FINANCE, PERFORMANCE & RESOURCES COMMITTEE

Tue 12 January 2021, 09:30 - 12:00

via MS Teams

Agenda

09:30 - 09:30
0 min

1. Apologies for Absence

09:30 - 09:30
0 min

2. Declaration of Members' Interests

09:30 - 09:30
0 min

3. Minute of the last Meeting held on 10 November 2020

Rona Laing

3 Unconfirmed FPR Notes 10.11.20 LS GM v2mm.pdf (10 pages)

09:30 - 09:30
0 min

4. Action List

Rona Laing

4 Rolling Action List Update from Nov 2020.pdf (1 pages)

09:30 - 09:30
0 min

5. MATTERS ARISING

5.1. Update on Smoke Free Environment Strategy

verbal *Nicky Connor*

09:30 - 09:30
0 min

6. GOVERNANCE

6.1. Board Assurance Framework – Financial Sustainability

Margo Mcgurk

Item 6.1 BAF Financial Sustainability - SBAR for 120121.pdf (4 pages)
6.1 1. NHS Fife Board Assurance Framework (BAF) v26.0 050121 - Financial Sustainability.pdf (1 pages)
6.1 1. BAF Risks – Financial Sustainability Linked Operational Risks as at 050121 (1).pdf (17 pages)

6.2. Board Assurance Framework – Strategic Planning

Chris McKenna

6.2 SBAR FPR BAF 5 110121 (1).pdf (3 pages)
6.2 5. NHS Fife Board Assurance Framework (BAF) V24.0 050121- Strategic Planning.pdf (1 pages)

6.3. Board Assurance Framework – Environmental Sustainability

Andrew Fairgrieve

- 6.3 SBAR (BAF) Environmental Sustainability FP&R 12-1-2021.pdf (3 pages)
- 6.3 2. NHS Fife Board Assurance Framework (BAF) V26.0 161220 - Environmental Sustainability.pdf (1 pages)
- 6.3 2. BAF Risks - Environmental Sustainability - Linked Operational Risks as at 171220.pdf (1 pages)

09:30 - 09:30
0 min

7. PLANNING

7.1. Strategic Planning and Resource Allocation Process 2021/22 to 2023/24

Margo Mcgurk

- 7.1 SBAR FPRC Strategic Planning and Resource Allocation process final 070121.pdf (5 pages)
- 7.1 Appendix 1 Strategic Planning and Resource Allocation Proposal GUIDANCE.pdf (12 pages)

7.2. Winter Performance Report

Helen Buchanan

- 7.2 SBAR FPR Committee Winter Report.pdf (5 pages)
- 7.2 Winter Planning Performance Summary Nov 2020 v1.0.pdf (17 pages)

7.3. Orthopaedic Elective Programme – Programme Bank Account

Margo Mcgurk

- 7.3 SBAR EOC Project Bank Account - FP&R.pdf (3 pages)

7.4. Laboratory Information Management System (LIMS) National Outline Business Case

Claire Dobson

- 7.4 SBAR LIMS OBC.pdf (89 pages)

7.5. East Region Recruitment Transformation

Sandra Raynor

- 7.5 FP&R - East Region Recruitment Transformation - 12.1.21.pdf (3 pages)
- 7.5 East Region Recruitment Services Business Case v4.pdf (99 pages)

09:30 - 09:30
0 min

8. PERFORMANCE

8.1. Integrated Performance & Quality Report

Margo Mcgurk/Clair Dobson/Nicky Connor

- 8.1 SBAR FPR Committee IPQR.pdf (4 pages)
- 8.1 IPQR Dec 2020.pdf (49 pages)

09:30 - 09:30
0 min

9. ITEMS FOR NOTING

9.1. Internal Audit Annual Report 2019-20

Margo Mcgurk

- 9.1 SBAR Annual Internal Audit Report 19-20.pdf (3 pages)
- 9.1 B06-21 Annual Internal Audit Report.pdf (38 pages)

9.2. Minute of IJB Finance & Performance Committee, dated 11 November 2020

- 9.2 Final IJB F&P Minute 110920.pdf (8 pages)

9.3. Minute of Primary Medical Services Committee, dated 1 December 2020

9.3 MINS011220.pdf (4 pages)

9.4. Audit Report B25/20 Capital Management – NHS Fife Elective Orthopaedic Project

9.4 B25-20 Capital Management FOEP.pdf (15 pages)

09:30 - 09:30
0 min

10. ISSUES TO BE ESCALATED

10.1. To the Board in the IPR & Chair's Comments

09:30 - 09:30
0 min

11. Any Other Business

09:30 - 09:30
0 min

12. Date of Next Meeting: 16 March 2021 at 9:30am, in the Boardroom, Staff Club, Victoria Hospital (TBC)

MINUTE OF THE FINANCE, PERFORMANCE & RESOURCES COMMITTEE MEETING HELD ON 10 NOVEMBER 2020 AT 09:30AM VIA MS TEAMS

Rona Laing
Chair

Present:

Ms R Laing, Non-Executive Director **(Chair)**	Mr E Clarke, Non-Executive Director
Dr L Bisset, Non-Executive Director	Ms J Owens, Non-Executive Director
Mrs M McGurk, Director of Finance	Mrs C Potter, Chief Executive
Dr Christopher McKenna, Medical Director	Mr A Morris, Non-Executive Director

In Attendance:

Mrs N Connor, Director of HSCP
Mr A Fairgrieve, Director of Estates & Facilities
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
Mrs R Robertson, Deputy Director of Finance
Mr J Crichton, Interim Divisional General Manager, HSCP (Item 5)
Dr F Baty, Consultant Clinical Psychologist (Item 5)
Mr L Cowie, Clinical Services Manager, CAMHS (Item 5)
Ms D Black, Project Manager, eHealth (Item 7.3)
Mr B Johnston, Project Manager (Item 7.4)
Miss L Stewart, PA to the Director of Finance (minutes)

1. Apologies for Absence

Apologies were received from Mrs Dona Milne, Director of Public Health, Mrs Helen Buchanan, Director of Nursing, and Mr Alan Wilson, Capital Projects Director.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 8 September 2020

The Committee formally **approved** the minute of the last meeting.

4. Action List

The Chair reviewed the action list and highlighted those that were not otherwise covered in the meeting agenda.

It was advised that for Action 133, a date for further consideration is to be confirmed.

It was advised that for Action 138, given the rise in Covid-19 cases, the current demand for services, and the impact on EDG time, the planned Committee Development Session was agreed to be postponed until the January Meeting, and this will remain under review.

It was advised that for Action 140, a date is to be confirmed when a paper will be submitted to the Committee.

5. MATTERS ARISING

5.1 Psychological Therapies Update

Mrs Nicky Connor, Director of HSCP, introduced the report to the Committee. Jim Crichton and Frances Baty were invited to provide an update to members.

Jim Crichton highlighted that there were three elements to this update, which include a pre-Covid trajectory until March 2020, the significant and complex impact of Covid in the months following, and the potential future impact on the service.

Dr Frances Baty advised that the paper details in depth the modelling work that was due to be undertaken earlier this year. The team were working alongside the Scottish Government Mental Health Directorate Performance & Improvement Unit. Following that, detailed modelling work was completed to understand the demand and capacity, the nature of the queue and the resource and the work which was required to meet the target. It was found that it would not be possible to meet the target by December 2020, but the work done to date allowed them to model different scenarios.

It was noted that the performance target had improved significantly during the lockdown period, however there was reduced referral activity during this time.

Future modelling shows that in order to meet the target, the service need to tackle the queue and address the needs of those who have been waiting longest, to create capacity. Waiting list work has commenced, with a significant change of direction. The team are working closely with colleagues in Adult Mental Health for patients with complex needs to find alternative routes of treatment. It is hard to quantify the impact digital therapy at this early stage. Referral rates are returning to what they were pre-Covid, and it is also hard to quantify the impact of the pandemic at this point.

The Chair queried the reduction in the number of staff available to support the waiting list. Dr Baty advised that, since remobilisation, they have worked closely with Mental Health colleagues and CMHT to look at patient pathways and have organised a training programme on how to increase skills and capacity of nursing staff to develop an alternative patient pathway. A lot of resources have been created in a digital format; this is at implementation stage but will help support the work.

It was advised that it is difficult at present to know the impact this work will have but they are optimistic the work undertaken will have a positive impact on patient care and will reduce the rates of patients coming into the service.

The Committee **noted** the update on psychological therapies performance.

5.2 CAMHS Update

Mrs Nicky Connor presented the paper to the Committee on CAHMS. Jim Crichton and Lee Cowie were invited to provide an update on this report.

Mr Jim Crichton advised that this paper shows a similar picture to psychological therapies. A lot of work has been undertaken to address how this workload is delivered throughout the pandemic period.

Mr Lee Cowie advised that Fife CAHMS has worked alongside the Scottish Government Mental Health Improvement Teams to support the workforce to work towards the targets. The focus for the last few months has been to embed a revised system to continue to provide a responsive service. The Committee were referred to section 2.1 of the report, which detailed the referral to treatment target - the chart on page 4 on referrals shows how they compare. The recovery period came over September and this is now at 71% capacity. The number of DNAs did increase significantly over the last period, perhaps due to the availability of online consultations.

There have been a number of challenges over the Covid period. Within 3-4 days of the usual service closing, the team were able to resume contact and establish a digital programme. A concerted effort was made to reduce the longest waits. Going into the Covid period 80 people were waiting over a year; this has now been reduced to 8. It has been apparent through the DNA rate that virtual appointments were however not as successful at engaging with young people as originally anticipated.

The current demand has returned to levels pre-Covid. The urgent contacts are seen on average within 7 weeks however, those who are not seen as urgent are put on a waiting list. There remain issues with the resource to support that waiting list. To address this staff have been given an opportunity to start evening and weekend clinics, but uptake of this has been limited as staff are already working at capacity. Two additional mental health workers have been introduced and a consultant psychiatrist position established. Group work has been challenging to introduce. These sessions were historically very successful, but it is hard to measure the impact given the current circumstances. During Covid, the number of low-level referrals i.e. first level anxiety, which would have been picked up by School Councillors, has flowed into specialist services.

Ms Nicky Connor advised that the HSCP senior leadership team are actively considering the recommendations made from the Scottish Government and decisions will be fed back to the Committee in March 2021 on what is possible.

The Committee **noted** the update on CAMHS performance.

6. GOVERNANCE

6.1. Board Assurance Framework – Financial Sustainability

Mrs Margo McGurk presented the report to the Committee on Financial Sustainability. It was highlighted to members that the key change is NHS Fife have now received funding allocations for Covid. Full costs have been funded for Q1 and an indicative NRAC share/or 70% funding allocation for Q2-Q4. This does not include funding for unachieved savings. Further detail will be provided to the Committee under agenda item 8.2, IPQR. The level of risk remains high.

The Committee **approved** the Financial Sustainability section of the Board Assurance Framework.

6.2. Board Assurance Framework – Strategic Planning

Dr Chris McKenna presented the report to the Committee on Strategic Planning. It was highlighted that this report was presented in detail to the Clinical Governance Committee and is with Finance, Performance & Resources Committee for noting. There has been no significant change following the last iteration of the BAF, since, due to the second peak of Covid-19, work has been paused on the transformation agenda. However, this will be a focus and priority when the Board emerges from this challenging period.

The Committee **noted** the current position in relation to the Strategic Planning Risk.

6.3. Board Assurance Framework – Environmental Sustainability

Mr Andy Fairgrieve presented the report to the Committee on Environmental Sustainability, and it was advised that there had been no significant change to the previous version considered at the last meeting.

The Committee **approved** the Environmental Sustainability section of the Board Assurance Framework.

6.4. Review of General Policies and Procedures

Dr Gillian MacIntosh presented the bi-annual report to the Committee on the ongoing review and updating of General Policies and Procedures.

It was advised that, due to the impact of Covid across services, policy review had been paused. However, 15 policies are now currently out for review, which will make an impact on the backlog of out-of-date documents. Discussions had taken place at previous committee meetings on introducing a digital system for policy management. .

Mr Eugene Clarke asked if national systems were in place, to introduce national policies i.e. on a Once for Scotland basis. Some of this work is underway for HR policies. However, it was clarified that at present each Board utilise their own system and manage their review in many different ways, with no one solution being used consistently.

It was highlighted that the current process of policy review and follow-up is very labour intensive. It is important to consider the financial impact of introducing an electronic system

alongside the productivity improvement. Availability of up-to-date policies for staff was also vital. Therefore, all options should be considered, especially an organisation-wide approach.

Mrs Carol Potter advised that this conversation will be taken back to EDG to progress further.

The Committee **noted** the update on the review of General Policies and Procedures. A further update will be provided to the Committee in six months.

7. PLANNING

7.1. Winter Plan

Mrs Claire Dobson introduced the Winter Plan to the Committee. It was highlighted that this was discussed in detail at the Board Development Session the previous week.

The Winter Plan describes the actions which are in place going into the winter period. It considers Covid pressures alongside usual Winter pressures. It is important that each patient gets the right care in the right place this Winter. It will be very challenging with the ongoing programmes, including Seasonal Flu Vaccine, Covid Vaccine and the Test and Protect work. There is a Bronze and Silver Command structure in place to ensure decisions are made efficiently.

Mrs Rona Laing advised that Appendix 7 was a helpful addition to the plan, as it will be helpful to monitor performance. The Committee were guided to Appendix 5. The Committee questioned the financial information, as in previous years the figure was significantly higher to compared to the funding received. Mrs Margo McGurk confirmed that this year it is more complex due to the plans in place for Covid. It is important to understand that the worst-case scenario costs have been shown in this plan. The Scottish Government are currently reviewing the funding to cover Winter spend alongside Covid.

Mrs Wilma Brown highlighted that there is a lack of detail around the Staffing Plan. It may be challenging to recruit the number of staff required, which will cause shortages and pressures in key areas. Mrs Nicky Connor emphasised that the position will be carefully monitored. If it is required, they plan to reprioritise staff, as the support from Bank and Agency staff may not be enough. This will be undertaken with full clinical advice.

The Committee **noted** the update on the Winter Plan.

7.2 Payroll Consortium Outline Business Case

Mrs Margo McGurk introduced the Outline Business Case. It was advised that it was discussed at Staff Governance Committee earlier in the month and will be considered again by that committee in January 2021, with the SBAR presented today.

Chief Executives decided to introduce a Programme Board several years ago, to identify how to support development and the resilience of payroll on a regional basis. The proposal is to build a single employer, with multiple bases, to ensure the service is fit for the future. Staff are engaged and are fully aware of this. Staff within NHS Fife do have an emotional concern around no longer working for NHS Fife, as staff would go through a TUPE process and will be recognised as employees of NSS. It may be worth proposing to the Consortium to implement this in a more phased approach as the timing of this may not be most appropriate.

Mrs Wilma Brown emphasised that staff are fully aware of the direction of travel, and this has gone through a huge consultation process. Staff do feel they have loyalty towards NHS Fife and are anxious about being transferred to NSS. However, staff would still fall under the same NHS Scotland terms and conditions.

Mr Eugene Clark questioned whether the consortium would experience the same challenges of recruitment nationally as NHS Fife do locally. It was advised that Payroll and financial services roles are generally easier to recruit to in the central belt and larger cities. A key benefit of the proposal is there will be more staff around to ensure the service is efficient and sustainable.

Mrs Margo McGurk highlighted that, at present, the NHS Fife payroll team are very stretched and regularly work weekends to meet the demand. The Head of Payroll has returned for 18 months, following initial retirement, to continue to support the service.

Mrs Carol Potter advised that this is a critical service within the Health Board. Staff do need to be paid on time, therefore it is very important to ensure we have a resilient service.

The Committee **considered** the recommendations and **agreed** to support the key benefits, recognising the importance of this project moving forward. The Committee also **considered** the timing of this proposal and supported the Director of Finance initiating a discussion with NSS on a more phased approach.

7.3 HEPMA Full Business Case

The Chair highlighted that it is positive that this paper is getting to this stage where the Full Business Case can be considered. The clinical aspects of this report were discussed in detail at Clinical Governance the previous week.

Mr Scott Garden, Director of Pharmacy introduced the Business Case to the committee. Debbie Black, Project Manager, joined the meeting for the discussion.

It was highlighted that the Outline Business Case was approved in September 2020. Following that, a mini competition took place. Following a robust evaluation process, a preferred supplier was identified.

The Committee discussed the capital and revenue consequences of the Full Business Case in detail. This also included a discussion on the change to the revenue charging model and the extended length of contract.

A key risk to note is that NHS Fife has taken a different approach compared to other boards. NHS Fife is the only Board in Scotland who has appointed this company. However, we are confident that that we have selected the most appropriate supplier for Fife.

Mr Les Bisset questioned why NHS Fife have gone for a 7-year contract compared to 5 years. Mrs Margo McGurk highlighted that this investment would be unlikely to cease after 5 years whether it was with the preferred supplier or an alternative one.

Mrs Margo McGurk advised that the capital and revenue consequences of the FBC would require to be considered as part of the medium-term financial plan.

The Committee **endorsed** the Full Business case.

7.4 Orthopaedic Elective Project Full Business Case

The Chair highlighted that it is positive to see the Full Business Case being presented. A significant amount of work has been undertaken to get the Business Case to this stage. Mr Alan Wilson was thanked for his hard work on this project and wished well in his new role at NHS Highland. Ben Johnston was congratulated on his new appointment as Director of Capital Planning.

Margo McGurk was invited to present the report to the Committee. It was noted that the Committee has been close to this business case as it has progressed through the programme board. It was noted that, in terms of a financial overview, there has been an increase in the capital costs, which equate to just over £1m. A proposal will be made that the Scottish Government fund this additional cost, as NHS Fife would not be able to support this from their formal capital allocation. Tracey Gardiner, Capital Accountant, is working with Alan Wilson to examine the costs profile in detail. The additional revenue costs are not expected to impact Fife until 2025. The last year of the medium-term financial plan will require a level of provision for the Elective Centre, but the exact level will depend on the progress of the build. There will therefore be an additional revenue consequence associated with this. This will be prioritised in the financial plan moving forward. The Fife Orthopaedic Centre has progressed well, and Scottish Government are keen this project continues to move forward.

NHS Fife members are being asked to present the Business Case at the Scottish Government Capital Investment Group meeting on 11 November. The group provided Fife with a detailed list of questions, and a response has been issued. Mrs Margo McGurk highlighted that it will be important to explore the wider use of digital within this project. This could release productive opportunities and could potentially support future developments.

Dr Chris McKenna emphasised the initial project was ambitious due to future proofing. The impact of Covid on the ability to deliver the current elective programme will take several years to recover. This project will expand the capacity to deliver orthopaedic care, which will be significant for Fife, but it may also be efficient for the region to deliver a modern orthopaedic centre. How NHS Fife brings in research, development and digital innovation to enhance the service will be key.

Mrs Carol Potter advised that this project will bring a very positive reputational impact for NHS Fife both locally and regionally. The ongoing work and development put into this project so far has been tremendous so far.

The Committee **endorsed** the Business Case for onward submission to the Board.

8. PERFORMANCE

8.1 Procurement Lessons Learned Report – PPE / Supplies

Mrs Margo McGurk presented the report to the Committee. It was advised that this report was identified as a suitable agenda item following on from consideration of the Internal Audit Governance Checklist.

The Committee discussed the report and took assurance from the learning during the initial stages of the pandemic which will be critical in supporting the supply of PPE as we go into winter.

The Committee **noted** the findings in the Lessons Learned report and took assurance from that.

8.2 Integrated Performance & Quality Report

Mrs Claire Dobson was invited to provide an update on Acute Services performance. The Committee were advised that this report shows figures for August, but the situation does feel different in Acute now it is November. The 4-hour access performance was positive and above the Scottish average. There was some improvement in Patient TTG but there are still a significant number of patients who are waiting. However, actions are in place to address this. There was improvement in new outpatients in August. Work was done to improve face to face contact and how to manage the outpatient flows. There was increased activity in diagnostics to improve waiting lists. Cancer services is a priority - there were a few breaches in August, but work is being undertaken to address that as a priority.

Mrs Claire Dobson was asked if it would be possible for a performance figure to be introduced to track the length of time for the diagnostic work to be reported back to the patient. It was confirmed that it would be a good performance indicator; however, as most follow ups with patients are done through conversations, this is not monitored. An indicator could be provided on when the report is provided to the clinician, which would be considered.

Mrs Nicky Connor was invited to provide an update on Health and Social Care Performance. The Committee were advised that the delayed discharge position was important to highlight - this continues to reduce and stabilise. This will become more challenging as we move into winter. Smoking cessation activity has been a challenge during the pandemic and alternatives are being explored, such as digital technology, to provide support. A number of vacancies have arisen due to staff applying to support Test and Protect, but there is active recruitment to engage additional staff.

Mrs Margo McGurk was invited to provide an update on Financial Performance. It was highlighted to the Committee that, in terms of the revenue position, funding for the first six months now has greater certainty; however, there are risks in relation to the second half of the year. NHS Fife have received an allocation for £33.5m to support Covid. This allocation represents either an NRAC share or 70% of the costs of Q2-4 and 100% of the costs for Q1. The Scottish Government continue to hold a level of contingency. NHS Fife's requirement may also require to be adjusted as we move into winter and if cases increase. The additional funding covers the expansion of our ICU capacity, test and protect, digital and information technology support for remobilisation of staff, public health expansion, laboratory expansion, seasonal flu and redesigning of urgent care.

The Finance team were thanked for their hard work in managing and reporting both the core and Covid financial impact which has been very challenging.

Mrs Margo McGurk took the Committee through a detailed review of the financial position to September 2020 and also the current forecast year-end position. For the first 6 months NHS Fife are reporting an overspend of £1.9m, which is made up of three aspects which include the run rate on core spend, core unmet savings and Covid related unmet savings.

Specific discussion was held in relation to the performance with the level of deliverable in-year savings, the treatment of offsetting costs and the remaining challenge in relation to the level of savings now deemed undeliverable in-year as a consequence of the pandemic. Mrs Margo McGurk advised that Scottish Government will not confirm their position on the funding available to support the undeliverable savings in-year until January 2021. Assuming no further funding is received for the latter and that the offsetting costs can remain with NHS Fife, a forecast year-end overspend is projected of £2.3m. Additionally however NHS Fife will require to recognise the current risk share agreement with the IJB, which could be an additional £7.2m, this would take the total forecast overspend to £9.5m. Mrs Carol Potter emphasised that the IJB share is a risk, but discussions are taking place between NHS Fife and Fife Council and they are hoping to reach an agreement which can be feedback to the Committee in January 2021.

Mrs Margo McGurk advised that the Capital Position is positive, the full allocation will be spent in line with the agreed plan by the end of the financial year. NHS Fife have also received confirmation of additional funding for MRI / Mammography equipment.

The Committee **noted** the contents of the report, with specific focus on the measures and performance relevant to Operational Performance and Finance.

9. ITEMS FOR NOTING

9.1. Internal Audit Report B17/20 – Operational Performance Management

The Committee **noted** the findings of Internal Audit Report B17/20.

9.2. Minutes of the IJB Finance & Performance Committee, 11 September 2020

The Committee **noted** the minute of the above meeting.

10. ISSUES TO BE HIGHLIGHTED

10.1. To the Board in the IPR & Chair's Comments

The Committee endorsed both the EOC and HEPMA full business cases for onward approval by the Board, noting that the revenue and capital consequences for both required detailed consideration and agreement on prioritisation as part of the medium-term strategic planning and resource allocation process.

The Committee had a full discussion on the projected year-end position for NHS Fife and the significant impact of both COVID 19 and the level of financial risk associated with the

projected year-end outturn for the IJB. The Committee advised that it is imperative that the NHS Fife position in relation to the IJB Risk Share agreement is confirmed and agreed no later than the end of the calendar year. The latter to be concluded as part of the current review of the IJB Integration Scheme.

11. Any Other Business

There was no other business.

Date of Next Meeting: 12 January 2020 at 9.30am in the Staff Club, Victoria Hospital, Kirkcaldy (location TBC).

ACTION POINTS ARISING FROM NHS FIFE FINANCE, PERFORMANCE & RESOURCES COMMITTEE MEETINGS

No.	Original Action Date	Item	Action By	Action Required / Current Status	Date Due
133	**10.09.19**	Kincardine & Lochgelly Health & Wellbeing Centres Initial Agreements	**NC**	Include in the Outline Business Cases information on how technology and digitisation would be utilised.	**Date TBC**
138	**10.03.20**	FP&R Development Session	**MM/GM**	Bi-annual Committee development sessions to be arranged from May 2020.	**Delayed to January 2021**
139	**08.09.20**	Smoke Free Environment Strategy	**NC**	Present an update to inform the Committee on the proposed strategy for a Smoke Free Environment.	**January 2021**
140	**08.09.20**	Mental Health Strategy	**NC**	Present a paper to the Committee at appropriate time around the implementation of the Mental Health Strategy.	**Date TBC**
141	**10.11.20**	CAMHS	**NC**	Provide an update to the Committee on which recommendations made by the Scottish Government can be actioned, once agreed by HSCP Senior Leadership.	**March 2021**

COMPLETED ACTIONS					
130	**14.05.19**	Review of General Policies & Procedures	**GM/AF**	Consider potential software solutions for managing policy updates, seeking opinions from other Boards. Agreed to take to EDG for future review of organisational needs.	**To be captured in routine bi-annual update reporting**
136	**14.01.20**	Update on PT and CAMHS	**NC**	Give an update on performance of both services to the Committee.	**Completed, November 2020**

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**12 January 2021**
Title:	**BAF – Financial Sustainability**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Margo McGurk, Director of Finance, Rose Robertson, Deputy Director of Finance**

1 Purpose

This is presented to the Board for:

- Awareness
- Discussion

This report relates to a:

- Annual Operational Plan
- Emerging Issue
- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to update the Committee on the BAF for Financial Sustainability and the associated risks.

The Committee has a vital role in scrutinising the risk and where indicated, Committee chairs will seek further information from risk owners. This report provides the Committee with an update on NHS Fife BAF specifically in relation to Financial Sustainability as at 31 December 2020.

2.2 Background

As previously reported, the BAF brings together pertinent information on the above risk integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk
- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- Links to performance reporting to the Board and associated risks, legislation & standing orders or opportunities

The Committee is invited to consider the following:

- Does the risk score feel right?
- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented would the outcome be achieved?
- Does the assurance provided describe how the controls are performing?
- Do the assurances come from more than one source including independent sources?
- Are limited resources being allocated appropriately i.e. on uncontrolled high risks or in otherwise well controlled areas of risk?

2.3 Assessment

The Committee can be assured that systems and processes are in place to monitor the financial performance and sustainability of NHS Fife, including the potential impact of the financial position of the Integration Joint Board.

The high-level risks are set out in the BAF, together with the current risk assessment given the mitigating actions already taken. These are detailed in the attached papers. In addition, further detail is provided on the linked operational risks on the corporate risk register. Each risk has an owner who is responsible for the regular review and update of the mitigations in place to manage the risk to financial sustainability and strategic planning.

Through the Code of Corporate Governance, the Board has delegated executive responsibility to the Chief Executive and Director of Finance to ensure the appropriate systems and processes operate effectively to manage and mitigate financial risk on behalf of NHS Fife. The Finance, Performance & Resources Committee is tasked on behalf of the Board to provide appropriate oversight and scrutiny of the associated financial performance. The accountability and governance framework associated with the financial performance of the organisation are key aspects of both internal and external audit review. Individual Directors and managers, through the formal delegation of budgets, are accountable for financial management in their respective areas of responsibility, including the management of financial risks. This framework has been strengthened through the establishment of a system-wide series of Performance & Accountability Review meetings.

The attached schedule reflects the position at 31 December 2020. The BAF current score has been held at High, with the target score remaining Moderate. This recognises the

ongoing financial challenges facing Acute Services in particular, as well as the pressures within Health & Social Care Partnership, specifically in relation to social care budgets and the ongoing work to review the risk share arrangement. It also reflects the level of challenge in delivering the Board efficiency savings target as a consequence of the impact of Covid 19. Linked operational risks are also attached for information.

Further detail on the financial position and projected year-end forecast is set out in the Integrated Performance & Quality Report.

2.3.1 Quality/ Patient Care

Effective financial planning, allocation of resources and in-year management of costs supports the delivery of high-quality care to patients.

2.3.2 Workforce

Effective financial planning, allocation of resources and in-year management of costs supports staff health and wellbeing and is integral to delivering against the aims of the workforce plan.

2.3.3 Financial

Please refer to the full report at Annex 1.

2.3.4 Risk Assessment/Management

Please refer to the full report at Annex 1.

2.3.5 Equality and Diversity, including health inequalities

Effective financial planning, allocation of resources and in-year management of costs includes the appropriate equality and diversity impact assessment process.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders is integral to the NHS Fife financial planning, allocation of resources and in-year management of costs processes.

2.3.8 Route to the Meeting

This paper 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.

- EDG 7 January 2021

2.4 Recommendation

The Committee is invited to:

- **Consider** the questions set out above; and
- **Approve** the updated financial sustainability element of the Board Assurance Framework

3 List of appendices

The following appendices are included with this report:

- BAF – Financial Sustainability
- BAF Risks – Financial Sustainability Linked Operational Risks

Report Contact

Margo McGurk
Director of Finance
Email margo.mcgurk@nhs.net

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Financial Sustainability																											
1671	Sustainable	04/01/2021	5 February 2021	There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will exceed the funding available. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	Current financial climate across NHS/public sector. This risk must now be considered in the context of managing the financial impact of the COVID 19 pandemic.	Margo McGurk Director of Finance	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* Implementation of the Strategic Planning and Resource Allocation (SPRA) process to underpin our Annual Operating Plan (AOP) process. Ensure budgets are devolved to an appropriate level aligned to management responsibilities and accountabilities. This includes the allocation of any financial plan shortfall to all budget areas. This seeks to ensure all budget holders are sighted on their responsibility to contribute to the overall requirement to deliver breakeven.	Nil	1. Continue a relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value. Responsible Person: Director of Finance / Director of Acute Services / Director of Health & Social Care Timescale: Ongoing 2. Continue to maintain an active overview of national funding streams to ensure all NHS Fife receives a share of all possible allocations. 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology and in particular ensure that EDG, FP&R and the Board are appropriately advised on the options available to manage any overspend within the IJB prior to the application of the risk share arrangement Responsible Person: Director of Finance Timescale: Ongoing	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.	1. Internal audit reviews on controls and process; including Departmental reviews . 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the the social care forecasts and the likely outturn at year end.	The response to the COVID 19 pandemic required the organisation to focus all our efforts initially on mobilising the response plan and then on remobilising services, the next challenge will be winter and the second COVID 19 peak. The financial impact of COVID 19 is significant however we have now received full funding for 2020/21 Q1 additional costs and 70% of the forecast costs to the year-end. There is a significant challenge remaining however regarding undelivered savings as a consequence of COVID 19 and the IJB Risk-Share arrangement.	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Financial risks will always be prevalent within the NHS / public sector however it would be reasonable to aim for a position where these risks can be mitigated to an extent.

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1364	Efficiency Savings	Active	High	20	McGurk, Margo
1513	Financial and Economic impact of Brexit	Active	High	20	McGurk, Margo
1363	Health and Social Care Integration	Active	High	20	McGurk, Margo
1784	Finance (Short Term/Immediate)	Active	High	16	Connor, Nicky
522	Prescribing and Medicines Management - Prescribing Budget	Active	High	15	McKenna, Christopher

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1357	Financial Planning, Management & Performance	No longer a high risk	Moderate	12	McGurk, Margo
1846	Test and Protect	No longer a high risk	Moderate	12	Connor, Nicky

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)	Current Management Actions	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Consequence (Target)	Risk level (Target)	Rating (Target)	Risk Owner	Handler	Previous Review Date	Next Review
1364	NHSFBD - Finance Directorate Risk Register	13.06.2017	Efficiency Savings	There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	The Financial Plan presented to Finance, Performance and Resources Committee in March highlighted the requirement for £20.015m cash efficiency savings to support financial balance in 2020/21. Whilst we had initially indicated an expected underachievement of savings of £14.2 via the Local Mobilisation Financial Template process; and a £5.8m efficiency savings target for NHS Fife; this has since been updated to reflect £11.2m expected achievement; and £8.8m anticipated underachievement of savings. SG plan to conduct a review of Boards' unmet savings to inform their decision on potential additional funding over the coming weeks to inform the January final Covid-19 allocation. We await SG decision on the treatment of offsetting cost reductions, there is a potential benefit of £5.701m if we can retain offsets. We would plan to use these offsetting cost reductions to mitigate some of the anticipated unachieved savings of £8.768m. If the aforementioned assumptions crystallise, the NHS Fife forecast RRL position would be an overspend of £2.285m. Further detailed review work will be undertaken to identify any further financial flexibility in an effort to deliver an improved position however, based on the current IJB Risk-Share agreement, the potential year-end outturn position could rise to £9.492m overspend.	4 - Likely - Strong possibility this could occur	5 - Extreme	High Risk	20	3 - Possible - May occur occasionally - reasonable chance	3 - Moderate	Moderate Risk	9	McGurk, Margo	Robertson, Rose	04.01.2021	05.02.2021
1513	NHSFBD - Brexit Risk Register	04.10.2018	Financial and Economic impact of Brexit	Brexit, and uncertainty over the final withdrawal agreement, has the potential to cause a large amount of uncertainty, both in respect to understanding what the Health Board's budget allocation may be (i.e. income), and on costs (i.e. expenditure). This risk has been escalated to the Finance, Performance and Resources Committee.	5 - Almost Certain - Expected to occur frequently - more likely than not	5 - Extreme	High Risk	25	The Director of Estates and Facilities has been appointed lead Director for the EU exit locally and is liaising with SG and NSS on this matter and will report updates through the EDG and governance committees. Modelling has been done at a national level with an initial focus on anticipated supply levels into the UK post the withdrawal in the event of a no-deal departure.	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	1 - Remote - Can't believe this event would happen	1 - Negligible	Very Low Risk	1	McGurk, Margo	Stewart, Laura	04.01.2021	05.02.2021
1363	NHSFBD - Finance Directorate Risk Register	13.06.2017	Health and Social Care Integration	There is a risk that a proportion of any Health and Social care overspend at the year end will require to be funded by NHS Fife. The Integration Scheme for Fife states "8.2.4. Any remaining overspend will be funded by the parties based on the proportion of their current year contributions to the Integration Joint Board".	4 - Likely - Strong possibility this could occur	5 - Extreme	High Risk	20	An Integration Scheme Review chaired by the Director of Health & Social Care; and a Risk Share Review chaired by the Chief Finance Officer, were established in 2019/20 - this was temporarily paused due to Covid 19, conversations across the partners are in progress to conclude the review. The Director of Finance has proposed a variation to the current risk-share scheme to remove the GMS, PMS and Resource Transfer budgets from the risk-share calculation. Fife Council have reviewed and currently have not agreed the variation. The matter has now been escalated to the CEs NHS Fife and Fife Council for discussion.	4 - Likely - Strong possibility this could occur	5 - Extreme	High Risk	20	3 - Possible - May occur occasionally - reasonable chance	3 - Moderate	Moderate Risk	9	McGurk, Margo	Robertson, Rose	04.01.2021	05.02.2021
1784	NHSFBD – COVID-19 Risk Register	28.04.2020	Finance (Short Term/Immediate)	There is a risk that the Coronavirus outbreak will have a negative financial impact on the HSCP in the short term	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20	18.12.20 Mobilisation plans submitted to Scottish Government. These reflect a year of costs. Regular meetings with NHS Fife and Fife Council Directors of Finance. Designated Covid -19 financial codes in both organisations. Letter of comfort from Scottish Government outlining agreement in principle to fund Covid 19 costs. Scottish Government have released an initial £50M across Scotland. Fife's share is £3.4M August 2020 - Confirmation received of a further £1.7M for Fife. A contribution of £680k has been received from the Scottish Government towards the 3.3% uplift for the living wage. However, this still leaves a pressure of £1M. Cross reference this risk to IJB Strategic Risk 3 Finance Further Government funding was announced at the end of September. £1.1Bn in total made available. However, unachieved savings are currently excluded. This is under review with further decisions expected in November for Social Care and January for Health. Recovery actions are being considered to help reduce the overspend.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	1 - Remote - Can't believe this event would happen	1 - Negligible	Very Low Risk	1	Connor, Nicky	Sweeney, Avril	18.12.2020	15.01.2021

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)	Current Management Actions	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Consequence (Target)	Risk level (Target)	Rating (Target)	Risk Owner	Handler	Previous Review Date	Next Review
522	CORPORATE RISK REGISTER, NHSFBD - Prescribing & Medicines Management Risk Register	30.03.2006	Prescribing and Medicines Management - Prescribing Budget	Prescribing and Medicines Management - Prescribing Budget: There is a risk that NHS Fife will be unable to control the prescribing budget.	3 - Possible - May occur occasionally - reasonable chance	3 - Moderate	Moderate Risk	9	02/12/2020 - GP Prescribing is £536k overspent at October, with an end of year forecast of £1m overspend on an annual budget of £70.6m. There has been retraction of budget in respect of Tariff reductions effective from April. Higher drug prices are being experienced due to short supply, likely exacerbated by COVID. Opportunity to realise planned saving schemes have been lost as the workforce is focused on COVID services and patient care. Implementation of Freestyle Libre (flash glucose monitoring system) continues to exceed original forecast and funding provided. Hospital prescribing is £328k overspent at October, with an in-year budget of £31.5m. Current year savings achieved in Acute is £193k, with a recurring benefit of £77k (net of investment totalling £85k). New medicine fund allocations up to month 7 is £3.2m, with an in-year budget of £5m. Based on current expenditure to date, it is likely there will be insufficient funds to cover claims for the full year. A pre-meeting of the Fife Prescribing Forum has taken place where draft Terms of Reference and service template were discussed. Monthly meetings with clinical specialities are being arranged for 2021. Risk level increased to 15.	5 - Almost Certain - Expected to occur frequently - more likely than not	3 - Moderate	High Risk	15	3 - Possible - May occur occasionally - reasonable chance	3 - Moderate	Moderate Risk	9	McKenna, Christopher	Reid, Euan	02.12.2020	05.02.2021

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)
1364	NHSFBD - Finance Directorate Risk Register	13.06.2017	Efficiency Savings	There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16

Current Management Actions	Likelihood (current)
The Financial Plan presented to Finance, Performance and Resources Committee in March highlighted the requirement for £20.015m cash efficiency savings to support financial balance in 2020/21. Whilst we had initially indicated an expected underachievement of savings of £14.2 via the Local Mobilisation Financial Template process; and a £5.8m efficiency savings target for NHS Fife; this has since been updated to reflect £11.2m expected achievement; and £8.8m anticipated underachievement of savings. SG plan to conduct a review of Boards' unmet savings to inform their decision on potential additional funding over the coming weeks to inform the January final Covid-19 allocation. We await SG decision on the treatment of offsetting cost reductions, there is a potential benefit of £5.701m if we can retain offsets. We would plan to use these offsetting cost reductions to mitigate some of the anticipated unachieved savings of £8.768m. If the aforementioned assumptions crystallise, the NHS Fife forecast RRL position would be an overspend of £2.285m. Further detailed review work will be undertaken to identify any further financial flexibility in an effort to deliver an improved position however, based on the current IJB Risk-Share agreement, the potential year-end outturn position could rise to £9.492m overspend.	4 - Likely - Strong possibility this could occur

5 - Extreme	Consequence (current)
High Risk	Risk level (current)
20	Rating (current)
3 - Possible - May occur occasionally - reasonable chance	Likelihood (Target)
3 - Moderate	Consequence (Target)
Moderate Risk	Risk level (Target)
9	Rating (Target)
McGurk, Margo	Risk Owner
Robertson, Rose	Handler
04.01.2021	Previous Review Date
05.02.2021	Next Review

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)
1363	NHSFBD - Finance Directorate Risk Register	13.06.2017	Health and Social Care Integration	There is a risk that a proportion of any Health and Social care overspend at the year end will require to be funded by NHS Fife. The Integration Scheme for Fife states "8.2.4. Any remaining overspend will be funded by the parties based on the proportion of their current year contributions to the Integration Joint Board".	4 - Likely - Strong possibility this could occur	5 - Extreme	High Risk	20

Current Management Actions	Likelihood (current)
An Integration Scheme Review chaired by the Director of Health & Social Care; and a Risk Share Review chaired by the Chief Finance Officer, were established in 2019/20 - this was temporarily paused due to Covid 19, conversations across the partners are in progress to conclude the review. The Director of Finance has proposed a variation to the current risk-share scheme to remove the GMS, PMS and Resource Transfer budgets from the risk-share calculation. Fife Council have reviewed and currently have not agreed the variation. The matter has now been escalated to the CEs NHS Fife and Fife Council for discussion.	4 - Likely - Strong possibility this could occur

5 - Extreme	Consequence (current)
High Risk	Risk level (current)
20	Rating (current)
3 - Possible - May occur occasionally - reasonable chance	Likelihood (Target)
3 - Moderate	Consequence (Target)
Moderate Risk	Risk level (Target)
9	Rating (Target)
McGurk, Margo	Risk Owner
Robertson, Rose	Handler
04.01.2021	Previous Review Date
05.02.2021	Next Review

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)
1513	NHSFBD - Brexit Risk Register	04.10.2018	Financial and Economic impact of Brexit	Brexit, and uncertainty over the final withdrawal agreement, has the potential to cause a large amount of uncertainty, both in respect to understanding what the Health Board's budget allocation may be (i.e. income), and on costs (i.e. expenditure). This risk has been escalated to the Finance, Performance and Resources Committee.	5 - Almost Certain - Expected to occur frequently - more likely than not	5 - Extreme	High Risk	25

Current Management Actions	Likelihood (current)
The Director of Estates and Facilities has been appointed lead Director for the EU exit locally and is liaising with SG and NSS on this matter and will report updates through the EDG and governance committees. Modelling has been done at a national level with an initial focus on anticipated supply levels into the UK post the withdrawal in the event of a no-deal departure.	5 - Almost Certain - Expected to occur frequently - more likely than not

4 - Major	Consequence (current)
High Risk	Risk level (current)
20	Rating (current)
1 - Remote - Can't believe this event would happen	Likelihood (Target)
1 - Negligible	Consequence (Target)
Very Low Risk	Risk level (Target)
1	Rating (Target)
McGurk, Margo	Risk Owner
Stewart, Laura	Handler
04.01.2021	Previous Review Date
05.02.2021	Next Review

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)
1784	NHSFBD – COVID-19 Risk Register	28.04.2020	Finance (Short Term/Immediate)	There is a risk that the Coronavirus outbreak will have a negative financial impact on the HSCP in the short term	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	High Risk	20

Current Management Actions	Likelihood (current)
18.12.20 Mobilisation plans submitted to Scottish Government. These reflect a year of costs. Regular meetings with NHS Fife and Fife Council Directors of Finance. Designated Covid -19 financial codes in both organisations. Letter of comfort from Scottish Government outlining agreement in principle to fund Covid 19 costs. Scottish Government have released an initial £50M across Scotland. Fife's share is £3.4M August 2020 - Confirmation received of a further £1.7M for Fife. A contribution of £680k has been received from the Scottish Government towards the 3.3% uplift for the living wage. However, this still leaves a pressure of £1M. Cross reference this risk to IJB Strategic Risk 3 Finance Further Government funding was announced at the end of September. £1.1Bn in total made available. However, unachieved savings are currently excluded. This is under review with further decisions expected in November for Social Care and January for Health. Recovery actions are being considered to help reduce the overspend.	4 - Likely - Strong possibility this could occur

4 - Major	Consequence (current)
High Risk	Risk level (current)
16	Rating (current)
1 - Remote - Can't believe this event would happen	Likelihood (Target)
1 - Negligible	Consequence (Target)
Very Low Risk	Risk level (Target)
1	Rating (Target)
Connor, Nicky	Risk Owner
Sweeney, Avril	Handler
18.12.2020	Previous Review Date
15.01.2021	Next Review

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)
522	CORPORATE RISK REGISTER, NHSFBD - Prescribing & Medicines Management Risk Register	30.03.2006	Prescribing and Medicines Management - Prescribing Budget	Prescribing and Medicines Management - Prescribing Budget: There is a risk that NHS Fife will be unable to control the prescribing budget.	3 - Possible - May occur occasionally - reasonable chance	3 - Moderate	Moderate Risk	9

Current Management Actions	Likelihood (current)
02/12/2020 - GP Prescribing is £536k overspent at October, with an end of year forecast of £1m overspend on an annual budget of £70.6m. There has been retraction of budget in respect of Tariff reductions effective from April. Higher drug prices are being experienced due to short supply, likely exacerbated by COVID. Opportunity to realise planned saving schemes have been lost as the workforce is focused on COVID services and patient care. Implementation of Freestyle Libre (flash glucose monitoring system) continues to exceed original forecast and funding provided. Hospital prescribing is £328k overspent at October, with an in-year budget of £31.5m. Current year savings achieved in Acute is £193k, with a recurring benefit of £77k (net of investment totalling £85k). New medicine fund allocations up to month 7 is £3.2m, with an in-year budget of £5m. Based on current expenditure to date, it is likely there will be insufficient funds to cover claims for the full year. A pre-meeting of the Fife Prescribing Forum has taken place where draft Terms of Reference and service template were discussed. Monthly meetings with clinical specialities are being arranged for 2021. Risk level increased to 15.	5 - Almost Certain - Expected to occur frequently - more likely than not

3 - Moderate	Consequence (current)
High Risk	Risk level (current)
15	Rating (current)
3 - Possible - May occur occasionally - reasonable chance	Likelihood (Target)
3 - Moderate	Consequence (Target)
Moderate Risk	Risk level (Target)
9	Rating (Target)
McKenna, Christopher	Risk Owner
Reid, Euan	Handler
02.12.2020	Previous Review Date
05.02.2021	Next Review

NHS Fife

Meeting:	**Finance, Performance and Resource Committee**
Meeting date:	**12 January 2021**
Title:	**NHS Fife Board Assurance Framework (BAF) Strategic Planning**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) is intended to provide accurate and timely assurances to this Committee and ultimately to the Board that the organisation is delivering on its strategic objectives in line with the following:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health & Social Care Integration Strategic Plan

The Committee has a vital role in scrutinising the risk and where indicated, Committee chairs will seek further information from risk owners.

This report provides the Committee with the next version of the NHS Fife BAF 5 on 14.01.21.

2.2 Background

This BAF brings together pertinent information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk
- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- Links to performance reporting to the Board and associated risks, legislation & standing orders or opportunities
- Provides a brief assessment of current performance. In due course, the BAF will provide detail on the progress of the risk over time - improving, moving towards or away from its target.

2.3 Assessment

There are five local key priorities for NHS Fife during 2020/21 aligned to the Clinical Strategy and Strategic Plan which underpin all aspects of the Health Board's strategic plan following the review of the integrated transformation programme:

1. Acute Services Transformation Programme
2. Joining Up Care - Community Redesign
3. Mental Health Redesign
4. Medicines Efficiencies
5. Integration and Primary Care

The priorities for the organisation will be reviewed and revised as part of the Strategic Planning Resource Allocation (SPRA) process taking into account the COVID-19 environment, service redesign and change programmes.

A full review of the Transformation programme and Strategic Planning has been undertaken currently in line with the Clinical Strategy and Remobilisation Plan.

However, due to the COVID-19 Emergency Planning Measures in place until 31 March 2021, the transformation work has been paused but will be recommenced when appropriate to do so including a revised management and reporting structure.

2.3.1 Quality/ Patient Care

Quality of Patient Care is part of the work of the Remobilisation Oversight Group

2.3.2 Workforce

No change.

2.3.3 Financial

Financial implications are dealt with through the process to restart services and the Finance Director is a member of the Remobilisation Oversight Group.

2.3.4 Risk Assessment/Management

Risk Assessment is part of the restart of services process.

2.3.5 Equality and Diversity, including health inequalities

Equality and Diversity is part of the restart of services process.

2.3.6 Other impact

n/a

2.3.7 Route to the Meeting

This paper 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.

