staffing and venues)	385,754
	Earmarked	ADP tranche 1 allocation & AfC uplift	117,449
		EARMARKED RECURRING ALLOCATIONS	**6,933,799**
NON-RECURRING	Non-Recurring	AfC Reform	1,015,143
	Non-Recurring	New Medicines Fund	908,553
	Non-Recurring	Digital Health and Care Strategic Fund	211,000
	Non-Recurring	IPACC Community Systems Funding	12,492
	Non-Recurring	Primary Care Workforce and Rural Tranche 1	41,000
	Non-Recurring	HCSA - NHS Board Implementation Leads	44,325
	Non-Recurring	EiC - NHS Board Leads and eHealth Support	1,727
	Non-Recurring	Open University Backfill - Q3&4 academic year 23/24	20,000
	Non-Recurring	The Best Start: Continuity of carer and Bliss Baby Charter	2,538
	Non-Recurring	Young Patients Family Fund - Tranche 1 funding	35,862
	Non-Recurring	Collaborative Care Home Support Teams	120,000
	Non-Recurring	Long COVID Support Fund	10,301
		NON-RECURRING ALLOCATIONS	**2,422,941**
TOTAL ALLOCATION LETTER			**80,203,552**

Appendix 2: Month 3 financial position detail

Previous Month Variance M2		Annual Budget	Budget YTD	Spend YTD	Variance YTD	Variance YTD
£000	**Core RRL**	**£000**	**£000**	**£000**	**£000**	**%**
(549)	Nursing & Acute Services	16,540	4,135	4,831	(696)	(16.83)
(8)	Medical Director	17,940	4,485	4,492	(6)	(0.14)
206	Integration Joint Board	30,683	7,296	7,063	233	3.19
42	Finance Directorate	3,189	797	713	84	10.51
(65)	Estates, Facilities & NPD Contracts	8,816	2,204	2,277	(73)	(3.31)
(42)	Chief Executive	2,058	515	605	(91)	(17.60)
13	Public Health	1,024	256	234	22	8.44
50	Director of Human Resources	1,966	491	390	102	20.67
837	Reserves	5,743	1,436	775	660	n/a
(1,230)	**Savings Targets (Board)**	**(7,378)**	*(1,845)*	*0*	(1,845)	**n/a**
0	*Savings Achieved (Board)*	**(0)**	**(0)**		(0)	*n/a*
(400)	**Savings Targets (IJB)**	*(2,400)*	*(600)*	*0*	(600)	**n/a**
0	*Savings Achieved (IJB)*	*500*	*500*		500	*n/a*
(1,148)	**Total Core RRL**	**78,680**	**19,670**	**21,380**	**(1,710)**	**(8.69)**
	Non Cash Limited					
(0)	Dental NCL	645	132	132	0	0.00
(0)	Ophthalmic Services NCL	299	76	76	0	0.00
(0)	Dental and Pharmacy NCL - IJB	912	200	200	(0)	(0.00)
(0)	**Total Non Cash Ltd**	**1,856**	**407**	**407**	**0**	**0.00**
	Non-Core					
(0)	Capital Grants	(1,964)	0	0	(0)	#DIV/0!
0	Non-cash Del	0	0	0	0	#DIV/0!
0	Annually Managed Expenditure	1	0	0	0	0.15
0	Donated Assets Income	0	0	0	0	#DIV/0!
(0)	Capital Charges	3,316	808	808	0	0.00
(0)	**Total Non-Core**	**1,353**	**809**	**809**	**(0)**	**(0.00)**
(1,148)	**Total for Board**	**81,889**	**20,886**	**22,596**	**(1,710)**	**(8.19)**

Nursing and Acute Services - £0.696m overspend

- *Hospital Medical Staff, £413k overspend*

Spend within Hospital Medical Staffing remains high, in the main this is due to locum and agency spend and cost pressures within Junior Doctors establishment.

- *Ambulatory Nurse Manager, £34k overspend*

Dialysis and Theatres & Day Unit are overspent at month 3 due to reliance on agency and bank staff to cover vacancies and gaps in rotas.

- *Clinical Nurse Manager, £210k overspend*

Inpatients 1, Inpatients 2 and the Emergency Department are all reporting significant overspends at month 3 due to reliance on agency and bank nursing to cover vacancies and gaps in rotas. Spend in these areas has slowed down due to reduction in acute agency nursing from November onwards.

- *Laboratories, £109k overspend*

Laboratories are reporting a significant overspend at month 3, both staffing due to agency usage and consumables are overspending, reagent spend has increased significantly and significantly exceeds the forecast spend for this area.

Medical Director - £0.006m underspend

- *Pharmacy, £15k underspend*

The Acute Pharmacy budgets are currently underspent. Spend in this area remains low and under review.

- *External Commissioning, £33k overspend*

External Commissioning including SLAs, unplanned activity, visiting specialist has a combination of over and underspending areas. The Grampian Acute Services SLA is the largest single element within the commissioning budget at £6m. A review of SLAs is underway as part of the Boards Improving Together Programme.

- *Patient Travel, £137k overspend*

Patient travel out with Orkney continues to overspend, spend relating to patients travelling to Aberdeen has seen an increase in recent months.

IJB – Delegated Services - £0.133m

The Delegated Services budgets report a net under spend of £0.133m (including £0.100m of unachieved savings and £0.233m operational underspend).

- *Integration Joint Board, £133k overspent*

This includes the unachieved savings to date.

- *Children's Services, £75k underspend*

The underspend is related to vacancies in Health Visiting and School Nurses.

- *Primary Care, Dental and Specialist Nurses, £36k underspend*

Dental is currently underspent whilst Primary Care is overspending due to locum and agency spend within this area.

- *Health and Community Care, £94k underspend*

There are both over and underspending services in Health and Community Care. Mental Health continues to be overspent by £30k. The overspend remains in the main due to the unfunded Consultant Psychiatrist post. Community Nursing is currently underspending (£72k) due to significant vacancies in this area.

- *Primary Care Pharmacy, £94k overspend*

Pharmacy services are currently overspent within prescribing unified with an overspend forecast by year-end. Invoices are now up to date following reporting issues nationally. This volatile cost area will continue to be closely monitored along with the accrual assumptions which are now based on payments made 2-months in arrears.

Finance Directorate - £0.084m underspend

The Finance Directorate is currently reporting an underspend of £84k which is primarily driven by vacancies within the team.

Estates and Facilities - £0.073m overspend

This Directorate is reporting an overspend of £73k to date, unit price of electricity has shown a significant increase. There are significant overspends across the directorate in particular, Estates reports, non-pay pressures within general services reporting an overspend on building maintenance £32k, energy overspend £11k and pay pressures within portering £9k overspend at month 3. There are also overspends within Facilities at month 3 with domestics reporting an overspend of £25k, catering an overspend of £14k and staff houses an overspend of £19k.

Chief Executive - £0.09m overspend

Currently overspent by £90k but this is driven primarily by management consultancy spend which is to be reconciled and adjusted as this expenditure is expected to be funded in full by Scottish Government.

Public Health - £0.02m underspend

Currently reporting an under spend of £22k.

Human Resources - £0.10m underspend

Currently under spent by £102k due to vacancies. Recruitment and relocation costs are impacting on the reported position.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Integrated Performance Report - June 2024**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight – Chief Executive**
Report Author:	**Debs Crohn – Head of Improvement**

1 Purpose

This report is presented to the NHS Orkney Board for Assurance:

The Board is asked to:

I. **Receive** and **scrutinise** June's Integrated Performance Report (IPR)
II. Seek **assurance** on delivery and consideration of the implications of current performance levels
III. **Note** the changes to the IPR from October 2024 (see agenda item 12.3 for fuller details)

This report relates to a:

- Corporate Strategy 2024/2028 - Performance
- Annual Delivery Plan 2024/25
- Emerging issue
- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred
- Quality

2 Report summary

2.1 Situation

The Integrated Performance Report (IPR) summarises NHS Orkney's performance based on national and local reporting requirements as well as those indicators which matter to our patients, staff, and local community. The IPR aligns to our Corporate Strategy 2024-28, Realistic Medicine Plan, Annual Delivery Plan 2024/25, and the Improving Together Programme.

The IPR in Appendix 1 contains a summary against each of NHS Orkney's key performance indicators (KPIs) highlighting what is going well, successes, causes for concern, challenges and planned mitigation/actions being taken to bring performance back on track.

2.2 Background

The IPR is the mechanism by which Executive Leads provide assurance to operational, Board Committees and the Board on how we are performing on national reportable metrics required by Scottish Government (SG).

As part of the evolution of the IPR, from October 2024, the way in which the IPR is created and presented will change. The IPR will form part of NHS Orkney's overarching Performance Management Framework (PMF), the umbrella framework for how we measure organisational performance. We will introduce the PMF in 2 phases:

- **Phase 1** (Quarter 2 2024/25) - the PMF will include KPIs from our Corporate Strategy (including the Anchor Strategy), our Annual Delivery Plan (NHS Scotland Planning Framework) and key national and operational metrics/local metrics.
- **Phase 2** (Quarter 1 2025/26) – the PMF will evolve to include KPIs from our refreshed Clinical Strategy and the Integrated Joint Board (IJB) strategic plan.

Performance reporting will be via a performance scorecard for each chapter of the IPR. Where a national/local indicator is off-track an exception report will be provided outlining the reasons, risks and mitigating and improvement actions being taken to bring performance back on track.

The full IPR will be brought to the Senior Leadership Team and public Board bi-monthly from October 2024 after the detailed chapters of the IPR have been scrutinised by our Board Committees (ie workforce chapter to Staff Governance Committee, Finance, Operational and Community performance to Finance and Performance Committee and Population Health and Quality, Safety and Experience to Joint Clinical Care Governance Committee).

Benchmarking against other Health Boards will not be included in the IPR unless it has been validated and published by Public Health Scotland as it is essential our data is correct and of a high quality and standard if we are to maintain a high-performing, accountable, and patient-centred healthcare system in Orkney.

To note – For some sections of the IPR the latest data is not available or does not reflect the current reporting period. The reasons are as follows:

- **Workforce Sickness Absence –** There is a 6-week lag in national reporting.
- **Population Health -** Most screening programmes report performance annually and several months after delivery.

Work is taking place at a national level to agree the national targets for Women and Childrens services, once agreed they will be included in the IPR.

2.3 Assessment

2.3.1 Quality/Patient Care

Performance metrics within the safety and quality section are vital as they provide assurance and evidence that our system is safe and we are focused on and demonstrating our commitment to delivering better outcomes for patients, through a structured approach to early resolution to challenges or obstacles to success.

The quality and patient safety metrics have been expanded and now include:

- Complaints received - stage 1 and stage 2: received, Closed within 5 days and % compliance over time
- Scottish Public Services Ombudsman (SPSO) requests over time
- Compliments received over time
- Incident reports by quarter and variation change
- Serious Adverse Event Reviews (SAERs) commissioned and overdue
- Inpatient falls and new pressure ulcers month on month
- Maternity Care RAG status and percentages on care indicators
- Number of primary/multiple births by quarter
- Babies breastfed by quarter

KPI's for Maternal Early Warning System, Paediatric Early Warning Scores (PEW's) and Multi-Drug Resistant Organism, (MDRO) hospital and community-acquired) will be included in the October 2024 IPR.

2.3.2 Workforce

Across NHS Orkney, 62 out of 90 teams (69%) completed their action plans within the iMatter system. This is an 11% increase from last year and a 40% increase from the 2022 results.

Aligned with our Corporate Strategy's People priority, an externally-commissioned review of our People and Culture function has been initiated. This review is being conducted by the Chartered Institute of Personnel and Development (CIPD). The review began on August 1 2024 and is expected to last approximately 8 weeks, with a feedback presentation anticipated at the beginning of October 2024.

Sickness absence had increased by 0.80% in May 2024 to 6.35% when compared to April 2024 when it was 5.56%. The national average for May 2024 was 6.39%, an increase of 0.20% when compared to the month before. Anxiety, stress, depression, and other psychiatric illnesses account for just over 30% of all absences followed by other musculoskeletal problems at 12.72%.

Recent challenges in the process for locum arrangements has caused delays in supporting some community-based services. Significant vacancies still exist in several key areas, most notably, Speech and Language Therapy and First Contact Physiotherapy.

2.3.3 Financial

We are delivering against our Board-approved deficit plan for 2024/25 of £5.778m, however this is non-compliant against the requirements set out by Scottish Government due to this not presenting an improvement on the 2023/24 financial planned deficit of £3m and is a deficit which is in excess of the £1m brokerage cap set by Scottish Government. The reliance on agency supply is much lower when compared to the first quarter of the 2023/24 financial period.

The overall savings delivery is higher than plan at the end of Quarter 1 with £3.192m in implementation, of which £2.547m is expected to be recurrent (above the 3% target).

2.3.4 Risk Assessment/Management

The following risks are captured in the Corporate Risk Register which may impact on the Board's ability to timeously deliver patient care, impacting on the patient experience:

Risk 510 - Corporate Finance Risk - The Board's financial plan is profiled to be more challenging over the second half of the year in line with the profile of the efficiency programme - therefore the current run rate

needs to reduce to deliver the full year deficit plan. The Board needs to try and improve on the £5.778m deficit plan and reduce the continued reliance on brokerage support from Scottish Government.

Risk 1225 - System Capacity - There is a risk that through lack of availability of Residential Care Home beds, that the patient journey is a poor experience with lengthy delays of transfers of care. This system wide pressure on Acute Capacity equates to a risk that elective procedures are cancelled meaning delays in treatment and staffing pressures are experienced with an increased nurse to patient ration. Lack of system capacity also risks longer waits for patients presenting acutely at the Emergency Department with a risk that we are unable to offload Scottish Ambulance Service (SAS).

Risk 1228 - Fragile Services - Lack of some sustainable clinical services leading to long waits for patients and potential adverse outcomes and harm (for example Pain, Ophthalmology, Dentistry, Rheumatology).

There will be changes to the provision and funding for the mobile MRI scanner from Apil 2025. Discussions are ongoing with the Scottish Government with options proactively being explored.

Major childhood programme schedule changes and the introduction of a new Varicella immunisation programme in 2025 may be affected by an expected 3-months delay in the national implementation of the new Child Health IT system, which was initially expected to be launched at the end of 2024. The local implementation group will monitor the situation and ensure that vaccination will be offered as per national policy.

2.3.5 Equality and Diversity, including health inequalities

The Local Screening Equity Plan will be presented at the Clinical Governance Group meeting on 13 August 2024 for approval and implementation to take forward actions to increase screening uptake in harder to reach populations.

2.3.6 Climate Change Sustainability

NHS Orkney is a leader in terms of sustainability and addressing climate change. There is one deliverable within the Annual Delivery Plan and NHS Orkney Strategic Priorities for 2023/24 linked to Climate Change Sustainability.

2.3.7 Other impacts

As outlined in NHS Orkney's Corporate Strategy, a key action is to work collaboratively with the five other Territorial Health Boards in the North of Scotland to ensure we have sustainable clinical, digital, and corporate services contributing to NHS Orkney's place strategic objective.

2.3.8 Communication, involvement, engagement, and consultation

Discussions have taken place with section leads, Executive Leads, Health Intelligence Team, Director of Improvement, Recovery Director, Head of Improvement and NHS Orkney's Chief Executive in the development of this paper. Executive Leads for Acute, Community and Finance have contributed to and signed off the IPR following engagement with services areas.

2.3.9 Route to the Meeting

The IPR has been prepared for the purposes of the Board in August 2024.

- Senior Leadership Team – 4 August 2024

2.4 Recommendation(s)

Assurance – The Board is asked to:

I. R**eceive** and **scrutinise** the Integrated Performance Report (IPR) for June 2024
II. Seek **assurance** on delivery and consideration of the implications of current performance levels
III. **Note** the changes to the IPR from October 2024 (see agenda item 12.3 for fuller details)

2 List of appendices

The following appendix is included with this report:

Appendix 1, Integrated Performance Report June 2024

NHS Orkney

Integrated Performance Report

June 2024

Chief Executive: **Laura Skaife-Knight**

Workforce, Safety & Quality, Finance, Operational Standards, Community, Population Health

HEALTH Intelligence
ORK.healthintelligence@nhs.scot

Executive Summary

Domain	Going Well	Cause for Concern
Workforce Pages 5 to 8	• Work continues on overseeing the Employee Assistance programme with the launch of the App to support staff. • Automated email reminders have positively impacted the learning modules, with all Statutory and Mandatory e-learning training within the 70-90% range. • Collaborative planning is underway across the organisation to embed the 23/24 Agenda for Change pay settlement; reduction in working week, protected learning time, Band 5 nursing job description review. • Appraisal rates are improving month on month (> 30%). • Across NHS Orkney, 62 out of 90 teams (69%) have completed their action plans within the iMatter system. This shows an 11% increase from last year and a 40% increase from the 2022 results. • Aligned with our Corporate Strategy's People priority, an externally commissioned review of our People and Culture function has been initiated. This review is being conducted by the Chartered Institute of Personnel and Development (CIPD). The review began on August 1 and is expected to last approximately 8 weeks, with a feedback presentation anticipated at the beginning of October 2024.	• Ongoing concerns regarding completion of Personal Development Plans and discussions taking place regarding contingencies to put in place. • Face-to-face compliance for Statutory and Mandatory training remains a problem for reporting – plans are currently being created to address this with trainers also undertaking additional training. • Sickness absence had increased by 0.80% in the month of May to 6.35% when compared to April when it was 5.56%. The national average for May was 6.39%, an increase of 0.20% when compared to the month before. Anxiety, stress, depression and other psychiatric illnesses account for just over 30% of all absences followed by other musculoskeletal problems at 12.72%.
Safety & Quality Pages 9 to 14	Operational clinical governance has been progressively updated over the last six months with clearer routes for reviewing and approving processes and procedures. There is now a need to ensure all those involved with clinical governance have visibility and clear understanding of what has changed and how this supports transparency and accountability. The metrics reported in the IPR have been expanded to include maternity, falls and pressure ulcers. The number of complaints remains low, with more positive feedback reports more than double that of complaints.	The electronic systems used to record and manage incident reporting, complaints, SAER and risks does not support thematic analysis and limits improvement activity in these domains. The system will be reviewed for potential replacement in 2024/25. Challenges remain of small teams, manual reporting and the resource requirements for board reporting to Scottish Government that are similar for all boards irrespective of patient population.
Finance Pages 15 to 18	• Director of Improvement, Recovery Director and Head of Improvement in post. • 2023/24 outturn in line with that most recently reported to Board and Scottish Government. The 2023/24 annual accounts production progressing on schedule. • 2023/24 outturn was favourable to the £6.2m deficit forecast at point of escalation. • 2024/25 financial plan approved by Board (although non-compliant with Scottish Government).	• 2023/24 outturn position was £5.1m above revenue allocation and £2.1m higher than the original £3.0m deficit plan. • Escalated to level 3 under the Scottish Government Intervention Framework. • 2024/25 financial plan of £5.8m non-compliant with Scottish Government. • Capacity and stability in the Financial leadership team. • Reliance on repayable Brokerage from Scottish Government.
Operational (Acute) Standards Pages 19 to 27	• Cancer Performance - Standard agenda for Orkney Cancer Care Delivery Group drafted, focussed calls with Scottish Government have taken place, and engagement with North Cancer Alliance to support planning. • Weekend discharge rates improving. • Continued strong performance vs. 4hr emergency access standard. • An improvement in inpatient waiting times; mainly in part due to Ophthalmology patients being treated within the month.	• High numbers of multiple cancelled operations - review underway. • Our outpatient waiting list continues to grow with long waits (>52 weeks) in Ophthalmology, Pain Management, and Dentistry. However, there was an increase in activity within Ophthalmology in June, with specialists from NHS Highland matching the time missed from earlier on in the year. • Bed occupancy remains high • Funding for the mobile MRI scanner will only continue until April 2025
Community Pages 28 to 35	• Both Child and Adolescent Mental Health Services and Psychological Therapies met the waiting time guarantee for June 2024. • Numbers seen within MSK Physio increasing; with more seen than referred. • Physio dashboard now developed; assisting greatly with using the data to drive improvement • No adverse waits in Orthotics. • More return patients seen since April within Speech and Language Therapy	• Increasing demand and complexity of patient need. • Very few MSK Podiatry patients seen this month due to continual annual leave of a small team • Staff working to the very top of their registration. • Shortage of a First contact Physio in Primary Care and staff shortages in Speech and Language Therapy.

Executive Summary - Continued

Domain	Going Well	Cause for Concern
Population Health Pages 37 - 40	• Roll out of Very Brief Intervention training for NHS Orkney, OIC and third sector to increase appropriate referrals. • Planning for RSV new vaccination programme underway. Childhood vaccination uptake consistently above Scottish average. Completion of Covid-19 programme delivery and delivery of breast screening programme.	• Consultant capacity for specialist delivery and leadership due to vacancy. • Smoking cessation target for NHS Orkney has remained unchanged since prior to the pandemic and is set at a level which is particularly challenging to achieve.

Sections

1. Workforce
2. Safety & Quality
3. Finance
4. Operational (Acute) Standards
5. Community
6. Population Health

Workforce

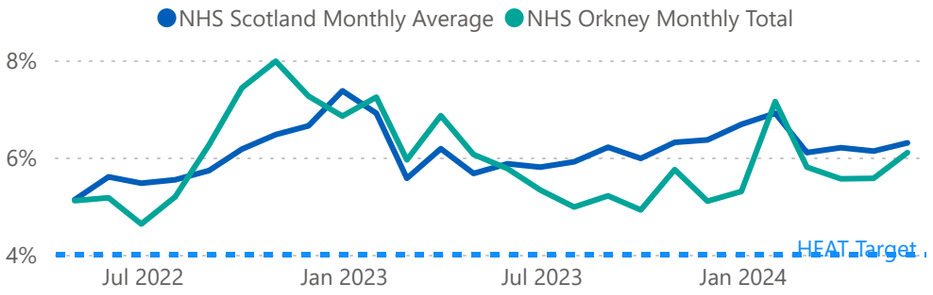
Section Lead: Director of People and Culture - Jay O'Brien

Comments	Successes	Challenges
The response rate to the iMatter survey for 2024 increased by 10% compared to the previous year. The results were published on 6 June 2024. In our organisation, the Employee Engagement Index score is 75, compared to 74 last year, and the overall experience of working in NHS Orkney, rated on a scale of 0-10, is 6.5, compared to 6.4 last year. As part of our commitment to continuous improvement, we are in the process of setting up an additional feedback system. This system, will support in-the-moment feedback and help us gather qualitative information to support our action plans.	Directorates have a better understanding of reasons for sickness absence through enhanced monthly reports. 12 people attended job evaluation training which will greatly improve the timeliness and partnership working for job matching and consistency checking. Safe care usage across the organisation is improving, with increased usage being seen weekly.	Continued focus is needed for mandatory training, in particular supporting staff to attend in-person courses. Appraisal rates has stalled at just above 30% so work is ongoing with managers to complete appraisals with their teams.

Sickness Absence (Source: Workforce Dashboard)

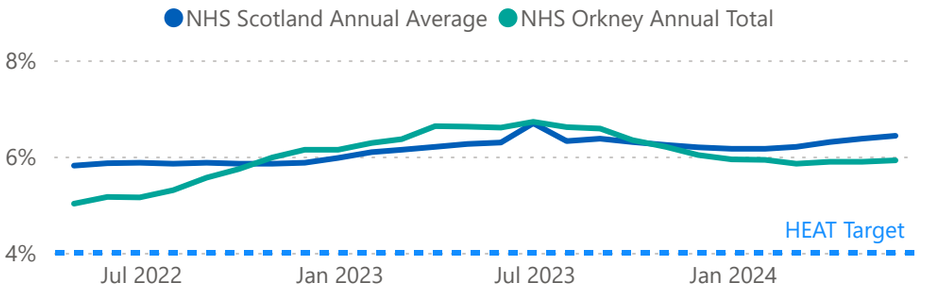
Latest Data: May 2024

Monthly Comparison - NHS Scotland & NHS Orkney



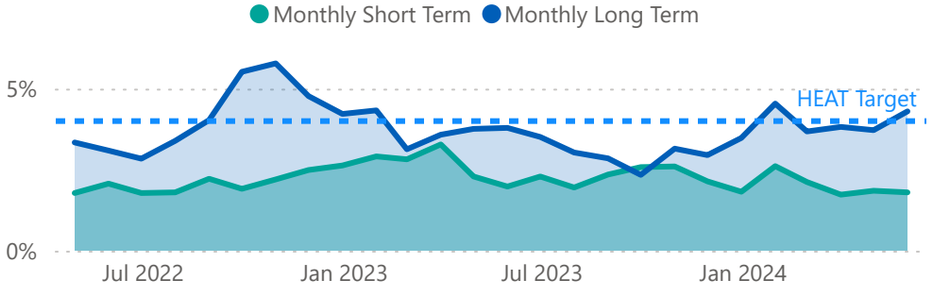
Latest Month
May 2024
6.30% NHS Scotland
6.10% NHS Orkney

Annual Comparison - NHS Scotland & NHS Orkney



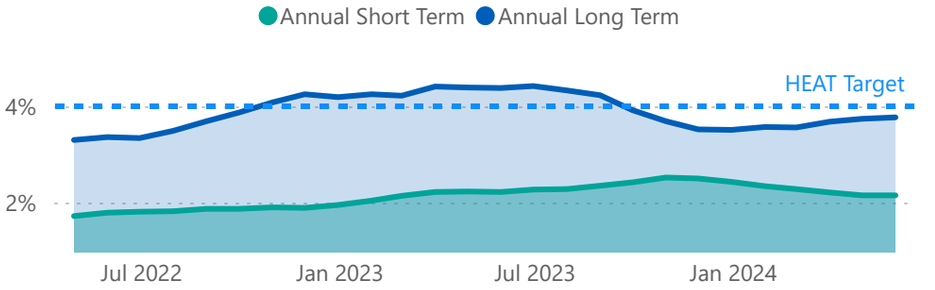
Latest Month
May 2024
6.43% NHS Scotland
5.92% NHS Orkney

Monthly Comparison - NHS Orkney Long & Short Term Absence



Latest Month
May 2024
1.80% Short Term
4.30% Long Term

Annual Comparison - NHS Orkney Long & Short Term Absence



Latest Month
May 2024
2.15% Short Term
3.77% Long Term

Issues/Performance Summary

For the month of May 2024, NHS Orkney monthly absence percentage is 6.10%, a decrease of 0.53% on April performance. The NHS Scotland average is 6.30%.

Sickness absence due to Anxiety/stress/depression/other psychiatric illnesses in May 2024 continues to be the most common reason for absence. Other musculoskeletal problems is the second most common reason in May 2024. This is being picked up through the Occupational Health, Safety and Wellbeing Committee and through responses to the staff stress survey, as it is unknown if this is related to a work or personal situations.

Planned/Mitigating Actions

Organisational responses are being built into the experience programme and managers are building local responses into iMatter action plans.
Employee Assistance Programme awareness sessions have been undertaken with management referrals being introduced where appropriate. We will continue to promote access to the self-help app.
Advanced reporting shared across Directorates to support managers to understand number of hours lost due to sickness absence but also to highlight the main reasons for absences.
A wellbeing micro site has been created with local information to support colleagues.
Best practice education sessions for appraisals include managers having regular one-to-one meetings with team members.

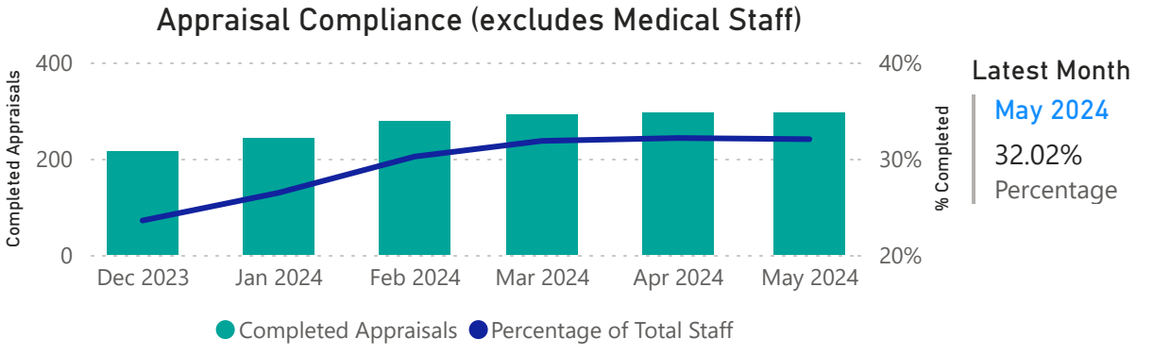
Assurance/Recovery Trajectory

Confident that all absences are being recorded in SSTS, and that the right training was provided to help managers talk about absence matters.

Areas where it is identified that sickness absence procedures are not followed will be escalated through Directorate line management.

Training is available when needed with an additional TURAS module now available.

Appraisals & Statutory/Mandatory Training (Source: Workforce Dashboard) Latest Data: May 2024



Division	June 2023	September 2023	December 2023	March 2024
Director of Finance	28.09%	27.40%	27.71%	38.27%
Director of Human Resources	31.82%	55.60%	58.62%	68.97%
Director of Nursing & AHP and Acute Services	16.63%	7.90%	20.17%	23.51%
Director of Public Health	38.89%	47.10%	52.94%	58.82%
Head Children Families and Criminal Justice	36.36%	36.80%	60.34%	62.07%
Head of Estates and Facilities	20.14%	20.40%	33.33%	48.25%
Head of Health & Community Care	6.40%	14.50%	6.61%	5.69%
Head of Primary Care	22.64%	20.50%	28.71%	33.33%
Organisational	19.40%	19.60%	23.57%	31.84%

Module	2023/05	2023/07	2023/09	2023/11	2024/01	2024/03	2024/05
Adult Support and Protection	33.3%	58.1%	67.0%	72.2%	78.5%	84.9%	83.6%
Breaking the Chain of Infection	81.8%	81.5%	81.5%	56.9%	87.4%	86.7%	89.2%
Child Protection	31.4%	56.4%	68.7%	73.8%	78.5%	84.4%	84.0%
Cyber Security	77.8%	80.3%	80.2%	67.7%	86.7%	88.8%	84.5%
Equality & Diversity	68.8%	76.8%	79.5%	68.6%	85.8%	86.3%	86.1%
General Fire Safety	42.2%	61.8%	66.1%	68.9%	77.0%	80.5%	75.5%
Hand Hygiene	78.3%	78.5%	78.7%	56.1%	85.5%	85.0%	87.6%
Health & Safety	71.3%	73.3%	75.6%	71.4%	77.0%	80.9%	78.6%
Information Governance	83.8%	83.8%	78.8%	70.1%	79.2%	78.7%	77.6%
Moving & Handling	84.6%	85.2%	86.1%	70.9%	85.3%	79.9%	77.1%
Prevent	59.3%	67.9%	71.1%	74.3%	80.9%	87.2%	84.4%
Respiratory & Cough Hygiene	77.1%	77.7%	77.9%	54.1%	85.4%	85.3%	86.7%
Violence & Aggression	81.1%	81.4%	82.5%	68.6%	87.7%	89.5%	85.4%
Why IP&C Matters	71.4%	68.2%	68.8%	56.4%	71.0%	73.4%	71.5%

>= 90% >= 70% < 90% >= 50% < 70% Under 50%

Issues/Performance Summary

March 2024 sees the compliance rate of 31.84% for appraisals across the organisation. This represents a 8.27% increase since December 2023. Work continues in this area with the Team providing overall support (including 1-2-1) with Managers and Teams which will see the improvements continue. Complexity within the system to provide 100% assurance of statutory/mandatory training (still operation with historical LearnPro training data).

Planned/Mitigating Actions

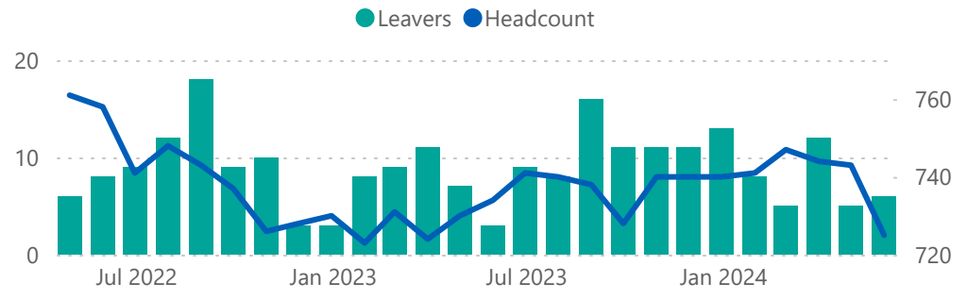
Action raised via Staff Governance Committee to the Board, Executives now have appraisal targets contained within personal objectives.
Currently reviewing all training available to support managers and colleagues to prepare and undertake yearly appraisals.
Direct emails continue to be sent to increase colleague awareness of training compliance.
Managers have been provided with training reporting awareness sessions and People and Culture are visiting teams to have collective conversations about best practices for appraisal.
Statutory/mandatory training compliance group review data for subject matter expert input.

Assurance/Recovery Trajectory

Appraisal awareness training is now available on Turas Learn. This is split into 2 sessions, which are targeting the reviewer and then the reviewee. Sessions are currently available twice monthly.

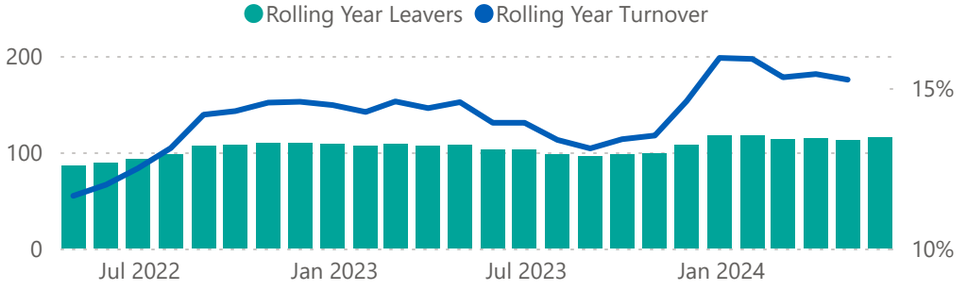
Staff in Post/Turnover & Breakdown of Hours (Source: Workforce Dashboard) Latest Data: May 2024

NHS Orkney - Headcount & Leavers



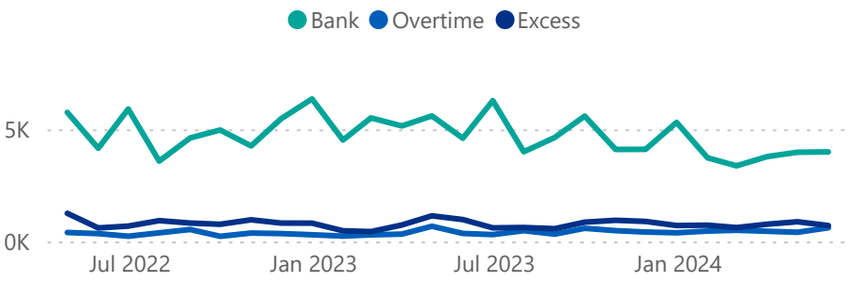
Latest Month
May 2024
725 Headcount
6 Leavers

NHS Orkney - Headcount & Leavers (Rolling Year)



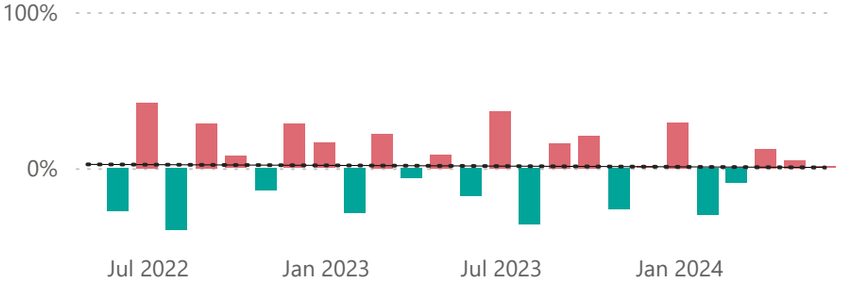
Last 12 Months
May 2024
115 Leavers
738.91 Avg. Headcount

NHS Orkney - Hours Utilisation



Latest Month
May 2024
3,994.97 Bank
609.92 Overtime
708.88 Excess

NHS Orkney - Bank Hours Utilised vs. Previous Month



Latest Month
May 2024
3,994.97 Hours
0.42% Variance

Issues/Performance Summary

There were 10 new starters in April 2024. 6 people left the organisation in the month, with a rolling twelve-month turnover of 15.26%.

Planned/Mitigating Actions

The workforce improvement stream is undertaking a full analysis of the contracted and budgeted information to better align these. Most Executive portfolios are complete with acute services and IJB to work through.
Bank, Overtime and Excess hours data will be shared with Senior Leadership Team monthly to support Directorate expenditure reviews.
Director of People and Culture now Chairs the Vacancy Control Panel and is revising Terms of Reference and Standard Operating Procedures.
Chief Executive has requested that overtime and travel requests also come through the Panel, or that a new Business as Usual sign-off approach is agreed. Recruitment campaign being planned for launch in the Quarter Three of 2024/25. NHSO continues to contribute to the international Recruitment Team for the North of Scotland and will review the local impact of participation.

Assurance/Recovery Trajectory

Detailed analysis of turnover is underway and will be reported through the Area Partnership and Staff Governance Committee. This will inform targeted recruitment activity.

To ensure overtime is used appropriately, overtime within each Directorate must be approved by their Executive Director prior to using it or via the Executive Director on-call if urgent.

The Improvement Hub is recording the approved hours versus the hours used for comparison and conversation within each Directorate.

Safety & Quality

Section Lead: Medical Director - Dr Anna Lamont

Comments

The metrics for IPR reporting have been expanded and now include:

- Complaints received - stage 1 and stage 2: Received, Closed within 5 days and % compliance over time
- SPSO requests graphed over time
- Compliments received over time
- Incident reports by quarter and variation change
- SAER reviews: Commissioned and Overdue
- Inpatient falls and new pressure ulcers month on month
- Maternity Care RAG status and percentages on care indicators
- Number and prim/multip births by quarter
- Babies breastfed by quarter
- Delivery method by quarter

Training overall for incident/complaint reporting, and investigation training remains an organisational objective. Suitable online modules are available and are promoted.

Improving take up of training will impact the quality of data NHSO can present for incidents and complaints in future.

The learning summaries from SAERs are shared with SLT for review and to the Clinical Quality Group for review, alongside the action plans for scrutiny and oversight.

Successes

- Continued reduction in the percentage and number of overdue SAER reports.
- The clinical governance structure has been under review and the quality forum is meeting as the monthly Clinical Quality Group with a quarterly Clinical Governance Committee. The first quarterly committee meeting was in June 2024.
- Responses to complaints within the target timeframe has risen over six months and remains high.
- Quarterly clinical governance forward look reporting established.

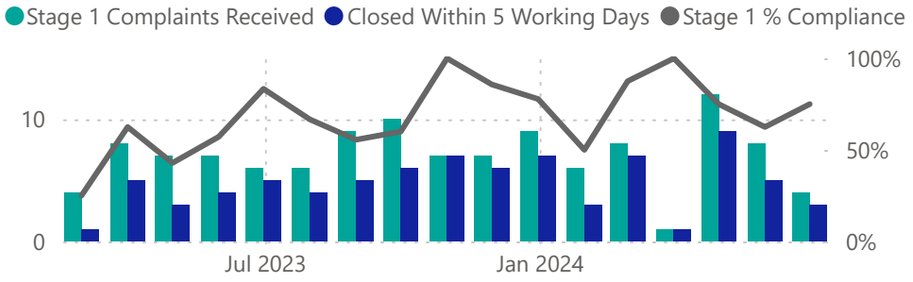
Challenges

- Vacancy within Clinical Governance (CG) team continues to impact on capacity to respond timeously.
- Limited capacity of team leads, senior charge nurse, senior charge midwife and senior leaders to review clinical incidents.
- Communication of the learning from incidents, complaints, and Significant Adverse Event Review to staff.
- Continuing effective senior clinical engagement in Q&S with operational challenges.
- Managing the overdue incidents effectively due to limited resource.
- Effectively embedding learning in the organisation and closing the loop on incidents and learning.
- Multiple sources of data, with particular challenges of validating over shared systems including NHS Grampian.

Complaints & Compliments (Source: Datix, Patient Experience Officer)

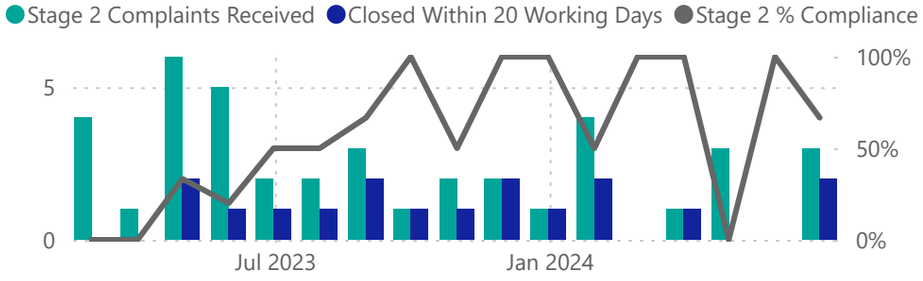
Latest Data: June 2024

Complaints Received - Stage 1



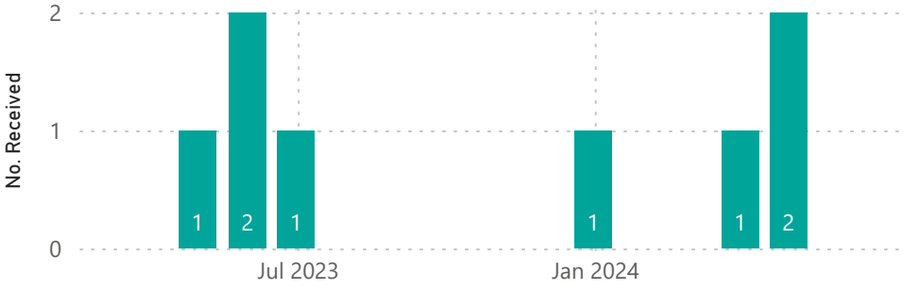
Latest Month
June 2024
4
Stage 1
3
Closed within 5 Days

Complaints Received - Stage 2



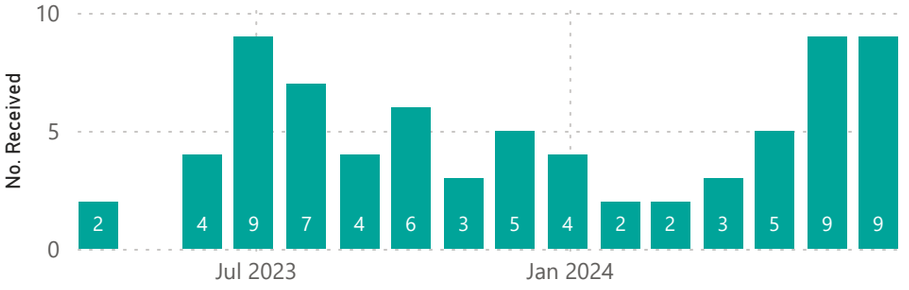
Latest Month
June 2024
3
Stage 2

Scottish Public Services Ombudsman



Latest Month
June 2024
0
SPSO Received

Compliments Received



Latest Month
June 2024
9
Compliments

Issues/Performance Summary

In Q1, April to June 2024, themes for complaints related to issues such as care and treatment, access to services and communication issues.
The complexity of complaints can lead to delays in responding within the expected timeframe when related to other Health Boards or spanning Health and Social Care. Currently the data doesn't capture when an extension has been agreed with the complainant and when we respond within the agreed timeframe. The system currently used to manage patient feedback is difficult to navigate and makes extracting information more difficult. The Safety, Quality and Risk team currently has a vacancy which reduces the capacity of the team to support the investigation on complaints. At present we don't look at themes and trends from Compliments. Implementation of Care Opinion will include encouraging staff to log compliments and how we collate themes and trends from these.

Planned/Mitigating Actions

Patient experience is recorded within RL Datix but the limitations to the system limits analysis to manual review and cannot collate with incidents, SAE and compliments. Further process developments are being assessed for future reporting including the use of Care Opinion for patient feedback.

The vacancy within the Safety, Quality and Risk team is currently going through the process to recruit to.

The policy for the management of complaints and other patient feedback is being reviewed. Part of this review is looking at how we pull themes and trends from patient feedback.

Assurance/Recovery Trajectory

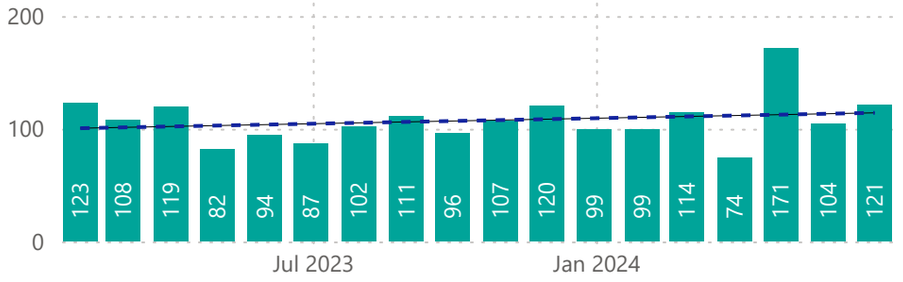
The Maternity Service have updated their bulletin board to include information to service users and guidance on where they can seek further support and they have increased the infographics that were already in place. The numbers of complaints received into the organisation remains low, with an average of 2.5 stage 2 complaints a month. The numbers of complaints escalated to the SPSO remains low.

The organisation continues to receive positive feedback from several sources about care and services.

Services are being actively encouraged to send compliments to the Safety, Quality and Risk team to highlight the good work that is being done.

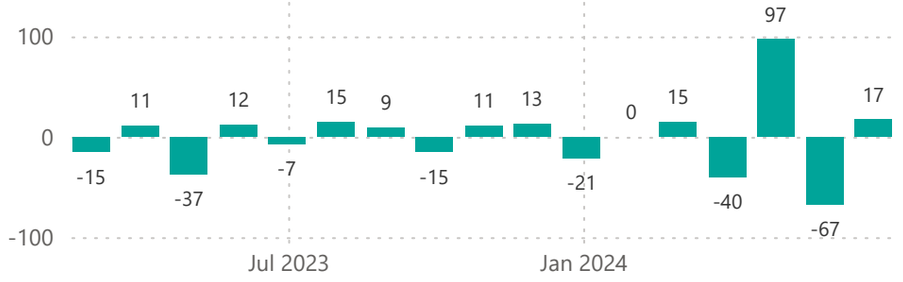
Incident Reporting & Significant Adverse Event Reviews (Source: Datix) Latest Data: June 2024

Incident Reporting



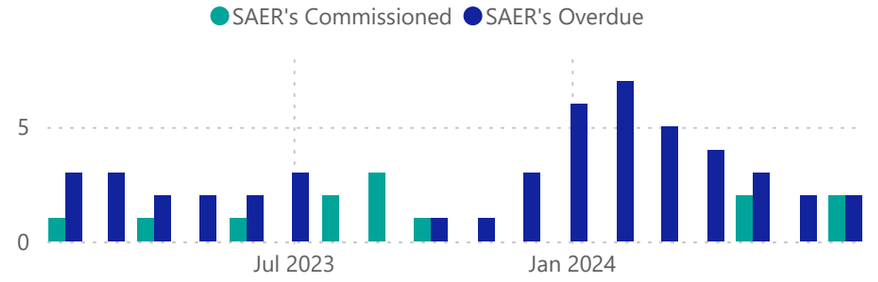
Latest Month
June 2024
121
Incidents Reported

Incident Reporting (Monthly Increase/Decrease)



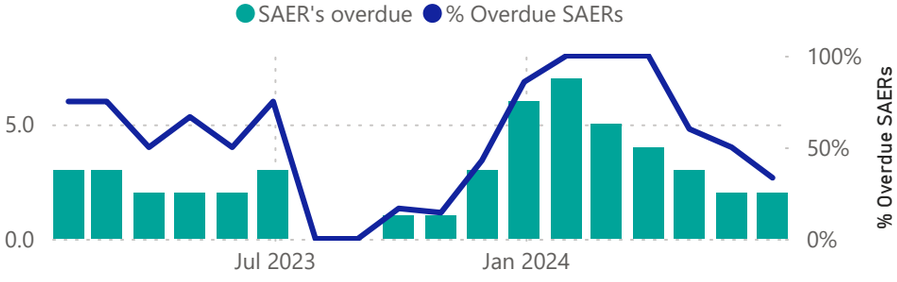
Latest Month
June 2024
121
Incidents Reported
17
Change vs. Last Month

Significant Adverse Event Reviews



Latest Month
June 2024
2
SAER's commissioned
33.33%
% Overdue SAERs

Significant Adverse Event Reviews - No. Overdue



Latest Month
June 2024
2
SAER's overdue
33.33%
% of Total SAERs

Issues/Performance Summary

Slips, Trips and Falls remains the highest reported incident category for each month. This category is used in NHSO to record when the patient is assisted by staff to chair or floor as well as falls. These cannot be differentiated within the current RL Datix system. Medication related incidents and information governance follow as the second highest reported incidents. None of the information governance incidents recorded were reportable under the General Data Protection Regulations and primarily related to internal emails being sent to the wrong recipient. No trend was identified in Medication incidents with these incidents reflecting the many diverse incidents that are included in this category. There was an increase in incidents reported about the emergency mental health transfer room, including reports from multiple staff involved in a significant adverse event and consequential impacts.

Planned/Mitigating Actions

The previous data showed overdue Significant Adverse Event Reviews that were commissioned within the year, this wasn't fully reflective of the numbers of overdue Significant Adverse Event Reviews. The data now reflects all open Significant Adverse Event Reviews.

A combined safety quality and experience quarterly report is now being provided to SLT from Q1 2024.

Training in complaints and feedback, and investigation skills have been identified and are available for staff but are not part of mandatory training requirements. These modules are now being highlighted to staff and those who may have to investigate complains are being encouraged to undertake the online training.

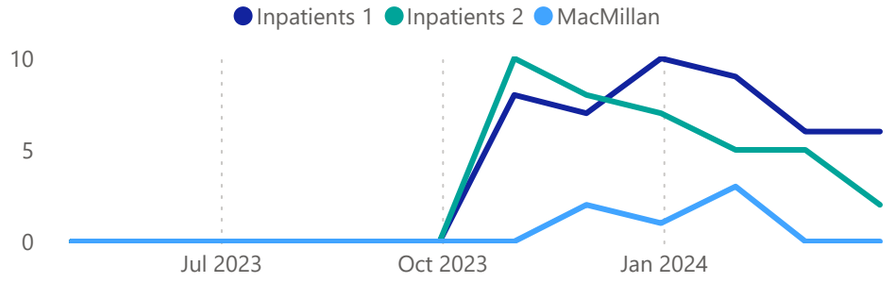
Assurance/Recovery Trajectory

SAEs are incidents that have resulted in serious harm or death. As an example of good practice NHSO manages all SAEs as if organisational duty of candour applies and offer an apology to the patient, invite them to be involved in the review of the incident and explain what the review entails. Once the review has concluded, we offer an opportunity to meet with the team patient to go through the report and answer any questions they have and give them provide a copy of the report. The numbers of Significant Adverse Event Reviews is low and reducing, though caution is advised in interpreting trends with such small numbers. The current overdue Significant Adverse Event Reviews have been reviewed within the updated clinical governance framework to be closed for sign off by end August 2024. The learning summaries will be shared with SLT as part of revised business as usual process.

Inpatient Falls & Pressure Ulcers (Source: Datix, Ward Documentation)

Latest Data: June 2024

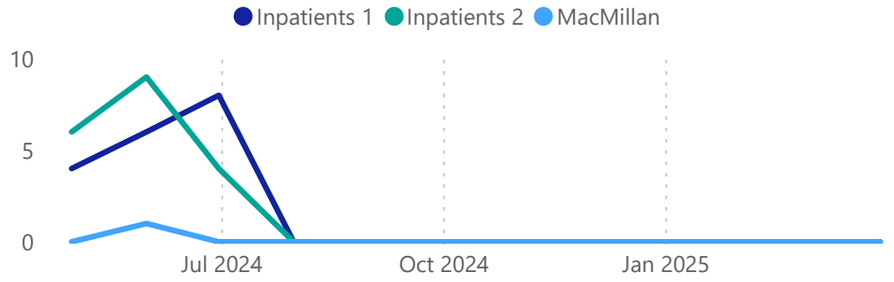
Inpatient Falls - 2023/24



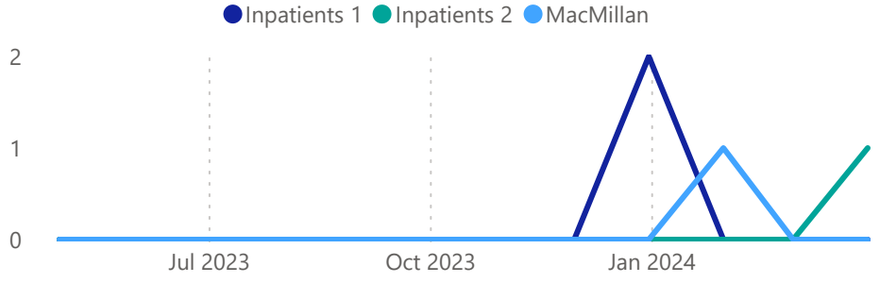
Latest Month: June 2024

- 8 Inpatients 1
- 4 Inpatients 2
- 0 MacMillan

Inpatient Falls - 2024/25



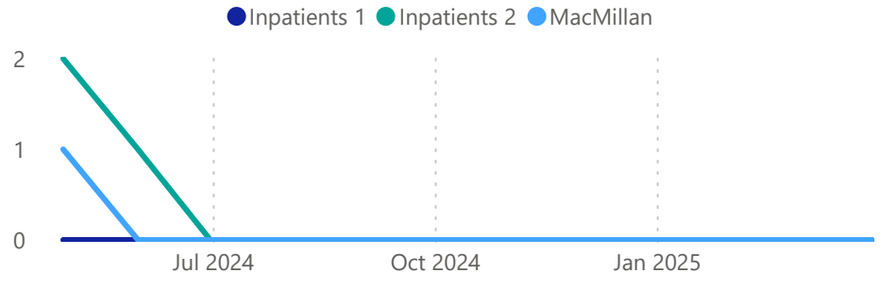
Inpatient Pressure Ulcers - 2023/24



Latest Month: June 2024

- 0 Inpatients 1
- 0 Inpatients 2
- 0 MacMillan

Inpatient Pressure Ulcers - 2024/25



Issues/Performance Summary

NHSO records falls through RL Datix and the limitations of this system means that identification of themes and trends remains a manual process. It is not yet possible to differentiate between when a patient is assisted by staff to chair or floor from a patient fall. While replacement of RL Datix has been deferred, further improvements in identifying trends and providing feedback to wards are being delivered through the Excellence in Care (EiC) combined data set and national electronic dashboard for analysis.