- EDG, 7 January 2021

2.4 Recommendation

The Committee is invited to:

- **Discuss** the current position in relation to the Strategic Planning risk

Report Contact
Susan Fraser
Associate Director of Planning and Performance
Email susan.fraser3@nhs.scot

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	05/01/2021	1 March 2021	There is a risk that NHS Fife will not deliver the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost with the consequence that the Clinical Strategy does not reflect current priorities. Key Risks 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the transformation programmes remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	Integrated Transformation Board now in place after the review of transformation in 2019. Following period of COVID-19, transformation planning is being revised and new structure being put in place following transformation workshop planned for 3 September 2020. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Margo McGurk Director of Finance	Clinical Governance. Dr Les Bisset.	*Ongoing actions designed to mitigate the risk including:* 1. Establishment of Integrated Transformation Board (ITB) in 2019 to oversee transformation programmes across NHS Fife, Fife IJB and Fife Council to drive the delivery of the H&SC Strategic Plan and the Clinical Strategy. 2. Establishment of programme management framework with a stage and gate approach. 3. 3 of the 4 key strategic priorities are being taken forward by the H&SCP/IJB. The remaining priority is being taken forward by Acute services and progress shared through regular highlight reports. Programme Boards provide oversight and strategic guidance to the programme. Collaborative oversight is provided by the ITB. 4. The annual Service Planning Reviews and regular Performance and Accountability Reviews of individual services supported this process but has now been replaced by the SPRA process. CONTROLS WILL BE REVIEWED DURING REMOBILISATON OF SERVICES WHICH WILL INCLUDE TRANSFORMATION AND REDESIGN WORK	Pause in governance of transformation since COVID-19 – will be restarted when services are remobilised.	Leadership to strategic planning coming from the Executive Directors Group. Clinical Strategy workstream update has been produced to reflect progress against recommendations. Establishment of governance group should provide assurance to the committees and Board that the transformation programme has strategic oversight and delivery. Senior Leadership for Transformation is being reviewed and revised. Refresh of the Clinical Strategy has been paused over COVID-19. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process. ON HOLD OVER COVID19 PERIOD Responsible Person: Director of Finance Timescale: 31/03/2021	1. Minutes of meetings record attendance, agenda and outcomes. 2. New governance in place with newly formed governance group. 3. Performance and Accountability Reviews now underway which will provide assurance to committees on performance of all services. 4. Reporting of key priorities to governance groups from the SPRA process .	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. SEAT Annual Report 2016 3.Governance committee oversight of performance assurance framework.	Business cases have been developed in support of the transformation programmes which address issues such as resource implications, workforce and facilities redesign. Standardised documentation will introduce a consistent approach to programme management. Risks to delivery have been identified at Programme level and mitigating actions are in place and regularly monitored.	Current challenges associated with delivery of our strategic objectives – key priorities to be agreed but on hold given emergency planning measures still in place. ON HOLD OVER COVID19 PERIOD. WILL BE RESTARTED AS PART OF REMOBILISATION	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Once governance and monitoring is in place and transformation programmes are being realised, the risk level should reduce. WILL BE REVIEWED AFTER COVID19 PERIOD.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife

Meeting: **FP&R**

Meeting date: **12th Jan 2021**

Title: Update on NHS Fife Board Assurance Framework (BAF)

Environmental Sustainability

Responsible Executive: **Andy Fairgrieve Director of Estates , Facilities & Capital Services**

Report Author: **Andy Fairgrieve Director of Estates , Facilities & Capital Services**

1 Purpose

This is presented to FP&R for:

- Decision

This report relates to a:

- Board Governance & Strategic Objectives

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

- Safe

2 Report summary

2.1 Situation

The BAF is intended to provide assurances to this Committee and ultimately to the Board, that the organisation is delivering on its strategic objectives as contained in the following:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health &Social Care Integration Strategic Plan

This report provides FP&R with an update on NHS Fife BAF in relation to BAF risks .

2.2 Background

Estates &Facilities receive capital funding from Scottish Government via Fife's Capital Investment Group to address any statutory compliance or backlog maintenance issues. This is never enough and the above projects there for need to be prioritised and the highest risks receive the funding.

2.3 Assessment

Assessment of FHB's current position-

Estates &Facilities continue to work on the risks as and when funding becomes available.

Both PFI providers at St Andrews and the VHK have started the replacement program for the flexible hoses . Only when these projects been completed will we remove them from the relevant BAF and risk registers .

There has been no change to the previous BAF report .

2.3.1 Quality/ Patient Care

There is no negative impact to patient care as the risks are being managed

2.3.2 Workforce

There is no negative impact to the workforce.

2.3.3 Financial

Capital projects are being managed as and when funding becomes available.

2.3.4 Risk Assessment/Management

Please see attached risks and BAF.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

External stakeholders are appointed where appropriate:

2.3.8 Route to the Meeting

This paper 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.

EDG was the first Group to be consulted .

2.4 Recommendation

- **Decision** – Note the report

3 List of appendices

The following appendices are included with this report:

- BAF Environmental Sustainability
- BAF Environmental Sustainability linked operational risks

Report Contact
Andy Fairgrieve
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NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Environmental Sustainability																											
1672	Clinically Excellent, Sustainable	08/12/2020	5 February 2021	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	4 - Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Andrew Fairgrieve Director of Estates	Finance, Performance & Resources (F,P&R). Rona Laing.	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating Responsible person: Director of Estates, Facilities & Capital Services Timescale: Ongoing as limited funding available 2. Increase number of site audits Responsible person: Estates Compliance Manager Timescale: Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS 5. Adverse Event reports.	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews.	None.	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 – Remote – Can't believe this event would happen	5 - Extreme	5	Low Risk	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	20	Fairgrieve, Andrew
1252	Flexible PEX hoses in PHASE 3 VHK	Active Risk	High Risk	15	Fairgrieve, Andrew
1007	Theatre Phase 2 Remedial work	Active Risk	High Risk	15	Cross, Murray

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
735	Medical Equipment Register	Closed Risk			
749	836 - VHK Ph.2 Main Foul Drainage Tower Block	Closed Risk			
1083	VHK CLO2 Generator (Legionella Control)	Closed Risk			
1207	Water system Contamination STACH	Active Risk	Moderate Risk	10	Fairgrieve, Andrew
1275	South Labs Plantroom	Active Risk	Moderate Risk	8	Lowe, David
1306	Risk of pigeon guano on VHK Ph2 Tower Windows	Active Risk	Moderate Risk	12	Lowe, David
1312	Vertical Evacuation - VHK Phase 2 Tower Block	Closed Risk			
1314	Inadequate Compartmentation of Escape Stairs and Lift Enclosures	Closed Risk			
1315	Vertical Evacuation - VHK Phases 1 and 2 (excluding Tower Block)	Closed Risk			
1316	Inadequate Compartmentation VHK Phase 1, Phase 2 floors B-1st	Active Risk	Moderate Risk	8	Fairgrieve, Andrew
1335	FCON Fire alarm potential failure	Closed Risk			
1341	Oil Storage - Fuel Tanks - Central/NEF	Active Risk	Moderate Risk	10	Keatings, Gordon
1342	Oil Storage - Fuel Tanks - QMH/DWF	Active Risk	Moderate Risk	10	Wishart, James
1352	Pinpoint malfunction	Closed Risk			
1384	Microbiologist Vacancy	Closed Risk			
1473	Stratheden Hospital Fire Alarm System	Closed Risk			

ID	1007	1252	1296
Position of Risk (Risk Register)	Acute Services - Planned Care - Theatres/Anaesthetics Risk Register	Corporate Directorate - Estates Risk Register	CORPORATE RISK REGISTER, Corporate Directorate - Estates Risk Register
Opened	11.02.2015	02.06.2016	22.08.2016
Title	Theatre Phase 2 Remedial work	Flexible PEX hoses in PHASE 3 VHK	Emergency Evacuation, VHK Phase 2 Tower Block
Description	Risk of increased loss of service due to deteriorating fabric of building resulting in reduced ability to reach TTG targets.	AF 2/8/16 There is a risk to patient safety due to a legionella risk in phase 3 building. EFA DH (2010)03 stated that flexible hoses when used for the supply of potable water may have an enhanced risk of harboring Legionella bacteria and other harmful microorganisms.	There is a risk that a second stage fire evacuation, or complete emergency evacuation, of the upper floors of Phase 2 VHK, may cause further injury to frail and elderly patients, and/or to staff members from both clinical and non-clinical floors.
Likelihood (initial)	3 - Possible - May occur occasionally - reasonable chance	3 - Possible - May occur occasionally - reasonable chance	4 - Likely - Strong possibility this could occur
Consequence (initial)	5 - Extreme	5 - Extreme	5 - Extreme
Risk level (initial)	High Risk	High Risk	High Risk
Rating (initial)	15	15	20
Current Management Actions	13/4/20 Risk remains unchanged and plans are being taken forward as outlined on 30/4/2019 M.C 30/04/2019 funding has been agreed and plans are well underway for a new Orthopaedic Building which will accommodate theatres, ward are and out-patient area. This will not be complete until 2022 Executive team reviewing options of undertaking surgery in alternative theatres.	JR/KD It was agreed that the flexible hose replacement would be a 2 year programme of work. The first 50% is to be rolled out this year, although this is likely to start later due to the current situation, and 50% is to be replaced in 2021.	JR - 04/11/2020 - The current management actions/position for this risk are: two tone fire alarm system to allow identification of zone of fire and progression of patients to a safe zone. :Fire response team in place all wit their own pagers, responding to a fire alert automatically. :Clinical coordinators/fire response team trained. :Fire wardens for the site trained.
Likelihood (current)	3 - Possible - May occur occasionally - reasonable chance	3 - Possible - May occur occasionally - reasonable chance	4 - Likely - Strong possibility this could occur
Consequence (current)	5 - Extreme	5 - Extreme	5 - Extreme
Risk level (current)	High Risk	High Risk	High Risk
Rating (current)	15	15	20
Likelihood (Target)	1 - Remote - Can't believe this event would happen	2 - Unlikely - Not expected to happen - potential exists	1 - Remote - Can't believe this event would happen
Consequence (Target)	5 - Extreme	5 - Extreme	5 - Extreme
Risk level (Target)	Low Risk	Moderate Risk	Low Risk
Rating (Target)	5	10	5
Risk Owner	Cross, Murray	Fairgrieve, Andrew	Fairgrieve, Andrew
Handler	Lowe, David	Bishop, Paul	Ramsay, Jimmy
Previous Review Date	14.04.2020	28.04.2020	04.11.2020
Next Review	30.04.2021	31.03.2021	31.03.2021

NHS Fife

Meeting:	**Finance, Performance and Resource Committee**
Meeting date:	**12 January 2021**
Title:	**Strategic Planning and Resource Allocation Update**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to:

- Strategic Planning and Resource Allocation Process

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Strategic Planning and Resource Allocation (SPRA) Process is now underway This paper outlines a proposed new strategic planning and resource allocation process for NHS Fife.

The SPRA process is intended to create a planning and resource allocation framework to support the development of the organisational strategy for NHS Fife. This will inform the 3 year financial and strategic plan to support the delivery of the strategy.

At the beginning of December 2020, a template was sent to all directorates and major programmes of NHS Fife for completion. This paper describes the SPRA process and provides an update on the submission process.

2.2 Background

The Service Review process has been in place for the past 3 years, but a different approach has been taken for 2021/22. The Strategic Planning and Resource Allocation process brings together the planning of services, financial and workforce implications of service delivery and change. Full description and guidance for the SPRA process can be found in Appendix 1.

2019/20 and 2020/21 has been characterised by a major disruption of services due to COVID-19 in terms of the mobilisation of services to deal with COVID-19 and the remobilisation of services in a COVID-19 sensitive environment. The NHS in Scotland continues to operate under emergency planning measures until at least the end of March 2021.The immediate response and subsequent planning for remobilisation of services has resulted in significant changes in service models and, in some cases, delivery.

The current uncertainty in the future means planning for 2021/22 is difficult and may need to be revised throughout the year. With this in mind, any planning undertaken now need to be agile to adapt to any new national guidance as well as local prioritisation.

2.3 Assessment

SPRA Process

Once the submission of all the directorate and programme templates have taken place, the process will be to review and collate the submissions in order to report back to EDG on the list of service changes and programmes that will be discussed and then prioritised. These service changes and programmes will be considered in terms of the overall objectives, quality of care as well as financial and workforce implications.

Once completed, the governance of this work will be to provide a paper on the organisation's priorities to the committees and through to the Board.

Key dates:

7 January	Update to SPRA process to EDG
21 January	Summary of submissions to EDG followed by prioritisation
24 February	Board Development Session
28 February	Submission of Remobilisation Plan 3 (RMP3)
5 March	SBAR to Staff Governance Committee
11 March	SBAR to Clinical Governance Committee
16 March	SBAR to Finance, Performance and Resource Committee
31 March	Final SPRA report and RMP3 to Board

Summary of Completed Templates

The response from directorates was positive, of the 14 submissions requested, including Health & Social Care, 10 have been received of which 3 were partially completed. Health & Social Care have agreed to submit high-level priorities separately as they are undertaking a similar piece of work for the IJB.

From 24 requested submissions for Programmes there has been 14 submitted, fully completed, to date.

An initial review of the submissions so far has provided detailed information on service priorities and risks that will inform the future strategic planning of the delivery of health care services in Fife.

Several reminders have been issued to remind directors of the request and the deadline dates. The missing returns will continue to be chased up.

2.3.1 Quality/ Patient Care

The main aim of SPRA process is to continue to deliver high quality care to patients.

2.3.2 Workforce

Workforce planning is key to the SPRA process.

2.3.3 Financial

Financial planning is key to the SPRA process.

2.3.4 Risk Assessment/Management

Risk assessment is part of SPRA process and will be part in the prioritisation of key objectives

2.3.5 Equality and Diversity, including health inequalities

Equality and Diversity is integral any redesign based on the SPRA process.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation throughout the SPRA process.

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

EDG is asked to:

- **Note** the update to the Strategic Planning and Resource Allocation process and the progress that has been made on the submission of templates from directorates and programmes.

3 List of appendices

Appendix 1: Strategic Planning and Resource Allocation Proposal Guidance

Report Contact

Susan Fraser

Associate Director of Planning and Performance

Email susan.fraser3@nhs.scot

Strategic Planning and Resource Allocation (SPRA)

Proposal and Guidance 2020/21- 2022/23

EXECUTIVE DIRECTORS GROUP November 2020

CONTENTS

Section A: Introduction

This paper outlines a proposed new strategic planning and resource allocation process for NHS Fife.

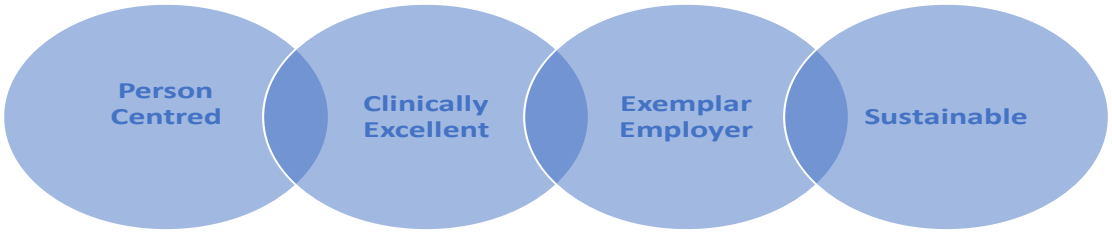
The Chief Executive has lead responsibility for developing the organisational strategy for NHS Fife for consideration and approval by the NHS Fife Board. The SPRA process is intended to create a planning and resource allocation framework to support that role. The Chief Executive relies on effective collaboration across the directorates to create the 3-year plan to inform and support the delivery of the strategy.

Each director also has a role to ensure that the knowledge and insights gathered from their individual or collective engagement with various national groups and key stakeholders is shared with EDG as part of the SPRA process and used to guide and inform this planning process.

Section B: NHS Fife Strategic Objectives

Strategic Objectives

Each year a review and objective setting exercise is completed for the Corporate Objectives. 2019/20 and 2020/21 were years characterised by a major disruption of services due to Covid-19. The immediate response and subsequent planning for remobilisation of services has resulted in significant changes in service models and, in some cases, delivery. Our 4 strategic objectives over the next 5-year period are summarised below.

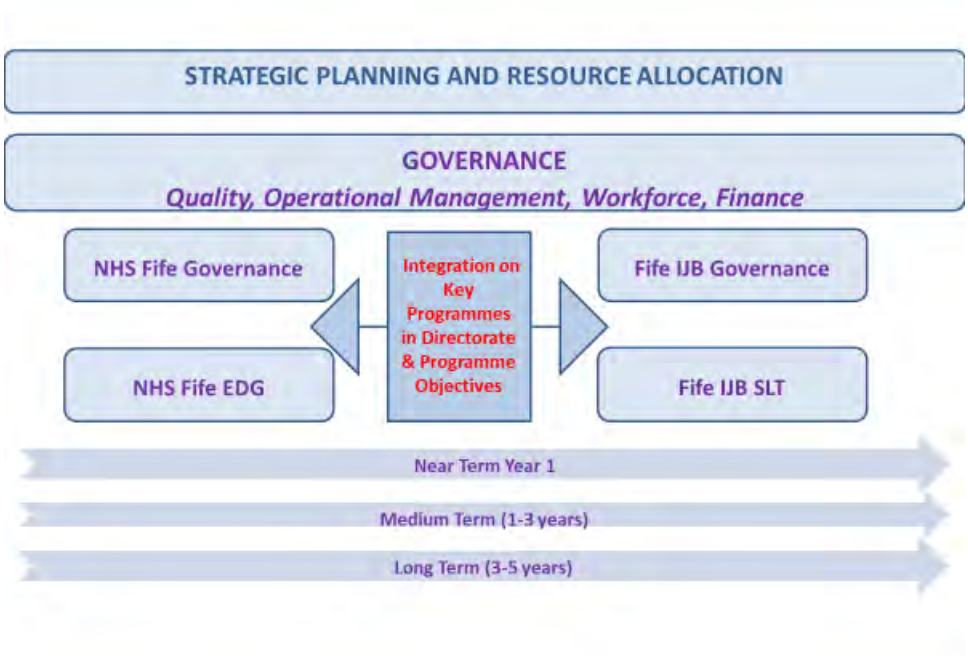


Person Centred	Clinically Excellent	Exemplar Employer	Sustainable
Listen to what matters to YOU	Work with YOU to receive the best care possible	Create time and space for continuous learning	Optimise resource for health and well-being
Design Services in partnership with service users, carers and communities	Ensure there is no avoidable harm	Listen to and involve staff at all levels	Ensure cost effective and within budget
Give YOU choices and information	Achieve and maintain quality standards	Give staff the skills, resources and equipment required for the job	Increase efficiency and reduce waste

Create environments that encourage caring and positive outcomes for all	Ensure environment is clean, tidy, well maintained, safe and something to be proud of	Encourage staff to be ambassadors for Health and Social Care in Fife	Service redesign will ensure cost effective, lean and minimise adverse variation
Develop and redesign services that put patients first supporting independent living and self-management	Embed patient safety consistently across all aspects of healthcare provision	Create high-performing MDT through education and development	Optimise use of property and assets with our partners
		Equip people to be the best leaders	

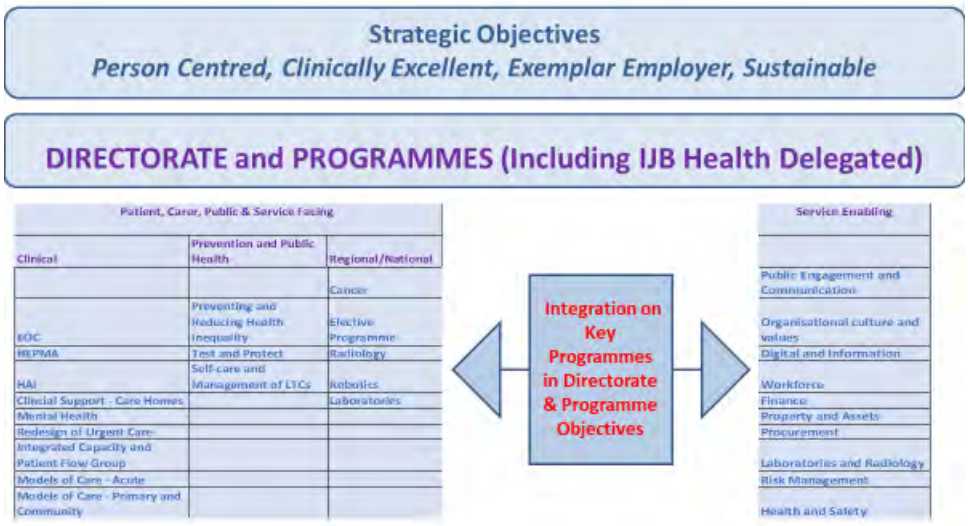
Section C: Governance

This new process will support the delivery of NHS Fife strategic objectives and will follow the current approvals and governance processes for NHS Fife. There will also be integration with Fife IJB governance to ensure consistency of approach and clarity of roles and assumptions across key programmes and objectives.



Section D: The Scope

One of the key aims of this new process is to articulate the scope of work across the organisation and within the IJB which requires to be done to deliver our strategic objectives. Understanding the scope and the potential phasing of activity will support the overall prioritisation process required to create a deliverable 3-year plan. It will also ensure that the resources available to us are targeted to those prioritised objectives.



Section E: Guidance on Preparing Strategic Planning and Resource Allocation Directorate and Programme Submissions

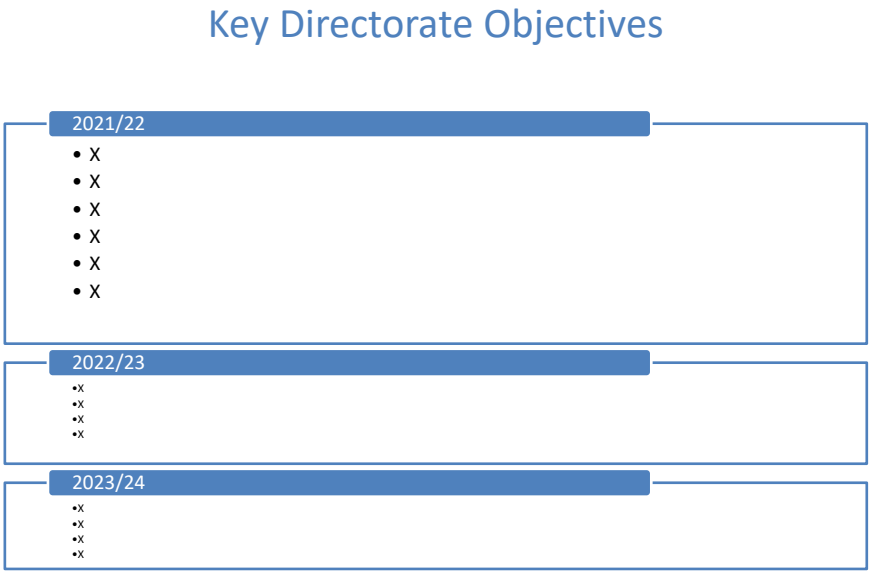
Strategic Planning and Resource Allocation (SPRA) is an annual process which details how each directorate/programme supports the delivery of the overall organisational strategy. Given this is a new approach, the proposal is to focus on the next 3 years in the first instance. The directorate positions are consolidated and considered by the EDG. The EDG discussion will require to focus on prioritisation based on delivering the most effective allocation of resources. That prioritisation will of course be influenced by the Scottish Government policy objectives and the recurring impact of COVID 19. The prioritisation process will also require to reflect that the NHS in Scotland is operating under the direction of the Scottish Government at least until the end of March 2020.

The sections below give some guidance on the content anticipated from the SPRA presentations.

In order to ensure the appropriate level of integration with the IJB strategic planning process, the proposal is that the IJB Chief Officer and the Chief Finance Officer will submit a return similar to that required from the NHS Fife directorates and programmes. This information will be drawn from the existing work and arrangements to create the strategic plan and objectives for the IJB.

Directorate/Programme Key Objectives

This summarises the key messages from the Directorate SPRA presentation. This slide sets the context for the rest of the presentation



This graphic articulates the key objectives for each directorate/programme over the next 3 years which can be shared with staff and stakeholders and outlines the key stages to be achieved with specific actions, thus enabling progress to be measured. This graphic is then consolidated to show the key objectives at an organisational level.

Directorate/Programme Service Engagement

This should be a mapping exercise against the key stakeholder groupings which we support and there should be an appropriate read across to the key objectives slide.

Directorate Service Engagement

2021/22

- X
- X
- X
- X
- X
- X

2022/23

- X
- X
- X
- X

2023/24

- X
- X
- X
- X

Workforce Planning Assumptions

Each directorate should outline the annual workforce planning assumptions supporting the 3-year plan. This will be shown at a summary "total WTE" level but will also show the detail by clinical/nonclinical staffing groups, the Workforce Directorate will support this information requirement but the planning assumptions and projections remain the responsibility of directorates.

Directorate Workforce Profile and Planning Assumptions

Workforce Plan	2021/22 WTE	2022/23 WTE	2023/24 WTE
Opening position			
Total	-	-	-

Workforce Plan	2021/22 WTE	2022/23 WTE	2023/24 WTE
Increases/Decreases			
Total	-	-	-

Workforce Plan	2021/22 WTE	2022/23 WTE	2023/24 WTE
Safe Staffing in-year			
Total	-	-	-

Workforce Plan	2021/22 WTE	2022/23 WTE	2023/24 WTE
Summary Overall Position			
Total	-	-	-

Financial Planning Assumptions

Each directorate should outline the annual budget and expenditure supporting the 3-year plan. This will be shown at a summary level but will also show the detail of pay and non-pay spend, the Finance Directorate will support this information requirement, but the planning assumptions and projections remain the responsibility of directorates.

Financial Plan	2021/22 £'000	2022/23 £'000	2023/24 £'000
Opening Position			
Total	-	-	-

Financial Plan	2021/22 £'000	2022/23 £'000	2023/24 £'000
Significant Cost Pressures			
Total	-	-	-

Financial Plan	2021/22 £'000	2022/23 £'000	2023/24 £'000
Planned Reductions			
Total	-	-	-

Financial Plan	2021/22 WTE	2022/23 WTE	2023/24 WTE
Summary Overall Position			
Total	-	-	-

Efficiency Savings Assumptions

Each directorate/programme should set out the level of planned efficiency savings for each of the 3 years of the plan. This should include a move to generate a significant proportion of recurring savings initiatives. For this initial stage in the planning process an assumption should be made that a minimum of 3% will be required.

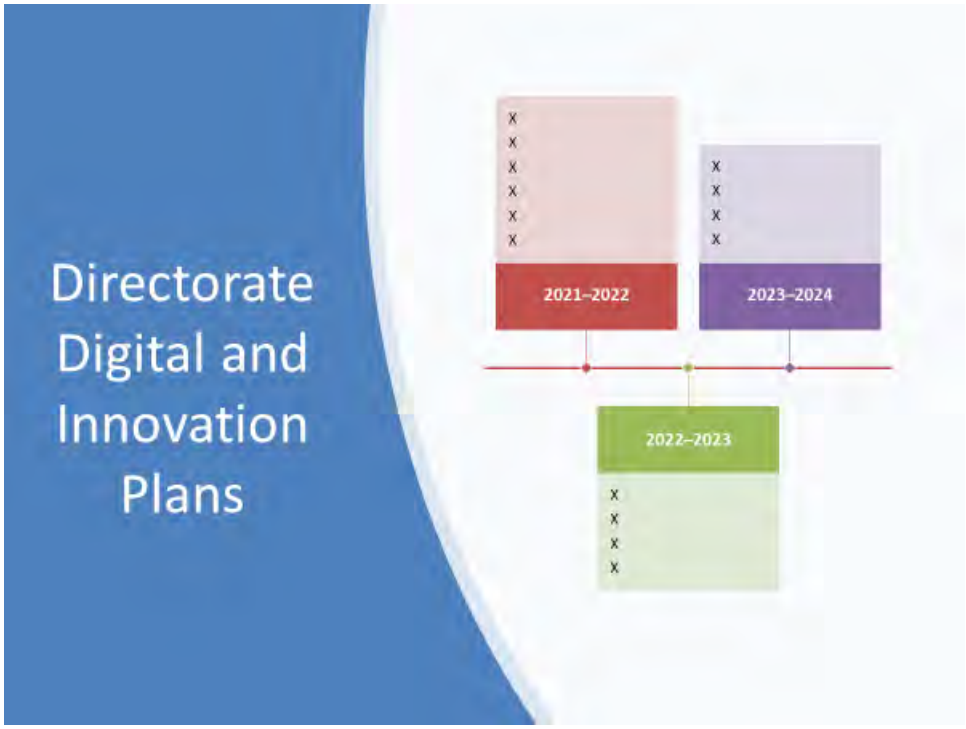
Efficiency Savings Plan	2021/22	2022/23	2023/24
	£'000	£'000	£'000
Total	-	-	-

Digital and Innovation Plans

The Digital and Information Directorate will submit a system wide plan covering capital and revenue planning assumptions. Each directorate will also submit the anticipated dependencies on this work to support key objectives.

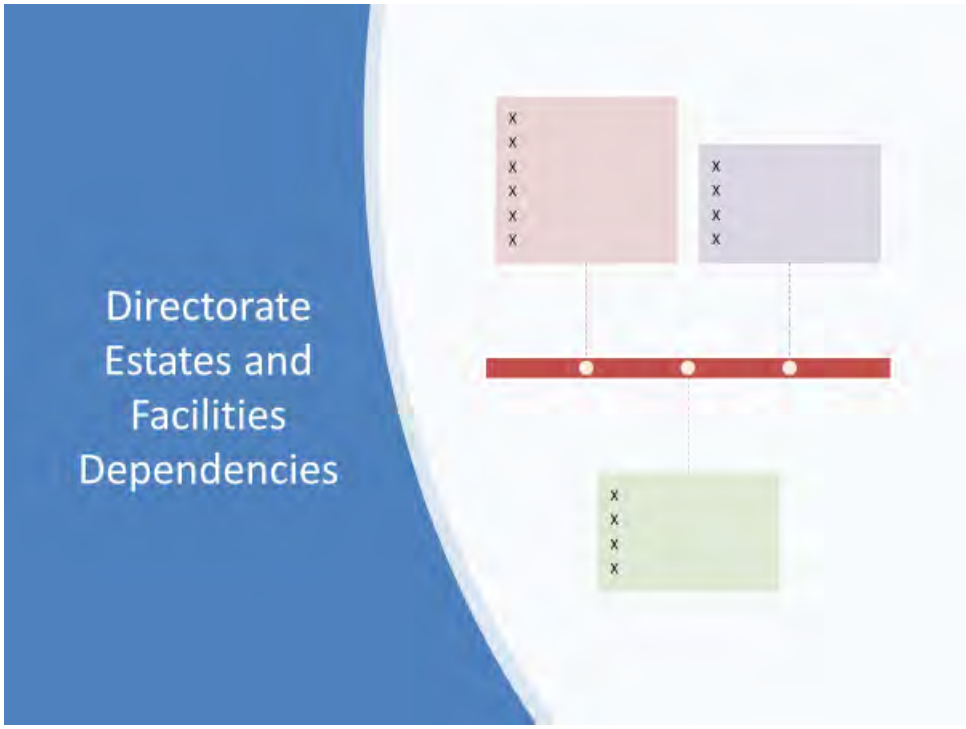
This slide should identify the main challenges and opportunities for your directorates in delivering outcomes associated with the implementation of digital solutions to support service delivery.

The plans should include an indication of how the ideas are being/will be developed, indicative timescales, costs, and sources of funds. Examples could include the roll-out of Nearme.



Directorate Estates and Facilities Dependencies

The Estates and Facilities Directorate will submit a system wide plan covering capital and revenue planning assumptions. Each directorate will also submit the anticipated dependencies on this work to support key objectives.



Directorate/Programme Risk Profile

Reflecting on the range of information gathered at directorate/programme level, an assessment should be made of the risk profile for each of the 3 years of the plan. This will be critical is supporting the prioritisation work which EDG will require to do when considering the consolidated returns.

Section D: SPRA Preparation and Governance Process

The EDG will be invited to consider and approve the SPRA process in November 2020. There will be a presentation on the process for the NHS Fife Board at the next available development session.

The Directorate SPRA presentations should be submitted by 18 December 2020 to the Director of Finance**.**

The returns will be consolidated for full EDG consideration in January 2020.

The SPRA will then be presented to the Finance, Performance and Resources Committee, the Staff Governance Committee, the Area Partnership Forum and NHS Fife Board. The SPRA outcomes will be used to populate the Annual Operating, Workforce Plan and other organisational strategies.

Mid-Year Review

A mid-year review takes place annually in September/October to assess progress. Following the mid-year review, a refreshed SPRA is presented to the EDG, Finance, Performance and Resources Committee, the Staff Governance Committee, the Area Partnership Forum and NHS Fife Board.

Annual Operating Plan

The NHS Fife plan for the 3-year period covering 2020/21 to 2022/23 will be due for submission in February 2020 as part of the Annual Operating Plan process.

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**12 January 2021**
Title:	**Winter Report 2020/21**
Responsible Executive:	**Helen Buchanan, Director of Nursing**
Report Author:	**Susan Fraser, Associate Director of Planning & Performance**

1 Purpose

This is presented to the Finance, Performance and Resources Committee for:

- Discussion

This report relates to the:

- Winter Report 2020/21 – Data to November 2020

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Winter Report is to provide assurance that the Winter Plan is being delivered in accordance with the submission to Scottish Government in November 2020.

2.2 Background

The Winter Report is produced monthly and provides update on key performance metrics and actions agreed within the Winter Plan. Weekly meetings between Acute Services, H&SC and Planning commenced in November 2020 using the Winter Planning Weekly Scorecard to discuss agreed performance metrics and escalate issues when required.

The Winter Plan aims to:

- Describe the arrangements in place to cope with increased demand on services over the winter period and subsequent COVID-19 waves
- Describe a shared responsibility to undertake joint effective planning of capacity
- Ensure that the needs of vulnerable and ill people are met in a timely and effective manner, despite increases in demand, and in accordance with national standards. (e.g. 4-hour emergency access target)
- Support a discharge model that has performance measures, a risk matrix and an escalation process
- Ensure staff and patients are well informed about arrangements for winter and COVID-19 through a robust communications plan
- Build on existing strong partnership working to deliver the plan that will be tested at times of real pressure

Planning priorities to ensure delivery of the different components of the plan are:

- Home First Model
- Near Me for Unscheduled Care
- Whole System Pathway Modelling
- Scale up direct entry to STAR units from community MDT's
- Point of Care Testing (POCT) in Paediatrics, A&E and Admissions Unit
- Restructure of medical assessment and admissions
- Scheduling of Unscheduled Care
- AHPs 7 day working

2.3 Assessment

A&E

95% Standard has not been met since Week Ending 27th September. On average, there are 369 less ED attendances per week this year (April to Nov) compared with last year. However, there are the challenges of Covid-19 as well as high acuity.

Covid-19

Since the start of the 2nd wave of Covid-19 our peak of Covid-19 Bed days was 514 with both confirmed and suspected patients, this was reached week ending 15th November. Peak for confirmed Covid-19 positive patients in hospital was 4th of November, 59 patients.

Occupancy

VHK occupancy appears to be low, continually under 90% but this does not reflect the occupancy on each of the Red, Amber and Green pathways. There are surge beds open to accommodate pressure on the amber pathway. Bed Occupancy within the community hospitals has been continuously above 90% since early September.

Delayed Discharges

In November, there was an average 15 bed days lost to Delayed Discharges per week in VHK this year compared to an average of 70 in 2019. Bed days lost in Community Hospitals are also considerably less than the year prior, 286 in November 2020 compared with 379 in 2019.

Health & Social Care Placements

H&SCP achieved an average of 92% of placements during the 4-week period. With downstream beds falling short of target a couple of weeks in the month. Social care placements have been particularly low throughout the month but especially the 2nd week in November.

There are a number of actions that are complete or on track. The following actions are ongoing, with slippage, but no concerns about impact on Winter Planning:

4.1.4 Restructure of medical assessment and admissions
4.1.12 Continue to Test change to reconfigure STAR bed pathway
4.2.1 Implementation of a sustainable 7-day OT and PT service for acute
4.2.2 Review of Paediatric nurse staff levels
4.2.8 Agree Flow & Navigation Care workforce levels and secure staffing
4.8.13 Local delivery framework for COVID-19 immunisation to be developed and implemented using outputs of national work
4.8.14 PMO to be established for COVID-19 immunisation programme and required workforce to be recruited

2.3.1 Quality/ Patient Care

The Winter Plan has been prepared prioritising patient care in the right place at the right time and by the right person.

2.3.2 Workforce

Workforce planning is key to Winter Planning

2.3.3 Financial

Financial planning is key to Winter Planning

2.3.4 Risk Assessment/Management

Options for Surge Capacity over winter have been risk assessed

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

2.3.6 Other impact

None.

2.3.7 Communication, involvement, engagement and consultation

Winter Report is produced by Planning and Performance Team, updates are provided for agreed actions in Winter Plan by relevant Services.

2.3.8 Route to the Meeting

First report of Winter Report 2020/21.

2.4 Recommendation

The Finance, Performance and Resources Committee is requested to:

- **Discussion** – Winter Report 2020/21

3 List of appendices

None

Report Contact
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Winter Planning

Monthly Report

Week Ending 8th November 2020 to 29th November 2020

Contents

Introduction

The purpose of this report is to assure the Chief Executive and EDG that the Winter Plan is being delivered in accordance with the submission to Scottish Government and against agreed performance targets.

In 2020/21, the Winter Plan is closely aligned to the Remobilisation Plan and describes the actions that will be taken forward by NHS Fife and the Health and Social Care Partnership to optimise service resilience during the winter months and beyond in a COVID-19 sensitive environment. Executive leadership sits with the Director of Nursing and delivery lies with both the directors of Acute Services in NHS Fife and the Health and Social Care Partnership.

A Silver Command has been established for winter planning which meets weekly and agrees actions, supported by the Bronze Command for winter planning monitoring the dashboard weekly and escalating to Silver Command where appropriate. A monthly report is provided to the board for assurance. The weekly reporting will cease at the end of March with the monthly report going to the NHS Fife Board in May 2021. Weekly reporting has commenced in October 2020 as part of the Winter Plan 2020/21.

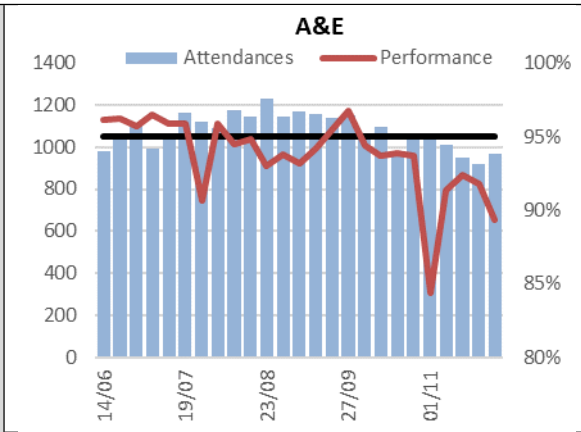
The Winter Planning Performance Review Summary will be considered by the Finance, Performance and Resources and Clinical Governance Committees.

Outlined below in Section C are the actions that were submitted to the Scottish Government at the end of October 2020 and current status of these actions.

Section A: Executive Summary

This is the First monthly report summarising performance against key indicators and actions for Winter 2020/21. The key points to note this month are as listed below.

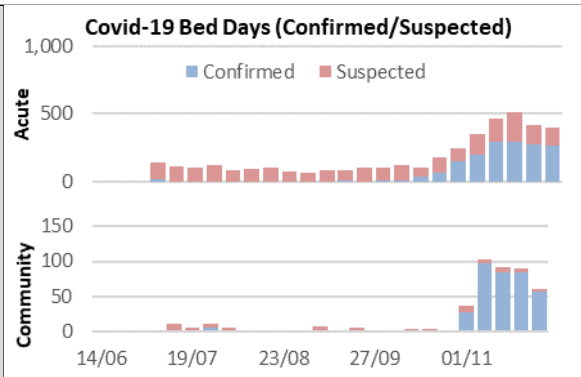
A&E



Narrative
The 95% Standard has not been met since Week Ending 27th September. The board average has also slipped beneath the Scotland average for a 5th time this financial year during week ending 29th November, however with quick recovery, has maintained above for the most part. On average, there are 369 less ED attendances per week this year (April to Nov) compared with last year

Commentary
ED performance has been challenged by waits for admitting beds as well the challenges of Covid-19 and high acuity across the hospital.

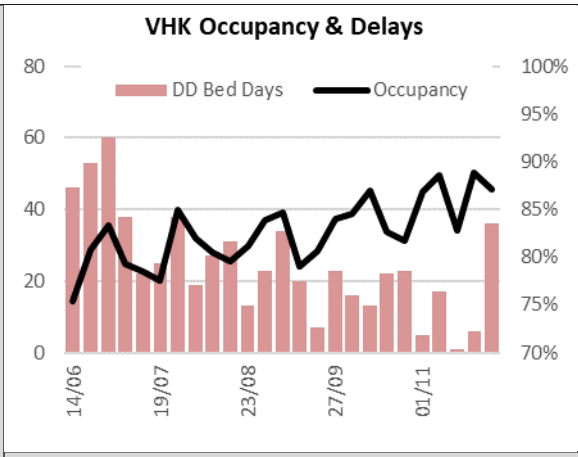
Covid-19 Bed Days



Narrative
Since the start of the 2nd wave of Covid-19 our peak of Covid-19 Bed days was 514 with both confirmed and suspected patients, this was reached week ending 15th November. Our peak for confirmed Covid-19 positive patients in hospital was 4th of November reaching 59 patients.

Commentary
<u>Acute</u> Confirmed cases of COVID-19 within the acute setting started to rise with pressure building on Critical Care necessitating the instigation of the 2nd wave escalation plan and the trebling of ICU capacity. <u>HSCP</u> The incidence of COVID19 within the Community Hospitals was significant. The consequence of this was that patient discharges from acute settings were delayed. This was further nuanced by the lack of transfers from community hospitals into care homes. Wards across all community hospitals were categorised amber. Two wards were closed due to outbreaks which further impacted on the patient pathways.

Acute Occupancy & Delays



Narrative

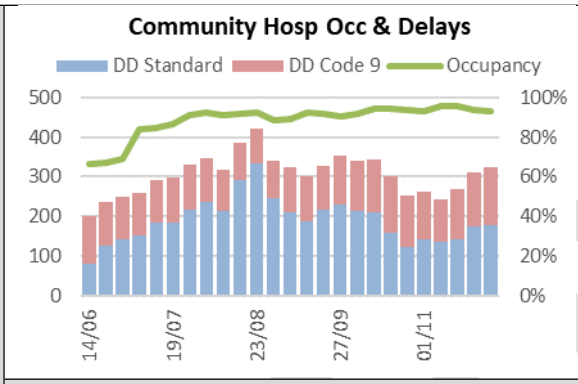
VHK occupancy appears to be low, continually under 90%,

In November there has been an average of 15 bed days lost to Delayed Discharges per week. This is compared to an average of 70 bed days lost in the same period 2019.

Commentary

VHK occupancy does not reflect the occupancy on each of the Red, Amber and Green pathways. Some are under greater pressure than others. There are also surge beds currently open to accommodate pressure on the amber pathway. DD bed days had improved but still vary based on demand for support on discharge.

Community Occupancy & Delays



Narrative

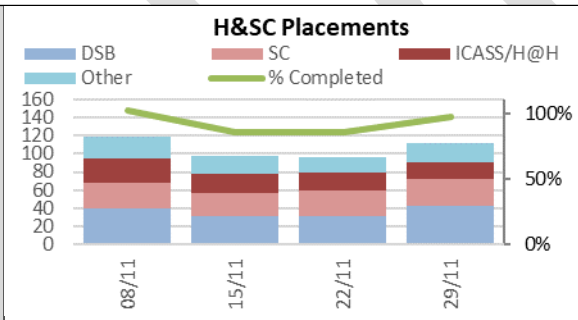
Bed Occupancy within the community hospitals has been continuously above 90% since early September.

There has been an average of 286 bed days lost per week in community hospitals due to delays in November. This compares to an average of 379 bed days lost per week at the same time in 2019.

Commentary

Length of stay has reduced across our community hospital beds with an average of 32 days for November. This is less than 2019. Balcurvie ward was also closed to new admissions due to covid from 2/11 until 26/11.

H&SCP Placements



Narrative

H&SCP achieved an average of 92% of placements during the 4-week period. With downstream beds falling short of target a couple of weeks in the month.

Social care placements have been particularly low throughout the month but especially the 2nd week in November.

Commentary

Care at Home, including START, achieved 87 discharges against a target of 85 for the month

For packages of care restarting with existing care at home providers, all requests (60) for a restart were progressed.

	STAR placements were restricted in November due to one care home, Ostlers House, being closed to admission, discharges, and transfers from 1st - 23rd November. Within Fife, over the month of November, a total of 45 care homes had a restriction at some point in the month, limiting their ability to accept new residents into the care homes. (For information, the 45 care homes include some that have been closed more than once in the month, and some care homes that were already closed before November but suspension on admissions was not removed within November). For packages of care restarting with existing care at home providers, all requests (60) for a restart were progressed.