Planned/Mitigating Actions

Within the inpatient acute areas care boards have been established to enable staff to record Excellence in Care (EiC) data and to improve visibility of fall and pressure ulcer rates are, along with the other EiC measures. This will be expanded to include more of the EiC data so that each area can see their areas of excellence and where they need to review their current processes.

Assurance/Recovery Trajectory

The data available for the whole of Q1 2024 for new pressure ulcers has shown a month on month decline from the end of 2023 for inpatient and Macmillan wards. As a new data set for the IPR the representation of this data in updated charts will be presented in the Safety Quality and Experience report for Q1.

Maternity Care RAG (Source: BadgerNet)

Latest Data: March 2024

Data to be recorded	Progress Report provided October 2019	Position as at 30 September 2022	Position as at 31 March 2023	Position as at 30 September 2023	Position as at 31 March 2024
Percentage of women booking in a Board area that are allocated to a primary midwife		100.00%	100.00%	100.00%	100.00%
Percentage of women who received midwifery care during the intrapartum period from their primary midwife and/or secondary midwife (the buddy) or a member of the same team that the woman had met during her pregnancy.		53.70%	70.50%	61.40%	62.60%
Through retrospective case note review is there evidence of a co-produced, individualised birth plan reflective of women's choice and with multidisciplinary input where required such as neonatal or obstetric?	90.20%		100.00%	100.00%	100.00%
Percentage of scheduled antenatal care appointments delivered by by the primary midwife and/or secondary midwife (the buddy)		56.60%	52.50%	63.00%	61.90%
Percentage of community based postnatal midwifery care appointments delivered by the primary midwife and/or secondary midwife (the buddy)		7.80%	5.90%	8.80%	

Issues/Performance Summary

The Maternity data for this month is from the Best Start action plan. This is a requirement for all Maternity Units. There are questions around how to document the 'buddy' Midwife on the BadgerNet system, therefore the data is not accurate at present in regard to the antenatal, intrapartum and postnatal appointments and care.

Planned/Mitigating Actions

Work is ongoing around how to provide assurance around the accuracy of the data provided with Clevermed.

There is work around how to record information within the BadgerNet notes (around additional professionals/buddy midwives) and the information completed for coding to ensure that it is accurate.

Assurance/Recovery Trajectory

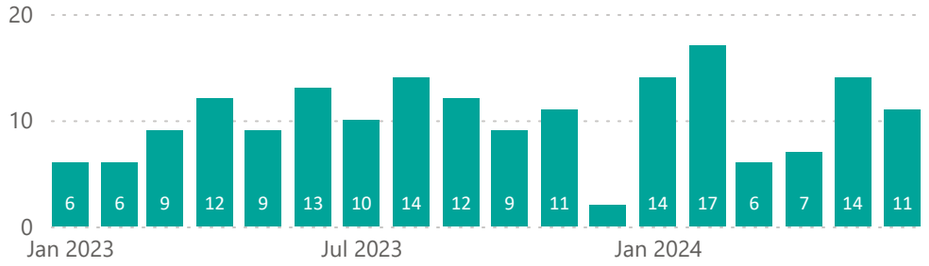
The Maternity service is already meeting several requirements from the Best Start action plan with 100% compliance.

Even without accurately recording 'buddy' midwives within BadgerNet the percentage of women being seen by their primary Midwife in the antenatal period and the intrapartum period remains above 50%.

Maternity (Source: BadgerNet, Senior Charge Midwife)

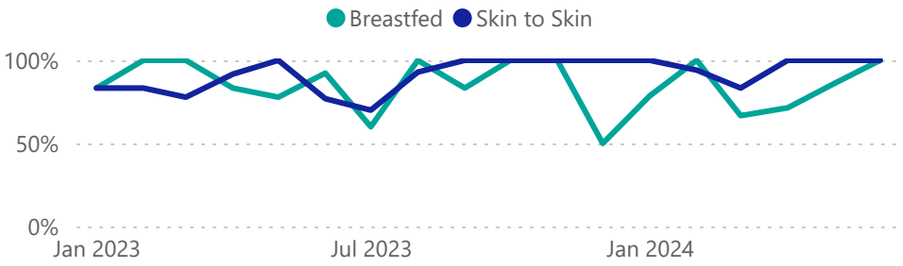
Latest Data: June 2024

Number of Births



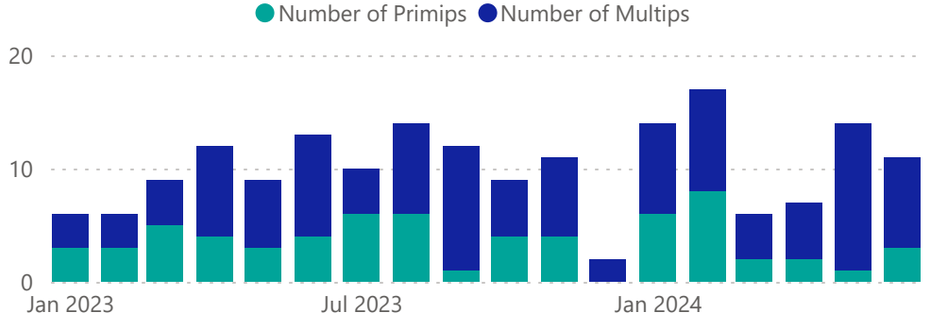
Latest Month
June 2024
11
Number of Births

% of Babies Breastfed and Skin to Skin Contact



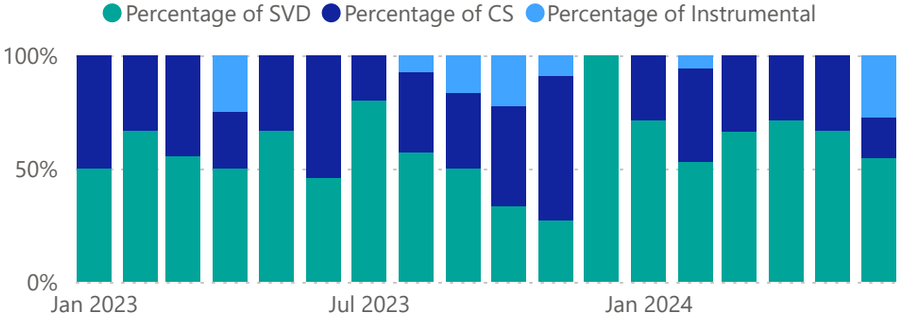
Latest Month
June 2024
100.00%
Breastfed
100.00%
Skin to Skin

Number of Births (Primip/Multip Breakdown)



Latest Month
June 2024
3
Number of Primips
8
Number of Multips

Delivery Method Summary



Latest Month
June 2024
54.50%
% SVD
18.20%
% Caesarean
27.30%
% Instrumental

Issues/Performance Summary

The data within this section is new for this report. Further data to support this is being reviewed and validated.

There is work on going around the Scottish Patient Safety Programme requirements and once the data has been reviewed and validated, this will be included in the IPR.

Planned/Mitigating Actions

Review of data provided currently and national data, so we can provide comparison in future reports.

Review of data available and the validation of this.

Assurance/Recovery Trajectory

Rates of skin to skin contact at birth remain high.

Rates of breastfeeding at birth remain high.

Ongoing training looking at feeding concerns/issues to support staff in continuing to provide high standards of care.

Finance

Section Lead: Recovery Director - Paul Corlass

Comments

NHS Orkney continues to be placed on level three of the NHS Scotland Support and Intervention Framework for Finance.

The Board required £5.156m of brokerage support from Scottish Government at the end of the 2023/24 financial period - 6.6% of the Boards revenue resource limit. This will be an indicator against the Boards future financial sustainability assessment.

The Board is delivering against a Board approved deficit plan for the 2024/25 financial year of £5.778m, however this is non-compliant against the requirements set out by Scottish Government due to this not presenting an improvement on the 2023/24 financial planned deficit of £3.000m and is a deficit which is in excess of the £1.000m brokerage cap set by Scottish Government.

Successes

The Board has made improvements in financial performance since November 2023, the point at which the Board was escalated to level three.

The financial performance after the first quarter of the 2024/25 financial period is a deficit of £1.710m which is slightly favourable to the planned deficit of £1.733m at this stage.

The reliance on agency supply is much lower when compared to the first quarter of the 2023/24 financial period.

The overall savings delivery is higher than plan at the end of Q1 with £3.192m in implementation, of which £2.547m is expected to be recurrent (above the 3% target).

The Board has £1.000m of efficiency schemes in the pipeline which are expected to be converted into delivery during Q2.

Progress is being made on cleansing budgets to improvement budgetary control and accountability.

Challenges

The Boards financial plan is profiled to be more challenging over the second half of the year in line with the profile of the efficiency programme - therefore the current run rate needs to reduce to deliver the full year deficit plan.

There are a number of emerging cost pressures and risks which need to be closely managed and mitigated, including the agenda for change reform.

The Board need to convert the existing pipeline of efficiency schemes into delivery to ensure achievement of the £4.000m full year savings target.

The Board need to try and improve on the £5.778m deficit plan and reduce the continued reliance on brokerage support from Scottish Government.

Capacity within the Senior Finance Team continues to be a challenge.

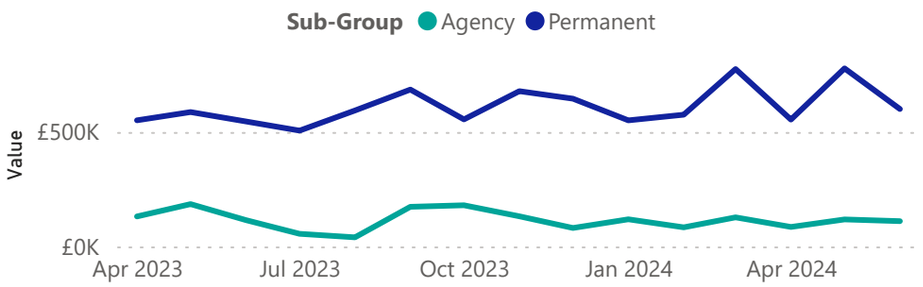
Summary Financial Position — Latest Data: March 2024

Group	Annual Budget	Budget YTD	Spend YTD	Variance YTD
Core RRL	0	0	0	0
Nursing & Acute Services	16,716	16,716	20,311	-3,595
Medical Director	17,592	17,592	17,132	460
Integration Joint Board	29,717	29,717	29,717	0
Finance Directorate	2,128	2,128	2,126	1
Estates, Facilities & NPD Contracts	8,287	8,287	9,027	-740
Chief Executive	1,688	1,688	1,647	41
Public Health	994	994	1,045	-51
Director of Human Resources	1,586	1,586	1,679	-93
Reserves	1,892	1,892	0	1,892
Savings Targets (Board)	-4,390	-4,390	0	-4,390
Additional Savings Target (Board)	-100	-100	0	-100
Savings Achieved (Board)	3,094	3,094	0	3,094
Savings Targets (IJB)	-2,400	-2,400	0	-2,400
Savings Achieved (IJB)	734	734		734
Total Core RRL	77,537	77,537	82,684	-5,146
Non Cash Limited				
Dental NCL	645	645	645	0
Ophthalmic Services NCL	299	299	299	0
Dental and Pharmacy NCL - IJB	912	912	912	0
Total Non Cash Ltd	1,856	1,856	1,856	0
Non-Core				
Capital Grants	-2,099	-2,099	-2,099	0
Non-cash Del	0	0	0	0
Annually Managed Expenditure	61	61	61	0
Donated Assets Income	0	0	0	0
Capital Charges	3,195	3,195	3,195	0
Total Non-Core	1,157	1,157	1,157	0
Total for Board	80,550	80,550	85,696	-5,146

Key Costs: Pay (Source: Board Financial Performance Return)

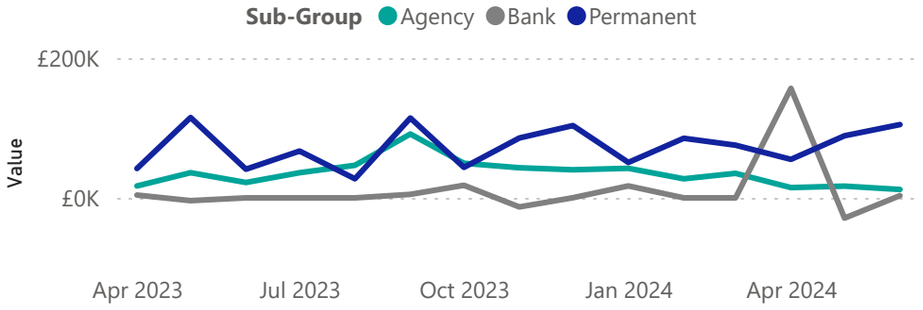
Latest Data: June 2024

NHS Orkney - Consultant



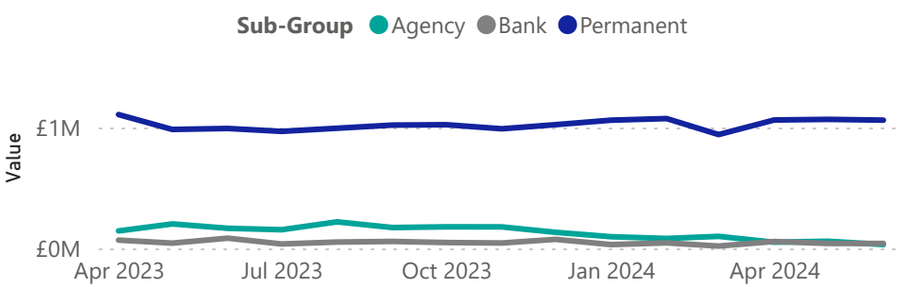
Latest Month
June 2024
£710,800
Value

NHS Orkney - Junior Doctor



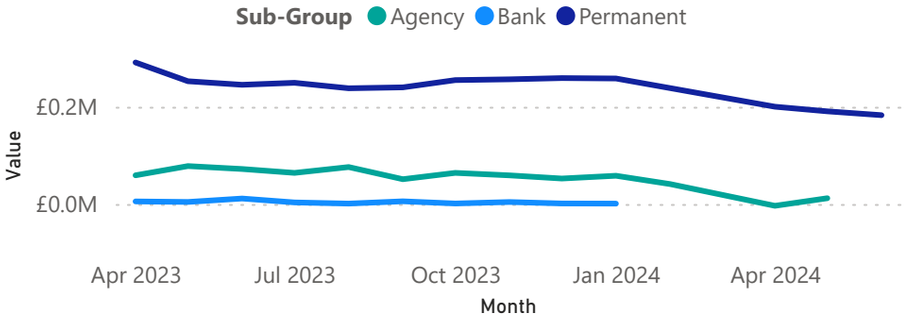
Latest Month
June 2024
£120,100
Value

NHS Orkney - Nursing (Registered & Unregistered)



Latest Month
June 2024
£1,132,400
Value

NHS Orkney - AHP



Latest Month
February 2024
£41,000
Value

Issues/Performance Summary

A significant contributor to the Board's overspend is the continued reliance on temporary staffing models staff to cover gaps in rotas and vacancies. The information presented includes the key costs as reported to Scottish Government through the Financial Performance Return.

There has been improvements in terms of spend relating to temporary staffing models across Acute Nursing, contributing to the improved financial forecast.

Planned/Mitigating Actions

The Director of Nursing, Midwifery, Allied Health Professionals and Chief Operating Officer Acute Services continues to implement, the instructions of the Supplementary Staff Task & Finish Group to reduce reliance and expenditure on nurse agency. There is an exit strategy for all Acute Agency nursing by 31 May 2024.

Work continues to build the Medical payroll locum bank to support unavoidable gaps in rotas in the most cost effective way, whilst ensuring continuity of care to patients.

Assurance/Recovery Trajectory

Enhanced grip and control measures have been introduced, including:

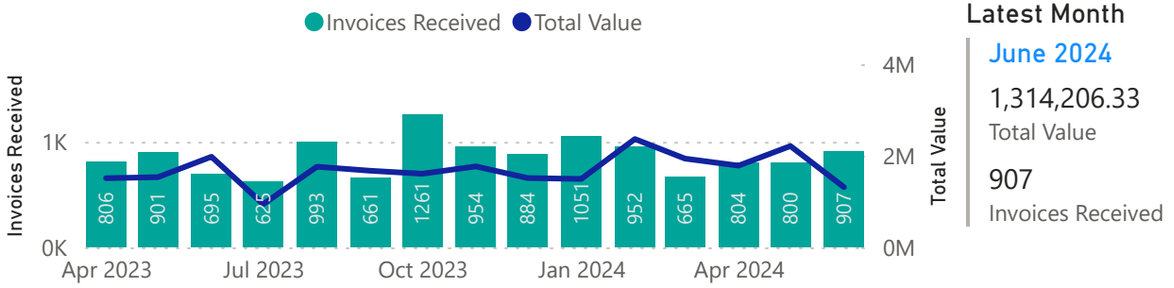
Additional approval for overtime in place with Corporate requests approved by CEO or Director of Finance. Clinical requests approved by the Director of Nursing, Midwifery, Allied Health Professionals and Chief Operating Officer Acute Services.

Locum and agency requests require approval by the Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services or Medical Director.

Accounts Payable (Source: AP Performance Report)

Latest Data: June 2024

NHS Orkney - Invoices Received & Value



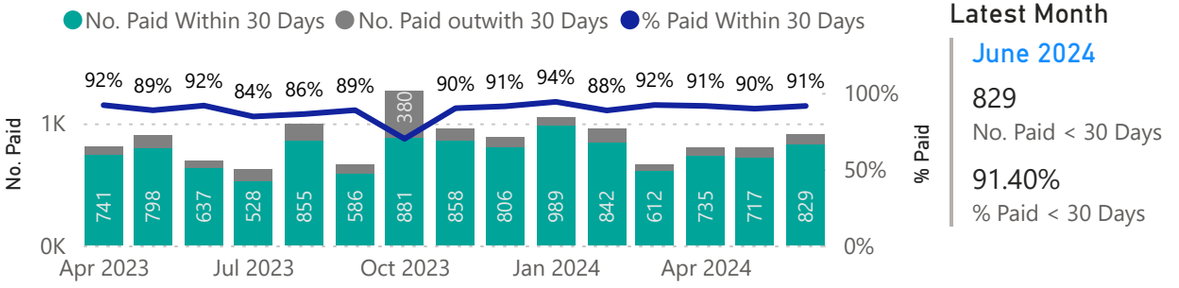
Latest Month

June 2024

1,314,206.33
Total Value

907
Invoices Received

NHS Orkney - Paid Within 30 Days



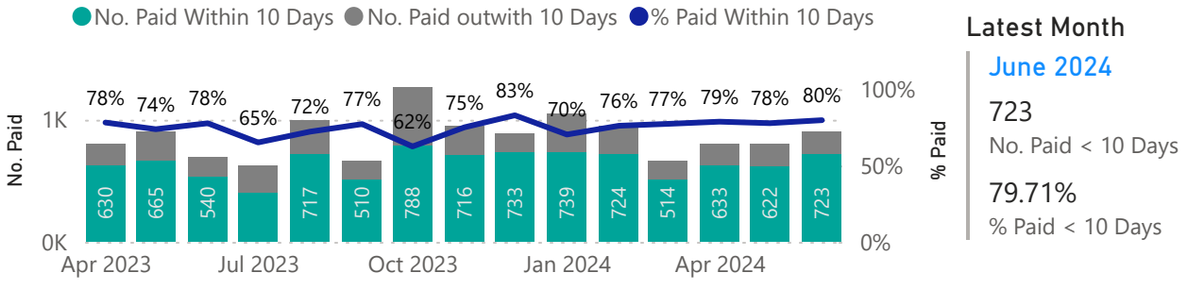
Latest Month

June 2024

829
No. Paid < 30 Days

91.40%
% Paid < 30 Days

NHS Orkney - Aspirational 10 Day Target



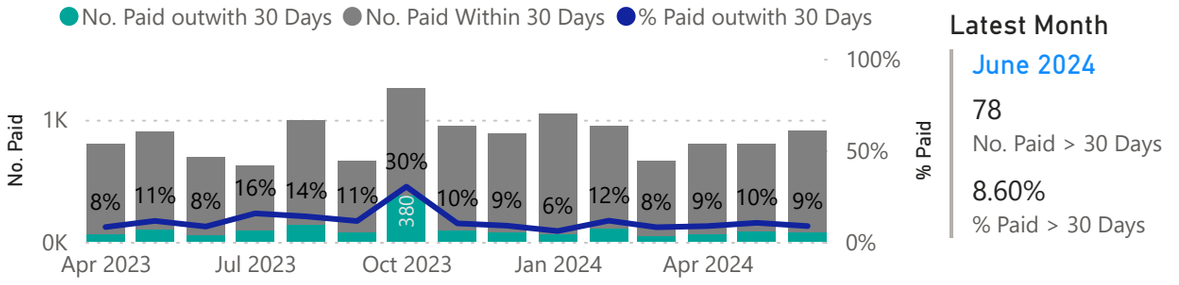
Latest Month

June 2024

723
No. Paid < 10 Days

79.71%
% Paid < 10 Days

NHS Orkney - Paid Outwith 30 days



Latest Month

June 2024

78
No. Paid > 30 Days

8.60%
% Paid > 30 Days

Issues/Performance Summary

91% of invoices processed in April 2024 were paid within the 30 day target. The aspirational target of payment within 10 days showed a performance of 79% in April 2024, an increase of 2% over March 2024 performance.

Planned/Mitigating Actions

The Finance Team continue to communicate to colleagues across the organisation with a view to improving first time matches for all invoices being received (for example goods being receipted at delivery point, no po/no payment).

Assurance/Recovery Trajectory

Increased capacity has resulted in a more proactive approach, with colleagues acting to clear/resolve invoice queries in a timelier manner.

Operational Standards

Section Lead(s): Medical Director - Dr Anna Lamont
Executive Director of Nursing, Midwifery, Allied Health Professionals & Chief Officer Acute - Sam Thomas
Director of Public Health - Dr Louise Wilson

Comments

- There is positive collaboration between clinical and non-clinical teams to address challenges and ensure the best patient experience and outcomes. This includes work to address waiting lists for General Surgery, Endoscopy and Pain Management.
- The weekly waiting times meeting has been refreshed and changes implemented creating clinical ownership for those waiting.
- The new Planned Care Programme Board held its first meeting in July. This will provide a supportive governance and scrutiny structure for the waiting times, cancer, improvement programme, implementation plans, cancer tracking, community care, and nationally funded planned care activities.

Successes

- Discharge planning continues to focus on pre-noon discharge with current performance at 8% for weekdays and 27% for weekends.
- Additional to the consistently strong performance in relation to emergency access 4-hour waits, work continues to support unscheduled care to support NHS Orkney achieving above 95% for both minors and admitted performance.
- A review of the weekly waiting times meeting has been undertaken with actions noted for next steps.

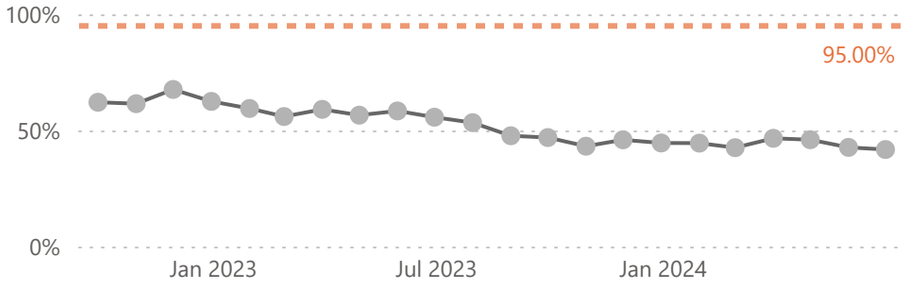
Challenges

- Lack of social care provision and residential beds availability and staff for both residential and care at home.
- Review of Outpatient service provision required to address increasing waits for patients.
- Ophthalmology is currently a challenge due to the existing arrangement with NHS Highland and their struggle to deliver the service required by NHS Orkney.

New Outpatients (Source: TrakCare)

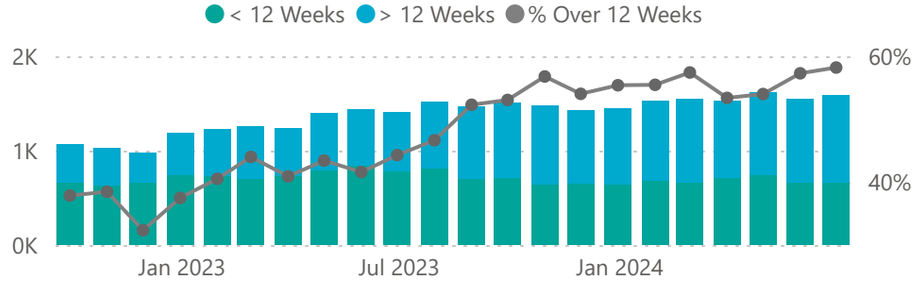
Latest Data: June 2024

New Outpatients Compliance

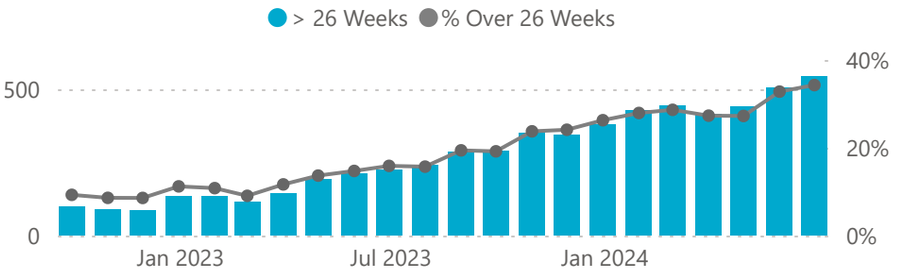


Latest Month
June 2024
1584
No. Waiting
41.79%
Compliance
922
>12 Wks.
58.21%
% Over 12 Weeks

New Outpatients Waiting > 12 Weeks

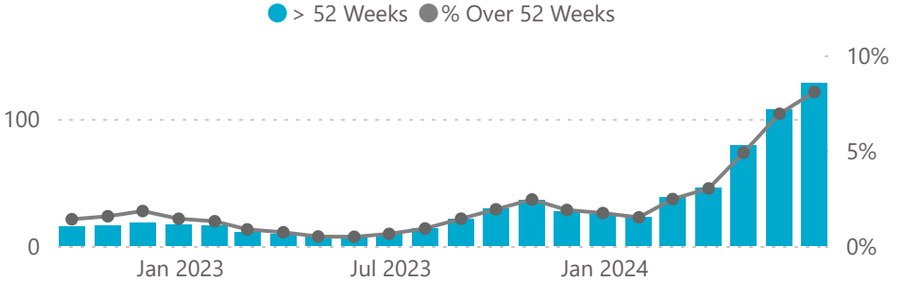


New Outpatients Waiting > 26 Weeks



Latest Month
June 2024
543
> 26 Weeks
34.28%
% Over 26 Weeks

New Outpatients Waiting > 52 Weeks



Latest Month
June 2024
128
> 52 Weeks
8.08%
% Over 52 Weeks

Issues/Performance Summary

- The longest waits (those over 52 weeks wait) continue within Ophthalmology, Restorative Dentistry, Oral Surgery, Oral and Maxillofacial Surgery and Pain Management.
- At the end of June 2024, 1,584 new patients are waiting to be seen in Outpatient Clinics, of this 128 patients have waited over 52-weeks for new Outpatient appointments. Those 5 patients awaiting Restorative Dentistry appointments are expected to be appointed during September 2024.
- There has been a sharp increase in the number of people waiting more than 52 weeks. This relates only to outpatients provided on island, and has been impacted by NHS Highland SLA provided Ophthalmology clinics not being provided in the first 4 months of the year.

Planned/Mitigating Actions

- Discussions continue to take place in relation to those Service Level Agreements which support activity around Trauma and Orthopaedics, Ophthalmology, Ear Nose and Throat, to ensure that they are fit for purpose and sufficient to meet the long waits and also the ongoing demand.
- A review of the space available to support additional clinics is being undertaken through the improvement and planning hub, with a view to improving performance for those patients waiting longest and with the greatest clinical need.
- The missing ophthalmology provision has been addressed in June with increased clinics from NHSH specialists intended to match the time.

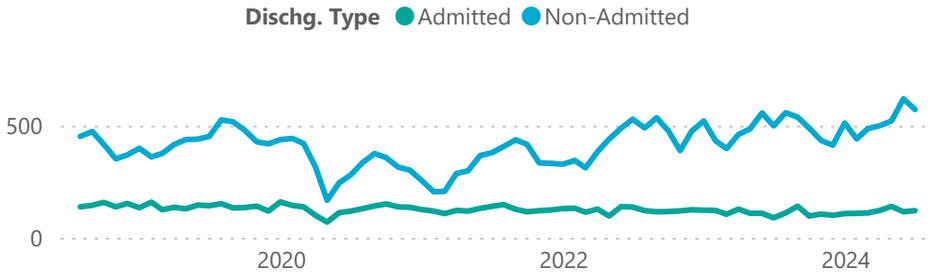
Assurance/Recovery Trajectory

- There are currently 5 restorative Dentistry patients who have waited over 104-weeks. We await final confirmation from NHS Grampian, but patients will be appointed at the earliest opportunity (estimated by September 2024).

Accident & Emergency (Source: TrakCare)

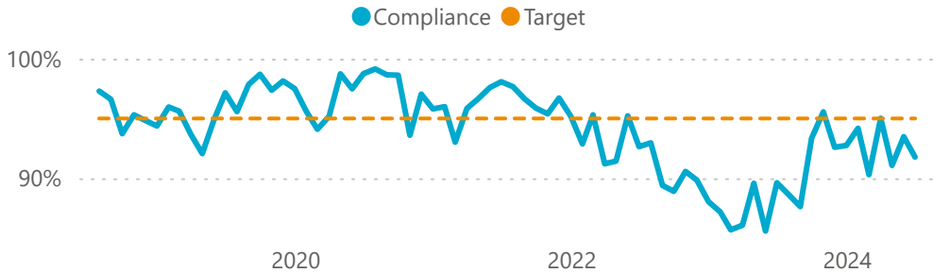
Latest Data: June 2024

Monthly Attendances



Latest Month
June 2024
693 Attended
121 Admitted

Monthly Compliance

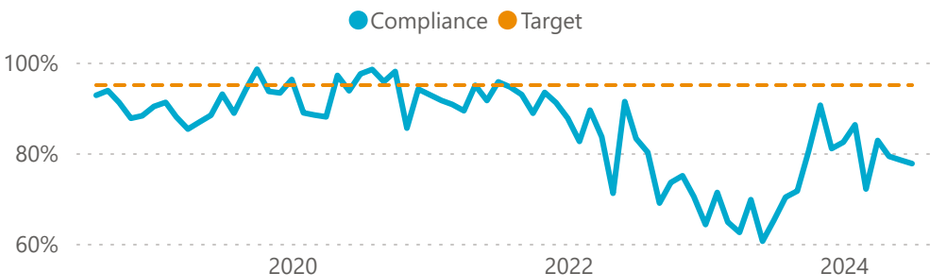


Latest Month
June 2024
693 Attended
57 Breach
91.77% Compliance

Monthly Compliance (Non-Admitted)

Latest Month
June 2024
572 Attended
30 Breach
94.76% Compliance

Monthly Compliance (Admitted)



Latest Month
June 2024
121 Attended
27 Breach
77.69% Compliance

Issues/Performance Summary

Emergency access performance remains strong. Some of the highlights, include:

- Performance against core performance measures remains > 90% for non admitted
- No 12-hour breaches reported within the last period
- Scottish Ambulance Services (SAS) turnaround time remains <15mins

Planned/Mitigating Actions

- Continued focus on 4-hour standard to ensure best outcome for patients. Mitigation is in place by utilisation of the additional surge capacity and preventing ambulance stacking.
- Active attendance and participation in National Workstream - Flow Navigation operational delivery group to bring best practice to NHS Orkney.
- Peer review of Emergency Department service provision and staffing took place 28/29 February 2024. The interim report has now been received and the final report including the actions taken and implementation will be presented to JCCGC in October 2024.

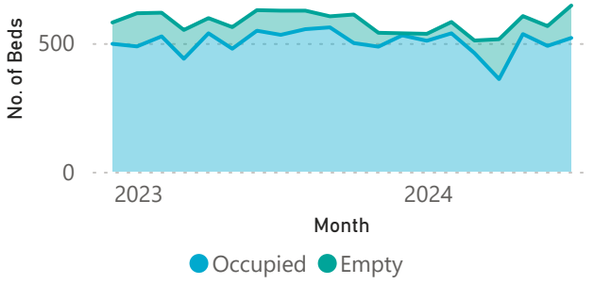
Assurance/Recovery Trajectory

- Site escalation plan implemented for The Balfour.

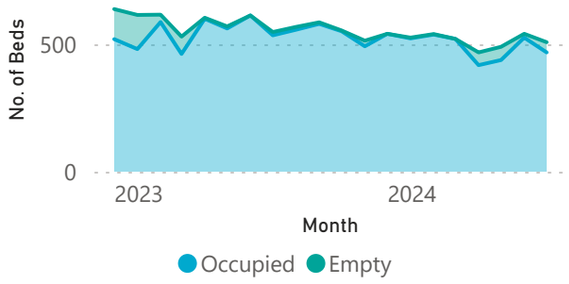
Bed Occupancy & Availability (Source: TrakCare)

Latest Data: June 2024

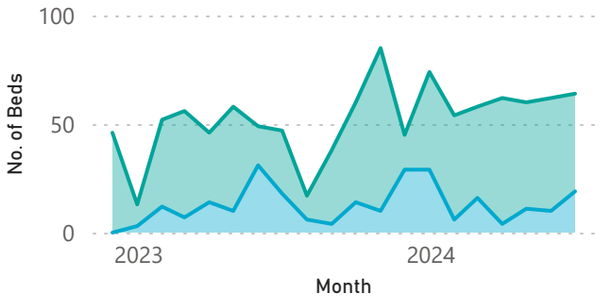
Inpatients 1



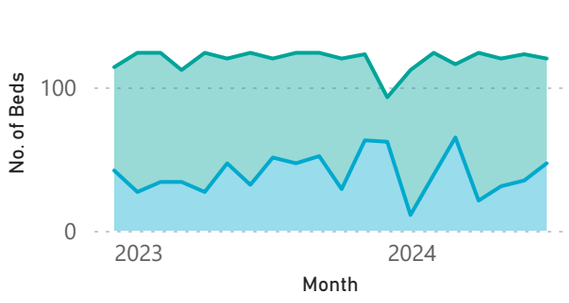
Inpatients 2



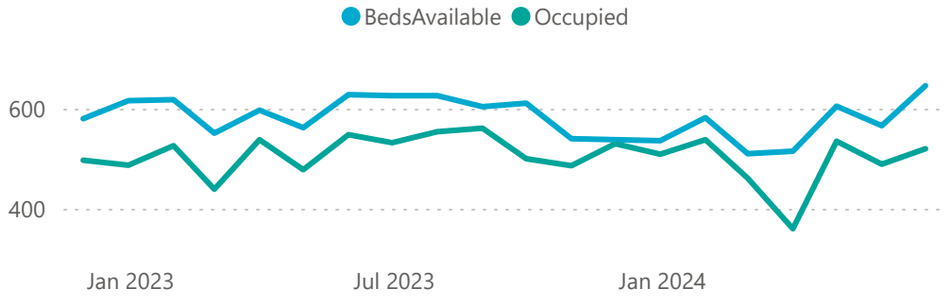
HDU



Maternity

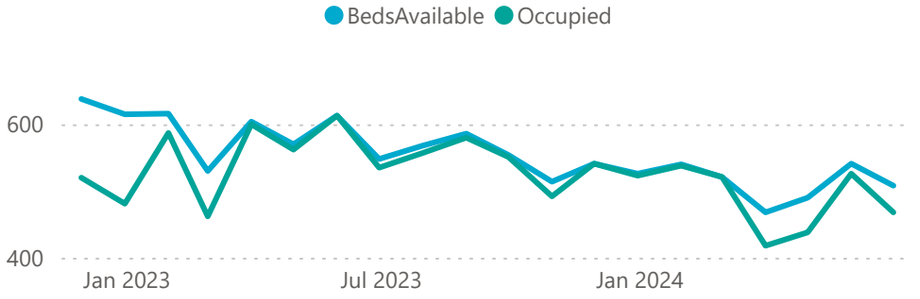


Inpatients 1 Availability & Occupancy



Latest Month
June 2024
780 BedsAssigned
134 BedsUnavail
520 Occupied
126 Empty

Inpatients 2 Availability & Occupancy



Latest Month
June 2024
690 BedsAssigned
182 BedsUnavail
468 Occupied
40 Empty

Issues/Performance Summary

- Current bed occupancy remains high. This means little to no capacity in the system. Over the course of May and June additional pressure on acute bed capacity was seen due to an increase in delayed transfers of care with a peak of 11.

Planned/Mitigating Actions

- Focus on discharge planning with early facilitated discharge and criteria-led discharge.
- System wide strategic leadership meeting - agreed actions were increase frequency of RMM (resource management meeting) to twice weekly.

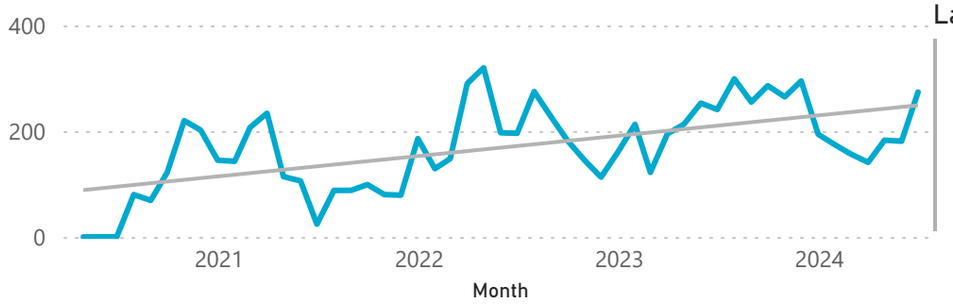
1. Target operating model to remain at full.
2. Review of provision of 7 day occupational therapy and Physiotherapy for re-enablement and early facilitated discharge.
3. Review of step up/step down bed provision and geriatric assessment.

Assurance/Recovery Trajectory

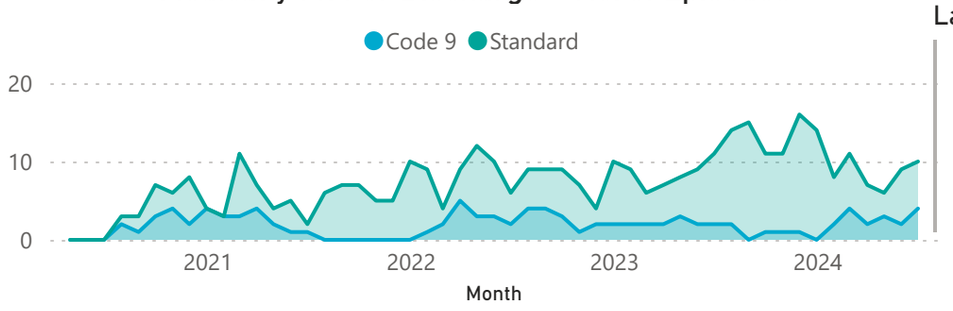
- The aim is to maintain bed occupancy across the site in each area at no more than 90%. Allowing for a surge in unscheduled presentations and to preserve elective activity.
- Work continues to facilitate discharge and timely transfer of care with links into national pieces of work around admission and discharge.
- Focus internally on predicted day of discharge setting, discharge planning process, discharge pre-noon.
- Currently (10th July 2024), there are 6 delayed transfers of care on site.

Delayed Transfers of Care & Length of Stay (Source: Bed Manager, TrakCare) Latest Data: June 2024

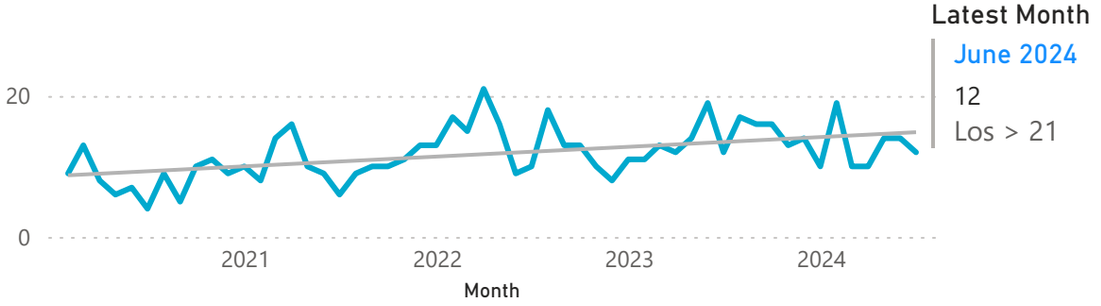
Medically Fit For Discharge - No. of Days



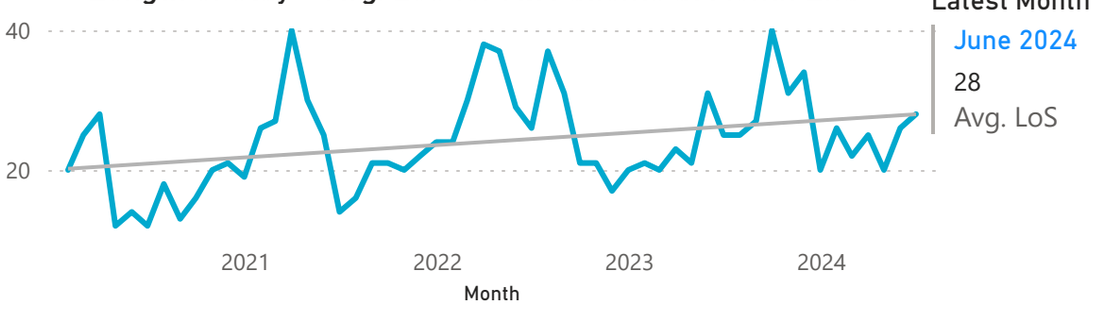
Medically Fit For Discharge - No. of Episodes



Length of Stay - No. of Patients with LoS > 21 Days at Month End



Length of Stay - Avg. LoS for All Patients at Month End



Issues/Performance Summary

- Capacity challenges continue to be noted. Peaking at 11 delayed transfers of care with a reduction to 6 delayed transfers of care at time of reporting. Although the data shows 14, this is a descrepancy in the way that a delayed transfer of care is viewed across our system.
- The average length of stay is 19 days. This remains an improvement from 26 days in January due to delayed transfers of care.
- During June, unscheduled admissions due to frailty and associated core morbidities was seen with multiple complex patients requiring admission review and focus discharge planning.

Planned/Mitigating Actions

- Weekly health attendance at Remote Monitoring and Management meeting. Agreement reached that if >6 delayed transfers of care, RMM to be stepped up to twice weekly.

1. Target operating model to remain at full.
2. Review of provision of 7 day occupational therapy and Physiotherapy for re-enablement and early facilitated discharge.
3. Review of step up/step down bed provision and geriatric assessment.

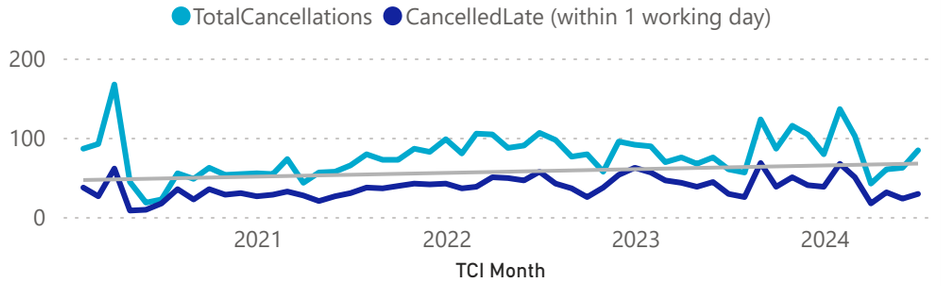
Assurance/Recovery Trajectory

- Each delayed transfer of care has been reviewed and alternative actions considered where applicable.
- Agreement via national Target Operating Model to achieve no more than 4 Delayed Transfers of Care on site, which will help to address challenges throughout the whole system.

Cancelled Operations (Source: TrakCare)

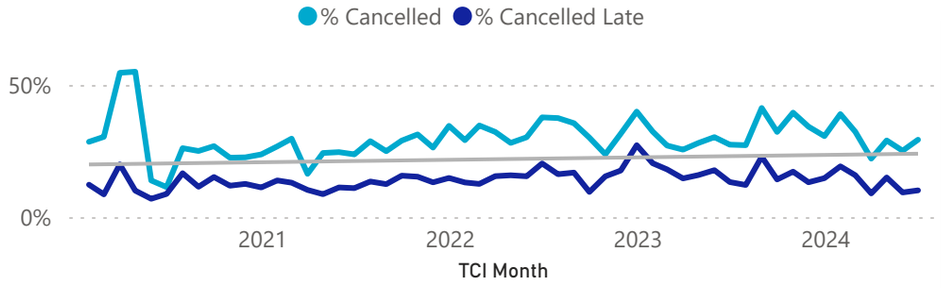
Latest Data: June 2024

Cancelled Operations - Total No. of Cancellations



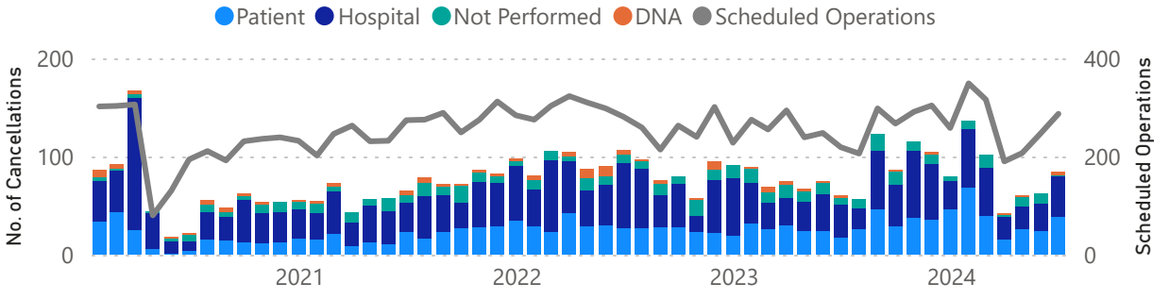
Latest Month
June 2024
80 Cancelled
29 CancelledLate
3 DNA
1 Not Performed

Cancelled Operations - Cancellations as % of Scheduled Ops.

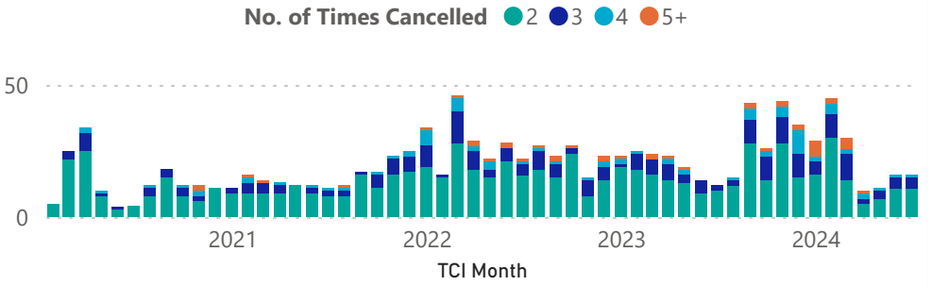


Latest Month
June 2024
287 Scheduled
29.27% % Cancelled
10.10% % Cancelled Late

Cancelled Operations - Initiator/Type of Cancellation



Cancelled Operations - Multiple Cancellations



Latest Month
June 2024
11 2nd Cancellation
4 3rd Cancellation
1 4th Cancellation
0 5th+ Cancellation

Issues/Performance Summary

- In June, one patient was cancelled on the day due to emergency activity. Other late notice cancellations were largely due to patients being unwell, or unfit for surgery on the day of procedure. No patients were cancelled due to inpatient bed capacity.
- Some gynaecology and General Surgery lists continue to be under-booked due to few available patients on the waiting list. This situation is being looked at as part of the theatre utilisation improvement workstream.

Planned/Mitigating Actions

- A review of the data submitted to Public Health Scotland is undergoing.
- Theatre utilisation is being captured as a critical workstream for the Improvement Hub and will review the data and look to address obstacles to success.
- A review of multiple cancellations is being undertaken to obtain more clarity around the reasons for these.

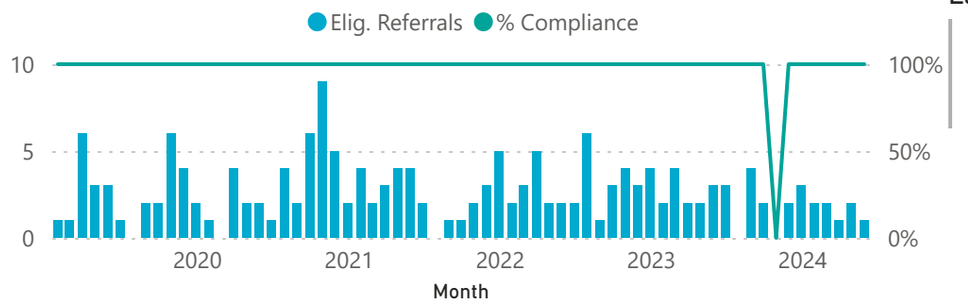
Assurance/Recovery Trajectory

- A review to ensure compliance against the Patient Access Policy is being undertaken.
- Ophthalmology lists have been successfully prepared with a shortlist of additional patients on standby, who can be added on to the list at short notice (including on the day) if a patient on the main list is cancelled. This has ensured that all five ophthalmology lists in June were fully utilised.

Cancer Waiting Times (Source: Cancer Waiting Times Co-Ordinators)

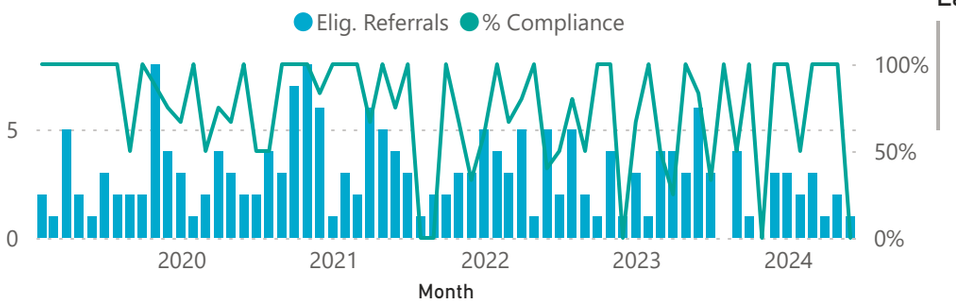
Latest Data: May 2024

31 Day Standard - % Compliance



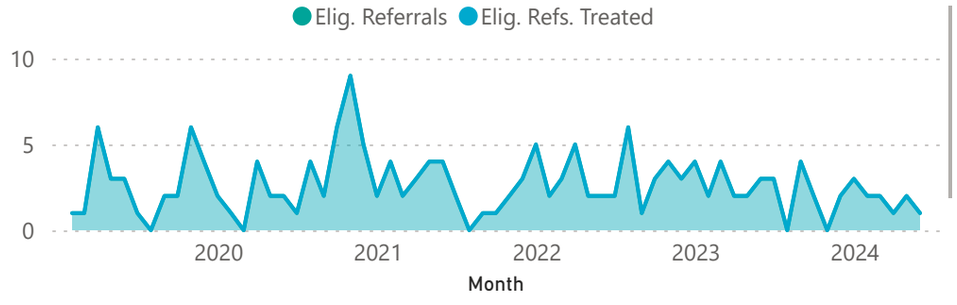
Latest Month
May 2024
100%
% Compliance

62 Day Standard - % Compliance



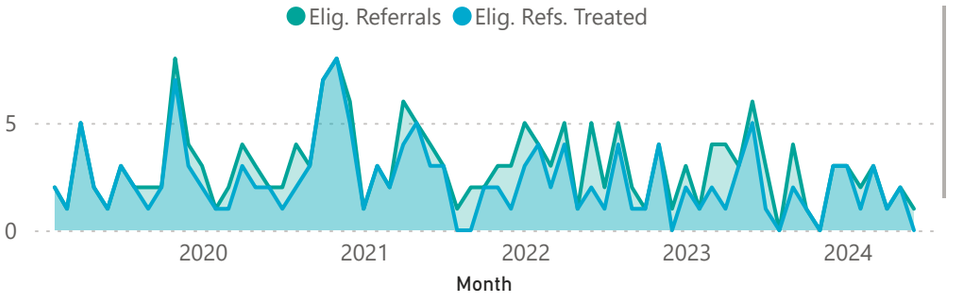
Latest Month
May 2024
0.00%
% Compliance

31 Day Standard - Referrals and Treatment



Latest Month
May 2024
1
Elig. Referrals
1
Elig. Refs. Treated

62 Day Standard - Referrals and Treatment



Latest Month
May 2024
1
Elig. Referrals
0
Elig. Refs. Treated

Issues/Performance Summary

Performance against both the 31-day and 62-day standards remains at 100%. Nationally NHS Orkney remains a positive outlier for meeting these targets however the small number of referrals tracked in this data means that trends in compliance with the standards would be late indicators of concern. To note that this data does not include cancer pathways referred to Aberdeen, which are tracked by NHSG. For North of Scotland boards combined, urgent suspicion of cancer referrals continues in line with national trends at 50 to 60% above pre-pandemic levels and are increasing further.