Section B: Performance Summary to Week Ending 29th Nov 2020

Weekly Unscheduled Care Monitoring Report

Area	Indicator	Trend	08-Nov	15-Nov	22-Nov	29-Nov
OOH Urgent Care	Contacts		1775	1810	1883	1743
	% ref to 2ndary Care		5.18%	4.36%	4.41%	6.20%
	OoT Home Visits		26	13	21	27
	COVID Ax Centre		117	118	120	113
	COVID Advice Calls		188	193	204	186
Emergency Department	Attendances		1012	947	922	969
	Performance		91.3%	92.4%	91.8%	89.4%
VHK	Admissions		665	670	668	696
	Emergency		586	585	595	626
	Discharges		644	635	673	652
Theatre Activity	Scheduled		297	247	241	237
	Cancelled		15	18	10	13
	Hospital Cancelled		1	0	1	1
VHK Bed Utilisation	Occupancy		89%	83%	89%	87%
	COVID Bed Days		470	514	419	403
	DD Bed Days		17	1	6	36
HSC Placements	% Completed		102%	85%	85%	97%
	Target		117	115	114	115
	Completed		119	98	97	112
	DSB		40	31	31	42
	SC		28	25	29	30
	ICASS/H@H		27	22	19	19
	Other		24	20	18	21
Community Hospital	Admissions		38	45	52	41
	Discharges		36	43	50	41
	Occupancy		96%	96%	94%	93%
	COVID Bed Days		102	91	89	60
	DD Bed Days		242	269	312	324
	DD Standard		135	143	174	179
	DD Code 9		107	126	138	145

Section C: Winter Plan Monitoring of Actions

Key:	Blue	Complete
	Green	On Track as expected
	Amber	Work ongoing, but slippage (with no concerns about impact on Winter Planning)
	Red	Work ongoing, but concerns about impact on Winter Planning

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
4.1.1	Scheduling of Unscheduled Care – creation of an integrated flow and navigation centre to triage, assess and manage unscheduled care	Nov-20	DOA DOHSC		DCOO GM EC	DGM West				Integrated flow and navigation hub soft launched on 1st December. Continuous monitoring of impact and pathway effectiveness underway.
4.1.2	Implement Home First Model - more timely discharges & realistic home-based assessments	Nov-20	DOHSC			DGM West				Short life working group established. Model being tested and any barriers worked though.
4.1.3	Scale up direct entry to STAR units from community MDT's	Nov-20	DOHSC			DGM West				Link social workers from STAR support locality MDT's. Early discussions ongoing regards the pathway.
4.1.4	Restructure of medical assessment and admissions	Apr-21	DOA		GM EC					The COVID 19 red pathway for admission will limit any changes that can be made to patient pathway and flow in the short term. Completion date changed to April 2021
4.1.5	Process re the use of Near Me for Unscheduled Care	Nov-20	DOA		DCOO					Near Me is being explored, however initial findings favour the use of telephone for triage.
4.1.6	Right Care – Right Place campaign to increase awareness of alternatives to the Emergency Department for minor, non-urgent illnesses and injuries and encourage local people to make use of local services	Oct-20	DON	Comms						Soft launch locally 1 December using national campaign assets. NHS Fife website updated, main banner promotion and regular social media posts. Media release and interview with Medical

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
										Director for local radio, prior to Christmas. Main national campaign will commence in January 2021 Staff Link Hub to support UC redesign created and working on the creation of a Ref Help section by end of December
4.1.7	Ensure national winter campaigns, key messages and services (including NHS 24 and NHS Inform) are promoted effectively across Fife and supported by relevant local information and advice	Nov-20	DON	Comms						Show you care prepare national campaign started on 4 December and NHS Fife communications supporting national messages and campaign, winter section updated on website and local comms via Social media, Staff Link and local media
4.1.8	New model of care for Respiratory Pathway	Nov-20	DOA DOHSC		GM EC	DGM West				A new nurse led advice line for respiratory patients that screens all referrals on the same day (GP and high health gains). This prevents deterioration and unnecessary admission. New pathway directly into hospital at home for direct step up. Another pathway has been developed for palliative care patients.
4.1.9	Ensure adequate Community Hospital capacity is available supported by community hospital and intermediate care redesign	Oct-20	DOHSC			DGM West				community hospital capacity monitored daily. Surge areas have been identified and utilised as per winter plan.
4.1.10	Review capacity planning ICASS, Homecare and Social Care resources throughout winter including 7-day access to H@H	Oct-20	DOHSC			DGM West				Capacity reviewed daily and additional recruitment underway to increase further ICAS & H@H capacity to support increased in demand.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
4.1.11	Focus on prevention of admission with further developments into High Health Gain, locality huddles to look at alternatives to GP admissions	Oct-20	DOHSC			DGM West				Eight locality huddles in operation. Prevention of admission continues at 35% and data indicates a net reduction in admissions for VHK. Data to be interrogated further. Frailty model embedded and frailty practitioner now in post.
4.1.12	Continue to Test change to reconfigure STAR bed pathway	Nov-20	DOHSC			DGM West				Stroke pathway has been developed. Small TOC completed. Plans to scale up to ensure its success.
4.1.13	Weekly senior winter monitoring meeting to review winter planning metrics and take corrective action	Oct-20	DOA DOHSC	AD P&P	DCOO GMs	DGM West				Daily senior meeting in place to review daily metrics and corrective action taken in real time.
4.2.1	Implementation of a sustainable 7-day OT and PT service for acute being progressed through the Integrated Capacity and Flow Group- invest to save to support effective patient flow and address de-conditioning.	Dec-20	DOA		GM WCCS		1.6 Band 6 PT 1.0 Band 5 OT 1.8 Band 4 HCSW 1 Band 4 HCSW	£72.5k		No confirmation of funding available yet
4.2.2	Paediatric nurse staff levels currently being reviewed. The increased activity associated with winter combined with the requirement for managing Covid-19 pathways will require additional staff to ensure safe staffing levels	Oct-20	DOA		GM WCCS		13.3 band 5 3 band 3			Discussions underway with key stakeholders to identify a funding stream for the posts.
4.2.3	Implement flexible staffing models to utilise resources accordingly – managed by tactical workforce group, chaired by Associate Director of Nursing	Nov-20	DON		DCOO	DGM West				The workforce hub has been re-instated

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
4.2.4	Ensure NHS Fife staff are kept informed about preparations for winter including arrangements for staff flu vaccinations, local service arrangements and advice for patients	Nov-20	DON	Comms						Flu section on NHS Fife website and Staff Link Hub, Lead from the Front Staff Flu Vaccination Campaign instigated. Winter hub live on NHS Fife website Regular updates on Staff Link and weekly CE update throughout December, January and February
4.2.5	Occupational Health medical and nursing support was increased temporarily to support the pandemic efforts, funding has been secured to recruit to these posts on a substantive basis	Nov-20	DOW	Workforce						Temporary x-cover provided with substantive posts being prepared for advertisement
4.2.6	Staff health and wellbeing signposting resources were provided from April 2020 and an expanded Staff Listening Service, (accessible to Health, H&SC Partnership, and care home staff), available from April 2020 to 31 March 2021	Nov-20	DOW / DON	Workforce /Nursing						Expanded listening service in place until 31/03/2021.
4.2.7	Mental Health Occupational Health nursing input in place for staff support from August 2020	Aug-20	DOW	Workforce						Completed
4.2.8	Agree Flow & Navigation Care workforce levels and secure staffing as early as possible. All rotas in place to ensure public can access OOH across the winter period	Oct-20	DOHSC			DGM West				Recruitment commenced for key posts. Contingency plans on place so that there will adequate staffing for go live date
4.2.9	Create and enact a workforce plan to staff surge capacity taking into account Fife Council Christmas shut down	Oct-20	DOHSC		DCOO GMs	DGM West				Workforce hub reinstated which will be open over xmas and new year. Social work staff involvement. Senior rota in place to cover out of hours.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
4.3.1	Whole System Pathway Modelling – development & implementation of capacity tool	Nov-20	DOA		GM EC	DGM West				Capacity tool complete. Daily meetings to proactively determine red flags and take corrective actions to maximise flow.
4.3.2	Daily Dynamic discharge and EDD to be embedded in all wards	Nov-20	DOA		GM EC	DGM West				EDD embedded.
4.3.3	Plan for Surge Capacity (including Community Hospitals, Care Home, Home care ICASS & H@H)	Oct-20	DOA DOHSC		DCOO	DGM West	See App2	Acute HSC		Surge plan complete across Acute and HSCP. Command structures in place for escalation. Daily surge meetings to assess capacity utilising real time intelligence.
4.4.1	Implementation of rapid diagnostic outpatient appointments for inpatients to ensure that no inpatient discharges are delayed whilst waiting on diagnostics	Oct-20	DOA		GM WCCS					Complete in Radiology
4.4.2	OPAT expansion to release bed capacity	Oct-20	DOA		GM EC					Unit working at full capacity for the staffing model and successfully delivering on bed day savings.
4.4.3	Configure SSSU as amber Unit to support peaks in Orthopaedic Trauma demand	Sep-20	DOA		GM PC					SSSU open Mon-Fri to Support Trauma/Emergency Surgery
4.4.4	In line with SG guidance, configure green elective areas and pathways within DIU, Ward 52 and Day Unit (within QMH) to maintain elective activity over winter	Sep-20	DOA		GM PC					Ward 52 now includes 4 SHDU beds
4.4.5	Set-up weekly theatre meetings to review theatres lists 3 weeks in advance, including full review of patients waiting by clinical priority to determine list allocation to be escalated to Clinical Prioritisation Group	Sep-20	DOA		GM PC					Weekly meetings take place every Monday chaired by the PCD Clinical Directors

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
4.5.1	Corporate Business Continuity Plan has been reviewed by the NHS Fife Resilience Forum	Aug-20	DPH	Business Continuity						The Plan was submitted and accepted by the NHS Fife Resilience Forum and EDG
4.5.2	Corporate Business Continuity Policy has been reviewed by the NHS Fife Resilience Forum	Aug-20	DPH	Business Continuity						The Policy was submitted and accepted by the NHS Fife Resilience Forum and EDG
4.5.3	Business Continuity templates to be updated, re-issued to all departments and returned	Oct-20	DPH	Business Continuity	DCOO	DGM West				All business continuity plans updated using new template across all of the HSCP and Acute Services Division.
4.5.4	Ensure severe weather communications plan is in place and provided to NHS Fife Resilience Forum and EDG	Oct-20	DON	Comms						Adverse weather communications plan reviewed and shared with LRP and Fife Council Comms
4.5.5	Local Resilience Partnership to hold a workshop to look at how Fife would manage events/incidents over winter including Covid-19, season flu, winter weather and EU-exit	Nov-20	DPH	Public Health						First workshop held on the 18th November further workshop being planned
4.6.1	Point of Care Testing (POCT) in A&E and Admissions Unit	Dec-20	DOA		DCOO			Funded separately		POCT estimated to commence from mid-December 2020
4.6.2	Define and agree paediatric COVID pathways to stratify patient flow based on clinical urgency and IPC measures	Dec-20	DOA		GM WCCS					Complete
4.6.3	Package of education/training to support best practice in IPC in NHS Fife acute & community settings	Oct-20		IPCT						Complete
4.7.1	Deliver the staff vaccination programme to health and frontline social care staff (NHS, Fife HSCP, independent and third sector) through peer vaccinator programme, occupational health clinics, care-home based and	Dec-20	DOHSC			DGM West				Flu staff vaccination exceeding projected targets at this point. Command structure in place for flu and covid vaccination. Mop up clinics to target staff who have been isolating or unwell being planned.

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
	pharmacy delivery in order to achieve 60% national target and 65% local target for uptake									
4.7.2	Implement actions required for staff and community seasonal flu vaccination delivery under the Joint Fife HSCP & NHS Fife Flu Silver Group	Dec-20	DOHSC			DGM West				As above
4.7.3	Ensure data collection methods enable weekly monitoring of flu vaccination uptake	Oct-20	DOHSC			DGM West				Monitoring and uptake rates collected.
4.7.4	Raise awareness of the flu campaign and encourage health and care staff and key workers in the public sector to take up the offer of a free flu vaccination and lead by example	Feb-21	DOHSC	Comms						Lead from the Front Staff Campaign and assets shared with HSCP and Fife Council campaign to end mid-December in line with roll-out of C19 vaccine
4.8.1	Produce plan for possible second Covid-19 wave in Acute and H&SC	Oct-20	DOA DOHSC		DCOO	DGM West				Escalation plan produced across Acute and HSCP Acute Second wave plan is completed, Critical care escalation commenced.
4.8.2	Refer to Business Continuity plans in event of resurgence in Covid-19 cases	Oct-20	DOA DOHSC		DCOO	DGM West				Business continuity plans and impact analysis in place for all HSCP services and Acute Services
4.8.3	Engage in regular review of care homes in collaboration with the HSCP	Oct-20	DPH	Public Health						Care Home Oversight Group established that meets regularly
4.8.4	Support weekly asymptomatic staff Covid-19 testing in care homes	Oct-20	DPH	Public Health						On Track as expected
4.8.5	Support symptomatic residents Covid-19 testing in care homes,	Oct-20	DPH	Public Health						On Track as expected

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
	and flu testing where there is a suspected outbreak									
4.8.6	Carry out resident Covid-19 surveillance testing on a care homes in Fife	Oct-20	DPH	Public Health						On Track as expected
4.8.7	Increase capacity and skills with Health Protection Team for outbreak management for care homes in Fife	Nov-20	DPH	Public Health				Funded Separately		On Track as expected
4.8.8	Increase and sustain capacity to undertake all contact tracing requirements for Fife residents as part of the National Contact Tracing Test and Protect Programme.	Nov-20	DPH	Public Health						On Track as expected
4.8.9	Maintain surge capacity to manage abrupt changes in incidence of Fife Covid-19 positive cases throughout the winter months	Oct-20	DPH	Public Health						On Track as expected
4.8.10	Develop action plans for outbreak prevention and management of high-vulnerability settings and events. The aim of identifying these settings is to minimise the outbreak risks.	Oct-20	DPH	Public Health						On Track as expected
4.8.11	Promote local and national messages associated with COVID-19 and Test and Protect	Nov-20	DPH	Comms						Arange of local campaigns have been activated via LRP Public Comms Group , these are also in line with National Campaign material and messages and have included a range of strands and themes identified by PH or community feedback, such as Car Sharing , 2 meters is, when to get tested, Self-Isolating and support

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
4.8.12	Review of outbreak management guidance in line with latest national guidance	Oct-20	DON	IPCT						
4.8.13	Local delivery framework for COVID-19 immunisation to be developed and implemented using outputs of national work	Dec-20	DOP	Pharmacy		DGM West				Command structure established. Workstreams and priorities agreed. Lessons learned from flu being incorporated. Awaiting national planning tool, training documentation and job descriptions. Local plan has been submitted to Scottish Government, awaiting formal feedback. Engagement with Clinical Governance Committee and Gold command secured - review with Board 23 Nov. Risks have been identified, significant risks about workforce capacity and downstream impact, as well as scheduling system/ team identification. Storage requirements will be met. Venue identification in progress 1) First vaccinations given to staff on 8th December. VHK and QMH sites both active from 9th December 2) Reduction in supply of vaccine requiring prioritisation of wave 1 groups 3) Care home residents and staff being vaccinated in care homes from 14th December. Some care home staff will attend QMH if not vaccinated on site 4) Vaccinator workforce in place for immediate demand, recruitment progressing for

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
										medium term 5) Complex storage requirements in place 6) Local comms approach being rolled out 8 December to complement national information 7) 7 of 11 community venues confirmed 8) 53/54 GP practices will support vaccination of over 80s population 9) Recording systems delivered on time

Ref	Action	Timescales	SRO	Lead/s			Workforce	Finance	Status	Progress
				Corp	Acute	H&SC				
4.8.14	PMO to be established for COVID-19 immunisation programme and required workforce to be recruited for the next 12 months which encompasses the different delivery models required at each stage of the plan	Dec-20	DOP	Pharmacy		DGM West				PMO has been established, including interim programme manager and supporting team. PID, supporting governance, being reviewed by Silver command today 1) Risk register in place and monitoring ongoing 2) EQIA at late stage development 3) DPIA in progress with data protection team 4) PID supported providing clarity on governance

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**12 January 2021**
Title:	**Project Bank Account**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Tracy Gardiner, Project Accountant**

1 Purpose

This is presented to the Committee for:

- Decision

This report relates to a:

- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The Elective Orthopaedic Centre is pending FBC approval. Once approved a project bank account has to be set up to process the PSCP payments – SG states any building project over £2m must have a separate project bank account.

The bank RBS has advised that the project bank account can either be set up within the existing NHS Fife Bank Account profile, advising that the contractor would not be able to view any of our banking information, or to set up a separate profile altogether for NHS Fife project bank accounts. This profile would only hold individual project bank accounts for the EOC and any planned projects over £2m in the future.

2.2 Background

The Review of Scottish Public Sector Procurement in Construction noted that the construction sector suffers from endemic late and extended payment terms between businesses. Scottish Government's Procurement and Property Directorate worked with the banking sector to develop Project Bank Account services, including Scottish Government's Banking Services Framework Agreement.

Project Bank Accounts (PBAs) are ring-fenced accounts which see payments made directly and simultaneously by a public sector client to members of the construction supply chain.

The purpose of a PBA is to hold money in trust for the benefit of named beneficiaries and disperse payments direct to them. The account will be opened in the joint names of the employer NHS Fife and main contractor. Both parties must also sign the trust deed and instruct the bank to authorise payment from the PBA to named beneficiaries. Both must agree the way which the account is to operate, including what they expect of each other and circumstance where action is needed to make payments.

2.3 Assessment

The project bank account is mandatory and has to be set up for the Elective Orthopaedic Centre.

The project accountant has been nominated as Project Bank Account Champion – this involves co-ordinating corporate PBA activity, including engaging with the bank, integrating SG guidance with local instructions, promoting continuous improvement and linking into Scottish Government's PBA activities.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

N/A

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

Executive Directors' Group – 19th November 2020

2.4 Recommendation

The Committee is asked to endorse the establishment of this account and is asked to recommend to the Board approval of the process of creating a project bank account for the Elective Orthopaedic Project to commence once FBC is approved. The Committee is also asked to agree to either a combined profile or a separate profile being set up for project bank accounts.

3 List of appendices

N/A

Report Contact
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NHS Fife

Meeting:	**FP&R Committee**
Meeting date:	**10th November 2020**
Title:	**Laboratory Information Management System (LIMS) National Outline Business Case**
Responsible Executive:	**Claire Dobson, COO**
Report Author:	**Lesly Donovan, GM**

1 Purpose

This is presented to EDG for:

- Decision

This report relates to a:

- Emerging issue
- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Laboratory Information Management System (LIMS) will become end of life in 2022, with the supplier withdrawing support for the product at that time.

An outline business case (OBC) across 11 NHS Scotland Consortium Boards has been produced to replace the aging Laboratory Information Management Systems (LIMS).

The LIMS Replacement aligns with the Digital and Information Strategy and forms part of the delivery plan.

The board is asked to support LIMS replacement proceeding to Full Business Case and onward approval.

.2 Background

Laboratory Medicine provides services to primary and secondary care across Fife. The LIMS is used to receipt, result and report more than 10 million tests per year. The system is 20+ years old and support for development will be withdrawn by the provider in 2022.

A consortium of 11 Health Boards has been formed to procure a national system and Deloittes were commissioned to develop the OBC and the work has been funded by the digital teams in local boards as part of the consortium.

2.3 Assessment

The consortium approach will deliver connectivity and standardisation across Health Boards, supporting cross-Board working, standardisation, increased electronic reporting and reducing the burden for both support and training.

There has been extremely good collaborative working across labs and digital teams in all the consortium boards and following a market testing and scoring of options the Outline Business case is presented for approval to each participating NHS Board.

The preferred option is to procure a new LIMS which includes genetics and blood transfusion functionality.

At this stage it is unclear whether the solution will be cloud hosted software as a service solution or a more traditional on-premise solution. This will depend on the market and outcome of procurement and may impact the financial model.

Implementation of the replacement LIMS will be a phased approach with NHS Fife implementation expected in Q3 of 2021/22.

2.3.1 Quality/ Patient Care

NHS Scotland's strategic aim for clinical laboratory services is that the delivery should take the form of a Distributed Service Model (DSM). Services will be developed incrementally following the National Blueprint published in the National Strategy and Business Case3. The aim is to ensure that no matter where health care is delivered in Scotland, patients will have equitable access to efficient, effective, sustainable and affordable laboratory services.

2.3.2 Workforce

The new system will support 'Demand Optimisation' as defined as the process by which diagnostic test use is optimised to maximise appropriate testing, which in turn optimises clinical care and drives more efficient use of a scarce resource.

2.3.3 Financial

The cost to NHS Fife is shown as £6.6m over 10 years, including a 30% optimism bias of £1.52m built in which is generous.

It is anticipated that as the procurement progresses, and final supplier is known cost will be driven down significantly. The highest costs from market sounding have been used as worst case.

The internal resource costs are expected to be lower but are factored in as if they are additional resources, again to present the worst case.

Although the source of funding is still to be agreed, there is provisional provision in the organisation's Capital Plan of £2.1M for next year. Revenue is still to be agreed but it is anticipated that future and current costs will be comparable.

2.3.4 Risk Assessment/Management

There is a risk that the LIMS is not replaced because of a lack of agreement to proceed within NHS Fife, resulting in no improvement to patient care. This has been mitigated by bringing this paper to the Board.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because the project is only at Outline Business Case stage and there is no preferred supplier.

2.3.6 Other impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

There has been extremely good collaborative working across labs and digital teams in all the consortium boards and following a market testing and scoring of options the Outline Business case is presented for approval to each participating NHS Board.

2.3.8 Route to the Meeting

A paper has been previously considered by the following group as part of the development. The group have supported the consortium approach and development of the FBC noting the risks associated with the current system.

- Acute Senior Leadership Team, 23 July 2020
- Digital and Information Board, 6th October 2020
- FCIG, 27th October 2020

2.4 Recommendation

- **Decision** – Reaching a conclusion after the consideration of options

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - LIMS Outline Business Case.

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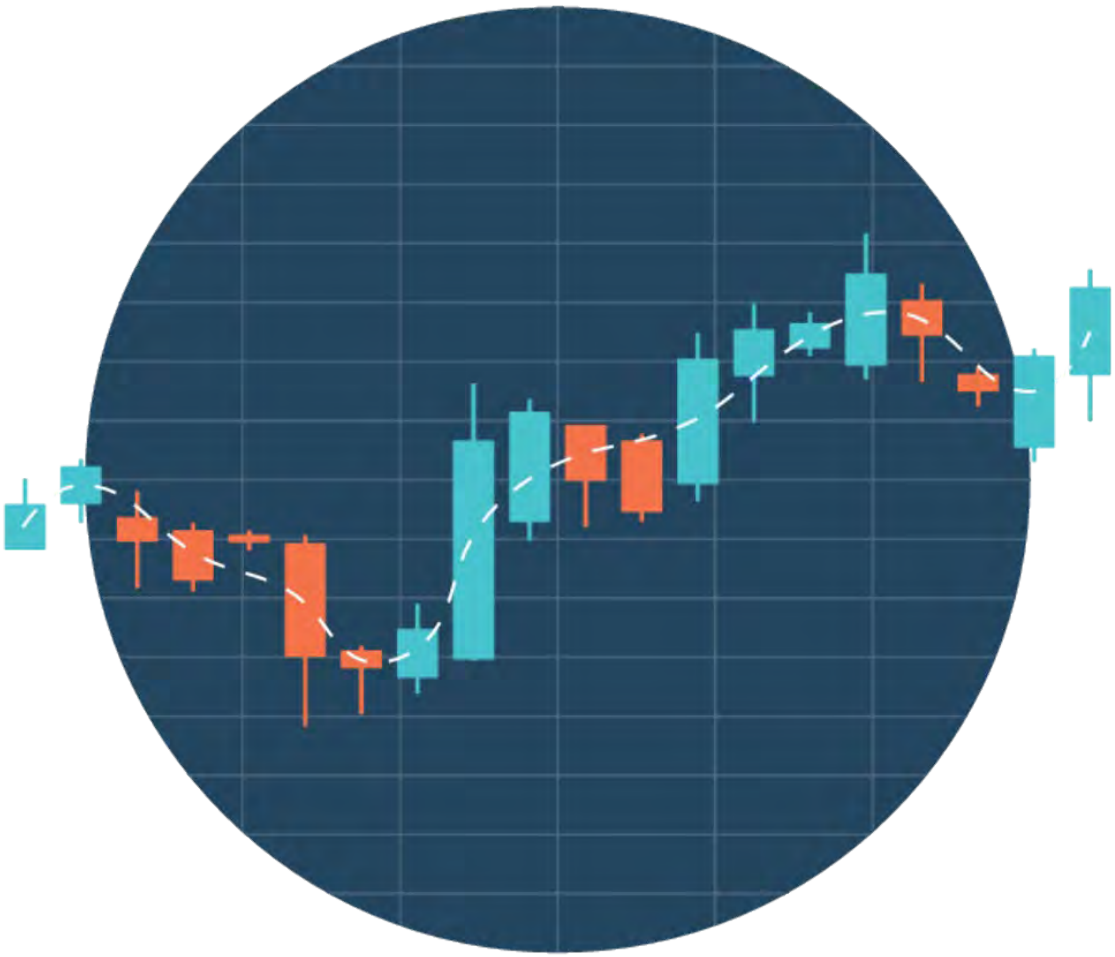
Appendix 1

Deloitte.

NHS SCOTLAND



NHS Scotland

Laboratory Information Management System (LIMS)
Outline Business Case

September 2020

Change Log

Revision History

Version	Date	Source of Changes	Author(s)
1.0 Final	July 2020	Final OBC issued	Deloitte
2.0 Revised	Sept 2020	Revised OBC with further appendices issued	Deloitte

Contents

Executive Summary

This document sets out the Outline Business Case (OBC) for Laboratory Information Management System (LIMS) across 11 NHS Scotland Consortium Health Boards. The purpose of this business case is to articulate the strategic rationale for the programme, outline its scope and breadth, and provide an indication of the likely benefits and costs associated with delivery.

Strategic Case

Introduction

Laboratory Medicine provides laboratory services to primary and secondary care centres across Scotland. LIMS is absolutely crucial to the function of Laboratory Medicine as it is used to result and report all primary, secondary and tertiary laboratory requests received by Laboratory Medicine (with the exception of Genetics). It also provides capability to create automation of workflows, integration of instruments, and management of samples and their associated information.

Current LIMS that underpin the function of the majority of departments within Laboratories within NHS Scotland Health Boards are archaic, often over 25 years in use, and are considered end of life. For most Boards, rolling support contracts are not offering value for money, while in others, the LIMS in use are nearing end of support. Differences in LIMS systems, versions, local service configurations and processes also lead to variation and complexity. Current disparity between laboratory software and data means that meaningful cross border analysis is not currently possible and does not enable optimal use of resources on a national basis.

National Collaborative LIMS Project

NHS Greater Glasgow & Clyde commissioned the development of this OBC in March 2020 on behalf of the LIMS Consortium Project. This business case will enable Boards (either individually or as a consortium) to make investment decisions around the potential acquisition and deployment of a modern LIMS. It will not replace the need for local business cases within Boards as the LIMS implementation may require fundamental changes to established ways of working as well as significant local investment of resources and effort.

Case for Change

Strategic Landscape

NHS Scotland's strategic aim for clinical laboratory services is that the delivery should take the form of a Distributed Service Model (DSM). Services will be developed incrementally following the National Blueprint published in the National Strategy and Business Case. The aim is to ensure that no matter where health care is delivered in Scotland, patients will have equitable access to efficient, effective, sustainable and affordable laboratory services.

Implementation of a common and modern LIMS would also help realise the aims of NHS Scotland's eHealth Strategies. "Scotland's Digital Health and Care Strategy" sets out the need for transformational change to services. There is a particular focus on working in partnership to deliver services in a radically different way, including the need for collaboration, innovation and flexibility.

Clinical Value

Alongside the move to a DSM, a modern LIMS is a key enabler to altering care pathways with potential benefits to patient experience and operational efficiencies through performance gains. LIMS will enable multidisciplinary team working, in particular the production of diagnostic pathways and cascading of tests to support appropriate use of resources. It will support improved productivity and efficiency across laboratories to allow staff to work smarter as well as streamline less efficient processes. This will help to improve turnaround times on referred patient results as well as improving the patient pathways resulting in an enhanced patient experience and

enable operational efficiencies. For example, the potential to reduce length of bed stay as faster availability of test results will help enable speedier diagnosis and therefore provides the opportunity to reduce the time to discharge.

Sustainability

As reported in the DSM business case, the current model of laboratory services delivery across Scotland is not equitable nor is it nationally sustainable in light of the challenges they face. Demand across services is increasing, requiring Boards to utilise the same, or even fewer, resources to maintain current services.

There is significant complexity with each of the Boards current LIMS which has evolved organically over many years. Due to the poor and limited functionality of existing solutions there is a high reliance on bolt-on solutions, many of which are built in-house and not properly supported. This presents a significant business continuity and security risk. Adopting a common LIMS and standardising associated processes and data sets across NHS Scotland provides a significant opportunity to have a more sustainable and robust solution. Standardisation may also make it easier to replace or rationalise other national solutions in the future (for example SCI Store).

Demand Optimisation

Nationally, for Laboratory Medicine, the vision for Scotland is to deliver the Right Test, in the Right Place, at the Right Time, with the Right Impact. Demand Optimisation is key to this vision. It has been recognised for many years that there is considerable variation in the use of diagnostic tests across NHS Scotland. While some of this variation can be explained by clinical circumstances and demographic differences, there still exists considerable levels of inappropriate requesting by clinicians, practises of over-requesting and under-requesting etc. A modern LIMS is a key enabler to reducing unnecessary testing across primary and secondary care. This will free up capacity to address rising demand and deliver testing that positively affects the patient pathway, supports primary care preventative measures, reduces hospital referrals and admissions, and supports equity of care for patients regardless of where they are or where they access Laboratory services.

Economic Case

Option Short-listing

Multiple options were set out for the implementation of LIMS. A short-listing exercise was undertaken to determine the options to take forward for further analysis within the OBC. This exercise was completed by Project Team & Evaluation User Group (see Appendix A).

The below options were shortlisted for further analysis:

Option 1: Do Nothing - all 'core'[1] laboratory services including blood sciences, microbiology, and histopathology[2] will be delivered from existing LIMS. For NHS Boards that have molecular genetics and blood transfusion, these will continue to reside on their own separate LIMS. There will be no change to cross Board / Region working practices or standards.

Option 3: Unified Consortium - boards collaborate to agree a national LIMS specification and select a solution all Consortiums adopt. The implementation approach, roll out strategy and hosting approach will be informed as part of the procurement process. However, it is anticipated that some Boards will work together to implement and utilise a common LIMS instance.

[1] 'Core' Lab services do not include Genetics & Blood Transfusion for the purposes of this OBC.
[2] For OBC purposes, Blood Sciences covers disciplines including biochemistry, haematology and immunology, and Microbiology covers disciplines including bacteriology and virology.

- Option A: Core LIMS, Genetics and Blood Transfusion - all disciplines are included in the procurement scope including Genetics and Blood Transfusion for Boards that require these capabilities.
- Option B: Core LIMS and Genetics - Core LIMS disciplines and Genetics, for Boards that require this capability, are in scope. Blood Transfusion is not included in the procurement scope.
- Option C: Core LIMS and Blood Transfusion - Core LIMS disciplines and Blood Transfusion for Boards that require this capability, are included in the procurement scope. Genetics is not included in scope.
- Option D: Core LIMS only - Core LIMS disciplines are only included in the procurement scope. Genetics and Blood Transfusion are not included in scope.

Benefits Assessment

The key benefits that are expected to be realised by a modern LIMS is described below. These benefits outline how replacing the current ageing LIMS system will provide improved clinical value, improved and sustainable operations and help Laboratory teams effectively manage and optimise demand. While the benefits are primarily described in the context of operational improvements, ultimately, they will contribute to improved patient outcomes.

- **Clinical Value**
  - Improved reporting, including integrated reporting in keeping with NICE guidelines
  - Improved functionality allowing modern analytical tests to be reported appropriately
  - Histopathology case tracking, and improved general laboratory tracking reducing chances of mismatching patient requests
  - Increased communication options between disciplines, lab sites and NHS Health Boards
  - Improved flagging of results requiring action
- **Operational**
  - Reduction in burden for transition of staff and work, through the reduction in re-training of staff & re-booking of results
- **Sustainability**
  - Reduction in risk of hardware and software failures through the innovative use of technology, the simplification of technical & clinical architecture
  - Supports the development of the DSM for Scotland
  - Standardisation of outputs will make it easier to replace connecting solutions in the future (e.g. SCI Store)
- **Demand Optimisation**
  - Optimises diagnostic testing use to maximise appropriate testing
  - Optimises the use of resource while reducing turnaround times by automating current clinical authorisation

A weighting and scoring exercise was undertaken to rank each of the shortlisted options in terms of their relative non-financial benefit. The purpose of this assessment was to understand any differential between shortlisted options in non-monetary terms.

Risks Assessment

The Evaluation User Group also undertook a similar exercise for identified risks. These are outlined below.

- **Supplier Capability / Capacity:** There is a risk that suppliers may fail to understand Boards' requirements, or that their product may not be capable of meeting those requirements.
- **NHS Resource Capacity:** There is a risk that there will be insufficient NHS resources to deliver and maintain the solution.
- **Incomplete Specification:** There is a risk that an incomplete specification leads to increased cost of the solution as a result of increased change control during the contract.

- **Integration / Technical Complexity:** There is a risk that suppliers may struggle to deliver interfaces to the required levels of functionality, performance, reliability and maintainability. This may lead to increased costs due to extra effort to develop the interfaces and delays to the project timescales.
- **LIMS Availability:** There is a risk that weakness in local infrastructure or a poorly designed/implemented solution leads to multiple and/or sustained periods of unavailability of the solution.
- **Change Management:** There is a risk that inadequate change management and/or leadership results in poor adoption of LIMS and or unrealistic expectations meaning that anticipated benefits are not realised.
- **Funding:** There is a risk that more funding is required and the LIMS replacement becomes unaffordable.
- **Divergence of Standards:** There is a risk that the governance is not effective and Boards adopt their own standards and therefore the anticipated benefits are not realised.

As with the identified benefits, the above risks were scored by the Evaluation User Group to distinguish between the shortlisted options. The objective of the scoring exercise was to assess the level of new or additional risk that each option may introduce.

Total Economic Cost

The full economic cost of each shortlisted option has been calculated for the full 10 year period for all Consortium Boards, and is based on a number of principles and assumptions as found within the main body of the OBC (Section 2.5.2).

Option 3a (Core LIMS, Genetics and Blood Transfusion) has a total NPC of c£82m over the 10 year, with option 3b (Core LIMS and Genetics) and 3c (Core LIMS and Blood Transfusion) being similar in cost at c£81m and c£80m respectively. Option 3d (Core LIMS only) has the lowest economic cost of c£78m, though this is unsurprising as a reduction in scope directly relates to cost reduction.

Option Appraisal and Preferred Option

Option 3a (Core LIMS, Genetics and Blood Transfusion) attracted the highest benefit score reflecting that increasing the scope of the LIMS will deliver the greatest opportunity for maximising benefits against each of the benefit categories. Option 3a also however attracted the highest risk score indicating that increasing scope will be more complex for Boards to implement whereas 3d (Core LIMS only) scored the lowest given the scope of the replacement is more closely aligned to current solutions in place by Boards.

The table below incorporates the economic cost of each option with the identified weighted benefits and risks.

Option Appraisal	Option 3a: Core LIMS, Genetics and Blood Transfusion	Option 3b: Core LIMS and Genetics	Option 3c: Core LIMS and Blood Transfusion	Option 3d: Core LIMS only
Weighted Benefits Points	931	805	673	558
Weighted Risk Points	1578	1406	1236	1167
Risk Per Benefit Point	1.69	1.74	1.84	2.09
Option Rank	1.00	2.00	3.00	4.00
NPC Per Option (£k)	82,060	80,610	80,020	78,130
Cost Per Benefit Point (£k)	88	100	119	140
Option Rank	1.00	2.00	3.00	4.00

Option 3A (Core LIMS, Genetics and Blood Transfusion) shows the lowest cost per benefit point, and as such has been identified as the preferred option for Consortium Boards. Option 3B has a relatively similar cost per benefit point evidencing the importance of Genetics inclusion in LIMS Replacement.

NHS Scotland Preferred Option for Each Consortium Board

The preferred option, Option 3a (Core LIMS, Genetics and Blood Transfusion) has been profiled over a 10 year period for each Consortium Board as shown in the below table. Further detail can be found in the main body of the OBC (Section 2.6.2) and Appendix F.

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Gram-pian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shet-land	NHS Tayside
LIMS Software Licence	0.04	0.05	0.12	0.07	0.01	0.19	0.67	0.27	0.00	0.00	0.17
Supplier Annual Support	2.06	2.06	2.29	2.29	2.06	3.16	6.27	6.27	2.06	2.06	3.16
Supplier Implementation	0.58	0.58	0.80	0.80	0.58	0.97	2.00	2.00	0.58	0.58	0.97
Design	0.01	0.01	0.03	0.02	0.00	0.04	0.11	0.06	0.00	0.00	0.04
Build & Local Config	0.07	0.08	0.24	0.18	0.01	0.43	1.44	0.79	0.01	0.01	0.40
Rollout	0.05	0.06	0.19	0.14	0.01	0.35	1.01	0.55	0.01	0.01	0.33
BAU	0.19	0.21	0.49	0.36	0.03	0.71	2.02	1.11	0.03	0.03	0.66
LIMS Interface Build	0.06	0.06	0.09	0.09	0.07	0.22	0.23	0.20	0.09	0.09	0.13
LIMS Interface Support	0.03	0.03	0.04	0.04	0.05	0.33	0.36	0.29	0.03	0.03	0.08
Add. Licences Build	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18
Add. Licences Recurring	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23
Downstream Interfaces	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
Hosting Hardware	0.22	0.22	0.33	0.33	0.22	0.44	0.88	0.88	0.22	0.22	0.44
Optimism Bias	**1.13**	**1.14**	**1.52**	**1.43**	**1.05**	**2.18**	**4.64**	**3.86**	**1.04**	**1.04**	**2.05**
Total with OB	**4.88**	**4.96**	**6.60**	**6.21**	**4.53**	**9.46**	**20.09**	**16.73**	**4.52**	**4.52**	**8.86**
Non Recurring Capital (NRC)	1.17	1.20	1.61	1.55	1.15	2.08	4.07	3.50	1.16	1.16	1.93
Non Recurring Revenue (NRR)	0.18	0.20	0.60	0.44	0.03	1.06	3.33	1.83	0.03	0.03	0.99
Recurring Revenue (RR)	3.53	3.56	4.40	4.22	3.36	6.32	12.69	11.41	3.33	3.33	5.94
Total with Optimism Bias over 10 years	**4.88**	**4.96**	**6.60**	**6.21**	**4.53**	**9.46**	**20.09**	**16.73**	**4.52**	**4.52**	**8.86**
NPC over 10 years	4.36	4.43	5.95	5.59	4.04	8.51	18.14	15.02	4.03	4.03	7.97

The table above shows the total NPC for each Consortium Board. NHS GGC and NHS Lothian have the highest cost (c£18m and £15m respectively over 10 years), as both are defined as Very Large Boards, while the smaller Boards including NHS Borders and NHS D&G have a similar total cost of c.£4m.

For each Board the highest costs are those associated with supplier support and implementation. **Optimism Bias** also adds **30% onto the total costs**, equating to an additional c.£1- 4m depending on Board size.

Financial Case

A financial appraisal based on a number of assumptions has been undertaken to illustrate the estimated affordability of the Preferred Option.

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Grampian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shetland	NHS Tayside
Consolidated Financial Considerations											
NRC (Incl. VAT & Indexation)	1.41	1.44	1.93	1.86	1.38	2.50	4.88	4.20	1.39	1.39	2.32
NRR (Incl. VAT & Indexation)	0.18	0.20	0.60	0.44	0.03	1.07	3.36	1.84	0.03	0.03	1.00
RR (Incl. VAT & Indexation)	4.49	4.52	5.50	5.31	4.30	7.92	15.76	14.32	4.26	4.26	7.44
Total (Incl. VAT & Index.)	**6.07**	**6.16**	**8.03**	**7.61**	**5.71**	**11.48**	**24.0**	**20.36**	**5.68**	**5.69**	**10.76**
Existing Resources In Post	(0.02)	(0.02)	(0.07)	(0.05)	(0.00)	(0.12)	(0.38)	(0.21)	(0.00)	(0.00)	(0.11)
Total Financial Cost	**6.05**	**6.14**	**7.96**	**7.56**	**5.70**	**11.36**	**23.63**	**20.16**	**5.68**	**5.68**	**10.64**

Capital Depreciation	1.17	1.20	1.61	1.55	1.15	2.08	4.07	3.50	1.16	1.16	1.93

*Due to rounding, '0.00' costs are less than £10k

The table illustrates that VAT & Depreciation considerations increase the total Financial Cost to each Board over the 10 year period. Each Board has a minimum VAT cost of c£800k, and indexation of c£300k over the 10 year period, with the larger Boards having higher costs as expected.

It has been assumed that the majority of funding, other than shared resources, for LIMS will come from individual Consortium Board budgets. However, as the project progresses, further discussions will be required to agree the most appropriate funding model.

Commercial Case

Procurement Procedure

NHS Scotland procurement advisors has advised that the Competitive Procedure with Negotiation (CPN) is the preferred procurement procedure.

CPN is a relatively new procedure but NHS Scotland has used this procurement route previously including on the GP IT and CHI procurements. This has provided valuable lessons to support the LIMS procurement including the need for strong governance, being clear on the points of negotiation upfront and the need for dedicated resource on the procurement team.

The items to be negotiated will need to be defined and documented as part dialogue planning. At this stage it is envisaged that dialogue is likely to focus on areas such as Genetics functionality, hosting, and managed service proposition.

An indicative timeline for the procurement process is outlined in the below table.

Milestone	Date
Contract Notice Publication & ESPD Issued	September 2020
ESPD Deadline	October 2020
Issue Instructions to Bidders	November 2020
Initial Bid Submission Deadline	December 2020
Initial Bid evaluation	January 2021
Initial Negotiation	April 2021
Negotiation Phase (Optional)	June 2021
Invitation to Submit Final Bids	July 2021
Return of Final Bids	July 2021
Successful Bidders Announcement	August 2021
Framework Agreement Award	August 2021

Having well-defined requirements in all areas is important to help expedite the process. Further consideration and detail of the procurement timelines will be undertaken when developing the Procurement Strategy.

Management Case

Governance

To realise the benefits of a common solution, the PMS project highlights the need for strong governance that supports a common approach, for example to agree national standards, sharing of resources and managing suppliers as a consortium to drive positive supplier behaviour.

The Project Board is responsible for approving the procurement strategy, shortlisting of vendors and selection of the preferred solution. The eHealth Leads Strategy Group is responsible for approving the Full Business Case (FBC).

The Project Team will be supported by a LIMS Evaluation User Group comprising of Subject Matter Experts (SMEs) and consortium board representatives. The Project Team may seek additional advice and support from the Regional Laboratory Medicine Delivery Boards as required however no formal reporting into these boards will be put in place.

The Laboratories Oversight Board (LOB) and Local Board Executive Management Teams will be kept informed however will not provide approval / sign-off of any of the procurement artefacts.

Benefits, risks and change management are also discussed in the main body of the OBC (Section 5).

Introduction

This document sets out an Outline Business Case (OBC) for investment in a modern Laboratory Information Management System (LIMS) across the following NHS Scotland Consortium Boards:

- NHS Borders
- NHS Dumfries & Galloway
- NHS Fife
- NHS Forth Valley
- NHS Golden Jubilee / NHS National Waiting Times Centre
- NHS Grampian
- NHS Greater Glasgow & Clyde
- NHS Lothian
- NHS Orkney
- NHS Shetland
- NHS Tayside

This OBC builds on existing work conducted in this area within NHS Scotland and presents a national picture of the benefits, costs and risks associated with investing in LIMS. It has been prepared in accordance with HM Treasury Green Book guidance and is structured into five sections as set out below:

- the **Strategic Case** considers the key strategic drivers and the case for change;
- the **Economic Case** sets out the options and option short-listing process, LIMS benefits and risks, cost assumptions, and the total economic cost of the preferred option;
- the **Financial Case** sets out the financial appraisal and funding options for the preferred option;
- the **Commercial Case** provides an overview of the proposed procurement approach; and
- the **Management Case** sets out the governance structures, project plan, implementation and risk management arrangements, and benefit realisation approach.

Further information is provided in a series of appendices including project membership and detailed assumptions.

1. Strategic Case

1.1. Introduction

In this section the background to the project is set out alongside the current Laboratory Information Management System (LIMS) landscape and case for change. It builds on existing work conducted by the Consortium Boards participating in this project.

1.1.1. Background

Laboratory Medicine provides laboratory services to primary and secondary care centres across Scotland. Laboratories across Consortium Boards perform over 84 million tests per year and employ over 4000 staff. Laboratories provide a 24/7 clinical and medical laboratory service and a comprehensive range of investigations including decentralised testing sites. Laboratory tests play a part in 70 – 80% of all health care decisions affecting diagnosis of disease, treatment and monitoring response to treatment.

LIMS is absolutely crucial to the function of Laboratory Medicine as it is used to result and report all primary, secondary and tertiary laboratory requests received by Laboratory Medicine (with the exception of Genetics). It also provides capability to create automation of workflows, integration of instruments, and management of samples and their associated information. LIMS systems interface with a number of key local and national healthcare systems, for example:

- Patient Administration Systems
- Electronic Patient Records
- Analytical Middleware
- Electronic Order Communication Systems
- Regional and National Systems

Current LIMS that underpin the function of the majority of departments within Laboratories within NHS Scotland Health Boards are archaic, often over 25 years in use, and are considered end of life. For most Boards, rolling support contracts are not offering value for money, while in others, the LIMS in use are nearing end of support.

Differences in LIMS systems, versions, local service configurations and processes also lead to variation and complexity. Current disparity between laboratory software and data means that meaningful cross border analysis is not currently possible and does not enable optimal use of resources on a national basis. Most suppliers now have a LIMS available that offers functionality and automation that is far in excess of what is currently used by Boards, for example:

- multidisciplinary team working; in particular the production of diagnostic pathways and cascading of tests to support appropriate use of resources;
- integrated reporting and multidisciplinary meetings capability; and
- real time access to information on performance, quality and cost.

There are strong drivers, as set out in the remainder of this section, for Boards to replace their existing solutions with a modern LIMS.

1.1.2. National Collaborative LIMS Project

In 2018, a Prior Information Notice (PIN) was published by NHS Greater Glasgow & Clyde (NHS GGC) to gather information on what LIMS were available in the market and indicative costs. Eight vendors responded and attended a Q&A day. After the PIN process was completed, NHS GGC were approached by three Boards from

the East region (undertaking work as part of the National Laboratories Programme in the East), to investigate the position of working collaboratively, as they were in the same position with an urgent need to replace their LIMS. Since then 11 Boards in total from across NHS Scotland have expressed an interest to join a national LIMS procurement (NHS Shetland, NHS Orkney, NHS Tayside, NHS Fife, NHS GG&C, NHS Forth Valley, NHS Dumfries & Galloway, NHS Lothian and NHS Grampian). The vision is for a single supplier framework which Boards can call off to procure a new LIMS.

It is expected that working together as a consortium will bring a number of benefits including:

- shared specification to promote standardisation across large parts of Scotland, based on the work already done for the National Laboratories Programme;
- the ability to use economies of scale to drive down costs; and
- an opportunity to share project costs between multiple Boards.

The Scottish Government eHealth Directorate commissioned the development of this OBC in March 2020 with NHS GGC providing overall sponsorship. Deloitte was engaged to support this work. The project will report into the National eHealth Leads Strategy Board who is responsible for approving the business case.

This business case will enable Boards (either individually or as a consortium) to make investment decisions around the potential acquisition and deployment of a modern LIMS. It will not replace the need for local business cases within Boards as the LIMS implementation may require fundamental changes to established ways of working as well as significant local investment of resources and effort.

A Project Team was formed and met regularly to review key outputs and provide overall assurance of the process. The Project Team membership is set out in Appendix A.

A LIMS Evaluation User Group was also formed to support the development of this OBC comprising of a number of cross-discipline technical and clinical stakeholders from various sub-groups across the Consortium Boards including eHealth and clinical representatives. The Evaluation User Group membership is also set out in Appendix A.

1.2. LIMS Landscape & Challenges

1.2.1. LIMS Landscape

Current IT infrastructures and architectures across NHS Boards are highly complex and have evolved over many years. Historically, each hospital site and discipline may have had its own instance of the LIMS or LIMS module respectively. This was thought appropriate for the working practices of the time but has resulted in a high degree of variation and challenges around working as part of a multidisciplinary team, which current practices require. Table 1 provides an overview of current LIMS in use across NHS Scotland.

Table 1: Current LIMS landscape

LIMS	Version	NHS Board
Clinisys / WinPath	1.1	Ayrshire & Arran
Medpath	1.12	Western Isles
Technidata	-	Lanarkshire
Clinisys / LabCentre	1.1	Shetland
		Orkney
	1.11	Borders
		Golden Jubilee / National Waiting Times Centre
	1.12	Tayside

	1.13	Fife
DXC/Telepath	1.9	Greater Glasgow & Clyde
DXC/iLab	5.8	Forth Valley
	5.8.10022.3b3	Dumfries & Galloway
	6.1b6	Lothian
	6	Grampian

Supplier development effort is now being directed towards the production of new LIMS offerings. This has resulted in markedly reduced product support for a number of Board solutions, with very significant timelines for problem resolution, even for issues considered as business critical. There is significant risk that support will be completely removed from existing products as new versions and solutions are brought to market. Lack of support also poses a significant security risk as new vulnerabilities may either not be caught or remain unpatched. The lack of development and old database architecture is also significantly impacting on the operational effectiveness of laboratory medicine and is preventing the streamlining of diagnostic workflows and demand optimisation pathways.

1.2.2. Board Challenges

The common challenges associated to current LIMS raised by the Consortiums are summarised below:

- Current LIMS do not meet the needs current and future needs of the service; modern collaborative working practices, streamlining of workflows and mainstreaming of new technology cannot be implemented. For example, the introduction of SNOMED-CT and other required standards to deliver against the National Laboratory Programme cannot be met.
- The continued use of disparate LIMS with local coding, requesting and reporting practices do not meet the National Laboratories Programme agenda of standardisation of tests, reduction in IT variation and facilitating cross Board working.
- Current disparity between both laboratory software and data across Boards means that meaningful cross border information sharing and analysis is challenging.
- Where common solutions are in place, differences in service configurations and processes lead to variation and complexity in LIMS configurations. Together, these introduce barriers to cross border working of laboratory professionals (e.g. cross border reporting and results validations) and aggregation of data.
- Multimodality/integrated reporting is not supported by current solutions to enable the production of comprehensive and consolidated diagnostics reports. This leads to significant inefficiencies in working practice and, since many vital pieces of patient information are still held on paper, this frequently makes them unavailable when needed and could be considered a risk to patient safety. This challenge has been highlighted during the current Covid-19 pandemic.
- There is limited or no support for modern communication methods (email, SMS, new HL7 standards e.g. FHIR). For example, in some Boards the Genetics and Cytogenetics LIMS do not interface with the Patient Administration Systems and their results do not get filed within the electronic patient record.
- There is a lack of integrated business intelligence tools making it difficult and time consuming to extract information from LIMS to provide timely management information, audit information and demand management control.
- There is no nationally agreed data set or definitions for laboratories in Scotland and therefore an inability to meaningfully collate data for strategic planning or service improvement. There is an inability to share test information between NHS Boards with disparate and disjointed approaches to data collection, analysis and storage.