The planned care plan for NHSO was provided to SG in April including projections of cancer care. The trajectory after efficiency and productive opportunities anticipates a small reduction in waiting lists for diagnostics, and a small increase in waiting list for planned specialist care.

Planned/Mitigating Actions

Cancer waiting lists and improvements will be monitored in future through the Planned care programme board, which met for the first time in July.

NHSO has Service Level Agreements (SLA) in place with NHS Grampian for many of our cancer pathways. Our 62-Day Cancer Performance for Orkney residents are often dependent on pathways and capacity of NHS Grampian. Cancer pathways as being scrutinised as part of a review of our SLA with NHS Grampian. Delivering better visibility of the patient experience for those being treated and supported via NHS Grampian pathways.

Cancer Waiting Times are reviewed as part of NHSO weekly Waiting Times meeting, and monthly meetings with SG.

Assurance/Recovery Trajectory

Funding for the mobile MRI scanner visits will only continue to April 2025. Continuation of on site MRI scanner provision has been escalated as a concern to the board and to Scottish Government.

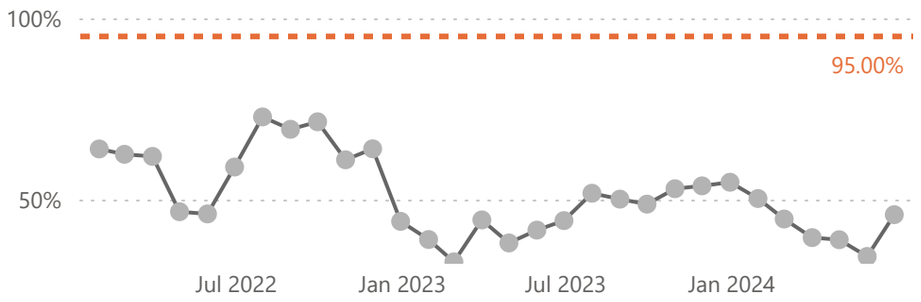
Endoscopy waiting lists are reducing through training of a consultant on site, and an additional consultant to support some colonoscopy clinics. The sponge capsule endoscopy clinic is now not expected to impact waiting lists till Q3.

The medical director is presenting with the cancer tracking team at the monthly SG monitoring calls. The information presented has been aligned to a template used by Shetland and recommended by SG colleagues.

Treatment Time Guarantee (Source: TrakCare)

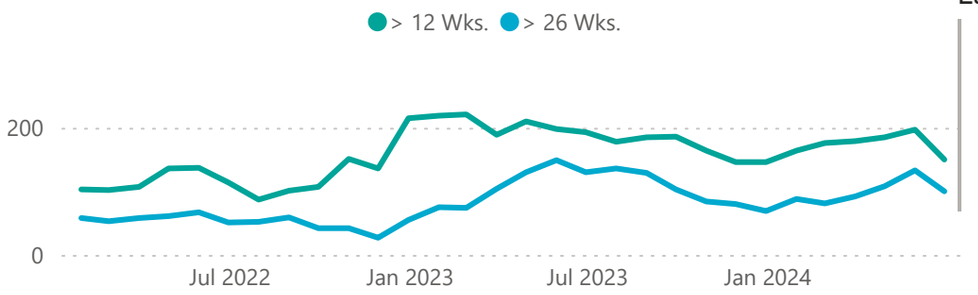
Latest Data: June 2024

TTG - % of Patients Waiting < 12 Weeks



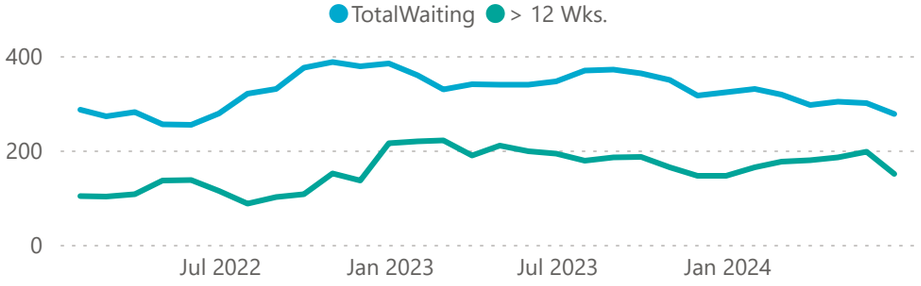
Latest Month
June 2024
277
TotalWaiting
150
> 12 Wks.

TTG - Patients Waiting >12 & 26 Weeks



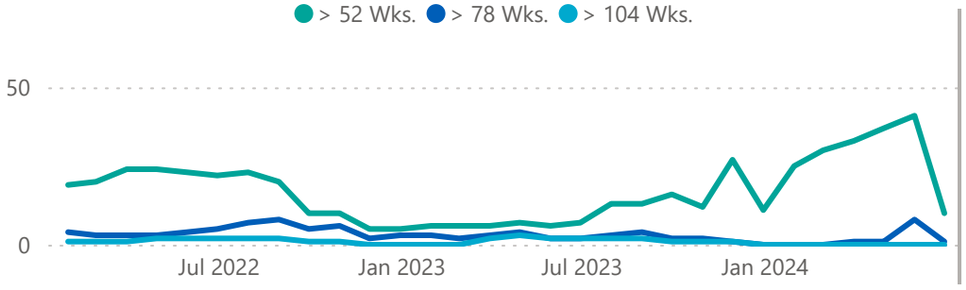
Latest Month
June 2024
150
> 12 Wks.
100
> 26 Wks.

TTG - Total Waiting & > 12 Weeks



Latest Month
June 2024
277
TotalWaiting
150
> 12 Wks.

TTG - Patients Waiting > 52, 78 & 104 Weeks



Latest Month
June 2024
10
> 52 Wks.
1
> 78 Wks.
0
> 104 Wks.

Issues/Performance Summary

- There continues to be long waits for Inpatient treatment/procedures, with waits over 52 weeks in Ophthalmology and Pain Management; impacted adversely due to lack of SLA provision for the Ophthalmology service.
- The total list size has shown improvement for June at 277 compared to 300 at the end of May 2024. This is mostly in part due to an Ophthalmology visit during June 2024.
- The number of people waiting more than 104 weeks has seen a sharp reduction following recommencing Ophthalmology clinics and recovery of 3 of the previous 4 clinic days missed and theatre time. There has been a smaller but still significant improvement in all in patient wait times from May.

Planned/Mitigating Actions

- Establish a focus group for Ophthalmology to create ownership and reduce the Inpatient waiting list.
- Initial meeting with the national ophthalmology performance lead to identify alternative ways of reducing the waiting list within the specialty.
- Formal SLA review meetings taking place on a monthly basis to discuss solutions for the unavailability to proceed the SLA service.
- The challenges relating to Ophthalmology have been raised with the SG planned care team. Future provision for see and treat through the Highland National treatment centre for cataracts is to be reviewed.

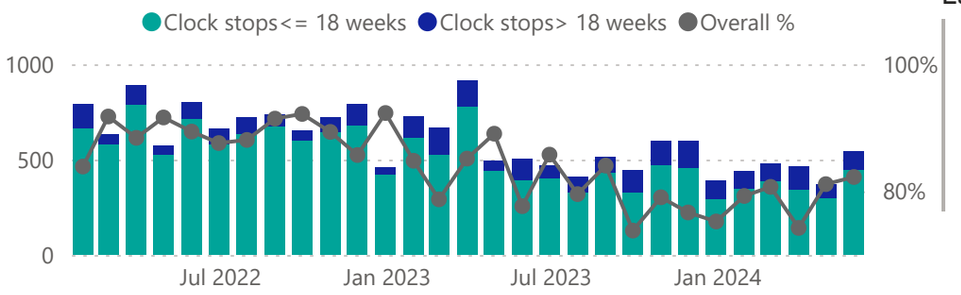
Assurance/Recovery Trajectory

- Review of SLA arrangements to be undertaken, with a view to agreeing accountability and ownership for 12 months of the year, to prevent the variability at the end of the year.

18 Week Referral to Treatment (Source: TrakCare)

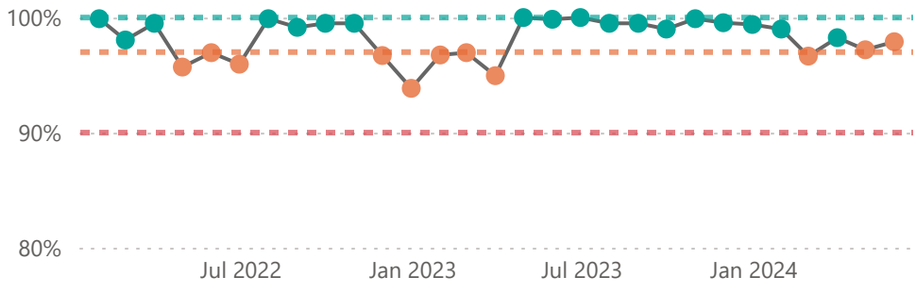
Latest Data: May 2024

18 Week RTT - Overall Compliance



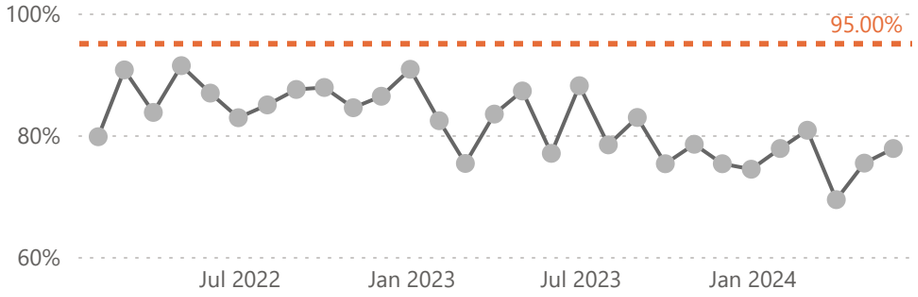
Latest Month
May 2024
445
<= 18 Weeks
96
> 18 Weeks

18 Week RTT - % of Pathways Linked



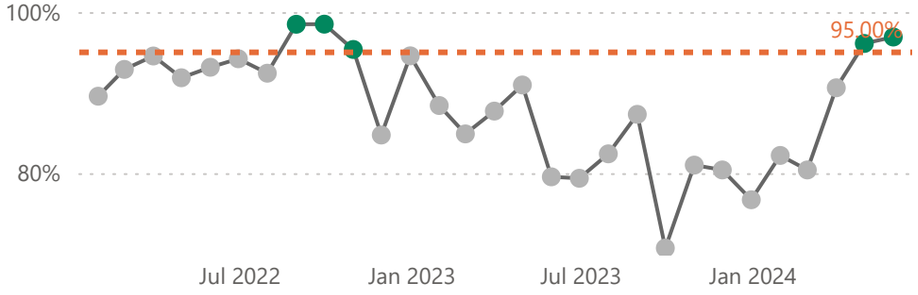
Latest Month
May 2024
98%
Linked Pathways

18 Week RTT - Non-Admitted Compliance



Latest Month
May 2024
322
<= 18 Weeks
92
> 18 Weeks

18 Week RTT - Admitted Compliance



Latest Month
May 2024
123
<= 18 Weeks
4
> 18 Weeks

Issues/Performance Summary

- Those services which reported above the 95% compliance of patients treated/ discharged within 18-weeks of referral at the end of May include Rheumatology, Ophthalmology and Gynaecology.
- Ophthalmology continues to report 100% compliance against the standard (for April and May 2024).

Planned/Mitigating Actions

- Continue to share audit reports to improve data quality particularly in relation to missing outcomes. The actions taken in relation to the audit will support increasing the accuracy of reporting and support identification of key areas for improvement.
- Improvement Plan in relation to Public Health Scotland Review is progressing well and actions are on track.

Assurance/Recovery Trajectory

- A refreshed approach to Waiting Times has now been implemented which incorporates representation from medical colleagues, to support timely action against obstacles to success and renewed ownership.
- The Obstetrics and Gynaecology Consultant chairs the meeting which has helped create better links between clinical and non-clinical teams, with a view to improving performance.

Community

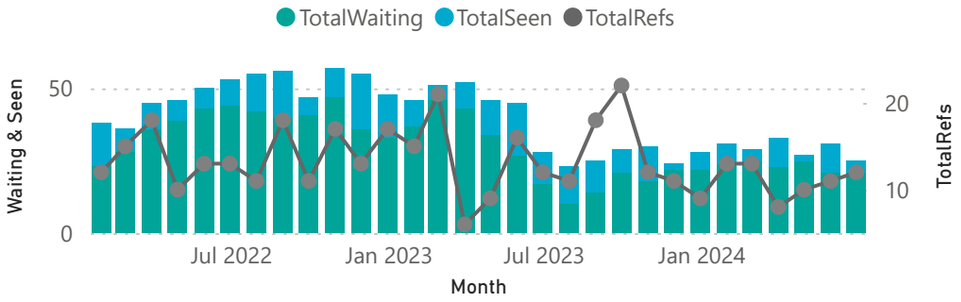
Section Lead: Chief Officer (Integration Joint Board) - Stephen Brown

Comments	Successes	Challenges
All community services continue to be stretched managing increased demand and presenting complexity. Superimposed on these pressures are shortages arising from vacancies and other absences.	Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies continue to perform well in relation to the referral to treatment times. Physiotherapy and Podiatry services have continued to make progress in reducing the average length of wait times.	Significant vacancies still exist in a number of key areas, most notably, Speech and Language Therapy and First Contact Physio.

CAMHS & PT (Source: TrakCare)

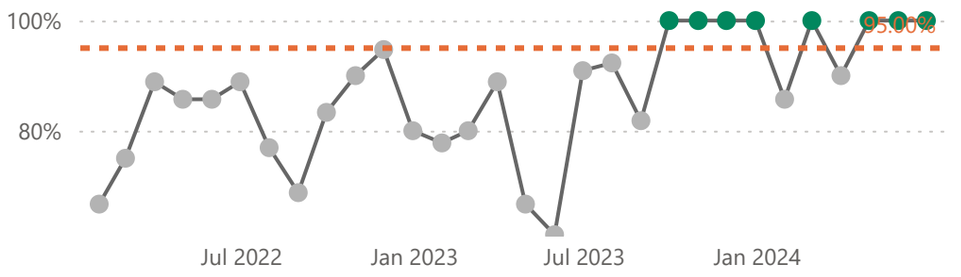
Latest Data: June 2024

CAMHS - Referrals, Patients Seen, Patients Waiting



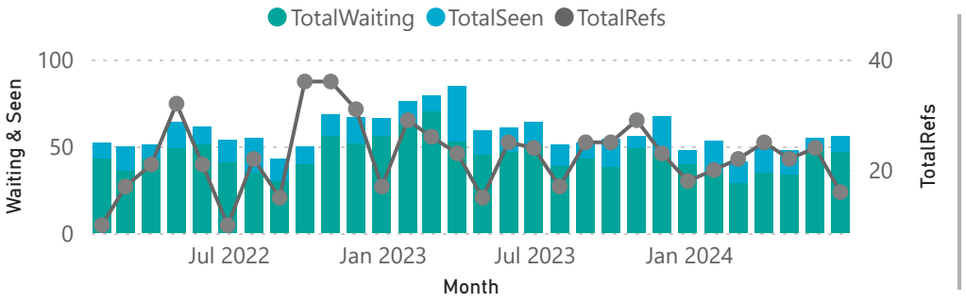
Latest Month
June 2024
21 Waiting
4 Seen
12 Referrals

CAMHS 18 Week RTT - Completed Waits % Compliance



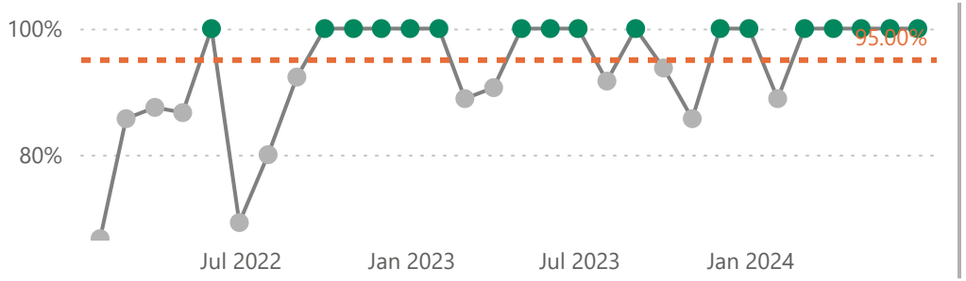
Latest Month
June 2024
4 Seen
0 > 18 Weeks
100.00% Compliance %

PT - Referrals, Patients Seen, Patients Waiting



Latest Month
June 2024
47 Waiting
9 Seen
16 Referrals

PT 18 Week RTT - Completed Waits % Compliance



Latest Month
June 2024
9 Seen
0 > 18 Weeks
100.00% Compliance %

Issues/Performance Summary

- Both Child and Adolescent Mental Health Services and Psychological Therapies exceeded the referral to treatment time target for this month and performance continues to be relatively strong.

Planned/Mitigating Actions

- CAMHS and Health Improvement continue to work towards submission of CAPTND data in line with the national Public Health Scotland ask. Work is ongoing to use the Grampian configuration of TrakCare for CAMHS and agreement has been reached to further that development over the coming months.

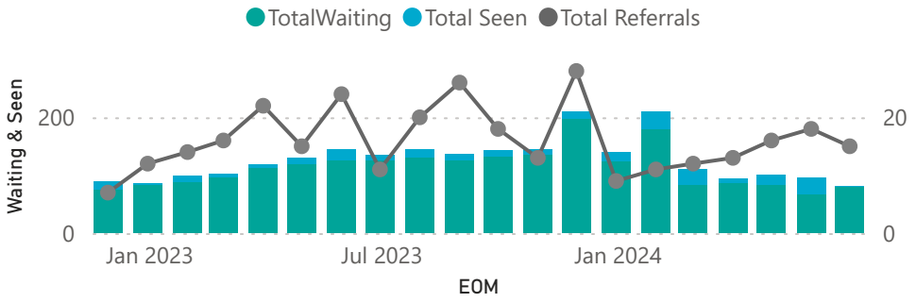
Assurance/Recovery Trajectory

- All efforts will be continue to meet the targets going forward but also achieve waiting times less than the national target. For the small number of patients who some months wait beyond the target time there is a valid and recognised reason for each individual.

MSK (Podiatry & Physiotherapy) (Source: TrakCare)

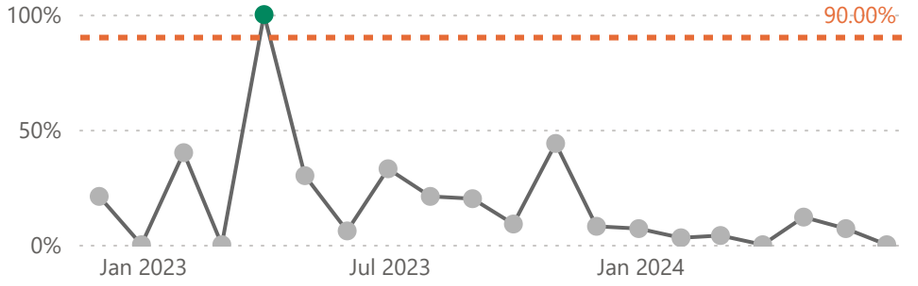
Latest Data: June 2024

Podiatry - Referrals, Patients Seen, Patients Waiting



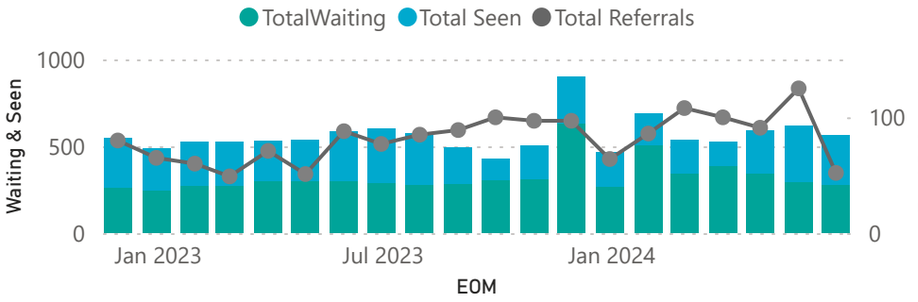
Latest Month
June 2024
80 TotalWaiting
1 Total Seen
15 Total Referrals

Podiatry 4 Week MSK - Completed Waits Compliance



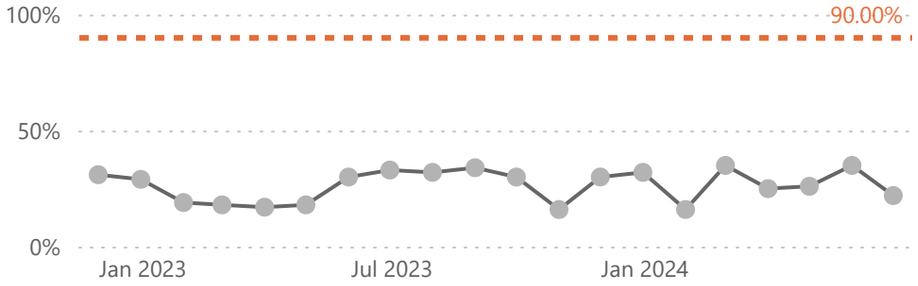
Latest Month
June 2024
1 Total Seen
1 > 4 Weeks
0.00% % Compliance

Physiotherapy - Referrals, Patients Seen, Patients Waiting



Latest Month
June 2024
279 TotalWaiting
286 Total Seen
52 Total Referrals

Physiotherapy 4 Week MSK - Completed Waits Compliance



Latest Month
June 2024
286 Total Seen
223 > 4 Weeks
22.03% % Compliance

Issues/Performance Summary

The continued absence of a First Contact Physio in Primary Care is contributing to the higher rates of referrals presenting to MSK Physio. Despite that, the service managed to see more people than were referred and has reduced the overall number of patients waiting.
Podiatry MSK referrals are clinically triaged, with those high risk diabetes, active foot diseases clinically prioritised. Where there is significant risk or increased morbidity and mortality. DNA rates have remained a factor of significant productivity losses. Longest waits are on an improving trajectory. The current podiatry resource for MSK is 0.4 WTE clinical time per week. June has seen very few MSK appointments due to continual annual leave of a small team which have had to concentrate on Active foot disease.

Planned/Mitigating Actions

FCP post - proposal for an Annex 21 option to attract and retain specialist clinician. SOP developed to address DNA patient levels. Service Access Policy being applied. Electronic patient booking and text alert system for all appointments would reduce DNA and cancellations. New to review ratio's benchmark as best performing across Scotland. Podiatry - people being signposted to appropriate independent and third sector providers. Recruitment efforts with job vacancy now active.

A piece of work has been undertaken addressing some of the patients with very long waits within MSK Physio, reducing this cohort significantly.

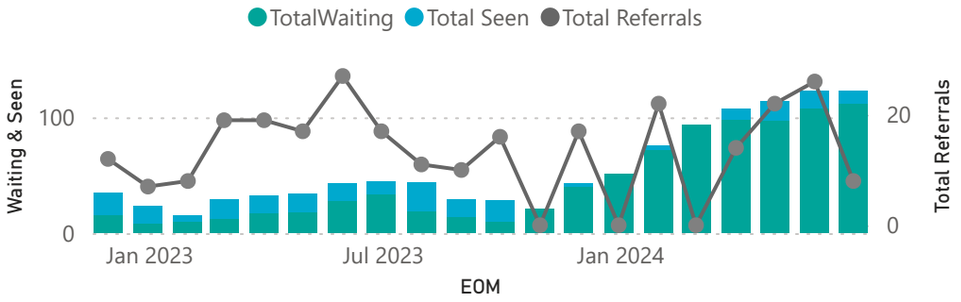
Assurance/Recovery Trajectory

Short term waiting list initiative is required to address legacy demand, improvement programme in physio along with triage work. Podiatry vacancy recruitment solutions to be explored. Vacancy impacts in both Physio and Podiatry MSK services. Physio dashboard now developed which will assist greatly in using the data to drive improvement and once embedded will be rolled out to other Outpatient Services. Although far from where we want to be, there are a number of pieces of recruitment that have happened, or are in the near pipeline. They will all work to support a stabilising of the staffing capacity to deal with the demand. This in turn will in the medium term start to reduce the waiting list and times.
Peripatetic Isles service proposal to address longest waits across Isles has been successfully undertaken

MSK (Orthotics & All Specialties Summary) (Source: TrakCare)

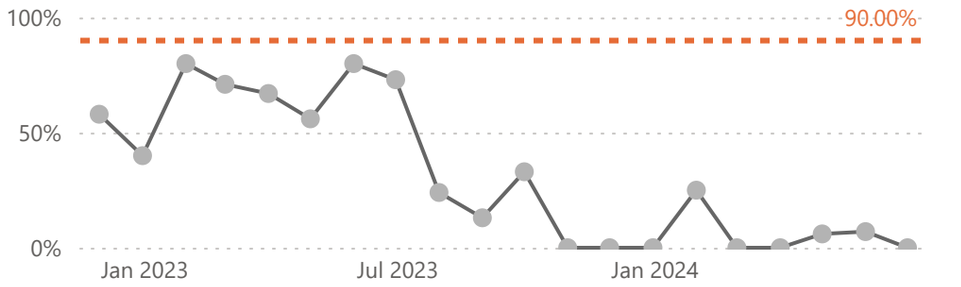
Latest Data: June 2024

Prosthetics/Orthotics - Referrals, Patients Seen, Patients Waiting



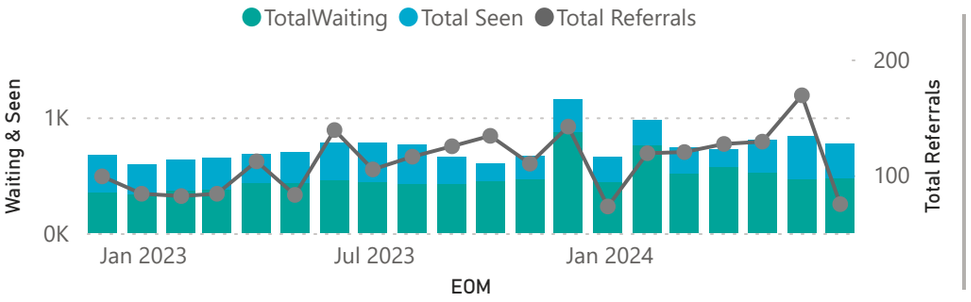
Latest Month
June 2024
112 TotalWaiting
11 Total Seen
8 Total Referrals

Prosthetics/Orthotics 4 Week MSK - Completed Waits Compliance



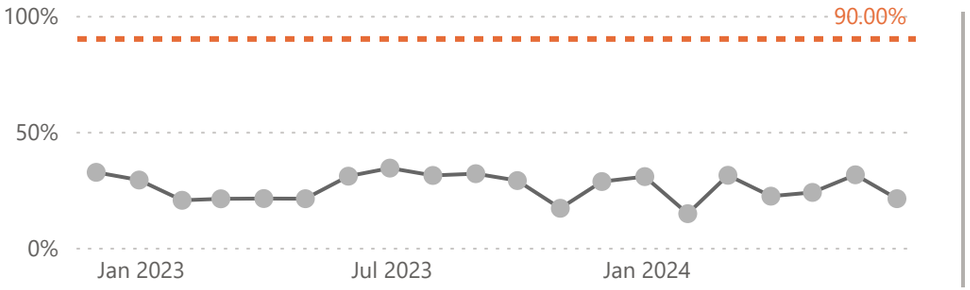
Latest Month
June 2024
11 Total Seen
11 > 4 Weeks
0.00% % Compliance

All Specialties - Referrals, Patients Seen, Patients Waiting



Latest Month
June 2024
471 TotalWaiting
298 Total Seen
75 Total Referrals

All Specialties 4 Week MSK - Completed Waits Compliance



Latest Month
June 2024
298 Total Seen
235 > 4 Weeks
21.14% % Compliance

Issues/Performance Summary

- No adverse waits for Orthotic Services.

Planned/Mitigating Actions

- Service Level Agreement (SLA) under review and option appraisal of sustainable model planned.

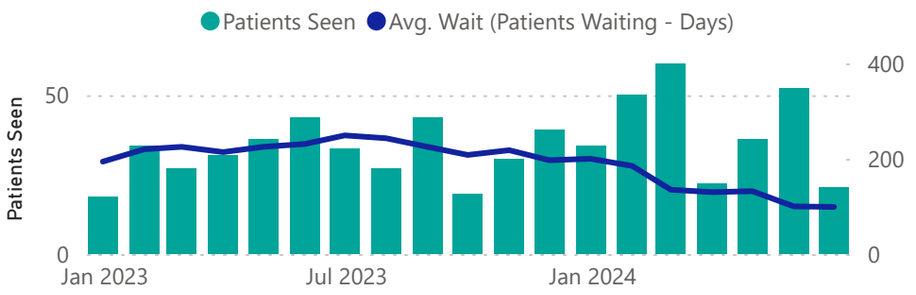
Assurance/Recovery Trajectory

No significant concerns at present.

Podiatry (Source: TrakCare)

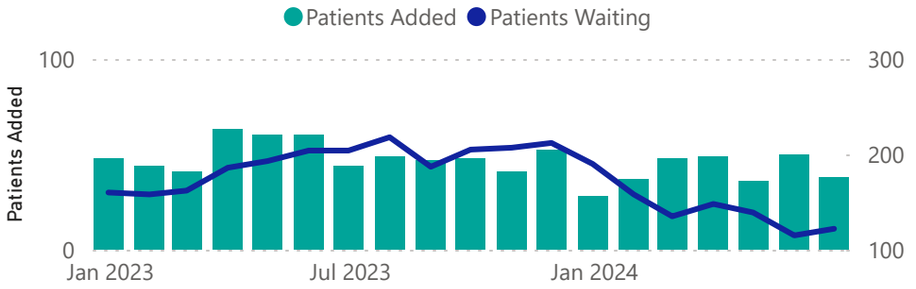
Latest Data: June 2024

Podiatry - Activity & Avg. Wait (Days)



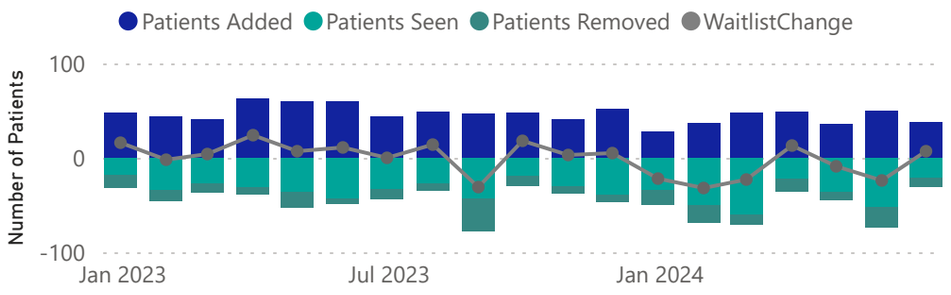
Latest Month
June 2024
21
Patients Seen
99
Avg. Wait (Days)

Podiatry - Waiting List Additions



Latest Month
June 2024
38
Patients Added
122
Patients Waiting

Podiatry - Demand & Activity Summary



Latest Month
June 2024
21
Patients Seen
38
TotalAdded
10
TotalRemoved
7
WaitlistChange

Podiatry - Waiting List % Change

Latest Month
June 2024
6.09%
% Change

Issues/Performance Summary

- Continual annual leave and Parental leave of a small team has reduced the service to Active foot disease interaction only at times, preventing the same number of foot protection and MSK clinics and contacts. Team down to WTE 2 for all of June.

Planned/Mitigating Actions

- Review of DCAQ, actions to address DNA's such as access policy and patient electronic alerts. Continue/refresh education and footcare training with stakeholders. ImplementionCPR for feet progress, active recruitment to vacancy and wait list initiatives. Triage of patient need to target staff resource most effectively.

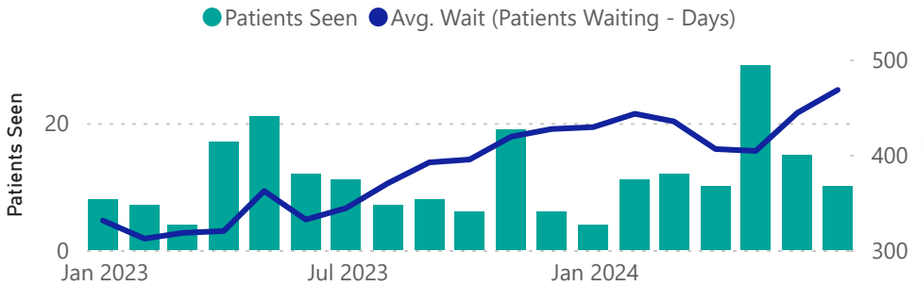
Assurance/Recovery Trajectory

- High risk patients treated on time and in line with evidence, MSK targets will not be met and a national discussion on the relevance with this target is required through Chief Allied Health Profession Officer. The more and most significant work is footcare protection, prevention of active foot disease and the management of active foot disease. Additional podiatry investment is needed to manage complex care, but it has been agreed to increase establishment to WTE 4 and the Job advert for a Band 5 Podiatrist is active at moment which will increase patient contact and enable flexibility to tackle waiting lists and address foot protection needs.

Speech and Language Therapy (Source: TrakCare)

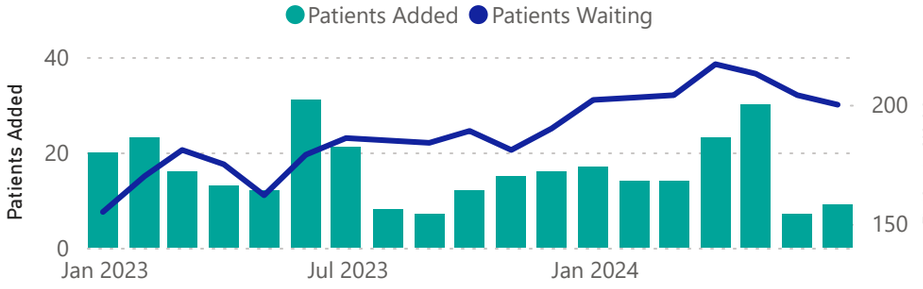
Latest Data: June 2024

SaLT - Activity & Avg. Wait (Days)



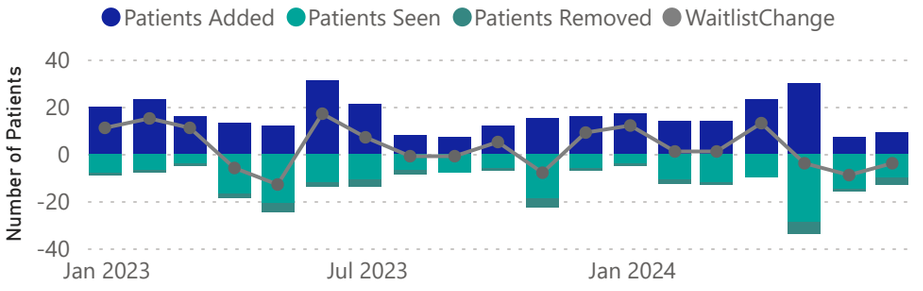
Latest Month
June 2024
10
Patients Seen
468
Avg. Wait (Days)

SaLT - Waiting List Additions



Latest Month
June 2024
9
Patients Added
200
Patients Waiting

SaLT - Demand & Activity Summary



Latest Month
June 2024
10
Patients Seen
9
TotalAdded
3
TotalRemoved
-4
WaitlistChange

SaLT - Waiting List % Change

Latest Month
June 2024
-1.96%
% Change

Issues/Performance Summary

Data only captures new patient activity and not returns which has seen significant uplift in April with permanent recruitment in Paediatric and Secondment in Adults (until end July). ALD remains unstaffed due to maternity leave and no locum cover (post holder due back July 2024). Data includes all SLT: Paediatric, Adult, and Adults with Learning Disability which doesn't enable accurate reporting of issues affecting different aspects of service.

Data doesn't include inpatient figures. Overall waiting times in Paediatric for new referrals significantly breach recommended waiting times. April shows more balanced demand and capacity figures for new patients overall.

Planned/Mitigating Actions

Awaiting update on recommendations from Deep Dive Into Planned Care Finance and Performance Committee 30th May 2024 Report, which contained a specific recommendation for funding to address paediatric SLT waiting times.

Contact made with Locum Agency but Paediatric SLT Lead does not currently have the capacity to take this forward.

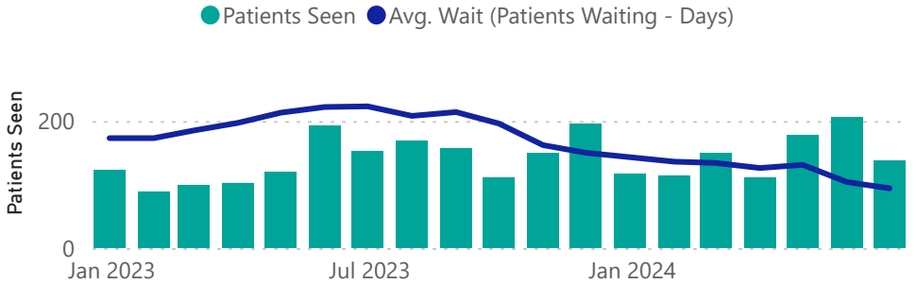
Assurance/Recovery Trajectory

- Improvement and service review plans in place. Recovery trajectory for Paediatric waiting times will take time but planning in place and will be pursued in more detail in summer.
- Adult trajectory uncertain due to need for permanent staffing and current interruption to service review plans. Clarity being sought.
- Adults with Learning Disability will remain as is unless locum can be found which will impact waiting times for new and return patients.

Physiotherapy (Source: TrakCare)

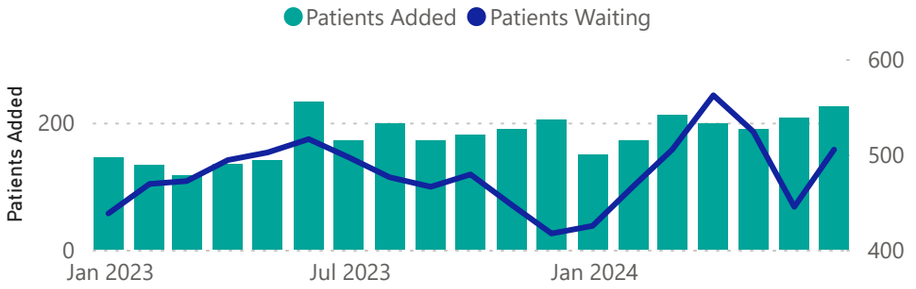
Latest Data: June 2024

Physiotherapy - Activity & Avg. Wait (Days)



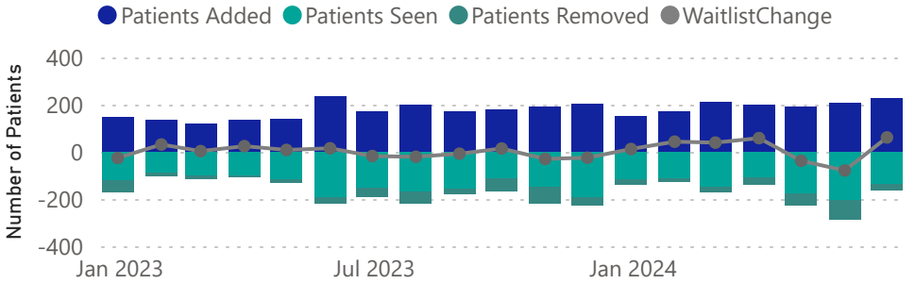
Latest Month
June 2024
138
Patients Seen
94
Avg. Wait (Days)

Physiotherapy - Waiting List Additions



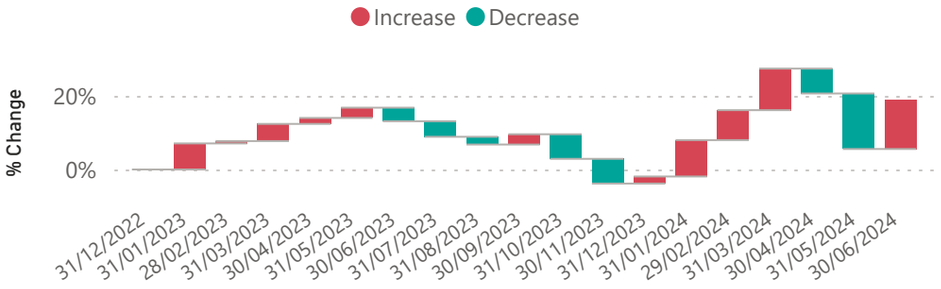
Latest Month
June 2024
225
Patients Added
505
Patients Waiting

Physiotherapy - Demand & Activity Summary



Latest Month
June 2024
138
Patients Seen
225
TotalAdded
26
TotalRemoved
61
WaitlistChange

Physiotherapy - Waiting List % Change



Latest Month
June 2024
13.48%
% Change

Issues/Performance Summary

- The whole Physiotherapy patient flow is most heavily influenced by the issues described in MSK section. Despite the current pressures and a waiting list that has continued to grow over the last three months, there has been a gradual and steady reduction in the average length of wait. This has been helped by the service improvement work of the team. Long waiting list for primary/secondary care; space issues.

Planned/Mitigating Actions

- Newly recruited Band 6 PT now in post split between wards and ICT. Dashboard for at a glance out-patient activity and performance has been completed, we just await final access with Power BI. Service standards being reviewed in line with best practice. Clinical Lead for PT will be in post at the end of May. Supervision training completed and sessions rolled out. Appraisal completion rates reviewed and actively managed. Documentation audits commenced.
- Meeting with Chief Officer about digital triage, Phio (AI), and utilising Band 6 MSK physios trained for advance practices by Clinical Lead over a period of several sessions.
- Utilisation Outpatients A to have four treatment rooms (physio hub) with curtains/plinths.

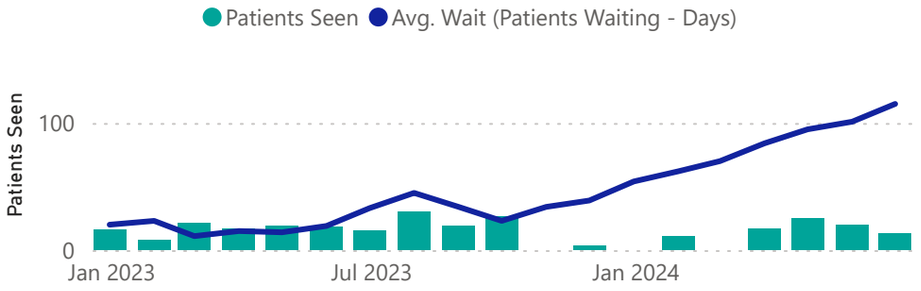
Assurance/Recovery Trajectory

- Clinical Lead commences on 20 May 2024, continue improvement work and option appraisal for most efficient effective models of person centred delivery. Recruitment to in-patient post also successful (commence April 2024) this will support timely rehab and discharge activity. These posts will also support weekend on call rota which can be challenging with a small team. Full respiratory /chest on call training (mandatory) planned for September. Ongoing service development work around building resilience within service by looking at developing core skills across all areas

Prosthetics/Orthotics (Source: TrakCare)

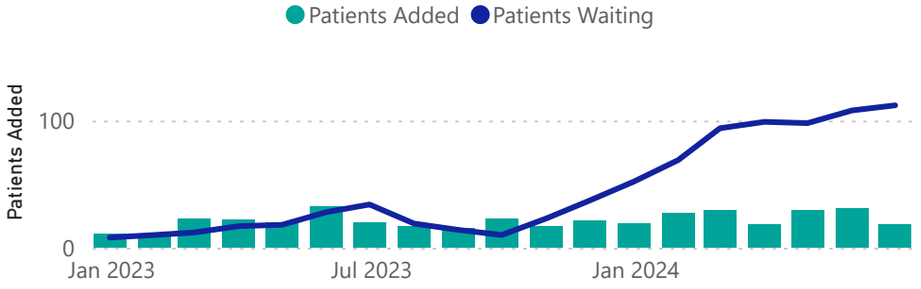
Latest Data: June 2024

Prosthetics/Orthotics - Activity & Avg. Wait (Days)



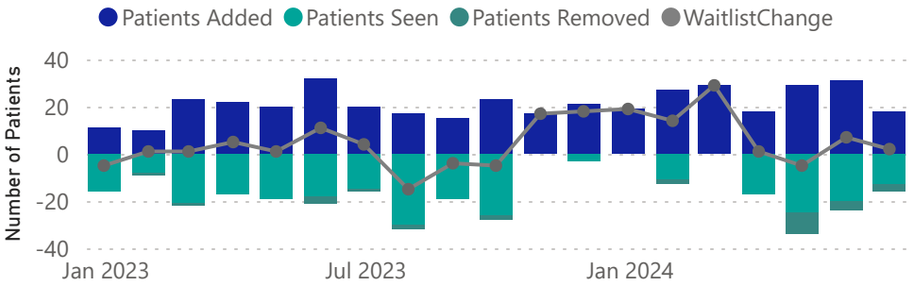
Latest Month
June 2024
13
Patients Seen
115
Avg. Wait (Days)

Prosthetics/Orthotics - Waiting List Additions



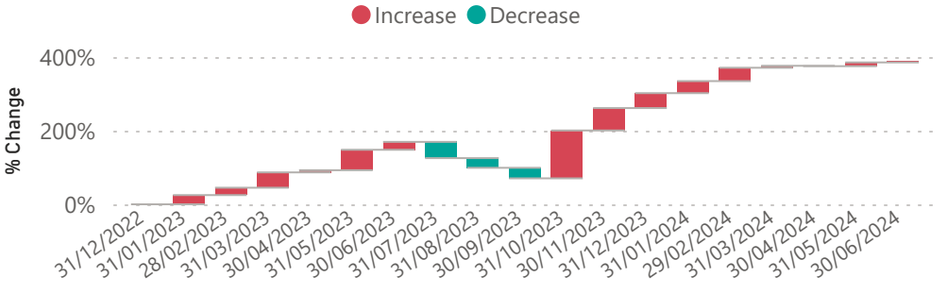
Latest Month
June 2024
18
Patients Added
112
Patients Waiting

Prosthetics/Orthotics - Demand & Activity Summary



Latest Month
June 2024
13
Patients Seen
18
TotalAdded
3
TotalRemoved
2
WaitlistChange

Prosthetics/Orthotics - Waiting List % Change



Latest Month
June 2024
3.70%
% Change

Issues/Performance Summary

- Orthotics SLA scoping progressing well, no adverse waits for service. Clinics booked and covered as clinically required. SLA proposal to be submitted to Senior Leadership Team for approval mid February to commence mid March.

Planned/Mitigating Actions

- No service delivery issues at present.

Assurance/Recovery Trajectory

- Anticipated cost reduction for the year 2024/25.

Population Health

Section Lead: Director of Public Health - Dr Louise Wilson

Comments

Quit Your Way Orkney (QYWO) continue to implement a systematic approach to enable the recording of anonymised referral data and referral results, which will be retained in the long term to allow for trend monitoring and the influence of service improvement activity on referrals.
National Screening and Immunisation Governance arrangements are being updated with a drive to increase uptake in hard-to-reach populations.

A new RSV (Respiratory Syncytial Virus) Vaccination Programme will be launched from 1 August 2024. Pregnant women will be offered immunisation from 28 weeks of their pregnancy by the Maternity Team. Individuals aged 75-79 years on 1 August 2024 will be invited for vaccination in August-September 2024.

Successes

53 participants from NHS Orkney and local statutory and third sector partners have received Very Brief Advice (VBA) training. QYWO have started receiving referrals from training attendees, demonstrating the practical impact of the training.
Spring Covid-19 booster implemented successfully, with uptake over Scotland average in all but one group. Childhood uptake consistently higher than Scottish average.
Local actions to increase pertussis and MMR uptake were taken recently in the context of UK and Europe increase of whooping cough and measles cases, with very low impact locally.
Breast screening programme ran from 29
April to 4 July 2024 with nearly 3200 women invited.
Uptake of Hearing, Bowel, AAA and Breast Screening uptake is above Scotland's average and targets.

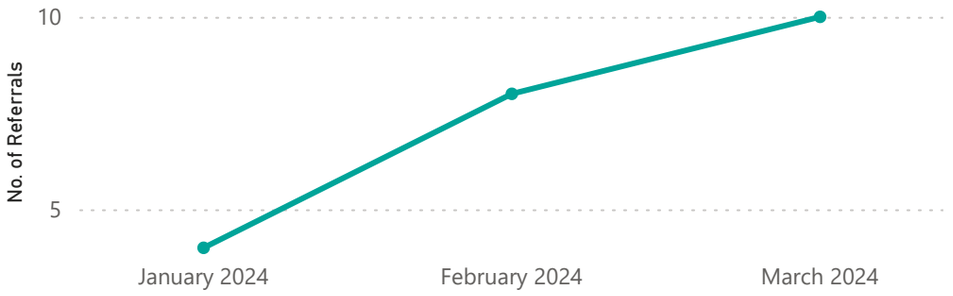
Challenges

There is a Consultant vacancy in the Public Health Department which has reduced strategic leadership capacity significantly, in the context of national Screening and Immunisation Governance arrangements being updated, local governance and assurance processes being tightened. Additional pressures include preparation for the NHS Orkney 2025 Island Games It is therefore becoming pressing that this is addressed.

Smoking Cessation Services (Source: Public Health Team)

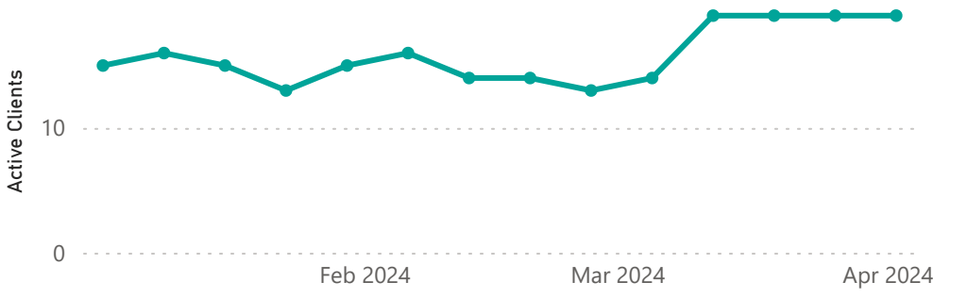
Latest Data: April 2024

Quit Your Way Orkney - No. of Referrals



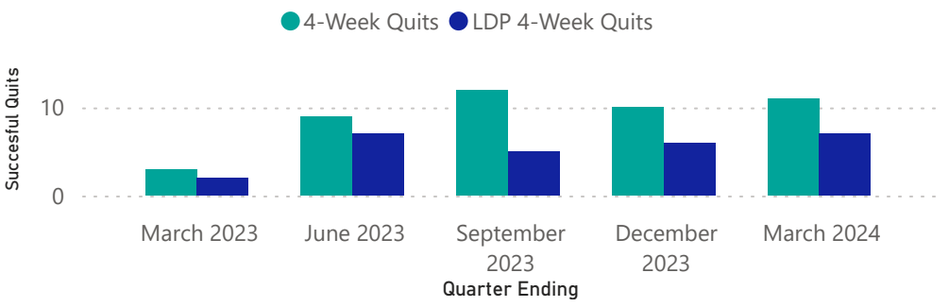
Latest Month
March 2024
10
No. of Referrals

Quit Your Way Orkney - Active Clients



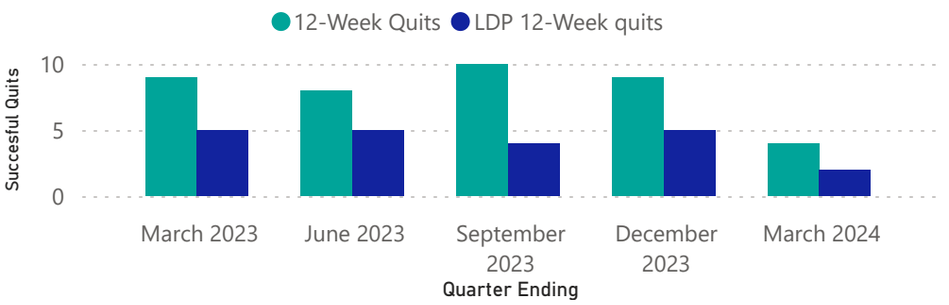
Latest Month
April 2024
19
Active Clients

4-Week Quits & LDP Comparison



Latest Quarter
March 2024
11
4-Week Quits
7
LDP 4-Week Quits

12-Week Quits & LDP Comparison



Latest Quarter
March 2024
4
12-Week Quits
2
LDP 12-Week quits

Issues/Performance Summary

- Data from management level unpublished data and therefore may be subject to change. The data only related to the specialist stop smoking service that is delivered through the Public health department and does not report on pharmacy level activity.
- Number of referrals rose across Quarter 4 2023/24.
- Service activity levels have remained fairly consistent over Quarter 4 2023/24.
- Quit rates at 4 weeks were higher in Quarter 4 2023/24 than the year previously, which potentially will translate to higher 12 week quits for this quarter compared to the same time last year as not all clients from Quarter 4 2023/24 have completed their 12-week course yet.
- There is a small seasonal pattern to successful quits.

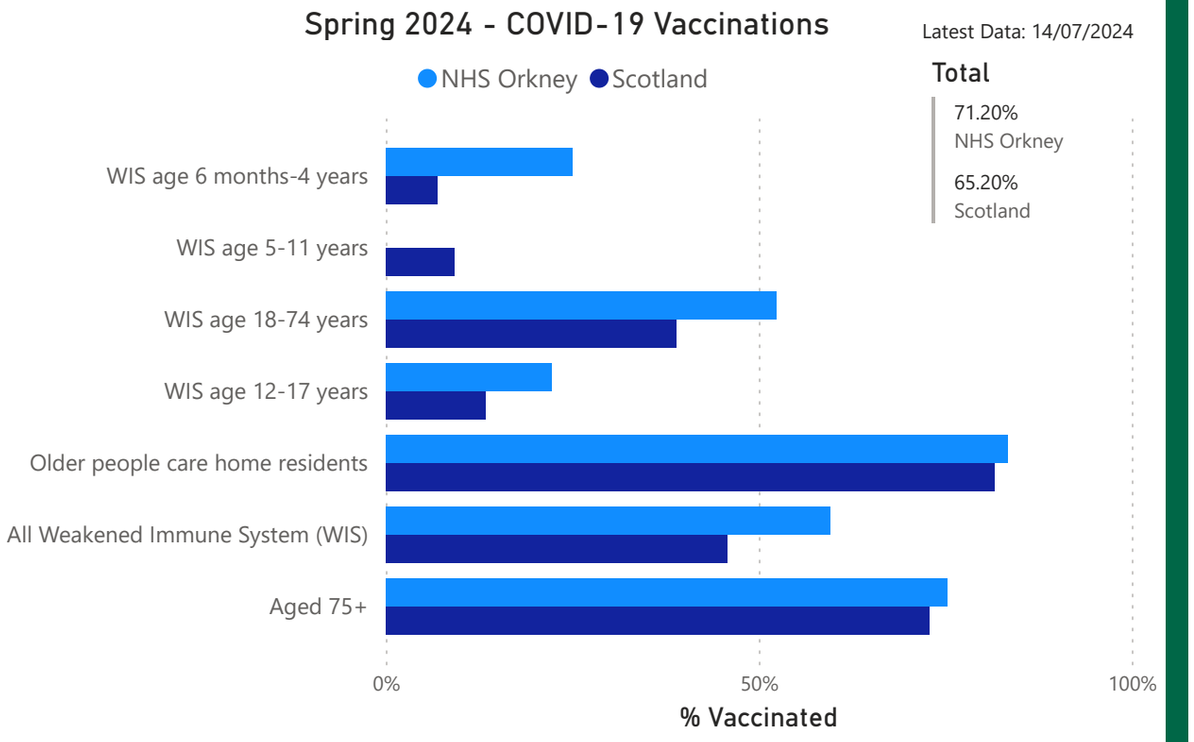
Planned/Mitigating Actions

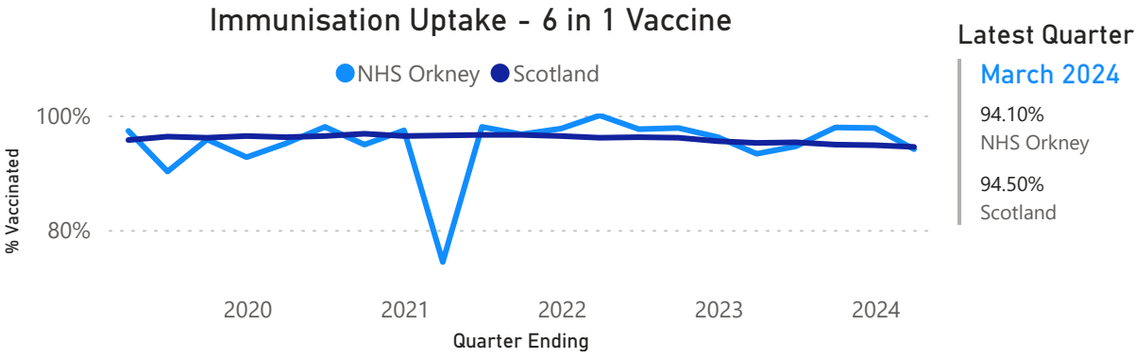
- Very brief advice training has been developed and is to continue to be rolled out to referrers throughout 2024/25.
- Work is ongoing with maternity services to improve the support for women who are pregnant to quit smoking.
- Continued delivery of the Quit Your Way specialist service in Orkney.
- Smoke Free Site Policy submitted to Senior Leadership Team.

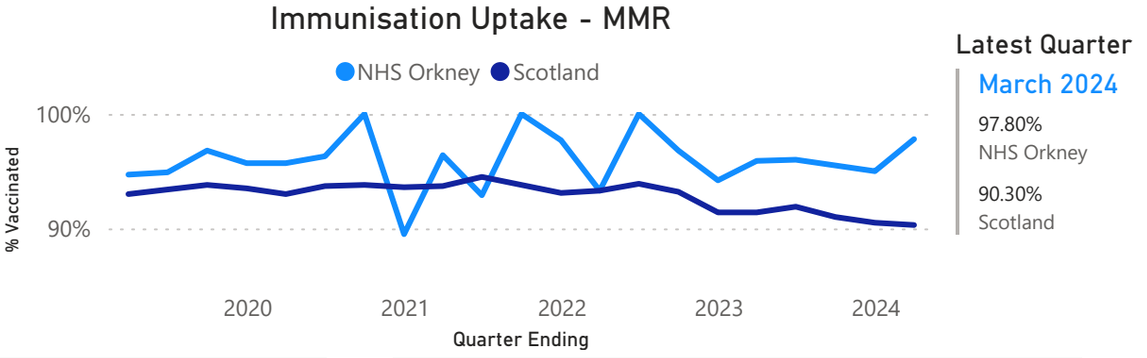
Assurance/Recovery Trajectory

- Continuing to engage with national groups to understand national direction and develop service accordingly.
- Targeting referrals from more high-risk groups through planned referrer engagement.

Vaccinations (Source: Public Health Team)







Issues/Performance Summary

Spring Covid-19 booster implemented successfully, with uptake over Scotland average in all groups except WIS 5-11 years – their parents were contacted individually and did not consent on vaccination.

National Immunisation Governance arrangements being updated, with a drive to increase uptake in hard-to-reach populations, which has increased significantly strategic input from Public Health Consultant lead in the context of a vacancy in the Public Health Department.

Planned/Mitigating Actions

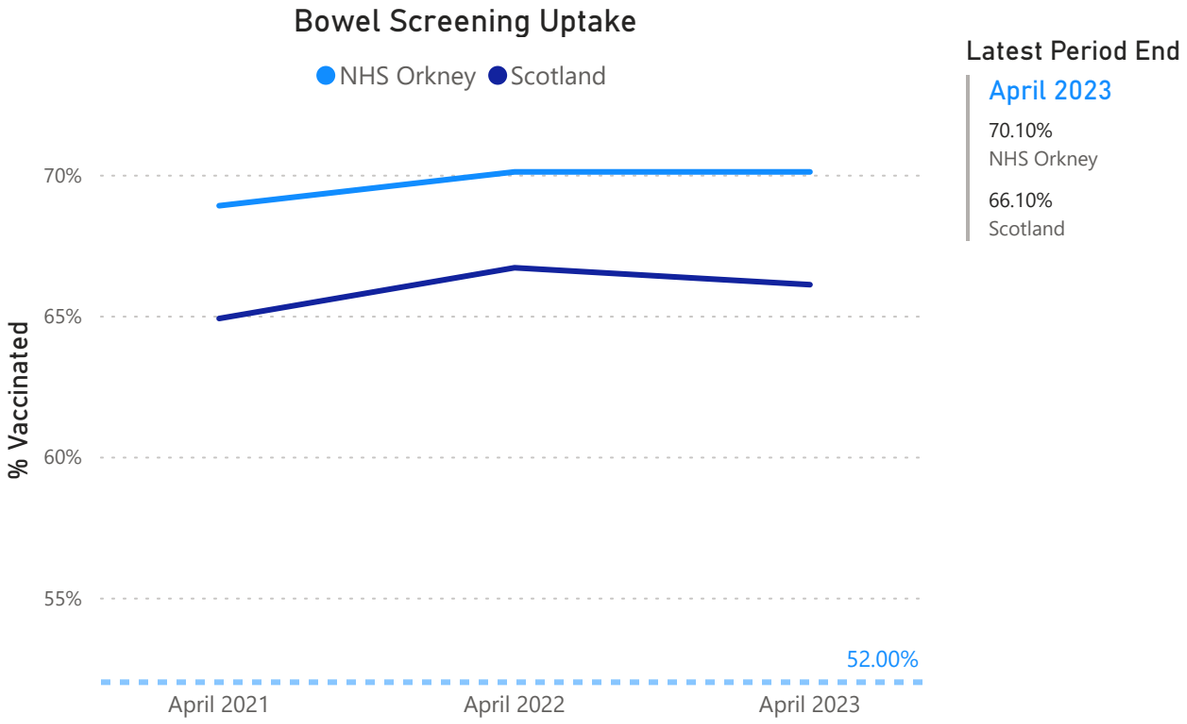
Awaiting final confirmation on national policy about Winter Flu and Covid-19 Vaccination Programme, to be launched from September 2024. Successful recruitment of vaccinators will allow implementation as per policy. Work underway to secure appropriate facilities and staffing resource for health and social care staff vaccination.

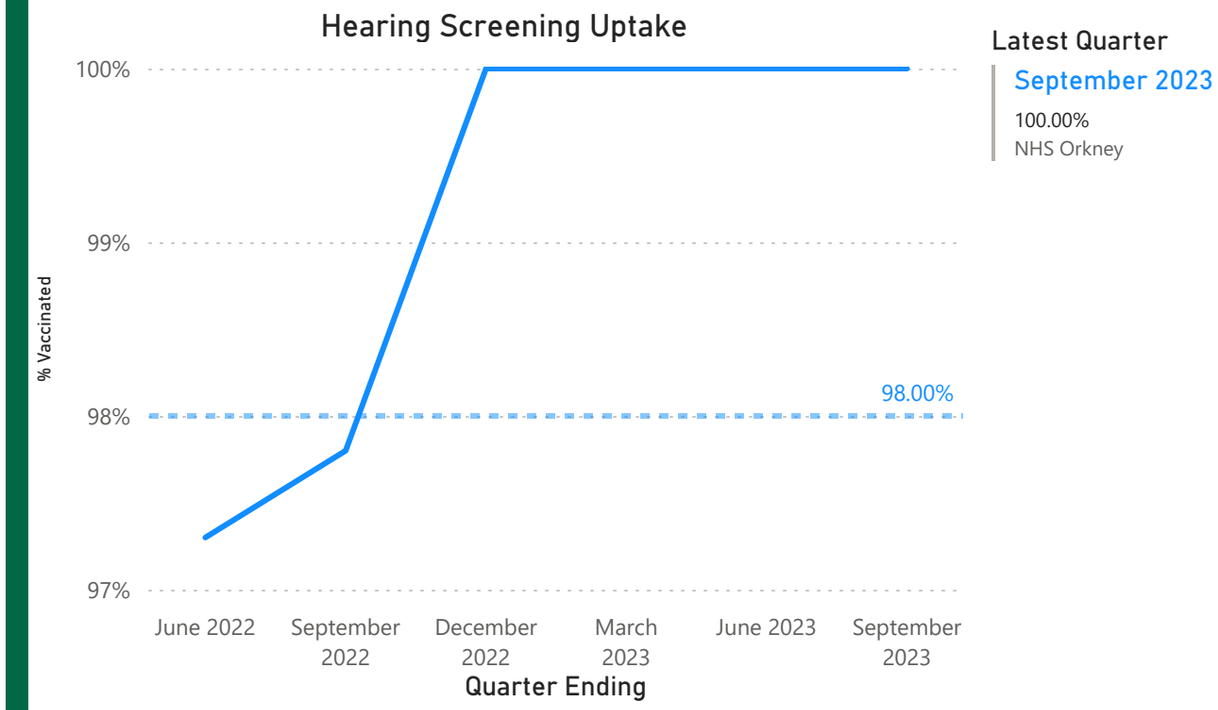
Major childhood programme schedule changes and the introduction of a new Varicella immunisation programme in 2025 may be affected by an expected 3-months delay in the national implementation of the new Child Health IT system, that was initially expected to be launched at the end of 2024. Local implementation group will monitor the situation and ensure that vaccination will be offered as per national policy.

Assurance/Recovery Trajectory

Childhood uptake consistently higher than Scottish average and generally above 95% recommended threshold, in the context of overall national decreasing trend. Uptake rate not affected by change to Kirkwall vaccination team from 1 April 2023. Local actions to increase pertussis and MMR uptake were taken recently in the context of UK and Europe increase of whooping cough and measles cases, with very low impact locally. Local figures (source: Badgernet) show that pertussis vaccination uptake in pregnant women from April 2023 to March 2024 was 95.4%. A new RSV (Respiratory Syncytial Virus) Vaccination Programme will be launched from 1 August 2024. Pregnant women will be offered immunisation from 28 weeks of their pregnancy by the Maternity Team. Individuals aged 75-79 years on 1 August 2024 will be invited for vaccination in August-September 2024.

Screening Services (Source: Public Health Team)





Issues/Performance Summary

National Screening Governance arrangements being updated, with a drive to increase uptake in hard-to-reach populations, which has increased significantly strategic input from Public Health Consultant lead in the context of a vacancy in the Public Health Department. Breast screening programme ran from 29 April to 4 July 2024 with nearly 3200 women invited.

Planned/Mitigating Actions

Local screening equity plan is about to be presented at Clinical Quality Group for approval and implementation to take forward actions to increase screening uptake in harder to reach populations.

Consultant vacancy has been highlighted.

Assurance/Recovery Trajectory

Most screening programmes report KPIs annually and several months after delivery.
Uptake of Hearing, Bowel, AAA and Breast Screening uptake is above Scotland's average and targets.
AAA Screening programme Apr 2022-Mar 2023: Percentage of eligible population who are tested before age 66 and 3 months is 83.1% in Orkney, 78% in Scotland (national minimum standard is 70%, national target is 80%).
Breast Screening Programme: Uptake Apr 2020-Mar 2023 is 83.7% in Orkney, 75.9% in Scotland (national target is 70%).

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Strengthening Performance Management arrangements – Integrated Performance Report by exception proposal**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight – Chief Executive**
Report Author:	**Debs Crohn, Head of Improvement**

1 Purpose

This report is presented to the NHS Orkney Board:

The Board is asked to:

I. To **receive, discuss** and **approve** the Integrated Performance Report (IPR) and exception reporting process which will commence from October 2024.

This report relates to a:

- Corporate Strategy 2024/2028 - Performance
- Delivery Plan 2024/25
- Emerging issue
- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred
- Quality

2 Report summary

2.1 Situation

As we mature as an organisation, and to provide robust assurance to our Board Committees and the Board, NHS Orkney is introducing a new Performance Management Framework (PMF). Part of the framework is the Integrated Performance Report (IPR).

This paper includes a 'mock up' of the IPR scorecard which sets out the full suite of Key Performance Indicators (KPIs) and an example of an exception report (appendix 1) for the operational standards section of the IPR for discussion and approval. By exception reporting for the IPR will commence at the October 2024 public Board. This means that in addition to the Board seeing an overall scorecard of all performance standards, the exception

report will enable the Board to focus on the standards where performance is 'off track', along with actions and mitigations to recover the position.

To note – the appendix is for demonstration purposes only.

2.2 Background

NHS Orkney's PMF is the umbrella framework for measuring performance of our Corporate Strategy (which includes the Anchor Strategy), NHS Scotland Planning Framework (including the Annual Delivery Plan) and key national operational performance metrics/local metrics. Performance against the KPI's will be presented via the Integrated Performance Report (IPR) on an exception only basis. Only KPI's which are off track (rated red) will be included in the IPR in detail. KPIs which are on track (rated green) will not be included with performance being monitored by services, and kept under review via our operational governance forums, including our monthly Planned Care Board and quarterly Performance Review Meetings (PRMs to give some examples).

The full IPR will be brought to the Senior Leadership Team and public Board bi-monthly from October 2024 after the detailed chapters of the IPR have been scrutinised by our Board Committees i.e. workforce chapter to Staff Governance Committee, Finance, Operational and Community performance to Finance and Performance Committee and Population Health and Quality, Safety and Experience to Joint Clinical Care Governance Committee).

2.3 Assessment

Regular performance monitoring helps to identify any deviations from KPI's. This early detection allows for quick interventions before issues escalate. Performance data, for example incident reports or patient outcomes, can be analysed to identify trends and areas needing improvement, ensuring decisions to enhance patient safety are based on solid evidence.

Benchmarking against other Health Boards will not be included in the IPR unless it has been validated and published by Public Health Scotland as it is essential our data is correct and of a high quality and standard if we are to maintain a high-performing, accountable, and patient-centred healthcare system in Orkney.

2.3.1 Quality/Patient Care

The IPR supports quality and patient safety by creating a structured environment where safety is an ongoing priority, monitored, and improved through continuous feedback, training, and accountability. It supports patient safety by providing structured processes and clear expectations for healthcare professionals and the Board as it clearly defines the goals and standards related to patient safety, ensuring safety is consistently monitored to ensure patient safer care outcomes are achieved and assurance provided to the Board.

.3.2 Workforce

The IPR makes it clear for our workforce who is responsible and accountable for each of the KPIs by clearly defining who is accountable for what, reducing ambiguity and ensuring everyone understands their role in maintaining patient safety and delivering high quality services.

2.3.3 Financial

There are no financial implications in relation to this paper.

2.3.4 Risk Assessment/Management

There is a risk that lack of long term financial sustainable solution and national escalation status impacts adversely on patient safety, quality, and experience, as well as organisational culture improvements that are underway. Having a robust IPR provides some mitigation against this risk.

2.3.5 Equality and Diversity, including health inequalities.

NHS Orkney actively seeks to address health inequalities through effective performance management. Central to our work is developing a culture of continuous improvement which has fairness and equity at its heart.

2.3.6 Climate Change Sustainability

NHS Orkney is a leader in terms of sustainability and addressing climate change. There is one deliverable within the Annual Delivery Plan and NHS Orkney Strategic Priorities for 2023/24 linked to Climate Change Sustainability.

2.3.7 Communication, involvement, engagement, and consultation

Discussions have taken place with section leads, Executive Leads, Health Intelligence Team, Director of Improvement, Recovery Director, Head of Improvement and NHS Orkney's Chief Executive in the development of this paper.

2.3.8 Route to the Meeting

The paper has been prepared for the purposes of the Board 22 August 2024.

- Corporate Leadership Team – 11 July 2024
- Senior Leadership Team – 4 August 2024

2.4 Recommendation(s)

Approval - The Board is asked to:

II. To **receive, discuss** and **approve** the Integrated Performance Report (IPR) and exception reporting process which will commence from October 2024.

2 List of appendices

The following appendices are included with this report:

Appendix 1, IPR scorecard - example of the Operational Standards section of the IPR (for demonstration purposes only).

NHS Orkney

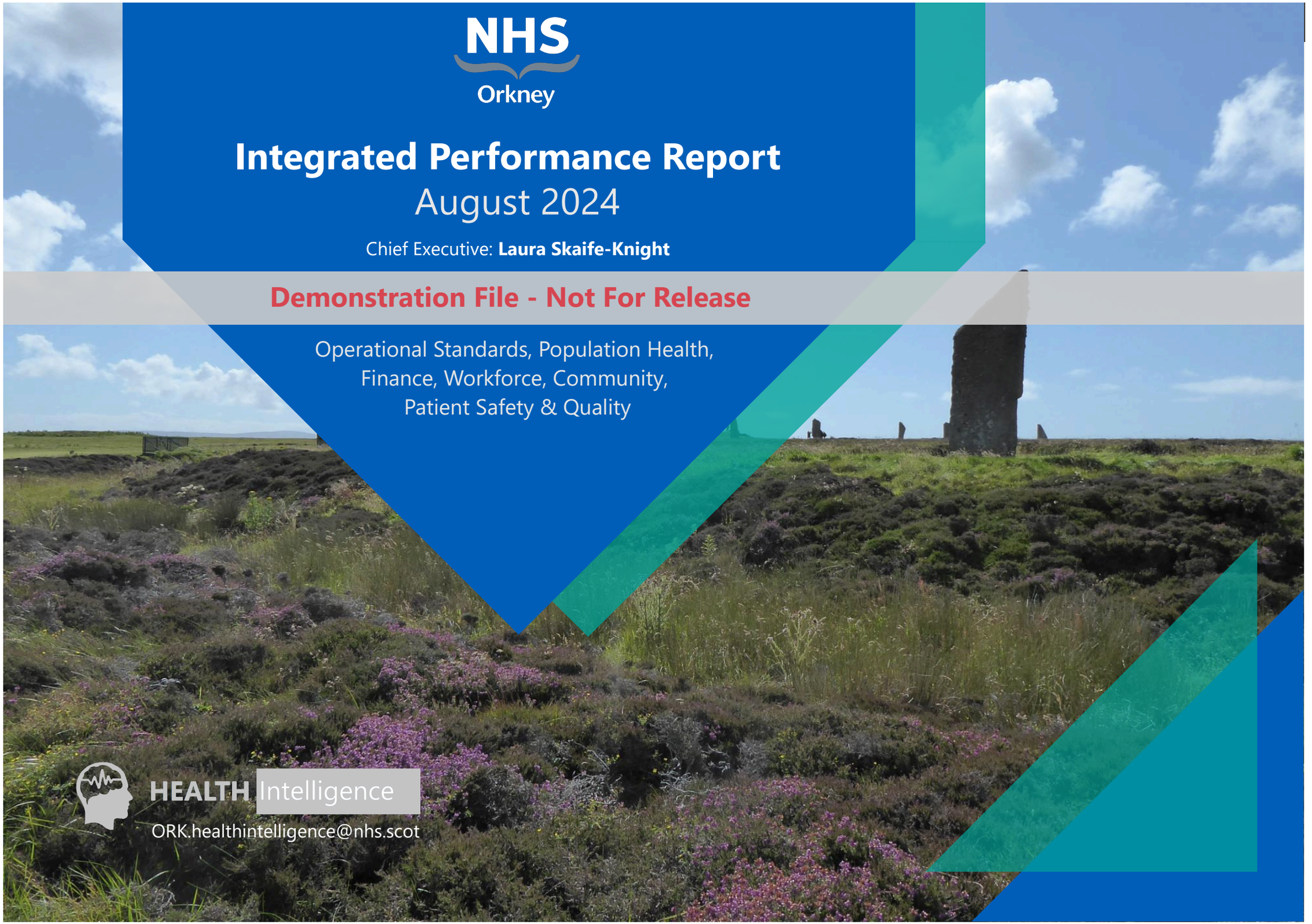
Integrated Performance Report

August 2024

Chief Executive: **Laura Skaife-Knight**

Demonstration File - Not For Release

Operational Standards, Population Health,
Finance, Workforce, Community,
Patient Safety & Quality



HEALTH Intelligence
ORK.healthintelligence@nhs.scot

NHS Orkney Performance Scorecard

	Section	Service Area	NHS Orkney KPI's	Executive Lead	Target	Actual	Latest RAG
1	Operational Standards	Planned Care Waiting Times	100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment (TTG)	Dr Anna Lamont			
2	Operational Standards	Planned Care Waiting Times	Reduction in waiting times for planned care services (Treatment Time Guarantee and outpatient standards) >10%	Dr Anna Lamont			
3	Operational Standards	Planned Care Waiting Times	95 per cent of patients wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census). Boards to work towards 100%	Dr Anna Lamont			
4	Operational Standards	Planned Care Waiting Times	90% of planned/elective patients to commence treatment within 18 weeks of referral	Dr Anna Lamont			
5	Operational Standards	Planned Care Waiting Times	100% of patients waiting for key endoscopy diagnostic tests and investigations should wait no longer than six weeks (42 days).	Dr Anna Lamont			
6	Operational Standards	Planned Care Waiting Times	100% of patients waiting for key imaging diagnostic tests and investigations should wait no longer than six weeks (42 days).	Dr Anna Lamont			
7	Operational Standards	Planned Care Waiting Times	100% of patients waiting for key cardiology diagnostic tests and investigations should wait no longer than six weeks (42 days).	Dr Anna Lamont			
8	Operational Standards	Cancer	90% of those referred urgently with a suspicion of cancer are to begin treatment within 62 days of receipt of referral	Dr Anna Lamont			
9	Operational Standards	Cancer	95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	Dr Anna Lamont			
10	Operational Standards	Inpatients	Ensure that acute receiving occupancy is 95% or less.	Sam Thomas			
11	Operational Standards	Unscheduled Care	95% of patients wait no longer than four hours from arrival to admission, discharge, or transfer for A&E treatment. Boards work towards 98%.	Sam Thomas	95%	93.5%	Red
12	Operational Standards	Unscheduled Care	Patients wait less than 12 hours to admission, discharge, or transfer from A&E	Sam Thomas			
13	Operational Standards	Unscheduled Care	SAS 90th Percentile turnaround within 60 minutes.	Sam Thomas	60:00	29:36	Green
14	Operational Standards	Delayed Transfer of Care	Number of people experiencing a delay discharged within 2 weeks (excluding complex code 9 delays)	Sam Thomas			
15	Operational Standards	Delayed Transfer of Care	Number of people experiencing a delay of any length or reason in discharge from hospital at the monthly census point	Sam Thomas			
16	Operational Standards	Delayed Transfer of Care	Number of hospital bed days associated with delayed discharges (any length or reason) in the calendar month.	Sam Thomas			
17	Operational Standards	Woman and Children	90% of eligible patients to commence IVF treatment within 12 months of referral	Sam Thomas			
18	Operational Standards	Woman and Children	% of women booking in a Board allocated to a primary midwife	Sam Thomas			
19	Operational Standards	Woman and Children	100% of women who received midwifery are during the intrapartum period from their primary midwife and or secondary midwife (buddy) or a member of the same team that the woman had met during her pregnancy	Sam Thomas			
20	Operational Standards	Woman and Children	50% of scheduled antenatal care appointments delivered by the primary midwife and or secondary midwife (buddy)	Sam Thomas			
21	Operational Standards	Woman and Children	75% of community based postnatal midwifery care appointments delivered by the primary midwife and or secondary midwife (buddy	Sam Thomas			
22	Population Health	Promoting health and wellbeing outcomes	Increase smoking cessation services across Scotland and successful quits year on year, including during pregnancy.	Dr Louise Wilson			
23	Population Health	Promoting health and wellbeing outcomes	NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas (60% in the Island Boards)	Dr Louise Wilson			
25	Population Health	Prevention of Disease	Immunisation uptake rate 6-in-1 primary Course by 12 months	Dr Louise Wilson			
26	Population Health	Prevention of Disease	Immunisation uptake rate MMR2 by 6 years of age	Dr Louise Wilson			
27	Population Health	Promoting health and wellbeing outcomes - Diabetic Retinopathy Screening (DRS)	Promoting health and wellbeing outcomes - Diabetic Retinopathy Screening (DRS) 100% of the population eligible sent at least one invitation for retinal screening (with or without a pre-booked appointment) within the Reporting Period.	Dr Louise Wilson			
28	Population Health	Promoting health and wellbeing outcomes - Breast Screening	Promoting health and wellbeing outcomes - Breast Screening 80% attendance rate for all routine appointments	Dr Louise Wilson			
29	Population Health	Promoting health and wellbeing outcomes - Cervical Screening	Promoting health and wellbeing outcomes - Cervical Screening 80% of eligible women (aged 25 to 64) who were recorded as screened adequately	Dr Louise Wilson			
30	Population Health	Promoting health and wellbeing outcomes - AAA Screening	Promoting health and wellbeing outcomes - AAA Screening 75% of eligible population are tested before reaching the age of 66 and 3 months	Dr Louise Wilson			
31	Population Health	Promoting health and wellbeing outcomes- Pregnancy Screening	Promoting health and wellbeing outcomes- Pregnancy Screening	Dr Louise Wilson			
32	Population Health	Promoting health and wellbeing outcomes- Newborn Bloodspot Screening	Promoting health and wellbeing outcomes- Newborn Bloodspot Screening 100% of newborn babies have bloodspot Screening completed by day 5	Dr Louise Wilson			
33	Population Health	Promoting health and wellbeing outcomes Universal Newborn Hearing Screening	Promoting health and wellbeing outcomes Universal Newborn Hearing Screening 100% of babies reicieve a newborn Hearing Screening prior to discharge	Dr Louise Wilson			
34	Finance	Finance	Financial performance against plan - in month, YTD and forecast	Director of Finance			
35	Finance	Finance	Efficiency performance against plan & recurrent % delivery - in month, YTD and forecast	Director of Finance			
36	Finance	Finance	Capital performance against plan - in month, YTD and forecast.	Director of Finance			
37	Finance	Finance	Capital performance against plan - in month, YTD and forecast.	Director of Finance			
38	Workforce	Sickness Absence	Sickness rates consistently below the national average of <6%	Jay O Brien			
39	Workforce	Sickness Absence	Monthly comparison for previous 12 months NHS Scotland and NHS Orkney	Jay O Brien			
40	Workforce	Appraisals	Appraisal compliance rate over the previous 12 months	Jay O Brien			
41	Workforce	Hours Utilised	Bank	Jay O Brien			
42	Workforce	Hours Utilised	Overtime	Jay O Brien			
43	Workforce	Hours Utilised	Excess	Jay O Brien			
44	Community	Drug and Alcohol Treatment	90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.	Stephen Brown			
45	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at AHP led MSK service	Stephen Brown			
46	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at AHP led Podiatry MSK service	Stephen Brown			
47	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at AHP led Physiotherapy MSK service	Stephen Brown			
48	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at AHP led MSK Orthotics service	Stephen Brown			
49	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at AHP led MSK SALT service	Stephen Brown			
50	Community	Dementia Post-Diagnostic Support	People newly diagnosed with dementia will have a minimum of one years post-diagnostic support	Stephen Brown			
51	Community	Child and Adolescent Mental Health Service (CAMHS)	90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral. Compliance rate 98.5%	Stephen Brown			
52	Community	Psychological Therapies	18 Week Referral to Treatment	Stephen Brown			
53	Patient Safety & Quality	Excellence in Care	Number of pressure sores this month	Sam Thomas			
54	Patient Safety & Quality	Excellence in Care	Maternal Early Warning System compliance	Sam Thomas			
55	Patient Safety & Quality	Excellence in Care	Multi-Drug Resistant Organism (MDRO) hospital and community acquired	Sam Thomas			
56	Patient Safety & Quality	Excellence in Care	Inpatient Falls with harm	Sam Thomas			
57	Patient Safety & Quality	Complaints	Complaints received this month	Dr Anna Lamont			
58	Patient Safety & Quality	Complaints	Complaints Received - Stage 1 5 Working Day Response Compliance	Dr Anna Lamont			
59	Patient Safety & Quality	Complaints	Complaints Received - Stage 2 20 Working Day Response Compliance	Dr Anna Lamont			
60	Patient Safety & Quality	Complaints	Complaints referred to SPSO	Dr Anna Lamont			
61	Patient Safety & Quality	Incident Reporting	Incident Reporting and 7 Working Day Review Compliance	Dr Anna Lamont			
62	Patient Safety & Quality	Significant Adverse Event Reviews	Significant Adverse Event Review Compliance	Dr Anna Lamont			

Operational Standards

Section Lead(s):
Medical Director - Anna Lamont
Executive Director of Nursing, Midwifery, Allied Health Professionals & Chief Officer Acute - Sam Thomas

What's Going Well?

RAG Status Values	
RED	Key performance indicator not achieved.
GREEN	Key performance indicator achieved.

RAG status values are assigned to each metric based on their compliance with national and/or locally set targets. Metrics assigned a red status will be accompanied with improvement actions, and a timeline for recovery of the position.

Metrics with a target of 'x̄' are given a RAG value based on their performance against their own average.

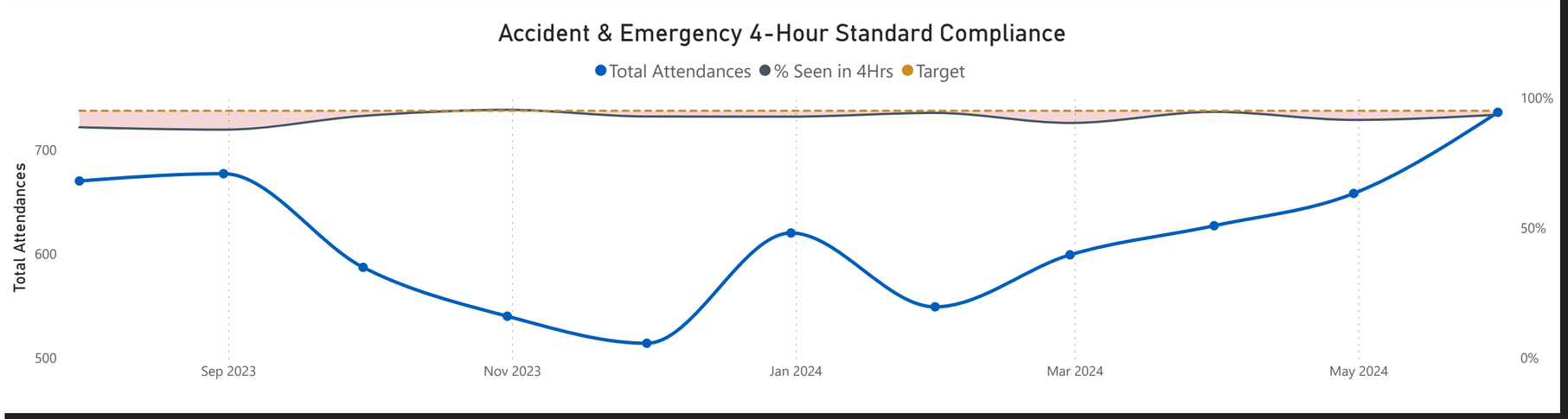
Areas of Concern

Operational Standards Performance Scorecard

	Service Area	Operational Standard KPI's	Executive Lead	Target	Actual	Latest RAG
1	Planned Care Waiting Times	100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment (TTG)	Dr Anna Lamont			
2	Planned Care Waiting Times	Reduction in waiting times for planned care services (Treatment Time Guarantee and outpatient standards) >10%	Dr Anna Lamont			
3	Planned Care Waiting Times	95 per cent of patients wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census). Boards to work towards 100%	Dr Anna Lamont			
4	Planned Care Waiting Times	90% of planned/elective patients to commence treatment within 18 weeks of referral	Dr Anna Lamont			
5	Planned Care Waiting Times	100% of patients waiting for key endoscopy diagnostic tests and investigations should wait no longer than six weeks (42 days).	Dr Anna Lamont			
6	Planned Care Waiting Times	100% of patients waiting for key imaging diagnostic tests and investigations should wait no longer than six weeks (42 days).	Dr Anna Lamont			
7	Planned Care Waiting Times	100% of patients waiting for key cardiology diagnostic tests and investigations should wait no longer than six weeks (42 days).	Dr Anna Lamont			
8	Cancer	90% of those referred urgently with a suspicion of cancer are to begin treatment within 62 days of receipt of referral	Dr Anna Lamont			
9	Cancer	95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	Dr Anna Lamont			
10	Inpatients	Ensure that acute receiving occupancy is 95% or less.	Sam Thomas			
11	Unscheduled Care	95% of patients wait no longer than four hours from arrival to admission, discharge, or transfer for A&E treatment. Boards work towards 98%.	Sam Thomas	95%	93.5%	Red
12	Unscheduled Care	Patients wait less than 12 hours to admission, discharge, or transfer from A&E	Sam Thomas			
13	Unscheduled Care	SAS 90th Percentile turnaround within 60 minutes.	Sam Thomas	60:00	29:36	Green
14	Delayed Transfer of Care	Number of people experiencing a delay discharged within 2 weeks (excluding complex code 9 delays)	Sam Thomas			
15	Delayed Transfer of Care	Number of people experiencing a delay of any length or reason in discharge from hospital at the monthly census point	Sam Thomas			
16	Delayed Transfer of Care	Number of hospital bed days associated with delayed discharges (any length or reason) in the calendar month.	Sam Thomas			
17	Woman and Children	90% of eligible patients to commence IVF treatment within 12 months of referral	Sam Thomas			
18	Woman and Children	% of women booking in a Board allocated to a primary midwife	Sam Thomas			
19	Woman and Children	100% of women who received midwifery are during the intrapartum period from their primary midwife and or secondary midwife (buddy) or a member of the same team that the woman had met during her pregnancy	Sam Thomas			
20	Woman and Children	50% of scheduled antenatal care appointments delivered by the primary midwife and or secondary midwife (buddy)	Sam Thomas			
21	Woman and Children	75% of community based postnatal midwifery care appointments delivered by the primary midwife and or secondary midwife (buddy	Sam Thomas			

Operational Standards
Accident & Emergency 4-Hour Compliance

Data Source	Latest Data
PHS A&E Publication	31/05/2024



KPI	Target	Actual	RAG Value
95% of patients wait no longer than four hours from arrival to admission, discharge, or transfer for A&E treatment. Boards work towards 98%.	95%	93.5%	Red

Actions to Improve Performance

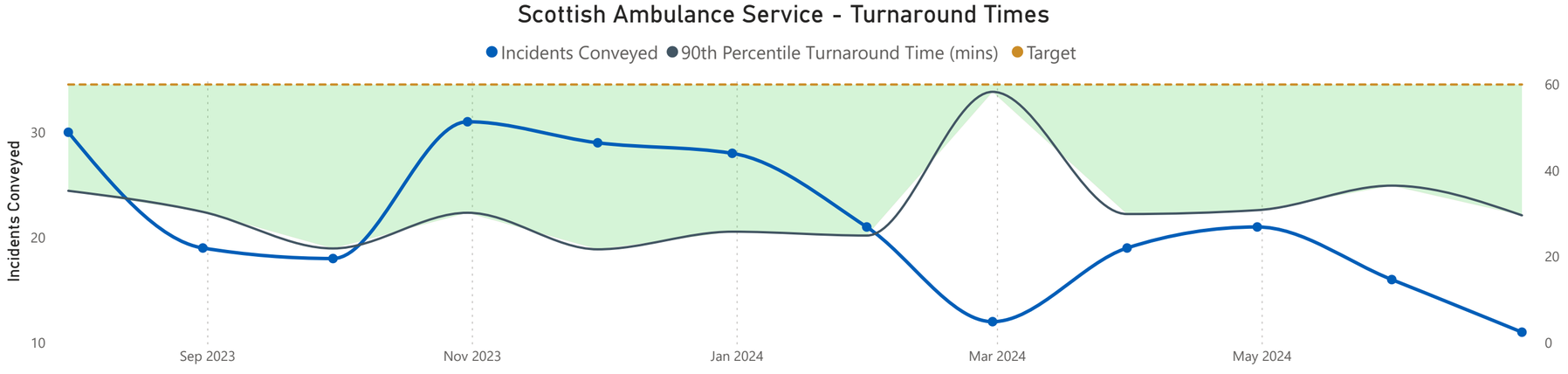
This is an example of how a metric that has been identified as 'off-track' will look. The target and actual compliances are shown above, and featured in this section for each off-track metric will be details on actions that will be taken to recover the position. Below this section is an improvement target date, which will be added to show the anticipated date that these actions will result in compliance with the above target. Off-track metrics will be included in all editions of the IPR.

Improvement Target Date

Operational Standards
Scottish Ambulance Service Turnaround Times

Data Source
SAS Weekly Operational Statistics

Latest Data
24/06/2024



KPI	Target	Actual	RAG Value
SAS 90th Percentile turnaround within 60 minutes.	60:00	29:36	Green

Actions to Improve Performance

This is an example of how a metric that has been identified as 'on-track' will look. This section and the Improvement Target Date seen below will not be populated for any on-track metrics. On-track metrics will only feature in full versions of the IPR and be excluded from the Exception Report variants.

Improvement Target Date

#

NHS Orkney

Meeting:	**NHS Orkney Health Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Performance Review Meetings (PRMs)**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight – Chief Executive**
Report Author:	**Phil Tydeman, Director of Improvement**

1 Purpose

This report is presented to the Board of Directors for:

Approval - to receive the recommendation from Senior Leadership Team to approve the proposal for quarterly performance review meetings to commence from October 2024.

This report relates to a:

- Corporate Strategy 2024/2028 - Performance
- Delivery Plan 2024/25

This aligns to the following NHS Scotland quality ambition(s):

- Effective
- Person Centred
- Quality

2 Report summary

2.1 Situation

This paper sets out a proposal to amend how performance of services and specialties is currently governed to a new quarterly cycle. NHS Orkney currently has an approach to support, monitor and hold services and specialties to account. The intention is to now move to a model that more closely aligns these performance meetings with the health board's new 5-year corporate strategy (2024 – 2028).

2.2 Background

Performance Review meetings are being established to support the delivery of the annual delivery plan and financial plan, monitoring progress against agreed performance trajectories and holding to account respective leads for the operational and clinical delivery of key performance indicators.

These meetings aim to supportively scrutinise performance against plan, provide early identification of risks associated with delivery, determine interventions necessary to correct adverse performance and provide a formal mechanism to escalate concerns to the executive in a timely manner and supportive environment.

The Board of Directors is asked to:

(a) approve the proposal to introduce quarterly performance review meetings from October 2024.
(b) note the draft terms of reference

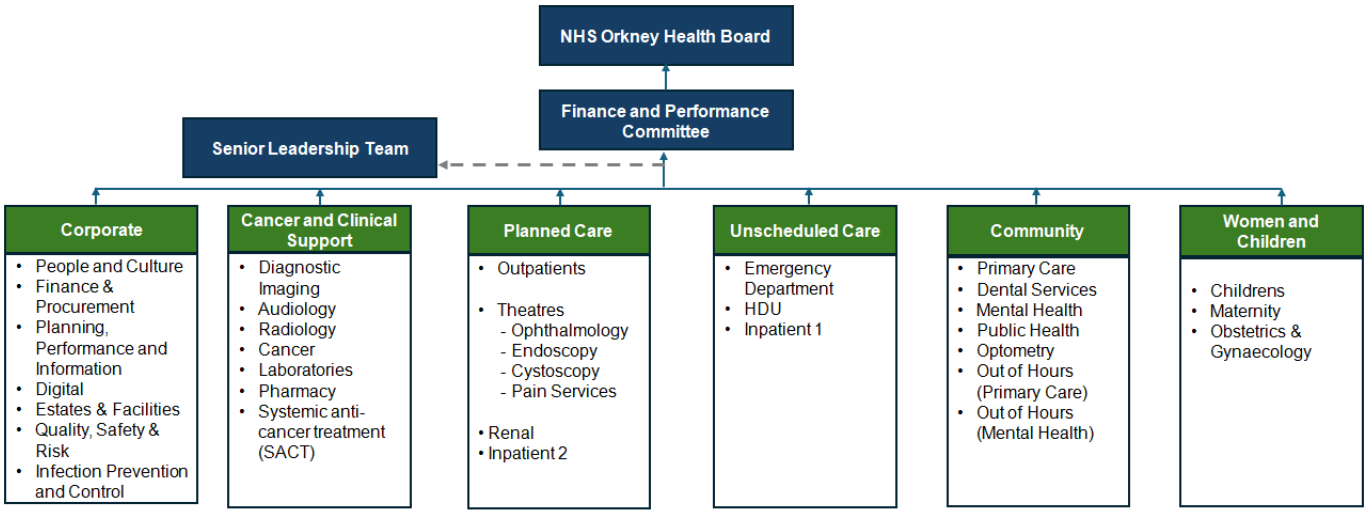
2.3 Assessment

The following sets out the proposed approach to enacting performance review meetings for NHS Orkney.

The governance framework for performance review meetings
As part of NHS Orkney's effort to strengthen its existing governance practices and to build upon how the executive currently hold specialities and services to account for performance, a proposal was submitted to Senior Leadership Team for discussion and approval.

The proposal sets out clear aims for PRMs including to establish clarity as to the expected level of performance in accordance with the annual delivery plan and financial plan at specialty or service level; review the performance of each area across all domains of integrated performance in line with plan targets, outcome measures, milestones and trajectories; and receive exception reports and recovery plans for areas where performance is below planned expectation.

Through discussion at Corporate Leadership Team (CLT), it was agreed that specialties and services would be grouped where there were similar or dependent services to align with operational performance, resulting in the establishment of six member groupings of Corporate, Cancer and Clinical Support, Planned Care, Unscheduled Care, Community and Women and Children. The below sets out those specialties and services aligned to each group.



This represents a shift both in the organisations accountability and governance frameworks but also in how corporate services are being asked to collate and present information.

Detailed information packs will be developed for each specialty and service under each grouping with key metrics across workforce, finance and health intelligence. These metrics will draw performance indicators from the integrated performance report (IPR), corporate strategy and other nationally required data sets into a singular report for each PRM grouping.

Colleagues across each of these corporate functions are now determining the most effective method to present this information from existing reports. There may be challenges in providing the full suite of metrics at speciality or service level for October, and where this is the case, further work will be undertaken to include for the next round of quarterly PRMs. It is recognised this will be an iterative process however there is a clear ambition to address these challenges early and be in a position to have robust processes in place prior to Q1 2025/26.

Information packs, complete with the most recent quarter's performance metrics will be shared with each grouping up to two weeks prior to the PRMs taking place. Teams will be expected to add written narrative into the packs to describe where performance is adverse to plan and steps being taken to recover the position. These packs will then be submitted to the executive; with a briefing session to be held with the executive team in the days leading up to PRM's to highlight key lines of enquiry.

The PRMs will be attended by members of the executive team with the Chief Executive Officer acting as Chair. For each of the six groupings, operational and clinical leads have been identified who will attend the meetings to speak to their respective area. Colleagues from workforce, finance and health intelligence will also attend to assist in discussions. The planned current meeting membership is set out in Appendix 1.

The PRMs will report into the Finance and Performance Committee.

Timetable for Performance Review Meetings

Performance review meetings will take place quarterly with representation from the executive team and clinical and operational leads across each of the six groupings. These meetings will be either 60 minutes or 90 minutes in length.

Meetings will take place in the month following the end of the previous quarter, aligned to the financial year. This will allow discussion around the latest available performance metrics. Focus will be on those areas of escalation where performance is outside of standards and targets with the aim to support teams to develop plans to return to compliant performance.

Meetings will take on one day so that similar issues can be understood, information shared with teams in a consistent manner and decisions taken in full understanding of the impact across all specialties and services.

Performance Review Group	Meeting time	Date of meeting	Date of meeting	Date of meeting	Date of meeting
Corporate	8:30 - 10:00	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Cancer and Clinical Support	10:15 - 11:15	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Planned Care	11:30 - 12:30	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Unscheduled Care	13:00 - 14:00	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Community	14:15 - 15:15	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Women and Children	15:30 -16:30	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July

Next Steps

The following sets out next steps, pending approval from the Board, to operationalise performance review meetings from October 2024:

Deliverable	Timescale
Amend the approach following Board feedback	23 August
Meeting invites to be sent to PRM members with explanatory email	30 August
Work with finance, health intelligence and workforce to collate information packs	30 August
Draft PRM information pack and Draft Terms of Reference to Finance and Performance Committee	Julie to advise
PRM packs to be distributed to six specialty and service groupings for narrative to be added	10 October
PRM packs to be submitted to Corporate for review by executive team	16 October
Inaugural PRMs held	23 October

2.4.1 Quality/Patient Care

Performance meetings are a standard approach to providing assurance that services are meeting standards and key performance indicators that indicate confidence in both quality of services and safety of care. These meetings will provide a focused opportunity to support services where performance needs to be improved through a supportive and constructive environment.

2.4.2 Workforce

Through these meetings, there will be a good level of oversight and discussion to support and create a healthy workforce through discussions on sickness absence, staff turnover and recruitment challenges. By focusing on people metric aligned to the corporate strategy, interventions can be put in place to provide a positive working environment for all staff.

2.4.3 Financial

NSH Orkney has a deficit plan for the 2024/25 financial year of £5.778m and is focused on delivering an in-year savings programme of £4m (of which 72% is expected to be recurrent). Through these meetings, there will be assurance around pay controls, alignment to budgets (where refreshed), agency reduction and overall financial performance. This will be a core function of supporting the organisation return to financial balance and achieve longer-term financial sustainability.

2.4.4 Risk Assessment/Management

Through these meetings, NHS Orkney aims to further build and strengthen the governance framework around service delivery.

2.4.5 Climate Change Sustainability

NHS Orkney is a leader in terms of sustainability and addressing climate change. There is one deliverable within the Annual Delivery Plan and NHS Orkney Strategic Priorities for 2023/24 linked to Climate Change Sustainability.

2.4.6 Communication, involvement, engagement, and consultation

Discussions have taken place with Corporate Leadership Team as well as finance, workforce and health intelligence teams to input into this submission.

2.4.7 Other impacts

N/A

2.4.8 Route to the Meeting

This paper has been prepared for the purposes of the discussions at Board through discussions at Senior Leadership Team and discussions at Corporate Leadership Team.

2.5 Recommendation(s)

The Board of Directors is asked to:

(a) approve the proposal to introduce quarterly performance review meetings from October 2024.
(b) note the draft terms of reference

3 Appendices

The following appendices are attached to this paper:

Appendix 1 Current meeting membership for each performance review meeting
Appendix 2 Draft Terms of Reference for Performance Review Meetings

NHS Orkney

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Appendix 1: Current meeting membership for each performance review meeting

Oversight Group	Members
Executive Team	• Chief Executive Officer (Chair) • Medical Director **or** Executive Director of Nursing, Midwifery, AHPs and Chief Officer, Acute **or** Director of Public Health • Chief Officer – IJB (or Deputy) • Director of Finance • Director of People and Culture

PRM Group	Clinical / Operational Lead	Finance Lead	Workforce Lead	Accompanying members
Corporate	• Julie Colquhoun • Debs Crohn • Sharon Smith • Alan Scott • Steven Phillips • Kat Jenkin • Sarah Walker	• Mareeya Monterro	• Steven Phillips	• Richard Rae
Cancer and Clinical Support	• Nick Crohn • Lorna Wilson • Wendy Lycett • Karen Barnett • Joy Tait • Moira Sinclair • Helen Thain	• Andrew Grassom	• Steven Phillips	• Ian Coghill
Planned Care	• Monique Sterrenburg • Nancy Faulkner • Helen Thain • Morven Gemmill	• Andrew Grassom	• Steven Phillips	• Ian Coghill
Unscheduled Care	• Catherine Siderfin • Wendy Corstorphine • Graham Johnston / Lynda Guthrie • Joanne Fergus • Lucy Flett • Yvonne Galland	• Bruce Young	• Steven Phillips	• By invitation
Community	• Lynda Bradford • John Daniels • Steven Johnstone • Lyndsey Steel • Morven Gemmill • Elvira Garcia	• Bruce Young	• Steven Phillips	• By invitation
Women and Children	• Darren Morrow • Michelle Mackie • Monique Sterrenburg • Lauren Flett • Louise Willis	• Bruce Young	• Steven Phillips	• By invitation

Performance Review Meetings (PRMs)

(Draft) Terms of Reference

Version	Action/Amend	Author/Editor	Date
V0.1	First Draft Terms of Reference	Phil Tydeman	11/06/2024
V0.2	Amended via Corporate Leadership Team	Phil Tydeman	27/06/2024
V0.3	Amended via Senior Leadership Team	Phil Tydeman	05/08/2024

Performance Review Meetings Terms of Reference

Purpose

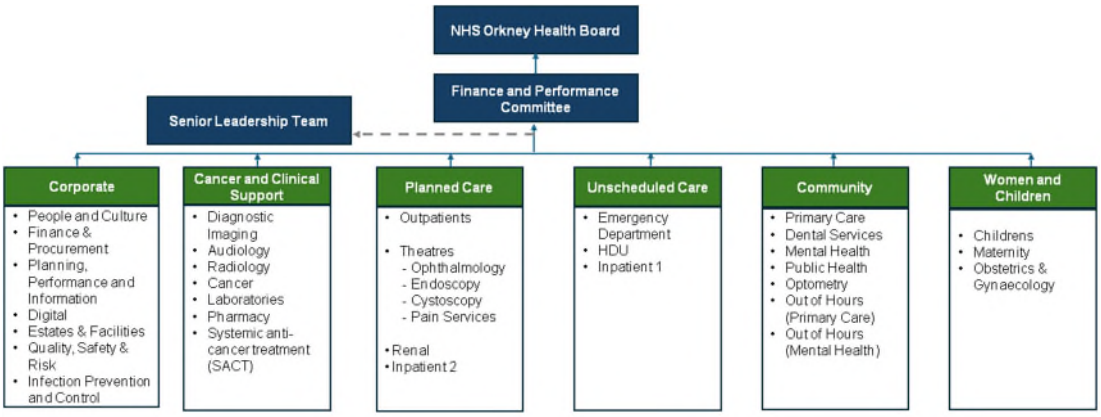
The Performance Review meetings are established to support the delivery of the annual delivery plan and financial plan, monitoring progress against agreed performance trajectories and holding to account respective leads for the operational and clinical delivery of the key performance indicators. These meetings function to scrutinise performance against plan, provide early identification of risks associated with delivery, determine interventions necessary to correct adverse performance and provide a formal mechanism to escalate concerns to the executive in a timely manner and supportive environment.

Authority

The Performance Review Meetings has delegated authority from the NHS Orkney Finance and Performance Committee to investigate any activity within its terms of reference.

Governance

The structure of reporting into the Performance Review Meetings by six agreed cohorted areas as well as the wider governance arrangements is detailed below.



Remit

The Performance Review Meeting will:

- establish clarity as to the expected level of performance in accordance with the annual delivery plan and financial plan.
- review the performance of each area across all domains of integrated performance in line with plan targets, outcome measures, milestones and trajectories.
- receive exception reports and recovery plans for areas where performance is below planned expectation.
- recognise and share learning and good practice.

- review the risk appetite and the appropriate management of risks within each area.
- evaluate opportunities for improvement, determining actions required to optimise performance in line with benchmark and evidence-based practice.
- celebrate success and create a culture of supported improvement.

Guiding Principles

The Performance Review Meeting is committed to:

- Ensuring alignment with the Corporate Strategy
- Operating in an open, honest, and transparent manner
- Facilitating improvement that is clinically and / or operationally owned and led
- Making decisions that deliver the greatest positive impact to our patients and population.