1.3. Case for Change

1.3.1. Strategic Landscape

NHS Scotland's strategic aim for clinical laboratory services is that the delivery should take the form of a Distributed Service Model (DSM). Services will be developed incrementally following the National Blueprint published in the National Strategy and Business Case[3]. The aim is to ensure that no matter where health care is delivered in Scotland, patients will have equitable access to efficient, effective, sustainable and affordable laboratory services.

A replacement modern common system implemented across Scotland is a key enabler for the vision of a DSM to be realised, and enable efficiencies associated with standardisation, service redesign regionally and ultimately nationally to be developed in a unified laboratory system without Board boundaries. However, it is also acknowledged that delivery of common LIMS for Scotland requires convergence of laboratory and other processes, use of shared protocols, common coding systems and taxonomies.

Implementation of a common and modern LIMS would also help realise the aims of NHS Scotland's eHealth Strategies. "Scotland's Digital Health and Care Strategy[4]" sets out the need for transformational change to services. There is a particular focus on working in partnership to deliver services in a radically different way. Furthermore, it highlights need for collaboration, innovation and flexibility. The strategy identifies the massive potential for digital technology to change the way health services are delivered for the better to deliver consistent outcomes across all health services.

Research undertaken by the Royal College of Pathologists[5] in January 2017 examined how integrated reporting across Histopathology and Genetics could be achieved. The report identifies currents LIMS as a key barrier given that reporting interfaces do not uniformly provide functionality to integrate data from a variety of sources into a single definitive report. Moving to a common modern LIMS is a key enabler to achieving the recommendations within this report.

Within the Scottish Public Sector there continues to be a focus on regional working and shared services. Testing volumes vary by discipline however overall anecdotal evidence provided to the project team estimates that there is approximately a 2-3% increase in testing each year. The increasing demand on services will have to be met within the resources to sustain current services - financial and human - that NHS Scotland has at its disposal. By adopting a 'Once for Scotland' approach and changing the way organisations work, the ambition is to improve, integrate and co-ordinate services within the Scottish public sector. This will be done through reducing geographical and organisational barriers to the delivery of support services and functions.

1.3.2. Clinical Value

Alongside the move to a DSM, a modern LIMS is a key enabler to altering care pathways with potential benefits to patient experience and operational efficiencies through performance gains. LIMS will enable multidisciplinary team working, in particular the production of diagnostic pathways and cascading of tests to support appropriate use of resources. It will support improved productivity and efficiency across laboratories to allow staff to work smarter as well as streamline less efficient processes. This will help to improve turnaround times on referred patient results as well as improving the patient pathways resulting in an enhanced patient experience and

[3]https://www.labs.scot.nhs.uk/wp-content/uploads/2019/01/Shared-Services-Laboratories-Programme-Business-Case-v1.0.pdf
[4] https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/04/scotlands-digital-health-care-strategy-enabling-connecting-empowering/documents/00534657-pdf/00534657-pdf/govscot%3Adocument/00534657.pdf?forceDownload=true
[5] https://www.rcpath.org/asset/442FCDC1-AF22-401F-8FCD1B4B65603810/

enable operational efficiencies. For example, the potential to reduce length of bed stay as faster availability of test results will help enable speedier diagnosis and therefore provides the opportunity to reduce the time to discharge.

LIMS will also provide capability for advanced reporting across multi disciplines, for example, older LIMS do not have the functionality to generate integrated report for genetics haematology and pathology - this capability would help clinicians identify appropriate treatments and follow up tests potentially leading to improved patient safety and outcomes.

1.3.3. Sustainability

As reported in the DSM business case[6], the current model of laboratory services delivery across Scotland is not equitable nor is it nationally sustainable in light of the challenges they face. Demand across services is increasing, requiring Boards to utilise the same, or even fewer, resources to maintain current services.

There is significant complexity with each of the Boards current LIMS which has evolved organically over many years. Due to the poor and limited functionality of existing solutions there is a high reliance on bolt-on solutions, many of which are built in-house and not properly supported. This presents a significant business continuity and security risk. Adopting a common LIMS and standardising associated processes and data sets across NHS Scotland provides a significant opportunity to have a more sustainable and robust solution. Standardisation may also make it easier to replace or rationalise other national solutions in the future (for example SCI Store).

1.3.4. Demand Optimisation

Nationally, for Laboratory Medicine, the vision for Scotland is to deliver the Right Test, in the Right Place, at the Right Time, with the Right Impact[7]. Demand Optimisation is key to this vision. Demand Optimisation is defined as the process by which diagnostic test use is optimised to maximise appropriate testing, which in turn optimises clinical care and drives more efficient use of a scarce resource.

It has been recognised for many years that there is considerable variation in the use of diagnostic tests across NHS Scotland. While some of this variation can be explained by clinical circumstances and demographic differences, there still exists considerable levels of inappropriate requesting by clinicians, practises of over-requesting and under-requesting etc. In addition, lack of availability of certain tests across the NHS Boards may also limit their optimal universal utility.

A modern LIMS is a key enabler to reducing unnecessary testing across primary and secondary care. This will free up capacity to address rising demand and deliver testing that positively affects the patient pathway, supports primary care preventative measures, reduces hospital referrals and admissions, and supports equity of care for patients regardless of where they are or where they access Laboratory services.

[6]https://www.labs.scot.nhs.uk/wp-content/uploads/2019/01/Shared-Services-Laboratories-Programme-Business-Case-v1.0.pdf
[7] https://www.labs.scot.nhs.uk/

2. Economic Case

2.1. Introduction

This section summarises the value for money assessment of the short-listed LIMS options including an appraisal of the benefits, risks and costs associated with each option.

The Economic Case, and in particular, the options, benefits and risks were developed working closely with the Evaluation User Group (see Appendix A for membership). A number of workshops with the Evaluation User Group were held during April and May 2020 as outlined below:

- **Workshop 1. Defining the Options**: this workshop focused on defining the long-list of options and undertaking an initial sifting exercise to determine the short-listed options to be taken forward.
- **Workshop 2. Benefit Assessment:** this workshop focused on identifying the benefits and weighting each benefit aligned to the Boards' priorities. A follow-up exercise was completed by the workshop participants to assign a benefit score for each option.
- **Workshop 3. Risk Assessment:** this workshop focused on identifying the implementation risks and weighting each risk by level of impact. A follow-up exercise was completed by the workshop participants to assign a risk score for each option.
- **Workshop 4. Implementation Approach:** this workshop focused on defining the implementation approach assumptions to be used for costing each shortlisted option.
- **Workshop 5. Financial Assumption:** this workshop focused on agreeing the financial assumptions including supplier costs, NHS resource profiles, optimism bias and accounting treatments to be applied to the shortlisted options.

The Project Team met regularly to review the output of these workshops and provide overall assurance of the process. They were also involved in reviewing the costs associated with each option and the implementation approach.

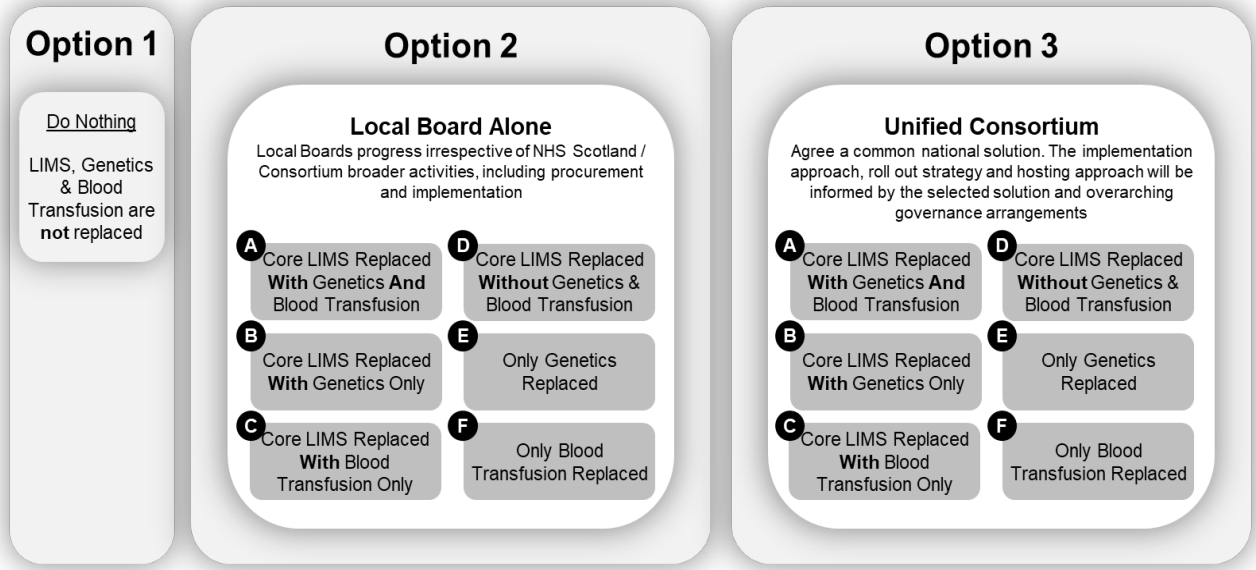
The Project Team also met with a subset of the eHealth leads (NHS Borders, NHS GGC, NHS Lothian, and NHS Grampian) twice during the project to review the workshop findings and the assumptions relating to the implementation approach.

2.2. Shortlisted Options

To determine the options to be taken forward (shortlisted) for detailed evaluation, a long list of options was drawn up describing possible scope and collaboration options. The long list of options was derived from discussions within the Project Team and a workshop with the Evaluation User Group

Figure 1 shows the long list of options identified for initial review.

Figure 1: LIMS Options Long List



Option 1: Do Nothing

All 'core'[8] laboratory services including blood sciences, microbiology, and histopathology[9] will be delivered from existing LIMS. For NHS Boards that have molecular genetics and blood transfusion, these will continue to reside on their own separate LIMS. There will be no change to cross Board / Region working practices or standards.

Option 2: Local Approach

Boards progress LIMS replacement alone, irrespective of national strategy. There will be no change to cross Board / region working practices or standards.

Option 3: Unified Consortium

Boards collaborate to agree a national LIMS specification and select a solution all Consortiums adopt. The implementation approach, roll out strategy and hosting approach will be informed as part of the procurement process. However, it is anticipated that some Boards will work together to implement and utilise a common LIMS instance.

Sub-options for Option 2 & Option 3

The sub options described below varies the discipline scope. Sub-options are the same for both Option 2 and Option 3:

- Option A: Core LIMS, Genetics and Blood Transfusion - all disciplines are included in the procurement scope including Genetics and Blood Transfusion for Boards that require these capabilities.
- Option B: Core LIMS and Genetics - Core LIMS disciplines and Genetics, for Boards that require this capability, are in scope. Blood Transfusion is not included in the procurement scope.

[8] 'Core' Lab services do not include Genetics & Blood Transfusion for the purposes of this OBC.
[9] For OBC purposes, Blood Sciences covers disciplines including biochemistry, haematology and immunology, and Microbiology covers disciplines including bacteriology and virology.

- Option C: Core LIMS and Blood Transfusion - Core LIMS disciplines and Blood Transfusion for Boards that require this capability, are included in the procurement scope. Genetics is not included in scope.
- Option D: Core LIMS only - Core LIMS disciplines are only included in the procurement scope. Genetics and Blood Transfusion are not included in scope.
- Option E: Genetics only - only Genetics is included in the procurement scope. Core LIMS disciplines and Blood Transfusion are not included in scope.
- Option F: Blood Transfusion only - only Blood Transfusion is included in the procurement scope. Core LIMS disciplines and Genetics are not included in scope.

The options were reviewed by the Evaluation User Group at two options appraisal workshops held during April 2020. The options were reviewed against the drivers set out in the Case for Change (see Section 1.3):

1. Alignment to national strategies including the move to a Distributed Service Model (DSM).
2. Maximises the opportunity to improve productivity and efficiency across laboratories leading to improved patient outcomes.
3. Contributes to the sustainability of laboratory services.
4. Maximises the opportunity for Demand Optimisation.

On this basis, the following options were discounted by the Evaluation User Group from further detailed benefit, risk and cost analysis for the reasons described below.

- **Option 2: Local Approach** – this option, including all sub options, would make it more difficult to move to a DSM given there would likely be continued divergence of solutions and standards. It also does not align to wider NHS Scotland strategies, which focus on working in partnership to deliver services in a radically different way.
- **Option 3E**: **Unified Consortium (Genetics only) –** this option was discounted as not replacing the core LIMS does not mitigate the risks associated with current LIMS such as support issues and collaboration limitations. Furthermore, it would have minimal impact on addressing the Sustainability, Demand Optimisation and Clinical Value drivers for change.
- **Option 3F**: **Unified Consortium (Blood Transfusion only) –** this option was discounted for the same reasons as outlined above in Option 3E.

The shortlisted options agreed by the Evaluation User Group for further benefit, risk and cost assessment are listed in Table 2 below. This assessment is described in the remainder of this section.

Table 2: LIMS Shortlisted Options

ID	Option	Sub Option
1	Do Nothing	N/A
3a	Unified Consortium	Core LIMS, Genetics and Blood Transfusion
3b	Unified Consortium	Core LIMS and Genetics
3c	Unified Consortium	Core LIMS and Blood Transfusion
3d	Unified Consortium	Core LIMS only

2.3. Benefits Assessment

This section describes the appraisal of the shortlisted options in relation to high level non-financial benefits. It describes the benefits framework employed and presents the results of the appraisal of the shortlisted options against this framework.

The key benefits identified by the Evaluation User Group that are expected to be realised by a modern LIMS is described in Table 3 below. These benefits outline how replacing the current ageing LIMS system will provide improved clinical value, improved and sustainable operations and help Laboratory teams effectively manage and optimise demand. While the benefits are primarily described in the context of operational improvements, ultimately, they will contribute to improved patient outcomes, for example:

- improved turnaround times on referred patient results;
- improved patient pathway – potential to reduce length of bed stays, faster availability of test results, quicker patient treatment and discharge;
- improved patient experience - reduced error rates in lab to lab requesting - reduced numbers of repeat patient attendances at clinics as a consequence of missing results;
- improved equity of care – a common and standardised LIMS enables a consistent approach regardless of patient location; and
- improved patient safety by reducing transcription errors with reports from provider labs being delivered electronically with commentary.

At this stage, it is not anticipated the move to a national LIMS will enable significant monetary benefits therefore, quantitative/monetary savings have not been included in the economic or financial appraisal elements of this business case. However, once the solution is more fully understood following the procurement it may be possible to quantity some efficiencies at FBC stage.

Quantitative savings will likely be as a result of a combination of initiatives involving modernising LIMS, implementation of a DSM and wider standardisation activity across NHS Scotland. Together these initiatives could achieve efficiencies to support future cost reduction initiatives e.g. reduction in administrative activities, reduced hosting costs through collaboration, increased clinical capacity through more efficient processes etc.

Table 3: LIMS Benefits

Category	Benefit Description
Clinical Value	Improved reporting, including integrated reporting in keeping with NICE guidelines
	Improved functionality allowing modern analytical tests to be reported appropriately
	Histopathology case tracking, and improved general laboratory tracking reducing chances of mismatching patient requests
	Increased communication options between disciplines, lab sites and NHS Health Boards
	Improved flagging of results requiring action
Operational	Reduction in burden for transition of staff and work, through the reduction in re-training of staff & re-booking of results
Sustainability	Reduction in risk of hardware and software failures through the innovative use of technology, the simplification of technical & clinical architecture
	Supports the development of the DSM for Scotland
	Standardisation of outputs will make it easier to replace connecting solutions in the future (e.g. SCI Store)
Demand Optimisation	Optimises diagnostic testing use to maximise appropriate testing
	Optimises the use of resource while reducing turnaround times by automating current clinical authorisation

A weighting and scoring exercise was undertaken to rank each of the shortlisted options in terms of their relative non-financial benefit. The purpose of this assessment was to understand any differential between shortlisted options in non-monetary terms.

This exercise involved distributing 100 points (100%) across the benefits with the most important benefits assigned the highest weighting. The second stage in the exercise was to score each option in terms of their relative benefit on a scale from one to five according to the degree to which the option contributes to the realisation of the benefit. The scorings across each benefit represent an average score provided by the Evaluation User Group participants. A worked example of this is presented beneath Table 4.

It should be noted that the status quo option was not scored against either benefit or risk. The key factor to consider was whether any of the options introduced additional benefits in comparison to benefits that are already delivered under existing arrangements. As such, the status quo option would be judged to score zero across all benefit categories.

The scoring of the short-listed options using the benefits evaluation criteria is presented in Table 4.

Table 4: Benefits Scoring Assessment

			Option 3a: Core LIMS, Genetics and Blood Transfusion	Option 3b: Core LIMS and Genetics	Option 3c: Core LIMS and Blood Transfusion	Option 3d: Core LIMS only
Category	**Benefit Description**	**Weighting**	**Average Score**	**Average Score**	**Average Score**	**Average Score**
Clinical Value	Improved reporting, including integrated reporting in keeping with NICE guidelines	10%	10	8	6	5
	Improved functionality allowing modern analytical tests to be reported appropriately	10%	10	8	7	6
	Histopathology case tracking, and improved general laboratory tracking reducing chances of mismatching patient requests	9%	9	8	8	6
	Increased communication options between disciplines, lab sites and NHS Health Boards	9%	10	9	7	6
	Improved flagging of results requiring action	8%	9	8	6	5
Operational	Reduction in burden for transition of staff and work, through the reduction in re-training of staff & re-booking of results	8%	9	8	7	5
Sustainability	Reduction in risk of hardware & software failures through the innovative use of technology, the simplification of technical & clinical architecture	9%	9	8	7	6
	Supports the development of the DSM for Scotland	10%	10	8	7	5
	Standardisation of outputs will make it easier to replace connecting solutions in the future (e.g. SCI Store)	10%	10	8	7	6

Demand Optimisation	Optimising diagnostic test use to maximise appropriate testing	9%	9	8	7	5
	Optimises the use of resource while reducing turnaround times by automating current clinical authorisation	8%	9	8	7	6
	Total Weighted Benefit Scores	100%	931	805	673	558
	Overall Benefit Ranking		1	2	3	4

Option 3a attracted the highest benefit score reflecting that increasing the scope of the LIMS will deliver the greatest opportunity for maximising benefits against each of the benefit categories. Conversely the lowest scoring option (Option 3d) scored significantly lower reflecting the impact a reduced scope would have on delivering benefits.

Worked Benefit Example:

- Benefit : Improved reporting, including integrated reporting in keeping with NICE guidelines
- Option : 3A Core LIMS Replaced WITH Genetics & Blood Transfusion
- Benefit Weighting:
    - 6 People Ranked it 5/5 = 30
    - 4 People Ranked it 4/5 = 16
    - 1 Person Ranked it 3/5 = 3
    - Total Ranking / Total People = 49 / 11 People = 4.4
    - Relative score of 4.4 (specific weighted benefit score) / total of 44 points (total of weighted benefits scores) = 10%

- Option Ability to Realise Benefit:
    - 6 People Ranked it 10/10 = 60
    - 1 Person Ranked it 7/10 = 7
    - Total Rank / Total People = 67 / 7 People = **9.6** (Rounded to 10 in Table 4).

2.4. Risk Assessment

The Evaluation User Group also undertook a similar scoring exercise for identified risks. A risk workshop focused on identifying the implementation risks and weighting each risk by level of concern. A follow-up exercise was completed by the workshop participants to assign a risk score for each option. Table 5 details the risks identified.

Table 5: LIMS Implementation Risks

Risk	Description	Mitigation
Supplier Capability / Capacity	There is a risk that suppliers may fail to understand Boards' requirements, or that their product may not be capable of meeting those requirements.	• At the time of writing there has been market engagement with suppliers and this input has been considered and reflected in the specification and approach to procurement where appropriate. • Strong governance arrangements will be implemented to QA the specification
NHS Resource Capacity	There is a risk that there will be insufficient NHS resources to deliver and maintain the solution.	• Regional and national working exploits economies of scale and shared learning • Deployment strategy to be phased according to capacity
Incomplete Specification	There is a risk that an incomplete specification leads to increased cost of the solution as a result of increased change control during the contract	• Strong governance arrangements will be implemented to QA the specification • Ensure the business requirements are identified by importance with the mandatory requirements being limited to the absolute essential ones
Integration / Technical Complexity	There is a risk that suppliers may struggle to deliver interfaces to the required levels of functionality, performance, reliability and maintainability. This may lead to increased costs due to extra effort to develop the interfaces and delays to the project timescales.	• Ensure that the full complexity of requirements is identified and understood before interfaces are developed, and by maintaining close dialogue between Boards and suppliers • New interfaces require ongoing monitoring, management and maintenance procedures
LIMS Availability	There is a risk that weakness in local infrastructure or a poorly designed/implemented solution leads to multiple and/or sustained periods of unavailability of the solution.	• Rigorous performance testing to provide confidence the availability requirements are satisfied • Motivate suppliers through appropriate service levels/credit regime in the contract • Ensure Boards are made aware of the relevant network and

		infrastructure requirements of the solution provider so that costs of upgrades are incorporated into local business cases
Change Management	There is a risk that inadequate change management and/or leadership results in poor adoption of LIMS and or unrealistic expectations meaning that anticipated benefits are not realised.	• It is essential that existing and future processes are examined and understood. This will help the implementation team support operational staff in the transition to the new LIMS • Strong clinical leadership is an essential part of successfully achieving this change to working practice, and in particular in ensuring that the new system and way of working is widely adopted • Implementation team to include appropriate levels of business change and readiness resource
Funding	There is a risk that more funding is required and the LIMS replacement becomes unaffordable	• Strong governance mechanisms will be implemented to ensure costs are closely managed and monitored • Project management will be based on good practice to ensure costs are closely managed and monitored • A robust procurement will be run to ensure it is competitive and best value can be achieved
Divergence of Standards	There is a risk that the governance is not effective and Boards adopt their own standards and therefore the anticipated benefits are not realised.	• Strong governance mechanisms will be implemented to ensure standards are set and controlled alongside appropriate change control processes • Clear expectations of the role and responsibilities of the consortium Boards will be defined and communicated including commitment to standardisation

The above risks were scored by the Evaluation User Group to distinguish between the shortlisted options. The objective of the scoring exercise was to assess the level of new or additional risk that each option may introduce. Each option was considered against each risk in turn and assigned a score in a range of 1 – 5 for the two key factors associated with risk - likelihood and impact:

Likelihood

- 0: The option will not introduce any additional or new risk in this area.
- 1: The option will introduce a marginal level of additional or new risk in this area.

- 2: The option will introduce a small level of additional or new risk in this area.
- 3: The option will introduce a moderate level of additional or new risk in this area.
- 4: The option will introduce a high level of additional or new risk in this area.
- 5: The option will introduce a very high level of additional or new risk in this area.

Impact

- 0: The risk will have no negative impact on the Board if it occurs.
- 1: The risk will have minimal negative impact on the Board if it occurs.
- 2: The risk will have some negative impact on the Board if it occurs.
- 3: The risk will have moderate negative impact on the Board if it occurs.
- 4: The risk will have a high negative impact on the Board if it occurs.
- 5: The risk will have a very high negative impact on the Board if it occurs.

The total risk score was calculated by multiplying the 'likelihood' score by the 'impact' score - once the weighting of the risk was applied, the total score was then presented as an overall ranking to align with the benefit scoring presentation. The weighting for risk categories indicates the area of risk judged to be of most concern and that Boards will have the least control over. A worked example of this is presented beneath Table 6.

It should be noted that the status quo option was not scored against either benefit or risk. The key factor to consider was whether any of the options introduced additional or new risks in comparison to risk that already exist under existing arrangements. As such, the status quo option would be judged to score zero across all risk categories.

The scoring of the short-listed options using the risk evaluation criteria is presented in Table 6.

Table 6: Scores from risk assessment of short-listed options

		Weighted Score			
Risk	**Weighting**	**Option 3a: Core LIMS, Genetics and Blood Transfusion**	**Option 3b: Core LIMS and Genetics**	**Option 3c: Core LIMS and Blood Transfusion**	**Option 3d: Core LIMS only**
Supplier Capability / Capacity	11%	197	153	102	114
Incomplete Specification	8%	98	88	78	70
Integration / Technical Complexity	9%	131	125	112	105
Deliverability of LIMS	11%	144	134	119	115
NHS Resource Capacity	12%	223	198	186	153
NHS Resource Capacity - Support	10%	168	168	148	120

LIMS Availability	10%	148	148	148	137
Change Management	9%	179	141	107	132
Divergence of Standards	10%	161	142	142	133
Funding	9%	129	109	94	88
Total Weighted Risk Score	100%	1578	1406	1236	1167
Overall Risk Ranking		4	3	2	1

Worked Risk Example:

- Risk : Supplier Capability / Capacity
- Option : 3A Core LIMS Replaced WITH Genetics & Blood Transfusion
- Risk Weighting:
    - 5 People Ranked it 5/5 = 25
    - 5 People Ranked it 4/5 = 20
    - Total Ranking / Total People = 45 / 10 People = 4.5
    - Relative score of 4.5 (specific weighted risk score) / total of 40 points (total weighted risk scores) = 11%

- Likelihood & Impact of Risk based on Option:
    - Likelihood:
        - 3 People Ranked it 5/5 = 15
        - 3 People Ranked it 4/5 = 12
        - Average Likelihood Score = 27/6 = 4.5
    - Impact:
        - 1 Person Ranked it 5/5 = 5
        - 3 People Ranked it 4/5 = 12
        - 2 People Ranked it 3/3 = 6
        - Average Likelihood Score = 23/6 = 3.8
    - Total Average Risk = 4.5 * 3.8 = 17
- Total Weighted Option Risk
        - Average Option Risk (17) * Risk Weighting (11%) *100 = **197** (seen in Table 6 above)

Option 3a (Core LIMS, Genetics and Blood Transfusion) attracted the highest risk score indicating that increasing scope will be more complex for Boards to implement whereas 3d (Core LIMS only) scored the lowest given the scope of the replacement is more closely aligned to current solutions in place by Boards and therefore was deemed to be lower risk. Option 3C (Core LIMS and Blood Transfusion) was assessed as being lower risk compared to Option 3b (Core LIMS and Genetics) which reflects that many Boards already have an implementation of Blood Transfusion incorporated within their LIMS whereas Genetics is outside the scope of existing LIMS and therefore would be a completely new implementation for most Boards.

A key point of discussion by the Evaluation User Group was the weighting % applied to the NHS Resource Capacity risk which reflects this was the highest area of concern amongst the Evaluation User Group. Given the complexity of the implementation it was highlighted that investment in NHS capacity would be critical to the success of the project to enable NHS staff to be backfilled to provide dedicated input into the project.

2.5. Economic Costing

In this section the economic costs of the shortlisted options are presented. The aim of the economic appraisal is to set out the relative cost of each option to identify the most economically efficient option for delivering LIMS replacement across Consortium Boards. The economic appraisal has been prepared in accordance with Treasury Green Book guidance.

2.5.1. Approach

This costing approach builds on previous work carried out by Consortium Boards via a national Prior Information Notion (PIN) exercise and NHS Lothian's Initial Agreement which sought approval to proceed to the next phase to replace the existing LIMS in use across NHS Lothian.

Cost assumptions have been developed and agreed in collaboration with the Project Team and Evaluation User Group.

2.5.2. Cost Principles

Key overarching principles applied to the cost assessment are described below:

- Costs per shortlisted option are presented as total costs for all Consortium Health Boards combined. Individual Board total cost for the preferred option are presented in section 2.5.7, with a detailed yearly breakdown for the Preferred Option provided in Appendix F.
- No quantitative/monetary savings have been identified as part of this work however the delivery of a modern LIMS is anticipated to achieve efficiencies which may support future cost reduction initiatives. Once the solution is more fully understood following the procurement it may be possible to quantity some of these efficiencies at FBC stage.
- As per standard practice, the Economic Case cost assessment has assumed that all expenditure is 'cash'. Any consideration of existing resources that could fill roles internally is taken into consideration in the Financial Case. Funding is also addressed in the Financial Case.
- Costs are based on relative Board size which has been calculated using an average of LIMS user numbers by Board and Board population.
    - For example, NHS Lothian has 523 LIMS users out of a total 4181 users across NHS Scotland (13%), and provides services to c900k people out of c5.4m (17%). The average of these (15%) is then used to categorise the relative board size as shown in Table 7, with the percentage thresholds shown in Table 8. The size has been used to estimate supplier costs and NHS resource costs for each Board.
- Procurement related costs and team have not been included and are assumed to be absorbed under existing budgets.
- Costs have been presented over an initial 10 year period to reflect the assumed useful life of the solution.
- The economic appraisal uses the Treasury recommended discount rate of 3.5%.

Table 7: Relative Board Size

Health Board	Region	Relative Percentage	Relative Size
NHS Ayrshire & Arran	West	6.2%	Medium
NHS Borders*	East	2.3%	Small
NHS Dumfries & Galloway*	West	2.6%	Small
NHS Fife*	East	6.2%	Medium
NHS Forth Valley*	West	4.6%	Medium

Golden Jubilee / National Waiting Times Centre*	West	0.3%	Small
NHS Grampian*	North	9.1%	Large
NHS Greater Glasgow & Clyde*	West	26.3%	Very Large
NHS Highland	North	7.1%	Medium
NHS Lanarkshire	West	10.6%	Large
NHS Lothian*	East	14.5%	Very Large
NHS Orkney*	North	0.3%	Small
NHS Shetland*	North	0.4%	Small
NHS Tayside*	North	8.5%	Large
NHS Western Isles	West	1.2%	Small

*Consortium Board

Table 8: Board Size Boundaries

Board Size	Lower Bound	Upper Bound
Very Large	12%+	
Large	8.1%	12.0%
Medium	4.1%	8.0%
Small	0.0%	4.0%

*Board size boundaries as agreed by the LIMS Project Team & Evaluation User Group

2.5.3. Supplier and Hardware Assumptions

This section describes the supplier and hardware cost assumptions. Once the solution is more fully understood following the procurement these assumptions should be reviewed and updated as required.

Supplier Costs

- CliniSys has been used as the basis for estimating the supplier costs (including LIMS user licences, supplier implementation, interface build and annual ongoing support) as this supplier provided the most comprehensive and robust cost information in response to the PIN exercise.
- Other suppliers that provided a response to the PIN exercise were assessed for potential comparison with CliniSys, however it was not possible to fully cost LIMS implementation for a like-for-like comparison using the limited information provided.

LIMS Software Licence

- Licence costs are based on those provided by CliniSys as per the rationale above.
- The total licence costs per shortlisted option are based on LIMS user numbers per discipline, per Board, multiplied by the average licence cost provided by CliniSys in their PIN response (£2k per concurrent user licence).
- The number of users under each option varies based on scope therefore licence costs vary by option.
- Individual Board's will also run at various levels of concurrency (active licences for use). For the purposes of this business case, a base assumption of 25% concurrency has been used.
- To provide a comparison for Boards likely to have concurrency rates closer to 50%, Appendix G show's total 10-year Economic and Financial costs for 50% and 100% concurrency for Each Board based on the preferred option.
- While the licencing model used in this Business Case is based on concurrency, this is for costing purposes only, and does not lock NHS Scotland Consortium Boards into this model. Other models (such as perpetual licences, charges by online user time, charges based on throughput of lab tests) may be preferred or offer better value for money. Licence model options will be explored and finalised during the procurement phase.

LIMS Supplier Implementation

- Supplier implementation costs are based on those provided by CliniSys as per the rationale above.

- Relative Board size has been used to determine implementation costs at a Board level.
- Varying concurrency levels of users will not affect Supplier Implementation costs, as, for example, the full user pool will require training on any new LIMS solution.
- As costs are presented as total Board cost, and not based on user numbers, the supplier implementation costs do not vary by option but do vary by Board size.
- Each Board has been costed with an individual supplier implementation based on relative size. It is likely this cost will reduce given the potential for regional collaboration which would likely lead to efficiency savings.

LIMS Supplier Annual Support

- Support costs are based on those provided by CliniSys as per the rationale above.
- Relative Board size has been used to determine support costs at a Board level.
- Varying concurrency levels of users will not affect Annual Support costs, as, for example, the entire user pool will require ongoing support from chosen supplier.
- As costs are presented as total consortium costs, support costs do not vary by option but do vary by Board size.
- Each Board has been costed with an individual annual support cost based on relative size. It is likely this cost will reduce given the potential for regional collaboration which would likely lead to efficiency savings.

LIMS Interfaces

- Interface implementation costs are based on those provided by CliniSys as per the rationale above.
- Implementation costs have calculated by multiplying the cost per interface by the number of Analyser Interfaces / Middleware by discipline by Board + additional interfaces required (assumed 4 interfaces including TRAK / NPECs / Order Comms / +1 Other HL7 interface), and Data Migration per discipline.
- The number of interfaces required under each option varies based on scope therefore licence costs vary by option.

3rd Party Downstream Interfaces

- Third party downstream interface costs have been included at £40k per board.
- This is an indicative cost for four key downstream systems that LIMS communicate with, at £10k per system.
- The four key systems are TrakCare, SCI Store, ECOSS and the Order Communication Systems (OCS) in use.
- Individual board configuration will have an impact on this cost, and this cost will need to be assessed as part of local business cases.

LIMS Hosting Hardware

- LIMS hardware costs are based on current LIMS hardware costs provided by Consortium Boards.
- At the time of drafting this document, the Project Team did not have access to all hardware costs for all of the Consortium Boards therefore the relative Board size has been used to extrapolate costs across all Boards.
- This includes a one-off hardware cost for hosting, which requires refreshing every 5 years and a 2% annual recurring support cost.
- This should be reviewed as part of future business cases, based on outcomes of the procurement exercise and preferred hosting model.
- It is likely this cost will reduce given the potential for regional collaboration which would likely lead to efficiency savings.

2.5.4. NHS Resource and Implementation Assumptions

This section describes the NHS resource assumption required for a LIMS implementation.

It has been assumed that the implementation of LIMS will follow a four phase approach based on a combination of national and local NHS resources. This is described in Table 9 below.

Table 9: Implementation Approach Assumptions

Phase	1. Design	2. Build & Configuration	3. Rollout	4. Business As Usual (BAU)
Delivered by	National Team	Board Team	Board Team	Board Team
Description	To ensure a national standard is followed, the Design phase will be carried out by a National team with representation and input from all Consortium Boards. This phase will be informed by the approach taken by the selected supplier but is likely to involve an upfront Discovery phase.	Each Board has varying systems and processes that a replacement LIMS would need to integrate with therefore this phase will be delivered locally. For example, while Trakcare is used across NHS Scotland, each Board has various versions and modules of Trakcare which would mean varying levels of bespoke integration development.	Local teams will be best placed to rollout LIMS. There may be potential efficiencies from a regional rollout and Boards should be encouraged to adopt this approach, however, this has not been assumed for the purposes of this OBC given these collaborations are not yet agreed.	As each Board currently has existing standalone labs, BAU activity to maintain LIMS is assumed to be based on Board resource. There may be further opportunity to achieve efficiencies in BAU costs if the lab services model changes.
Phase Length Assumption	6 months	Based on relative Board size with a minimum length of 4 months assumed	Based on a discipline-based rollout, with 1 month required per discipline	Ongoing

The number of months to complete each phase by Board size and by option is shown in table 10 below.

Table 10: Implementation timescales by option

Months Per Implementation Phase						
Board Size	Design (National Team)	Build & Configuration (Board Team)	Rollout (Board Team)			
			Option 3A	Option 3B	Option 3C	Option 3D
Very Large	6	4+3	5	4	4	3
Large		4+2	5	4	4	3
Medium		4+1	5	4	4	3
Small		4	5	4	4	3

Implementation Team

This section describes the implementation team which formed the basis of the cost assessment for each of the shortlisted options. The team roles and grades were developed collaboratively with the Project Team and Evaluation User Group over a series of workshops carried out during May 2020.

Table 11 details the National team NHS Scotland resource requirements. This encompasses all required resources for the Design phase. To calculate a cost per Board, the total cost is *divided* by relative Board size as calculated in the previous section.

Table 11: National NHS resource requirements for the Design phase

Role	Grade	WTE
LIMS Programme Team		
Programme Manager	8a	1.0
Labs Lead	8b	1.0
eHealth Lead	8a	1.0
Clinical Lead (Option dependent)	PAs	0.6 (Option 3d) / 0.8 (Option 3b/c) / 1.0 (Option 3a)
PMO / Admin	5	1.0
Business Analyst (Option dependent)	7	3.0 (Option 3d) / 4.0 (Option 3b/c) / 5.0 (Option 3a)
Information Governance Lead	7	0.5
eHealth Resources		
Config and Testing	5	1.0
Network	6	1.0
PM Technical	7	1.0
Desktop Support	5	1.0
Development	6	1.0
Totals		**13.1 (Option 3d) / 14.3 (Option 3b/c) / 15.5 (Option 3a)**

A brief description of the National Team roles is provided below:

- **Project Team.** An overarching Programme Team put in place to govern the initial design to be implemented across all Consortium Boards and lead and manage the subsequent transition to local Board implementation teams for Board roll out. This team focuses on the high-level Design period ensuring that commonality and standardisation across all Consortium boards is incorporated within the design. This team includes programme management, laboratory lead, clinical lead and eHealth lead, business analysis, Information Governance and admin support roles. None of these roles continue into BAU.

- **Laboratory Resources.** These resources focus on standardisation of code lists and common use of ISD Reference files; standardisation and creation of patient and other report templates; the Development and initial build of Interfaces for common systems such as Patient Management Systems (TrakCare, SCI Store) and Order Communication Systems (ICE), ECOSS, NPEX, EDT feeds; the standardisation and creation of RBACS; and initial system and interface testing.

- **eHealth Resources.** These resources focus on the Development and initial build of Interfaces for common systems such as Patient Management Systems (TrakCare, SCI Store) and Order Communication Systems (ICE), ECOSS, NPEX, EDT feeds, working closely with Lab resources. This also includes initial system and interface testing as above. They also are responsible for security, infrastructure reviews, initial server design and where possible configuration.

As this National Team will be comprised of resources from Consortium Boards, this cost will be shared. The timescales and cost distribution for these costs should be clarified at FBC stage, with any potential national capital funding through the Scottish Government Digital stream identified.

Table 12 details the resource requirements that NHS Lothian has estimated would be needed for their local Build & Configuration, Rollout and BAU phases. This profile has been *extrapolated* based on relative Board percentage as outlined I then previous section to determine estimated costs for each Board.

Table 12: NHS Lothian resource requirements (used for extrapolation)

Role	**Grade**	**WTE**		
LIMS Programme Team		Build & Config	Rollout	BAU
Programme Manager	8a	1.0	1.0	-
Labs Lead	8b	1.0	1.0	-
eHealth Lead	8a	1.0	1.0	-
Clinical Lead (Option Based)	PAs	0.6 (Option 3d) / 0.8 (Option 3b/c) / 1.0 (Option 3a)		-
Training Facilitator	5	0.5	1.0	-
PMO / Admin	7	1.0	1.0	-
Business Analyst	7	2.0	1.0	-
Lab Resources				
Lab Tech (2 Per Discipline Based On Option)		6.0 (Option 3d) / 8.0 (Option 3b/c) / 10.0 (Option 3a)		-
Lab Tech - 2 Overarching		2.0	2.0	3.0
eHealth Resources				
Config and Testing	5	1.0	1.0	-
Other integration & Data Migration	5	1.0	1.0	-
Network	6	1.0	1.0	-
PM Technical	7	1.0	1.0	-
Desktop Support	5	1.0	1.0	-
Development	6	1.0	1.0	-
Totals		**21.1 (Option 3d) / 23.3 (Option 3b/c) / 25.5 (Option 3a)**		**3.0**

A brief description of the Local Team roles is provided below:

- **Project Team.** Local project teams will be responsible for the management of all local board day to day implementation activities such as project management, local RAID logs etc., management of local teams and assigned tasks.

- **Lab Team Resources.** Following transition from the National Design phase, the local Lab resources will be responsible for building local configuration of the LIMS, covering such areas as creation of required local codes where no national\standard code exists, local RBACS where no standard national RBAC exists, local workflows, creation of local rules, development of local interfaces to analysers and middle platforms, etc. They will also be responsible for local configuration of interfaces delivered by the National team for systems including Patient Management systems and Order Communication Systems. Local testing and accreditation activities, such as UKAS/MHRA, will also be covered by this team.
- **eHealth Resources.** This team will assist with local configuration of interfaces delivered by National team as with the above Lab resources. They will also, where required, assist with infrastructure tasks such as networking, hardware and software build. Other activities include, but not limited to, testing of systems and interfaces and assisting with local RBACS.

LIMS Replacement Start Year

For the purposes of OBC costing, the costs for each Consortium has been profiled over 10 years. This is to provide a 10 year Net Present Cost (NPC) for each Board.

As this is for costing purposes only, it does not commit Boards to starting their LIMS replacement in Year 1 and it does not assume that this will be the preferred or feasible approach. There may also be potential collaboration opportunities for Boards to consider, for example regions may collaborate to reduce implementation timescales and/or costs through implementation of a single LIMS instance.

Final implementation profiling will be based on supplier capacity, available internal resources by Board and other collaboration considerations. This should be further reviewed following the national LIMS procurement and reflected within local business cases.

2.5.5. Contingency / Optimism Bias

The Treasury Green Book published in 2003 introduced a requirement for an adjustment to be made for optimism bias for all business cases. This refers to the known tendency for the costs of projects to be underestimated, particularly in the early stages of developing and costing projects. The adjustment for optimism bias/contingency is a requirement to make explicit, upward adjustments to the costs to counteract this known tendency.

In this business case contingency adjustments have been applied to both internal resource costs and supplier licence, implementation and annual support costs, to cover residual uncertainty at the time of writing.

For the purposes of this OBC, a single **optimism bias figure of 30%** has been applied to all cost items including supplier costs and internal NHS costs. This equates to an additional c.£1-4m depending on Board size. This was calculated using the optimism bias calculator recommended in the Scottish Capital Investment Manual (SCIM). The level of optimism applied has been influenced by a number of factors, including:

- the Specification has yet to be finalised;
- capability and capacity of supplier is not yet confirmed and will be confirmed through the procurement process;
- work has not yet been undertaken to confirm whether there is sufficient capacity and skills for implementation at each Board level; and
- There is uncertainty in the policy environment from potential classification of LIMS as a medical device, as well as COVID19 response.

It is important to note that as this is an Outline Business Case, the level of optimism bias is significant, and should be reviewed following procurement and included in local business cases.

Further detail behind the optimism bias calculation can be found in Appendix C.

2.5.6. Total Economic Costs

The estimated economic cost of each shortlisted option has been calculated based on the assumptions outlined in the previous section. These are full 10 year costs for each short-listed option for all Consortium Boards.

Table 13 : Total Economic Option cost comparison (£m)

Cost (£m)	Cost Type	Option 3a: Core LIMS, Genetics and Blood Transfusion	Option 3b: Core LIMS and Genetics	Option 3c: Core LIMS and Blood Transfusion	Option 3d: Core LIMS only
LIMS Software Licence	NRC	1.60	1.53	1.46	1.39
Annual Support	RR	33.74	33.74	33.74	33.74
Supplier Implementation	NRC	10.45	10.45	10.45	10.45
Design	NRR	0.33	0.30	0.30	0.25
Build & Local Configuration	NRR	3.67	3.31	3.31	2.68
Rollout	NRR	2.70	1.96	2.04	1.25
BAU	RR	5.82	5.87	5.87	5.92
LIMS Interface Build	NRC	1.34	1.34	1.20	1.20
LIMS Interface Support	RR	1.29	1.29	0.92	0.92
Additional Interface Build	NRC	2.07	2.07	2.07	2.07
Additional Interface Recurring	RR	2.54	2.54	2.54	2.54
Downstream Interfaces	NRC	0.44	0.44	0.44	0.44
Hosting Hardware	RR	4.40	4.40	4.40	4.40
Optimism Bias (30%)	-	21.08	20.74	20.59	20.15
Total with Optimism Bias		**91.36**	**89.88**	**89.23**	**87.30**
Non Recurring Capital (NRC)		20.58	20.49	20.22	20.14
Non Recurring Revenue (NRR)		8.70	7.24	7.34	5.43
Recurring Revenue (RR)		62.08	62.15	61.66	61.73
Total		**91.36**	**89.88**	**89.23**	**87.30**
Net Present Cost - 10 Year		82.06	80.61	80.02	78.13

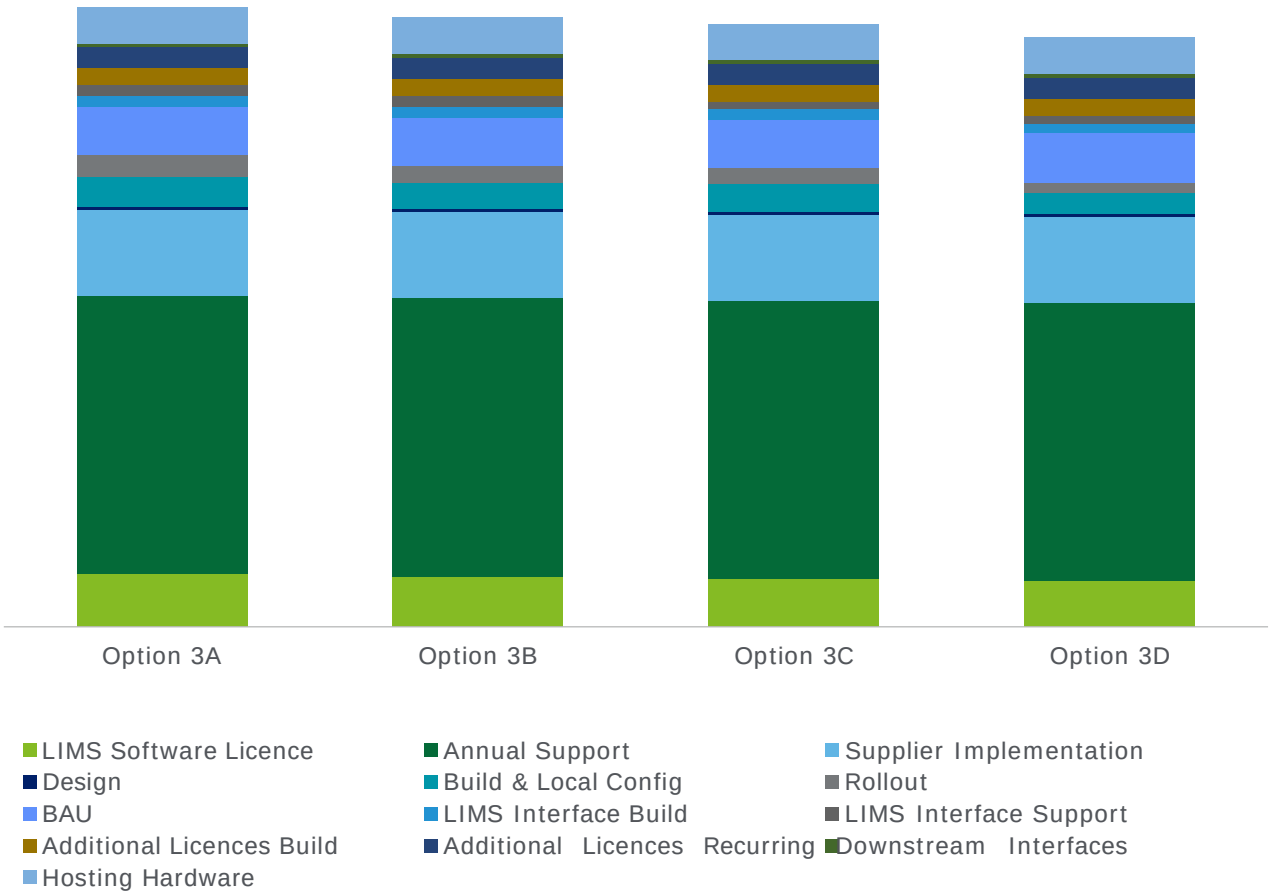
The table shows that the option with the lowest economic cost is option 3D: Core LIMS only, with a Net Present Cost (NPC) of c£78m. This is unsurprising as each shortlisted option is comprised of variation of discipline scope, which is directly related to cost.