Membership

Core membership of the Performance Review Meeting for the executive panel is as follows:

Name	Job Title
Laura Skaife-Knight	Chief Executive Officer (Chair)
Dr Anna Lamont *	Medical Director
Samantha Thomas *	Executive Director for Nursing, Midwifery, AHPs and Chief Officer Acute
Louise Wilson *	Director of Public Health
Paul Corlass	Recovery Director
Jarrard O'Brien	Director of People and Culture
Stephen Brown (or deputy)	Chief Officer, Integration Joint Board

* *A minimum of one clinical executive director is expected to attend*

Invites will be extended by the Chair to additional individuals as and when required for specific agenda items.

Membership for each of the six functions to attend PRMs is set out in appendix 1.

Quoracy

Quorum for meetings shall be not less than two members of the executive panel and a minimum of two clinical or operational leads for each of the six functions.

Where the Chair is unable to attend, the Chair will appoint a member to preside in their absence. Where a member is unable to attend, they will ensure an informed designated deputy will attend on their behalf.

If a quorum has not been reached, then the meeting may proceed if those attending agree but no formal decisions may be taken.

Frequency

Meetings will take place quarterly. The dates and times are set out in Appendix 2.

The Executive team will meet prior to the scheduled day of the Performance Review Meetings to receive a briefing on matters of importance and discussion. Briefing meetings will last for 30 minutes and be held within two days of the performance review meeting.

Meeting arrangements

The Chair will set the agenda. The meeting will be supported administratively by the Improvement Hub and will include:

- Co-ordination of meetings
- Collation and dissemination of papers
- Working with the Chair to agree the agenda
- Updating and circulating of the action log and risk register
- Keeping a record of matters arising and issues to be carried forward

Meeting papers will be circulated no later than **five working days** before the scheduled date of the meeting. Papers for the meeting must be submitted to **ork.improvementhub@nhs.scot** by 12:00 noon no later than six working days before the scheduled date of the meeting.

All meetings will be summarised in the form of an action Log and a record kept of all reports/documents considered. The action log will be circulated within two working days after each meeting.

Administrative support for the Performance Review Meetings will be provided by the corporate executive team.

Collation of the documentation for Performance Review Meetings will be collated by the Improvement team working in conjunction with the information team. This arrangement will be reviewed prior to the 2025/26 meeting cycle.

Reporting arrangements

This Performance Review Meetings will receive quarterly standardised written reports from each of the six function areas.

The Senior Leadership Team and Finance & Performance Committee will receive a Chairs Assurance Report quarterly summarising progress, performance, and items of escalation from the Chair from the Performance Review Meetings held.

Confidentiality

All Members are expected to adhere to the NHS Scotland Standards of Business Conduct and Conflicts of Interest Arrangements.

Appendix 1: Performance Review Meeting Membership

Corporate
Julie Colquhoun
Debs Crohn
Sharon Smith
Alan Scott
Steven Phillips
Kat Jenkin
Mareeya Monterro
Sarah Walker
Richard Rae
Cancer and Clinical Support
Nick Crohn
Lorna Wilson
Wendy Lycett
Karen Barnett
Joy Tait
Moira Sinclair
Helen Thain
Steven Phillips
Andrew Grassom
Ian Coghill
Planned Care
Monique Sterrenburg
Nancy Faulkner
Helen Thain
Steven Phillips
Andrew Grassom
Ian Coghill
Unscheduled Care
Catherine Siderfin
Wendy Corstorphine
Graham Johnston
Lynda Guthrie
Joanna Fergus
Lucy Flett
Steven Phillips
Bruce Young
Community
Lynda Bradford
John Daniels
Steven Johnstone
Lyndsey Steel
Morven Gemmill
Elvira Garcia
Steven Phillips
Bruce Young
Women and Children
Darren Morrow
Michelle Mackie
Monique Sterrenburg
Lauren Flett
Louise Willis
Steven Phillips
Bruce Young

Appendix 2: Performance Review Meeting dates and times

Performance Review Group	Meeting time	Date of meeting	Date of meeting	Date of meeting	Date of meeting
Corporate	8:30 - 10:00	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Cancer and Clinical Support	10:15 - 11:15	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Planned Care	11:30 - 12:30	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Unscheduled Care	13:00 - 14:00	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Community	14:15 - 15:15	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July
Women and Children	15:30 -16:30	Wednesday 23 October	Wednesday 22 January	Wednesday 23 April	Wednesday 23 July

NHS Orkney

Meeting:	**NHS Orkney Health Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Improving Together Efficiency Programme**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight, Chief Executive**
Report Author:	**Phil Tydeman, Director of Improvement**

1.0 Purpose

This is presented to the Board of Directors for:

Assurance - to provide an update on the Team Orkney: Improving Together programme progress for 2024/25.

This report relates to:

- Corporate Strategy 2024 – 2028 – Potential, Performance, People, Patient Safety, Quality and Experience, Place
- Annual Delivery Plan 2024/25 (ADP)
- Annual Financial Plan
- Financial Sustainability

This aligns to the following NHS Scotland quality ambition(s):

- Effective
- Person-centred

2.0 Situation

2.1 The purpose of this paper is to provide SLT with a progress update on the development of and implementation phases of the 2024/25 Improving Together efficiency programme.

2.2 NHS Orkney is required to deliver £4m (6%) in-year efficiency savings as part of its commitment to return to financial balance and achieve a model of financial sustainability. NHS Orkney has submitted a plan to the Scottish Government to deliver £2.9m recurrently (72%) and £1.1m (28%) non-recurrently this financial year. This represents a material step-change compared to 2023/24 where recurrent savings in 2023/24 were 24%.

The Board of Directors is asked to note for assurance:

(a) progress of the 2024/25 Improving Together Programme and further work to convert pipeline ideas to 'in implementation' approved schemes by the Improving Together Programme Board in August.
(b) the risk-assessment of the current programme and steps being taken to close the gap to £4m target.
(c) other papers presented to the Board to progress development of the improvement team form and function, a quality improvement methodology and training proposal, and the response to Scottish Government of our self-assessment against the national 15-box efficiency grid.

3.0 Background

3.1 NHSO Orkney has established its Team Orkney: Improving Together Programme for 2024/25, its associated governance framework and reporting and escalation processes. Focus now has firmly moved from the development phase to the implementation (or delivery) phase. The health board has committed to deliver £4m of in-year savings of which a minimum of £2.9m must be recurrent. The ambition is to exceed £4m of opportunities to mitigate any slippage associated with risk to delivery.

4.0 Assessment

The 2024/25 Efficiency Programme

4.1 NHS Orkney has made good progress in developing its financial efficiency programme through July. At the time of writing, the programme has identified productivity and efficiency savings of £3.8m in-year and £3.9m full-year savings. This represents an £0.6m increase since June 2024. These have been risk-adjusted through discussions with workstream teams and therefore represent the 'base-case' scenario for in-year savings, although there are material and considered risks as detailed later in the paper.

Workstream	Executive Lead	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	24/25 IY Savings Total	Full Year Effect
Cancer	Dr Anna Lamont	£0	£0	£0	£12,028	£12,028	£12,028	£12,028	£12,028	£12,028	£12,028	£12,028	£12,028	**£108,248**	**£144,331**
Diagnostics	Sam Thomas	£23,135	£23,135	£23,135	£23,135	£23,135	£42,898	£42,898	£42,898	£42,898	£42,898	£42,898	£42,898	**£415,963**	**£514,781**
Estates & Facilities	Laura Skaife-Knight	£0	£0	£0	£3,553	£3,553	£3,553	£3,553	£3,553	£3,553	£3,553	£3,553	£3,553	**£31,974**	**£42,632**
Outpatients	Dr Anna Lamont	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**	**£0**
Digital	Debs Crohn	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**	**£0**
Pharmacy	Dr Anna Lamont	£27,675	£27,675	£27,850	£27,933	£30,016	£35,350	£33,175	£30,675	£30,675	£30,675	£30,675	£30,675	**£363,047**	**£395,400**
Finance	Paul Corlass	£0	£0	£0	£0	£0	£0	£0	£0	£0	£100,000	£0	£0	**£100,000**	**£100,000**
Procurement	Paul Corlass	£0	£2,600	£19,325	£26,825	£44,325	£22,896	£30,396	£22,896	£22,896	£30,396	£22,896	£30,396	**£275,850**	**£311,900**
Social Care & Community (IJB)	Stephen Brown	£52,083	£52,083	£52,083	£52,083	£52,083	£68,750	£68,750	£68,750	£68,750	£68,750	£68,750	£68,750	**£741,667**	**£825,000**
Workforce	Jay O'Brien	£93,520	£93,520	£173,046	£84,450	£84,450	£159,450	£84,450	£84,450	£153,961	£76,620	£75,171	£150,171	**£1,313,260**	**£1,322,313**
Vacancy Factor (Recurrent)	Jay O'Brien	£0	£0	£50,000	£0	£0	£50,000	£0	£0	£50,000	£0	£0	£50,000	**£200,000**	**£200,000**
Vacancy Factor (Non-recurrent)	Jay O'Brien	£0	£0	£50,000	£0	£0	£50,000	£0	£0	£50,000	£0	£0	£50,000	**£200,000**	**£0**
TOTAL		**£196,413**	**£199,013**	**£295,439**	**£230,007**	**£249,590**	**£344,925**	**£275,250**	**£265,250**	**£334,761**	**£364,919**	**£255,971**	**£338,471**	**£3,750,009**	**£3,856,357**

4.2 Recurrent savings currently equate to £2.6m (69%) with £1.15m (31%) identified as non-recurrent. This level of recurrence is broadly in line with the plan submitted to Scottish Government and focus and effort continues to progress ideas that improve this ratio.

Risk Assessment of the current programme

4.3 The Improvement Team continue to risk-assess the current programme to determine the robustness of the savings profile and the potential downside scenario position. This is critical to inform the potential gap to target.

Workstream	SRO	24/25 In-Year Total	Recurrent / Non-Recurrent	High Risk	Medium Risk	Low Risk
Cancer	Dr Anna Lamont	£108,248	Recurrent			£108,248
		£138,345	Recurrent		£138,345	
Diagnostics	Sam Thomas	£277,618	Non-recurrent		£277,618	
Estates & Facilities	Laura Skaife-Knight	£31,974	Recurrent	£29,276		£2,699
Outpatients	Dr Anna Lamont	£0	Recurrent			
Digital	Debs Crohn	£0	Recurrent			
Finance	Paul Corlass	£100,000	Non-Recurrent			£100,000
Pharmacy	Dr Anna Lamont	£363,047	Recurrent			£363,047
Procurement	Paul Corlass	£150,000	Recurrent			£150,000
		£125,850	Non-recurrent			£125,850
Social Care & Community (IJB)	Stephen Brown	£241,667	Recurrent		£125,000	£116,667
		£500,000	Non-recurrent			£500,000
Workforce	Jay O'Brien	£1,229,119	Recurrent		£350,000	£879,119
		£84,142	Non-recurrent			£84,142
Vacancy Factor (Recurrent)	Jay O'Brien	£200,000	Recurrent		£100,000	£100,000
Vacancy Factor (Non-recurrent)		£200,000	Non-Recurrent			£200,000
Total		£3,750,009		29,276	990,963	2,729,771

4.4 The current assessment is £2.7m is green-rated, £0.8m amber-rated and £0.1m red-dated for delivery. In stating this position:

Red-rating

(a) £29k relates to a validation exercise of external income currently underway that may impact on recruitment and retention efforts, although we believe this may be offset through a reduction in accommodation spend as we move to maximise rental properties from 01 October.

Amber-rating

(b) £138k relates to the expansion of an echocardiogram service in diagnostics is subject to clinical approval and recruitment of clinical staff.

(c) £277k relates to the repatriation of MRI patients and this is dependent on patients being seen at NHS Orkney through increased capacity.

(d) Across all workforce, we have assessed £575,000 as amber due to the challenge in reducing agency costs, in particular for medical staffing, although there has been excellent work to reduce nurse agency costs last year and this should continue.

4.5 The programme continues to be challenged by a lack of financial input into the validation and phasing of savings, largely due to vacancies and unforeseen absences. Our ability to properly evidence savings at individual workstream level at M04 raises some concern as to how confidently the organisation can forecast its year-end position. This needs to be a key focus of the finance team through Month 05.

4.6 Positively, we are reporting an on-plan position at M03, and through individual workstream teams, we are building an evidence-base of decisions taken to demonstrate completion of the deliverables across many schemes. There is also demonstrable benefit being derived from increased scrutiny from our pay and non-pay panels to curb unwarranted spend.

4.7 The engagement of staff and the ownership of this programme by workstream leads, supported by the Improvement Team, have been instrumental to the effort to deliver savings. This will only be reinforced with the recruitment of additional finance resource currently underway.

Programme Risk

4.8 Attached in Appendix A is the programme risk register. This register is reviewed monthly through the Delivery Group and Programme Board meetings. Due to the previous and current availability of financial input and ownership into the programme, it has been agreed to rescore ITPB002 to a score of 20:

> *There is a risk that current capacity constraints within the finance team hinders the ability to validate savings and phasings, thereby delaying the implementation of schemes and reducing the in-year delivery of savings.*

4.9 The risk score will be maintained at 20 until finance has increased oversight of financial reporting of this programme, there is a robust and workstream-agreed forecast year-end savings position, and an increase in staffing within the finance team.

Closing the gap to £4m

4.10 NHS Orkney is concurrently focused on scoping additional opportunities to bridge the minimum c£0.25m gap to target. There is an increased need now to finalise these pipeline ideas at pace and there was a commitment by executive directors at the programme board in July to finalise and validate savings, where possible, for presentation at the August programme board.

4.11 A list of the seven key opportunities being progressed is set out below.

Material pipeline opportunities	Indicative Value (£'000)	Update
GP Primary Care Service Model	150	Chief Officer - IJB and Head of Primary Care meeting to model through in-year opportunity and risks to delivery. Further discussion at August Improving Together Board Meeting.
Golden Jubilee Funding	120	Previous years had seen a rebate of due to cases being below plan. Indicative savings based on 23/23. A full review of all planned care monies is being undertaken and initial findings will be presented at the Planned Care Programme Board on 14 August.
Receipt of King Street site	200	Subject to review by the Strategic Estates and Property Group and external advisors on full estates assessment. Potential, pending board decision, to dispose of property in-year and retain monies from sale.
Allocations and Contributions	TBC	Meetings with Heads of Service scheduled 14 - 16 August with finance. Savings recommendation to August Programme Board on recurrent and non-recurrent opportunities. Scope of review c£12m.
Outpatient Improvement	TBC	Fortnightly meetings now established since July. Work with NHS Highland to enable more near-me appointments underway, supported by interim Head of Strategy. Total patient spend equal to c£1.4m, of which a component relates to OPD. Ambition to enact from Q3 to realise travel cost reduction.
Escort Policy	TBC	Strengthened approval process in place. Work to evidence savings to be completed. Further savings will be realised in line with work with NHS Grampian. Draft proposal to be taken through SLT in September.
Bright Ideas and other pipeline schemes	100	Assumes conversion of long list of ideas through remainder of year, including Adalimumab (Pharmacy) with c£100k in-year savings from September.
Indicative Total Value (£'000)	**570**	

4.12 There are other developments to note:

Outpatient Improvement: A nine-week audit of all outpatient rooms at the Balfour site was conducted from 01 April to 31 May 2024 to establish a singular narrative around clinic room utilisation. We were able to evidence that across the 22 rooms; which equates to 220 room slots per week, the average weekly utilisation over this period was 73%.

The clinical administration team are assured there is a clear process in place for requesting rooms to meet demand. An organisation-wide email as part of communications was issued on 09 August as a reminder on how to book and cancel clinic rooms.

There is opportunity to work with colleagues to provide additional rooms to address long wait times in specialties that exceed the national standard. This work will be presented to the Planned Care Programme Board on 14 August.

A review of each clinic by patient utilisation is now being completed to ensure that we are maximising available appointments. This will include a review of clinic templates by specialty and will be finalised prior to the end of August for presentation to the Outpatient Improvement Group.

Pipeline schemes (Accommodation): An audit of rental properties has been completed for the rental properties utilised by NHS Orkney. There is an opportunity to increase usage The Executive Director of Nursing, Midwifery, AHPs and Chief Officer – Acute has drafted a letter being issued to all visiting staff that from 01 October, use of hotels will not be supported where accommodation can be met through existing rentals.

Quality Impact Assessment Panel

4.13 A quality impact assessment was completed for the majority of schemes (£3.2m) and submitted to the QIA panel for formal review by the Executive Director for Nursing, Midwifery, AHPs and Chief Officer Acute Services and the Medical Director to ensure patient safety and staff health and well-being are safeguarded. A separate paper is being presented to Board detailing the work of this panel. The next panel is scheduled for remaining schemes on 10 September with a final report to be submitted to the Joint Clinical Care Governance Committee.

5.1 Quality/Patient Care

Successful transformation delivers multiple benefits, from improved clinical outcomes and patient/service user experience, through to financial savings. The benefits of having a safe and effective Improvement function will be realised at an individual, Board, and whole system level.

Substantial medium to long-term benefits can only be achieved and sustained with organisational change that goes beyond quick fixes and technology upgrades.

5.2 Risk Assessment/Management

The Improvement programme's risk register reconciles to departmental and corporate risk registers. This will be regularly updated throughout the course of the programme. The key risks identified at this stage include:

- Financial capacity and understanding around validating opportunities and evidencing delivery will delay scheme implementation and lead to underperformance against the planned savings profile.
- There is a risk without the appropriate resources in place for the Improvement Hub, we will be unable to implement the necessary changes to support our Improvement Plan and achieve the efficiencies required by the Scottish Government.
- There is a risk that lack of robust activity data will hinder decision making.
- There is a risk that failure to cost-up efficiency projects and schemes will hinder prioritisation of deliverable milestones.

5.3 Equality and Diversity, including health inequalities

Central to our work is developing a culture of continuous improvement which has fairness and equity at its heart. Evidence that satisfies each of the six elements regarding Diversity and Inclusion as listed in the QIA guidance document:

- Alignment with The National Plan for Scotland's Islands 2019 and Islands (Scotland) Act 2018

5.4 Climate Change Sustainability

Incorporated in the Efficiency Improvement Programme, are schemes to review the number of journeys both to and from the Island for both patients and staff. An additional scheme, The Green Theatres Programme enables environmentally sustainable care by reducing the environmental impact in Theatres and contributing towards Scotland's net zero target.

- Consideration has been given to the NHS Scotland Climate Emergency and Sustainability Strategy

5.5 Route to the Meeting

Components of this paper have been shared with the Improving Together Delivery Group and Programme Board, as well as Senior Leadership Team.

6.0 Recommendation

The Board of Directors is asked to note for assurance:

(a) progress of the 2024/25 Improving Together Programme and further work to convert pipeline ideas to 'in implementation' approved schemes by the Improving Together Programme Board in August.

(b) the risk-assessment of the current programme and steps being taken to close the gap to £4m target.

(c) other papers presented to the Board to progress development of the improvement team form and function, a quality improvement methodology and training proposal, and the response to Scottish Government of our self-assessment against the national 15-box efficiency grid.

Appendix A: Programme Risk Register

Ref No.	Risk Description	Likelihood	Impact	Score	Mitigations Description	Residual Likelihood	Residual Impact	Residual Score
ITPB001	There is a risk that the Health Board will not be able to identify £4M of in-year savings aligned to annual financial plan and furthermore will not achieve the level of recurrent savings (£2.9M) as part of our submission to Scottish Government.	**4**	**5**	**20**	(1) Workstreams established to progress schemes to implementation (2) Established Delivery Group and Programme Board to facilitate pace and provide executive oversight (3) Work underway to strengthen grip and control measures to curb temporary staffing and other pay elements	**3**	**5**	**15**
ITPB002	There is a risk that current capacity constraints within the finance team hinders the ability to validate savings and phasings, thereby delaying the implementation of schemes and reducing the in-year delivery of savings.	**5**	**4**	**20**	(1) Interim Director of Recovery recruited from April 2024 (2) HR to support return to work for finance team currently not at work (3) Interim Director of Recovery to review workload prioritisation through Q1 (4) External finance support provided by the Scottish Government for two days per week	**4**	**4**	**16**
ITPB003	There is a risk that the availability of granular data does not support the ability for clinical decision making to inform the impact and benefits related to clinical transformation, thereby restricting progress of schemes and quantification of benefits.	**4**	**4**	**16**	(1) Close working with the Health Intelligence Team to provide data to workstream teams. (2) Ongoing engagement with clinical Executive Directors. (3) Work with clinicians to interpret available data.	**3**	**4**	**12**
ITPB004	There is a risk that reducing workforce agency (£4.2M) which is a key driver for the Health Board's overspend will require lead-in times for delivery that will result in savings only being realised from 2025/26.	**4**	**4**	**16**	(1) Director of People & Culture SRO for workstream (2) Improvement Hub providing additional resource to understand opportunity (3) Potential to review supplementary pay through strengthened controls	**3**	**4**	**12**
ITPB005	There is a risk that repatriating patients may result in unidentified cost pressures	**3**	**2**	**6**	(1) Discussions with support services to ensure additional costs identified and included in cost savings calculations (2) Clinical review by SRO (3) Enquiry to be applied to all activity based schemes	**2**	**2**	**4**

NHS Orkney

Meeting:	**NHS Orkney Health Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Proposal for future Improvement Function**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight, Chief Executive Officer**
Report Author:	**Phil Tydeman, Director of Improvement**

1.0 Purpose

This is presented to the Board of Directors for:

Approval - to receive the recommendation from Senior Leadership Team to approve the structure, function and resource for the future improvement team.

This report relates to:

- Corporate Strategy 2024 – 2028 – Potential, Performance, People, Patient Safety, Quality and Experience, Place
- Annual Delivery Plan 2024/25 (ADP)
- Financial Sustainability

This aligns to the following NHS Scotland quality ambition(s):

- Effective
- Person-centred

2.0 Situation

Last year, NHS Orkney published its five-year Corporate Strategy for 2024 - 2028 that sets out the ambition for the future and the health boards promise to the community. Compared to previous years, this represents an enhanced scale of improvement and transformational change for our c800 person workforce and in how we deliver and provide clinical care to our patients.

Within the five priorities of the corporate strategy are programmes of work that require a continued focus from the Improvement team – such as implementing our ambitious digital priorities, supporting the Health Board return to financial sustainability and being de-escalated from level three of the NHS Scotland Support and Intervention Framework. There are also clinical, operational and workforce priorities that will need some additional level of support, above those that can be delivered within existing team resources.

A review of the form and function of the current Improvement Team aligned to the corporate strategy was therefore warranted and undertaken. A recommendation was subsequently presented to the Senior Leadership Team in July that received formal approval.

The Board of Directors is asked to:

(a) to receive the recommendation from Senior Leadership Team to approve the proposal for the future function of the Improvement Team.

3.0 Background

The current improvement team at NHS Orkney was previously known as the Financial Sustainability Office (FSO). The FSO had a relatively narrow remit with a material focus on developing and delivering the financial efficiency programme. Aligned to a move by the organisation to deliver on key strategic programmes of work, a review of this team has recently taken place with this proposed new approach developed to better engage and support teams through sustained periods of improvement.

4.0 Assessment

The following sets out the proposed approach to developing and establishing the Improvement team function.

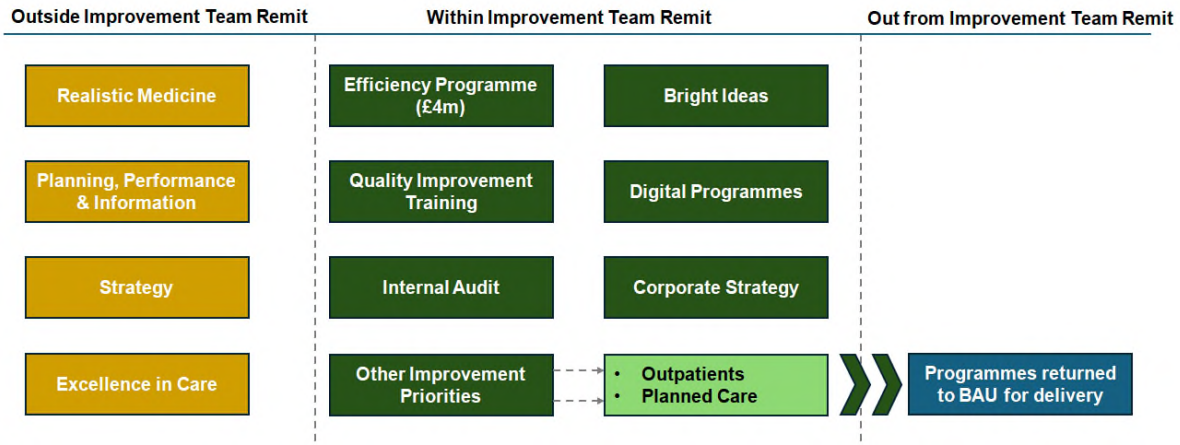
Improvement Team priorities for 2024/25

The Improvement Team will retain a defined remit of programmes for the remainder of this financial year. The current demands on the team are already significant and it is important the team can continue to competently demonstrate its ability to deliver against a core set of programmes this year to build further credibility across the organisation.

It is equally important that there is clarity across the organisation of where the Improvement team will take an active leadership role and what will sit outside of its remit. Communicating this to staff will help to reinforce the specific role of the Improvement Team and draw clear boundaries for where and how the team will be engaged.

Seven priority programmes have been approved for this year. These are programmes already within the teams remit and therefore represent a continuation of ownership, leadership and support. For these programmes, the Improvement Team will report progress through to the relevant governance committees or boards as is current practice.

Table 1: Defining the scope of programmes within the Improvement Team



It is expected certain core programmes will be recurrently retained annually within the Improvement Team remit. While this will be subject to agreement by Senior Leadership Team, these are likely to include the efficiency programme, Bright Ideas, QI training, Digital and other improvement priorities.

Other improvement priorities for this year will focus on two programmes: Outpatient Improvement and Planned Care. The Improvement Team have established programme boards for both priorities and through defined terms of reference are supporting clinical and operational teams to realise a set of agreed deliverables.

These improvement priority programmes - as a general rule - will receive Improvement Team support for no longer than one year. Over this period, the team will help define the improvement trajectory, establish good practice governance, and develop, implement and embed change working alongside BAU staff. These programmes will then be migrated back to their corporate or operational function as business-as-usual once the agreed improvements have been implemented.

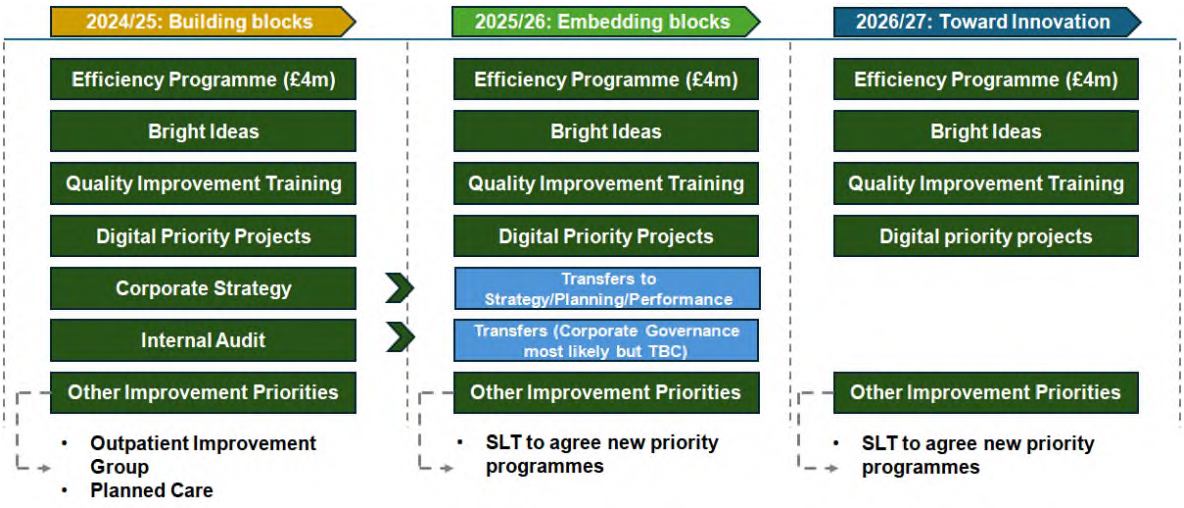
Work is currently underway to explicitly depict how this transition process back to BAU will occur. A set of criteria will be established to act as a 'check-list' that both the Improvement Team and responsible executive director must agree have been met prior to Improvement Team support being withdrawn. This will de-risk the possibility that the corporate or operational function do not have the capacity to maintain the benefits achieved.

Building the blocks to a mature improvement function

The improvement function at present is in the early stages of development. The focus this year must therefore be on establishing the core building blocks to deliver the basic and most fundamental programme improvements. As this function develops over several years, it presents the opportunity to provide a greater leadership role across culture, training and innovation.

The following sets out current thinking on the 'core' programme elements and those anticipated to transfer in 2025/26.

Table 2: Building blocks and defining priorities into the near-term



With the interim Head of Strategy now in post, it is projected that responsibility for managing the Corporate Strategy will transfer to Strategy, Planning and Performance. Internal Audit will also transfer once we have embedded a solid reporting and assurance framework. A decision on where this will transfer is subject to further consideration.

As described above, table 2 illustrates how SLT will approve the new priority programmes for each year. These will be aligned to key elements of the corporate strategy, informed by discussions with executive directors, and substantial in transformative change to warrant resource beyond the available operational and corporate resource. These programmes will be agreed towards the end of Q3 or early in Q4 to enable sufficient mobilisation prior to the start of the new financial year.

Key deliverables for the Improvement Team in 2024/25

Aligned to building confidence across the organisation and establishing the Improvement Team as the 'go-to' function for support, we are clear on the deliverables for this year. This list is not exhaustive however it does set out those of materiality.

Table 3: Material outputs for 2024/25

Q2	Q3	Q4
• Launch of Outpatient Improvement Group • Launch of Planned Care Programme Board • Commence standardised programme documentation group • Delivery of the Improving Together Programme • Launch Quality Improvement Methodology	• Standardised documentation in place • Quality Improvement methodology and training agreed by SLT • Review of Grip & Control measures and integration with business-as-usual • Preparatory work to commence 2025/26 financial efficiency programme	• Internal audit responsibility transfers to function (to be confirmed) • Quality Improvement training commences with first cohort of SIFS • Year 2 Corporate Strategy away day and milestone mapping • Proposal to SLT on priority programmes within improvement team remit • Launch of the 2025/26 financial efficiency programme

Resourcing the Improvement Team

The Improvement Team must be properly resourced if it is to meet the remit set out within this paper. With the agreed extension of the Director of Improvement until March 2025 (albeit with reduced on-site presence through Q4, as we test the resilience of the organisation to continue this work), there is not any requirement to increase investment beyond the current resource envelope.

As some programmes within this year's portfolio transfer to other parts of the organisation; the currently budgeted establishment will be sufficient to deliver on the 2025/26 portfolio, subject to no further expansion by the Senior Leadership Team.

The budgeted core substantive team will consist of 4.0 WTE. The team will be led by the Head of Improvement who will hold overall strategic and operational responsibility for the improvement portfolio. This post will report into the Chief Executive. There will be 2.0 WTE Band 7 Project (or Improvement) managers and 1.0 WTE Band 4 Project Support Officer who will provide analytical support and prepare detailed accurate reports.

Table 4: Budgeted Improvement Team structure

Role	WTE
Head of Improvement	1.0
Project Manager	2.0
Project Support Officer	1.0
Total	**4.0**

The Improvement Team will be supported by those staff trained in the Quality Improvement methodology and will be champions to promote and support the wider improvement agenda, within available capacity.

Next Steps

Following approval by the Board of Directors, a communications plan will be developed to promote the Improvement Team across NHS Orkney and begin the work to plan the transitional period of moving corporate strategy and internal audit to other corporate functions; as well as building a sustainable approach within the organisation to manage the full remit of work as the Director of Improvement exits from March 2025.

5.1 Quality/Patient Care

This new model will ensure improvement resource is focused in those areas where successful transformation delivers multiple benefits, from improved clinical outcomes and patient/service user experience, through to financial savings. The benefits of having a safe and effective Improvement function will be realised at an individual, Board, and whole system level.

Substantial medium to long-term benefits can only be achieved and sustained with organisational change that goes beyond quick fixes and technology upgrades.

5.2 Risk Assessment/Management

The key risks identified at this stage include:

- There is a risk without the appropriate resources in place for the Improvement Team; the organisation will not have the required capacity to deliver on the ambition set out in the corporate strategy.
- Without an investment in programme management resource, the organisation will not have the capability to effectively monitor, report and assure performance of our improvement agenda.
- There is a risk that without investment to develop a culture of quality improvement, staff will not feel adequately supported to deliver local changes to improve patient experience and quality of care.

5.3 Equality and Diversity, including health inequalities

Central to our work is developing a culture of continuous improvement which has fairness and equity at its heart. Evidence that satisfies each of the six elements regarding Diversity and Inclusion as listed in the QIA guidance document:

- Alignment with The National Plan for Scotland's Islands 2019 and Islands (Scotland) Act 2018

5.4 Climate Change Sustainability

Consideration has been given to the NHS Scotland Climate Emergency and Sustainability Strategy

5.5 Route to the Meeting

This paper has been prepared for the purposes of the discussions at Board through discussions at Senior Leadership Team and discussions at Corporate Leadership Team.

6.0 Recommendation

The Board of Directors is asked to:

(a) to receive the recommendation from Senior Leadership Team to approve the proposal for the future function of the Improvement Team.

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Proposal for Quality Improvement (QI) methodology**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight, Chief Executive Officer**
Report Author:	**Phil Tydeman, Director of Improvement**

1. Purpose

This is presented to the Board of Directors for Assurance:

The Board of Directors is asked to

I. **Approve** the approach to developing a quality improvement methodology and training programme for NHS Orkney staff.

This report relates to:

- Corporate Strategy 2024 – 2028 – Potential, Performance, People, Patient Safety, Quality and Experience, Place
- Annual Delivery Plan 2024/25 (ADP)

This aligns to the following NHS Scotland quality ambition(s):

- Effective
- Person-centred
- Safe
- Quality

2.1 Situation

With NHS Orkney publishing its new five-year corporate strategy (2024 – 2028), the health board has a clear set of deliverables across a range of strategic and operational priorities, with focused key performance indicators in place for Year 1.

This level of improvement and transformation requires a step-change in how staff own and lead key programmes of work. It is therefore incumbent on NHS Orkney to equip staff with the necessary skills and tools to feel empowered and able to deliver on this ambitious agenda.

Empowering staff through training and development is a key factor in motivating staff, increasing retention rates, and supporting local efforts to improve patient experience, clinical outcomes and staff health and well-being.

This paper sets out the approach approved by the Senior Leadership Team (SLT) on the 4 August 2024 to develop a Quality improvement (QI) methodology and training framework for NHS Orkney.

2.2 Background

NHS Orkney has previously engaged with NHS Education for Scotland (NES) to provide staff training in quality improvement. There are nationally offered quality improvement training courses through the Scottish Improvement Foundation Skills (SIFS) programme which are free to all NHS Scotland staff.

NHS Orkney has also engaged other teaching providers for bespoke training around programme management, continuous improvement, and quality improvement although these have been sporadic rather than part of a co-ordinated approach to building capacity and competency across the organisation.

Currently, we have 12 staff trained in NHS Scotland's QI methodology including the delivery of the SIFS programme. 80 staff recently completed in-house change management training. Involvement to date has been limited in terms of accessing NHS Scotland QI training resulting from an apportionment model of available spaces to health boards which restricts the pace and quantity of staff that can be trained simultaneously or within a calendar year.

To address this challenge, more progressive health boards have used the training material to adopt and implement locally led quality improvement methodologies at an introductory and intermediate level within their own respective organisations. This progressive approach has been aided by National Education Scotland (NES) training materials being available for free, adaptable, and conducive to a train-the-trainer model. There is also a well-established mentoring network nationally and close collaboration with NHS Shetland who have offered SIF training to NHS Orkney staff at no cost.

NHS Orkney is clear achieving the ambition set out in our corporate strategy will require staff to feel competent and confident in demonstrating personal ownership to lead their teams through often complex new ways or working with an expectation to introduce, integrate and implement changes to defined timescales.

This paper sets out how NHS Orkney will model itself on the success of the more progressive health boards in developing its own QI methodology and training framework.

2.3 Assessment

Rationale for adopting the Scottish Improvement Foundation Skills approach

In determining how to develop a quality improvement (QI) methodology, the improvement team undertook a review of QI programmes across England and Scotland. While there are differing models used, and at variable costs, it was concluded that utilising the Scottish Improvement Foundation Skills (SIFS) as part of NHS Education for Scotland programme was the preferable option based on several factors:

a) Several staff at NHS Orkney have completed various levels of SIFS training and so it is a natural continuum of this effort; this enables the organisation to draw on a small group of local improvement champions.
b) This model is adopted by other health boards and therefore new staff recruited from other health boards will more likely have received this training and be able to contribute through a shared methodology.
c) Given the adoption across Scotland, we will be able to shape and develop our programme from learning from other health boards; as well as engage with improvement experts through both the development phase and then as training commences.
d) NES continually introduce new models and tools for quality improvement at no-cost which provides an opportunity to recurrently up-skill staff and build competency.
e) NES is moving to a train-the-trainer model which is seen as good-practice and a sustainable model.

Developing NHS Orkney's Quality Improvement methodology

From our research, we are aware of well-established locally led QI programmes already in place across health boards including NHS Lothian, NHS Tayside, NHS Fife, and NHS Shetland.

While it would be efficient to adopt one of these models and introduce it at NHS Orkney within a matter of weeks, the model presented to and approved by Senior Leadership Team was informed by a different strategy following engagement with members of staff who have previously completed the NES QI training or are currently on training.

A 'Bringing QI to NHS Orkney' working group has been established to listen to individuals who have completed QI training to help shape the QI model for Orkney. The purpose of the working group (recognising that each have varying capacity to contribute) is to develop and roll out a NHS Orkney QI model, based on implementing a range of listening events, and other tools to solicit feedback from clinical, operational, and corporate colleagues.

The discovery phase will take place over 16 weeks, with the group meeting fortnightly. The group will be supported by the Head of Improvement and Director of Improvement to assure the process is facilitated and results are delivered. The Group will develop a final model for discussion and approval at the Senior Leadership Team meeting in November 2024, with the first QI training cohort to take place in Q4, 2024/25.

The final model will include clarity on the core training elements of the programme. The introductory SIFS programme consists of seven modules delivered in-person or on-line each for 90 minutes, with the aim to support individuals to develop the skills and knowledge of improvement techniques to test, measure, and report on changes.

The final model will outline the process for staff being selected and how to apply for the QI training. There will be a requirement for staff being accepted on to the training to identify an improvement project or idea which they will implement as part of the training enabling staff to apply learning as well as for the organisation to articulate the benefits derived for patients or staff. The model will also set out training dates and a communications plan for the year to promote engagement with teams.

Concurrent to the work being undertaken by this Group, the Improvement Team continues to engage with NHS Tayside, NHS Fife, and NHS Shetland to understand their QI programmes, specific tools, models, and techniques applied including how these models were developed with buy-in across the organisation. Throughout the discovery phase, the Group will test some of these models with our staff to make sure the QI programme fits local need.

To support this work, we have approached the Medical Director for Quality Management from NHS Tayside to act as a clinical mentor to the working group.

Implementing the QI programme for NHS Orkney

Our ambition is to train 20-25 staff in the SIF programme over the course of 2025/26. There are 12 staff in NHSO who have completed more senior level QI training programmes offered through NHS Education for Scotland including the Scottish Improvement Leader Programme (ScIL) and the Scottish Quality and Safety Fellowship Programme (SQSF). Our long-term intention is for those staff with higher level QI training to deliver the training for NHSO. In the short term, there will be a need to engage the services of an interim trainer who will work alongside our QI champions to build their confidence and skills to eventually become lead QI trainers, thus resulting in a locally owned and led QI programme.

NHS Shetland's QI training who has already delivered training for our staff, has indicated there is a possibility they could be released to support our programme, although we do recognise there are other individuals who are trained in this QI methodology and there will be a cost associated with this in 2025/26.

Key considerations for the Improving Together programme

In developing NHSO's QI programme, there are some considerations worth noting:

1. The availability for staff to be released for this training will require careful thought recognising the impact this will have on clinical staff and ensuring backfill arrangements are in place to safeguard patient care. This cost will need be factored into the final models anticipated costings.

2. This approach introduces an additional training programme into the organisation. We are aware the mandatory training requirements for some staff is significant and it may not be possible for staff to participate, if they cannot be released from business-as-usual activities, or if there are chronic vacancies within their departments.

2.3.1 Quality/Patient Care

This new model will ensure improvement resource is focused in those areas where successful transformation delivers multiple benefits, from improved clinical outcomes and patient/service user experience, through to financial savings. Substantial medium to long-term benefits can only be achieved and sustained with organisational change that goes beyond quick fixes and technology upgrades.

2.3.2 Workforce

There are several changes being introduced at present and planned over the next 12 months. Sensitivity needs to be applied to ensure staff do not feel fatigued. There may be a need to scale back the number of staff to be trained in Year 1 to reflect what the organisation can manage.

As the programme develops into future years, the Improvement Team will need to develop a network for trained staff to keep them engaged as QI champions and ensure on-going development of their skills to sustain QI as a core methodology.

2.3.3 Financial

Whilst the QI training currently provided is at no-cost to the Board, there will be a financial cost for staff backfill. As outlined above, we acknowledge there is a benefit to employing an interim trainer in Year 1 (2025/26) and Year 2(2026/27) to facilitate the pace of our ambition. Costs will be presented to the SLT in November 2024 as part of the final proposed QI model.

2.2.4 Risk Assessment/Management

There is a risk that:

- without the appropriate trained staff, the organisation will not have the required competency to deliver on the ambition set out in the corporate strategy.
- without investment to develop a culture of quality improvement, staff will not feel adequately supported to deliver local changes to improve patient experience and quality of care.

2.2.5 Equality and Diversity, including health inequalities

Central to our work is developing a culture of continuous improvement which has fairness and equity at its heart. Evidence that satisfies each of the six elements regarding Diversity and Inclusion as listed in the QIA guidance document:

- Alignment with The National Plan for Scotland's Islands 2019 and Islands (Scotland) Act 2018

2.2.6 Climate Change Sustainability

Consideration has been given to the NHS Scotland Climate Emergency and Sustainability Strategy.

2.3.7 Other impacts

N/A

2.2.8 Route to the Meeting

This paper has been prepared for the purposes of discussion and approval at the Board following discussion at Corporate Leadership Team and approval at SLT 4 August 2024.

3. Recommendation

The Board of Directors is asked to

(a) **Approve** the approach to developing a quality improvement methodology and training programme for NHS Orkney staff.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Strategic Digital Update – Quarter 1 2024/25**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight, Chief Executive**
Report Author:	**Debs Crohn – Head of Improvement**

1 Purpose

This is presented to the NHS Orkney Board for Assurance:

The Board is asked to

I. **Note** the Quarter 1 progress update and work underway within the digital services and IT Infrastructure team.

This report relates to a:

- Corporate Strategy 2024 – 2028 – Potential Strategic Objective
- Annual Delivery Plan 2024/25 (ADP)
- Annual Financial Plan
- Financial Sustainability

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Quality
- Person centred

2 Report summary

2.1 Situation

The Enabling, Connecting and Empowering: Care in the Digital Age strategy sets out key deliverables Scottish Government (SG) expect Health Boards to deliver as part of the Annual Delivery Planning Process. This includes outlining how we make better use of data and technology to improve access services ensuring a strong focus on addressing known gaps and weaknesses in how we collect, share, and analyse data to improve health outcomes in a secure, transparent, and ethical manner.

To accelerate digital transformation across NHS Orkney, a Digital and Information Services Delivery Plan for 2024/2025 has been developed (see Appendix 1) which sets out key national and local deliverables, timelines, and outcomes with clear alignment to our Improving Together Programme, NHS Scotland 10 national recovery drivers and our new Corporate Strategies 2024 – 2028.

This paper is presented to the Board for assurance and to note the quarter 1 progress update and work underway within the digital services and IT Infrastructure team.

2.2 Background

To support the adoption and implementation of the Enabling, Connecting and Empowering Care in the Digital Age Strategy 2021, and NHS Orkney's Corporate Strategy 2024 – 2028, a Digital and Information delivery plan for 2024/26 has been developed and managed by the Digital Information Operations Group.

NHS Orkney is required to deliver Scottish Government's National digital programmes. Appendix 1 provides an overview of the national and local digital projects the Digital Services team have delivered since the last update.

Digital improvement and transformation are central to our Corporate Strategy and continuous improvement. To deliver our digital priorities/workplan we need strong leadership and a service model that is fit for what our organisation needs moving forward. In September a full-day, in-person engagement session for Digital Services will be externally facilitated enabling the team to work together to discuss: what works well, what needs to change/be different and to explore together what the options are for the service moving forward.

Central to this session will be engagement and contribution from the team, so we can listen to hear their views, and to agree next steps together to start to design the future of our digital vital services.

Delivering our digital priorities

As set out in NHS Orkney Corporate Strategy 2024-28 a key priority under the Potential Strategic Objective is how technology and digital services can reduce patient journeys. Appendix 1 provides an overview of the national and local digital deliverables and outlines progress to date on actions in NHS Orkney's Corporate Delivery Plan for 2024/25.

2.3 Assessment

Prioritising the acceleration of digitisation Quarter 1 update

Appendix 1 provides an update on delivery against each of the digital projects at the end of Quarter 1 as well as outlining the projects which have been deferred to 2024/25 following a digital prioritisation exercise.

There are 39 actions in the Digital Delivery Plan for 2024/25. Table 1 outlines the number of actions within each RAG status.

Status	Number of actions
Red – significantly delayed.	1
Amber – partially delayed.	1
Green – remains on track.	25
Blue – action complete	2
Deferred to 2025/26	10

Table 1 – Status of Digital Actions end of Quarter 1 2024/25

Actions being taken to bring amber and red deliverables back on track

GP IT implementation and re-provisioning – The action is rated amber as the Primary Care IT Facilitator resource is not yet in place as still in the job evaluation process. To expedite the resource being in place, conversations are taking place with NHS Grampian in relation to an alternative model of support as a mitigation to the risk on non-delivery.

National Child Health System – Whilst this action is rated red, national programmes are out with the control of NHS Orkney as they are managed by several delivery partners on behalf of Scottish Government. NHS Orkney's Board Lead Officer attends the national meetings, update reports are brought to the Digital Information Operations Group for oversight.

2.3.1 Quality/ Patient Care

Successful digital transformation delivers multiple benefits, from improved clinical outcomes and patient/service user experience, through to financial savings. The benefits of having a safe and effective digital infrastructure will be realised at an individual, Board, and whole system level.

Substantial medium to long-term benefits can only be achieved and sustained with organisational change that goes beyond quick fixes and technology upgrades.

One of the challenges in delivering much needed digital transformation is the capacity to implement, train and change culture in doing so. Limited capacity across the organisation to embed change at the pace required to deliver the projects listed above requires an honest conversation.

To ensure no adverse impact on the business of rolling-out new digital capabilities, a prioritisation exercise has been undertaken on all the local and national digital projects in 2024/25. It has been agreed that some projects/deliverables will be deferred to 2025/26 enabling the digital services team to focus on the following 3 key priorities.

- cCube Migration and Upgrade
- Roll out of Community Electronic Patient Record
- GP IT re-provisioning.

2.3.2 Workforce

There is work to do across the organisation to raise awareness of digital transformation and the changing health and social care landscape. The success of digital transformation is entirely reliant on people's ability to know when, why and crucially how to use digital.

The delivery of safe, person-centred quality care demands the development and effective running of our technology to fully realise the benefits systems offer. Having the right tools and technology in place will enable our workforce to be more productive and efficient as we continue our improvement journey.
We are in the process of using the Essential digital skills framework - GOV.UK (www.gov.uk) to create a digital skills development pathway for NHS Orkney.

The first meeting of the Digital Champions Network took place on 18 June 2024, at which the group's terms of reference and agenda were set. Office holders are being confirmed so that the Network can be self-led, with support from the training and improvement teams.

Work is also underway to provide clinical system users with a local dedicated eHealth Learning area within TURAS. All appropriate Grampian eLearning for hosted applications will be uploaded along with user guides for all our eHealth systems. Bookable one to one eHealth system training sessions will be made available for clinicians & nurses. Once uploaded/set up eHealth will recommend a Board review of documented & recording of all system training requirements.

2.3.4 Risk Assessment/Management

All the digital priorities outlined in our Corporate Strategy address a risk on the Corporate Risk Register. However, there is a risk that not having resources available to deliver digital transformation will impact on our ability to transform our services which is one of the 10 drivers of change set out by Scottish Government. This is being mitigated through the refresh of our digital governance and the development of the Digital Services and Information Delivery plan 2024/25.

There is a significant risk that the lack of digital maturity, leadership, governance, and a digital strategy which is understood across the Organisation will impact on the delivery of our corporate strategy, the delivery of safe patient care and the implementation of our improvement programme across health and social care.

There is an operational and reputational risk due to the lack of staff, skills, and experience within the Digital Services team which will impact on our ability to deliver safe patient care and the implementation of our improvement programme across health and social care.

Organisational capacity to embed digital changes.

We recognise not having the capacity and resources required to deliver the local priorities set out in our Corporate Strategy and the nationally mandated programmes will put the organisation further behind other boards, current industry standards and increase the risks around non-compliance with the Network and Information Systems (NIS) Regulations (2018). Having a clear set of digital priorities will help support our workforce as they will be clear on what is being taken forward and what is not.

2.3.5 Equality and Diversity, including health inequalities.

Central to our work is developing a culture of continuous improvement which has fairness and equity at its heart.

2.3.6 Climate Change Sustainability

NHS Orkney is a national leader in terms of sustainability and addressing climate change, by tactically utilising central computer processing and storage this will reduce the overall carbon footprint of NHS Scotland and NHS Orkney.

2.3.7 Financial impact

NHS Orkney is required to contribute a National Resource Allocation Formula (NRAC)[1] share to all national programmes. Whilst national programmes are not delivered by NHSO's Digital Services team, there is a financial impact for staffing resources who are required to be involved in the deployment of programmes and to support business change.

2.3.8 Communication, involvement, engagement, and consultation

Discussions have taken place with the eHealth Team in NHS Grampian, NHS Orkney's Integrated Improvement Hub Senior Management Team, and NHS Orkney's Chief Executive in the development of this paper.

[1] National Resource Allocation Formula (NRAC) is the Formula used to inform the geographical allocation of the NHS Budget in Scotland.

2.3.9 Route to the Meeting

This paper has been developed in consultation with the Chief Executive, Recovery Director, Head of Improvement, IT Manager, IG Manager, Corporate Records Manager, and NHSO's eHealth Team Leader.

- Digital Information Operations Group – 17 June 2024
- Senior Leadership Team – 3 July 2024
- Finance and Performance Committee – 11 July 2024

The groups and individuals who have either supported the content or provided feedback have informed the development of the content presented in this report.

3. Recommendation(s)

Assurance – The Board is asked to

I. **Note** the Quarter 1 progress update and work underway within the digital services and IT Infrastructure team.

Appendices

Appendix 1, Digital & Information Services Delivery Plan 2024-26

Appendix 2 Update on Digital Services, and IT Infrastructure projects

Appendix 2, Update on Digital Services, and IT Infrastructure projects

Optimising Microsoft 365

Our approach to the implementation of the agreed configuration of all Microsoft 365 products is as per NHS Scotland approach. We are working collaboratively with the North of Scotland Digital leads and the M365 Operational Delivery Group (ODG) to ensure we have a regional and national approach to optimising M365 and how we could better use resources to achieve economies of scale.

At present increasing information security on the M365 tenancy is our priority, after which governance documents will be drafted and records management features such as information architecture, classification mechanisms (including business functions and security labels) will be implemented, along with naming conventions and metadata guidelines.

Working with the national IG and RM forums this will ensure adherence with all legal and regulatory standards, as well as implementing best practice approaches going forward. The local programme at NHS Orkney relies on the national project team being fully resourced and implementing many of the required features, owing to the single tenancy across all NHS Scotland Boards. At present there are very few staff members assigned to the national programme, and all other advisory and decision-making groups are made up of those with additional substantive roles.

Information Governance

To ensure we protect the rights of both patients and colleagues, information governance must run through the centre of all developments which involve how we process and store information. Working on both a local and national level is key to ensuring that we maintain data subject's rights when making digital developments in our unique setting.

The digital developments outlined in our priorities will improve how we deliver services to patients, improve the experience of colleagues delivering services and improve our ability to uphold the data rights of our population.

Working very closely with colleagues in Records Management, eHealth, and IT the Information Governance Team will provide support to ensure that all digital developments not only comply with relevant legislation but improve our ability to demonstrate compliance.

Records Management

Records are required for information and evidence. They must be stored appropriately and accessed by those who need them in a timely manner. The purpose of information held within a digital system must be considered when making risk-based decisions around which systems are business-critical and therefore which to implement when.

The prioritisation process outlined in the paper will ensure efficiencies across the Organisation and support the core functions of patient assessment, diagnosis, and treatment. Those critical business functions which do not have an adequate solution already in place are being prioritised to ensure secure storage and appropriate access to the information required by operational staff.

Reference should also be made to the legislative requirements relating to information as a vital asset of the Organisation, both as a whole and in relation to specific specialties and departments, as this should also govern the categorisation of NHS Orkney's digital priorities and the workplan for 2024/25.

Digital Systems Security

Digital Services and Cybersecurity are two of the corner stones of NHSO's digital landscape and have a crucial role when developing and deploying digital services as they ensure access points and devices, as well as the entire communication systems operate correctly. Cybersecurity is essential and a legal requirement under the

National Information Security regulations (2018) when delivering digital platforms required by users undertaking their day-to-day work in an efficient, effective, and stable manner.

Cyber Security activities ensure that the information used by the organisation is safe from unauthorised access, whilst balancing the need for security with the need for an operational service. Cyber Security is central to all designs, digital platform onboarding and service commissioning from our partners, and play a pivotal role in all digital aspects.

All digital initiatives undertaken by the board, must pass the relevant internal processes including Cyber Security.

Cloud hosted systems

The use of cloud hosted applications is both a challenge and opportunity for hosting sensitive data as there are advantages and disadvantages to cloud hosting.

Benefits of Cloud-based systems

Moving to cloud-based system can reduce capital expenditure on hardware and maintenance by paying only for the resources you use. Cloud-based solutions like Microsoft means resources can be scaled up or down based on demand without over-provisioning, Organisations can access services and data from anywhere with an internet connection, supporting remote working and collaboration. Digital Services Team is in the process of updating the network, however, can do this currently.

Cloud based systems offer enhanced disaster recovery options with automatic backups, high performance, and increased reliability due to robust infrastructure and global distribution of resources. As cloud-based systems cater for global solutions, advanced security measures and compliance with industry standards provided by cloud providers which means software and patches can be automatically updated ensuring systems are up to date with the latest features and security enhancements.

A tangible benefit of moving to cloud bases systems like Microsoft 365 is Improved collaboration tools and shared workspaces enabling real-time co-operation amongst team members and faster deployment of modern technologies and services online enables quicker adaptation to market changes and innovation.

There are environmental benefits and efficiencies to be gained as use of computing resources leads to lower energy consumption and reduced carbon footprint which contributes to SG’s net zero strategy.

Challenges of using Cloud-based systems

Ensuring data protection and compliance with regulations can be challenging, particularly with sensitive information. Migration to a cloud platform does not remove the need for robust cyber security scrutiny as it increases the effort and work required from the Board to protect itself and its digital systems.

The increase comes from the extra management of data in cloud environments and ensuring process that are required are and monitored to a high standard. This is a challenge for NHS Scotland as many of our national systems are hosted in a cloud environment increasing the profile for cyber-attacks, as recently experienced at NHS Dumfries & Galloway.

The process of transferring data to the cloud can be complex, time-consuming, and risk data loss or corruption with a potential for service outages and downtime, which can impact business operations.

While cloud services can be cost-effective, managing and predicting costs can be challenging, especially with scalable usage models for example Microsoft 365. Having a dependence on a single cloud provider can make it difficult to switch vendors or migrate services back on-premises should this be required. Integrating cloud services with on-premises systems and legacy applications can be technically challenging.

Latency issues may arise due to data being stored and processed in remote data centres, affecting performance for certain applications.

Contract management and robust procurement process is vital when purchasing cloud-based systems particularly given SG's policy mandate which is a cloud first approach. Evidence from the private sector is showing they are reversing their decision of using cloud-based system and are move back to on premise systems where data can be secured and controlled by staff.

Ensuring compliance with local and international laws and regulations can be complicated, particularly with data sovereignty concerns. NHS Scotland's national systems are monitored and controlled through the national Cyber Centre of Excellence (CCoE) who monitor the internal systems of all NHS Boards. NHS Orkney is a recipient of this service; our Head of Information Technology is a member on the governing board.

Cloud based providers tend to prefer and schedule their resources for the high value customers adding further pressure on the account management resource within NHSO.

In many cases, the user accounts are not synchronised to the board's main account increasing the number of logins people need to manage and adding further pressure to the Service Desk to support these.

Adapting organisational culture and processes to embrace cloud technologies and the associated changes in workflows and responsibilities.

How NHS Orkney protects on premises and cloud-based systems

As an organisation we protect our systems both on-premises and in the cloud by implementing a security strategy which includes the following measures:

Encrypting data both at rest and in transit to protect it from unauthorised access and having multi-factor authentication (MFA) and role-based access controls (RBAC) means we have strict access controls and identity management practices in place.

All Boards are subject to three yearly security audits by the Scottish Competent Health Authority. Our nationally hosted systems are continuously monitored by the CCoE and our inhouse infrastructure team for unusual activity or potential threats demonstrating compliance with relevant regulations and standards. This includes General Data Protection Regulations (GDPR), National Information Security Regulations (2018) and effective Records Management and Information Governance policies and procedures.

We select cloud service providers through the national framework only, this requires vendors to demonstrate strong security credentials, proven track records, and compliance with healthcare regulations before being included on the framework.

For on-premises systems we have a robust data backup and recovery procedure in place to protect against data loss and ensure continuity in case of an incident. This service is provided by NSS for nationally hosted systems.

Our Digital Services team have an incident response plan in place to quickly address and mitigate security incidents should they arise. We recently undertook a firewalls upgrade; this will protect against intrusion and secure our network architecture to protect cloud and our on-premises systems.

All software and systems are regularly updated with the latest security patches to remove any vulnerabilities within our systems.

In summary

Having personal sensitive data in any system creates a risk, a risk that needs to be mitigated by robust monitoring, a skilled workforce and evidence of compliance with the National Information Security (2018) regulations.

NHSO systems which are hosted by National Services Scotland (NSS) or other Health boards, are subject to the NIS regulation audits which provides a certain level of assurance. The rest of the assurance is provided by regular North of Scotland cyber meetings where the boards come together to discuss any issues.

Whilst NHSO has a mixture of cloud-based systems, by implementing the measures outlined in this paper, we will significantly enhance the security of our digital systems and protect sensitive health data.

All servers siting within The Balfour are behind a robust security system which our Digital Services Team control and monitor. All systems commissioned on the cloud and on premises must have a Data Privacy Impact Assessment in place. Part of this process is to ensure security processes (internal and external) are in place including, recovery and business continuity processes. Whilst there are risks associated with moving to a 'Once for Scotland' approach to service delivery, the National CCoE commissioned by SG and our inhouse digital services team is well placed to ensure our systems are protected and mechanisms are in place to keep our data safe.

As part of the next re-design of our digital infrastructure the core switches (which moves data across the Organisation are being migrated to new firewalls. This means our digital services team can provide the following capabilities to protect our digital systems.

- Anti-virus and ransomware attack
- Intrusion Protection Systems (IPS) is operational to stop attempted penetration attacks into our systems.
- User authentication access controls are in place including two step Multi Factor Authentication before anyone can access our systems.
- All login access attempts are recorded at the network level.

To provide assurance, our servers both on-premises and cloud based have a satisfactory level of protection, however it cannot be completely de- risked.

e-Health Update

eHealth Resource Demand

eHealth has experienced a severe increase in absenteeism over the last few months, this in turn has impacted their ability to meet demands and in turn created work stressors on the remainder of the team. Morale is low and the remaining team are at risk of burnout as they cannot continue to sustain the current expectation. Immediate action is necessary to address staff shortages, decline in our operations, planned project resource requirements and staff wellbeing.

NHS Orkney SCI store de-commissioning

The NHS Orkney SCI Store was taken offline from Monday 27th May. Communications were circulated on Friday 24th May 2024 to ensure users were aware and that there will be a 3-month cooling off period in which time users can raise a ticket to gain access should they need to cross check data.

Once the team are confident all is going well, a reminder will be sent to users on the 9 August 2024 with a final communication being issued on 16 August that the NHSO sci store will be switched off and no longer available from the 19 August 2024.

TrakCare ED move to Scottish edition - Pilot underway - (6 users have now been set up to pilot within our ED)

The main reason for moving to the Scottish Edition is in response to negative feedback regarding the current Emergency Department (ED) Discharge Letter.

Having to PDF/save and email GP practices increases the risk of letters being missed/not sent/sent to incorrect practices. In relation to visitors to Orkney we print and post discharge letters running the risk of letters getting lost or not received.

The Scottish Edition provides the functionality for ED Letters to be sent to GPs electronically and in real time. The patient journey functionality on Scottish Edition works very much in the same way as the existing version.

Our e-Health team are working with InterSystems who provide TrakCare and colleagues within ED to set this functionality up but have asked us to progress with rolling out the Scottish Edition, we anticipate this functionality will be rolled out in the next few months.

TrakCare Inpatient Electronic Patient Record

Preparatory work was undertaken to allow for adoption of Grampians Trakcare Inpatient Electronic Record (IP EPR) functionality. Our digital services team have carried out business analysis and provided Grampian eHealth with our required assessment documentation. Orkney Clinical colleagues have met with the Grampian clinical IP EPR lead to assess clinical requirements and are looking at using a paper version of the EPR. Latest feedback from Alisdair Miller suggests supporting the nursing staff with trailing the NHS Grampian 'Ask me' risk assessment as a first step.

TrakCare eLearning onto TURAS

Due to the lack of resource to drive this forward, this has not progressed as quickly as expected. In the meantime, users have been reminded that all guidance documents are available via the blog.

TrakCare Upgrade

An upgrade to next version of TrakCare has been signed off by NHS Grampian and is expected to take place summer 2024. The upgrade is scheduled to commence July, with the expectation of delivery release T2024.3. Main drivers for the upgrade include the push to move to native Edge. A patch is likely to be applied in 2025 to enable us to take the waiting times functionality. eHealth is working with Grampian to determine the local resource requirement, testing/sign off requirement for local functionality along with establishing features & benefits and the roll out there of.

TrakCare Waiting Times National Workshop feedback.

Cross Boundary Data Capture

Prior to the new Waiting Times Guidance, when a referral was transferred from one board to another, it was the responsibility of the referring board to report, customisation was carried out for GJNH (Golden Jubilee National Hospital) to allow referring boards to send waiting times information to GJNH via their SCI Gateway referrals.

The GJNH solution will be extended to the other Boards to provide an interim step in supporting the new reporting requirements, functionality will be incorporated into a new feature. The unavailability period added will have a specific unavailability reason which will then support this period being excluded from the extract going forward.

The unavailability will continue to cover cancellations, DNAs or other resets which happened at the Referring Board report on the wait to the Waiting Times Warehouse. Under the new guidance it is now the responsibility of the receiving board to carry out this reporting. Delivery of this functionality will be in version T2024.4

Change to TTG Rules - Clocks to Reset after TTG Date. Core Change to deliver this - T2025.1

This change will amend the rules to enable resets and clock adjustments to take place after the TTG (Treatment Time Guarantee) Date. The final date for the implementation of the new Waiting Times Guidance is

November 2025. Boards have been advised that implementation of the change will be around the same time, the requirement will be built into the specification enabling Boards to switch on the change at a defined date.

Add New Fields to Wait Times for External Services Screen. Core Change to deliver this – T2025.1.

Additional fields are required to record the details of the activity that occurred at the Referring Board, this will allow the full Cross Boundary Data Capture solution to be delivered.

Cross Boundary Data Capture - Include and Map Additional Fields. Edition. Change to deliver this - T2025.1

Mapping will need to be developed to take the new pieces of information from the SCI Gateway messages and drop them into the additional fields in TrakCare.

Release Schedule / Delivery T2025.1 is January 2025

Boards need to have plans to move to that release or higher at some point through 2024/25. A general concern was raised regarding Boards being able to uplift to the required level in time to get the fixes to implement the guidance by November 2025. Boards need to plan now to take T2025.1

SCI Gateway Improvements

Options for referrer to highlight patient can attend as Near Me have now been added to SCIT Gateway.

Options for referrer to highlight patient unavailability has been added to appropriate referrals.

Option for referrer to have a referral that is an RFA (request for advice) has been discussed and is awaiting clinical decision.

5 national templates under the Orkney Ophthalmology speciality on Orkney SCI-Gateway is now operational enabling Clarks (Optometrists) to refer to the Balfour using the Gateway electronic referral process:

- Ork Ophthalmology General
- Ork Ophthalmology Cataract
- Ork Ophthalmology Glaucoma
- Ork Ophthalmology Paediatric
- Ork Ophthalmology RA Wet AMD

Community Mental Health - NHSO now looking at morse and no longer looking to adopt the Grampian SCI Gateway/Trakcare solution. Early discussions are underway to scope out & determine requirements.

HEPMA

Discussions underway around how regional system changes will be progressed. Wards have reported that they are still awaiting dual screen COWs following the introduction of HEPMA to allow for the simultaneous use of Trak & HEPMA on ward rounds.

Laboratory Information Management System (LIMs)

Once Grampian go live, NHSO will aim to look at Trak OCS for labs.

Child Health System (national solution)

RAG status of Red - The project will not make the march 2025 timeline originally set out. The national team are looking to re baseline the project to provide realistic timelines for the programme board to review.

Infection Control (national solution)

No update

Newborn Screening (national solution)

Conversations around costs continue, provisional 'okay' from CEOs has been based on costs of ~£85k. However, costs have since increased and last indication was that these are now a minimum of 3x the original amount.

Still at the exploratory phase and there are no timescales agreed.

PACS (national solution)

Planning underway, kick off meeting held with national project team. Go live proposed for Sept 2025

Upgrade and migrate current version of cCube.

cCube Version 3 was introduced at NHS Orkney in 2018 as a requirement when moving into the new Balfour Hospital where no provision was made available for storing paper-based patient records. cCube is a business-critical system used by services; cCube is a repository for digitised paper records, used since many services do not have a digital patient record system. cCube was commissioned to hold digitised historic paper records which would be referred to occasionally, however has now become operationally critical as teams still require to scan current records to cCube since many services do not have a digital patient record system.

Since go live in 2018, no upgrade or system patch has been undertaken preventing NHSO from benefiting from cCube developments and bug fixes, rendering our current version out of date.

Outdated software affects computer performance resulting in the system freezing, device failure and the overall stability of the system and can also present a security risk.

Users have voiced concerns about the inability to store and recall electronic documents in a chronological order which is essential when viewing historical case notes. The current cCube system is slow and crashes frequently leading to frustration for users. This creates additional work for the e-Health team as it requires servers to be restarted locally as well as cCube having to reset the server each time.

The migration is scheduled to take place in July 2024 with the system upgraded early September 2024.

GP IT Re-provisioning

A GP IT Reprovisioning Project Team has been set up within NHSO to oversee this project. Dr Iain Cromarty has agreed to be part of the multi-disciplinary General Practice IT Reprovisioning Project Team and is willing to be the Lead User and represent all GPs. Dr Huw Thomas has also agreed to be part of the Project Team, representing EMIS practices. There is also representation from Practice Administrators, Practice Managers, Pharmacists, IT, Digital Services, Primary Care, Procurement, Finance, and Information Governance colleagues.

Confirmation has been sent to NSS of our authority to award the contract to Cegedim.

The project is rated amber in Quarter 1 as a Primary Care IT Facilitator resource is not in place. Conversations continue with NHS Grampian in relation to an alternative model of support as a mitigation to the risk.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Population Health and Prevention Integrated Performance Report**
Responsible Executive/Non-Executive:	**Louise Wilson, Director of Public Health**
Report Author:	**Louise Wilson, Director of Public Health**

1 Purpose

This is presented to the Board for

- Discussion - To scrutinise and seek assurance from the Integrated Performance Report (IPR) for Population Health

This report relates to a:

- Annual Operation Plan
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Integrated Performance Report (IPR) for Population health summarises NHS Orkney's performance based on national and local reporting requirements as well as those indicators which matter to our patients, staff, and local community. The IPR aligns to our Corporate Strategy 2024-28 and Annual Delivery Plan 2024-25.

2.2 Background

The IPR provides the Board with an overview of performance and key metrics in relation to Population Health as set out in our Corporate Strategy and national reportable metrics required by Scottish Government.

2.3 Assessment

Performance for immunisations and screening is generally good meeting national uptake standards although there is quarter by quarter variability due to the small numbers involved. The smoking cessation service continues to engage with clients and raise awareness of the service. The integrated performance report for population health will be included in the reporting by exception overall integrated performance report moving forward.

2.3.1 Quality/ Patient Care

Monitoring performance supports delivery of timely quality care.

2.3.2 Workforce

Ensuring performance requires a sustainable workforce.

2.3.3 Financial

Preventative care may reduce treatment costs.

2.3.4 Risk Assessment/Management

Population health risks are managed through the organisational risk process.

2.3.5 Equality and Diversity, including health inequalities

NHS Orkney actively seeks to address health inequalities through effective performance management. Central to our work is developing a culture of continuous improvement which has fairness and equity at its heart.

2.3.6 Climate Change Sustainability

NHS Orkney is a leader in terms of sustainability and addressing climate change. There is one deliverable within the Annual Delivery Plan and NHS Orkney Strategic Priorities for 2023/24 linked to Climate Change Sustainability.

2.3.7 Other impacts

None identified.

2.3.7 Communication, involvement, engagement and consultation

Discussions have taken place with members of the public health department.

2.3.9 Route to the Meeting

This report has been developed through the IPR process.

2.4 Recommendation

- **Discussion** – Examine and consider the implications of a matter.
  The Board is asked to
  Scrutinise the report and
  Seek assurance on delivery.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Population health integrated performance report

Population Health

Section Lead: Director of Public Health - Dr Louise Wilson

Comments

Quit Your Way Orkney (QYWO) continue to implement a systematic approach to enable the recording of anonymised referral data and referral results, which will be retained in the long term to allow for trend monitoring and the influence of service improvement activity on referrals.
National Screening and Immunisation Governance arrangements are being updated with a drive to increase uptake in hard-to-reach populations.

A new RSV (Respiratory Syncytial Virus) Vaccination Programme will be launched from 1 August 2024. Pregnant women will be offered immunisation from 28 weeks of their pregnancy by the Maternity Team. Individuals aged 75-79 years on 1 August 2024 will be invited for vaccination in August-September 2024.

Successes

53 participants from NHS Orkney and local statutory and third sector partners have received Very Brief Advice (VBA) training. QYWO have started receiving referrals from training attendees, demonstrating the practical impact of the training.
Spring Covid-19 booster implemented successfully, with uptake over Scotland average in all but one group. Childhood uptake consistently higher than Scottish average.
Local actions to increase pertussis and MMR uptake were taken recently in the context of UK and Europe increase of whooping cough and measles cases, with very low impact locally.
Breast screening programme ran from 29
April to 4 July 2024 with nearly 3200 women invited.
Uptake of Hearing, Bowel, AAA and Breast Screening uptake is above Scotland's average and targets.

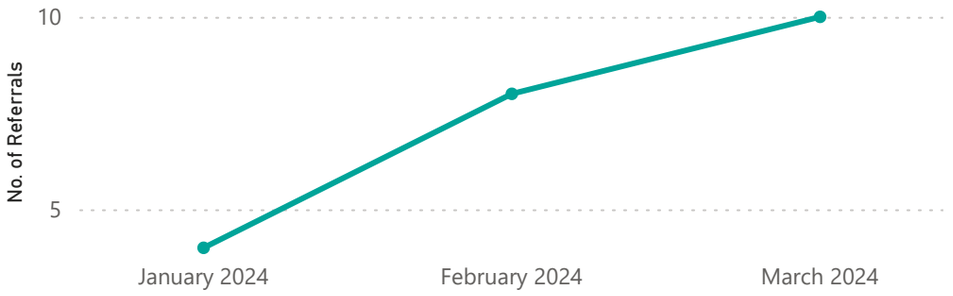
Challenges

There is a Consultant vacancy in the Public Health Department which has reduced strategic leadership capacity significantly, in the context of national Screening and Immunisation Governance arrangements being updated, local governance and assurance processes being tightened. Additional pressures include preparation for the NHS Orkney 2025 Island Games It is therefore becoming pressing that this is addressed.

Smoking Cessation Services (Source: Public Health Team)

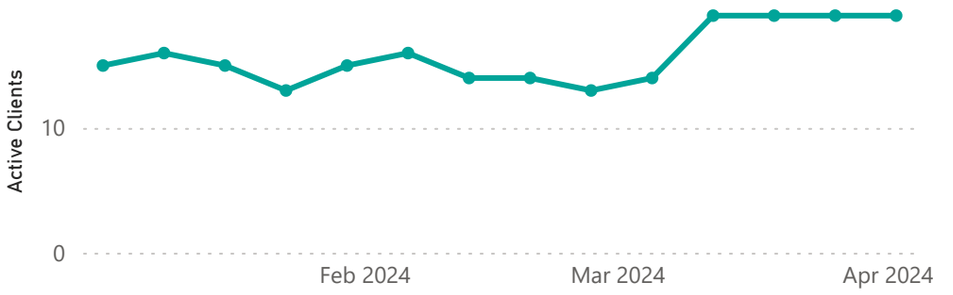
Latest Data: April 2024

Quit Your Way Orkney - No. of Referrals



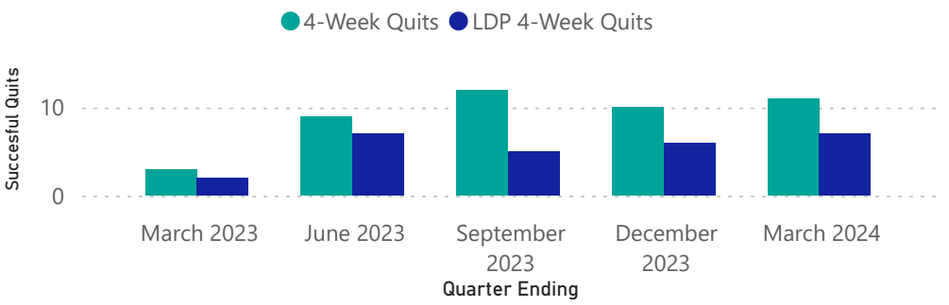
Latest Month
March 2024
10
No. of Referrals

Quit Your Way Orkney - Active Clients



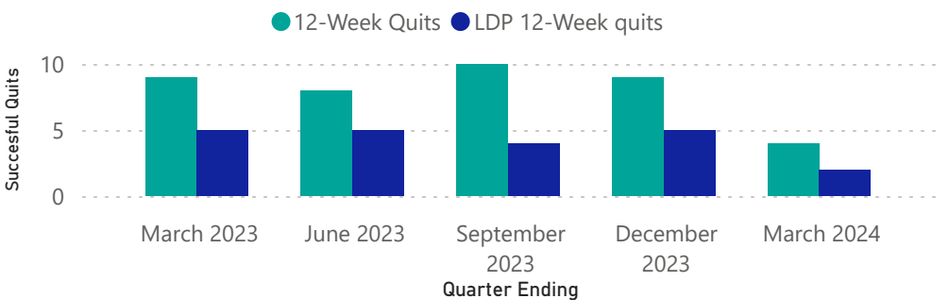
Latest Month
April 2024
19
Active Clients

4-Week Quits & LDP Comparison



Latest Quarter
March 2024
11
4-Week Quits
7
LDP 4-Week Quits

12-Week Quits & LDP Comparison



Latest Quarter
March 2024
4
12-Week Quits
2
LDP 12-Week quits

Issues/Performance Summary

- Data from management level unpublished data and therefore may be subject to change. The data only related to the specialist stop smoking service that is delivered through the Public health department and does not report on pharmacy level activity.
- Number of referrals rose across Quarter 4 2023/24.
- Service activity levels have remained fairly consistent over Quarter 4 2023/24.
- Quit rates at 4 weeks were higher in Quarter 4 2023/24 than the year previously, which potentially will translate to higher 12 week quits for this quarter compared to the same time last year as not all clients from Quarter 4 2023/24 have completed their 12-week course yet.
- There is a small seasonal pattern to successful quits.

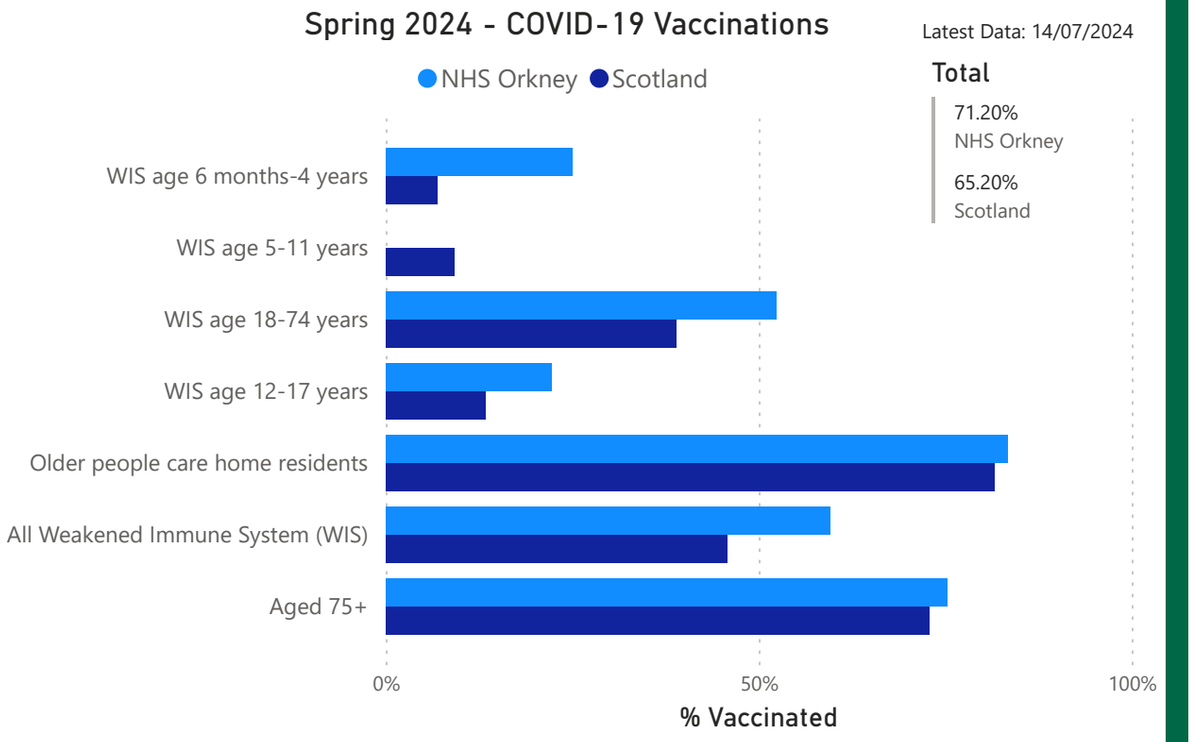
Planned/Mitigating Actions

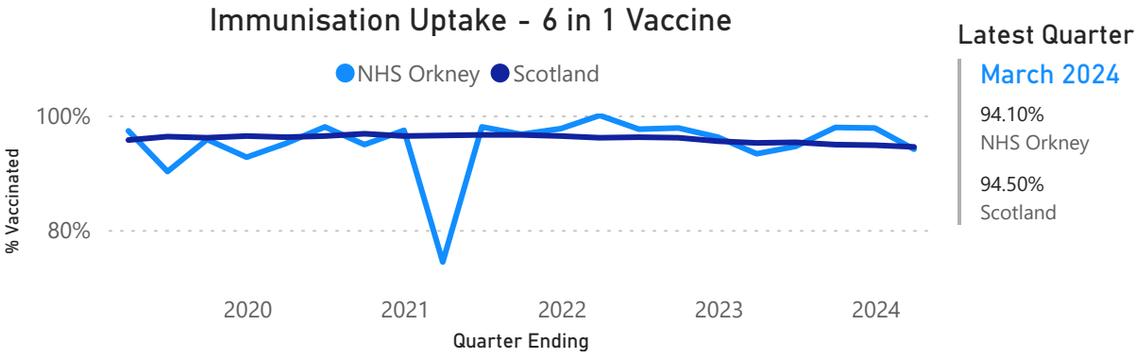
- Very brief advice training has been developed and is to continue to be rolled out to referrers throughout 2024/25.
- Work is ongoing with maternity services to improve the support for women who are pregnant to quit smoking.
- Continued delivery of the Quit Your Way specialist service in Orkney.
- Smoke Free Site Policy submitted to Senior Leadership Team.

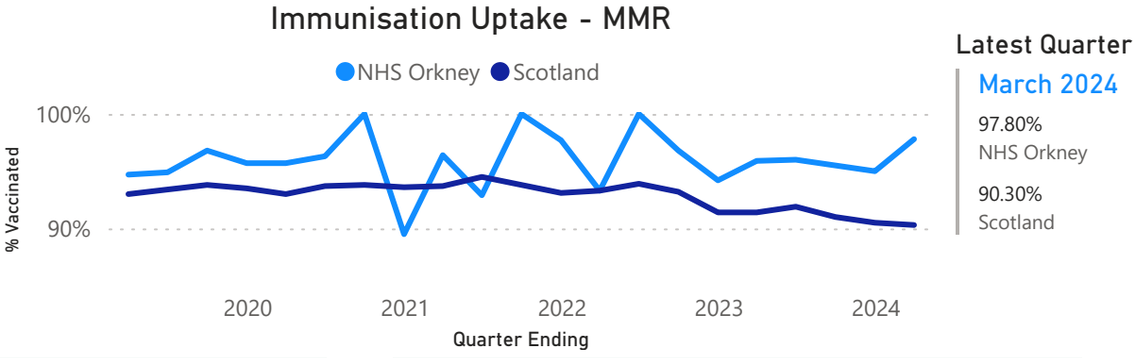
Assurance/Recovery Trajectory

- Continuing to engage with national groups to understand national direction and develop service accordingly.
- Targeting referrals from more high-risk groups through planned referrer engagement.

Vaccinations (Source: Public Health Team)







Issues/Performance Summary

Spring Covid-19 booster implemented successfully, with uptake over Scotland average in all groups except WIS 5-11 years – their parents were contacted individually and did not consent on vaccination.

National Immunisation Governance arrangements being updated, with a drive to increase uptake in hard-to-reach populations, which has increased significantly strategic input from Public Health Consultant lead in the context of a vacancy in the Public Health Department.

Planned/Mitigating Actions

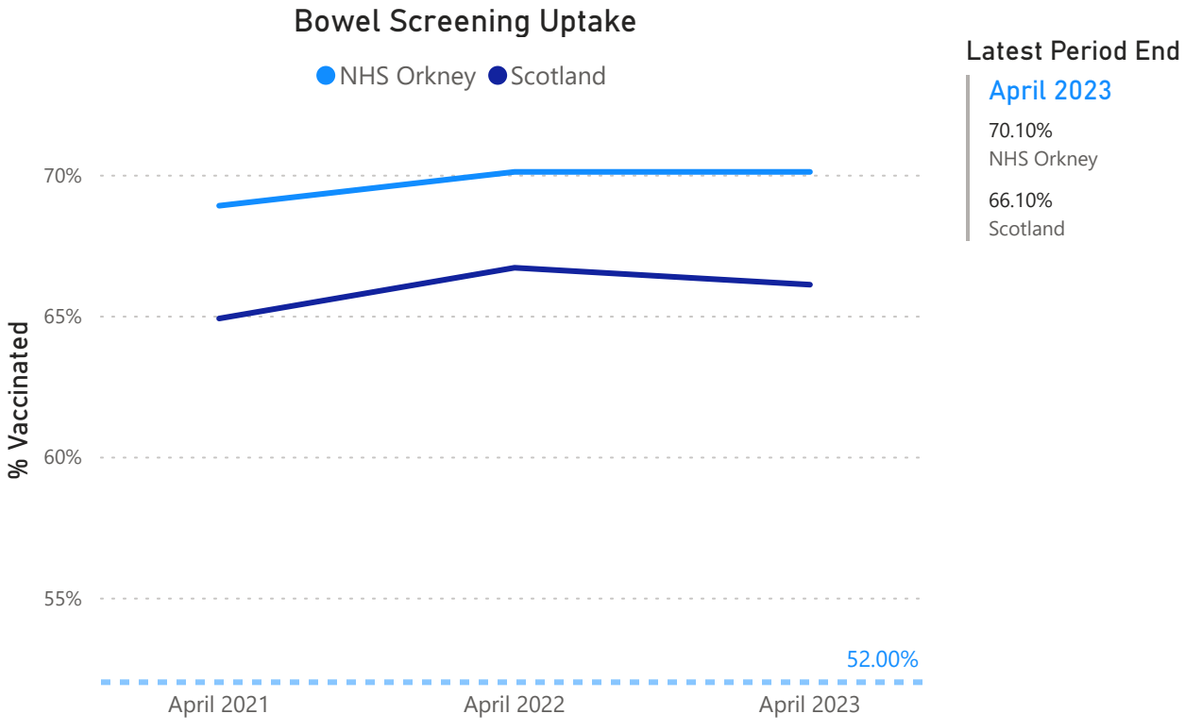
Awaiting final confirmation on national policy about Winter Flu and Covid-19 Vaccination Programme, to be launched from September 2024. Successful recruitment of vaccinators will allow implementation as per policy. Work underway to secure appropriate facilities and staffing resource for health and social care staff vaccination.

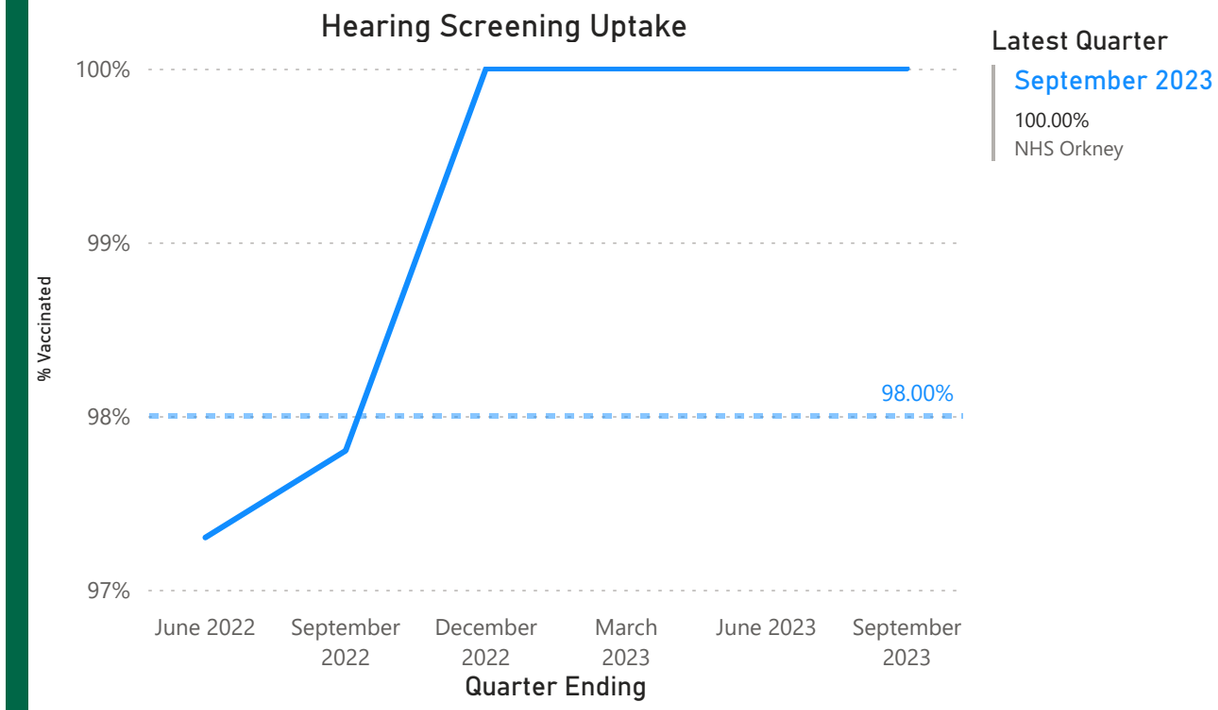
Major childhood programme schedule changes and the introduction of a new Varicella immunisation programme in 2025 may be affected by an expected 3-months delay in the national implementation of the new Child Health IT system, that was initially expected to be launched at the end of 2024. Local implementation group will monitor the situation and ensure that vaccination will be offered as per national policy.

Assurance/Recovery Trajectory

Childhood uptake consistently higher than Scottish average and generally above 95% recommended threshold, in the context of overall national decreasing trend. Uptake rate not affected by change to Kirkwall vaccination team from 1 April 2023. Local actions to increase pertussis and MMR uptake were taken recently in the context of UK and Europe increase of whooping cough and measles cases, with very low impact locally. Local figures (source: Badgernet) show that pertussis vaccination uptake in pregnant women from April 2023 to March 2024 was 95.4%. A new RSV (Respiratory Syncytial Virus) Vaccination Programme will be launched from 1 August 2024. Pregnant women will be offered immunisation from 28 weeks of their pregnancy by the Maternity Team. Individuals aged 75-79 years on 1 August 2024 will be invited for vaccination in August-September 2024.

Screening Services (Source: Public Health Team)





Issues/Performance Summary

National Screening Governance arrangements being updated, with a drive to increase uptake in hard-to-reach populations, which has increased significantly strategic input from Public Health Consultant lead in the context of a vacancy in the Public Health Department. Breast screening programme ran from 29 April to 4 July 2024 with nearly 3200 women invited.

Planned/Mitigating Actions

Local screening equity plan is about to be presented at Clinical Quality Group for approval and implementation to take forward actions to increase screening uptake in harder to reach populations.

Consultant vacancy has been highlighted.

Assurance/Recovery Trajectory

Most screening programmes report KPIs annually and several months after delivery.
Uptake of Hearing, Bowel, AAA and Breast Screening uptake is above Scotland's average and targets.
AAA Screening programme Apr 2022-Mar 2023: Percentage of eligible population who are tested before age 66 and 3 months is 83.1% in Orkney, 78% in Scotland (national minimum standard is 70%, national target is 80%).
Breast Screening Programme: Uptake Apr 2020-Mar 2023 is 83.7% in Orkney, 75.9% in Scotland (national target is 70%).

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Population Health and Prevention – Proposal for Future Reporting**
Responsible Executive/Non-Executive:	**Louise Wilson, Director of Public Health**
Report Author:	**Louise Wilson, Director of Public Health**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS in Scotland is facing challenging times, with increasing demand for services and financial constraints. Scottish Government is developing a new approach, which will be outlined in the forthcoming Population Health Framework alongside the existing public health priorities. Shifting the focus of the NHS from a treatment orientated organisation to a health improving organisation requires a renewed focus and shift in mindset, including for NHS Orkney.

NHS Orkney is well placed to undertake the transition with its five year Corporate Strategy "Delivering what matters to our community". This includes a focus on Place as a strategic objective (Executive Director Lead: Director of Public Health) with the ambition that by

2028 we will "be a key partner in leading the delivery of place-based care which improves health outcomes and reduces health inequalities for our community". Our Clinical Strategy also focuses on improving the health and wellbeing of the population of Orkney with an emphasis on smoking, alcohol, healthy bodyweight and physical activity. Furthermore, our Anchor Strategic Plan will be a route to deliver community wealth building outcomes, with a particular focus on employment, procurement and land and assets – all of which are linked to our overall ambition of improving the quality of life for our community and reducing health inequalities.

2.2 Background

Public health is often broken down in to health improvement, health protection and screening and health care public health, underpinned by public health intelligence. In 2018, Scottish Government published the Public Health priorities which were adopted and localised (Table 1), aiding reporting to Scottish Government on the management of funding allocated to specific priorities. The COVID-19 pandemic has re-emphasised the fundamental importance of health protection and the need for a capable and adequately resourced health protection function in Scotland.

Table 1: Orkney adaptation of the Scottish public health priorities

• An Orkney where we live in vibrant, healthy and safe places and communities • An Orkney where we flourish in our early years • An Orkney where we have good mental wellbeing • An Orkney where we reduce the use of an harm from alcohol tobacco and other drugs • An Orkney where we have a sustainable inclusive economy with equalities of outcomes for all • An Orkney where we eat well, have a healthy weight and a physically active

More recently Public Health Scotland (PHS) and Scottish Government have expressed interest in the Marmot principles (Table 2) which are evidence-based policy objectives to reduce inequalities. In NHS Orkney, the Public Health department have been using the Marmot principles as well as the Scottish public health priorities over the past year to focus local action.

Table 2: Marmot principles

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention
- Tackle racism and its outcomes
- Tackle climate change and health equity in unison

Scottish Government is producing a Population Health Framework in the summer for consultation. The general elements of the framework have been discussed at the national Directors of Public Health meetings with Scottish Government colleagues with briefing notes on aspects of public health produced. However a key time for input will be when the framework is published in its entirety later this year. A care and wellbeing dashboard (Table 3) is being developed nationally although some of the metrics are still under development and some of the data in the dashboard is dated but the dashboard is framed along the Marmot principles. (https://scotland.shinyapps.io/phs-care-and-wellbeing-dashboard/). As these metrics are developed we will use them locally to demonstrate progress across the key Marmot areas.

Table 3: Care and wellbeing dashboard overview

Early years	Give every child the best start in life
Education	Enable all children, young people and adults to maximise their capabilities and control their lives
Work	Create fair employment and good work for all
Living standards	Ensure a healthy standard of living for all (to be developed)
Places	Create and develop healthy and sustainable places and communities (to be developed)
Impact of ill health prevention	Strengthen the role and impact of ill health prevention
Discrimination and racism	Tackling discrimination, racism and their outcomes (to be developed)
Sustainability and equity	Pursuing environmental sustainability and health equity together (to be developed)

In August, Public Health Scotland will encourage Community Planning Partnerships to consider becoming Marmot areas and three areas will be chosen to formally link with a national Marmot programme led by Public Health Scotland. NHS Orkney will engage in this work and explore any local opportunities.

2.3 Assessment

Development of indicators for population and public health NHS Orkney

There are a wide range of variables which can be used to measure population health, however the availability of up to date data for many of them can be problematic. Some may be measured only once a year or even every four years. Nationally with the development of the population health plan, national indicators are being considered.

The public performance reporting of a number of health boards was reviewed to understand how other boards are reporting on public health outcomes. For the majority of boards if public health was reported in their performance section this primarily related to the number of people stopping smoking at 12 weeks, and 'flu and Covid-19 vaccination. This may be due to the fact that many public health outcomes occur over a longer time period and data available at quarterly intervals is quite limited. A few boards reported on other vaccination rates e.g. MMR at 2 years.

In addition examples were sought from England's Office for Health improvement, Australia and OECD (Organisation for Economic Co-operation and Development) countries and shared at the clinical quality governance committee.

There are some overarching indicators which are widely used and are key in overall monitoring of population health.

- Life expectancy for males and females with comparators of other boards
- Healthy life expectancy for males and females with comparators of other boards
- All cause mortality age 15-64 years
- Premature mortality for respiratory, cardiovascular and cancer with Scottish comparator

These indicators are published annually and in general we perform well. We need to maintain or improve our position in relation to these key indicators, being mindful of year to year variation due to small numbers. So how can we do this as a health board? The key mechanisms are through preventing disease (health protection and screening), promoting health and well being (health improvement), and prolonging healthy life (healthcare public health). Much of this work is done collaboratively, with teams outwith of the public health department, with other partner health boards like NHS Grampian or through the community planning partnership – emphasising the element of place.

We will work towards having clearer metrics that better evidence improvement year-on-year as we develop our reporting in this space.

Preventing disease -Health protection and screening programmes

Ensuring robust vaccination programmes with timely introduction of new vaccination programmes is an essential bedrock of public health. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine-preventable communicable diseases. Coverage is closely related to levels of disease and monitoring coverage identifies possible drops in immunity before levels of disease rise. Whilst oversight across all vaccination programmes will be undertaken we will focus reporting on

- Vaccination uptake by quarter for key childhood immunisations
- Flu vaccination uptake for winter season
- Covid vaccination uptake for specific programmes.

We will aim to meet or exceed the national recommended uptake rates for the relevant vaccinations, and we will monitor cases and outbreaks of vaccine preventable disease locally.

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. NHS Scotland offers a range of screening tests to different sections of the population. There are currently six national population screening programmes delivered in Scotland (see Table 4 below). These programmes have been introduced based on recommendations from the UK National Screening Committee. Each screening programme proactively invites people who, on the basis of age and sex, have a higher risk of the disease or condition. For some of the screening programmes part of the pathway is delivered by NHS Grampian, and close working is essential.

Table 4: Screening programmes

National Screening Programme	Eligible Population	Screening Interval
Scottish Abdominal Aortic Aneurysm (AAA) Screening Programme *	All men and people assigned male at birth aged 65	One-off screen
Scottish Bowel Screening Programme	People aged 50 to 74 People aged 75 and over can request a screening test but will not be routinely invited	Every 2 years
Scottish Breast Screening Programme*	Women and people assigned female at birth aged 50 to 70 Those aged	Every 3 years

	71 to 75 can self-refer for breast screening.	
Scottish Cervical Screening Programme*	Women and people with a cervix, aged 25 to 64	Every 3-5 years depending on findings
Scottish Diabetic Eye (DES) Screening Programme	People aged 12 and over with type 1 or type 2 diabetes	Every 1-2 years depending on findings
Scottish Pregnancy and Newborn Screening Programme	Pregnant women and people who are pregnant. Various tests from before 10 weeks, through to between 18 to 21 weeks. Newborn babies. Various tests within the first days and weeks.	Various one-off screens including some with a two stage process

Delivery in conjunction with NHS Grampian *

We will aim to meet or exceed the national uptake standards for the national screening programmes. Screening data is usually published annually, although some data for management purposes is available quarterly for bowel screening. A screening equity plan has been developed and actions are being prioritised to promote uptake.

The new Clinical Quality Group, which reports to Joint Clinical and Care Governance Committee will be utilised for the routine reporting of issues in screening and vaccination performance data of which a subset will feature in the integrated performance report ("6 in 1" vaccination at 12 months and mumps, measles rubella (MMR2) uptake at 6 years, and uptake of seasonal flu and COVID-19 vaccinations). Any key issues will be highlighted in the public health report to Joint Clinical and Care Governance Committee.

Working collaboratively with environmental health colleagues to protect health is important. The joint health protection plan is a plan produced every 2 years with environmental health colleagues as per the requirements of the Public Health etc. (Scotland) Act 2008 which outlines key areas where we will work together. The NHS aspects of the plan are due to be finalised in September 2024. Any key issues related to the delivery of the plan will be highlighted in the public health report to Joint Clinical and Care Governance Committee.

Like a number of our screening programmes, work relating to sexual health and blood borne viruses is often undertaken in conjunction with NHS Grampian. The local multidisciplinary sexual health and blood borne virus group is being re-established and will develop a work plan based on the 2022 Sexual Health Standards, utilising a chair's report

for assurance. This will be incorporated in to the public health report to the Joint Clinical and Care Governance Committee, which the Committee will see on a quarterly basis.

Promote health and wellbeing - Health improvement

Many staff across the organisation play a role in promoting health and wellbeing. Over time greater understanding of the need to shift the emphasis from the individual to the system and environment has occurred. This is recognised in the place element of our corporate strategy which includes work on the anchor strategy. Much of an individual's health and health forming behaviours and actions are determined by their circumstances, wider influences and environments.

There remains a need for sustained action on alcohol, drugs (led by the alcohol and drugs partnership), smoking, diet and physical activity to improve health and reduce the prevalence of preventable disease such as cardiovascular disease, diabetes and some cancers.

Supporting individuals to stop smoking and stopping individuals starting smoking are important activities supporting the goal of making Scotland tobacco-free (population smoking prevalence of 5% or less) by 2034. NHS Island Boards are to sustain and embed successful smoking quits at 12 weeks post quit, in the 60 per cent most deprived SIMD areas. Performance in relation to the smoking cessation service will be included in the integrated performance report to board.

NHS Orkney receives ring fenced money for the delivery of healthy weight services for adults and children. A multidisciplinary group leads the work in these areas. Six monthly activity and financial returns on child and adult healthy weight are required by Scottish Government and will be presented to the senior leadership team for oversight and to the clinical quality governance committee.

Progress on the Anchor Strategic Plan is currently reported to the board on a six monthly basis and primarily uses metrics that are incorporated in departments' reporting for other plans and strategies to reduce the burden of reporting. Work has been undertaken to focus down on what the key priorities are for year one of the plan for departments whilst ensuring linkage to the government set indicators. The plan is also supporting work undertaken in the local Community Wealth Building group of the Community Planning Partnership (CPP).

Working in collaboration with our CPP is essential for promoting health and wellbeing. The work of the CPP is captured through the Local Outcomes Improvement Plan (LOIP) which is due to be updated in September 2024. The new CPP update for the board will enable Board members to be better sighted on the plan and progress against it. The

Integration Joint Board (IJB) strategic plan includes as priorities unpaid carers, supporting older people, community led support and mental health and wellbeing with two overarching priorities of early intervention and prevention, and tackling inequalities and disadvantage. Work is underway to develop a new strategy and the new IJB reports to board will improve visibility of work undertaken.

Prolong healthy life - Health care public health

The Scottish Burden of Disease study highlights key clinical conditions which contribute to ill-health. Local profiles were then created by Public Health Scotland and these have been used locally to develop a series of focused reports on key clinical issues such as cardiovascular disease and respiratory disease. These enable scrutiny of primary secondary and tertiary prevention in relation to key conditions and can highlight variance in outcomes. These will help develop new areas of focus to prolong healthy life and relate to the metrics for premature mortality for cardiovascular, respiratory and cancer. These reports will now go to the Joint Clinical and Care Governance Committee as part of the composite public health report.

A new workstream for the organisation is around preparedness for the Island Games which will be held in Orkney in July 2025. The chair's assurance report for the Island Games preparedness group is scrutinised at Senior Leadership Team and Finance and Performance Committee. A full medical and operational plan is under development.

As more information on the Scottish Government population health framework becomes available and indicators for the care and being board are further developed, where appropriate these will be included in our local reporting.

2.3.1 Quality/ Patient Care

Delivery of public health programmes to key standards supports quality care.

2.3.2 Workforce

No impact on workforce

2.3.3 Financial

Provision of public health services often reduces demand on health care.

2.3.4 Risk Assessment/Management

Risks related to public health are managed through the organisational risk management programme

2.3.5 Equality and Diversity, including health inequalities

No specific impact assessment undertaken.

2.3.6 Climate Change Sustainability

Preventative activities may reduce future clinical care needs which impact on climate change

2.3.7 Communication, involvement, engagement and consultation

Key public health screening standards have been developed by Healthcare improvement Scotland through consultation. Senior staff in public health have contributed to the planned reporting programme.

2.3.9 Route to the Meeting

This has been considered by senior staff in the public health department.

2.4 Recommendation

- **Decision** - The Board is asked to scrutinise the approach to maximising life expectancy through the focus on protecting health, promoting health and wellbeing, and prolonging healthy life and endorse this approach and proposed reporting scheme to enable progress to be monitored.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 Population health reporting

Appendix 1: Population health reporting

Area	Frequency	Committee
Improved life expectancy		
Life expectancy (male and female)	annual	Board
Under-75 mortality	annual	Board
Prevent disease		
Uptake across all vaccinations	quarterly	clinical quality group (JCCGC)
Key subset of vaccinations	quarterly	integrated performance report
Overall vaccination uptake	annual	Board
Management data on screening uptake	quarterly	clinical quality group (JCCGC)
Key subset of screening performance	quarterly	integrated performance report
Uptake of screening programmes	annual	Board
Joint health protection plan	by exception	Joint clinical and care governance
Sexual health and blood borne virus	quarterly	Joint clinical and care governance
Promote health and wellbeing		
Smoking cessation	2 monthly	integrated performance report
Child and adult healthy weight	6 monthly	clinical quality group (JCCGC) Senior leadership team
Anchor plan	6 monthly	Board
Local outcomes improvement plan	annual	CPP report to the Board
IJB strategy performance report	annual	IJB report to the Board
Clinical strategy	quarterly	Board
Prolong healthy life		
Island Games Preparedness	monthly	Senior Leadership Team, Finance and Performance
Burden of disease topic report	2 monthly	Joint Clinical and Care Governance

CPP : Community Planning Partnership

IJB: Integrated Joint Board

JCGGC: Joint Clinical and Care Governance Committee

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 22 August 2024**
Title:	**Planning with People: Community engagement and participation guidance – updated 2024**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight, Chief Executive**
Report Author:	**Laura Skaife-Knight, Chief Executive**

1 Purpose

This is presented to the Board for:

- Discussion
- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement
- Board Values
- Plan on a Page

This aligns to the following NHSScotland quality ambition(s):

- Person Centred
- Safe
- Effective Care

2 Report summary

The purpose of this report is to update the Board on the updated Planning with People Guidance which was published on 29 May 2024. The updated guidance takes into consideration the current challenges faced by NHS Boards to ensure all parties are clear on respective roles, responsibilities and processes and reinforces the statutory duties for engagement regardless of financial pressures.

2.1 Situation

Planning with People sets out the responsibilities NHS Boards, local authorities and Integration Joint Boards (IJBs) have to community engagement when health and social care services are being planned, or when changes to services are being considered and supports them to involve people meaningfully.

The updated Planning with People Guidance was published in May 2024 (Appendix 3).

This paper summarises:

1. The key changes to the national guidance that our Health Board needs to be aware of
2. How NHS Orkney keeps in touch with Healthcare Improvement Scotland (HIS) throughout the year and works with HIS to ensure compliance with this guidance

2.2 Background

The duty to involve people and communities in planning how their public services are provided is enshrined in law in Scotland (Joint Strategic Needs Assessment and Strategic Commissioning Planning must be fulfilled).

Ensuring Planning with People is understood and adopted by all stakeholders is a key role for NHS Chief Executives, Chief Officers in IJBs and local authority Chief Executives.

The decision-making process for NHS major service change is unchanged. Scottish Ministers will continue to make the final decision regarding whether to approve proposed service changes by NHS Boards that will have a major impact on people and communities.

Healthcare Improvement Scotland (HIS) and the Care Inspectorate have statutory responsibilities to assure and support improvement in the quality of care of services. HIS ensures people and communities are engaged in shaping health and care services. It has a legal duty to support, ensure and monitor the discharge of health bodies' duties in respect of public involvement, including quality assurance of changes to delegated health services being made by IJBs.

The Care Inspectorate is responsible for inspecting and improving social care and social work services and regulates all registered services for adults and children.

There is a specific requirement for NHS Boards and IJBs (for delegated health services) to formally consult on issues which are considered major service change. The process for that has not changed.

When an NHS Board or IJB proposes any service change, it must work with HIS to ensure appropriate levels of engagement with the communities potentially affected are taking place.

In the absence of an agreed consensus on the level of engagement to take place, the NHS or IJB should seek a final decision on designation from the Health Sponsorship Division at the Scottish Government.

The main changes in the guidance pertain to proposed changes to regional or national services. In such instances, the Board proposing the change should lead the involvement process.

Regional Planning Groups are made up of NHS Board staff from across the region who are working on behalf of the constituent NHS Boards. All decisions and proposals must be referred to individual NHS Boards for consideration and approval.