Option 3A (Core LIMS, Genetics and Blood Transfusion) has a total NPC of c£82m over the 10 year, with option 3B (Core LIMS and Genetics) and 3C (Core LIMS and Blood Transfusion) being similar in cost at £81m and £80m respectively.

The greatest cost over the 10 year period is Supplier Annual Support – this is due to each Board having their own supplier annual support cost included. This cost is expected to be driven down following supplier

engagement, procurement, and regional collaboration opportunities identified and taken forward as part of local business cases. Figure 2 below visually emphasises that each option does not greatly vary from one another

Figure 2 : Economic cost comparison for each Short-Listed Option



While all costs for all options are within 10% of each other, Option 3A (Core LIMS, Genetics and Blood Transfusion) has the highest economic cost. The primary difference in costs comes from the LIMS User Licences by option (less discipline in scope results in less users), interfaces required per discipline (less disciplines in scope results in less interface requirements) and the internal NHS resources costs (also based on discipline numbers).

2.5.7. Option 1: 'Do Nothing' Costs

Option 1 has not been included in the above cost analysis as the implementation costs items do not apply.

The Project Team did not have access to complete recurring BAU costs for each Board therefore it has not been possible to accurately state what the recurring costs are under Option 1. Analysis should be carried out on comparing recurring revenue costs when the costs associated to the selected solution are more fully understood and further investigation on Board's BAU costs have been determined.

2.6. Option Appraisal and Preferred Option

Taking the shortlisted options benefit and risk weighting and including the NPC in Table 14 below provides an overall cost per benefit score. This evaluation process aligns with the approach followed in the NHS Lothian Initial Agreement and provides a balanced view of cost in relation to weighted benefit.

Table 14: Economic Appraisal Summary

Option Appraisal	Option 3a: Core LIMS, Genetics and Blood Transfusion	Option 3b: Core LIMS and Genetics	Option 3c: Core LIMS and Blood Transfusion	Option 3d: Core LIMS only
Weighted Benefits Points	931	805	673	558
Weighted Risk Points	1578	1406	1236	1167
Risk Per Benefit Point	1.69	1.74	1.84	2.09
Option Rank	1.00	2.00	3.00	4.00
NPC Per Option (£k)	82,060	80,610	80,020	78,130
Cost Per Benefit Point (£k)	88	100	119	140
Option Rank	1.00	2.00	3.00	4.00

Following the inclusion of NPC per option, Option 3A (Core LIMS, Genetics and Blood Transfusion) shows the lowest cost per benefit point (while having the highest NPC) and as such has been identified as the preferred option for Consortium Boards. Option 3B has a relatively similar cost per benefit point evidencing the importance of Genetics inclusion in LIMS Replacement.

2.6.1. NHS Scotland Consortium Boards Preferred Option

The preferred option, Option 3a (Core LIMS, Genetics and Blood Transfusion) has been profiled over a 10 year period as shown in Table 15 below.

Table 15: Option 3A: Core LIMS with Genetics & Blood Transfusion – Total Economic Cost (£m)

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	1.60	-	-	-	-	-	-	-	-	-	6.38
Supplier Annual Support	RR	-	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	33.74
Supplier Implementation	NRC	10.45	-	-	-	-	-	-	-	-	-	10.45
Design	NRR	0.33	-	-	-	-	-	-	-	-	-	0.33
Build & Local Configuration	NRR	3.35	0.32	-	-	-	-	-	-	-	-	3.67
Rollout	NRR	0.17	2.53	-	-	-	-	-	-	-	-	2.70
BAU	RR	-	0.40	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	5.82
LIMS Interface Build	NRC	1.34	-	-	-	-	-	-	-	-	-	1.34
LIMS Interface Support	RR	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	1.29
Additional Interface Build	NRC	2.07	-	-	-	-	-	-	-	-	-	2.07
Additional Interface Recurring	RR	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	2.54

Downstream Interfaces	NRC	0.44	-	-	-	-	-	-	-	-	-	0.44
Hosting Hardware	RR	2.04	0.04	0.04	0.04	0.04	2.04	0.04	0.04	0.04	0.04	4.40
Optimism Bias		**6.63**	**2.22**	**1.45**	**1.45**	**1.45**	**2.05**	**1.45**	**1.45**	**1.45**	**1.45**	**21.08**
Total		**28.72**	**9.64**	**6.30**	**6.30**	**6.30**	**8.90**	**6.30**	**6.30**	**6.30**	**6.30**	**91.36**
Non Recurring Capital (NRC)		20.58	-	-	-	-	-	-	-	-	-	20.58
Non Recurring Revenue (NRR)		5.0	3.70	-	-	-	-	-	-	-	-	8.70
Recurring Revenue (RR)		3.15	5.94	6.30	6.30	6.30	8.90	6.30	6.30	6.30	6.30	62.08
Total		**28.72**	**9.64**	**6.30**	**6.30**	**6.30**	**8.90**	**6.30**	**6.30**	**6.30**	**6.30**	**91.36**
Discount Factor	3.5%	*1.00*	*0.97*	*0.93*	*0.90*	*0.87*	*0.84*	*0.81*	*0.79*	*0.76*	*0.73*	
Net Present Cost		28.72	9.31	5.88	5.68	5.49	7.49	5.12	4.95	4.78	4.62	**82.06**

The Design activity and the majority of local Build and Configuration is assumed to complete in Year 1, with Rollout finishing within 18 months. The yearly annual cost is c£6m for all Consortium Boards, except for in Year 1 where the cost is c.£29m, Year 2 at c.£10m and then in Year 6 at c£9m (due to 5 year hardware refresh cycle). The total NPC for the 10 year period is c.£82m for all Consortium Boards.

2.6.2. Consortium Board Preferred Option Economic Cost

The preferred option, Option 3a (Core LIMS, Genetics and Blood Transfusion) has been profiled over a 10 year period for each Consortium Board as shown in Table 16 below.

As outlined in the preceding Economic Case sections, the Design phase is the only shared cost line item as this assumes a national team approach. All other cost line items are incurred by each Board and do not take into account potential collaboration approaches to implementation – as this are not agreed at this stage - and would provide an opportunity for Boards to reduce costs further. Therefore, the costing approach assumes a potential 'worst case' cost for each individual Board. These costs are expected to be driven down following supplier engagement, procurement, and regional collaboration opportunities identified and taken forward as part of local business cases.

Table 16: Economic Costs (£m) by Consortium Board for Option 3a (Core LIMS, Genetics and Blood Transfusion)

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Gram-pian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shet-land	NHS Tayside
LIMS Software Licence	0.04	0.05	0.12	0.07	0.01	0.19	0.67	0.27	0.00	0.00	0.17
Supplier Annual Support	2.06	2.06	2.29	2.29	2.06	3.16	6.27	6.27	2.06	2.06	3.16
Supplier Implementation	0.58	0.58	0.80	0.80	0.58	0.97	2.00	2.00	0.58	0.58	0.97
Design	0.01	0.01	0.03	0.02	0.00	0.04	0.11	0.06	0.00	0.00	0.04
Build & Local Config	0.07	0.08	0.24	0.18	0.01	0.43	1.44	0.79	0.01	0.01	0.40
Rollout	0.05	0.06	0.19	0.14	0.01	0.35	1.01	0.55	0.01	0.01	0.33
BAU	0.19	0.21	0.49	0.36	0.03	0.71	2.02	1.11	0.03	0.03	0.66
LIMS Interface Build	0.06	0.06	0.09	0.09	0.07	0.22	0.23	0.20	0.09	0.09	0.13
LIMS Interface Support	0.03	0.03	0.04	0.04	0.05	0.33	0.36	0.29	0.03	0.03	0.08
Add. Licences Build	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18
Add. Licences Recurring	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23
Downstream Interfaces	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04

Hosting Hardware	0.22	0.22	0.33	0.33	0.22	0.44	0.88	0.88	0.22	0.22	0.44
Optimism Bias	**1.13**	**1.14**	**1.52**	**1.43**	**1.05**	**2.18**	**4.64**	**3.86**	**1.04**	**1.04**	**2.05**
Total with OB	**4.88**	**4.96**	**6.60**	**6.21**	**4.53**	**9.46**	**20.09**	**16.73**	**4.52**	**4.52**	**8.86**
Non Recurring Capital (NRC)	1.17	1.20	1.61	1.55	1.15	2.08	4.07	3.50	1.16	1.16	1.93
Non Recurring Revenue (NRR)	0.18	0.20	0.60	0.44	0.03	1.06	3.33	1.83	0.03	0.03	0.99
Recurring Revenue (RR)	3.53	3.56	4.40	4.22	3.36	6.32	12.69	11.41	3.33	3.33	5.94
Total with Optimism Bias over 10 years	**4.88**	**4.96**	**6.60**	**6.21**	**4.53**	**9.46**	**20.09**	**16.73**	**4.52**	**4.52**	**8.86**
NPC over 10 years	4.36	4.43	5.95	5.59	4.04	8.51	18.14	15.02	4.03	4.03	7.97

The table above shows the total NPC for each Consortium Board. NHS GGC and NHS Lothian have the highest cost (c£20m and £16m respectively over 10 years), as both are defined as Very Large Boards, while the smaller Boards including NHS Borders and NHS D&G have a similar total cost of c.£4m

For each Board the highest costs are those associated with supplier support and implementation. **Optimism Bias also adds 30%** onto the total costs, equating to an additional c£1-4m, depending on Board size, over the 10 year period.

3. Financial Case

In this section the financial appraisal of LIMS is set out. It illustrates additional financial charges could significantly increase the cost of the solution.

3.1. Financial Appraisal – Total Consortium

A financial appraisal has been undertaken to illustrate the affordability of the Preferred Option. The appraisal has been prepared over an initial ten year period as shown in Table 17 and is based on the following assumptions regarding the accounting and VAT treatment of the solution:

- **Accounting Treatment.** It has been assumed that the initial purchase of software licences, supplier implementation, and additional interface build will be treated as capital expenditure. All other services have been assumed to be revenue, including the Board's internal resource costs for implementation.
- **VAT Position.** It has been assumed that VAT will be payable at the standard rate of 20% on all supplier costs (upfront licence costs, supplier implementation, interface build, and annual support), and that VAT is not recoverable. It is likely that VAT can be recovered, although this is subject to the specification and procurement outcomes (such as potential bespoke nature of the solution, or Managed Service provision).
- **Indexation.** External supplier costs have been adjusted for inflation at 2% in line with the Bank of England CPI target. Internal Board resource costs have also been adjusted for inflation at 2% in line with current guidance on public sector salaries. As previously outlined in the economic case, 2020/21 prices have been used.
- **Existing Resources In Post.** While the Economic Case calls out the total required resource and cost to replace LIMS across Consortium Boards, it is assumed that 60% of eHealth resource requirements will be absorbed within existing team structures across each Board. As such, this cost (including Optimism Bias & Indexation) has been deducted from the total cost outlined in the tables below. This assumption should be revisited following the procurement exercise and further local business case work, as if Boards were able to utilise further resource already in post to undertake the implementation the overall financial cost would reduce. It is important to note that utilising this internal resource will be achievable only if Boards make a commitment to realign priorities to ensure these resources can focus purely on LIMS implementation for the required time period. As implementation begins, there is also potential for buying resource time from other Boards that have already replaced their LIMS and as such have the experience from their implementations.
- **Capital Depreciation.** Capital expenditure has been depreciated using the straight-line method over ten years. Depreciation will start in the year of purchase, depreciating the full Capital costs until being fully written down at the end of year ten, which is the anticipated useful life of the LIMS solution. This is accounted for as Non-Core costs to Boards, and as such is shown as a separate line item below the Total Financial Cost.

These assumptions have been agreed in collaboration with the NHS Lothian VAT and finance team. It is recommended that these issues are considered further as part of the subsequent procurement exercise and local business cases.

Table 17: Total Financial Cost (£m) for Option 3a (Core LIMS, Genetics and Blood Transfusion)

Cost (£m)	Year										Total
	1	2	3	4	5	6	7	8	9	10	
Consolidated Financial Considerations											
NRC (Incl. VAT & Indexation)	24.69	-	-	-	-	-	-	-	-	-	24.69
NRR (Incl. VAT & Indexation)	5.0	3.78	-	-	-	-	-	-	-	-	8.78
RR (Incl. VAT & Indexation)	3.24	7.13	7.63	7.76	7.89	10.90	8.17	8.31	8.45	8.60	78.08
Total (Incl. VAT & Index.)	32.94	10.90	7.63	7.76	7.89	10.90	8.17	8.31	8.45	8.60	111.55
Existing Resources In Post	(0.56)	(0.42)	-	-	-	-	-	-	-	-	(0.99)
Total Financial Cost	**32.37**	**10.48**	**7.63**	**7.76**	**7.89**	**10.90**	**8.17**	**8.31**	**8.45**	**8.60**	**110.57**

Capital Depreciation	2.06	2.06	2.06	2.06	2.06	2.06	2.06	2.06	2.06	2.06	20.58

The financial appraisal illustrates that implementation of LIMS will cost in the region of £111m for all Consortium Boards over a ten year period and given the current constraint on public sector funding it will be important to establish the most appropriate funding mechanism.

It has been assumed that the majority of funding, other than shared resources, for LIMS will come from individual Consortium Board budgets. However, as the project progresses, further discussions will be required to agree the most appropriate funding model.

The shared resources as part of the Design phase will be comprised of Consortium Board resources, and as such the cost will be shared. The current assumption is this cost will be divided based on relative Board size, however this should be clarified at FBC stage. Furthermore the timescales of when this cost is to be incurred, relative to the specification and procurement should also be clarified, with any potential national capital funding through the Scottish Government Digital stream identified and included.

As outlined above, existing resources in post have been assumed to include 60% of eHealth resources for implementation. While there may also be existing resources to fill roles identified in the Project & Lab teams, these have not been included in the above Financial Case as at this point there are significant unknowns on specific resource requirements.

The full capital cost will depreciate over a 10 year period, resulting in a yearly depreciation cost of £2.06m. As this is a Non-Core cost, and not an implementation cost, it has been shown as a separate cost item.

Further breakdown of specific cost types is included in Table 18 – 20 below (not including existing resources / deprecation). These tables provide further clarity for Consortium Board Finance networks.

Table 18: Non-Recurring Capital Financial Cost Breakdown

Cost (£m)	Year										Total
	1	2	3	4	5	6	7	8	9	10	
Non Recurring Capital											
NRC – LIMS Software Licence	1.60	-	-	-	-	-	-	-	-	-	1.60
NRC – Supplier Implementation	10.45	-	-	-	-	-	-	-	-	-	10.45
NRC – LIMS Interface Build	1.34	-	-	-	-	-	-	-	-	-	1.34
NRC – Additional Interface Build	2.01	-	-	-	-	-	-	-	-	-	2.01

NRC – Downstream Interfaces	0.44	-	-	-	-	-	-	-	-	-	0.44
NRC – Optimism Bias	4.75	-	-	-	-	-	-	-	-	-	4.75
VAT	4.12	-	-	-	-	-	-	-	-	-	4.12
Indexation	-	-	-	-	-	-	-	-	-	-	-
Total NRC Financial Cost	**24.69**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**24.69**

Table 19: Non-Recurring Revenue Financial Cost Breakdown

Cost (£m)	Year										Total
	1	2	3	4	5	6	7	8	9	10	
Non-Recurring Revenue											
NRR – Design	0.33	-	-	-	-	-	-	-	-	-	0.33
NRR – Build & Local Configuration	3.35	0.32	-	-	-	-	-	-	-	-	3.67
NRR – Rollout	0.17	2.53	-	-	-	-	-	-	-	-	2.70
NRR – Optimism Bias	1.15	0.85	-	-	-	-	-	-	-	-	2.00
VAT	-	-	-	-	-	-	-	-	-	-	-
Indexation	-	0.07	-	-	-	-	-	-	-	-	0.07
Total NRR Financial Cost	**5.00**	**3.78**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**8.78**

Table 20: Recurring Revenue Financial Cost Breakdown

Cost (£m)	Year										Total
	1	2	3	4	5	6	7	8	9	10	
Recurring Revenue											
RR – Supplier Annual Support	-	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	33.74
RR – BAU	-	0.40	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	5.82
RR – LIMS Interface Support	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	1.29
RR – Additional Interface Recurring	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	2.51
RR – Hosting Hardware	2.04	0.04	0.04	0.04	0.04	2.04	0.04	0.04	0.04	0.04	4.40
RR – Optimism Bias	0.73	1.37	1.45	1.45	1.45	2.05	1.45	1.45	1.45	1.45	14.33
VAT	0.10	1.07	1.07	1.07	1.07	1.07	1.07	1.07	1.07	1.07	9.76
Indexation	-	0.12	0.25	0.39	0.52	0.93	0.79	0.94	1.08	1.23	6.25
Total RR Financial Cost	**3.24**	**7.13**	**7.63**	**7.76**	**7.89**	**10.90**	**8.17**	**8.31**	**8.45**	**8.60**	**78.08**

3.2. Financial Appraisal – By Consortium Board

The financial appraisal illustrates the total financial cost of LIMS by Consortium Board over the ten-year period. As with costs outlined in the Economic Case, the costs in Table 21 below are estimates based on the key assumptions within this OBC. The costs per Board will be further refined during subsequent business cases.

Table 21: Total 10 Year Financial Cost by Consortium Board

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Grampian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shetland	NHS Tayside
Consolidated Financial Considerations											
NRC (Incl. VAT & Indexation)	1.41	1.44	1.93	1.86	1.38	2.50	4.88	4.20	1.39	1.39	2.32
NRR (Incl. VAT & Indexation)	0.18	0.20	0.60	0.44	0.03	1.07	3.36	1.84	0.03	0.03	1.00
RR (Incl. VAT & Indexation)	4.49	4.52	5.50	5.31	4.30	7.92	15.76	14.32	4.26	4.26	7.44
Total (Incl. VAT & Index.)	**6.07**	**6.16**	**8.03**	**7.61**	**5.71**	**11.48**	**24.0**	**20.36**	**5.68**	**5.69**	**10.76**
Existing Resources In Post	(0.02)	(0.02)	(0.07)	(0.05)	(0.00)	(0.12)	(0.38)	(0.21)	(0.00)	(0.00)	(0.11)
Total Financial Cost	**6.05**	**6.14**	**7.96**	**7.56**	**5.70**	**11.36**	**23.63**	**20.16**	**5.68**	**5.68**	**10.64**
Capital Depreciation	1.17	1.20	1.61	1.55	1.15	2.08	4.07	3.50	1.16	1.16	1.93

*Due to rounding, '0.00' costs are less than £10k

Table 18 illustrates that VAT & Depreciation considerations increase the total Financial Cost to each Board over the 10 year period. Each Board has a minimum VAT cost of c£800k, and indexation of c£300k over the 10 year period, with the larger Boards having higher costs as expected. Further breakdown of financial considerations by Board is shown in the below tables (not including existing resources / deprecation), with yearly costs included in the Appendix.

Table 22: Non-Recurring Capital Financial Breakdown by Board

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Grampian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shetland	NHS Tayside
Non-Recurring Capital											
NRC – LIMS Software Licence	0.04	0.05	0.12	0.07	0.01	0.19	0.67	0.27	0.0	0.0	0.17
NRC – Supplier Implementation	0.58	0.58	0.80	0.80	0.58	0.97	2.0	2.0	0.58	0.58	0.97
NRC – LIMS Interface Build	0.06	0.06	0.09	0.09	0.07	0.22	0.23	0.20	0.09	0.09	0.13
NRC – Additional Interface Build	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18
NRC – Downstream Interfaces	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
NRC – Optimism Bias	0.27	0.28	0.37	0.36	0.26	0.48	0.94	0.81	0.27	0.27	0.45
VAT	0.23	0.24	0.32	0.31	0.23	0.42	0.81	0.70	0.23	0.23	0.39
Indexation	-	-	-	-	-	-	-	-	-	-	-
Total NRC Financial Cost	**1.41**	**1.44**	**1.93**	**1.86**	**1.38**	**2.50**	**4.88**	**4.20**	**1.39**	**1.39**	**2.32**

Table 23: Non-Recurring Revenue Financial Breakdown by Board

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Grampian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shetland	NHS Tayside
Non-Recurring Revenue											
NRR – Design	0.01	0.01	0.03	0.02	0.02	0.04	0.11	0.06	0.0	0.0	0.04
NRR – Build & Local Configuration	0.07	0.08	0.24	0.18	0.01	0.43	1.44	0.79	0.01	0.01	0.40
NRR – Rollout	0.05	0.06	0.19	0.14	0.01	0.35	1.01	0.55	0.01	0.01	0.33
NRR – Optimism Bias	0.04	0.05	0.14	0.10	0.01	0.24	0.77	0.42	0.01	0.01	0.23
VAT	-	-	-	-	-	-	-	-	-	-	-
Indexation	0.0	0.00	0.00	0.00	0.00	0.01	0.03	0.02	0.00	0.00	0.01
Total NRR Financial Cost	**0.18**	**0.20**	**0.60**	**0.44**	**0.03**	**1.07**	**3.36**	**1.84**	**0.03**	**0.03**	**1.00**

Table 24: Recurring Revenue Financial Breakdown by Board

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Grampian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shetland	NHS Tayside
Recurring Revenue											
RR – Supplier Annual Support	2.06	2.06	2.29	2.29	2.06	3.16	6.27	6.27	2.06	2.06	3.16
RR – BAU	0.19	0.21	0.49	0.36	0.03	0.71	2.02	1.11	0.03	0.03	0.66
RR – LIMS Interface Support	0.03	0.03	0.04	0.04	0.05	0.33	0.36	0.29	0.03	0.03	0.08
RR – Additional Interface Recurring	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23
RR – Hosting Hardware	0.22	0.22	0.33	0.33	0.22	0.44	0.88	0.88	0.22	0.22	0.44
RR – Optimism Bias	0.81	0.82	1.01	0.97	0.78	1.46	2.93	2.63	0.77	0.77	1.37
VAT	0.60	0.60	0.67	0.67	0.61	0.97	1.78	1.76	0.60	0.60	0.90
Indexation	0.36	0.36	0.44	0.42	0.34	0.63	1.29	1.15	0.33	0.33	0.60
Total RR Financial Cost	**4.49**	**4.52**	**5.50**	**5.31**	**4.30**	**7.92**	**15.76**	**14.32**	**4.26**	**4.26**	**7.44**

4. Commercial Case

4.1. Introduction

This section outlines the proposed procurement in relation to the preferred option outlined in Section 3. It considers a range of procurement elements required to deliver LIMS - scope, procurement procedure, approach and timetable. Following approval of this Business Case these considerations should be further developed and detailed in a Procurement Strategy.

4.2. Procurement Approach

4.2.1. Required Services

At time of drafting this Business Case a detailed national LIMS specification is under development. At this stage the procurement scope is envisaged to include the following key components:

- a core LIMS solution and additional optional modules providing functionality for Genetics and Blood Transfusion;
- integration with a suite of existing national and local solutions;
- future proofing of upgrades and updated releases; and
- a range of optional support and implementation services: project management, data migration, configuration, testing, integration and business change support.

This scope of services will be finalised as part of the national LIMS specification.

4.2.2. Hosting

Consideration should be given to asking bidders for costed proposals for hosting LIMS as part of the procurement process without any commitment to buy these services. This would provide an alternative route to securing hosting services and will provide a comparison to local hosting costs in the event that Boards choose not to host the solution locally or as part of a wider shared arrangement with other Boards.

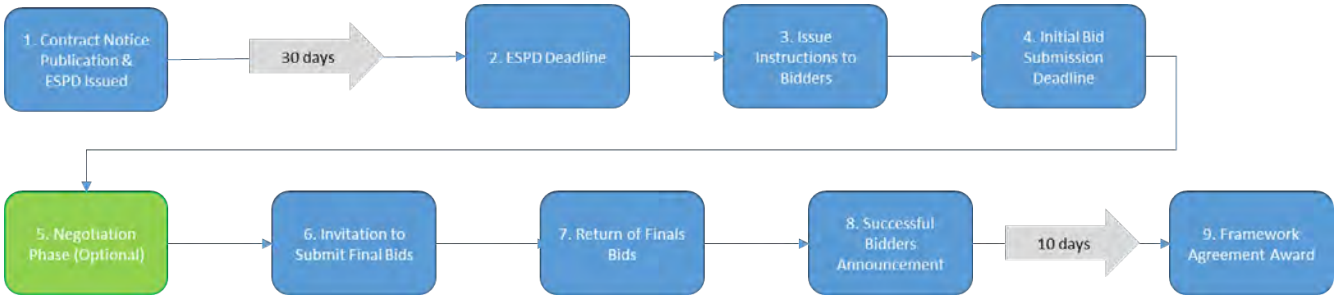
4.2.3. Procurement Procedure

NHS Scotland procurement advisors has advised that the Competitive Procedure with Negotiation (CPN) is the preferred procurement procedure. This procurement procedure has been assessed as suitable for LIMS for the following reasons:

- provides flexibility to reduce the number of suppliers to be invited to negotiate;
- provides NHS Scotland and the supplier the opportunity to negotiate to help ensure the optimum solution is procured;
- provides flexibility around what element to negotiate on (not possible with the Competitive Dialogue process);
- provides the opportunity to not negotiate and move straight to contract award if bids submitted at the start of the process are deemed sufficient to meet all the requirements without further discussion; and
- generally quicker than Competitive Dialogue process;

CPN is a relatively new procedure but NHS Scotland has used this procurement route previously including on the GP IT and CHI procurements. This has provided valuable lessons to support the LIMS procurement including the need for strong governance, being clear on the points of negotiation upfront and the need for dedicated resource on the procurement team.

Figure 3 : Key Stages of CPN Process



The items to be negotiated will need to be defined and documented as part dialogue planning. At this stage it is envisaged that dialogue is likely to focus on areas such as Genetics functionality, hosting, and managed service proposition.

An indicative timeline for the procurement process is outlined at Table 25.

Table 25: Indicative procurement timetable based on CPN procedure

Milestone	Date
Contract Notice Publication & ESPD Issued	September 2020
ESPD Deadline	October 2020
Issue Instructions to Bidders	November 2020
Initial Bid Submission Deadline	December 2020
Initial Bid evaluation	January 2021
Initial Negotiation	April 2021
Negotiation Phase (Optional)	June 2021
Invitation to Submit Final Bids	July 2021
Return of Final Bids	July 2021
Successful Bidders Announcement	August 2021
Framework Agreement Award	August 2021

It should be noted that the procurement timeline is ambitious and dependent on a number of factors including: the number of suppliers taken through to the final stages and the number and complexity of dialogue topics; the need to achieve buy-in to the process from each group of stakeholders; and a significant reliance on NHS Scotland making timely decisions and approvals at key milestones in the procurement process.

Having well-defined requirements in all areas is important to help expedite the process. Further consideration and detail of the procurement timelines will be undertaken when developing the Procurement Strategy.

4.2.4. Form of Tender

NHS Scotland procurement advisors has advised that they are seeking to establish a single supplier National Framework to secure the services required to provide LIMS. This will provide flexibility in dealing with uncertainty over deployment phasing and timing and commitment of funding whilst also delivering a route to a national solution. As each Board becomes ready, it can call off its deployment.

Some services required may vary by Board given differences in scope, for example Genetics and Pathology is not required for all Boards and there may be local requirements in areas such as hosting and business change.

However, it is anticipated the core requirements will be common across all Boards in order to realise the full benefits of a national solution.

It should be noted that that a framework agreement is not a commitment contract; a 'call off' from a framework agreement is a commitment contract. Given that two of the largest health boards in Scotland (NHS GGC and NHS Lothian) are committed to this procurement should act as incentive to attract sufficient market interest to ensure a competitive procurement.

4.2.5. Framework Duration

The maximum duration of a framework agreement is typically four years.

Boards would be required to exit or give appropriate notice to existing LIMS contract. Within four years it is envisaged that all Consortium Boards will be in a position to issue termination to their current vendor, however, there is a risk that implementation within four years may not be realistic. NHS Scotland has recent experience under the GPIT procurement where a longer Framework agreement was established on the basis that Year 1 was focussed on development of the solution and therefore there was insufficient time for all boards to complete implementation. The LIMS procurement could adopt a similar position to agree a longer framework agreement period. This should be reviewed as part of the procurement strategy alongside Board preparedness for LIMS.

5. Management Case

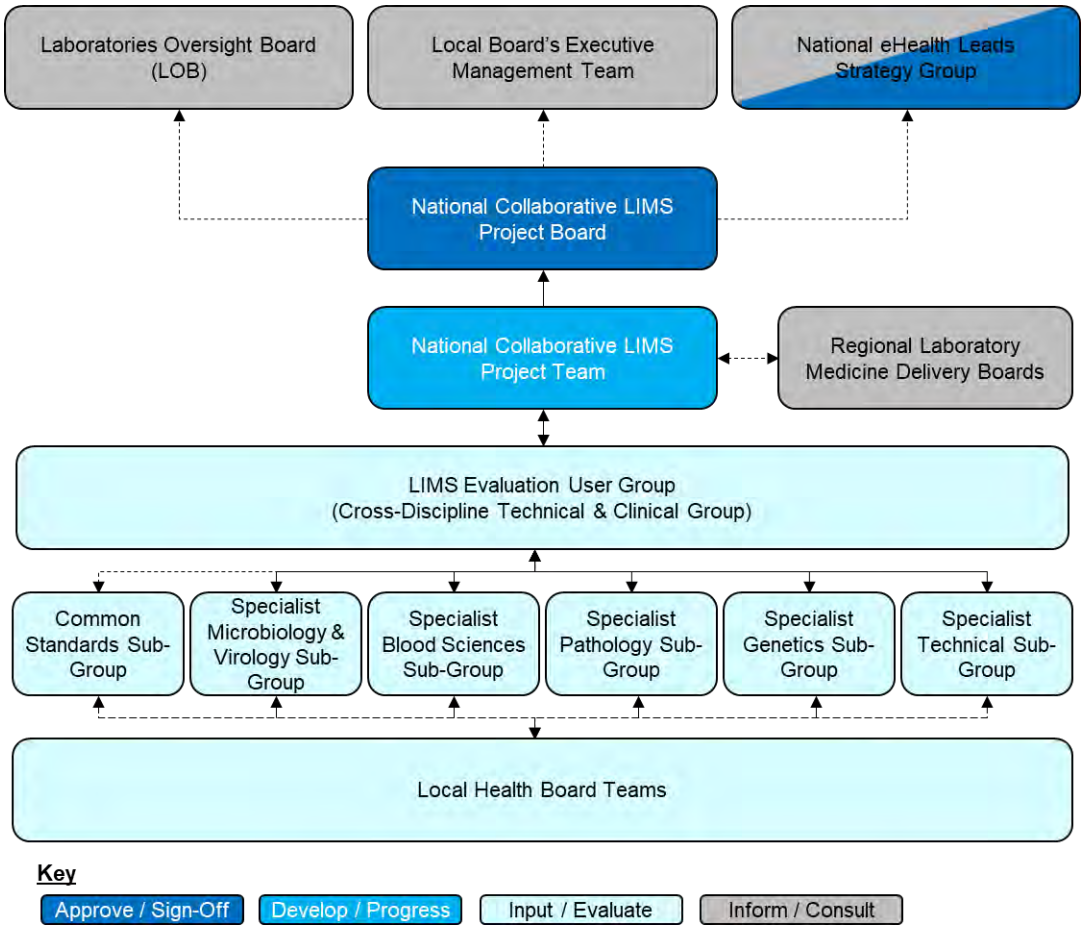
This section outlines the proposed governance approach for the procurement phase of the project.

5.1. Governance

To realise the benefits of a common solution, the PMS project highlights the need for strong governance that supports a common approach, for example to agree national standards, sharing of resources and managing suppliers as a consortium to drive positive supplier behaviour.

Figure 6 shows the proposed governance arrangements for the procurement phase. These governance arrangements will need to be further reviewed and updated following the procurement phase based on the selected solution and implementation approach agreed.

Figure 4: Project Governance



The Project Board is responsible for approving the procurement strategy, shortlisting of vendors and selection of the preferred solution. The eHealth Leads Strategy Group is responsible for approving the Full Business Case (FBC).

The Project Team will be supported by a LIMS Evaluation User Group comprising of Subject Matter Experts (SMEs) and consortium board representatives. The Project Team may seek additional advice and support from the Regional Laboratory Medicine Delivery Boards as required however no formal reporting into these boards will be put in place.

The Laboratories Oversight Board (LOB) and Local Board Executive Management Teams will be kept informed however will not provide approval / sign-off of any of the procurement artefacts.

5.2. Key Responsibilities

5.2.1. National Collaborative LIMS Project Board

The prime purpose of the Project Board is to drive the project forward and deliver the project outcomes. The Project Board will empower a Project Lead to run the project on a day-to-day basis. The Project Lead is accountable for the successful delivery of the project and reports to the Project Board.

The Board is comprised of senior stakeholders from across NHS Scotland Consortium Boards, with authority to make decisions within either their individual Board or region they represent. The following should be considered as standing members of the Project Board.

- Project Board Chairman
- Project Lead
- Consortium Health Board & Region Representatives
- Procurement Lead
- Discipline Specific Representatives
- National Labs Programme Representatives
- eHealth Lead Representatives

The full membership of the Project Board and Terms of Reference (ToR) is provided in Appendix A. This board will continue to have existing responsibilities as outlined in the ToR however specifically for the procurement phase this board will have responsibility for:

- sign off key procurement documents including the procurement strategy and requirements specification;
- shortlisting / evaluation decisions;
- approval of the preferred solution; and
- updating stakeholder groups of key decisions and outcomes including the National eHealth Leads Strategy Group, LOB and Local Board Executive Management Teams.

5.2.2. National Collaborative LIMS Project Team

The National Collaborative LIMS Project Team is responsible for managing the project and ensuring that project outcomes are delivered. This cross functional team, working in collaboration with the LIMS Evaluation User Group, will be responsible for:

- ensuring that the project is maintaining the strategic direction set by the Project Board;
- ensuring the necessary levels of project governance are in place to support project day-to-day operations;
- reporting progress to the Project Board;
- leading the development of the procurement strategy;
- conducting and managing all dialogue with potential suppliers;
- planning and managing the procurement process including developing the evaluation strategy, model, and overseeing the negotiations;
- development of all key procurement documentation i.e. ESPD, ITT, and framework contract; and
- development of the full business case

The Project Team is comprised of nominated representatives from Consortium Boards. The full membership of the Project Team is provided in Appendix A.

5.2.3. LIMS Evaluation User Group

The LIMS Evaluation User Group is responsible for the development of the overarching specification for LIMS, the review and evaluation of supplier responses (including supplier demonstrations and ITT scoring), and for ensuring that solutions reviewed and ultimately procured meet the need of NHS Scotland Consortium Boards. Final sign-off will come through the Project Board, via the Project Team.

This group is comprised of nominated representatives from each Laboratory discipline sub-group, nominated representatives from clinical networks, financial / commercial SMEs and technical SMEs from the Consortium Boards.

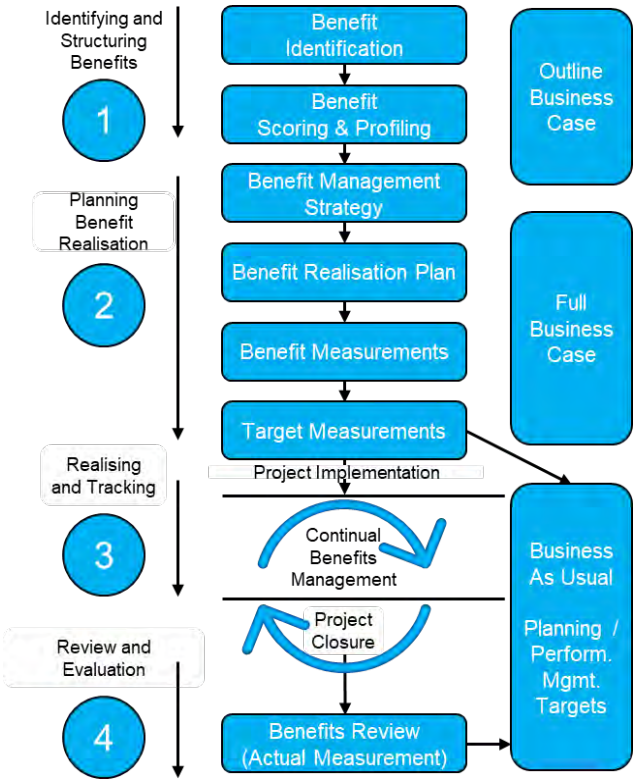
5.3. Benefits Realisation & Measurement

The economic section identified a number of non-financial benefits to be delivered by the implementation of LIMS. It is important that a benefits management approach is adopted by each board that enables benefits realisation to be monitored and benefits to be proactively managed across all Consortium Boards.

Prior to implementation it is recommended that further analysis of current processes is carried out in order to develop detailed baseline measures against which to monitor and assess LIMS benefits.

A proposed approach for benefits realisation is shown in the Figure 7 below.

Figure 5: Potential Benefits Realisation Approach



A number of key metrics will need be developed to track the delivery of benefits post implementation. It is recognised that post implementation benefit realisation activities are difficult to resource; however it will be important to drive value out of the LIMS system and have specified metrics. These should focus on key benefit areas and provide a realistic basis on which to monitor and assess benefits realisation.

As the project progresses the details for the strategy, framework and plan for the management delivery and evaluation of benefits should be developed and documented as part of local cases.

5.4. Risk Management Process

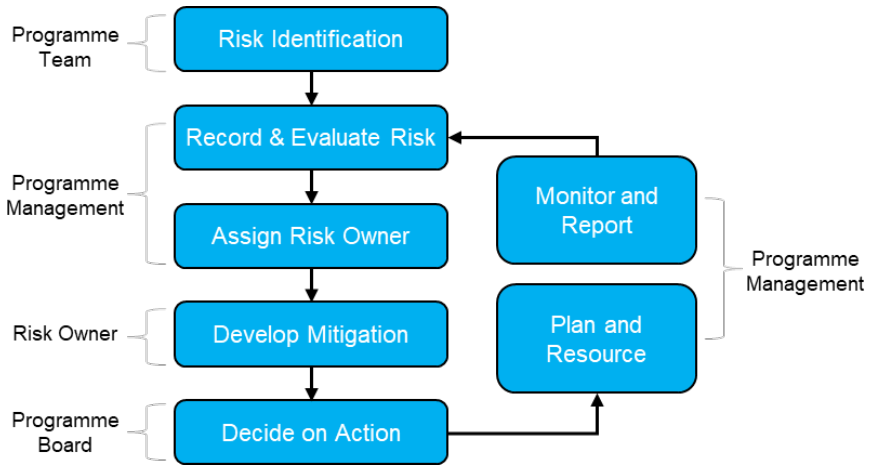
Risk identification and management will be a continual process to monitor the level of exposure to risk at any point and keep unwanted outcomes to a minimum. The National Collaborative LIMS Project will approach risk definition, initial risk identification, management and resolution; and Issue identification, management and resolution in line with the eHealth Risk and Issue Management guidelines.[10]

It is important to ensure that the following risk processes are established at a national and Board level:

- up-to-date risks register. It is recommended formal updates are made by designated individuals only;
- all risks should be reviewed regularly and key risks escalated to the LIMS Project Board for management by exception;
- significant risks must have mitigation plans which are formally reviewed by the LIMS Project Board; and
- processes should be put in place to monitor risk.

It will be the responsibility of all Project Team members to identify risks as and when they become aware of them, and to use the risk management processes. These processes ensure that the risks are logged and assigned to owners to manage and continually review the individual risks.

Figure 6: Risk Management Approach



5.5. Change Management

Effective change management and visible leadership will be critical to the success of the project in order to:

- achieve buy-in across stakeholder groups from various Laboratory disciplines;
- gain commitment from users, recognising potential disruption to services and additional effort required of laboratory staff during the implementation period;
- support the changes in working practices that the new arrangements will require (depending on collaboration approach; and

[10] http://www.healthscotland.scot/media/1177/24561-health-scotland-management-of-risk-policy.pdf

- realise the benefits of LIMS replacement, as outlined in the section 5.3.

It is recommended Boards develop the following artefacts as part of their local planning activities:

- Change Management Strategy: to include an assessment of the potential impact of the proposed change on the culture, systems, processes and people. An underpinning communication strategy for affected disciplines and staff will also need to be defined;
- Change Management Framework: this sets out the organisational structure and personnel required to direct, manage, implement and evaluate the change, along with details of roles and responsibilities, and to support staff through the change; and
- Change Management Plans: this defines the communication required for the implementation phase.

Appendix A: Project Membership

National Collaborative LIMS Project Board

Member Name	NHS Health Board	Functional Area	Role in Host Board
William Edwards	NHS Greater Glasgow & Clyde	Board Co-Chair / eHealth	Director of eHealth
Mike Gray	NHS Lothian	Board Co-Chair / Laboratories Service Manager Representative	Service Manager for Laboratory Medicine
Jackie Wales	Golden Jubilee National Hospital	Golden Jubilee National Hospital Representative	Head of Laboratories
Sally Smith	Golden Jubilee National Hospital	Golden Jubilee National Hospital Representative	Head of eHealth
Bill Bartlett	National Services Scotland	National Labs Programme Representative	Clinical Lead
George Futcher	National Services Scotland	Procurement	Senior Business & Procurement Advisor
Jackie Stephen	NHS Borders	eHealth	Head of IM&T
Martyn McAdam	NHS Dumfries & Galloway	NHS Dumfries & Galloway Representative	Blood Science Service Manager
Donna Galloway	NHS Fife	NHS Fife Representative	Head of Laboratory Services
Richard Bell	NHS Forth Valley Representative	Service Manager	Ambulatory, Diagnostics and Theatres
James Allison	NHS Grampian	NHS Grampian Representative	Unit Clinical Director – Laboratory Medicine Unit
Gareth Bryson	NHS Greater Glasgow & Clyde	West Region Representative	Head of Service for Pathology
Arwel Williams	NHS Greater Glasgow & Clyde	Diagnostics Management Representative	Director - Diagnostic Services
Carol Thomson	NHS Lothian	East Region Representative	Labs IM&T Service Manager
Carol Thomson	NHS Lothian	Laboratories Systems Manager Representative	Labs IM&T Service Manager
Elizabeth Furrie	NHS Tayside	NHS Orkney Representative	Consultant Clinical Scientist and Clinical Lead

Elizabeth Furrie	NHS Tayside	NHS Shetland Representative	Consultant Clinical Scientist and Clinical Lead
Ellie Dow	NHS Tayside	North Region Representative	Consultant in Biochemical Medicine
Susie Buchanan	Scottish National Blood Transfusion Service	Blood Transfusion Representative	Associate Director
Stephen McGlashan	NHS Fife	SMVN Representative	Microbiology Service Manager
Debbie Crohn	NHS Orkney	NHS Orkney Representative	Head of Digital Transformation and Information Technology
Scott Douglas	NHS Greater Glasgow and Clyde	Programme Manager	Programme Manager

Responsibilities include (extract from the ToR):

- Establishing a forum for effective links and engagement between senior stakeholders from across Scotland to provide delivery assurance, support and guidance to the National Collaborative LIMS Project
- Taking a holistic view and making decisions on what is best for NHS Scotland as a whole and not individual Boards, whilst recognising that some Boards may have more predominant prevailing need than others for a replacement system
- Ensure alignment with broader NHS Scotland strategy ambitions including The National Clinical Strategy, Scotland's Digital Health and Care Strategy and Beating Cancer: Ambition and Action.
- Ensure a viable and achievable Business Case exists for the National Collaborative LIMS Project
- The resourcing, management and monitoring of the delivery of the National Collaborative LIMS Project plan and its individual component projects / workstreams / deliverables
- Use the opportunity to critically evaluate existing services and how these can be redesigned and improved, taking account of changing population needs, demographics and patterns of service usage
- Ensuring the individual component projects / workstreams produce deliverables that provide the desired outcomes and meet the user requirements
- Issue resolution at the appropriate level associated with National Collaborative LIMS Project plan and individual component projects
- Providing guidance and suggestions on the strategic direction, prioritisation and associated timelines of the plan deliverables in conjunction with interested stakeholders
- Allocation of a Senior Responsible Officer (SRO) for the National Collaborative LIMS Project
- Ensuring appropriate and proportionate project management products are in place to manage, monitor and control the output of the National Collaborative LIMS Project plan and individual component projects / workstreams / deliverables
- Acting as forum for sharing knowledge and best practice across NHS Scotland
- Acting upon any matters referred to it from executive governance authorities or escalated to it from underlying component projects / workstreams

LIMS Evaluation User Group

Name	Board	Role	Role on Project
Mike Gray	NHS Lothian	Lab service Manager	Co-Chair of Project Board
James Allison	NHS Grampian	Unit Clinical Director – Laboratory Medicine Unit	NHS Grampian rep on Project Board
Bill Bartlett	NSS	Clinical Lead National Laboratory Programme	National Laboratory Programme rep on Project Board
Nick Bradbury	NHS Lothian	Capital Finance Manager	Project Finance lead
Gareth Bryson	NHS GGC	Head of Service (Pathology)	West Region rep on Project Board
Paul Docherty	NHS GGC	Applications Architecture Manager	Technical lead
Scott Douglas	NHS GGC	Programme Manager	Programme Manager
Ellie Dow	NHS Tayside	Consultant biomedical medicine	NHS Tayside rep on Project Board
George Futcher	NSS	Business and Procurement advisor	Procurement Lead
Ian Godber	NHS GGC	Consultant Clinical Scientist (Biochemistry)	Technical and Clinical User Group
Jackie Stephen	NHS Borders	eHealth Lead	NHS Borders rep on Project Board
Carol Thomson	NHS Lothian	Labs IM&T Service Manager	Laboratory lead
Moray Saville	NHS Grampian	Labs IM&T Service Manager	Laboratory lead
Paul Westwood	NHS GGC	Consultant Clinical Scientist (Genetics)	Chair of Genetics subgroup
Daniel Wood	NHS GGC	Senior Business Analyst/Project lead	Senior Business Analyst/Project lead

Responsibilities include (extract from the ToR):

- Review the specifications presented by the subgroups to ensure that the specifications from the area they represent have been considered and are being met
- Make decisions that will used to inform the overarching LIMS specification
- Set specifications and standards
- Horizon scan, future proof where possible and build innovation into the specification
- Where possible and if appropriate rationalise and reduce variation
- Advise on the range of goods and services to be included as part of this procurement
- Participate in Tender evaluation
- Take responsibility for the deliverables relating to their assigned work stream
- Undertake tasks related to their assigned work stream
- Provide updates on the progress of their work stream and their assigned tasks

- Where required Escalate any issues that arise to the Project leads\Chair of the subgroup or to the appropriate local Board governance group where required in a timeous manner
- Identify risks and exceptions and recommend the appropriate course of action
- Act as a point of contact for their respective locations/teams in relation to the project – liaising with the project leads/other subgroups as appropriate
- Proactively share information with colleagues
- Be Change Champions for the LIMS re-procurement project within their respective locations/teams.
- Undertake project activities as directed by the Project Leads and LIMS Consortium Project Board and Team.

National Collaborative LIMS Project Team

Name	Board	Role	Role on Project
Mike Gray	NHS Lothian	Lab service Manager	Co-Chair of Project Board
Scott Douglas	NHS GGC	Programme Manager	Programme Manager
Daniel Wood	NHS GGC	Senior Business Analyst/Project lead	Project Manager
Project Manager – *To be Confirmed*	-	-	Project Manager
Mike Gray	NHS Lothian	Lab service Manager	Co-Chair of Project Board
Carol Thomson	NHS Lothian	Labs IM&T Service Manager	LIMS Systems Manager Lead
Moray Saville	NHS Grampian	Labs IM&T Service Manager	LIMS Systems Manager Lead
Paul Docherty	NHS GGC	Application Architect	Technical/ eHealth Lead
George Futcher	NHS NSS	Senior Business & Procurement Advisor	Procurement Lead
Nick Bradbury	NHS Lothian	Capital Finance Manager	Finance Lead
Maxine Marr	NHS Lothian	Assistant Accountant	Finance Support
Legal Lead – *To Be Confirmed*	-	-	Legal Lead
Clinical Lead – *To Be Confirmed*	-	-	Clinical Lead
Wendy Regan	Deloitte	OBC Support Lead	OBC Support Lead
Andy Fleming	Deloitte	OBC Support Manager	OBC Support Manager
David Smith	Deloitte	OBC Support Consultant	OBC Support Consultant

Responsibilities include (extract from the ToR):

- Undertaking project activities as directed by the National Collaborative LIMS Project Board.
- Take responsibility for all activities required to ensure the successful procurement of a new LIMS.

- Managing and where required escalate project Risks via appropriate governance channels.
- Establishing and managing the Evaluation User Group / Technical & Clinical User Group whose primary role will be to advice the procurement team on the clinical, technical, and commercial aspects associated with the procurement of the LIMS.
- Ensuring discipline specific subgroups are established.
- Develop a viable and achievable Business Case for the National Collaborative LIMS Project.
- The resourcing, management and monitoring of the delivery of the National Collaborative LIMS Project plan and its individual component projects / workstreams / deliverables
- Use the opportunity to critically evaluate existing services and how these can be redesigned and improved, taking account of changing population needs, demographics and patterns of service usage
- Ensuring the individual component projects / workstreams produce deliverables that provide the desired outcomes and meet the user requirements
- Issue resolution at the appropriate level associated with National Collaborative LIMS Project plan and individual component projects
- Ensuring appropriate and proportionate project management products are in place to manage, monitor and control the output of the National Collaborative LIMS Project plan and individual component projects / workstreams / deliverables
- Acting upon any matters referred to it from executive governance authorities or escalated to it from underlying component projects / workstreams

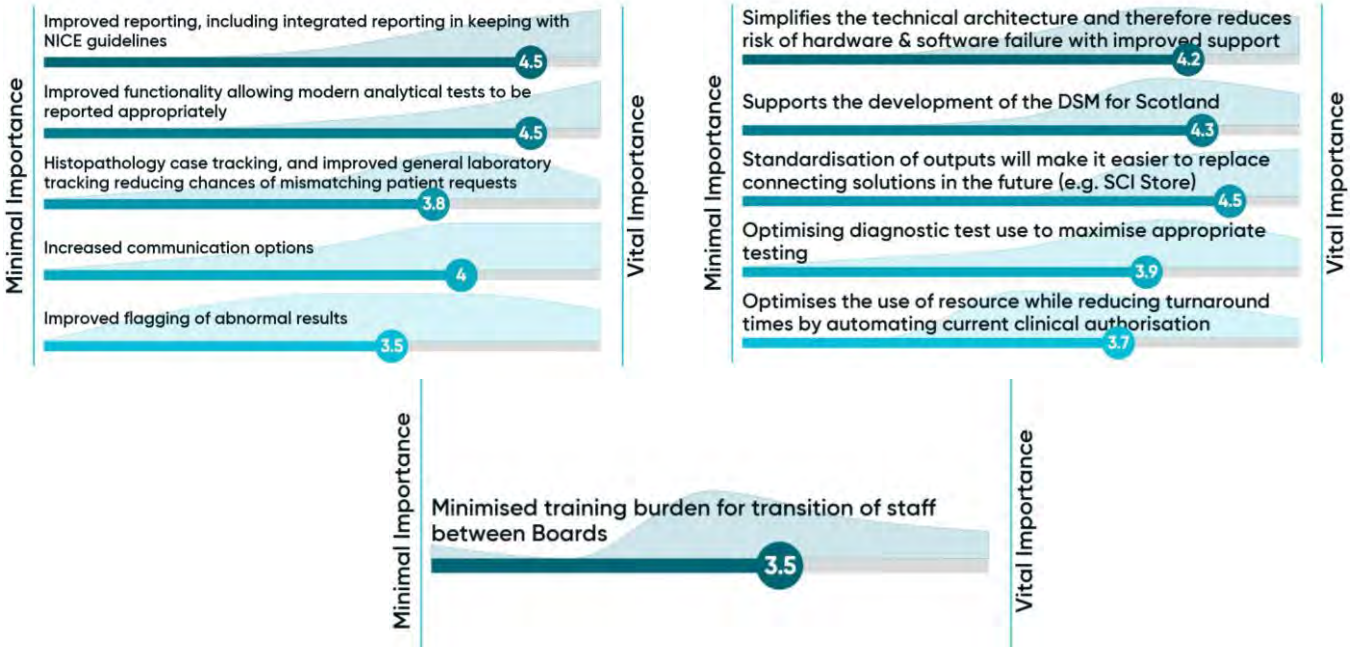
Appendix B: Workshop Exercise Outputs

Benefits Workshop

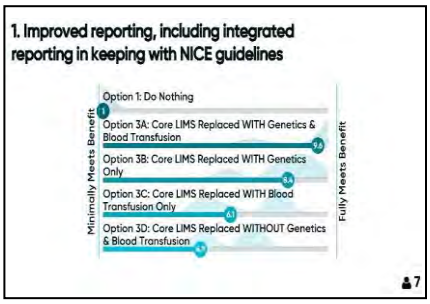
Attendees utilised digital collaboration tool *Mentimeter* to vote on each benefit, both in terms of importance weighting and against each short-listed option.

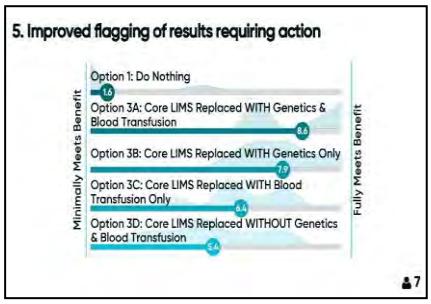
The graphics below show the average across all attendees, with the shaded graph above the line showing the spread of responses.

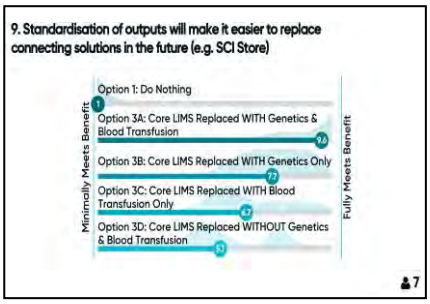
Benefit Weighting

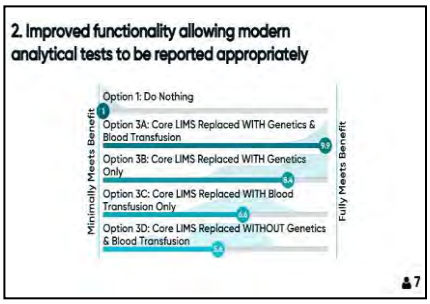


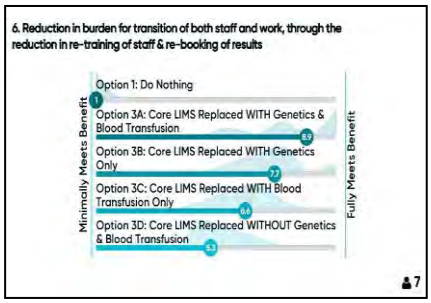
Option Benefit Scores

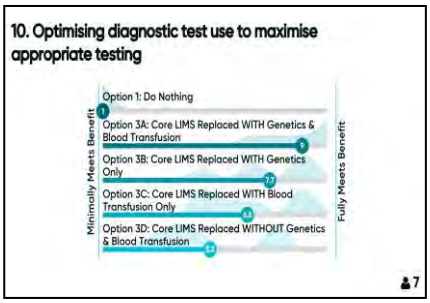


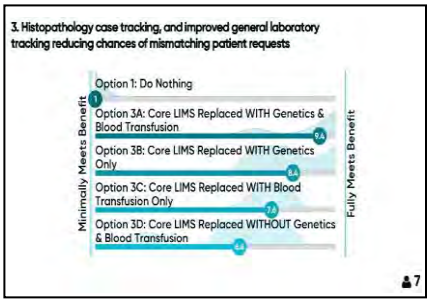


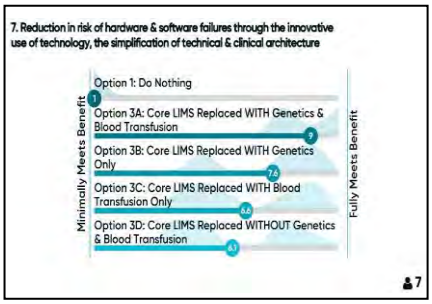


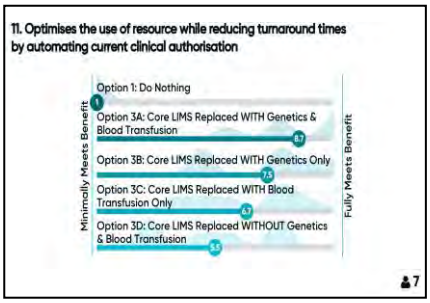


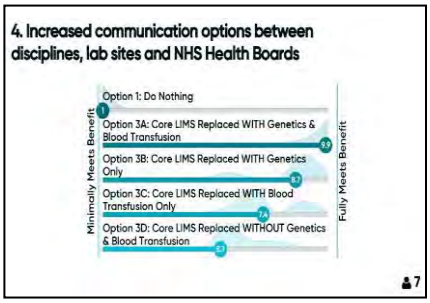


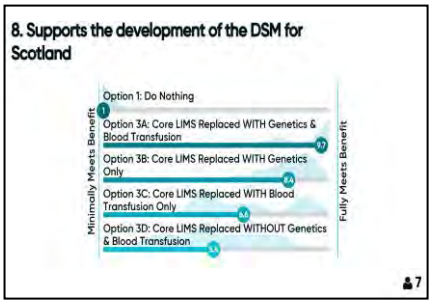










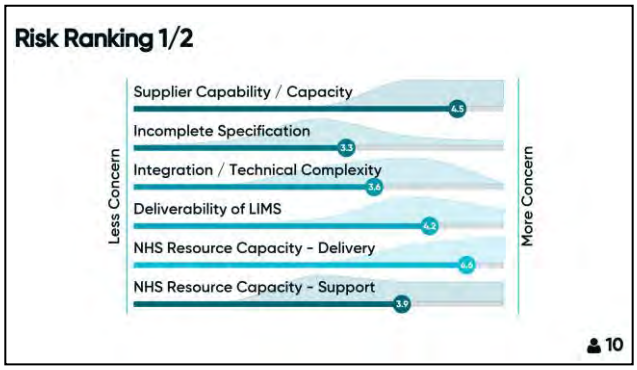


Risks Workshop

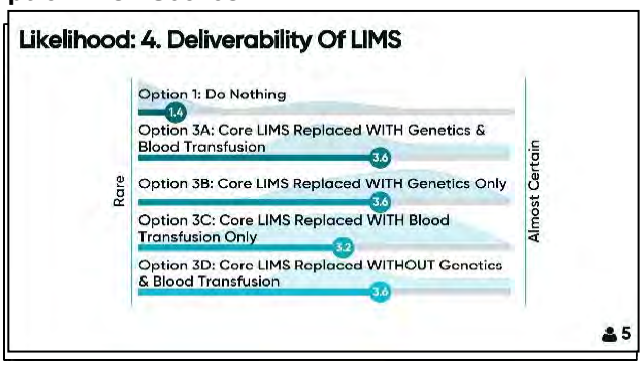
Using the same method as within the Benefits Workshop, attendees utilised digital collaboration tool *Mentimeter* to vote on each risk based on level of concern (to identify weighting), and against each short-listed option.

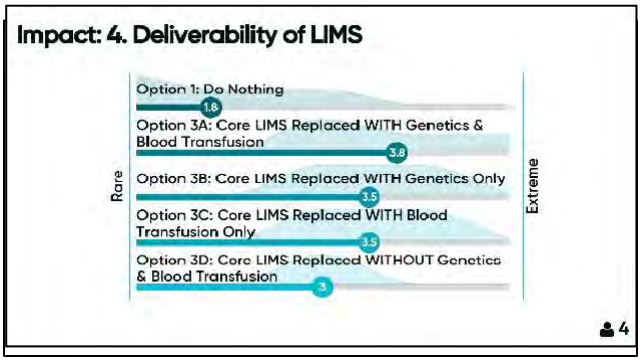
The graphics below show the average across all attendees, with the shaded graph above the line showing the spread of responses.

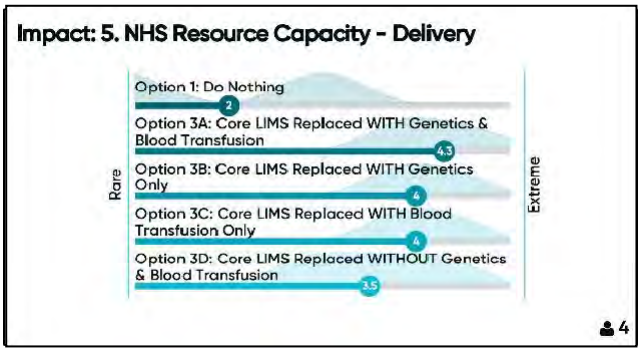
Risk Weighting

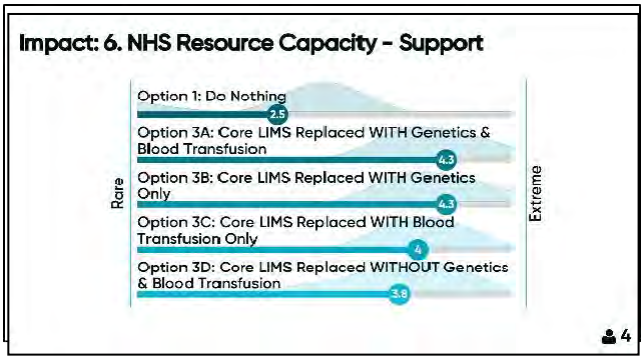


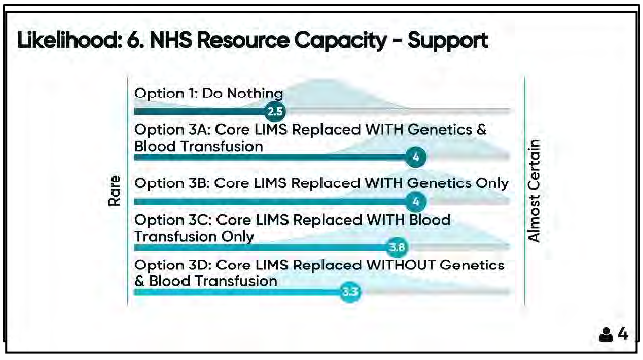
Option Risk Scores

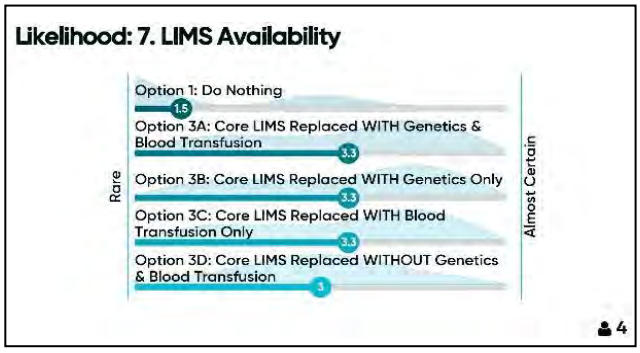


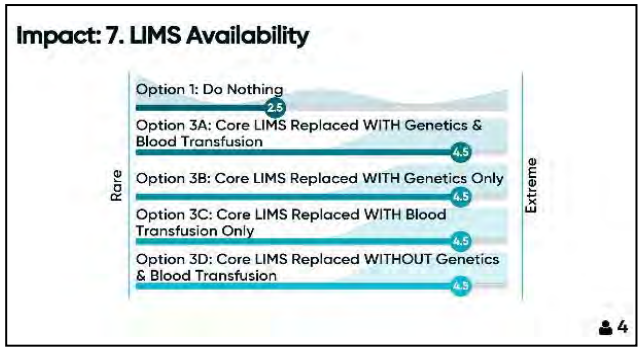




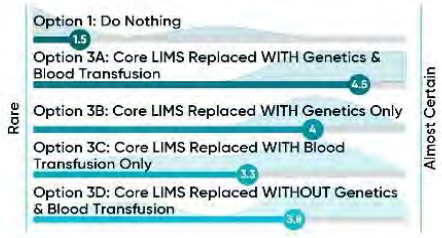








Likelihood: 8. Change Management



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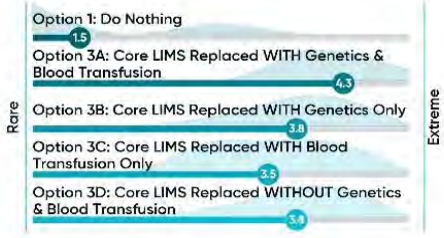
Impact: 8. Change Management



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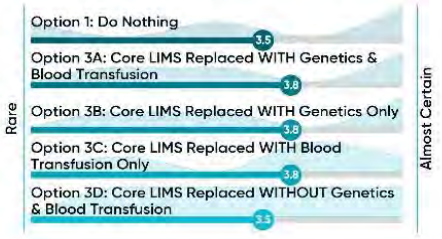
Likelihood: 9. Divergence of Standards



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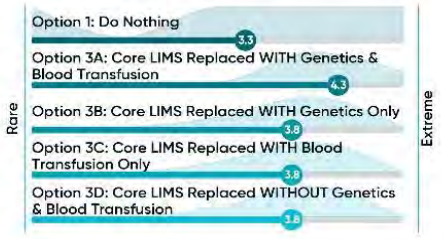
Impact: 9. Divergence of Standards



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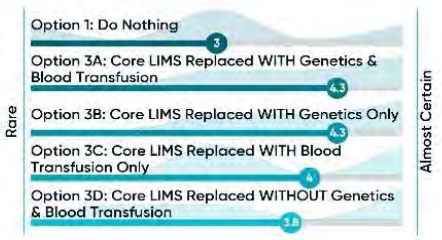
Likelihood: 10. Funding



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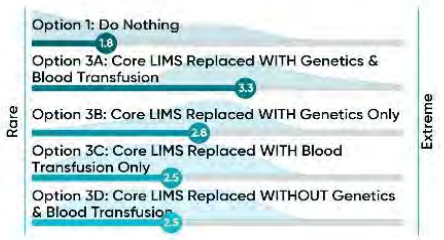
Impact: 10. Funding



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Appendix C: OBC Optimism Bias Calculation

Contributory Factor to Upper Bound	% Factor Contributes	% mitigation of factor possible (0-100%)	Explanation for mitigation	% Factor Contributes after mitigation
Progress with Planning Approval	4%	100%	Not Applicable	0.0%
Progress with other Regulatory approvals	4%	75%	UCAS / MHRA accreditation required. Regulatory approvals are known and understood, however not completed.	1.0%
Depth of surveying of site/ground information	3%	100%	Not Applicable	0.0%
Detail of design	4%	75%	Specification not concluded, anticipated but outline of spec completed.	1.0%
Innovative project/design (i.e. has this type of project/design been undertaken before)	3%	50%	Project has been undertaken before, but not recently in NHS Scotland	1.5%
Design complexity	4%	50%	Complex design and implementation - national complexity around standardisation.	2.0%
Likely variations from Standard Contract	2%	50%	Uncertain until further along the procurement process, however unlikely to be significant variation from standard contract. Inclusion of Genetics service may require variation.	1.0%
Design Team capabilities	3%	75%	Skilled and experienced project team, although time may be a limiting factor. Mitigated by well-resourced project team.	0.8%
Contractors' capabilities (excluding design team covered above)	2%	10%	Uncertain until further along the procurement process. Inclusion of Genetics potentially adds complexity	1.8%
Contractor Involvement	2%	25%	Uncertain until further along the procurement process	1.5%
Client capability and capacity (NB do not double count with design team capabilities)	6%	33%	Skilled and experienced project team nationally, however uncertain if skills and experience available at Board level. Time may be a limiting factor.	4.0%
Robustness of Output Specification / project brief	25%	75%	Clear deliverables and project brief agreed at senior level.	6.3%
Involvement of Stakeholders, including Public and Patient Involvement	5%	80%	Good engagement through Labs / eHealth / Finance. Limited requirement for public involvement.	1.0%
Agreement to output specification / project brief by stakeholders	5%	80%	Project Brief widely agreed by stakeholders	1.0%
New service or traditional	3%	60%	Replacement of existing infrastructure, uncertainty over hosting model and integrated model will required significant integration between disciplines.	1.2%
Local community consent	3%	100%	Not Applicable	0.0%

Stable policy environment	20%	75%	Potential uncertainty around Software, and the classification of LIMS as a medical device (policy delayed until 2022). Potential uncertainty over COVID response.	5.0%
Likely competition in the market for the project	2%	75%	Initial bidder interest, and experience in other health systems, indicates likely competition in the market.	0.5%
TOTAL	**100%**			**29.5%**

The project team completed the optimism bias calculator suggested in the Scottish Capital Investment Manual (SCIM), which indicates an optimism bias of 30% is appropriate. This is driven by a number of factors.

The optimism bias figure will be reviewed at FBC, and potentially ultimately replaced by a costed risk register for specific risks.

Appendix D: OBC Cost Assumptions

Cost Item Assumptions

Cost Item	Unit Cost	Type	Source	Assumption
LIMS Software Licence	c£2,000 Per LIMS User	One Off - NRC	CliniSys Response to National PIN & NHSGGC Clarification Questions	Based on total number of users by discipline, multiplied by licence cost multiplied by concurrency of 25%
Annual Support	£228k (S) / £255k (M) / £351k (L) / £697k (VL)	Annual - RR		Based on relative Board size using supplier costs for each size
Supplier Impl.	£581k (S) / £801k (M) / £970k (L) / £2,000k (VL)	One Off - NRC		Based on relative Board size using supplier costs for each size
Design	Based On NHS Team Resources & 20/21 Salary Bandings + On-Costs	One Off - NRR	Project Team & Evaluation User Group	Based On NHS Team Resources & 20/21 Salary Bandings + On-Costs
Build & Config		One Off - NRR		
Rollout		One Off - NRR		
BAU		Annual - RR		
LIMS Interfaces Build - Analyser Interfaces	£4,800 Per Interface	One Off - NRC	CliniSys Response to National PIN & NHSGGC Clarification Questions	Based on the number of Analyser Interfaces by discipline by Health Board
LIMS Interface Support - Analyser Interfaces	£1,300 Per Interface	Annual - RR		
LIMS Interfaces Build - Data Migration	£15k / £20k / £25k Per Discipline	One-Off - NRC		Single cost per discipline per Board (varies by discipline). Varies based on short-listed option (i.e. including Blood Transfusion / Genetics or not). Included in the Interface Build Total Cost Line in OBC
Additional Interface Build	£46k Per HL7 Interface Per Board	One-off - NRC		Based on additional integration build per Board (assumed 4 HL7 Interfaces per Board)
Additional Interface Recurring	£6k Per HL7 Interface Per Board	Annual - RR		
Downstream Interfaces	£10k Per Interface Per Board	One-off - NRC		TrakCare, SCI Store, ECOSS and the Order Communication Systems (OCS)

Hosting Hardware (5 Year Refresh)	£100k (S) / £150k (M) / £200k (L) / £400k (VL)	One-Off - RR	Project Team & Evaluation User Group	Based On average refresh costs per Board current hardware costs & relative Board size
Hosting Hardware (Annual Support)	£2k (S) / £3k (M) / £4k (L) / £8k (VL)	Annual - RR	Project Team & Evaluation User Group	Based on average of known annual hardware support costs percent of known refresh costs

Financial Assumptions

Cost Item	Optimism Bias	Indexation	VAT	Depreciation
LIMS Software Licence	30%	2.0%	20%	Yes
Annual Support	30%	2.0%	20%	-
Supplier Impl.	30%	2.0%	20%	Yes
Design	30%	2.0%	-	-
Build & Local Config	30%	2.0%	-	-
Rollout	30%	2.0%	-	-
BAU	30%	2.0%	-	-
LIMS Interfaces Build - Analyser Interfaces	30%	2.0%	20%	Yes
LIMS Interface Support - Analyser Interfaces	30%	2.0%	20%	-
LIMS Interfaces Build - Data Migration	30%	2.0%	20%	Yes
Additional Interface Build	30%	2.0%	20%	-
Additional Interface Recurring	30%	2.0%	-	-
Downstream Interfaces	30%	2.0%	20%	Yes
Hosting Hardware (5 Year Refresh)	30%	2.0%	-	-
Hosting Hardware (Annual Support)	30%	2.0%	-	-

CliniSys Supplier Costs

Source	Board Size	Users Assumed	LIMS Software Licence		Supplier Implementation	Annual Support
			Total Quoted Cost	Cost Per User		
National PIN & Clarification Questions	Small	100	£416k	£4k	£582k	£229k
	Medium	200	£508k	£3k	£802k	£255k
	Large	500	£757k	£2k	£967k	£351k
	Very Large	1205	£1,900k	£2k	£2,002k	£697k

CliniSys Interfaces Costs			
Type	**Detail**	**One-Off**	**Annual Support**
Interface Required	Analyser Interface Connection	£4,800	£1,300
Interface Required	Data Migration - Blood Sciences	£14,066	-
Interface Required	Data Migration - Microbiology	£19,476	-
Interface Required	Data Migration - Histopathology	£19,476	-
Interface Required	Data Migration - Genetics	£19,476	-
Interface Required	Data Migration - Blood Transfusion	£24,866	-
Additional Interface Requirement	HL7 - WinPath Point to Point Analyser Interfacing – Off-the-shelf (Cell Path Only)	£6,800	£1,300
Additional Interface Requirement	HL7 - CliniSys Integration Manager (CIM) ADT Per Connection	£17,600	£1,600
Additional Interface Requirement	HL7 - CIM OCS/RR Per Connection	£10,600	£1,400
Additional Interface Requirement	HL7 - CIM third party data-feed interface	£10,600	£1,400

Appendix E: OBC Board Assumptions

Total User Numbers By Discipline By Board

Health Board	Blood Sciences	Histo-pathology	Micro-biology	Blood Trans.	Genetics	Total
NHS Ayrshire & Arran	70	65	50	50	-	235
NHS Borders*	39	21	-	11	-	71
NHS Dumfries & Galloway*	47	30	23	6	-	106
NHS Fife*	145	45	35	10	-	235
NHS Forth Valley*	70	36	40	-	-	146
NHS Golden Jubilee*	-	7	-	4	-	11
NHS Grampian*	136	72	102	25	45	380
NHS Greater Glasgow & Clyde*	557	285	286	59	140	1,327
NHS Highland	100	90	106	50		346
NHS Lanarkshire	100	90	106	79		375
NHS Lothian*	290	101	80	10	42	523
NHS Orkney*	4	-	-	1	-	5
NHS Shetland*	4	-	-	1	-	5
NHS Tayside*	134	80	72	5	46	337
NHS Western Isles	20	20	20	20	-	80
Total	**1,716**	**942**	**920**	**330**	**273**	**4,181**

*Consortium Board figures provided through project team

**Non-Consortium Board figures based on previous ISD data

Hosting Hardware Assumption

Health Board	Hardware Cost - Refresh	Hardware Cost - Annual	Relative Size
NHS Ayrshire & Arran	£150,000	£3,000	Medium
NHS Borders*	£100,000	£2,000	Small
NHS Dumfries & Galloway*	£100,000	£2,000	Small
NHS Fife*	£150,000	£3,000	Medium
NHS Forth Valley*	£150,000	£3,000	Medium
NHS Golden Jubilee*	£100,000	£2,000	Small
NHS Grampian*	£200,000	£4,000	Large
NHS Greater Glasgow & Clyde*	£400,000	£8,000	Very Large
NHS Highland	£150,000	£3,000	Medium
NHS Lanarkshire	£200,000	£4,000	Large
NHS Lothian*	£400,000	£8,000	Very Large
NHS Orkney*	£100,000	£2,000	Small
NHS Shetland*	£100,000	£2,000	Small
NHS Tayside*	£200,000	£4,000	Large
NHS Western Isles	£100,000	£2,000	Small

*Consortium Boards

Hardware refresh costs are based on average current costs by relative Board size, and are assumed to be required on a 5 year cycle. Annual support costs are calculated at 2% of the total refresh cost, based on the average of known annual hardware support cost percent of known refresh costs.

Appendix F: Financial Costs by Board – 25% Concurrency

NHS Borders

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Annual Support	RR	-	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	2.06
Supplier Implementation	NRR	0.58	-	-	-	-	-	-	-	-	-	0.58
Design	NRR	0.01	-	-	-	-	-	-	-	-	-	0.01
Build & Local Config	NRR	0.07	-	-	-	-	-	-	-	-	-	0.07
Rollout	NRR	0.04	0.02	-	-	-	-	-	-	-	-	0.05
BAU	RR	-	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.19
LIMS Interface Build	NRC	0.06	-	-	-	-	-	-	-	-	-	0.06
LIMS Interface Support	RR	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.03
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.10	0.0	0.0	0.0	0.0	0.10	0.0	0.0	0.0	0.0	0.22
Optimism Bias		0.34	0.09	0.08	0.08	0.08	0.11	0.08	0.08	0.08	0.08	1.13
Total		1.49	0.38	0.36	0.36	0.36	0.49	0.36	0.36	0.36	0.36	4.88
Non-Recurring Capital (NRC)		1.17	-	-	-	-	-	-	-	-	-	1.17
Non-Recurring Revenue (NRR)		0.15	0.02	-	-	-	-	-	-	-	-	0.18
Recurring Revenue (RR)		0.17	0.36	0.36	0.36	0.36	0.49	0.36	0.36	0.36	0.36	3.53
Total Economic Cost		1.49	0.38	0.36	0.36	0.36	0.49	0.36	0.36	0.36	0.36	4.88
Net Present Cost		1.49	0.37	0.34	0.32	0.31	0.41	0.29	0.28	0.27	0.26	4.36
NRC (Incl. VAT & Indexation)		1.41	-	-	-	-	-	-	-	-	-	1.41
NRR (Incl. VAT & Indexation)		0.15	0.02	-	-	-	-	-	-	-	-	0.18
RR (Incl. VAT & Indexation)		0.17	0.43	0.44	0.45	0.46	0.61	0.47	0.48	0.49	0.50	4.49
Financial Cost		1.73	0.45	0.44	0.45	0.46	0.61	0.47	0.48	0.49	0.50	6.07
Assumed Resources In Post		(0.02)	(0.0)	-	-	-	-	-	-	-	-	(0.02)
Total Financial Cost		1.72	0.45	0.44	0.45	0.46	0.61	0.47	0.48	0.49	0.50	6.05

Depreciation (Capital Costs)		0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	1.17

*cost shown as '0.0' are less than £10k a year

NHS Dumfries & Galloway

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.05	-	-	-	-	-	-	-	-	-	0.05
Annual Support	RR	-	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	2.06
Supplier Implementation	NRR	0.58	-	-	-	-	-	-	-	-	-	0.58
Design	NRR	0.01	-	-	-	-	-	-	-	-	-	0.01
Build & Local Config	NRR	0.08	-	-	-	-	-	-	-	-	-	0.08
Rollout	NRR	0.04	0.02	-	-	-	-	-	-	-	-	0.06
BAU	RR	-	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.21
LIMS Interface Build	NRC	0.06	-	-	-	-	-	-	-	-	-	0.06
LIMS Interface Support	RR	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.03
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.10	0.0	0.0	0.0	0.0	0.10	0.0	0.0	0.0	0.0	0.22
Optimism Bias		0.35	0.09	0.08	0.08	0.08	0.11	0.08	0.08	0.08	0.08	1.14
Total		1.54	0.39	0.36	0.36	0.36	0.49	0.36	0.36	0.36	0.36	4.96
Non-Recurring Capital (NRC)		1.20	-	-	-	-	-	-	-	-	-	1.20
Non-Recurring Revenue (NRR)		0.17	0.03	-	-	-	-	-	-	-	-	0.20
Recurring Revenue (RR)		0.17	0.36	0.36	0.36	0.36	0.49	0.36	0.36	0.36	0.36	3.56
Total Economic Cost		1.54	0.39	0.36	0.36	0.36	0.49	0.36	0.36	0.36	0.36	4.96
Net Present Cost		1.54	0.37	0.34	0.33	0.32	0.42	0.30	0.29	0.28	0.27	4.43
NRC (Incl. VAT & Indexation)		1.44	-	-	-	-	-	-	-	-	-	1.44
NRR (Incl. VAT & Indexation)		0.17	0.03	-	-	-	-	-	-	-	-	0.20
RR (Incl. VAT & Indexation)		0.17	0.43	0.44	0.45	0.46	0.61	0.48	0.48	0.49	0.50	4.52
Financial Cost		1.78	0.46	0.44	0.45	0.46	0.61	0.48	0.48	0.49	0.50	6.16
Assumed Resources In Post		(0.02)	(0.0)	-	-	-	-	-	-	-	-	(0.02)
Total Financial Cost		1.76	0.46	0.44	0.45	0.46	0.61	0.48	0.48	0.49	0.50	6.14
Depreciation (Capital Costs)		0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	1.20

*cost shown as '0.0' are less than £10k a year

NHS Fife

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.12	-	-	-	-	-	-	-	-	-	0.12
Annual Support	RR	-	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	2.29
Supplier Implementation	NRR	0.80	-	-	-	-	-	-	-	-	-	0.80
Design	NRR	0.03	-	-	-	-	-	-	-	-	-	0.03
Build & Local Config	NRR	0.24	-	-	-	-	-	-	-	-	-	0.24
Rollout	NRR	0.05	0.14	-	-	-	-	-	-	-	-	0.19
BAU	RR	-	0.04	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.49
LIMS Interface Build	NRC	0.09	-	-	-	-	-	-	-	-	-	0.09
LIMS Interface Support	RR	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.04
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.15	0.0	0.0	0.0	0.0	0.15	0.0	0.0	0.0	0.0	0.33
Optimism Bias		0.52	0.14	0.10	0.10	0.10	0.15	0.10	0.10	0.10	0.10	1.52
Total		2.25	0.61	0.44	0.44	0.44	0.64	0.44	0.44	0.44	0.44	6.60
Non-Recurring Capital (NRC)		1.61	-	-	-	-	-	-	-	-	-	1.61
Non-Recurring Revenue (NRR)		0.41	0.19	-	-	-	-	-	-	-	-	0.60
Recurring Revenue (RR)		0.23	0.42	0.44	0.44	0.44	0.64	0.44	0.44	0.44	0.44	4.40
Total Economic Cost		2.25	0.61	0.44	0.44	0.44	0.64	0.44	0.44	0.44	0.44	6.60
Net Present Cost		2.25	0.59	0.41	0.40	0.39	0.54	0.36	0.35	0.34	0.32	5.95
NRC (Incl. VAT & Indexation)		1.93	-	-	-	-	-	-	-	-	-	1.93
NRR (Incl. VAT & Indexation)		0.41	0.19	-	-	-	-	-	-	-	-	0.60
RR (Incl. VAT & Indexation)		0.24	0.51	0.53	0.54	0.55	0.78	0.57	0.58	0.59	0.60	5.50
Financial Cost		2.58	0.70	0.53	0.54	0.55	0.78	0.57	0.58	0.59	0.60	8.03
Assumed Resources In Post		(0.05)	(0.02)	-	-	-	-	-	-	-	-	(0.07)
Total Financial Cost		2.54	0.67	0.53	0.54	0.55	0.78	0.57	0.58	0.59	0.60	7.96
Depreciation (Capital Costs)		0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	1.61

*cost shown as '0.0' are less than £10k a year

NHS Forth Valley

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.07	-	-	-	-	-	-	-	-	-	0.07
Annual Support	RR	-	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	2.29
Supplier Implementation	NRR	0.80	-	-	-	-	-	-	-	-	-	0.80
Design	NRR	0.02	-	-	-	-	-	-	-	-	-	0.02
Build & Local Config	NRR	0.18	-	-	-	-	-	-	-	-	-	0.18
Rollout	NRR	0.03	0.10	-	-	-	-	-	-	-	-	0.14
BAU	RR	-	0.03	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.36
LIMS Interface Build	NRC	0.09	-	-	-	-	-	-	-	-	-	0.09
LIMS Interface Support	RR	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.04
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.15	0.0	0.0	0.0	0.0	0.15	0.0	0.0	0.0	0.0	0.33
Optimism Bias		0.48	0.13	0.10	0.10	0.10	0.14	0.10	0.10	0.10	0.10	1.43
Total		2.08	0.55	0.42	0.42	0.42	0.62	0.42	0.42	0.42	0.42	6.21
Non-Recurring Capital (NRC)		1.55	-	-	-	-	-	-	-	-	-	1.55
Non-Recurring Revenue (NRR)		0.30	0.14	-	-	-	-	-	-	-	-	0.44
Recurring Revenue (RR)		0.23	0.41	0.42	0.42	0.42	0.62	0.42	0.42	0.42	0.42	4.22
Total Economic Cost		2.08	0.55	0.42	0.42	0.42	0.62	0.42	0.42	0.42	0.42	6.21
Net Present Cost		2.08	0.53	0.39	0.38	0.37	0.52	0.34	0.33	0.32	0.31	5.59
NRC (Incl. VAT & Indexation)		1.86	-	-	-	-	-	-	-	-	-	1.86
NRR (Incl. VAT & Indexation)		0.30	0.14	-	-	-	-	-	-	-	-	0.44
RR (Incl. VAT & Indexation)		0.24	0.49	0.51	0.52	0.53	0.76	0.55	0.56	0.57	0.58	5.31
Financial Cost		2.40	0.63	0.51	0.52	0.53	0.76	0.55	0.56	0.57	0.58	7.61
Assumed Resources In Post		(0.03)	(0.02)	-	-	-	-	-	-	-	-	(0.05)
Total Financial Cost		2.37	0.61	0.51	0.52	0.53	0.76	0.55	0.56	0.57	0.58	7.56
Depreciation (Capital Costs)		0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	1.55

*cost shown as '0.0' are less than £10k a year

NHS Golden Jubilee

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.01	-	-	-	-	-	-	-	-	-	0.01
Annual Support	RR	-	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	2.06
Supplier Implementation	NRR	0.58	-	-	-	-	-	-	-	-	-	0.58
Design	NRR	0.0	-	-	-	-	-	-	-	-	-	0.0
Build & Local Config	NRR	0.01	-	-	-	-	-	-	-	-	-	0.01
Rollout	NRR	0.01	0.0	-	-	-	-	-	-	-	-	0.01
BAU	RR	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.03
LIMS Interface Build	NRC	0.07	-	-	-	-	-	-	-	-	-	0.07
LIMS Interface Support	RR	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.05
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces		0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.10	0.0	0.0	0.0	0.0	0.10	0.0	0.0	0.0	0.0	0.22
Optimism Bias		0.31	0.08	0.08	0.08	0.08	0.11	0.08	0.08	0.08	0.08	1.05
Total		1.34	0.34	0.34	0.34	0.34	0.47	0.34	0.34	0.34	0.34	4.53
Non-Recurring Capital (NRC)		1.15	-	-	-	-	-	-	-	-	-	1.15
Non-Recurring Revenue (NRR)		0.02	0.0	-	-	-	-	-	-	-	-	0.03
Recurring Revenue (RR)		0.17	0.34	0.34	0.34	0.34	0.47	0.34	0.34	0.34	0.34	3.36
Total Economic Cost		1.34	0.34	0.34	0.34	0.34	0.47	0.34	0.34	0.34	0.34	4.53
Net Present Cost		1.34	0.33	0.32	0.31	0.30	0.40	0.28	0.27	0.26	0.25	4.04
NRC (Incl. VAT & Indexation)		1.38	-	-	-	-	-	-	-	-	-	1.38
NRR (Incl. VAT & Indexation)		0.02	0.0	-	-	-	-	-	-	-	-	0.03
RR (Incl. VAT & Indexation)		0.18	0.41	0.42	0.43	0.43	0.59	0.45	0.46	0.47	0.47	4.30
Financial Cost		1.57	0.42	0.42	0.43	0.43	0.59	0.45	0.46	0.47	0.47	5.71
Assumed Resources In Post		(0.0)	(0.0)	-	-	-	-	-	-	-	-	(0.0)
Total Financial Cost		1.57	0.42	0.42	0.43	0.43	0.59	0.45	0.46	0.47	0.47	5.70
Depreciation (Capital Costs)		0.11	0.11	0.11	0.11	0.11	0.11	0.11	0.11	0.11	0.11	1.15

*cost shown as '0.0' are less than £10k a year

NHS Grampian

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.19	-	-	-	-	-	-	-	-	-	0.19
Annual Support	RR	-	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	3.16
Supplier Implementation	NRR	0.97	-	-	-	-	-	-	-	-	-	0.97
Design	NRR	0.04	-	-	-	-	-	-	-	-	-	0.04
Build & Local Config	NRR	0.43	-	-	-	-	-	-	-	-	-	0.43
Rollout	NRR	-	0.35	-	-	-	-	-	-	-	-	0.35
BAU	RR	-	0.05	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.71
LIMS Interface Build	NRC	0.22	-	-	-	-	-	-	-	-	-	0.22
LIMS Interface Support	RR	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.33
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.20	0.0	0.0	0.0	0.0	0.20	0.0	0.0	0.0	0.0	0.44
Optimism Bias		0.70	0.24	0.15	0.15	0.15	0.21	0.15	0.15	0.15	0.15	2.18
Total		3.02	1.05	0.64	0.64	0.64	0.90	0.64	0.64	0.64	0.64	9.46
Non-Recurring Capital (NRC)		2.08	-	-	-	-	-	-	-	-	-	2.08
Non-Recurring Revenue (NRR)		0.61	0.45	-	-	-	-	-	-	-	-	1.06
Recurring Revenue (RR)		0.34	0.60	0.64	0.64	0.64	0.90	0.64	0.64	0.64	0.64	6.32
Total Economic Cost		3.02	1.05	0.64	0.64	0.64	0.90	0.64	0.64	0.64	0.64	9.46
Net Present Cost		3.02	1.01	0.60	0.58	0.56	0.76	0.52	0.50	0.49	0.47	8.51
NRC (Incl. VAT & Indexation)		2.50	-	-	-	-	-	-	-	-	-	2.50
NRR (Incl. VAT & Indexation)		0.61	0.46	-	-	-	-	-	-	-	-	1.07
RR (Incl. VAT & Indexation)		0.35	0.71	0.77	0.79	0.80	1.10	0.83	0.84	0.86	0.87	7.92
Financial Cost		3.45	1.18	0.77	0.79	0.80	1.10	0.83	0.84	0.86	0.87	11.48
Assumed Resources In Post		(0.07)	(0.05)	-	-	-	-	-	-	-	-	(0.12)
Total Financial Cost		3.39	1.12	0.77	0.79	0.80	1.10	0.83	0.84	0.86	0.87	11.36
Depreciation (Capital Costs)		0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21	2.08

*cost shown as '0.0' are less than £10k a year

NHS Greater Glasgow & Clyde

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.67	-	-	-	-	-	-	-	-	-	0.67
Annual Support	RR	-	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	6.27
Supplier Implementation	NRR	2.0	-	-	-	-	-	-	-	-	-	2.0
Design	NRR	0.11	-	-	-	-	-	-	-	-	-	0.11
Build & Local Config	NRR	1.23	0.21	-	-	-	-	-	-	-	-	1.44
Rollout	NRR	-	1.01	-	-	-	-	-	-	-	-	1.01
BAU	RR	-	0.12	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	2.02
LIMS Interface Build	NRC	0.23	-	-	-	-	-	-	-	-	-	0.23
LIMS Interface Support	RR	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.36
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.41	0.01	0.01	0.01	0.01	0.41	0.01	0.01	0.01	0.01	0.88
Optimism Bias		1.48	0.63	0.30	0.30	0.30	0.42	0.30	0.30	0.30	0.30	4.64
Total		6.43	2.72	1.30	1.30	1.30	1.82	1.30	1.30	1.30	1.30	20.09
Non-Recurring Capital (NRC)		4.07	-	-	-	-	-	-	-	-	-	4.07
Non-Recurring Revenue (NRR)		1.75	1.57	-	-	-	-	-	-	-	-	3.33
Recurring Revenue (RR)		0.61	1.15	1.30	1.30	1.30	1.82	1.30	1.30	1.30	1.30	12.69
Total Economic Cost		6.43	2.72	1.30	1.30	1.30	1.82	1.30	1.30	1.30	1.30	20.09
Net Present Cost		6.43	2.63	1.22	1.17	1.13	1.53	1.06	1.02	0.99	0.96	18.14
NRC (Incl. VAT & Indexation)		4.88	-	-	-	-	-	-	-	-	-	4.88
NRR (Incl. VAT & Indexation)		1.75	1.61	-	-	-	-	-	-	-	-	3.36
RR (Incl. VAT & Indexation)		0.62	1.37	1.55	1.58	1.61	2.21	1.66	1.69	1.72	1.75	15.76
Financial Cost		7.26	2.97	1.55	1.58	1.61	2.21	1.66	1.69	1.72	1.75	24.0
Assumed Resources In Post		(0.20)	(0.18)	-	-	-	-	-	-	-	-	(0.38)
Total Financial Cost		7.06	2.79	1.55	1.58	1.61	2.21	1.66	1.69	1.72	1.75	23.63
Depreciation (Capital Costs)		0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	4.07

*cost shown as '0.0' are less than £10k a year

NHS Lothian

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.27	-	-	-	-	-	-	-	-	-	0.27
Annual Support	RR	-	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	6.27
Supplier Implementation	NRR	2.0	-	-	-	-	-	-	-	-	-	2.0
Design	NRR	0.06	-	-	-	-	-	-	-	-	-	0.06
Build & Local Config	NRR	0.68	0.11	-	-	-	-	-	-	-	-	0.79
Rollout	NRR	-	0.55	-	-	-	-	-	-	-	-	0.55
BAU	RR	-	0.07	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	1.11
LIMS Interface Build	NRC	0.20	-	-	-	-	-	-	-	-	-	0.20
LIMS Interface Support	RR	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.29
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.41	0.01	0.01	0.01	0.01	0.41	0.01	0.01	0.01	0.01	0.88
Optimism Bias		1.17	0.45	0.27	0.27	0.27	0.39	0.27	0.27	0.27	0.27	3.86
Total		5.06	1.93	1.15	1.15	1.15	1.67	1.15	1.15	1.15	1.15	16.73
Non-Recurring Capital (NRC)		3.50	-	-	-	-	-	-	-	-	-	3.50
Non-Recurring Revenue (NRR)		0.96	0.86	-	-	-	-	-	-	-	-	1.83
Recurring Revenue (RR)		0.60	1.07	1.15	1.15	1.15	1.67	1.15	1.15	1.15	1.15	11.41
Total Economic Cost		5.06	1.93	1.15	1.15	1.15	1.67	1.15	1.15	1.15	1.15	16.73
Net Present Cost		5.06	1.87	1.08	1.04	1.0	1.41	0.94	0.91	0.88	0.85	15.02
NRC (Incl. VAT & Indexation)		4.20	-	-	-	-	-	-	-	-	-	4.20
NRR (Incl. VAT & Indexation)		0.96	0.88	-	-	-	-	-	-	-	-	1.84
RR (Incl. VAT & Indexation)		0.61	1.28	1.39	1.42	1.44	2.04	1.49	1.52	1.55	1.57	14.32
Financial Cost		5.77	2.17	1.39	1.42	1.44	2.04	1.49	1.52	1.55	1.57	20.36
Assumed Resources In Post		(0.11)	(0.10)	-	-	-	-	-	-	-	-	(0.21)
Total Financial Cost		5.67	2.07	1.39	1.42	1.44	2.04	1.49	1.52	1.55	1.57	20.16
Depreciation (Capital Costs)		0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	3.50