In cases where there is a nationally-determined service change, the Scottish Government will provide written, advance notice to all affected NHS Boards and to HIS. Scottish Ministers will also alert the Scottish Parliament.

The decision will then prompt a discussion between the affected NHS Board and HIS to consider what local action is then required for the local NHS Board to fulfil its duty to proportionately engage with local people.

In general, next steps on local engagement for NHS Boards in such cases will fall into two categories: (1) where there is scope for them to influence how the national decision may be implemented locally and (2) where there is not sufficient scope for local Boards to inform the service model or location of services.

In such instances, local Boards should contact HIS at the earliest opportunity following receipt of a written notice from Scottish Government of a national-determined service change to discuss and agree next steps.

The flow charts in Appendices 1 and 2 set out the engagement process that NHS Boards and IJBs must follow based on the updated guidance.

At NHS Orkney, the Chief Executive is currently the lead for public engagement, and this will be reviewed by April 2025 to ensure better alignment with community, patient and public engagement as part of a broader portfolio review ahead of 2025/26.

Regular relationship meetings and touchpoints take place between NHS Orkney and HIS, which the Chief Executive and Chair attend along with wider officers depending on the service or change under discussion.

Where there are opportunities to better align engagement activities between NHS Orkney, Orkney Islands Council and wider partners, including the third sector, we will continue to do so. The Community Planning Partnership is one of the key forums through which many of these conversations and alignment will happen.

Next steps

1. NHS Orkney will explore where there are further opportunities to join-up with the IJB and Orkney Islands Council on any engagement activities to ensure better alignment and to avoid 'engagement fatigue'

2. To consider any engagement requirements as part of the delivery of Year 1 (2024/25) of our Corporate Strategy

3. As we commence planning in Quarter 3 for Year 2 of the Corporate Strategy, we will give careful thought to any engagement requirements in 2025/26 and work proactively with the IJB, HIS and other partners to plan this activity for the year as part of our wider patient, community and public engagement work

4. To determine the Executive and Board-level lead for patient and public engagement to ensure revised leadership arrangements are in place by April 2025 and to bring all aspects of engagement together into a single Executive and Board-level portfolio

2.3 Appendices

Appendix 1 – Overview of engagement process for NHS Boards (flow chart)

Appendix 2 – Overview of engagement process for IJBs (flow chart)

Appendix 3 – Updated Planning with People Guidance (May 2024)

2.4 Recommendation

- **For discussion and awareness**

COSLA

Scottish Government
Riaghaltas na h-Alba

PLANNING WITH PEOPLE

Community engagement and participation guidance

Updated 2024

CofSLA
@COSLA
www.cosla.gov.uk

TheScottishGovernment
@ScotGov
www.gov.scot

Planning with People – Joint Foreword

Scotland's national and local governments are committed to involving people and communities in the decision-making that affects them. Nowhere is that more vital than in the development of the health and social care services, which we all rely on.

Listening to the views of people who use services, and involving them throughout the process of planning care delivery, is a key improvement recommendation of the Independent Review of Adult Social Care in Scotland.

Planning with People has been updated to take into consideration the current challenges being faced by NHS Boards and ensure that all parties are clear on respective roles, responsibilities and processes and reinforce the statutory duties for engagement regardless of financial pressures.

By working together with people and communities, care providers can transform the experience of people who use services, as well as the experience of those who deliver them. Planning with People will help us to achieve that widely and with consistency.

During the pandemic, many new and different ways of working were developed to support the continued delivery of critical services, and Boards and their planning partners continue to develop their strategic plans to renew local services. We want to build on these new and different ways of delivering health and care to ensure that more individuals receive person centred care in the right place, at the right time. As our recovery from the pandemic gathers momentum, the duty to involve people is as important as ever to guarantee delivery of high quality care. This guidance will ensure that the necessary, proportionate public engagement that informs proposals for change is as robust and efficient as practicable.

Planning with People promotes real collaboration between NHS Boards, Integration Joint Boards and Local Authorities. It sets out the responsibilities each organisation has to community engagement when services are being planned, or changes to services are being considered, and supports them to involve people meaningfully.

Fundamentally, good engagement is essential to good service planning. And there is no doubt that greater participation brings better outcomes for communities all round. We encourage everyone in Scotland to get involved in shaping the care services they receive. Ultimately, it is their experience that will be the real measure of what impact it is making.

Signed,

Neil Gray MSP, Cabinet Secretary for NHS Recovery, Health and Social Care

Councillor Paul Kelly, Health and Social Care Spokesperson, COSLA

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Part 1 – Planning with People

'Planning with People – Community engagement and participation guidance' (Planning with People) represents a national approach to engagement. It promotes consistency, culture change, and true collaboration, while encouraging creativity and innovation, based on best practice. It places people and communities at the center of care service design and change, to deliver the best results. The guidance is co-owned by the Scottish Government and the Convention of Scottish Local Authorities (COSLA).

When 'Planning with People' was published in March 2021 it marked the first time in ten years since guidance on community engagement for healthcare was last issued by the Scottish Government. Much has changed since February 2010 – not least the integration of health and social care services and the coronavirus pandemic. The virus and the public health measures necessary to suppress it had, and continue to have, a substantial, wide ranging impact on our lives, and our public services[1].

This edition of 'Planning with People' follows a review of the guidance to make sure it meets the needs of those for whom it is designed, and is aligned to the recommendations of The Independent Review of Adult Social Care in Scotland. 'Planning with People' was previously updated in 2023 following public and service user consultations, (feedback of those consultations can be found here) and feedback from the wider Scottish public, individuals, organisations representing the equality sector, and health and social care (HSC) engagement professionals.

'Planning with People' also contains additional supporting information for public bodies, including the Quality Framework for Community Engagement, which was developed by Healthcare Improvement Scotland and the Care Inspectorate. The guidance has been produced by people from right across the health and social care spectrum, and it will continue to develop as experience of collaborative community engagement grows.

NHS Boards and Integration Joint Boards have a statutory duty to involve people and communities in the planning and development of care services, and in decisions that will significantly affect how services are run.

'Planning with People' replaces previous guidance on engagement, and replaces the Chief Executive Letter 4 (2010) for NHS Boards. The guidance also applies to health services that are delegated to Integration Joint Boards.

The decision-making process for NHS major service change is unchanged. Scottish Ministers will continue to make the final decision regarding whether to approve proposed service changes by NHS Boards that will have a major impact on people and communities.

[1] Scottish Government Covid Recovery Strategy: for a fairer future (2021) Covid Recovery Strategy: for a fairer future

‘Planning with People’ applies to all care services; for children, young people and adults. It should be followed not only by health and social care providers, but also by local, regional, and national planners, special health boards and all independent contractors and suppliers, such as care homes, pharmacies and general practices.

‘Planning with People’ sets out how members of the public can expect to be engaged by NHS Boards, Integration Joint Boards and Local Authorities. By recognising all the good work that is taking place, the guidance is designed to complement and strengthen organisations' existing engagement strategies. It also encourages close working between bodies to minimise duplication and share learning.

Reflecting the spirit of partnership, and to be inclusive of community members who might wish to refer to it, the language used in this guidance is deliberately accessible and ‘jargon-light’. Scotland's Health and Social Care Standards use 'care' to encompass both health and social care, so this terminology is used throughout.

The guidance was developed before, during, and after the coronavirus pandemic, which transformed methods of engagement. Digital approaches, including the use of social media, are acknowledged by ‘Planning with People’.

Healthcare Improvement Scotland (HIS) has a range of case studies to help illustrate best practice and capture impacts on communities and engaging organisations, Healthcare Improvement Scotland - Community Engagement, sharing-practice, case-studies

1.1 Defining community engagement

Effective services must be designed with and for people and communities – not delivered, top down for administrative convenience.[2] In order to be effective, community engagement must be relevant, meaningful and have a clearly defined focus. NHS Boards, Integration Joint Boards and Local Authorities should engage with the communities they serve, following the principles set out in the National Standards for Community Engagement.

This defines ‘community engagement’ as:

'A purposeful process that develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue between everyone involved, aimed at improving understanding between them, and taking joint action to achieve positive change.'

1.2 Purpose of the guidance

Effective community engagement and the active participation of people is essential to ensure that Scotland's care services are fit for purpose and lead to better outcomes for people.

[2] Christie Commission on the future delivery of public services (2011) Christie Commission on the future delivery of public services

Planning with People

The Scottish Government and COSLA have published 'Planning with People' to support greater collaboration between those making decisions about care services in Scotland, those delivering services, and people in communities who are affected. This guidance supports public service planners, commissioners and providers to consider how to continually improve the ways in which people and communities can become involved in developing services that meet their needs.

Supporting Leadership

The duty to involve people and communities in planning how their public services are provided is enshrined in law in Scotland.

Key statutory responsibilities, such as Joint Strategic Needs Assessment and Strategic Commissioning Planning must be fulfilled both in the letter and in the spirit of the legislation. *Planning with People* supports care organisations to meet their legal responsibilities.

'Planning with People' must be understood and adopted by all stakeholders, and there are key roles for NHS Chief Executives, Chief Officers in Integration Joint Boards, and Local Authority Chief Executives to ensure that engagement is undertaken effectively.

To achieve meaningful and effective engagement, leaders must demonstrate a commitment to it and take action to embed it within their organisations. Organisational barriers that could hinder or impact negatively on engagement must be identified and addressed by effective leadership.

> Engagement that takes place routinely helps to develop trust between communities and public bodies, fosters mutual understanding, and makes it easier to identify sustainable service improvements.

1.3 Policy and legislative context

'Planning with People' was published in response to the Ministerial Strategic Group for Health and Community Care Review of Progress with Integration of Health and Social Care, which urges an increase in the pace and effectiveness of integration across Scotland. That includes a proposal to develop revised guidance on local community engagement and participation based on existing good practice, to apply across health and social care bodies.

All relevant public bodies are expected to demonstrate how they are engaging with communities, and to evidence the impact of engagement.

This guidance takes account of relevant recent policy drivers and legislation. It promotes a shared understanding among Scotland's care planners and commissioners, to support consistently high-quality engagement with communities.

Statutory duties of community engagement

Planning with People

NHS Boards and Integration Joint Boards have a statutory duty to involve people in the planning and development of services, and in the decision making process. This guidance supports care organisations to meet their legal responsibilities. It also supports delivery of obligations in respect of clinical and care governance. This includes NHS Boards duty of quality[3] and requirements of NHS Scotland in respect of clinical governance. [4] [5] [6]

NHS Boards are bound by duties of public involvement set out in the NHS (Scotland) Act 1978, Section 2B

Integration Joint Boards engagement and participation duties are specified by the Public Bodies (Joint Working) (Scotland) Act 2014. Integration Joint Boards are expected to apply this guidance and work with colleagues in NHS Boards and Local Authorities to share learning and develop best practice.

The duty to involve people in the design and delivery of care services was strengthened with the introduction of the Community Empowerment (Scotland) Act 2015.

Participation is also a key element of a Human Rights based approach, which requires that people are supported to be active citizens and that they are involved in decisions that affect their lives.

Assurance, support and oversight

Healthcare Improvement Scotland and the Care Inspectorate, have statutory responsibilities to assure and support improvement in the quality of care services. Where appropriate, they collaborate in the delivery of these duties.

Healthcare Improvement Scotland ensures people and communities are engaged in shaping health and care services. It has a legal duty to support, ensure and monitor the discharge of health bodies' duties in respect of public involvement, including quality assurance of changes to delegated health services being made by Integration Joint Boards. HIS is overseen by the Scottish Health Council, a governance committee of the HIS Board.[7]

Healthcare Improvement Scotland considers service change to be a service development or change in the way in which patients and service users access services. This may include the enhancement of a service through increased access, new resources and technologies, or new build facilities. It may also include the

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[3] National Health Service (Scotland) Act 1987
https://www.legislation.gov.uk/ukpga/1978/29/section/12H
[4] Scottish Executive Clinical Governance Letter October 2001
http://www.sehd.scot.nhs.uk/mels/HDL2001_74.htm
[5] Scottish Executive Clinical Governance Letter June 2000
http://www.sehd.scot.nhs.uk/mels/2000_29final.htm
[6] The Scottish Office Clinical Governance Letter November 1998
http://www.sehd.scot.nhs.uk/mels/1998_75.htm
[7] The NHS Quality Improvement Scotland (Establishment of the Scottish Health Council) Regulations 2005
https://www.legislation.gov.uk/ssi/2005/120/regulation/2/made

reduction, relocation or withdrawal of a service or the centralisation of specialist services. Some changes are made on a long-term or permanent basis while others are provided on a temporary basis.

The Care Inspectorate is responsible for inspecting and improving social care and social work services and regulates all registered services for adults and children.

Healthcare Improvement Scotland and the Care Inspectorate, together with stakeholders, have developed the Quality Framework for Community Engagement and Participation (the Quality Framework). This supports NHS Boards, Local Authorities and Integration Joint Boards to carry out effective community engagement and demonstrate how these organisations are meeting their statutory responsibilities to engage. In addition, the Quality Framework will provide opportunities to develop practice and share learning.

Further details on the Quality Framework can be found in 'Part 5 – Governance and decision-making'.

Joint Strategic Inspections

In partnership with other scrutiny bodies, Healthcare Improvement Scotland and the Care Inspectorate also carry out joint strategic inspections for care services of NHS Boards, Integration Joint Boards and Local Authorities. These inspections examine how integrated services are planned, commissioned and delivered to meet people's needs, and meaningful engagement is taken into account.

Healthcare Improvement Scotland and the Care Inspectorate both work to the Health and Social Care Standards in their scrutiny and improvement activities. The rights of people to be involved in decision-making regarding the provision of care underpin the joint standards, which also require people to be supported to participate fully.

Capital Investment Projects

Where capital is required, engagement with people and communities, as set out in this guidance, should be taken forward, in alignment with the Scottish Capital Investment Manual process.

Part 2 – Engaging with People

'Planning with People' supports NHS Boards, Integration Joint Boards and Local Authorities to build strong two-way dialogue with the diverse communities they work alongside and serve. The purpose of engagement will influence the methods to be used, and in most cases a range of different engagement tools will be necessary to reach the right people.

Engagement should not be a one-off event or only used for high-profile projects. High-quality and ongoing community engagement builds relationships and trust.

Healthcare Improvement Scotland can provide advice on the type of involvement it would expect to see for proposed engagement by health bodies. It can give views on similar work and best practice elsewhere, support meaningful engagement, and offer guidance on the evaluation process.

Individual engagement projects must be planned as part of an organisation's wider engagement strategy. It is important that community groups are involved from the earliest opportunity, and throughout the development, in the planning and decision-making process for service change. Involving community representatives in the engagement planning team at the earliest possible stage informs an effective approach.

Throughout this section, 'Planning with People' references the growing body of expertise in community engagement that is developing within Scotland's public organisations. Further information is listed in Annex B 'Supporting Information'

2.1 Defining community engagement

The principles that inform this guidance promote a change of focus from a culture of 'telling' to one of 'listening' when it comes to community engagement. Consistent, relevant, open communication between all parties is vital, and there is an expectation for organisations to do more.

- 'Community' refers to a group of people who share a common place, a common interest, or a common identity. There are also individuals and groups with common needs. It is important to recognise that communities are diverse and that people can belong to several at one time.

- 'Engagement' covers a range of activities that encourage and enable people to be involved in decisions that affect them. This can range from encouraging communities to share their views on how their needs are best met and influence how services should be delivered, to giving communities the power to inform decisions and even provide services.

2.2 The case for community engagement

Effective and ongoing engagement brings many benefits, including:

1. Organisations hear new ideas and understand all the issues for communities, creating opportunities to identify sustainable solutions to service challenges
2. Communities, especially vulnerable and seldom-reached groups, are connected and engaged with services, improving access to care services and health outcomes
3. Improved public confidence and less resistance to change due to better understanding of the reasons for change
4. Reduced risk of legal challenge resulting from concern about the process of engagement

Other important considerations

Co-production - The involvement of people in the design of care services should be central to all community engagement activity. Co-production is defined by the Scottish Co-Production Network as the process of active dialogue and engagement between people who use services and those who provide them. Co-production requires people to act together on an equal basis, contributing their lived experience, skills and ideas about what works to make our communities better. By adopting a Co-production approach, decisions affecting people are made with them, not for them.

Clarity of purpose - It is important, from the outset, to be very clear about the reason for engagement. The issue under consideration may be better suited to formal consultation, or another approach to gathering community views.

Consultation - Consultation also forms an essential element of structured engagement and participation plans, for any change process being considered, as having a defined beginning, middle and end: it might be part of an ongoing period of engagement, but it is a process in its own right. Its remit should be finite and the scope for stakeholder input and influence should be clearly stated.

There is a specific requirement for NHS Boards and Integration Joint Boards (for delegated health services) to formally consult on issues which are considered major service change – the process for that has not changed. See 'Part 5 – Governance and decision-making'

Part 3 – When to use Planning with People

'Planning with People' applies when decisions are being made about the planning or development of all care services, including temporary service change [8]. From large-scale plans to local initiatives, it can be applied in any context where community engagement might inform service planning. (For further detail on all aspects of service change, including temporary, regional and national, please see 'Part 5 – Governance and decision-making').

The guidance complements and supports existing local engagement plans, providing a foundation of shared principles that NHS Boards, Integration Joint Boards and Local Authorities should use to meet specific needs. It intends to further benefit those experienced in community engagement whilst also providing a comprehensive framework for those new to the field.

Organisations involved in developing integrated care services in Scotland must follow relevant aspects of the guidance as they plan future engagement activities.

Key steps in the community engagement process that should be followed in any engagement cycle are outlined below. Further information is highlighted in relevant 'Supporting Information', Annex B.

3.1 Service change or re-design

[8] 'temporary change'- e.g., including those that are time limited (temporary), or trialled through a pilot initiative, which will have an impact on the way in which people access or use services.

NHS Boards and Integration Joint Boards have a statutory duty to involve people and communities in the planning and development of care services, and in decisions that will significantly affect how services are run.

Service change can occur at local, regional and national level and in degrees of scope. It can involve reviewing existing services and planning new services, or it may be consulting people on changes to the way in which services are delivered.

It is essential that **all** planned service change or design, including temporary arrangements, must be communicated clearly and at the earliest opportunity, to the people affected potentially by the service.

3.2 Collaborative working / partnership

NHS Boards, Integration Joint Boards and Local Authorities should explore the opportunities for joined-up engagement activities. Where a number of organisations are undertaking community engagement in a local area the engagement activity should be aligned, where possible. This can help reduce 'engagement fatigue' among communities.

Organisations must work collaboratively to draw on their existing collective expertise and infrastructures to support community engagement. For example, there will be parts of NHS Boards and Local Authorities with a strong track record of engaging with specific communities, e.g., third sector, and this knowledge should be shared.

3.3 Self-evaluation

Before embarking on the community engagement improvement journey, it is important for organisations to assess objectively how they currently involve and engage with people.

Self-evaluation is central to continuous improvement. It enables organisations to reflect on past and current engagement activity to help identify what they do well and what they need to do better. A completed self-evaluation will focus on outcomes rather than activities including a description of the impact of engagement, changes made as a result of feedback, or information on how potential impact is being monitored.

A self-evaluation tool has been developed by Healthcare Improvement Scotland and the Care Inspectorate. The tool is part of the Quality Framework for Community Engagement & Participation.

Further details on the Quality Framework can be found in ‘Part 5 – Governance and decision-making’.

Part 4 – How to use Planning with People

NHS Boards, Integration Joint Boards and Local Authorities must engage with the people and communities they serve following the principles set out in the National Standards for Community Engagement.

The National Standards for Community Engagement are a set of clear principles that describe the main elements of effective community engagement. The standards are not designed to replace existing community engagement or participation frameworks. They are intended to act as a benchmark for best practice and are helpful for organisations across public, third and private sectors to reference during community engagement and user involvement.

The engagement cycle illustrated below is underpinned by principles of the National Standards for Community Engagement, and should be followed in order to demonstrate good practice. Each stage is important and should be applied proportionately to the scale of the activity and level of change proposed.

Engagement Cycle

Identify the issue

Agree a clear purpose to identify engagement objectives, anticipate outcomes, and to help determine the scope of the engagement. There should be clarity and a shared understanding of the objectives at the outset to help shape the process and identify the best methods to reach people and communities. Project goals may evolve as engagement progresses, but they are necessary to keep the process focused.

Identify stakeholders who may be affected by the issue

Stakeholder mapping is important to identify all groups and individuals within the community who may be affected, or who might have an interest in the proposal. Existing networks can help to identify potentially affected people, including those who do not find it easy to share their views. Recruiting representatives of communities to the engagement planning team at the earliest possible stage will help to inform the process and ensure an effective approach.

Plan engagement

Identifying the best approaches to reach the people whose views need to be shared is vital. *All steps in the cycle*, including an early EQIA, as well as an evaluation of the project's development so far, should be considered to ensure an inclusive approach from the outset. By involving community representatives, providing any support they may require, will help to encourage the flow of ideas and suggestions, resulting in better engagement and robust and sustainable outcomes.

Engage those potentially affected

Every effort should be made to engage with the right people throughout planning, development and options appraisal of potential options or models. There are many different engagement methods and no one method will suit all engagement purposes. A range of methods should be considered at the planning stage. This ensures that all views are heard and considered.

Evaluation

It is important to carry out evaluation throughout the engagement process to ensure that outcomes set at the beginning, are being met. On-going evaluation also demonstrates that people are being listened to by adapting the approach where appropriate. Evaluation can also identify areas for improvement and will help you understand what works and what doesn't. All information gathered from the engagement process should be captured and evaluated to support future learning.

Feedback and decision making

It is important to keep participants informed about a project's development throughout the engagement cycle and to encourage on-going feedback. This helps to improve project and programme management by supporting two-way communication, as well as continuous review and reflection. It also helps to monitor progress towards the goals outlined at the planning stage and improves accountability by fully reporting what is being done and what is being achieved. Throughout the engagement process, decisions will need to be made and community representatives must be involved so that robust, evidence-based and person-centred outcomes are achieved. When engagement activity reaches conclusion, it is the responsibility of NHS Boards, Integration Joint Boards and Local Authorities that must approve or reject recommendations. The quality of the engagement process should be taken into account by decision makers.

4.1 Identify the issue

The objective of all care service change should be to achieve an improvement in the quality, safety and sustainability of person-centered services.

Agreeing a clear purpose to identify engagement objectives, anticipate outcomes and determine the scope of the engagement, must be the first step of engagement planning. Project goals may evolve as engagement progresses, but they are necessary to keep the process focused.

Sometimes the purpose of engagement is clear, as it is the result of an identified issue. In other cases, communities will raise issues that matter to them and they must be heard. Regardless, the remit of the engaging organisation should be finite and the scope for stakeholder input and influence should be clearly stated. It is important to explain clearly the process of engagement, including how and when decisions will be made, to allow people[9] to understand how their involvement will be taken into account.

Organisations should consider using current / recent data to help provide clarity, e.g. use existing feedback to gather together and review patients', service users' and carers' experiences and expectations and take this into account in informing service review.

It is important to involve community representatives in engagement planning from the outset. As part of the planning team, they can help to inform the design of an inclusive process.

Consider:

- What are the challenges you want engagement to address?
- What would you like engagement to achieve?
- What level of engagement is considered proportionate?
- Who will be making final decisions?

4.2 Identify stakeholders

'Stakeholder mapping' or identifying the people who have an interest in, or who are potentially affected by the design /re-design of a service, is an essential part of effective communication and engagement. Stakeholders can be internal, such as members of your organisation's staff (e.g., hospital managers and clinicians) or external, such as patients, carers, the general public, third sector and community groups.

Existing networks can help to identify potentially affected people, including those who do not find it easy to share their views. Support for stakeholder mapping may come from community groups, localities, third sector organisations or Community Councils. Identifying and building relationship with key individuals, who can act as links for information-sharing makes a huge difference.

An initial EQIA should be carried out to ensure an inclusive approach at this early stage in the engagement process. This is the right time to ensure the right people are involved.

Equality Impact Assessment (EQIA) – in brief

[9] The word 'people' should be interpreted to refer to health service users, patients, staff, members of the public, carers, volunteers, and the voluntary organisations that represent them.

Not everyone will identify themselves as 'stakeholders', so organisations need to ensure they have fully considered everyone who may have an interest in a particular matter. Wider impact assessment, including Equality Impact Assessments, are discussed in section 4.4, however, organisations should consider carrying out an EQIA at this stage to ensure that all potential stakeholders have been identified.

Individuals, groups and communities that may have an interest or be affected by the proposed changes should include:

- Patients and people who may be directly affected by change, including family members and carers
- Groups or organisations who support people who may be affected
- Health and social care staff who deliver services being considered for change
- Managers of services being considered for change
- Members of the local community who may not be affected directly but have an interest in potential changes, including the media
- Elective representatives and government officials

It is essential to involve people in this exercise, including members of the public, to ensure the list is inclusive and considers everyone who may have an interest.

Not all stakeholders will want to be engaged in the same way, so it is important to identify their needs to determine what engagement activities might be required, and at which stage of the project.

Healthcare Improvement Scotland has developed a range of supporting tools to support the process HIS: Stakeholder Identification.

Consider:

- Who is directly impacted by this work?
- Who is indirectly impacted?
- Whose engagement is essential?
- What are the key issues or areas of interest?
- What is the level of public interest?
- Who are the key contacts?

Don't forget to evaluate – it is important to evaluate continuously, not just at the end of the engagement process. Evaluation should be prioritised and factored into the initial plan for engagement and implemented throughout.

Once stakeholder analysis is complete, it may be necessary to revisit the original objectives of the engagement and review any negotiable and non-negotiable goals.

In time, effective engagement should become routine, with fewer decisions being challenged and referred for review, which can carry significant costs.

Trusted and open dialogue achieves:

- Clear communication and information sharing to achieve mutual understanding of challenges
- Agreement about what is out of scope - the more non-negotiable elements there are, the less likely members of the community will want to participate
- Realistic expectations and reduced risk of conflict or disappointment

4.3 Plan engagement

People and communities who may be affected by a proposed service development or change should be involved at the earliest opportunity and throughout the development of the engagement plan. It is vital that the best approaches for engaging with individuals and groups are identified. This will help to ensure that views are shared, and ideas encouraged. This will result in better engagement and robust and sustainable outcomes.

Timeframes and budgets

The length of time it will take to engage the community, and the budget required, is dependent on a range of factors, including the level of impact, level of public participation required, and the community engagement tools and techniques chosen for each stakeholder group. The higher the level of impact and more stakeholders there are, the more time and resources will need to be allocated to community engagement. Existing stakeholder feedback should be taken into account when developing the materials for engagement.

Legislative requirements and timeframes which may apply should also be considered. Timeframes must take into account key events such as school holidays, public holidays or religious festivals. These should be avoided to maximise people's ability to participate.

Resourcing engagement

To engage effectively, organisations must be committed to supporting and improving the participation of people. That means dedicating resources to engagement activity, which may include:

- Engagement and inclusion champions – senior staff to promote and support meaningful engagement and inclusion. Executives and Board non-executives need to understand why engagement is essential and must ensure that engagement is undertaken effectively. Organisational barriers that could hinder or impact negatively on engagement, should be identified and addressed by effective leadership.
- Engagement and inclusion leads – members of staff who know how to help individual services to reach communities and access any support that may be required.
- Skilled staff – the right number of skilled staff ensure that meaningful engagement activity is conducted in depth, monitored and evaluated. Training may be required.

- Dedicated budget – there are costs associated with community engagement, depending on the scale. Realistic budgets have to be agreed.
- Sufficient time – effective engagement cannot be rushed. Adequate time is required to reach affected community members, and flexible and innovative approaches may be required.
- Collaboration – organisations should embrace partnership working to help promote efficiency and effectiveness of engagement.

Additional support

Depending on the capacity within organisations and the scale of the engagement activity, it may be appropriate to procure the services of specialist providers to deliver some services.

Consideration must be given to whether this a 'quick fix' option, potentially less effective than using existing methods and working with people who are known to the community. Alternatively, independence of the organisation can be an advantage if there is community mistrust.

Any independent or external contractors will be expected to follow this guidance and to adhere to its principles.

There is no handy formula to work out what an engagement project might cost. Each element has to be assessed separately to project an accurate budget.

4.4 Impact assessment

The Scottish Government: Health and Social Care Standards set out what we should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone; to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld.

Impact assessment examines how policy or service design proposals may affect different communities taking into consideration equality, human rights, sustainability and environment. Impact assessment should inform and be an integral part of engagement plans, which should also make it clear which assessments have been identified and how engagement will inform these.

Healthcare Improvement Scotland has developed a range of supporting information to help guide organisations through this important key step on the engagement journey, HIS: Integrating Service Change and Impact Assessment

Equality Impact Assessment (EQIA)

Nobody should be treated unfairly because of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation or any other status. These are known as 'protected characteristics'.

Planning with People

The Equality Act 2010 and Human Rights Act 1998 should be considered as early as possible to help identify people and groups who should be involved, as well as highlight any potential barriers or imbalance of power that may need to be considered.

Undertaking an Equality Impact Assessment (EQIA) helps to identify potential disadvantages and offer an opportunity to take appropriate actions to remove or minimise any adverse impact. People who face the biggest barriers to realising their rights should be prioritised when it comes to taking action.

Fairer Scotland Duty

The Fairer Scotland Duty (The Duty) came into force in April 2018. The Duty seeks to tackle socio-economic disadvantage and reduce the inequalities that are associated with being disadvantaged. It places a legal responsibility on named public bodies in Scotland to actively consider how they can reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions. The Fairer Scotland Duty guidance for public bodies should be consulted for advice on undertaking assessment – Scottish Government: Fairer Scotland Duty: guidance for public bodies

Island Communities Impact Assessment

An Island Communities Impact Assessment (ICIA) should also be considered were relevant, to ensure improved outcomes for island communities. This is particularly relevant when planning regional or national services. The Island Communities Impact Assessment guidance should be consulted for advice before undertaking assessment – Scottish Government: Island Communities Impact Assessment guidance (and tools)

4.5 Engage people potentially affected

Choosing a method, or combination of methods, for engaging both digitally and/or in person, is a critical step in the planning process.

Organisations have adapted their approaches to engagement and are using digital technology, including social media, more than ever before. Although digital technologies will not meet everyone's needs, a growing number of people find digital engagement easier.

However, organisations should consider the appropriateness of a 'digital-first, not digital only' approach to engagement. The methods and medium used should take into consideration the needs of the people you are trying to reach and the topic of engagement. While the use of online engagement has increased, it should not replace all face-to-face approaches. There will continue to be a role for traditional engagement, as this type of activity allows for deliberative engagement and building trust over the long term.

Healthcare Improvement Scotland has completed an HIS Equality Impact Assessment of a digital-first approach to community engagement which will be of value in planning and designing such activity.

Planning with People

Healthcare Improvement Scotland has produced Engaging Differently for digital engagement during the pandemic. HIS Engaging Differently

Healthcare Improvement Scotland has also developed the HIS Participation Toolkit to support organisations to select the most appropriate methods of engagement.

'Our Place' has developed the Place Standard assessment tool. It is useful in helping generate the discussions required to understand the assets of a place and ensuring the experiences of people living in a particular place are captured, valued and integrated into the heart of decision-making processes.

Options appraisal

Organisations need to consider a wide range of options to decide what care services to provide for their communities / local populations, and how to best deliver them. Local people should be involved in developing options that are robust, evidence-based and person-centred.

Engagement plans should consider how and when an options appraisal will be used, what will happen with the outcome, and how engagement will influence the selection of options that will then be consulted on.

There may be occasions where the number of practical options is limited, for example, by requirements to comply with national policy or legislation. Where this is the case, the option development process should still be used to involve potentially affected people and communities, and to seek to achieve a consensus around the limited number of practical options.

> If there are areas that the engaging organisation believes cannot be influenced, for instance safety, working practices, national policy decisions or budgetary restraints, they must be clearly explained. Any such limitations should be evidenced, and organisations receptive to challenge over scope. It is important to be ready to revisit assumptions or decisions following discussions with the community, or the emergence of new evidence.

Healthcare Improvement Scotland (HIS) has produced an Options Appraisal guide HIS Options Appraisal Guide

By this stage, you should have considered:

1. The scope, context and improvement sought
2. Identified the people and communities potentially affected.
3. Budget, timeline and resources required
4. Skills of team and their availability to lead events at times and in locations to maximise attendance

People's needs will vary. Involving community representatives in the planning process will make it easier to choose appropriate engagement methods.

Also consider:

- Given the timeframe, budget and resources which engagement technique(s) might work best?
- What are the strengths and weaknesses of these?
- Will the people to be engaged feel comfortable with this approach?
- Will it reach the target group?
- Will it help to achieve the stated improvements sought?
- Is the information provided balanced, written in plain language and easy to understand.
- Does it require to be translated into other languages?
- Are updates and feedback provided regularly and made widely available?
- Is all the information co-produced?
- Do people have the information and support they need to effectively participate in the process.
- Local people have been involved in developing and considering a wide range of options to identify sustainable solutions; heard new ideas and understood all the issues.

Everyone needs access to accurate information in order to engage effectively. It should be co-produced, presented clearly, and made widely available. If there are reasons why information cannot be shared (for instance it would allow identification), that must be clearly explained.

For some people, the headline facts are sufficient, while others prefer to analyse raw data. So, it is important to present background information in different languages and formats – online, on paper or by another means – on request.

4.6 Evaluation

It is important that engagement activity is continually assessed and that evaluation arrangements are part of the initial plan for engagement. The key to successful evaluation is to evaluate progress and act on lessons that emerge during the process.

Evaluating an engagement process will help you to consider if it has met the outcomes set out at the beginning of the project, and the difference that engaging with communities has made. It demonstrates that you are listening to people and flexible in your approach to engagement. Evaluation can also identify areas for improvement and will help you understand what works and what doesn't. All information gathered from the engagement process should be captured. That can be done by:

- Surveys
- Reports
- Themes
- Audio and/or video recordings
- Graphics

Consider:

- Did we meet our objectives?
- Did we reach all the people we needed to reach?
- Did we develop our knowledge of communities and gather useful data?

Undertaking evaluation helps to improve your organisation's community engagement processes, and supports learning for future projects.

Healthcare Improvement Scotland has developed an HIS Evaluation guide and toolkit for health and social care practitioners. A partner to the HIS Participation Toolkit, the evaluation guide is a stand-alone support for assessing the way in which engagement has been undertaken (process) and the results of that activity (outcomes). It does not set out to be a definitive guide to evaluation, but aims to provide resources, references and tools to help you to develop your own approach to evaluation.

Any methods chosen should be continually reviewed throughout the engagement activity and changed or adapted based on community feedback.

4.7 Feedback and decision-making

It is important to keep participants up to date and informed about the engagement process as it develops.

Throughout the engagement cycle, decisions will need to be made and community representatives must be involved, so that robust, evidence-based, and person-centred outcomes are achieved. When engagement activity reaches conclusion, it is the responsibility of NHS Boards, Integration Joint Boards and Local Authorities to approve or reject recommendations. The feedback received and the quality of the engagement process will be taken into account.

When decisions are reached, speedy information sharing should be provided as a priority explaining the impact of community engagement on the outcome.
It is important to welcome critical challenges and respond to them by demonstrating a willingness to answer questions openly and to consider adapting plans according to emerging evidence.

Organisations must explain clearly the rationale for decision making and the impact this has had on the outcome. Transparency is essential to generate trust.

The feedback stage is of vital importance in maintaining public confidence and trust in the integrity of the involvement process. Stakeholders who take part in a consultation must be given feedback to:

- inform them of the outcome of the consultation process and the final agreed development or change.

- provide a full and open explanation of how views were taken into account in arriving at the final decision.
- provide reasons for not accepting any widely expressed views.

Privacy and confidentiality must always be observed. Reporting and feedback must be anonymised unless consent has been given by individuals to publish or release their personal information.

Part 5 – Governance and decision-making

NHS Boards, Local Authorities and Integration Joint Boards are required to make decisions about how any proposed service changes and developments should be taken forward.

Although there are separate processes each must follow, they are the public bodies that must decide on proposed service changes and developments. Overall, the decision-making process must be transparent and clearly demonstrate that the views of communities have been taken into account. Organisations should ensure that they have evidence to assure these principles as practically embedded and effectively implemented in practice.

Healthcare Improvement Scotland (along with the Care Inspectorate) has statutory responsibilities to assure and support improvement in the quality of care services.

Additionally (and as outlined earlier in this guidance), Healthcare Improvement Scotland ensures people and communities are engaged in shaping health and care services. It has a legal duty to support, ensure and monitor the discharge of health bodies' duties in respect of public involvement, including quality assurance of changes to delegated health services being made by Integration Joint Boards.. This legal duty has been operationalised by the establishment of the Scottish Health Council, within the corporate governance structure of HIS, as a sub-committee of the HIS Board.[10]

When an NHS Board or Integration Joint Board proposes a service change, it should work with Healthcare Improvement Scotland, to ensure that people and communities potentially affected have the information and support they need to play a full part in the consultation process. Where appropriate, NHS Boards and Integration Joint boards should collaborate in the delivery of these duties.

Where a proposed service change will have a major impact on a patient or carer group (including where changes are proposed by Integration Joint Boards), members of equalities communities or on a geographical community, Healthcare Improvement Scotland can advise on this. Where a proposed service change being considered by an Integration Joint Board has a clearly identifiable health component that is being

[10] The NHS Quality Improvement Scotland (Establishment of the Scottish Health Council) Regulations 2005 https://www.legislation.gov.uk/ssi/2005/120/regulation/2/made

provided under delegated authority from an NHS Board, Healthcare Improvement Scotland has a duty to undertake quality assurance of engagement.

This approach reflects the requirements of guidance and advice supporting the implementation of the Public Bodies (Joint Working) (Scotland) 2014 Act and in particular, the expectations on partners across the health and social care landscape, and their stakeholders to focus together on their joint responsibility to improve outcomes for people.

This approach is also recommended as best practice in corporate governance as outlined in Scottish Government: The Blueprint for Good Governance in NHS Scotland (second edition)(sections 4.26 and 4.27) in recognition of the key role of Healthcare Improvement Scotland, in supporting NHS Boards and Integration Joint Boards to meaningfully engage with people and communities to shape national policies and health and social care services; and the requirement on NHS Boards and Integration Joint Boards to collaborate with Healthcare Improvement Scotland in support of the statutory duty to review existing services and planning new services or care pathways, ensuring appropriate engagement with local communities throughout changes to services.

NHS Boards should be assured that actions and decision-making in respect of changes to services (proposed by them or as a consequence of changes proposed by stakeholders) reflect the requirements of the 'Engaging Stakeholders' section of The Blueprint for Good Governance in NHS Scotland (Second Edition).

The decision-making process for NHS major service change is unchanged. Scottish Ministers will continue to make the final decision regarding whether to approve proposed service changes by NHS Boards that will have a major impact on people and communities.

NHS Boards will continue to make most decisions about how health services should be delivered locally. The outcome of community engagement and other relevant information must inform these decisions.

Integration Authorities were established under the Public Bodies (Joint Working) (Scotland) 2014 Act and include Integration Joint Boards and, in the case of Highland, lead agency partnership agreements. The Act does not identify a process for engagement that must be adhered to for community engagement however Planning With People applies to delegated health services. It recognises that Integration Joint Boards will have the local knowledge to undertake engagement that best suits their local population in line with Planning With People
Local Authorities are responsible for the provision of a wide range of public services. There is no requirement for these bodies, led by elected councils, to adopt a particular decision-making and scrutiny structure. Each council decides the most appropriate structure suited to its particular circumstances and must be transparent about decisions made and the quality of services provided.

While different organisations have different ways of working, and have different statutory functions to fulfil, the Community Empowerment (Scotland) Act 2015 requires equal opportunities duties to be met when it comes to participation.

Local authorities work with other public bodies to deliver services and are required by law to deliver an integrated approach, along with care providers, through Health and Social Care Partnerships They are expected to work together to develop common engagement approaches.

5.1 The Quality Framework for Community Engagement and Participation

Healthcare Improvement Scotland and the Care Inspectorate have developed a Quality Framework for Community Engagement and Participation. The Quality Framework is designed to support self-evaluation and improvement activity in relation to routine engagement; specific engagement activities; and organisations' internal governance systems for community engagement activity. It is not intended to be used for individual service changes.

The Quality Framework should be used to identify and support improvement in community engagement practice, as well as identify and share good practice. It is not intended to be used for individual service changes The Quality Framework supports self-evaluation in three areas:

- Ongoing engagement and service user involvement
- Involvement of people in service planning and design
- Governance/Organisational Culture and Leadership

The Quality Framework should be used as a guide for improving the quality of engagement. It will help NHS Boards, Local Authorities and Integration Joint Boards to understand what good engagement involves and how it can be evaluated and demonstrated.

The Quality Framework is an improvement tool, developed in collaboration with, and for the use of health and social care providers. It has been designed to support reflection and self-evaluation, which is an important first stage in any quality improvement journey.

Organisational self-evaluation

It is important to understand how well your organisation is currently engaging. Senior leaders within the organisation should support the use of the Quality Framework's self-evaluation tool, to provide assurance to their Board members on the quality of their community engagement activity. Health and care services should complete a self-evaluation, which should focus on outcomes rather than activities. This could include a description of the impact of engagement, changes made as a result of feedback, or information on how potential impact is being monitored.

That can be done systematically, efficiently, and quickly using a range of methods.

You might want to know:

- What role do communities have in your organisational structures? How do people respond when you communicate with them? Are levels of public satisfaction and trust, high or low?

- How does your organisation view engagement? Is it regarded as important and is there a shared view of what it means? Has there been a culture of tokenism?
- Has engagement influenced decisions?

Assessing the view of all stakeholders is essential and to understand the quality of your engagement activity you need to know the views of the people who participate or have participated. Feedback should be sought from patients, the public, service users, family, carers, staff, communities, third sector and wider stakeholders. This can be done via surveys and interviews, or data reviews and reference to good practice. Following the self-evaluation process will help to identify good practice and show where improvement is required.

Healthcare Improvement Scotland can discuss how best to apply the framework to an organisation. Further information on the Quality Framework for Community Engagement and Participation, as well as a Guide to self-evaluation can be found in the supporting information section at the end of this section.

5.2 Service change

NHS Boards and Integration Joint Boards have a statutory duty to involve people and communities in the planning and development of care services, and in decisions that will significantly affect how services are run.

It is essential that all planned service change or design, including temporary arrangements, must be communicated clearly and demonstrably influence engagement at the earliest opportunity, to the people who may be affected by the proposal.

When an NHS Board or an Integration Joint Board proposes any service change, it must work with Healthcare Improvement Scotland; to ensure that the Board is engaging proportionately; and that local people and communities potentially affected have the information and support they need to play a meaningful part in the process.

Healthcare Improvement Scotland has produced flowcharts that outline the key stages for both non-major change (which is ultimately decided locally) and major change (which ultimately requires Ministerial approval for NHS Boards). These can be accessed at: Overview of Engagement Process.

NHS Boards and Integration Joint Boards will continue to make most decisions about the services that should be delivered locally. The outcome of community engagement must inform these decisions. HIS provides a range of information and support to NHS Boards on public engagement elements of all service change; as noted, the vast majority is non-major, so does not directly involve Scottish Ministers.
Further information on major service change is copied at sections 5.3 and 5.4 below.
Links to previous major change reports can also be found on the Healthcare Improvement Scotland website: HIS major service change reports.

Changes to services provided by independent contractors

Services delivered by General Practitioners (GPs) etc., through Primary and Community Care are delegated services to Integration Joint Boards. While services are provided by independent contractor GPs, dentists, optometrists and pharmacists, Boards are still required to adhere to this guidance when they are considering changes to the contractual, and other, arrangements for primary care services.

While independent contractors are responsible for running their own practices they are also expected to engage in a proportionate way with their patients and relevant community groups, when planning any changes to the way they deliver services.

Temporary service changes

Some changes are made on a long-term or permanent basis, while others are provided on a temporary basis, due to the need to take immediate short-term action to deliver services, for example:

- Infection prevention and control measures (environmental concern, outbreak of infection/virus, either within a limited or confined space such as a ward or wider community outbreak)
- Interim changes, as a result of staffing pressures that could have an impact on the configuration of services.
- Pilot projects where patients have an expectation that this is part of service (patients do not differentiate between pilot projects and day to day service delivery, they just see that a service has been withdrawn)

Temporary changes also need to be implemented with due regard to this guidance and should take account of the following:

Understanding impact: identify those people who currently use, or could potentially use, the service(s) that have undergone urgent change, and ask them about potential impacts and potential mitigations moving forward. This information will support understanding and response to unintended consequential impacts of change.

Communicating clearly: ensure that communications are clear, transparent, and accessible, and include information on how to access services and the support available to people remotely or in person. Communications may give an indication of how the service is being evaluated and indicative timescales for the temporary arrangement being in place. It may be helpful to consider that communication can be undertaken with service users and their carers face-to-face when they interact with the service, as well as digitally or by post with others.

Using feedback: seek on-going feedback from people and communities on the interim and urgent changes and consider how this can be used to inform current practice and future service design. Feedback may be gathered from people when using services, at the point of service delivery, through surveys (postal or digital) or via Care Opinion: Care Opinion, what's your story?

Agree the approach: for those changes that were introduced on a temporary basis, due to service pressures (such as part of the response to the COVID-19 pandemic), NHS Boards or Integration Joint Boards should contact Healthcare Improvement Scotland to discuss the approach to move forward in line with national guidance and policy on community engagement and participation. The period of temporary change may have enabled the collection of valuable service user experience and evidence to support a case for change.

5.3 Major Service Change

The established principles and requirements for major service change decision-making process for NHS Boards, remain unchanged from those outlined in CEL 4 (2010). As noted above, the process is set out in the Healthcare Improvement Scotland flowcharts at Overview of Engagement Process.

Healthcare Improvement Scotland has developed guidance to help identify major service change. HIS: Guidance: Identifying major health service changes.

NHS Boards and Integration Joint Boards (for delegated health services) can categorise proposals as major service change themselves, as informed by the above Healthcare Improvement Scotland guidance, and then follow the established process as set out in the relevant flowchart (and at section 5.4 below).

NHS Boards and Integration Joint Boards should consider a range of issues to help identify major service change. There are other factors that will be important drivers for change, including workforce issues and clinical standards. However, the key issues listed below must be taken into account (as a general rule, the more issues that apply, the more likely it is that a service change should be considered major):

- The impact on patients and carers
- Changes in the accessibility of services
- Emergency and unscheduled care
- Public or political concern
- Alignment with national policy or professional recommendations
- Changes in the method of service delivery
- Financial implications and consequences for other services

Nonetheless, NHS Boards and Integration Joint Boards must contact Healthcare Improvement Scotland at the outset to try and reach a shared understanding on the required approach in each specific case.

Healthcare Improvement Scotland can offer a view on whether proposals are major or not based on the completed template and associated discussions.

In the absence of an agreed consensus (i.e. following discussion, should Healthcare Improvement Scotland consider the proposals to be major, whilst the relevant NHS Board or Integration Joint Board does not), the NHS Board or Integration Joint Board should seek a final decision on designation from the Health Sponsorship Division at the Scottish Government.

Responsibility for identifying a major service change

NHS boards and Integration Joint Boards (in collaboration with Healthcare Improvement Scotland) have responsibility for identifying if a potential service change or design proposal should be considered ‘major service change’.

Healthcare Improvement Scotland has developed guidance to help identify major service change. HIS: Guidance, Identifying 'major' health service changes

If considered major service change:

There is a specific requirement for NHS Boards and Integration Joint Boards (for delegated health services) to consult formally on issues which are considered to be major service change.

For any service changes that are considered to be major, NHS boards and Integration Joint Boards (for delegated health services) should not start the consultation stage until Healthcare Improvement Scotland has confirmed that their engagement to that point, has been in accordance with ‘Planning with People’.

Following the public consultation, a full meeting of the NHS Board or Integration Joint Board will then consider the proposals and make a decision. A range of information, including responses to the consultation and a report from Healthcare Improvement Scotland, will help to inform the Board's decision.

Healthcare Improvement Scotland is required to quality assure the process and can provide advice on the nature and extent of the process being considered. The final decision on the way forward, following a consultation, requires Ministerial approval for NHS Boards.

Proposed change affecting two or more NHS Boards or Integration Joint Boards

Where a proposed service change would impact the public in another area, the Board proposing the change should lead the public involvement process. The Board, and any other affected Board(s), should aim to maximise the involvement of affected individuals and communities in the process.

Proposed changes to regional or national services

Proposed changes to regional services should follow the principles set out in this guidance and, as above, the Board proposing the change should lead the involvement process, ensuring that it engages with the public and its wider stakeholders.

Regional Planning Groups are made up of NHS Board staff from across the region, who are working on behalf of the constituent NHS Boards. All proposals and decisions must be referred to individual NHS Boards for consideration and approval.

This means there is a clear responsibility on the Planning Groups to make sure there is effective engagement in the planning and development of service models. The statutory duty to involve people and local communities in the planning and development of services, and in the decision-making process for regional services rests with NHS Boards. Each NHS Board should consider the differential impact of the proposed changes in their local area.

Implications of nationally determined service change

Should a national Health Board (e.g. NHS National Services Scotland) make a decision about a nationally provided service (as opposed to a territorial Board implementing a national decision made by the Scottish Government), the national Board should follow the process set out in this guidance.

However, in terms of who is responsible for both local engagement for a territorial Board implementing a national decision made by the Scottish Government, and for the assurance of that engagement, the following process will apply.

In cases of nationally determined service change, the Scottish Government will provide written, advance notice to all affected NHS Boards and to Healthcare Improvement Scotland. Scottish Ministers will also alert the Scottish Parliament.

This communication will set out the reasons why the decision is being made on a national basis; and how it has been appropriately informed by meaningful engagement activity consistent with the Scottish Government's *Participation Framework.*

This communication should also prompt a discussion between the affected NHS Board and Healthcare Improvement Scotland: to consider what local action is then required for the NHS Board to fulfil its duty to proportionately engage with local people. This discussion is required to agree the next steps as what is appropriate may differ from case to case, and from area to area; based on the provision and disposition of relevant services in each Board area.

In general, next steps on local engagement for NHS Boards in such cases will fall into two categories: (i) where there is scope for them to influence how the national decision may be implemented locally; and (ii) where there is not sufficient scope for local Boards to inform the service model or location of services. The implications of these categories are set out below.

Where there is scope to influence how the national decision may be implemented locally

In this scenario, a decision has been taken to implement the national service change but there is scope for engagement to influence the detail of how the model is implemented.

The national work would be considered a 'driver' for change and the NHS Board/IJB should contact Healthcare Improvement Scotland and follow the 'Planning with People' guidance. In this scenario, there is scope to influence the nationally defined

service model, but there may still be some constraints on the number or range of viable options for how the model can be implemented. In such cases, the NHS Board/IJB should use the evidence developed by Scottish Government to demonstrate why the options are limited.

Healthcare Improvement Scotland's expectations for local engagement in such a scenario are:

- Public involvement in option appraisal about how the model is implemented, where appropriate, on location and design;
- Wider communication about the process and proposal based on the information received from the Scottish Government (for example, website, social media, newsletter);
- Local Equality Impact Assessment of the involvement process and preferred option(s) for implementing the national model locally – it is good practice to consider this with people who have experience of the service e.g. travel and access;
- Proportionate consultation on local implementation – taking into account impact on people, location;
- Fairer Scotland Duty assessment before decision on local implementation;
- People's feedback is used to inform local decision-making; and
- Feedback provided to people on the decision reached and an explanation of how this decision was made.

Where there is not sufficient scope for local Boards to inform the service model or location of services

In this scenario, a decision has been taken to implement the national service change and there is no scope to influence the local implementation.

Healthcare Improvement Scotland's expectations for local engagement in such a scenario are:

- Share information, in collaboration with Scottish Government, on background and rationale for the changes being made and how this may impact on services locally;
- Offer an opportunity for people to ask questions and respond to these to provide public assurance; and
- Feedback from people should be provided to Scottish Government to ensure their impact assessments (including Fairer Scotland Duty assessments) are updated iteratively.

As emphasised above, in order to ensure local engagement is appropriate, meaningful and proportionate; local Boards should contact Healthcare Improvement Scotland at the earliest opportunity following receipt of a written notice from the Scottish Government of a nationally determined service change to discuss and agree next steps.

5.4 Major Service Change – process

Proposals for major service change in the NHS (including delegated services for Integration Joint Boards) must be subject to at least three months of public consultation. For NHS Boards, Ministerial approval is required.

NHS Boards and Integration Joint Boards should not move to consultation until Health care Improvement Scotland has agreed that the engagement up to that point has been in accordance with the national guidance.

Healthcare Improvement Scotland is required to quality assure the public consultation aspects of the major change process and so can provide advice on the nature and extent of the process being considered.

An inclusive consultation process should encourage and stimulate discussion and debate. While it may not result in agreement and support for a proposal from all individuals and groups, it should demonstrate that the NHS listens, is supportive and genuinely takes account of views and suggestions. Ultimately, NHS Boards and Integration Joint Boards should demonstrate that there has been a wide ranging consultation, which has taken all reasonable steps to take account of differences of view.

Healthcare Improvement Scotland does not comment on clinical or financial issues or the effectiveness of an organisation's engagement with its own staff. It will, however, look to the organisation to provide evidence that the views of potentially affected people and communities have been sought, listened to and acted on, and treated with the same priority (unless in exceptional circumstances) as clinical standards and finance performance.

Healthcare Improvement Scotland will set out its views in its report as to whether the NHS Board or Integration Joint Board has appropriately involved local patients, carers and communities in line with this guidance. Further detailed information on major service change, including links to previous major change reports can also be found on the Healthcare Improvement Scotland: HIS major service change reports.

Following the public consultation, a full meeting of the NHS Board or Integration Joint Board will then consider the proposal/s and reach a decision. A range of information, including responses to the consultation and a report from Healthcare Improvement Scotland on the consultation process, will help to inform the Board's decision.

For major service changes led by NHS Boards

Following the Board decision, the major service change proposal/s must be submitted to Scottish Ministers for final approval. Ministers will take all the available information and representations into account, including the report of Healthcare Improvement Scotland.

The proposals may be approved or rejected by Scottish Ministers. Where appropriate, Ministers may also instruct the relevant NHS Board to conduct further engagement activity.

Once Scottish Ministers have concluded their considerations they will write to the Board to set this out and Parliament will also be notified.

The Board can then be formally assured on the outcome of Ministers' considerations and agree the next steps.

5.5 Integration Joint Board decision-making (delegated health services)

Specific requirements (known as Planning Principles) are laid out for involvement and participation of a range of stakeholders. Integration Joint Boards are required to have as members a carer representative, a person using social care services, a patient using health care services and third sector representatives.

Healthcare Improvement Scotland (HIS) major service change guidance applies when Integration Joint Boards are considering the potential impact on people and communities of any proposed changes to delegated health services to help inform their engagement process.

Each Integration Joint Board should have its own strategy for community engagement and participation, which should be taking place on a regular and routine basis and not just at time of change. Strategies must take this guidance into account.

Strategic Commissioning Planning

Decision-making by Integration Joint Boards takes place within the context of strategic commissioning, and so it is important that community engagement is part of this process.

Strategic commissioning is the term used for all activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services, and working in partnership to put these in place.

There is a duty on Integration Joint Boards to create strategic commissioning plans for the functions and budgets they control, which must be reviewed at least every three years with the involvement of the Strategic Planning Group. This requires close working with professionals and local communities to deliver sustainable models of care and support that are focused on improving outcomes for people.

A key principle of the commissioning process is that it should be equitable and transparent. Therefore, it must be open to influence from all stakeholders, including the community, via ongoing dialogue with people who use services, their carers and service providers.

Planning with People

During the development of their strategic plan, each Integration Joint Board is required to run consultations on various drafts of the document.

The role and minimum composition of a Strategic Planning Group can be found in Strategic Commissioning Plans: Guidance. The Strategic Commissioning Plans Guidance is currently under review and updated guidance is expected to be published in 2023.

It is important that Integration Joint Boards develop agreed communication and engagement plans at an early stage to suit the needs and makeup of their community. Boards should use 'Planning with People' to help develop their approach to engagement.

Strategic Commissioning Plans must be published and it is best practice for Integration Joint Boards to also publish the Strategic Commissioning Plan in easy-read format.

Localities

Another important route for community engagement is through locality arrangements. Each Integration Joint Board divides its geographical area into at least two localities, and the views of people who live there must be taken into account as part of the strategic commissioning process to inform strategic thinking.

Many Integration Joint Boards have well established locality planning forums that bring together professionals and local community representatives involved in strategic commissioning planning.

Further information can be found in Scottish Government: Health and social care integration - localities: guidance.

Significant decisions out-with the Strategic Commissioning Plan

Sometimes, an Integration Joint Board must make a decision that would have a significant effect on the provision of an integrated service, out-with the context of the strategic planning cycle. It must then involve and consult its Strategic Planning Group, along with users (or potential users) of the service.

Decisions for specific services and functions

While the Strategic Commissioning Plan provides the direction of travel and ambition for the Integration Joint Board, decisions about service change, service redesign, and investment and disinvestment may be made at regular meetings. These are open to members of the public who may attend but not participate, with papers and minutes available online.

Alongside this, Integration Joint Boards are required to undertake ongoing engagement and feedback with the local community, so that the views of service

users, their carers, and service providers are taken into account in this continuous process of decision-making. The form of this engagement will vary between Boards and should reflect the makeup of the local community.

5.6 Local Authority decision-making

A full council meeting is the key governing body of a Local Authority, where councillors debate and take key decisions. The Local Government (Scotland) Act 1973 allows Local Authorities to devolve most decision-making to committees, sub-committees or council officers. Individual councils set out their arrangements for delegation to committees in their internal governance documents.

Legislation has been introduced to give communities a stronger say in how public services are planned and provided and to allow communities to have a greater say in local decisions and in scrutinising local services.

The Local Government (Scotland) Act 2003 gave a statutory basis to partnership working between all agencies responsible for delivering public services in an area, including Health Boards. This Act established the role of councils in facilitating the community planning process, at the heart of which is 'making sure people and communities are genuinely engaged in decisions made on public services which will affect them'.

The duty to involve people in the design and delivery of services has increased since the publication of The Christie Commission on the future delivery of public services (2011) and subsequently the enactment of The Community Empowerment (Scotland) Act 2015.

Community Planning Partnerships

There are 32 Community Planning Partnerships across Scotland, one for each council area, which represent all the services that come together to take part in community planning. Each focuses on where partners' collective efforts and resources can add the most value to their local communities, with particular emphasis on reducing inequality.

Annex A – Supporting information resources

In addition to national policy, each NHS Health Board, Integration Joint Board and Local Authority will have local policies on communication and engagement that should be referred to.

This guidance takes account of relevant legislation, including:

NHS (Scotland) Act 1978 as amended by the NHS Reform (Scotland) Act 2004

Equality Act 2010

Public Services Reform (Scotland) Act 2010

Patient Rights (Scotland) Act 2011

Planning with People

The Local Government (Scotland) Act 2003 gave a statutory basis to partnership working between all agencies responsible for delivering public services in an area, including health boards. This act established the role of Councils in facilitating the Community Planning process, at the heart of which is 'making sure people and communities are genuinely engaged in decisions made on public services which will affect them'.

The Community Empowerment (Scotland) Act 2015 gave new rights to community bodies and new duties to public sector authorities to help empower communities by strengthening their voices in decisions about public services.

The Islands (Scotland) Act 2018 introduced measures to support and help meet the unique needs of Scotland's islands now and in the future.

The Public Bodies (Joint Working) (Scotland) Act 2014 put in place a requirement for NHS Boards and Local Authorities to work together to deliver integrated health and social care services through Health and Social Care Partnerships.

Principles of Engagement and Participation

A number of standards and principles should be read alongside this guidance to help plan engagement, identify who should be involved and make sure engagement activity is meaningful.

Health and Social Care Standards

Joint Strategic Needs Assessment

Strategic Commissioning Planning

Link Inspectors

Planning Principles The Public Bodies (Joint Working) (Scotland) Act 2014 contains the 'Planning Principles': Planning and delivering integrated health and social care: guidance'

Localities Guidance

Co-production Scotland

Participation Toolkit

Reporting on participation

Engaging Differently

Evaluating Participation Toolkit

Producing a report on findings

Quality Framework for Community Engagement

Scottish Community Development Centre - The National Standards for Community Engagement

National Involvement Network

Principles for Community Empowerment aims to raise awareness of community empowerment and promote such a shared understanding across scrutiny bodies to support high-quality scrutiny of community empowerment.

PANEL principles a human rights based approach to ensure that people's rights are at the centre of policies and practices.

Place Standard a simple framework to structure conversations about place, this tool provides prompts for discussions.

The Scottish Approach to Service Design a framework to guide how to design user-centred public services.

Gunning Principles a strong legal foundation from which the legitimacy of public consultations is assessed.

Principles of Inclusive Communication produced to help public authorities deliver effective, well organised and equally accessible services that provide value for money.

Principles of health and social integration The Public Bodies (Joint Working) (Scotland) Act 2014, sets out 12 principles for health and social care integration.

Right First Time: a practical guide for public authorities to decision-making and the law - second edition, January 2021 Right First Time: a practical guide for public authorities to decision-making and the law - second edition

National health and wellbeing outcomes NHS Boards, Local Authorities and Integration Joint Boards work together to ensure that key outcomes are meaningful to the people they serve.

Visioning Outcomes in Community Engagement (VOiCE) can be used to plan community engagement and service user participation, conduct it effectively, monitor progress and evaluate outcomes.

Christie Report

Scottish Government
Riaghaltas na h-Alba

This publication is available at **www.gov.scot**

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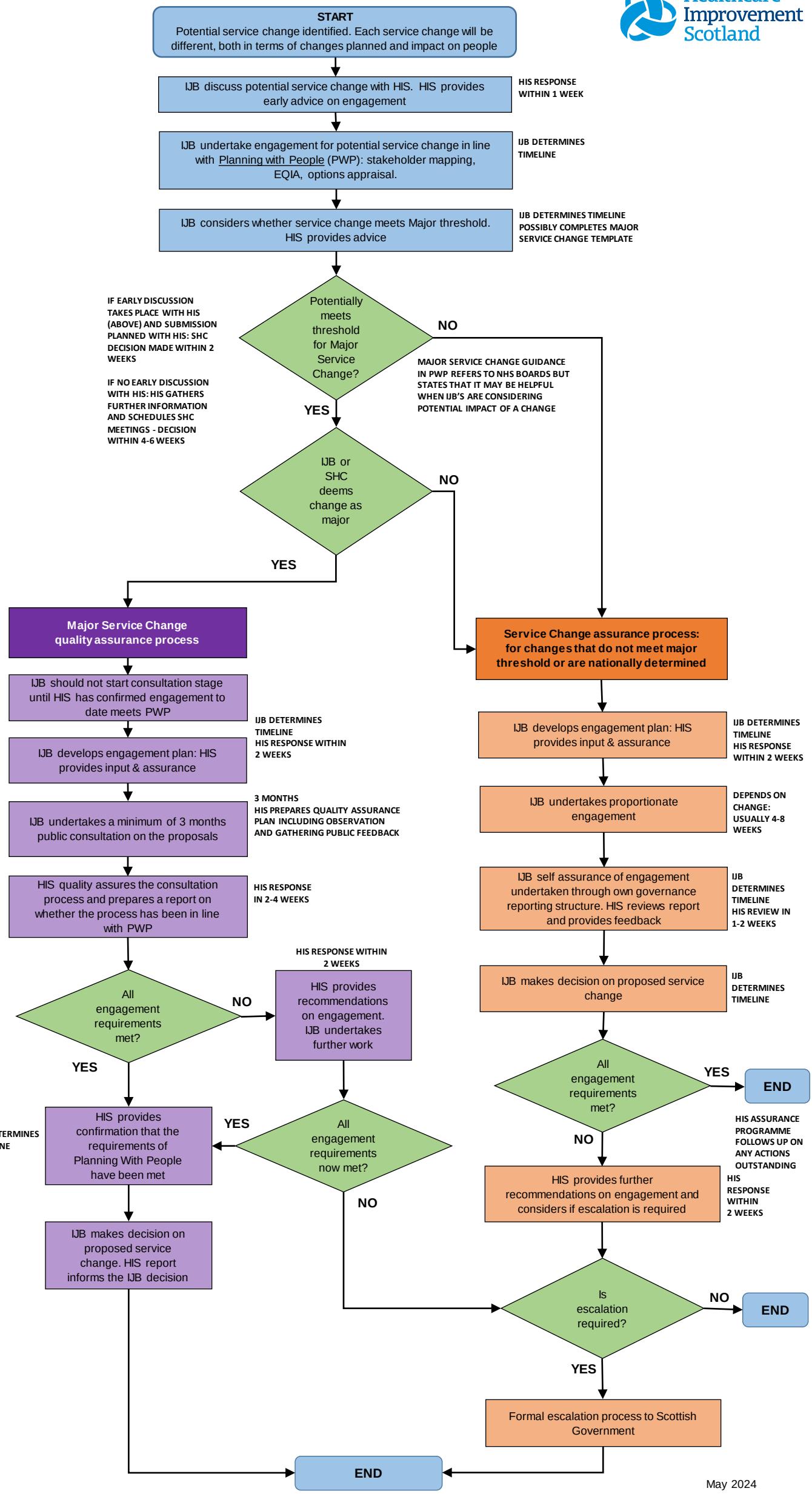
SERVICE CHANGE: OVERVIEW OF ENGAGEMENT PROCESS FOR INTEGRATION JOINT BOARDS

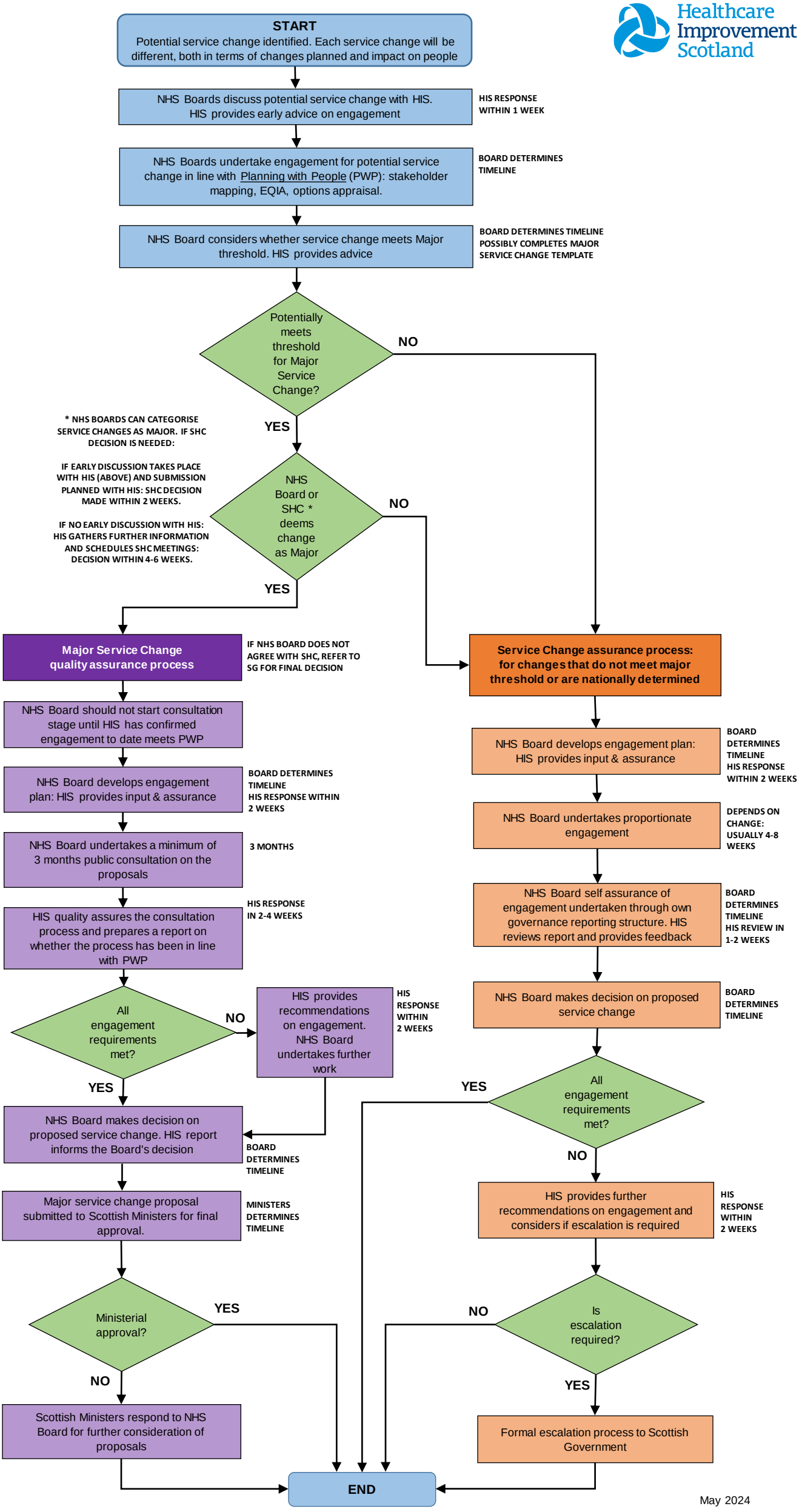
Healthcare Improvement Scotland



May 2024

SERVICE CHANGE: OVERVIEW OF ENGAGEMENT PROCESS FOR NHS BOARDS

Healthcare Improvement Scotland



May 2024

Joint Clinical and Care Governance Committee - 14 June 2024 Minutes

Friday, 14 June 2024 at 09:30 BST

Attendance

Present:
Members: Kirsty Cole, Anna Lamont, Rona Gold, Laura Skaife-Knight, Jean Stevenson, Sam Thomas, Louise Wilson

In attendance: Wendy Lycett, Darren Morrow, Kat Jenkin

Apologies: Issy Grieve and Ivan Taylor

1. Apologies (Presenters: Chair)

   The Chair welcomed members acknowledging the attendance and work done for the additional meeting to ensure the reports were given scrutiny prior to the next Public Board meeting on 27 June 2024. Apologies were received from Stephen Brown, Chief Officer (IJB) and Issy Grieve, Non-Executive - it was noted that Kirsty Cole, Non-Executive was deputising for Issy as a member.

2. Declarations of Interests – Agenda Items (Presenters: Chair)

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

3. Minute of Meeting Held 3 April 2024 (Presenters: Chair)

   The minutes of the Joint Clinical and Care Governance Committee meeting held on 3 April 2024 were approved as an accurate record of the meeting.

4. Matters Arising (Presenters: Chair)

   The Chair referred to two items for updates:
   - Integration of Care Opinion into patient experience framework - the Medical Director confirmed this had been to the Senior Leadership Team.
   - Mental Health Assurance Report - the Chief Executive advised that there is a Mental Health Welfare Commissioning action plan which is reported through the Committee, however following speak up concerns there is a broader piece of work is underway to support the Mental Health Team.

5. Annual Reports

   5.1. Duty of Candour and SAER Annual Report - JCCGC2425-18 (Presenters: Medical Director)

   The Head of Safety, Quality and Risk presented the Annual Report advising members that the Duty of Candour principals are applied to all significant adverse events. She went on to advise that Duty of Candour reporting is a requirement as set out in the Duty of Candour Procedure (Scotland) Regulations 2018, and the report should include the numbers of serious adverse events (SAE) and the numbers of time Duty of Candour (DoC) was applied. It should also

include how we applied DoC and how this process is managed. A template is provided as guidance for NHS Boards to support them with completion of the report.
The Head of Safety, Quality and Risk asked members to note that there remain three open SAE reviews and these will be included in the following year's report, in the same vein that the remaining open SAE reviews from the previous year have been included in this report.
Members were asked to recommend to the Board for approval.
J Stevenson referred to information in the report about the prevalence of pressure ulcers. She asked if it would be possible to have sight on the data, and any improvements that have come as outcomes to complaints, to see if there is improvement . The Head of Safety, Quality and Risk advised that this is something that is under review with a view to reporting through the Integrated Performance Report. The Director of Nursing acknowledged the issues in terms of tissue viability advising members that there is currently dependence on NHS Grampian to support NHS Orkney , however she advised that the business case for a Tissue Viability Nurse has been supported and this is progressing well towards recruitment.
The Director of Public Health asked how confident we are that we are picking up all the incidents that require Duty of Candour in addition to those that are seen as significant adverse events. The Head of Safety, Quality and Risk advised that all incidents that come in through the incident management process are reviewed and those issues that are raised through patient feedback, and act upon these accordingly.
The Chief Executive asked about the governance route for reporting on actions, she noted that the report presented some actions complete, some ongoing and some on track. In addition she asked if there is Orkney Health and Care (OHAC) representation at the Weekly Incident Review Group. The Head of Safety, Quality and Risk confirmed OHAC attendance at the Clinical Quality Group where all action plans are reviewed and not recorded as completed until signed off by the Clinical Quality Group.
Members approved the Duty of Candour Report, for onward submission to the Board.

5.2. Health Complaints Performance Annual Report - JCCGC2425-19 (Presenters: Medical Director)

The Medical Director presented the report acknowledging the comitment to respond to concerns from patients. She went on to note that whilst the main focus of the report is on complaints, the report does acknowledge the positive feedback received.
The Head of Patient Safety, Quality and Risk reminded members that the report is developed to accommodate the KPIs that the Scottish Government set. She went on to say that there has been a drop in the number of complaints, since the last annual report, noting that the highest category is communication.
The Director of Public Health acknowledged the report suggesting the detail gives important insight into the experience of our patients. She went on to ask about accessibility for children and young people -should they wish to raise complaints and concerns. The Head of Safety, Quality and Risk advised of new guidance recently received for managing complaints from children and young people which is being looked at alongside the current complaints policy. It was acknowledged that in implementing Care Opinion, it offers much more accessibility for young people.
The Chief Executive noted the balance between the areas for improvement and those areas of success. She asked for an update in terms of the patient experience surveys that have taken place across the organisation in the last year, asking where they are reported in respect of our internal governance. She also asked that any national surveys that are completed are reported through the appropriate governance structure. The Head of Safety, Quality and Risk advised that work is planned to programme in internal clinical audits and patients surveys, which will be reported through the Clinical Quality Group and Clinical Governance Committee.
J Stevenson, noting the issue in the report about sharing private and confidential information in the Emergency Department (ED) reception, advised members that this is an area where she

receives lots of complaints from the public. The Director of Nursing advised that where people feel uncomfortable sharing confidential information when they come into the Emergency Department the triage room can be used.
The Chair asked how we know that the improvements, such as this in the ED, are making a difference. The Medical Director advised that reporting will go through the new Clinical Quality Group and Clinical Governance Committee and onto the Joint Clinical and Care Governance Committee. The Chair welcomed this.
K Cole acknowledged the detail in the report and the ability to identify trends and themes, particularly the way the data was broken down in the primary care data sets, with subsequent data sets showing. However, she noted that there is not a similar breakdown for the Acute Services, which means there is no ability to understand the areas that are getting more complaints than others, or understand the themes and being able to put in improvements accordingly. The Medical Director advised that there is not the data to validate the themes advising that one of the objectives this year is to increase the data and routes to gather feedback. Members were assured on the work taking place to improve the quality of data. The Chair queried why training outlined in the report, as supportive to staff in managing complaints, was not mandatory, given the importance of this matter for the organisation.
A discussion took place in relation to training, members noted that there is some training done as part of the induction process for new staff, that there is specific training for those investigating complaints but no mandatory training specific to handling complaints. The Head of Safety, Quality and Risk advised members that as implementation of Care Opinion progresses, training will be made available for staff.
The Chair asked about when the KPI's for Scottish Government would be known and it was discussed that this was overdue and expected at anytime. The Committee acknowledged that the Annual Report may be subject to change if the KPI's for the Scottish Government reporting, when released, were different to those in the submitted report.
Members approved the report for onward submission to the Board.

5.3. Infection Control Annual Report - JCCGC2425-20 (Presenters: Director of NMAHP and Chief Officer Acute)

The Director of NMAHP and Chief Officer Acute presented the report acknowledging the work done by the Infection Control Manager and team who have maintained the standards and are achieving against the majority of the nationally set standards, respecting as a small organisation, with small numbers it can be presented as high percentages.
Members discussed and acknowledged the section in terms of antimicrobial stewardship, noting the feedback from K Cole and The Head of Pharmacy in resourcing appropriate drugs. It was agreed that an additional line should be added to the report prior to going on to Board.
ACTION: The Director of Nursing, Midwifery, AHP and Acute Services agreed to add, sharing with colleagues and the Chair prior to submission to Board to acknowledge this as a current and emerging impact of potential significance.
Members approved the report for onward submission to the Board.

5.4. Whistleblowing Standards – Annual Report 2023/24 - JCCGC2425-21 (Presenters: Chief Executive)

The Chief Executive presented the Annual Reported, highlighting key points:

- No formal whistleblowing concerns have been raised in the year
- 30 concerns raised from a speak up perspective
- Significant learning from a case in raised 2022/23, which is still a live case, the report shows the learning so far
- Lack of clarity where services straddle OHAC and NHS Orkney on where to go to if you need to speak up

- 3 confidential contacts now trained
- Lot of work been done to communicate the different ways to speak up
- Quarterly meetings with Chief Executive, the Non-Executive Whistleblowing Champion and the confidential contacts, sharing learning locally and national learning
- iMatter results just published show the questions in the speak up remain the same
- The Report sets out the priorities for the year ahead.

Members approved the report for onward submission to Board.

5.4.1. Whistleblowing Champion – Assurance Statement JCCGC2425-22 (Presenters: Whistleblowing Champion)

The Chair noted the statement, in the absence of the Whistleblowing Champion, acknowledged the assurance taken from the relevant opinion in the statement. Members approved the Assurance Statement.

6. Emerging issues (Presenters: Chair)

The Chair raised the Antimicrobial Stewardship section of the Infection Control Annual Report, and lack of available drugs.

K Cole highlighted the lack of specific data for complaints data for Acute services to be able to review the feedback re specific departments, she advised members that she is not assured that if there are themes, we can see or address them.

7. AOCB (Presenters: Chair)

There were not additional matters raised.

8. Agree items to be included in Chair's Assurance Report to Board (Presenters: Chair)

Matters were raised throughout the meeting.

9. Items for Information and Noting Only

9.1. Schedule of Meetings 2024/25

9.2. Record of Attendance

Staff Governance Commitee Minutes

NHS Orkney
Thursday, 9 May 2024 at 09:30 BST

Attendance

Present:
Members: Kat Jenkin, Joanna Kenny, Ryan McLaughlin, Nickie Milne, Jarrard O'Brien, Steven Phillips, Rachel Ratter, Laura Skaife-Knight, Jason Taylor, Sam Thomas

Absent:
Members: Kirsty Cole, Karen Spence
Guests: Ali Sabiston (item 14.1), Lynn Adam, Jenny Fraser, Lawrence Green, Karyn Tait (Staff Story), Huw Thomas

1. Staff Story Leader of the Year, Team Orkney Awards – Karyn Tait - Verbal

   K Tait, Oral Health Team Lead provided an overview of the oral health team and her successful leadership style, which lead to her achievement of "Leader of the year" award at the NHS Orkney Staff Awards.
   The Chief Executive congratulated Karyn on her award, and celebrated the successful leadership demonstrated within the oral health team.
   J Taylor thanked Karyn for the presentation and was interested to know whether the Child Smile programme was back to running at full capacity. K Tait informed members, the activity was back to business as usual and was thankful for the data used as a measurement. Overall, there was very healthy teeth in Orkney.
   The Chair thanked Karyn for the presentation and her great leadership.

2. Apologies (Presenters: Joanna Kenny)

   Apologies were received from K Cole and K Spence.

3. Declarations of Interest - Verbal (Presenters: Joanna Kenny)

   No declaration of interests were raised.

4. Minute of meeting held on 28 February 2024 Chairs assurance report 28 February 2024 - Verbal (Presenters: Joanna Kenny)

   The minute of the Staff Governance Committee meeting held on 28 April 2024 was accepted as an accurate record of the meeting and approved with the following amendment:
   - S55 - J Taylor requested to record that the Head of People and Culture had agreed to review the undertaking of the proactive approach in relation to appraisals.

5. Matters Arising - Verbal (Presenters: Joanna Kenny)

   There were no matters arising

6. Action Log - Verbal (Presenters: Joanna Kenny)

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

7. RISK

7.1. Risk and Assurance Report - SGC2425-01 (Presenters: Kat Jenkin)

The Head of Patient Safety, Quality and Care presented the report which provided an overview and update on risk management across NHS Orkney. Members were advised that following feedback, there had been a change to the layout of the Corporate Risk Register to clarify the impact of each risk and included the breakdown of the risk score to determine the impact and likelihood.
During the last reporting period there were 5 risks associated to the Staff Governance Committee, updates to Staff Turnover risk would be provided at the next meeting.
The first three risks from the Corporate Risk Register had been reviewed and completed and a further update of risks would be included in the next report.
The Employee Director queried whether the Staff Governance committee should receive the risk update in relation to Insufficient Residential Care Beds. Members were advised a number of risks were presented to more than one committee, however the risk had been updated and would only be presented to the Joint Clinical and Care Governance Committee in future.
The Chief Executive highlighted the need to challenge the risk in relation to Staff Turnover and did not believe the description against it was satisfactory. She advised members the risk around frugality of leadership was changing to a reflect frugality in relation to capability and capacity around the wider senior leadership community. The Director of People and Culture advised that it was proposed the risk was closed and workforce risks would be included on the risk register.
The Risk Management Position paper was included for awareness and highlighted there were over 1000 active risks recorded and more than 50 risk registers, processes and systems were unable to provide assurance that risk was managed safely or effectively across different sectors of the organisation. This hampered the ability to foster a culture of learning and to streamline the escalation of risks effectively. A new process for the management of operational risk registered had been presented to SLT.
The Employee Director queried the potential upgrade from Datix system to the potential In-face system in terms of capturing the Health and Safety risk assessments. Members were advised this was yet to be looked into however, once a decision had been made regarding the system, a paper would be provided to the committee. The Health and Safety Lead offered to contribute to conversations around the integration of safety control books within the new system.
The Chair emphasised the importance of sufficient engagement with staff during the implementation of a new system and no ensure everyone had access.
J Taylor informed members that there would be an updated Risk Management Position paper at the Audit and Risk Committee meeting on 28th May with a test of change on the agreed way forward as well as a paper on the procurement of the Datix replacement.
The Chief Executive conveyed it was essential that the new system was aligned with best practice across the NHS and confident through engagement that it would work within NHS Orkney, taking training into consideration.
Decision/Conclusion
Members noted the update and were assured of progress

8. ASSURANCE

8.1. Staff Governance Committee Annual Report 2023/24 - SGC2425-02 (Presenters: Joanna Kenny)

Members ratified the Staff Governance Annual report for 2023/24.

8.2. Staff Governance Action Plan End-of-Year report 2023/24 - SGC2425-03 (Presenters: Steven Phillips)

The Head of People and Culture delivered the Staff Governance Action Plan for 2023/24, providing an update on the previously agreed action plan. The plan was brought in line with the Board's Plan on a Page, to enable the organisation to measure all activities in a consistent manner and continue to move the organisation forward and create a strong foundation of developing, enabling, co-creating and delivering activities where staff feel included and validated.
The committee thanked everyone involved in the plan and the evidence of clear progress.
The Chief Executive requested alignment with the People Strategic Objective and clarity around progress of each action.
Decision / Conclusion
Members approved the the Staff Governance Action plan for 2023/2024 and looked forward to receiving the next quarterly update which would include the above amendments.

8.3. Scottish Government response letter – Staff Governance Monitoring Return 2022/23 - SGC2425-04 (Presenters: Jarrard O'Brien)

The Director of People and Culture presented the Scottish Government response to the Staff Governance Action Plan and highlighted areas of success and areas of improvement/continued development.
Recommendations for areas of improvement would be prioritised and built into the forthcoming year.
Decision / Conclusion
Members noted the positive report and acknowledged the effort that went into the work.

8.4. Area Partnership Forum Annual Report 2023/24 - SGC2425-05 (Presenters: Laura Skaife-Knight, Ryan McLaughlin)

The Chief Executive presented the Area Partnership Forum Annual Report 2023/24 for approval by members highlighting the key areas and the increase in partnership working.
Decision / Conclusion
Members approved the Area Partnership Forum Annual Report 2023/24.

8.5. Equality and Diversity Monitoring Report - SGC2425-06 (Presenters: Steven Phillips)

The Head of People and Culture presented the NHS Orkney Equality and Diversity Monitoring Report 2023/24 highlighting the following key points:

- Colleagues would continue to be encouraged to update their data entry
- Interesting to note the comparison to Scotland and the comparison to Orkney Health Board area in relation to characteristics and attaching them to colleague information
- Key focuses to prioritise supporting colleagues
- Data would be analysed to inform actions
- The implementation of workforce policies would continue to support NHS Orkney being an equitable employer

The Employee Director raised concern around the under reporting and representation of people identified as disabled within the data, however, did note the actions in place and highlighted the need to be careful with language used.
J Taylor referred to the age demographics and queried the basis of NHS Orkney being a diverse employer and the reasons for the variation from the previous figures. He also requested clarity around the number of Job Train applicants received from foreign nationals not then feeding

into appointments. Members were advised that the new starts and increase of the Orkney population, the age range matched the population employed by the organisation. The Head of People and Culture would circulate a previous paper created around age. With regards to the number of unsuccessful appointments of foreign national applicants, an additional question would be added to the application form to support applicants in terms of suitable qualifications essential to the post.

Decision / Conclusion

Members approved the Equality and Diversity Monitoring Report 2023/24.

9. WORKFORCE PERFORMANCE

9.1. Q4 Workforce Report – Jan – March 2024 -SGC2425-07 (Presenters: Steven Phillips)

The Head of People and Culture presented the Workforce report for Quarter 4, highlighting the following key points:

- Since April 2023, the workforce's whole-time equivalent (WTE) and headcount had increased by 9.56 and 14, respectively.
- The total rolling-year bank hours were 55,127.03, down from 60,264.73 hours during the same period last year. The total additional hours recorded with the bank, overtime, and excess hours equated to an average of 37.63wte staff.
- The sickness absence rate fluctuated between 4.92% and 7.15% this year and was at 5.8% in February 2024. Anxiety/stress/depression/other psychiatric illnesses remained the highest recorded reason for sickness absence and accounted for 25.98% of all sickness absences from April 2023 to February 2024. Long-term absences accounted for 60.33% of all sickness during the 2023-24 year.
- A great amount of work had led to increased mandatory training figures, focus would remain on improving training and support for colleagues
- The Appraisal rate for Agenda for Change staff was up to 31.84%, and all medical appraisals were completely up to date.
- From Apr 2023 to Mar 2024, there have been 134 new starts and 114 leavers.

N Milne queried why there had been an increase in overtime hours and whether it was due to the recent reduction in the working week. She also raised concern around the low appraisal compliance rate for nurses.

The Director of Nursing, Midwifery, AHPs and Chief Officer Acute explained whilst nursing and midwifery was the largest staff group, some appraisals would have been captured but not signed off, and, previously there had not been sufficient staffing in place to carry out the appraisals. However, during the last quarter of 2023/24 there had been close working within teams to ensure appraisals were, and continued to be undertaken. Staff were required to be released to undertake appraisals, which at times could be challenging.

The Chair queried if it would be possible to target the communication around appraisals, to ensure people reflect and record.

The Employee Director advised that positive feedback had been received in relation to training for managers and the differences in performance in sickness absence reviews. He also noted that most people employed on fixed-terms contracts had been successfully re-deployed. With regards to appraisals, there was an upward trend however the areas of focus should be in areas of no increase of appraisal rates and the possibility of including number of appraisals required from managers. The Head of People and Culture agreed that it would be possible to include the numbers.

J Taylor noted the positives within the report and the progress made to date. He echoed the requirement to focus on certain areas with low or no increase in appraisal rates and the proactive approach that had been employed in improving mandatory training rates, to ensure individuals were aware that there appraisal was due. He asked whether the additional details

requested for the Integrated Performance Report regarding excess hours, bank and overtime hours could be provided to the committee. In relation to demographics, he noted the ageing population and the importance of succession planning.
The Head of People and Culture explained there was no capacity in relation to undertaking an alternative approach to increase appraisal rates due to the roll out of the training. The Chair queried whether there was any staff members who does not access their emails and how communication was reaching staff if they do not look at their emails. J Fraser advised that all of the local consultants do not have access to emails when they are not on the island. Work would continue to develop an area within the organisation to allow staff to access.
The Chief Executive noted the number of appointments carried out by occupational health and queried whether there was risk associated with a potentially fragile service. Members were advised that performance review meetings would be introduced for every clinical service and corporate team by the end of quarter 1. The Director of People and Culture confirmed that the occupational health department was a fragile service, a review would take place within the People and Culture review and there was a business case for the service.
With regards to job planning, the Chief Executive requested that the Medical Director would produce a report to the Staff Government committee every 6 months and emphasised that all consultants required a job plan. J Fraser emphasised the importance of a consultant job plan.
It was requested that the graphs around mandatory training could be presented in an alternative format.

Decision / Conclusion

Members noted the update and were assured of progress.

9.2. Health and Care (Staffing) Act (2019) implementation update - SGC2425-08 (Presenters: Lynn Adam)

L Adam presented the report to advise that the health and Care (Staffing) (Scotland) Act 2019 (HCSA) came in to effect on 1 April 2024. The legislation placed a duty on health boards and care services to put in place the systems and processes to enable real-time assessment of staffing to identify risks that could be addressed or escalated to support frontline staff delivering services.
The report included progress of NHS Orkney's implementation and the mandatory legislation required from the organisation.
Members were advised that a DL had been issued that required that the annual report was also submitted to the Patient Safety Commissioner for Scotland.
The Employee Director queried whether Safe Care was being used to capture staffing data. Members were advised that a roll out programme was in place however would not provide all of the required information. He also queried whether the workforce data would be captured in a way to identify certain trends and the route of the data would be shared. L Adam assured members that the legislation required organisations to evidence analysing data over time and to inform the work force plan and identify re-currant risk. The Director of People and Culture approved the recommendation that the annual report was presented to the Staff Governance committee as recommended.
J Taylor queried the medium to long term resource requirement to enable achieving all of the required legislation. The Director of Nursing, Midwifery, AHPs and Chief Officer Acute explained that whilst funding was in place it was important to consider what was classed as business as usual and that it was the responsibility of each and every staff member. By quarter three the organisation should be in a position to create a business case.

Decision / Conclusion

Members accepted the update and sought assurance.

9.2 - Health and Care (Staffing) Act (2019) implementation update.docx

9.3. Agenda for Change non-pay amendments update -SGC2425-09 (Presenters: Jarrard O'Brien)

The Director of People and Culture provided an update on the agenda for change non-pay elements since it was first implemented on 1 April 2024. The highlights were:

- A national portal was being developed for submissions of nursing roles that may be entitled to increase from Band 5 to Band 6.
- A consistent approach to Protected Learning Time would be rolled out across all NHS Scotland Boards, which would include the completion of statutory, mandatory, and profession-specific training for AfC staff within working hours. Each team in NHS Orkney had been asked to build this into the roster until 01 April 2025.
- A full plan had been developed in relation to the reduction in the working week with the intention for most teams to 'go live' with the reduction on 01 May 2024 and the remaining teams on 01 June 2024. There were a small number of teams, mostly single handed or with multiple vacancies within their establishment, who would not be able to reduce their hours by June and Quality Impact Assessments are being done for those teams, including calculating the ongoing cost pressure to the organisation.

The Chief Executive highlighted that the report identified an additional potential cost pressure which required to be included in the Chairs Assurance Report to the Finance and Performance committee.

Decision / Conclusion

Members accepted the update and sought assurance.

10. CULTURE

10.1. Staff Stress Survey Results -SGC2425-10 (Presenters: Lawrence Green)

The Health and Safety Lead presented the report highlighting the results of the Staff Stress Survey that was conducted over a six week period from 13 November to 23 December 2023. A total of 277 staff completed the survey (26%) and provided a snapshot of staff perception around stressors within the organisation and in light of the pressures already placed upon staff, it might be argued that the response was better than expected.

At an organisational level, out of the 7 Stress Management Standards, 2 of 7 fell into the 2nd quartile and the remaining 5 of 7 fell into the 3rd quartile. There were no management standards that were in the bottom first quartile and those that were in the second quartile were well above the top half of the bracket.

Following positive implementation of the 3 year action plans and subsequent improvements to the survey results, it was suggested that the surveys were run every 2 years to ensure the positive actions taken remain in place and effective at reducing stress within the organisation, so far as is reasonably practicable.

The results for individual Directorates were also important elements of the survey as a poorly performing Directorate under 1 single Management Standard heading could be somewhat hidden within an overall organisational result, if further 'drilling down' did not take place.

The Health & Safety Team would engage with all Directorates to work through their individual Stress Management Action Plans and to also deliver two types of Stress Awareness Training, which are "Stress Management for Manager" and "General Staff Stress Awareness".

The Director of Nursing, Midwifery, AHPs and Chief Officer Acute raised concern around some of the language used within the reports and exclaimed that if all staff were to be treated with the same level of clarity, fairness and equality, there should not be a difference between directorates. There was also a concern around the timescale for the proposed next stress survey, taking into account competing demands across the organisation.

Decision / Conclusion

The committee noted the results from the 2023 Stress Audit Survey and approved the introduction of the Organisational Stress Risk Assessment and implementation of the Stress Survey Actions for 2024. Members agreed that the Staff Stress Survey would be re-run in 2024 and further consultation would take place at SLT regarding the action plans. A broader conversation would take place and a suggested way forward would be provided to the committee.
The Chair thanked the Health and Safety Lead for the great work carried out to date.

11. STAFF EXPERIENCE

11.1. Planning for the iMatter survey 2024/25- SGC2425-11 (Presenters: Ali Sabiston)

The Head of People and Culture presented the iMatter 2024 update highlighting the following:

- iMatter planning had commenced with interaction with teams to confirm participation
- A communication plan has been developed for each stage of the cycle.
- The survey would be live from 13 May 2024
- Sessions would include raising awareness across the organsiation to have stations set up in the main reception
- Training around awareness of the report analysis would continue and managers would continue to be supported throughout

Decision / Conclusion
Members noted the update

12. LEADERSHIP AND PROFESSIONAL DEVELOPMENT

12.1. No items

13. RECRUITMENT AND RETENTION

13.1. No items

14. EDUCATION AND TRAINING

14.1. Corporate Training Plan Update for 2024/25 - SGC2425-12 (Presenters: Ali Sabiston)

The Talent and Culture Manager presented the Corporate Training Plan Update for 2024/25 highlighting the follwoing:

- After discussion at the corporate leadership team meeting on 8 Feb 24, the training plan guidance and request form was circulated to the directorates for completion. Training was requested as detailed within the report
- The training requests from Directorates detailed within the lead to a total of £266,734 in requests. All requests under the statutory compliance category would be allocated with a remaining core and CPD categories budget of £84,592.
- The talent and Culture team would be conducting a number of steps to ensure training plans were supported through 24/25.

J Taylor queried the allocation of training funding. Members were advised that directorates would be responsible for prioritising the learning for the need of the service, taking training and appraisal rates into consideration.
Decision / Conclusion
Members noted the update

15. OCCUPATIONAL HEALTH AND SAFETY

15.1. Health & Safety Lead Annual Report 2023/2024 SGC-13

The Health and Safety Lead presented the Annual Report for 2023/2024 highlighting the following:

- Face Fit testing had continued throughout the year for new starters and anyone who had found subsequent problems with their face masks had been re-tested and provided with a fully fitting mask type.
- Slips, trips and falls remained the highest cause for adverse events
- In 2023/24 there were 3 RIDDOR reports in 2023/24.
- Over the past 12 months, a number of Health and Safety related Policies and Procedures had been reviewed, updated and taken through the Governance Committee Approval.
- Control Book implementation had been delivered across NHS Orkney and the process of auditing Control Book Owner's progress had begun
- The Health & Safety Lead had established a Safety Management Systems Audit that is conducted annually, and the second audit had been run in November 2023 and an action plan had been developed from the results of the audit to identify and track improvements until the next audit review date.
- A new job description was created for Health & Safety Officer (Violence Prevention) to enable greater flexibility to support the overall objectives of the Safety Team.
- The introduction of the NHS Moving & Handling Passport Scheme within NHS Orkney had been completed in 2023/24.

  The Employee Director thanked the Health and Safety Lead and the wider organisation for the continued movement of developing the health and safety culture. He did however raise concern around no mention of the emergency intervention statistic of 35%, and stressed the importance of ensuring all staff undertake the necessary training to reduce the health and safety risk. An assurance report around the would be provided at the next meeting

  J Taylor echoed the concerns around emergency intervention in relation to training and emphasised that there should be an urgent focus in that area. He also requested that the annual report encapsulated the lessons learned and how they were embedded from the significant events within the RIDDOR reporting. The Health and Safety Lead advised members that the information was provided within the quarterly Health and Safety reports.

  Members were re-assured that discussions were in place around the health and safety training elements and were an urgent priority. The implementation of the Safe Care (Staffing) Act 2019 and the advent of Safe Care offered to all teams across the organisation would identify gaps in training.

  The Chair strongly implied that NHS Orkney staff should not carry out their work without the vital mandatory training from a health and safety perspective.

Decision / Conclusion

Members approved the annual report and praised the work of the Health and Safety Lead and Team over the previous year.

15.2. Occupational Health, Safety and Wellbeing – Chair's Assurance Report, approved action notes and constitution SGC2425-14 (Presenters: Ryan McLaughlin)

The Employee Director presented the report from the Occupational Health, Safety and Wellbeing Committee for noting by members, highlighting some of the current challenges.

Decision / Conclusion

Members noted the update provided from the Occupational Health, Safety and Wellbeing Committee.

16. ENGAGEMENT AND PARTNERSHIP

16.1. Area Partnership Forum Chair's Assurance Reports 20 February 2024 25 March 2024 Area Partnership Forum Minutes 20 February 2024 SGC2425-15 (Presenters: Laura Skaife-Knight, Ryan McLaughlin)

The Employee Director presented the Chair's report from the Area Partnership Forum for noting by members.

Decision / Conclusion

Members noted the update provided from the Area Partnership Forum and noted the approved minutes as submitted.

16.2. JLNC Update SGC2425-16 (Presenters: Jenny Fraser)

J Fraser provided a verbal update to inform members that the Joint Local Negotiating Committee had met and had a positive meeting with good attendance and work would continue to resurrect the group.

Decision / Conclusion

Members noted the update provided from the committee.

16.3. Report on Status of Once for Scotland Policy SGC2425-17 (Presenters: Steven Phillips)

The Head of People and Culture provided an update to the Committee on the Once for Scotland Workforce Policies Programme and Implementation Plan following the Go Live of the Work Life Balance Policies on 1st November.

Following the consultation and soft launch period of the 11 Workforce Policies refreshed under Supporting Work Life Balance, the Policies were fully implemented in partnership on 1st November 2023 and could be accessed on the NHS Orkney website.

Decision / Conclusion

Members noted the update.

17. Items to be included on the Chair's Assurance Report - Verbal (Presenters: All)

- Agenda for Change - n pay elements
- Cost pressure
- Spiritual Care
- Health and Safety training

18. Any other competent business - Verbal

Spiritual Care

The Employee Director raised that there had been concerns around spiritual care following feedback from a recent staff feedback session. With a vacant spiritual care post, it posed a challenge for NHS Orkney to progress with the spiritual care framework for NHS Scotland that was launched in June 2023. He suggested that the Staff Governance Committee included the implementation of the framework in the Staff Governance Action Plan and that the Director of People and Culture provided an update at the next committee meeting.

19. ITEMS FOR INFORMATION AND NOTING

19.1. Schedule of Meetings for 2024/25 (Presenters: Joanna Kenny)

The schedule of meetings for 2024/2025 was noted.

19.2. *Record of Attendance (Presenters: Joanna Kenny)

The record of attendance was noted.

Orkney NHS Board

Minute of meeting of **Area Clinical Forum of Orkney NHS Board** held virtually on **4 June 2024 12:15pm.**

Present:	Kirsty Cole, GP Sub Committee – Chair Nick Crohn, TRADAC – Vice Chair Rona Harcus, TRADAC Lyndsay Steel APC Scott Tulloch, ADC
In Attendance:	Anna Lamont, Medical Director Louise Wilson, Director of Public Health Paul Corlass, Recovery Director (item 9.2) Helen Thain, Nurse Manager

ACF26 **Apologies**

Apologies were received from S Brown, M Flett, K Jones and L Skaife-Knight.

ACF27 **Declaration of interest – Agenda items**

No interests were declared in relation to agenda items.

ACF28 **Minute of meeting held on 5 April 2024**

The minute from the meeting held on the 5 April 2024 was accepted as an accurate record of the meeting and was approved.

ACF29 **Matters Arising**

There were no matters arising that were not covered on the agenda.

ACF30 **Area Clinical Forum Action Log**

The Action Log was reviewed, noting that there were no current outstanding items.

ACF31 **Log of Items Escalated**

The Chair drew members attention to the items previous escalated.

Chairs Reports:

ACF32 **Board**

No update this meeting due to appointment of new Chair.

ACF33 **ACF Chairs Group**

No update this meeting due to appointment of new Chair.

Professional Advisory Committees

ACF34 **Area Dental Committee – ADC**

There had been no ADC meetings held over this period, S Tulloch advised that there had been contact with independent practices regarding attending meetings and availability of the Dental Director and Head of Primary care was being sought.

It was highlighted that there was a recurring theme of limited availability of dental trained staff, specifically dental nurses and dentists causing significant recruitment challenges. Additionally there is a trend of independent dental staff moving to work for the health board due to higher salaries being offered . There was a request from independent practices that the health board train their own dental nurses as it was a growing concern and disruption to the service.

A draft constitution for the ADC had been submitted to the Chief Officer and Head of Primary Care for comment.

ACF35 **Area Pharmaceutical Committee – APC**

L Steel provided an update highlighting the following:

- an APC meeting had taken place however there was only representation from two pharmacists. It was hoped that representation would increase following discussion at the meeting.
- L Steel was the new Chair of the committee, a Vice Chair had not been confirmed
- Russell Mackay, Hospital Pharmacist was appointed as Secretary
- No admin support was provided from Corporate Governance, there was administrative support within the Pharmacy department.

Decision/Conclusion

Members noted the approved minutes from meetings held on 26 March 2024.

ACF36 **GP Sub-Committee**

K Cole, provided an overview of the Chairs report submitted, highlighting the following:

- Members requested a full breakdown of Primary Care Improvement Plan funding, including areas of underspend be brought to the June meeting to ensure funding not currently being used due to vacant posts was still available for reprovisioning.
- Work was underway to prepare for system migration of GP IT reprovisioning, with Practice Managers invited to attend training sessions and scheduling being prepared in order to prioritise and ensure any negative impacts were minimal

Decision/Conclusion

Members noted the approved minutes from meetings held on 13 March 2024.

ACF37 **Hospital Sub-Committee**

No hospital-sub re present.
Members noted the Hospital Sub-Committee report.

Decision/Conclusion

Members noted the approved minutes from meetings held on 11 April 2024.

ACF38 **Nursing and Midwifery Advisory Committee - NAMAC**

H Thain, provided a verbal update highlighting that Kirsty Jones was the new Chair and Ellen Kesterton was the Vice Chair.

Decision/Conclusion

Members noted the update provided.

ACF39 **Therapy, Rehabilitation, Assessment and Diagnostic Advisory Committee – TRADAC**

R Harcus provided an overview of the Chairs report submitted, highlighting the following:

- A formal agenda setting and workplan for 2024/25 was being implemented, with Executive input from the Director of Nursing, Midwifery, AHPs and Chief Officer Acute. Acknowledging close working relationships with NAMAC but also the requirement for dedicated space to discuss core TRADAC business.

Decision/Conclusion

Members noted the chairs report and the approved minutes.

Governance

ACF40 **Terms of Reference review – ACF2425-**

The Chair presented the terms of reference for review and approval.

Members requested further clarification around the decision to remove non-executive board members from the in-attendance section.

Further discussions was required with Corporate Governance around the members and composition section.

Decision/Conclusion

Members requested further clarity around composition prior to approving the terms of reference.

Business Items

ACF41 **Island Games 2025 - Verbal**

The Vice Chair provided a verbal update advising a Medical Director had been appointed to the Island Games and a session had been arranged with stakeholders from the Board and the Medical Director to discuss concerns raised from NHS Orkney.

The Chair requested that the item remained as a standing agenda item.

Decision/Conclusion

Members noted the update provided.

ACF42 **Financial Recovery – verbal**

The Recovery Director attended the meeting providing an overview of the financial improvement programme which had supported the Board from December 2023.

The primary focus of the recovery team was the annual accounts and ensuring NHS Orkney was statutory compliant in terms of the financial position.

Moving forward there would be focus on the delivery of the financial plan for 2024/25.

It was agreed that the next meeting would include an update on the national figures and benchmark local progress of NHS Orkney.

Decision/Conclusion

Members noted the update provided.

Development Sessions

ACF43 **May Development Session outcomes – Improving Together Programme**

Members noted the outcomes from the enthusiastic session.

ACF44 **Development session plan 2024/25**

Members noted the draft pan for development sessions in 2024/25 and agreed dates for the topics as proposed.

It was agreed that a session on Risk Management – Island Games would take place in July 2024 and the Island Games would be required as a session in September.

ACF45 **Any Other Competent Business**

No items of AOCB were raised.

ACF46 **Chair's Assurance report to Board**

Members agreed on the content of the Chairs Assurance Report to Board.

- Challenges faced by independent dental practices around staff moving to Board positions due to salary
- Continued lack of accommodation in terms of clinical space

ACF47 **Items to be Communicated with the Wider Clinical Community**

No items were to be communicated with the wider clinical community that had not already been captured elsewhere on the agenda.

For Information and Noting

ACF48 **Correspondence**

No correspondence had been received.

ACF49 **Schedule of Meetings 2023/24 and 2024/25**

Members noted the schedule of meetings for 2024/25.

ACF50 **Record of Attendance**

Members noted the record of attendance.

Meeting Closed:13:48

NHS Orkney - Board - Attendance Record - Year 1 April 2024 to 31 March 2025:

Name:	Position:	25 April 2024	27 June 2024	18 July 2024	22 August 2024	24 October 2024	19 December 2024	27 February 2024
Members:								
	Non-Executive Board Members:							
M McEwen	Chair	Attended	Attended	Attended				
D Campbell	Vice Chair	Attended	Attended	Attended				
D Creasey	Non Executive Board member	Attended	Attended	Attended				
I Grieve	Non Executive Board Member	Attended	Attended	Attended				
R Gold	Non Executive Board Member	Attended	Attended	Attended				
K Cole	Area Clinical Forum Chair	Attended	Attended	Attended				
J Kenny	Non Executive Board member	Attended	Attended	Attended				
R McLaughlin	Employee Director	Attended	Attended	Attended				
J Taylor	Non Executive Board member	Attended	Attended	Attended				
J Stevenson	Non Executive Board Member	Attended	Attended	Apologies				
	Executive Board Members:							
A Lamont	Medical Director	Attended		Attended				
L Skaife-Knight	Chief Executive	Attended	Attended	Attended				
S Thomas	Director of Nursing, Midwifery, AHP and Acute	Attended	Attended	Attended				
L Wilson	Director of Public Health	Attended	Attended	Attended				
	In Attendance:							
Paul Corlass	Recovery Director	Attended	Attended	Attended				
Phil Tydeman	Director of Improvement	Attended	Attended	Attended				
S Brown	Chief Officer – IJB	Attended	Attended	Attended				
J O'Brien	Director of People and Culture	Attended	Attended	Attended				
J Colquhoun	Corporate Governance Lead	Attended	Attended	Attended				