*cost shown as '0.0' are less than £10k a year

NHS Orkney

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.0	-	-	-	-	-	-	-	-	-	0.0
Annual Support	RR	-	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	2.06
Supplier Implementation	NRR	0.58	-	-	-	-	-	-	-	-	-	0.58
Design	NRR	0.0	-	-	-	-	-	-	-	-	-	0.0
Build & Local Config	NRR	0.01	-	-	-	-	-	-	-	-	-	0.01
Rollout	NRR	0.01	0.01	-	-	-	-	-	-	-	-	0.01
BAU	RR	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.03
LIMS Interface Build	NRC	0.09	-	-	-	-	-	-	-	-	-	0.09
LIMS Interface Support	RR	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.03
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.10	0.0	0.0	0.0	0.0	0.10	0.0	0.0	0.0	0.0	0.22
Optimism Bias		0.31	0.08	0.08	0.08	0.08	0.11	0.08	0.08	0.08	0.08	1.04
Total		1.35	0.34	0.34	0.34	0.34	0.47	0.34	0.34	0.34	0.34	4.52
Non-Recurring Capital (NRC)		1.16	-	-	-	-	-	-	-	-	-	1.16
Non-Recurring Revenue (NRR)		0.02	0.01	-	-	-	-	-	-	-	-	0.03
Recurring Revenue (RR)		0.17	0.34	0.34	0.34	0.34	0.47	0.34	0.34	0.34	0.34	3.33
Total Economic Cost		1.35	0.34	0.34	0.34	0.34	0.47	0.34	0.34	0.34	0.34	4.52
Net Present Cost		1.35	0.33	0.31	0.30	0.29	0.39	0.27	0.26	0.26	0.25	4.03
NRC (Incl. VAT & Indexation)		1.39	-	-	-	-	-	-	-	-	-	1.39
NRR (Incl. VAT & Indexation)		0.02	0.01	-	-	-	-	-	-	-	-	0.03
RR (Incl. VAT & Indexation)		0.17	0.41	0.42	0.42	0.43	0.58	0.45	0.45	0.46	0.47	4.26
Financial Cost		1.59	0.42	0.42	0.42	0.43	0.58	0.45	0.45	0.46	0.47	5.68
Assumed Resources In Post		(0.0)	(0.0)	-	-	-	-	-	-	-	-	(0.0)
Total Financial Cost		1.59	0.42	0.42	0.42	0.43	0.58	0.45	0.45	0.46	0.47	5.68
Depreciation (Capital Costs)		0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	1.16

*cost shown as '0.0' are less than £10k a year

NHS Shetland

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.0	-	-	-	-	-	-	-	-	-	0.0
Annual Support	RR	-	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	2.06
Supplier Implementation	NRR	0.58	-	-	-	-	-	-	-	-	-	0.58
Design	NRR	0.0	-	-	-	-	-	-	-	-	-	0.0
Build & Local Config	NRR	0.01	-	-	-	-	-	-	-	-	-	0.01
Rollout	NRR	0.01	0.01	-	-	-	-	-	-	-	-	0.01
BAU	RR	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.03
LIMS Interface Build	NRC	0.09	-	-	-	-	-	-	-	-	-	0.09
LIMS Interface Support	RR	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.03
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces		0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.10	0.0	0.0	0.0	0.0	0.10	0.0	0.0	0.0	0.0	0.22
Optimism Bias		0.31	0.08	0.08	0.08	0.08	0.11	0.08	0.08	0.08	0.08	1.04
Total		1.35	0.34	0.34	0.34	0.34	0.47	0.34	0.34	0.34	0.34	4.52
Non-Recurring Capital (NRC)		1.16	-	-	-	-	-	-	-	-	-	1.16
Non-Recurring Revenue (NRR)		0.02	0.01	-	-	-	-	-	-	-	-	0.03
Recurring Revenue (RR)		0.17	0.34	0.34	0.34	0.34	0.47	0.34	0.34	0.34	0.34	3.33
Total Economic Cost		1.35	0.34	0.34	0.34	0.34	0.47	0.34	0.34	0.34	0.34	4.52
Net Present Cost		1.35	0.33	0.31	0.30	0.29	0.39	0.27	0.26	0.26	0.25	4.03
NRC (Incl. VAT & Indexation)		1.39	-	-	-	-	-	-	-	-	-	1.39
NRR (Incl. VAT & Indexation)		0.02	0.01	-	-	-	-	-	-	-	-	0.03
RR (Incl. VAT & Indexation)		0.17	0.41	0.42	0.42	0.43	0.58	0.45	0.45	0.46	0.47	4.26
Financial Cost		1.59	0.42	0.42	0.42	0.43	0.58	0.45	0.45	0.46	0.47	5.69
Assumed Resources In Post		(0.0)	(0.0)	-	-	-	-	-	-	-	-	(0.0)
Total Financial Cost		1.59	0.42	0.42	0.42	0.43	0.58	0.45	0.45	0.46	0.47	5.68
Depreciation (Capital Costs)		0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	1.16

*cost shown as '0.0' are less than £10k a year

NHS Tayside

Cost (£m)	Cost Type	Year										Total
		1	2	3	4	5	6	7	8	9	10	
LIMS Software Licence	NRC	0.17	-	-	-	-	-	-	-	-	-	0.17
Annual Support	RR	-	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	3.16
Supplier Implementation	NRR	0.97	-	-	-	-	-	-	-	-	-	0.97
Design	NRR	0.04	-	-	-	-	-	-	-	-	-	0.04
Build & Local Config	NRR	0.40	-	-	-	-	-	-	-	-	-	0.40
Rollout	NRR	-	0.33	-	-	-	-	-	-	-	-	0.33
BAU	RR	-	0.04	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.66
LIMS Interface Build	NRC	0.13	-	-	-	-	-	-	-	-	-	0.13
LIMS Interface Support	RR	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.08
Additional Interface Build	NRC	0.18	-	-	-	-	-	-	-	-	-	0.18
Additional Interface Recurring	RR	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.23
Downstream Interfaces	NRC	0.04	-	-	-	-	-	-	-	-	-	0.04
Hosting Hardware	RR	0.20	0.0	0.0	0.0	0.0	0.20	0.0	0.0	0.0	0.0	0.44
Optimism Bias		0.65	0.23	0.14	0.14	0.14	0.20	0.14	0.14	0.14	0.14	2.05
Total		2.81	0.98	0.60	0.60	0.60	0.86	0.60	0.60	0.60	0.60	8.86
Non-Recurring Capital (NRC)		1.93	-	-	-	-	-	-	-	-	-	1.93
Non-Recurring Revenue (NRR)		0.57	0.42	-	-	-	-	-	-	-	-	0.99
Recurring Revenue (RR)		0.30	0.56	0.60	0.60	0.60	0.86	0.60	0.60	0.60	0.60	5.94
Total Economic Cost		2.81	0.98	0.60	0.60	0.60	0.86	0.60	0.60	0.60	0.60	8.86
NPC (10 years discounting)		2.81	0.95	0.56	0.54	0.52	0.73	0.49	0.47	0.46	0.44	7.97
NRC (Incl. VAT & Indexation)		2.32	-	-	-	-	-	-	-	-	-	2.32
NRR (Incl. VAT & Indexation)		0.57	0.43	-	-	-	-	-	-	-	-	1.0
RR (Incl. VAT & Indexation)		0.31	0.67	0.73	0.74	0.75	1.05	0.78	0.79	0.80	0.82	7.44
Financial Cost		3.20	1.10	0.73	0.74	0.75	1.05	0.78	0.79	0.80	0.82	10.76
Assumed Resources In Post		(0.06)	(0.05)	-	-	-	-	-	-	-	-	(0.11)
Total Financial Cost		3.14	1.05	0.73	0.74	0.75	1.05	0.78	0.79	0.80	0.82	10.64
Depreciation (Capital Costs)		0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	1.93

*cost shown as '0.0' are less than £10k a year

Appendix G: Alternate User Concurrency Costing

Total 10 Year Economic Cost for Consortium Boards – 50% User Concurrency

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Gram-pian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shet-land	NHS Tayside
LIMS Software Licence	0.07	0.11	0.24	0.15	0.01	0.39	1.35	0.53	0.00	0.00	0.34
Supplier Annual Support	2.06	2.06	2.29	2.29	2.06	3.16	6.27	6.27	2.06	2.06	3.16
Supplier Implementation	0.58	0.58	0.80	0.80	0.58	0.97	2.00	2.00	0.58	0.58	0.97
Design	0.01	0.01	0.03	0.02	0.00	0.04	0.11	0.06	0.00	0.00	0.04
Build & Local Config	0.07	0.08	0.24	0.18	0.01	0.43	1.44	0.79	0.01	0.01	0.40
Rollout	0.05	0.06	0.19	0.14	0.01	0.35	1.01	0.55	0.01	0.01	0.33
BAU	0.19	0.21	0.49	0.36	0.03	0.71	2.02	1.11	0.03	0.03	0.66
LIMS Interface Build	0.06	0.06	0.09	0.09	0.07	0.22	0.23	0.20	0.09	0.09	0.13
LIMS Interface Support	0.03	0.03	0.04	0.04	0.05	0.33	0.36	0.29	0.03	0.03	0.08
Add. Licences Build	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18
Add. Licences Recurring	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23
Downstream Interfaces	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
Hosting Hardware	0.22	0.22	0.33	0.33	0.22	0.44	0.88	0.88	0.22	0.22	0.44
Optimism Bias	**1.14**	**1.16**	**1.56**	**1.46**	**1.05**	**2.24**	**4.84**	**3.94**	**1.04**	**1.04**	**2.10**
Total with OB	**4.93**	**5.03**	**6.76**	**6.31**	**4.54**	**9.71**	**20.96**	**17.08**	**4.52**	**4.52**	**9.08**
Non Recurring Capital (NRC)	1.22	1.27	1.76	1.64	1.15	2.33	4.94	3.85	1.17	1.17	2.16
Non Recurring Revenue (NRR)	0.18	0.20	0.60	0.44	0.03	1.06	3.33	1.83	0.03	0.03	0.99
Recurring Revenue (RR)	3.53	3.56	4.40	4.22	3.36	6.32	12.69	11.41	3.33	3.33	5.94
Total with Optimism Bias over 10 years	**4.93**	**5.03**	**6.76**	**6.31**	**4.54**	**9.71**	**20.96**	**17.08**	**4.52**	**4.52**	**9.08**
NPC over 10 years	4.40	4.50	6.10	5.68	4.05	8.76	19.02	15.37	4.03	4.03	8.19

Total 10 Year Financial Cost for Consortium Boards – 50% User Concurrency

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Grampian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shetland	NHS Tayside

Consolidated Financial Considerations											
NRC (Incl. VAT & Indexation)	1.46	1.52	2.11	1.97	1.38	2.80	5.93	4.61	1.40	1.40	2.59
NRR (Incl. VAT & Indexation)	0.18	0.20	0.60	0.44	0.03	1.07	3.36	1.84	0.03	0.03	1.00
RR (Incl. VAT & Indexation)	4.49	4.52	5.50	5.31	4.30	7.92	15.76	14.32	4.26	4.26	7.44
Total (Incl. VAT & Index.)	**6.13**	**6.24**	**8.22**	**7.72**	**5.71**	**11.79**	**25.05**	**20.78**	**5.69**	**5.69**	**11.02**
Existing Resources In Post	0.02	0.02	0.07	0.05	0.00	0.12	0.38	0.21	0.00	0.00	0.11
Total Financial Cost	**6.11**	**6.22**	**8.15**	**7.67**	**5.71**	**11.67**	**24.68**	**20.57**	**5.68**	**5.69**	**10.91**

Capital Depreciation	1.22	1.27	1.76	1.64	1.15	2.33	4.94	3.85	1.17	1.17	2.16

Total 10 Year Economic Cost for Consortium Boards – 100% User Concurrency

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Gram-pian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shet-land	NHS Tayside
LIMS Software Licence	0.14	0.22	0.48	0.30	0.02	0.77	2.69	1.06	0.01	0.01	0.68
Supplier Annual Support	2.06	2.06	2.29	2.29	2.06	3.16	6.27	6.27	2.06	2.06	3.16
Supplier Implementation	0.58	0.58	0.80	0.80	0.58	0.97	2.00	2.00	0.58	0.58	0.97
Design	0.01	0.01	0.03	0.02	0.00	0.04	0.11	0.06	0.00	0.00	0.04
Build & Local Config	0.07	0.08	0.24	0.18	0.01	0.43	1.44	0.79	0.01	0.01	0.40
Rollout	0.05	0.06	0.19	0.14	0.01	0.35	1.01	0.55	0.01	0.01	0.33
BAU	0.19	0.21	0.49	0.36	0.03	0.71	2.02	1.11	0.03	0.03	0.66
LIMS Interface Build	0.06	0.06	0.09	0.09	0.07	0.22	0.23	0.20	0.09	0.09	0.13
LIMS Interface Support	0.03	0.03	0.04	0.04	0.05	0.33	0.36	0.29	0.03	0.03	0.08
Add. Licences Build	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18
Add. Licences Recurring	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23
Downstream Interfaces	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
Hosting Hardware	0.22	0.22	0.33	0.33	0.22	0.44	0.88	0.88	0.22	0.22	0.44
Optimism Bias	**1.16**	**1.19**	**1.63**	**1.50**	**1.05**	**2.36**	**5.24**	**4.10**	**1.04**	**1.04**	**2.20**
Total with OB	**5.02**	**5.17**	**7.07**	**6.50**	**4.55**	**10.21**	**22.71**	**17.77**	**4.53**	**4.53**	**9.53**
Non Recurring Capital (NRC)	1.31	1.41	2.07	1.84	1.17	2.83	6.70	4.54	1.17	1.17	2.60
Non Recurring Revenue (NRR)	0.18	0.20	0.60	0.44	0.03	1.06	3.33	1.83	0.03	0.03	0.99
Recurring Revenue (RR)	3.53	3.56	4.40	4.22	3.36	6.32	12.69	11.41	3.33	3.33	5.94
Total with Optimism Bias over 10 years	**5.02**	**5.17**	**7.07**	**6.50**	**4.55**	**10.21**	**22.71**	**17.77**	**4.53**	**4.53**	**9.53**
NPC over 10 years	4.50	4.64	6.41	5.87	4.06	9.26	20.77	16.06	4.04	4.04	8.64

Total 10 Year Financial Cost for Consortium Boards – 50% User Concurrency

Option 3A - 10 Year Cost (£m)	NHS Borders	NHS D&G	NHS Fife	NHS Forth Valley	NHS Golden Jubilee	NHS Grampian	NHS GGC	NHS Lothian	NHS Orkney	NHS Shetland	NHS Tayside
Consolidated Financial Considerations											
NRC (Incl. VAT & Indexation)	1.58	1.69	2.49	2.20	1.40	3.40	8.03	5.44	1.41	1.41	3.12
NRR (Incl. VAT & Indexation)	0.18	0.20	0.60	0.44	0.03	1.07	3.36	1.84	0.03	0.03	1.00
RR (Incl. VAT & Indexation)	4.49	4.52	5.50	5.31	4.30	7.92	15.76	14.32	4.26	4.26	7.44
Total (Incl. VAT & Index.)	**6.24**	**6.41**	**8.59**	**7.96**	**5.73**	**12.39**	**27.16**	**21.60**	**5.70**	**5.70**	**11.56**
Existing Resources In Post	0.02	0.02	0.07	0.05	0.00	0.12	0.38	0.21	0.00	0.00	0.11
Total Financial Cost	**6.22**	**6.39**	**8.52**	**7.91**	**5.73**	**12.27**	**26.78**	**21.40**	**5.69**	**5.69**	**11.45**

Capital Depreciation	1.31	1.41	2.07	1.84	1.17	2.83	6.70	4.54	1.17	1.17	2.60

Appendix I: Hosting Comparison

Cloud Vs On-Premise

While costing purposes assume local hosting hardware, the advantages and limitations of cloud-based hosting has been included in this section for reference.

Three types of hosting have been included below, on premise / local data centre hosting, Infrastructure-as-a-Service (Cloud Hosting), and Software-as-a-Service (Managed Service).

On-Premise (Local Hosting)

Description:

On-premise involves all software being stood up and hosted on local hardware which is owned and managed by the organisation in question, who has both full control and full responsibility of security and upkeep. This requires in-house server hardware, software licences, integration capabilities and IT staff on hand to support and manage any potential issues that arise.

Advantages:

- Organisations are fully in control of their own hardware
- Data is fully owned and managed within internal infrastructure
- No reliance on 3rd party service providers

Limitations:

- **Capital Costs.** On-premise environments often have higher associated capital expenditure costs as all hardware and software is needed to be purchased and managed.
- **Maintenance**. Can be further costly to maintain and keep up-to-date as full responsibility of organisation.
- **Scaling Difficulty.** Difficult to scale as required as further physical would be needed.

Infrastructure-as-a-Service (Cloud Hosting)

Description:

Cloud infrastructure services, known as Infrastructure as a Service (IaaS), are made of scalable and automated compute resources. IaaS is fully self-service for accessing and monitoring computers, networking, storage, and other services. IaaS allows businesses to purchase resources on-demand and as-needed instead of having to buy hardware outright.

Advantages:

- The most flexible cloud computing model
- Easy to automate deployment of storage, networking, servers, and processing power
- Hardware purchases can be based on consumption
- Clients retain complete control of their infrastructure
- Resources can be purchased as-needed
- Highly scalable

Limitations:

- **Security.** While control of the applications, data, middleware, and the OS platform, security threats can still be sourced from the host or other virtual machines (VMs).
- **Legacy systems operating in the cloud**. While legacy apps can run in the cloud, the infrastructure may not be designed to deliver specific controls to secure the legacy apps.
- **Internal resources and training**. Additional resources and training may be required for the workforce to learn how to effectively manage the infrastructure.
- **Multi-tenant security**. Since the hardware resources are dynamically allocated across users as made available, organisations must rely on the vendor to ensure that VMs are adequately isolated within the multitenant cloud architecture.

Software-as-a-Service (Managed Service)

Description:

Software as a Service, also known as cloud application services, represents the most commonly utilized option for businesses in the cloud market. SaaS utilizes the internet to deliver applications, which are managed by a third-party vendor, to its users. A majority of SaaS applications run directly web browsers, which means they do not require any downloads or installations on the client side.

Advantages:

- Typically significantly reduced deployment time
- No requirement for installing, managing, and upgrading software
- No hardware costs, beyond existing hardware
- Updates are typically pushed directly to end-user

Limitations:

- **Interoperability.** Integration with existing apps and services can be an issue if the SaaS app is not designed to follow open standards for integration.
- **Vendor lock-in.** Vendors may make it easy to join a service and difficult to get out of it. For instance, the data may not be portable–technically or cost-effectively–across SaaS apps from other vendors without incurring significant cost or in house engineering rework. Not every vendor follows standard APIs, protocols, and tools, yet the features could be necessary for certain business tasks.
- **Lack of integration support**. Many organizations require deep integrations with on premise apps, data, and services. The SaaS vendor may offer limited support in this regard, forcing organizations to invest internal resources in designing and managing integrations.
- **Data security.** Large volumes of data may have to be exchanged to the backend data centres of SaaS apps in order to perform the necessary software functionality.
- **Lack of control.** SaaS solutions involves handing control over to the third-party service provider. These controls are not limited to the software–in terms of the version, updates, or appearance–but also the data and governance.
- **Performance and downtime.** The vendor controls and manages the SaaS service, including security and performance. Planned and unplanned maintenance, cyber-attacks, or network issues may impact the performance of the SaaS app despite adequate service level agreement (SLA) protections in place.

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NHS Fife

Meeting:	Finance Performance and Resources Committee
Meeting Date:	Tuesday 12 January 2021
Title:	East Region Recruitment Transformation
Responsible Executive:	Linda Douglas, Director of Workforce
Report Author:	Sandra Raynor, Senior HR Manager

1. Purpose

This is presented to NHS Fife Board members for:

- Discussion on the Business Case and consideration of next steps in the governance and review process.

This report relates to an:

- On-going issue.

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

- Effective, Safe and Person Centred.

2. Report Summary

2.1 Situation

The Recruitment Service Transformation is a national initiative supported by NHS Scotland Chief Executives to provide a National Recruitment Service model delivered regionally (East, West and North) underpinned by a single national recruitment IT system, Jobtrain with a national standardised process and practice.

2.2 Background

An East Region Recruitment Transformation Programme Board chaired by Janis Butler, Director of Workforce, NHS Lothian, as Responsible Officer for the programme, has been created and the programme board are responsible for ensuring the East Region Recruitment Transformation programme and its constituent projects achieve the required outcomes.

The work of the East Region group was paused during the COVID-19 pandemic, however, activity recommenced in August 2020 to progress this initiative.

2.3 Assessment

Non financial option appraisal workshops have taken place which took forward discussions about potential regional delivery models of recruitment services to the 6 Boards aligned to the East Region Recruitment collaboration.

Overall there is a recognition that an East Region Recruitment Service would lead to an increase in collaboration, improve communications and an increase in effectiveness. It was also noted there is general risks regarding equity of Board's priorities, recruitment staff roles and responsibilities and how local knowledge and relationships will be preserved.

Following the financial appraisal, a Business Case has been developed, attached at Appendix 1, which advises local Boards of the preferred service model option identified, includes the benefits, risks and costs of the preferred option and details of the proposed service model. The preferred service model is Single Employer, Single Location.

Both the Executive Director's Group and Staff Governance Committee have endorsed the business case and to proceed as one of the six Boards within this project.

2.3.1 Quality / Patient Care

A regional recruitment service will enhance the candidate experience and streamline the recruitment process, leading to an improved filling of vacancies for the Board.

2.3.2 Workforce

Implementing a regional recruitment model will have an impact on the workforce roles and responsibilities, with a new model potentially offering a career progression framework. The full proposal represents a change to the current arrangements for staff where they would require to be TUPE transferred to Lothian.

2.3.3 Financial

The costs of the new service delivery model will be met from within the existing financial envelope of the Board's current costs for our recruitment function.

2.3.4 Risk Assessment / Management

An East Region Risk Register for the transformation programme is in place.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other Impacts

N/A

2.3.7 Communication, Involvement, Engagement and Consultation

Discussions have taken place within the East Regional Recruitment Transformation Programme Group. Previous papers and regular updates have been shared with the Area

Partnership Forum, Staff Governance Committee and the Executive Director's Group within the Board. Both the Executive Director's Group and Staff Governance Committee have endorsed to proceed as one of the six Boards within this project.

2.3.8 Route to the Meeting

This paper was discussed and endorsed by members of the Executive Director's Group, Area Partnership Forum and Staff Governance Committee during August to October 2020.

2.4 Recommendation

Finance Performance and Resources Committee members are asked to discuss and determine Committee support in principle for this proposed change. The Committee is asked to consider in particular:

- The value of the key benefit from the case which is to protect the resilience of recruitment services, both locally and nationally
- The need to consider carefully the timing of such a change in the context of the current pandemic with all the on-going challenges for teams across the organisation.

3. List of Appendices

- **Appendix 1 – East Region Recruitment Transformation Business Case**

Report Contact: Sandra Raynor, Senior HR Manager
Email: Sandra.Raynor@nhs.scot

East Region Recruitment Services

Business Case v.0.4

Date July 2020

Document Control

Title:	Recruitment Transformation Programme – East Region
Date:	7th February 2020

Version History

Version	Date	Author(s)	Comments
0.1	7.2.20	Belinda Wilson	1st draft
0.2	27.5.20	Belinda Wilson	Post Covid Edit
0.3	14.7.20	Belinda Wilson	Draft Review for Programme Board
0.4	28.7.20	Belinda Wilson	Economic and Financial case updated

Executive summary

The East Region Recruitment Services Consortium is made up of 6 boards: NHS Lothian; NHS Fife; NHS Borders; Healthcare Improvement Scotland (HIS); NHS Education for Scotland (NES) and the Scottish Ambulance Service (SAS). It is one of three consortia in Scotland tasked with developing a consistent and sustainable approach to recruitment services on a regional basis.

This report provides an analysis of recruitment services in the East region and sets out to explain issues and variations between the services. The reasons for change are highlighted and the subsequent Options Appraisal process detailed. The case for a regionalised 'Single Employer, Multiple Base' solution is proposed as the preferred option and details are explored on how this proposed service model could be implemented from a day one and phased perspective.

Issues

As described in the NHS Scotland Shared Services Recruitment – Strategic Proposal Paper (12th June 2018), NHS Scotland delivers world class healthcare to the population of Scotland through a workforce which is person centred and focused on high quality services. NHS Scotland Boards were not experiencing the labour market pressures observed within other areas of the UK. However, that position changed, and a recognised need to make our employment opportunities attractive for a new generation whose expectations of job opportunities are values based.

In addition, with an increase in hard to fill posts across NHS Scotland; this is both an opportunity and a challenge to think differently as to where services are delivered with more scope to work across Board boundaries, particularly with an evolving Regional approach and a need to explore different roles within patient pathways. This has led to exploring different approaches to recruitment not only through the digital market, but also by recognising a wider supply chain than the local market. This in itself can bring expert challenge as the pathway for recruiting outwith the UK, particularly for professional posts can be lengthy and at times unclear to ensure all the requirements are articulated and actioned appropriately to enable candidates to remain onboard. The increasing complexity and volume has led to increasing demand and imbalance within boards.

The report summarises the main issues driving change. This includes the sustainability of the recruitment services workforce and variations in approach to recruitment services across the 6 boards, the Scottish Government 'Once for Scotland' approach and other national and local drivers.

Findings

A series of Option Appraisal exercises were carried out with the preferred option of a 'Single Employer, Multiple Base' from both the non-financial and financial appraisal perspectives. The main benefits for Single Employer, Multiple Base' are:

Single Employer and Multiple Base

- The main benefits for a Single Employer and Multiple Base within the East Region will enable a robust governance structure and provide more flexible and resilient management arrangements.
- A single employer will create one collective HR resource targeting the full weight of the East Region recruitment service where and when it is needed to optimise the service to customers, whether these are Boards, service users or applicants.
- A single employer will also help with workforce planning, identify skill gaps and support the creation of career paths, in relation to recruitment staff.
- Multiple bases will support recruitment and retention of staff with a potential for staff to remain in their existing base or have the opportunity to move to/work from another base.
- Multiple bases will allow local knowledge to be retained and other locations could pick up other work if system issues occur or manpower vacancies or gaps occur.

Vision

Effective and efficient recruitment services have a key role to ensure we facilitate change in a competitive employment market, locally, nationally and internationally. The following proposal has been developed to support the delivery of high quality, person centred service ensuring we can attract, retain and provide appropriate opportunities for our workforce within health and social care. A shared regional recruitment service model will allow sharing of expertise, experience and allow workloads to be distributed across recruitment teams to address strategic workforce issues. It will provide improved alignment of workforce, service and financial plans leading to better service planning and better intelligence about future demands which in turn will improve user experience and better collaboration.

The aim and vision of Recruitment Transformation is to ensure that as advances in recruitment services continue to grow, a new and innovative service model to enable staff and users to obtain maximum benefit will be developed.

The preferred option for delivery could provide further savings through technological advances providing a streamlined service across boards optimizing gains in productivity through the use of an online enquiry platform such as Service Now which will reduce the time spent answering

initial enquires through current phone and email methods. There are also opportunities to share valuable expertise, knowledge and skills that exist across the six Boards current resource, to the benefit of the regional service provision.

Currently, due to the Covid-19 pandemic the recruitment services across the 6 boards have had to quickly mobilise to respond to the demands of the crisis and provide their services remotely and virtually. Analysis and feedback from the teams during this period has demonstrated that these services were implemented at pace utilising the available technology, and provided the service with a unique opportunity to test out alternative models of delivery. The pandemic also lessened the requirement for a single physical location to house an East Region recruitment service as Boards have maintained service provision by remote and virtual means due to necessity during the pandemic. Along with the roll out of Microsoft Teams this has enabled the recruitment services across the 6 boards to deliver services with improved efficiencies and flexibility for both staff and candidates in line with the original vision of a modern and innovative East Region Recruitment service model.

Value of a Regional Service

A shared regional service will enable effective collaboration and sharing of knowledge, skills and experience, to develop into a robust, efficient, quality driven recruitment service. Leading by example and building on the work that has already taken place through a **'Once for Scotland'** approach, to provide efficient and consistent delivery of functions including;

- opportunities for increased efficiencies and productivity through consistency in approach to standardised processes, recruitment services and continuing embedment of JobTrain
- increased flexibility to meet capacity and demand, particularly around peak demands where increased levels of staff are required for increased vacancies and where staffing gaps are identified
- increased career development opportunities for staff with more opportunity to succeed in a variety of roles within the recruitment service and the service will be able to attract and support entry level positions such as apprenticeships
- capacity to be more fluid within roles, enabling staff to learn new skills to enhance career development potentially leading to increased wellness and job satisfaction which will benefit the regional service

Next Steps

Engagement work will be completed to obtain informal notes of expression from boards interested in becoming the Single Employer, Multiple Base'. The formal process will be followed once decisions are received from each board. This will be completed following the appropriate process and guidelines for a prospective Single Employer Board.

The appointment of a Single Employer of Recruitment Services across the East Region Recruitment Consortium will require that recruitment staff employed within the 5 other NHS Boards transfer to the new Single employer board. This transfer will be enacted in accordance with the Transfer of Undertakings (Protection of Employment) Regulations 2006 (updated in 2014) - TUPE.

Contents

1. Strategic Context

1.1 Introduction

This Business Case sets out the preferred option for recruitment services in the East Region Recruitment Services Consortium which aims to deliver a service that is sustainable, efficient, cost-effective, person centred and to a high quality, that is consistent and regionally agreed.

1.2 Drivers for change

National Drivers for change

The focus of a future Shared Recruitment Service is on allowing NHS Scotland the agility and flexibility needed to respond to changing needs now and in the future. The way services are delivered in NHS Scotland is changing, with a drive to deliver on a 'Once for Scotland' basis and improved collaborative working. As the delivery of health and social care integration intensifies, our resourcing needs will continue to shift and increase in complexity. As set out in the NHS Scotland Shared Services Recruitment – Strategic Proposal Paper (12th June 2018) The National Drivers for change include:

- **Health and Social Care Delivery Plan** – aiming for: Better Care; Better Health; and Better Value. A move to a shared service in recruitment supports the aims of: Developing collaboration of regional services to support the delivery of clinical services regionally; Designing services that meet the needs of local/regional communities; Obtaining better value through use of resources; Developing the once for Scotland approach in areas where it will be most impactful.

- **2020 Vision "Achieving sustainable quality in Scotland's healthcare", September 2011 -** Recruitment is key to supporting clinical services and patient care in terms of ensuring that NHS Scotland attracts staff and selects individuals who will deliver person centred care.

- **Scotland's NHS Workforce: The current picture - Audit Scotland Report 2017** - Recruitment services face increasing workload and pressure due to each of the issues highlighted. Addressing inefficiencies and improving 'time to hire' through standardised services, processes and systems while utilising NHS Scotland's shared Recruitment expertise will help to address these issues.

- **National Health & Social Care Workforce Plan -** Moving to a regional shared recruitment service is key in supporting the recruitment and retention aims of the workforce plan by sharing expertise in tackling the challenging recruitment and workforce issues facing NHS Scotland.

Local Drivers for change

- **Service model & local variations -** Minimising variances and introducing best practice where appropriate is required in the move to an optimal model of service delivery. An optimal model of service delivery would embrace "Once for Scotland" – one NHS Scotland, vision, process, IT system, and data set, targeting the full weight of NHS Scotland's recruitment service where and when it is needed to provide the best service possible to customers.

- **Candidate experience -** Having a joined up approach, with streamlined consistent processes, support and information throughout would lead to an improved candidate experience and recruitment journey from day one. Moving to new services supported by advanced consistent IT will enable recruitment services across Scotland to build on areas where customer satisfaction is high and identify and remedy areas where improvement is required.

- **Varying levels of performance -** Improving productivity and achieving efficiency savings, by moving to an optimal model of service delivery, would ensure improved performance of services across NHS Scotland.

- **Supporting Strategic recruitment interventions -** Shared or expertise and experience in recruiting hard to fill roles would also benefit those areas who face these challenges currently.

- **Service resilience -** Recruitment services need to be strengthened and shared to help address future resourcing challenges, and make best use of the Recruitment capability across Scotland.

- **Shared Knowledge & Continuous improvement -** There are areas of expertise across Scotland which could be shared and developed further to benefit NHS Scotland as a whole. This would lead to increased opportunities for staff to develop skills and expertise, to work collaboratively, and to develop their careers in new structures on a continuous improvement basis.

- **Branding & Marketing -** A national or regional approach to branding and marketing would build expertise of new approaches including social media, and a greater ability to market NHS Scotland as an employer as a whole, in an increasingly competitive marketplace.

- **Reporting & Data -** Having a consistent approach to technology and processes would lead to enhanced functional, analytical and reporting ability for recruitment services across NHS Scotland.

1.3 Workforce & Service Evolvement

The current position is that while there is some collaboration between Health Boards, particularly in relation to medical recruitment, recruitment is still a function that is largely carried out by Boards on an individual basis. The current scope and structure of Recruitment services across Scotland provide a variety and range of services, which cannot always enable the most efficient service to be provided.

It is recognised that Boards have made efficiencies through the recent implementation of JobTrain. However the absence of a consistent Regional approach is a barrier to driving out any real level of efficiency or productivity savings within the existing arrangements. Moving to an optimal model of service delivery will enable a more sustainable and cost effective Recruitment service to be developed, which in turn will contribute to the overall sustainability of wider NHS Scotland services.

NHS Scotland needs to be able to attract the best candidates and have a “world class” Recruitment Service, that is easy for candidates to use and access vacancies across NHS Scotland. The changing aspirations and expectations of the new generation workforce requires Recruitment services to be flexible and adaptable in their approach to service delivery, with creative engagement and attraction strategies in response to changing customer expectations, whilst making best use of modern technology to be competitive in this fast-paced digital age.

Improving and standardising services, process and technology would reduce the time to hire, and release significant resources, as the traditional hiring manager panel and selection process becomes more efficient. Boards are beginning to identify efficiencies through the recent implementation of JobTrain. However the absence of a consistent Regional approach is a barrier to driving out any real level of efficiency or productivity savings within the existing arrangements. Moving to an optimal model of service delivery will enable a more sustainable and cost effective Recruitment Service to be developed, which in turn will contribute to the overall sustainability of wider NHS Scotland Services.

- **Managing Demand, Function and Capacity**

  The existing service model (6 boards with separate levels of recruitment service) also significantly contributes to the inability to flex capacity to meet peaks in demand with increased vacancies requiring increased staff. Regional recruitment services will build on the work that has already taken place through a **'Once for Scotland'** approach to provide efficient and consistent delivery of functions.

- **East Region Recruitment Transformation Programme Board**

  The NHSS Shared Services Recruitment Strategic Proposal Paper, approved by the Chief Executives Group in June 2018, outlined next steps and recommendations for work to be undertaken on the options of national and regional shared services for recruitment. The East Region Recruitment Transformation Board was established in February 2019, to progress the programme of transformation for the East Region configuration, comprising of the 3 territorial boards within East and 3 national boards. The programme board is responsible for ensuring the East Region Recruitment Transformation programme and its constituent projects achieve the required outcomes. The Programme Board oversees the delivery of the programme, reporting to the National Recruitment Steering Group and National HR Directors on related outcomes, benefits and risks.

  The objectives of the programme board align to the 6 recommendations of the Shared Services Strategic Proposal agreed by NHS Scotland Chief Executives in June 2018 **(Appendix 1).** These recommendations are based on a national recruitment service model delivered regionally, underpinned by a single national recruitment IT system (Jobtrain) and a national standardised process and practice.

1.4 Limitations and variations with existing services

Jobtrain has been fully implemented in the East Region and version updates and continuous improvement is in place to ensure that Jobtrain delivers the best available service to the recruitment service. Similarly, standardised recruitment processes have been developed nationally, for adoption and implementation by local Boards, with services working to the appropriate set of guidelines and model of practice across the recruitment service. However, variations remain between Boards within the East Region Recruitment configuration, both in terms of the degree to which Boards are currently utilizing Jobtrain functionality, and in their application of the national standardised recruitment processes. The East Region Recruitment Service presents an opportunity to reduce variances further and progress service improvement towards delivering a first class recruitment service across the 6 boards.

In terms of Operating Model, there continues to be significant operating variances between recruitment teams across Boards currently in terms of policies and the application of national standardized recruitment processes and adoption of Jobtrain functionality. These variances impact on levels of productivity and the efficiency of recruitment services as follows:

- Performance metrics such as 'time to hire' varies significantly across Boards. This variance is underpinned by differing processes and systems and suggests that that improvement is possible with the right infrastructure and sharing of resources.
- Currently knowledge isn't pooled across Boards or Regions. In some areas there is also limited scope for career progression, inter Board collaboration or developing best practice
- Recruitment staffing across the East region and similarly across Scotland is a mixed model with some Boards having dedicated teams specialising in recruitment where demand determines this is the correct approach and other Boards including recruitment as a component of their generalist HR service. This results in varying levels of expertise and an ill defined career path for recruitment professionals who often have to look outside the service for promotion opportunities.
- Currently each local Board is responsible for marketing themselves to potential candidates, which leads to multiple Boards marketing their opportunities independently through the same media channels and events. This creates confusion for candidates when applying for roles in different areas, is an inefficient use of resources and a missed opportunity to achieve economies of scale.
- Currently there are variances in the levels of data around recruitment services Boards are able to produce to report on internal KPIs and for wider stakeholders including Scottish Government
- Currently there are various approaches and systems in place across the Boards, for handling customer service enquiries, from individual staff phone/email contacts to a system where all enquiries are received via a single contact centre enquiries system to respond triage and manage telephone enquiries or the HR/Recruitment enquiries email box. With the Hiring Manager and existing NHS Scotland candidate guidance held on local Board intranet sites to help manage enquiries through self service.

2. Overview of Recruitment Services

2.1 Recruitment Services in Scotland

Recruitment services are currently provided by 21 NHS Boards on behalf of all 22 NHS Boards in Scotland.

Recruitment services most commonly consist of the following functions: Campaign strategies; advertising vacancies; redeployment searches; receiving applications; shortlisting candidates; confirming interviews/assessments; candidate regret/feedback; issuing and completing interview packs; contract offers; prepare for on boarding. Selective boards recruitment teams also have direct involvement with bank staff and agency staff recruitment.

Traditionally, particularly in relation to medical recruitment, recruitment was a function that was largely carried out by Boards on an individual basis and they did not always have the same working practices, processes and staffing structures. As part of the wider transformation of Recruitment Services, collaborative actions are already in place as part of the move to standardized process, practice and system.

Regionally however, larger Health Boards have dedicated recruitment sections, with staff having this as their sole function. In other areas staff will carry out recruitment activities as one of a number of other functions. There are still significant variances in the levels of recruitment activity carried out by different boards and this is reflected both in the numbers of staff carrying out the function and in the way that function is organised and managed.

2.2 Recruitment Services in the East Region

The East Region Recruitment Services Consortium is currently made up of six Boards: NHS Fife, NHS Lothian, NHS Borders, Healthcare Improvement Scotland (HIS), NHS Education for Scotland (NES) and the Scottish Ambulance Service (SAS).

There are 6 recruitment teams across 10 sites in 5 geographical locations within the East Region Consortium.

Based on the National Recruitment Baseline Data Survey 2018-2019 **(Appendix 2),** the recruitment staffing employed across the East Region Boards was approximately 63 whole time equivalent, with an annual figure of 9417 vacancies, 81190 applications received; 17253 invite to interviews issued, with an average of 50 vacancies filled per recruitment WTE.

2.3 Recruitment Services Demand

Based on the National Recruitment Baseline Data Survey 2018-2019, the figures below show the demand for recruitment services activities across the East Region during that period:

Table 2 Current Demand – East Region

	Activity	No.
Current Demand - East Region	No of Vacancies processed (annually)	9417
	No of Vacancies processed(weekly)	181
	Average Time to Hire (weeks)	17
	Number of vacancies likely to be processed in each time to hire period	3079
	Total WTE required to deliver	63
	Available Annual Capacity (hours)	122850
	Hours taken to deliver each vacancy	13.05

Demand on recruitment services has also increased as a direct result of an increase in the NHS workforce. There have been seven consecutive years of growth and whilst the growth has slowed in recent years (June 2016 0.5%; June 2017 0.6%; June 2018 0.1%), the latest census[1] shows a higher rate of annual growth. At 30 June 2019, there were 163,617 staff employed by NHS Scotland representing an increase of 0.8%, compared with the previous year.

2.4 Recruitment Services Costs

The Baseline costs as at 31st March 2020 (at top end of scale) for recruitment staff are reflected in the table below with a comparison with projected costs for 2021-2022:

[1] NHSScotland Workforce Quarter ending 30 June 2019 - A National Statistics publication for Scotland (NHS National Services Scotland Information Statistics Division, Publication date: 03 September 2019)

Table 3 Recruitment baseline costs

Band	WTE	2020-21	2021-22
2	1.85	49,278	50,819
3	19.41	568,998	586,719
4	17.51	569,411	587,081
5	8.04	283,081	291,844
6	2.75	120,292	123,993
7	1.50	80,947	83,426
8a	0.50	32,765	33,765
8b	0.40	31,632	32,594
ESM B	1.00	91,468	94,246
Total	**52.96**	**1,827,872**	**1,884,486**

The economic and financial case considers the full cost of delivering the Recruitment Service which includes the introduction of Service now and call handling kits, IT equipment along with the use of Microsoft teams and technology to support delivery of the East Region Recruitment Service from across multiple locations.

3. Non-financial Option Appraisal

3.1 Engagement

Non-financial option Discovery and Appraisal workshops were held in April and May 2019 and were attended by a range of staff from across the 6 boards **(Appendix 3).** The key outputs of the workshops were:

- Benefit criteria generation, ranking and weighting
- Risks generation
- Operating model option development (from long list to subsequent shortlisting)
- Scoring the aspects against the agreed benefit criteria

3.2 Benefit Criteria

The sequential workshops were carried out between April and May 2019, where benefits of a regional recruitment model were generated at each local engagement session. The benefits were matched against the national benefit criteria and descriptions, of which the only additional input was to add 'increase and widen candidate talent pool' in the description of Efficiency and Effectiveness in Service Delivery criteria.

Participants agreed the 5 benefit criteria as below:

- Standardise/Simplify and Share
- Finance
- Efficiency and Effectiveness in Service Delivery
- Customer Experience
- Recruitment Staff Experience

The Benefit Criteria was used for scoring an agreed shortlist of service model options at the option appraisal stage **(Appendix 4)** from a list of model options **(Appendix 5).**

3.3 Option Generation

Options for how recruitment services could be set up across the East region were generated using the following principles: option generation should be open, transparent and accessible; initial thinking should lead to a 'long list' of options; people should be encouraged to think creatively; short listing against specified criteria may be required; the shortlist should include the 'status quo' as a benchmark option.

Participants were given a framework to help guide option generation discussions and generated an initial long list of options **(Appendix 6).** The process for option generation is detailed in **Appendix 7**.

3.4 Shortlisted Options

A shortlist of 5 model options generated through the Discovery Workshop were agreed to be taken forward to the non-financial Options Appraisal Workshop.

Table 4 Shortlist of Model Options

	AGREED PROPOSED SHORTLIST OF MODEL OPTIONS
Short List Ref	**Model Option Description**
1	Status Quo (baseline measure)
2	Single Employers, Single Management, Single Location
3	Single Employers, Single Management, Multiple Locations
4	Multiple Employers, Single Management, Single Location
5	Multiple Employers, Single Management, Multiple Locations

At the workshop, participants individually scored each aspect of the model options against the benefit criteria.

Option 4 (Multiple Employers/Single Location) scored the lowest across all five benefit criteria and was also scored the lowest by all Stakeholders. On this basis, the proposal to remove option 4 from further consideration and to progress options 2, 3 and 5 forward to the next stage of the appraisal process was approved by the East Region Recruitment Transformation Programme Board.

4. Risk Assessment

Local engagement sessions were carried out to generate the risks of a regional recruitment model. A formal risk assessment workshop was carried out to score the risks against each shortlisted option and the status quo and the outcomes of this assessment logged **(Appendix 8).**

4.1 Option 1 – Status Quo option

4 key risks were identified with the status quo with 3 scoring High and 1 scoring Very High prior to mitigation. Following mitigation, 3 risks were reduced with 2 scoring High moved to Medium and 1 scoring Very High reduced to High.

High mitigated risks:

- There is a risk that the current service model does not meet the Scottish Government Once for Scotland agenda.
- There is a risk of lack of governance around standardisation.

Potential Impact

Continuing with the Status Quo option will not allow the service to be reactive to a better service. This could lead to a loss of innovation and wider collaborative opportunities. The lack of improvements and investment in electronic processes could pose reputational risks with the service and keeping the status quo would mean non-compliance with the Scottish Government “Once for Scotland” agenda.

4.2 Option 2 – Single Employer, Single Location

6 risks were identified under the single employer, single location option. Prior to mitigation, 2 risks scored Very High, 3 risks scored High and 1 risk scored Medium. Following mitigation, 1 Very High risks was reduced to High, 3 High risks were reduced to Medium, 1 Medium risk reduced to Low and 1 Very High risk remained unchanged.

Very High Risks:

- Financial risks - Single location could be costly and redeployment/relocation to staff could be costly.

High Risks:

- Disruption to existing staff and team.

Potential Impact

Under the single employer, single location option, there is a risk of a loss of direct customer service leading to loss of local knowledge and geographically could present geographical challenges impacting service delivery and a loss of invested candidate interest. It is certain that moving to a single employer, single location will lead to disruption to staff routines with relocation and potential redeployment leading to low staff morale impacting attrition rates. There are financial risks as the cost of a single location is costly as is the high cost of relocation and redeployment of staff and it is unlikely that one existing location could support the new regional recruitment service.

4.3 Option 3 – Single Employer, Multiple Locations option

6 key risks were identified prior to mitigation. 4 Medium risk and 2 High risks. Following mitigation, 1 risk was reduced from High to Medium and 1 risk remained High.

High Risks:

- There is a risk that technology solutions to support any shared service model are not consistently available or resourced.
- There is a risk of uncertainty for those with mixed job roles within a shared regional service.

Potential Impact

Under the single employer, multiple locations option, there are identified risks that a regional shared service on multiple locations could lead to a variance and lack of equity across working processes and practices, workloads, roles and bandings. Potentially, if technology solutions were not available and resourced effectively this could lead to an inability to deliver a shared service across board boundaries. It was identified that a single employer, however, would lead to singular clarity of roles and that effective governance would reduce any variations in interpretations around processes, roles and bandings.

4.4 Option 5 – Multiple Employers, Multiple Locations

7 key risks were identified with Option 3, Multiple employers, Multiple locations. Prior to mitigation there were 5 High risks and 2 Medium risks. Following mitigation, 3 High risks were reduced to Medium status, 2 High risks and 2 Medium risks remained unchanged.

High risks:

- There is a risk that technology solutions to support any shared service model are not consistently available or resourced.
- There is a risk that the governance of tasks will not be controlled.

Potential Impact

Under the multiple employer, multiple location option, there is a risk that there will be a lack of equity across roles and workloads that could lead to conflict of duties. Whilst the new delivery model will clarify roles, it could still lead to a singular way of working at various locations losing sight of workloads and leading to a lack of interpersonal contact between staff. Lack of continued progress towards electronic technology solutions could lead to an inability to deliver a shared regional service.

4.5 Preferred Option – Risk Mitigation

The risks identified for the preferred option Single Employer, Multiple base, have been mitigated and actions logged for implementation considerations in section 7.

4.6 Removal of Single Employer, Single Location Option

During the Covid crisis, the Recruitment services from the 6 boards within the East region moved from physical sites to home working or rota based home/office working. Key challenges were witnessed at the beginning of the pandemic but within a short few weeks the majority of the recruitment services had moved to working effectively from home and have arrangements in place to fully support home based working as opposed to office based working in line with the current Scottish government guidelines. The majority of recruitment activities and tasks are able to be completed remotely and through digital means and this has maximised the efficiencies of the service and increased flexibility in the service for both employees and candidates.

The majority of workers within the recruitment services of each of the 6 boards are able to work from home and able to carry out normal recruitment activities digitally. There is a very minimal requirement for office based staff to attend any physical sites and if this is required it is being carried out on a rota basis in line with social distancing guidelines. Staff have a laptop to carry out electronic recruitment activities, interviews can be held more flexibly and quickly via Microsoft Teams and the previous geographical challenges are no longer present for potential candidates from across the country or from overseas.

Feedback was obtained from the recruitment leads of each board on the approach of each board towards the Covid crisis and analysis carried out. This analysis has produced key opportunities for the East Region Recruitment service to adapt their approach into providing an agile and digitally progressive recruitment service.

The learning and reflections from Covid gathered from the Boards, suggested that the single location model is no longer fit for purpose as an option for the foreseeable future. It is no longer relevant given the 6 boards agile response to the Covid crisis and the ability to provide an efficient service from a remote base rather than a physical office based location for a workforce circa 89 heads.

Further discussions took place during June 2020 with each board's HR Directors to gain feedback and perspective on the validity of the Single location option as a delivery model for the East Region Recruitment services. Consensus from these discussions was conclusive across all boards with each HR Director in agreement that the Single Location option was no longer a practical and viable option and supported the recommendation to remove it from the model options appraisal leaving the 2 remaining options below to be submitted for financial appraisal. This recommendation as subsequently approved by the East Region Recruitment Transformation Programme Board on 16th July 2020.

5. Economic Case

5.1. Monetary Costs and Benefits

Costs have been valued on an opportunity cost basis at current market prices[2]. A whole life costing approach has been applied when considering the costs and benefits relevant to the options. Sunk costs have been excluded from the economic appraisal[3]. The total cost approach has been adopted for this appraisal, as recommended by Scottish Government guidance[4].

Costs are net of VAT and subsidies. The standard discount rate of 3.5% has been applied.

The costs produced have then been used to produce the economic costs for each option and determine value for money. These will be incorporated in the cost-benefit analysis to determine the preferred option, and the financial costs for use in the affordability analysis. Finally, a sensitivity exercise was undertaken to identify possible risks in terms of potential variability of identified costs.

5.2. Short listed Options for Costing

The costs included within the financial appraisal are inclusive of VAT, subsidies and other indirect costs. This is required to demonstrate the affordability of the options.

A long list of options was identified as part of the non-financial option appraisal stage in the programme. The following options were then subsequently short listed and subject to an indicative costing exercise:

Scenario	Description
Status Quo / Do Nothing	Multiple employers Multiple bases
Option 1	Existing staffing structure

[2] Opportunity costs are the valuation of assets based on the higher of the best value that could be obtained for its current use and the most valuable feasible alternative use.
[3] Sunk costs are costs which have already been incurred and are irrevocably committed.
[4] The total cost approach concerns the total resource consequences of all options (including option 1 – do nothing).

Option 2	Single employer Multiple bases – retain existing bases Proposed new staffing model
Option 3	Multiple employers Multiple bases – retain existing bases Proposed new staffing model

5.3. Proposed New Staffing Model

A proposed new staffing model has been agreed by the East Recruitment Programme Board the required posts and staffing numbers have been identified. The new staffing model has been agreed and the required posts and staffing numbers identified using a capacity and demand framework (**Appendix 9).** It should be noted that the proposed staffing model is a 'Day One' staffing model following an Organisational Change process that will be the responsibility of the Single Employer. A maturity model approach is proposed that is likely to lead to changes to staffing in future years.

Band	Existing WTE	Proposed WTE	WTE Movement	Existing Model 2021-22 Cost	Proposed Model 2021-22 Cost	Cost Movement
Band 2	1.85	0	↓ 1.85	50,819	-	↓ 50,819
Band 3	19.41	4.43	↓ 14.98	586,719	133,909	↓ 452,811
Band 4	17.51	34.42	↑16.91	587,081	1,154,045	↑566,964
Band 5	8.04	6	↓2.04	291,844	217,794	↓ 74,050
Band 6	2.75	2	↓0.75	123,993	90,176	↓ 33,816
Band 7	1.5	2	↑0.5	83,426	111,235	↑27,809
Band 8a	0.5	1	↑0.5	33,765	67,530	↑ 33,765
Band 8b	0.4	0	↓0.4	32,594	0	↓ 32,594
Exec & Senior Manager B – *(similar to proposed costed at AFC B8c)*	1	1	No change	94,246	94,246	No change
Total	**52.96**	**50.85**	**↓ 2.11**	**1,884,486**	**1,868,934**	**↓ 15,552**

5.4. Economic Analysis

Option	Equivalent Annual Charge (£)
Option 1 Status Quo	2,063,793
Option 2 Single employer, multiple bases, new staffing model	2,096,488
Option 3 Multiple employers, multiple bases, new staffing model	2,096,488

The table above shows that, in terms of pure economic cost, **Option1** is the most affordable options. However these options have been subject to an economic appraisal which considers the overall value for money of each option. The results are presented in section 6 below.

The additional cost associated with options 2 and 3 is mainly driven by potential salary protection entitlements included within the costs. These are discussed in further detail in **Appendix 10 - Costing Assumptions and Methodology, Section 4.2.** Removal of these costs would result in the Equivalent Annual Charge for options 2 and 3 reducing to £2,050,361 which would result in both options being more affordable than option 1. The salary protection payments included in the costing have been costed as 'worst case' scenario. The costing assumes all potential salary protection payments would be incurred recurrently throughout the entire costing period. In reality, a number of the Boards current staffing compliments are made up of roles with responsibility for a mix of both in and out of scope recruitment/HR related activities. As such, it is potentially possible that an element of resource transfer may be a financial rather than staff, which may impact on the estimated protection costings. However, this would be dependent upon individual circumstances and Board discussion with minimal impact on staff, recognising too that the workforce position is likely to remain fluid until transition. In circumstances of redeployment, the employer would seek to redeploy affected staff members into another role as part of the organisational change process.

5.5. Economic Appraisal

The economic appraisal considers the benefits, costs and risks of the shortlisted options to inform a value for money assessment and arrive at a rank order of the options in terms of value for money.

The economic appraisal is shown in the table below:

Option	BENEFITS	COSTS	Costs per Benefit	Costs per Benefit	RISK	Costs per Benefit	RISK
	Weighted Benefit Score	Equivalent Annual Charge	£000 / Points	Rank Order (lowest cost per benefit first)	Median risk quotient	% of Total	% of Total
	Points	(£)	(£)			%	%
Option 1 Do nothing (status quo)	490	2,063,793	4,212	3	11	56	44
Option 2 Single employer, multiple sites, new staffing model	1,324	2,096,488	1,583	1	5	21	20
Option 3 Single employer, single site, new staffing model assumed 50% Fife & FV attrition rate	1,209	2,096,488	1,734	2	9	23	36

The above identifies that the preferred option which optimises value for money is **Option 2 - Single employer, multiple sites, and new staffing model**. The equivalent annual charge for options 2 and 3, as in no material difference in cost has been identified between a single employer and multiple employers. However, different benefits scores have impacted the value for money assessment.

5.6. Sensitivity Analysis

The sensitivity analysis was undertaken using the 'switching values' approach. This 'what if' scenario indicates how much a variable would have to change to impact upon the choice of the preferred option.

- As shown in the economic appraisal table above, **Option 2** has been given the highest rank order in terms of cost per benefit. In order to test the sensitivity of this outcome, analysis has been performed to determine the increase in costs or decrease in benefits which would be required to amend the rank order of the options.
- The cost per benefit of Option 2 would have to increase by a minimum of 10% before the rank order would change with Option 3 becoming the higher ranking option. However, it would have to increase by a minimum of 166% to result in Option 1 (the status quo) becoming a higher ranked option. This shows that, in terms of cost, the options are not very sensitive to fluctuation.
- The benefits gained from Option 2 would have to decrease by a minimum of 9% before the rank order is changed to favour Option 3. This suggests that the benefit scores for options 2 and 3 are somewhat sensitive to fluctuation. However, the benefits gained from

Option 2 would need to decrease by 63% to result in Option 1 (Status Quo) becoming a higher ranked option. The represents a large decrease and shows that, in terms of benefits, the option is not very sensitive to fluctuation.

5.7. Preferred Option

The preferred option has therefore been identified as **Option 2 - Single employer, multiple sites, and new staffing model**. The economic appraisal shows that this option is the higher ranking option based on benefits versus expenditure. It also carries a medium risk profile. The sensitivity analysis has demonstrated that this option is not very sensitive to fluctuation in terms of cost and benefits.

6. Financial Case

The Financial Case

A full financial appraisal of all short listed options has been undertaken to determine the anticipated costs associated with implementation. This section is not concerned with the theoretical cost indicators used in the economic appraisal, but with actual forecast costs, including VAT, and their affordability in relation to the funding streams likely to be available.

1. Non Recurring Revenue Costs

Option	2021/22	2022/23	2023/24	2024/25	2024/25	Total
Option 1	-	-	-	-	-	**-**
Option 2	100,000	-	-	-	-	**100,000**
Option 3	100,000	-	-	-	-	**100,000**

2. Recurring Revenue Costs

Option	2021/22	2022/23	2023/24	2024/25	2024/25	Total

Option 1	1,955,779	2,009,507	2,069,997	2,132,301	2,196,474	**10,364,058**
Option 2	1,969,867	2,023,984	2,084,874	2,147,592	2,212,190	**10,438,508**
Option 3	1,969,867	2,023,984	2,084,874	2,147,592	2,212,190	**10,438,508**

The recurring revenue costs for options 2 and 3 include provision for salary protection payments. It is assumed that the full entitlement will be required throughout the five financial years costed to reflect the 'worst case' scenario. As staff members will progress and leave the recruitment service, these costs will reduce over time and will result in options 2 and 3 being more affordable than option 1. This is illustrated in the table below with reference to financial year 2024/25.

Option	Total Cost 2024/25	Less: Salary Protection Payments	Revised Cost 2024/25
Option 1	2,196,474	-	2,196,474
Option 2	2,212,190	(49,070)	2,163,120
Option 3	2,212,190	(49,070)	2,163,120

3. Assumptions

Detailed costing assumptions and costing methodologies are included in **Appendix 10- Costing Assumptions and Methodology.**

7. Preferred option – 'Day One' Proposed Service Model

This section of the Business Case outlines the service model that has been developed following staff engagement and demand and capacity modelling.

It is recognised that it is a 'Day One' service model i.e. the model that would be implemented following TUPE transfer of staff and as part of the subsequent organisational change process.

The Single Employer will be responsible for developing a full Target Operating Model (see **Appendix 11** for a potential framework); for supporting the service to embed and implementing any associated longer term changes (see Section 8 for potential opportunities).

7.1 Proposed Service Model Overview

The table below provides an overview of the 'Day One' service model.

Table 5 'Day One' Service Model

Aspect	Description
Boards in scope	• Three territorial Boards: NHS Borders, NHS Fife, NHS Lothian • Three national Boards: NHS Education for Scotland; Healthcare Improvement Scotland; Scottish Ambulance Service
Employer Status	• Single Employer for Recruitment Services Staff
Reporting Line	• Within the Human Resources Directorate of the Single Employer Board • Formal Service Level Agreements (SLA) established with remaining Boards • Principle of equitable service to all Boards
Recruitment Functions	• In scope: Recruitment Services • Out of scope: Agency Temporary workers recruitment for SAS, NHS

	Borders, Lothian, Fife, Staff bank recruitment for HIS, SAS, NES, NHS Lothian and Fife. Application of psychometric and online testing for ALL boards and active participation in assessment centres.
Structure Overview	• Single management structure • Customer Service • Processing Function • Bespoke Function
High Level Process Flow	• Processes to be electronic where possible • Information flow into recruitment service from JOBTRAIN system • Recruitment services enquiries to be managed by recommended service provider Service Now • Hybrid model of individual and team allocation of activity • Peer based checking where appropriate • Lead checking for more complex activity
Location	• The service model to operate from existing multiple bases.

Phased Approach

The focus of the bespoke service is relationship management between the east region recruitment service and boards in the east region. Provide customer with specialised advice and support which could include campaign, marketing and bulk/cohort recruitment. It is clear from discussion and feedback obtained from each board that there are different approaches towards bespoke recruitment services with varying complexities and activities involved in delivering bespoke recruitment across each board. In particular, each board has variances in the departments that carry out assessment centre activities and psychometric testing and the levels of resources involved in the process. There is also varying practice across the boards in terms of the current application of values based recruitment. It is essential that further assessment and evaluation on bespoke services takes place within phase one to enable the regional recruitment service to build initial relationships with Hiring managers to support and better understand, reflect upon and build on the needs and requirements of a future bespoke service for all boards. It is anticipated that phase 1 will last up to 12-18 months.

7.2 Service Model Structure

The proposed service model has a Single management structure sitting within the Human Resources Directorate of the Single Employer. The structure below the management team consists of a Service wide enquiry management helpdesk service function though existing enquiry methods with the expectation that an online helpdesk enquiry function, such as Service Now will be introduced during phase 1.

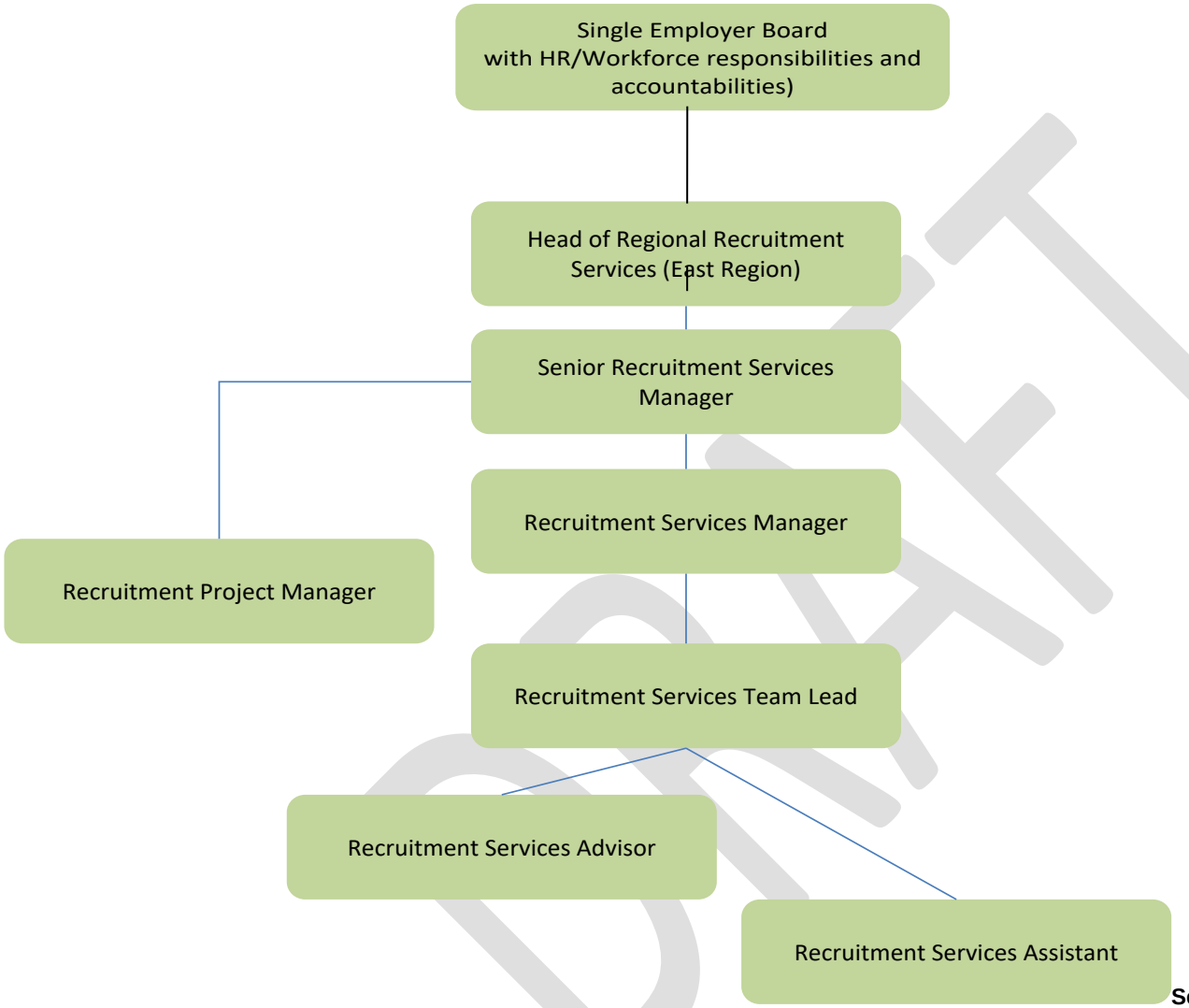

Figure1 **Service Model Structure**

A brief summary of descriptions for all projected roles and bandings are detailed in **Appendix 12**.

7.3 Recruitment Service Function and Activities

Recruitment Service Functions
The proposed East Region Recruitment Service would consist of the following three functions:

- **Service Management**
  The service management function is responsible for the corporate governance, performance and strategic management of the Regional Recruitment Services. It will provide leadership and operational direction for the recruitment service ensuring an efficient and effective and customer focus service delivery. Create a culture of continuous learning and improvement, customer focus and service excellence within the Regional Recruitment Services Team

- **Bespoke Service**
  The focus of the bespoke service is relationship management between the east region recruitment service and boards in the east region. Provide customer with specialised advice and support which could include campaign, marketing and bulk/cohort recruitment. Support the development of continuous learning and improvement, customer focus and service excellence within the Regional Recruitment Services Team. Manage the delivery of service improvement.

- **Recruitment Customer Service**
  The service provides recruitment advice and solutions to service users on the range of recruitment process and procedures in addition to undertaking the day to day transaction of end to end recruitment process

It is expected that the Single employer will put into place a robust business continuity plan to safeguard the recruitment service functions and activities following implementation of the East region recruitment service. Following the recent Covid 19 pandemic where recruitment services were subject to major changes in it's approach to meet recruitment services in a high speed and uncertain environment, analysis was carried out to assess the impact on the current service and to gain insight into future opportunities into what benefits the East Region recruitment service could incorporate in the future. Details of the analysis can be viewed in **Appendix 13.**

7.4 Staffing Levels and Roles

Service demand and capacity modeling has been undertaken and the following staffing levels proposed as part of the ‘Day One’ model.

Table 6 Required Staff Structure

Role	Proposed Structure
(B3) Customer Service Assistants	4.43
(B4) Customer Service Advisors	34.42
(B5) Customer Service Team Leads (Reporting to Band 7 - span: 1 in 7)	6
(B6) Project Managers (Reporting to 8a)	2
(B7) *Service Managers (reporting to Band 8a - Span: 1 in 3)	2
(B8A) *Senior Service Managers (Span: 1 in 3)	1
Head of Recruitment	1
Total (based on 9417 vacancies)	50.86

Activity to develop draft job descriptions has enabled indicative bands to be assigned. It is planned to further develop the proposed job descriptions prior to TUPE transfer which will act as a strong foundation for the Single Employer to build on.

7.5 Process Flow

- **Long Term Vision**

The long term vision for the regional recruitment service is to support customer enquiry handling through an online enquiry helpdesk facility, to be able to respond accurately and timeously to enquiries without the need for escalation. It is expected this online enquiry platform will primarily replace the current telephone and email enquiry systems. This has the potential to reduce the resource time required for enquiry handling and support a more equitable workload distribution enabling staff work through enquiries digitally from receipt to completion. Service Now as the proposed new system, has been considered and whilst scoping is at a relatively early stage, it has the potential to support the long term vision. Initial costing and recommendations for online platform Service Now can be viewed in **Appendix 14**.

The vision is described through the following design principles:

- **Key Design Principles of the Operating Model**

1. Customers and how we serve them are at the heart of what we do and how we do business
    - Emphasis on the candidate's journey and the Recruitment Service responsibilities around this
    - Recruitment service provision is clear, easily accessible & transparent to users
    - Provides a consistent customer recruitment experience within the East Region and across the Regional Recruitment Services

2. Provide a centre of excellence, where functions will be easy to do business with and customer journeys are fluid.
    - Centre of excellence, providing expertise within the field of recruitment
    - Pro-active liaising with workforce planning & service management to plan for capacity and demand
    - Transparent recruitment process

3. Agile and adaptable service
    - A stable, resilient, responsive and pro-active service, to support the needs of both the business and the customer
    - An employer of choice for recruitment service staff, with an emphasis on staff retention and service resilience
    - Embraces change and practices continuous quality improvement.
    - Enhances the users experience through close collaboration with service partners and shared learning across the regional recruitment service

- Proactive use of available technologies, to support and develop smarter recruitment practice and processes

4. Optimal delivery model enables a more sustainable and cost effective recruitment service to be delivered.
   - Be clear about the services offered by the East Region Recruitment Service
   - Unnecessary complexity and duplication is removed
   - Maximise the increased 'purchase and branding power' of the collective Boards within the East Region Recruitment Service

- **Hybrid Model**

A hybrid model would be adopted in relation to process flow as part of a 'Day One' model. On 'Day One', recruitment activity would be processed as it is currently. A service improvement approach (e.g. process mapping, tests of change) would be applied to establish how recruitment processing (shared work pool) could apply to regional recruitment processing at scale.

- **Training and Support**

The service model includes dedicated staff with recruitment knowledge and training expertise to be able to support service improvement, internal staff and customer training and education.

7.6 Service Location

Single Employer, Multiple Location - On 'Day One', the service would continue to be based in existing bases: Edinburgh (Gyle Square, West Port and Waverley Gate), Falkirk, Livingston, Kirkcaldy, Dundee and Melrose. In the future, it is anticipated that the Single Employer will monitor and review the benefits and risks of delivering the service from existing multiple locations on an ongoing basis from a quality and service improvement perspective.

7.7 Delivering the Benefit Criteria

The assessment of the high level shortlisted options against the non-financial benefit criteria (Section 3) highlights the benefits of a Single Employer, Multiple Base option. The subsequent service model outlined in this section has also been qualitatively assessed in relation to its potential to deliver against the benefit criteria (see table below).

It is recognised that benefits realisation is dependent on an implementation phase that is planned and fully resourced and that takes account of wider considerations (see Section 12 for more detail). It should also be noted that although it is anticipated that the service model will deliver economies of scale, these will take time and will require service improvement activity.

Table 7 Service Model Benefits

Benefit Criteria	Description
Standardise/Simplify and Share	• One NHS Scotland brand – promoting and marketing NHS Scotland as a world class exemplar employer that can hone campaigns to suit either local/national/speciality etc. on a Once for Scotland basis. • Once for Scotland i.e. Vision, National policy, process, IT system, data set, and SOPs for NHS Scotland recruitment promoting equity, effectiveness and branding of NHS Scotland as a world class employer • One collective HR resource - targeting the full weight of NHS Scotland's recruitment service where and when it is needed to optimise the service to customers, whether these are Boards, service users or applicants • Combined HR expertise, knowledge and skill leading to increased development and implementation of best practice across Scotland • Sustainable and resilient model of delivering an exemplar HR recruitment service. • Create a dedicated National Recruitment Service function with its own identity, which can optimise economies of scale and has an excellent customer care ethos with a primary focus on service quality

Finance	• Move to the National Recruitment Service results in resource related financial saving in terms of both the time to hire, and the cost of recruitment events. • The enhanced quality improvements and efficiency releases staffing resources, to include hiring managers' time, which could be redirected to other areas of NHS activity. • Move to the National Recruitment Service results in non-labour related financial savings e.g. advertising/marketing/IT

Efficiency and Effectiveness in Service Delivery	• Absolute Clarity: Rights, responsibilities and expectations of Boards/service users and the National Recruitment Service are clearly and consistently defined. • Service evolves to become a singular dedicated professional entity for recruitment on behalf of NHS Scotland. • Enhanced reporting and analytical capability, enabling improved performance management with KPIs and targets focussed on achieving value for money and customer satisfaction. • Service performance both improves against baseline and becomes more consistent, moving away from current high levels of variation across Scotland • Enhanced efficiency reduces duplication, streamlines and improves the quality, speed and cost of hiring. • Increased efficiency in the structure for managing recruitment across Scotland enabling Boards to focus on more effective local delivery of front line services • Increased collaboration between Boards to enhance innovation and encourage continuous improvement • National Recruitment Service transformation improves recruitment in “Difficult to recruit” specialties / occupations/areas across Scotland. • Increased and widen candidate talent pool.

Customer Experience	• One stop shop service that provides streamlined end to end recruitment and on boarding service to Managers. • Enhanced level of customer service to the hiring manager from the National Recruitment Service, to deliver the best services on a consistent basis across Scotland • Access to Centres of Excellence providing high level advice, guidance, and expertise to all service users across NHS Scotland • Easier to apply for posts e.g. One application form required for multiple posts across NHS Scotland • Slicker, more efficient and bespoke targeted service that attracts high calibre applicants to the NHS Scotland • The recruitment experience is enjoyable for applicants and our reputation is enhanced with positive downstream implications for staff retention
Recruitment Staff Experience	• Increased scale of new shared service creates increased potential for career structure and development in a shared service centre • Staff develop new skills and expertise in implementing the new service • Staff work more collaboratively to enable once for Scotland solutions on a continuous improvement basis.

8. Next Steps– Potential Opportunities

Prospective Employer Boards will be asked to informally state their vision for recruitment services in the East region and outline how they will realise the potential non-financial benefits as well as any financial benefits or implications as a result of moving to a shared service model.

8.3 Introduction of Jobtrain

All East Regions are live with Jobtrain and this is now a BAU process. Version 7 upgrade work is underway, although paused due to Covid-19, with an expected delivery date in July 2020. Training will be rolled out across all boards in relation to on-boarding/updated contracts and learning is being shared regularly through the appropriate channels.

A recent Jobtrain survey was carried out and the feedback is being reviewed and themed by the National Team. Additional benefits will be realized in due course as the system updates evolve and user knowledge increases. A regional lead role for the purposes of supporting the implementation roll out of Jobtrain across East, was introduced to support the transformation programme. This has worked well and provides the opportunity to consider such a role going forward as part of Jobtrain 'Business as Usual' systems arrangement and relationship with the East Region Recruitment Service.

8.4 Sharing Best Practice

Becoming a regional service will present opportunities to share existing workforce knowledge and expertise. Across the 6 boards there is a wealth of knowledge and skills, particularly in the area of bespoke and values based recruitment which with further evaluation could provide added value to a regional recruitment service.

8.5 Workforce Redesign

The service model has 7 Recruitment positions and indicative bandings have been evaluated through matching and consistency panels.

There is also the introduction of a Recruitment Project Manager post. It is envisaged that the Recruitment Project Manager will support the Senior Recruitment Services Manager with the delivery and implementation of agreed quality improvement and test for change projects across the Regional Recruitment Services.

There is the potential to consider further skill mix redesign as the recruitment role job descriptions continue to develop.

8.6 Standardisation

Standardisation is currently in place across the East Region boards and the regional recruitment service presents opportunities to continue work to reduce any existing variations across boards working to the “Once for Scotland” recommendations of the National Recruitment Strategic Proposal as agreed by Chief Executives and HR Directors.

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9. Integrated Impact Assessment

A full integrated Impact assessment (IIA) was carried out prior to implementation and put forward to the East Region Recruitment programme board for approval.

Whilst the importance of recruitment services is recognised, the proposed changes in the preferred option do not impact on patients and the general public due to the ‘back office’ nature of recruitment services.

The main change will be a move from six employers to a Single employer for recruitment services staff in NHS Fife, NHS Borders, NHS Lothian, NHS Health Improvement Scotland (HIS), National Education Scotland (NES) and the Scottish Ambulance Service (SAS).

The IIA looked at the impact the proposed model would have on following three areas.

- **Equality, Health and Wellbeing and Human Rights**
- **Environment and Sustainability**
- **Economic**

It is acknowledged that the Single Employer will be responsible for mitigating any negative impacts and enhancing positive impacts that may arise as the proposals are further developed. It is recommended that the Single Employer undertakes a further IIA at the appropriate time.

10. Communication and Engagement

Stakeholder communication and engagement has been key to achieving a high degree of consensus in designing and agreeing the preferred option and the detailed service model within the Business Case.

10.1 Consortium Staff Engagement Sessions

Early local board engagement sessions were held to give staff the opportunity to ask questions or raise any concerns they may have. The sessions were well attended. A communications strategy and communications action plan was developed following the engagement sessions (**Appendix 15).**

10.2 Workshop Participation

Along with Programme board members, recruitment services staff representatives participated in the non-financial option Discovery workshop prior to the non-financial Appraisal workshop. To ensure all staff were kept informed and had the opportunity to contribute, local staff sessions were also held with recruitment teams prior to the workshops and a written update was shared with all recruitment services staff after each workshop. Recruitment representatives have also been involved in appraisal design sessions held to develop the details of the proposed service model.

10.3 Staff Side Engagement

Staff side engagement has taken place through the East Region Programme board and 4 staff side representatives from across 4 boards (NHS Lothian, NHS Fife, NHS Borders & NES) participated in the non-financial option Discover and Appraisal workshops. Staff side representatives were also present at the risk workshop and Integrated impact Assessment and have also been engaged through local board communications governance and updates on the transformation programme.

10.4 Programme Updates

The East Region Consortium Board Directors of Finance, HR Directors and Employee Directors have been kept informed throughout the process with written updates provided regularly; more detailed information has also been distributed at key milestones.

Regular written updates and a quarterly newsletter have also been shared with the East Region Transformation Programme Board and appropriate East Region groups.

10.5 Customer Feedback

Wider customer feedback was gained through stakeholder participation at engagement and workshop sessions. This has provided an insight into what is important to staff who regularly use recruitment services and will help provide the start of a baseline to build on.

10.6 Future Engagement

Ongoing communication and engagement will be critical to support the next phase of the programme. It is imperative that staff, staff side representatives and all local boards feel involved, are appropriately supported and communicated with throughout the transition to a regional service. It is recognized that the transition may present challenges for people as the transition to a regional service moves forward and a robust change plan including future engagement for staff will be created to support leaders taking their people through change. To fully engage the majority of stakeholders, a variety of mediums will be used to engage staff keeping in line with all board's common values and behaviours. Planned activities for staff engagement that have either commenced or will be due to commence include:

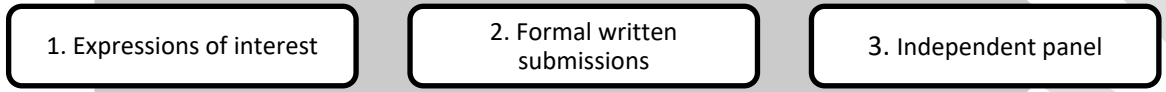
- Distribution of Quarterly Newsletter
- Newsletter Engagement survey
- Organisational Development (OD) sessions with Consortium Project Board and recruitment managers and staff
- Accessible online portal for staff to access key programme information & materials to support change and transition
- Q and A factsheets - regularly reviewed and updated
- Regular sessions with Recruitment leads to share learning experiences through the transitional period and to share feedback and best practice in methods to support staff
- Face to Face sessions when practible and permissible

11. Single Employer Decision

This section outlines the Single Employer decision-making process – a key aspect of the preferred option.

11.1 Overview of Process

The flowchart below outlines the three main stages that will be followed to decide on the Single Employer:



The process will be underpinned by the following principles:

- Transparent and sufficiently robust to be able to stand up to scrutiny
- Not led by any of the East Region member Boards
- Allows sufficient time for interested parties to participate

11.2 Expressions of Interest

Expressions of Interest will be sought by the Chair of the East Region Recruitment Transformation Programme Board (Senior Responsible Owner) and submitted to the Directors of Human Resources for each of the East region member Boards asking for their formal position in relation to initial expressions of interest in becoming the Single Employer.

11.3 Formal Submissions

The Board or Boards that express an interest will be asked to submit a formal application using a standard template based on agreed Single Employer Responsibilities.

11.4 Independent Panel

An independent panel will convene to review the formal submissions received. The review will take the form of a Board presentation followed by a question and answer session by the panel. Submissions will be formally assessed using an agreed methodology.

It is anticipated the panel will consist of members that are independent, experienced and senior within their field of expertise and do not include individuals from within the East Region Recruitment boards. The exception to this may be in the event that only 1 board submits interest where discussions will take place with all boards on the panel formation.

12. Implementation Considerations

Subject to Business Case approval, the following aspects will require due consideration as part of the implementation phase.

12.1 Transfer of Undertakings Protection of Employment Regulations 2006 (TUPE)

As a result of the Single Employer aspect of the preferred option, recruitment staff employed in the other NHS Boards in scope will transfer to the NHS Board that has been selected as the Single Employer. This transfer will be enacted in accordance with the Transfer of Undertakings (Protection of Employment) Regulations 2006 (updated in 2014). This means that the staff will transfer to the single employer on their existing terms and conditions of employment and continuous NHS service record.

In accordance with TUPE, this will require a Formal Consultation process to be undertaken within each impacted NHS Board to agree transfer arrangements

12.2 Implementation of the New Model of Service Delivery and New Organisational Structure

Following confirmation of the Single Employer, transition to the new model of service delivery for the East Region Recruitment Service and organisational change process will commence.

12.3 Conditions for Change

One of the most important implementation considerations is creating the conditions for change by developing, resourcing and implementing a robust change management plan to be able to fully realise the agreed benefits.

This is anticipated to include an assessment of the readiness for change (at an individual and service level) as well as support for the service to develop a shared vision; common values and behaviours; strong leadership and informed and engaged staff.

All change activities will be carried out in line with organisational policy on change management and the Staff Governance Standard.

12.4 Workforce Planning

As part of the development of the Business Case, workforce planning for the service model commenced using the Scottish Government 6 steps workforce planning methodology[5].

The completion of this process will help to support the identification of workforce requirements; workforce gap analysis and a subsequent action plan which will include staff training and development.

12.5 Process Standardisation

Embedding of Process standardisation of recruitment processes and practice will continue across the service, supported by continuous service improvement expertise, to reach agreement in relation to best practice and the development of associated service standards.

Priority within the East region will be in embedding shared best practice and knowledge of process standardization and maintaining comparison and consistency with other regions. There will be a Recruitment Operational forum in place nationally to take this forward and appropriate governance around this. Representatives from the East Region Recruitment Service will be part of the Operational forum to ensure continuous improvement moves forward.

[5] http://www.knowledge.scot.nhs.uk/workforceplanning/resources/six-steps-methodology.aspx

12.6 Technology

The service model is based on the assumption that information will flow into the service through existing enquiry platforms and the introduction of a new online platform with Service Now during phase 1. All boards have implemented Jobtrain and this system will continue to develop with an updated version 7 soon to be introduced and additional functionality planned for Jobtrain to continue to improve the quality and efficiency of recruitment services.

Analysis was carried out into the recommended online platform Service Now and consultation made with NSS as provider of Service Now, for indicative costing of the service and demonstration. Further exploration and feedback was sought from existing boards using Service now (ehealth, NHS Lanarkshire) to gain a full rounded view of the service including benefits and challenges.

Currently, the Covid-10 pandemic has resulted in the recruitment services across all boards delivering their services remotely and virtually using laptop equipment and accessories. An assumption of the costs of necessary user equipment and maintenance of this equipment and accessories has been made as part of the financial appraisal. Actual projected costings for individual equipment has been sourced and can be viewed in **Appendix 16**. It should be noted that these costs would still be required outwith a regional service model should the current distancing guidelines continue for the longer term.

12.7 Information Governance

Data sharing and data transfer arrangements will be required to support the development and implementation of a shared service model.

12.8 Benefits Realisation and Management

A measurement framework will need to be developed prior to TUPE transfer to ensure there is comprehensive baseline data to support and monitor benefits realisation and management.

This will include a combination of qualitative and quantitative process, outcome and balancing measures drawing from staff imatter surveys; customer feedback; national baseline data; further demand and capacity modeling and East workforce data analysis.

13. Appendices

List of Appendices

1	Extract from Original document - 6 Recommendations of the Shared Services Strategic Proposal agreed by NHS Scotland Chief Executives
2	National Baseline Data 2019
3	List of Attendees at Options and Discovery Appraisals workshops
4	Non-Financial Benefit Criteria
5	List of Model Options
6	Initial Long List of Options
7	Scoring Rationale & Options Generation against Benefit Criteria
8	Risk Workshop Outcomes
9	Capacity and Demand Framework
10	Costing Assumptions and Methodology
11	Target Operating Model Example
12	Summary of Job Descriptions
13	Covid summary and analysis
14	Costing for Online services
15	Communications Plan
16	Technology & Equipment Costing

Extract from original document: NHS Scotland Shared Services Recruitment – Strategic Proposal Paper (12th June 2018)

Recommendations - Shared Services Strategic Proposal agreed by NHS Scotland Chief Executives in June 2018

- **Key recommendations**

Based on stakeholder engagement and the work undertaken by the Recruitment Shared Services Development Group, a number of key recommendations have been developed for a future NHS Scotland Recruitment service:

Recommendation 1: Regional service design and delivery

There is firm support across NHSScotland for a regional approach to development of a shared service in recruitment as evidenced by the stakeholder workshops. The regional models will align to the existing structures of each of the 3 territorial regions plus the inclusion of National Boards to the most appropriate region or regions for them.

A number of National Boards have intimated that their preference is to align to one main territorial region based on geography. However, other National Boards have advised that they would wish to have more detail on the scope, nature and services that the regional models will provide before coming to a definitive view.

Outcomes expected:

Regional models will be developed for recruitment service delivery which take cognisance of the recommendations of this report and ensure a best fit to the strategic intent of both the Regional Delivery Plan it supports and other relevant strategies and plans.

Statement of intent/ Design principles:

- Customers and how we serve them should be at the heart of all change
- Functions will be easy to do business with and customer journeys will be more fluid
- Un-necessary complexity and duplication will be removed, while maximising collaboration throughout.

- Our staff, Unions, customers and stakeholders will be involved in the design of services to maximise the viability of services
- Recommendations in this report will be contained in the service design
- Digital technology will be embraced
- Financial frameworks should align with section 3
- As a minimum the baseline data referred to in section 2.4 should be refreshed to current year.
-

Strategic problems addressed and benefits:

- Supports the regionalisation agenda and Regional Development Plans.
- Sharing recruitment services on regional basis will allow sharing of expertise, experience and allow workload to be shared across recruitment teams to address strategic workforce issues.
- Improved alignment of workforce, service and financial plans
- Better service planning over a longer timescale, and better intelligence about future demand to help meet need
- Improved user experience and better collaboration

Scalability: Regional

Recommendation 2: 'Once for Scotland' Infrastructure

Description: Implementation of a National Recruitment IT product to replace iRec which designed on a National 'Once for Scotland' basis and implemented and managed on a Regional basis.

Implementation of National or Regional IT solutions for an IT portal and telephony systems which will provide call logging and reporting facilities, and a customer enquiry system which will log, report on and monitor the progress of workflows. Ideally these facilities would all be in place at inception of a recruitment shared service in any region. These recommendations have been raised at the Business Systems Strategy Group under the consideration of a wider HR Service, and have been recommended that these are implemented on a Regional basis; however we would recommend that common processes and knowledge around these are shared nationally for consistency of service delivery.

Outcomes expected:

NHS Scotland's recruitment service will transform its IT systems, using modern digital delivery, in order to encourage automation, self-service and collaboration, provide better access to a single source of data and analytics, improve user experience and reduce time spent on administration; freeing-up staff to focus on value-adding activities.

Economies of scale will be found by purchasing portal, telephony and CRM systems only once for Scotland or where this is not viable once per region.

Statement of intent/ Design Principles:

- Use the latest methods and technology to improve outcomes
- Processes and workflows will be automated where possible
- Standard products with customisation agreed nationally
- Consistency across technologies will be implemented where possible to provide seamless experience for customers across NHSScotland.
- Common standards and protocols will be applied on a 'Once for Scotland' basis

Strategic problems addressed and benefits:

- Better value
- Clear ownership of systems
- Improvements in data quality and accessibility
- Efficiencies in processing & reporting
- Automated workflows leading to more reliable KPI information
- Consistent hiring managers and candidate experience across NHSScotland
- Using consistent technologies and processes will enable Recruitment staff to have improved opportunities for career progression, and an ability to move easily between areas.
-

Scalability: National

<u>Recommendation 3:</u> 'Once for Scotland' Standardisation

Description: Implementation of standard processes, policies and documentation across NHSScotland's recruitment service.

Work to develop standardised recruitment processes is currently being conducted nationally through the Recruitment Shared Services Standardisation Group. There is a symbiotic link between the development of common processes and the implementation of the national recruitment IT system therefore it is recommended that both these workstreams should continue at a National level and be brought together.

Outcomes expected:

- A consistent approach to recruitment service delivery across NHS Scotland
- Streamlined replicable processes which are aligned to the new recruitment IT solution
- An consistent customer experience of recruitment across NHS Scotland

Statement of intent/ Design Principles:

- Standardisation applies across our systems, standards and processes
- Standardised processes will be designed for the future with best practice and the customer at the heart with customisation at National level only. Accountabilities, ownership and outcomes with personal responsibilities will be clearly defined
- The work should build upon the Recruitment Standardisation Groups agreed work plan which is appended at **Appendix 11**. The work undertaken was based on the high level process maps developed for a recruitment shared service by the HR Recruitment Shared Services Development and National IT System Group which should also be considered a key design principle and are attached in **Appendix 8.**
-

Strategic problems addressed and benefits:

- Process variances across Boards reduced
- Enhanced knowledge sharing and continuous improvement
- Consistent customer experience
- Enhanced collaboration to address challenges and wider strategic issues
- Improved efficiency and performance
- Reductions in end to end processes
- Ability for staff to work across boundaries as processes and policies are consistent
-

Scalability: National

Recommendation 4: 'Once for Scotland' Reporting & performance metrics

Description: Implementation of a Nationally agreed set of performance measurement metrics for the NHS Scotland recruitment service which is real time, consistent and reliable. Currently there is limited standardisation in the data collected and performance metrics used in each Board. This is limited mostly by recruitment IT systems available.

Outcomes expected: Agreement and implementation of national standardised performance metrics and reporting requirements

Statement of intent/ Design Principles:

- Use the latest methods and technology to improve outcomes
- Processes and workflows will be automated with limited manual intervention in reporting
- Common standards and protocols will be applied on a 'Once for Scotland' basis
- Aligned to the Recruitment Shared Services Standardisation Group and the iRec replacement team work

Strategic problems addressed and benefits:

- consistent appraisal of the performance of our recruitment services across Scotland
- Supports definition of best in class models and highlight areas of improvement
- Currently due to non-standardised systems, processes and data there is limited means for understanding NHSScotland recruitment performance and use this in turn to understand how to better address strategic workforce issues.

Benefits:

- Better access to a single source of data and analytics
- More time for analysing data rather than collecting and processing it
- Better access to a single source of evidence, data and analytics
-

Scalability: National

<u>Recommendation 5:</u> 'Once for Scotland' Operational knowledge sharing & collaboration

Description: Establishment of an operational forum which will allow knowledge to be shared, career development to be enhanced and best practice and continuous improvement to evolve.

Outcomes expected: An operational Network for Recruitment Professionals to enable collaboration and knowledge sharing across NHSScotland.

Statement of intent/ Design Principles

- A number of Boards have developed expertise in specific areas which will be maximised and shared
- Knowledge and skills will be shared across all Boards
- Career paths will be enriched by the proposals

- Focus will be operational with insights shared with strategic groups working at National and Regional level

Strategic problems addressed and benefits:

- Peer support for recruitment colleagues
- Support mechanism for testing and implementing national initiatives
- Knowledge sharing to avoid duplication in relation to problem solving.
- Increased opportunities for staff to develop their skills and expertise Allow staff to contribute to continuous improvement of service delivery.
- Ability to harness the expertise of all NHSScotland recruitment teams to address larger strategic issues

Scalability: National

Recommendation 6: 'Once for Scotland' - National Governance

Description: There is broad support from stakeholders for the creation of a National Steering Group, on a transitional basis, to oversee service delivery and ensure collaboration across the regions.

Outcomes expected: National Steering Group is established prior to Regional implementation to provide oversight of the work carried out in each of the 3 regions

Statement of intent/ Design Principles:

- As set out in Section 5.1

Strategic problems addressed and benefits:

- Ensuring the principles and recommendations laid out in this paper are adhered to throughout planning
- Open communication will allow a standardised approach to service design and implementation, building on experience from colleagues, while ensuring the best outcomes for NHSScotland
- Improved decision making and collaboration
- Improved alignment of workforce, service and financial plans
- Better service planning over a longer timescale
- Professional expertise from a multidisciplinary team to shape and guide transformation
- Facilitated knowledge sharing

Scalability: National

Baseline Recruitment Data – Survey 2019

Appendix 2

NHS Scotland – Baseline Data	Indicator	Scotland	East	North	West
GENERAL	WTE Staff numbers for Board	140253.75	37219.05	33740.41	69294.29
	Annual Employee Turnover Rate (%)	9.89%	2.48%	3.12%	4.29%
STAFFING	WTE Recruitment Staff Numbers	210	63	52	96
ACTIVITY	No of Vacancies	31823	9417	7673	14733
	No. of Posts Advertised	23513	5934	8019	9560
	No. of Applications Received	284588	81193	72055	131340
	No. of Shortlists issued	29218	6776	13002	9440
	No. of Interview Invites issued	82088	17253	24200	40635
	No. of Conditional Offer Letters issued	26886	6604	8155	12127
	No. of References Issued	39555	5049	9128	25378
	No.of References received	22800	8320	4922	9558
	No. of Disclosure Scotland checks requested	15406	3986	6015	5405
	No. of Occupational Health checks	21007	4439	6431	10137
	No. of "Right to Work" Visas requested	118	15	46	57
	No. of Unconditional Offer Letters/Contracts issued	24799	6519	2515	15765
EXPENDITURE	Direct Salary Costs (Including On Costs)	5667861	1760910	1536748	2370202
	Average Salary Cost per Recruitment WTE	25049	6235	6943	11872
	Annual Advertising and Marketing Expenditure	1283773	325226	317111	641436
	Annual Expenditure on Psychometric Testing	98354	10334	150	87870
	Annual Expenditure on Executive Search	106786	9167	57582	40037
	Annual Expenditure on "Right to work" Visa Applications	115260	41985	30441	42834
	Current Total Employee Relocation Costs	1881683	387150	1086905	407629
	Current Total IT costs for existing recruitment systems	199592	119588	28000	52004
	Total Expenditure on Recruitment	9353309	2654360	3056937	3642012
	Total non labour spend	3685448	893450	1520189	1271810
PERFORMANCE	Average Time to Hire	58	17	16	26
	Average Cost of Hire	299	116	37	146
	Vacancies Filled per Recruitment WTE (annually)	181	50	39	93
	Average No.of days to open advert from receipt of RTH (Request to Hire)	5	2	2	1
	Average No. of days to issue shortlist -	2	1	0	1
	Average No. of days to return shortlist	5	3	1	2
	Average No. of days to issue invite to interview	3	1	1	1
	Average No. of days to make offer	5	2	2	1
	Average No.of days to complete Pre Employment Checks	16	7	2	7

Non-Financial Option Appraisal Workshop Participants (May-June 2019)

Board/Organisation	Number of People Work shop 1 Appraisal Attendance	Number of People Work shop 2 Discovery Attendance
Borders	8	5
Fife	4	7
HIS	7	6
Lothian	7	8
NES	5	8
SAS	3	4

Workshops:

28 May 2019

28 June 2019

List of Workshop Attendees

Name	Job Title	Stakeholder Group	Board	Workshop Attended
Dora Nemeth	Programme Manager	Business/Hiring Manager	HIS	Both
Mark Bisset	HR Project Officer	HR/Recruitment	HIS	Both
Caroline Arnott	Senior Inspector	Business/Hiring Manager	HIS	Both
Anne Hanley	Operations Manager	Business/Hiring Manager	HIS	Both
Ann Laing	Head of People & Workplace	HR/Recruitment	HIS	Both
Dougie Craig	Resource Specialist	HR/Recruitment	HIS	Both
Ben Lukins	Programme Manager	Business/Hiring Manager	HIS	Appraisal
Sharon Purves	HR Advisor	HR/Recruitment	NHS Borders	Both
Edwina Cameron	HR Manager/OD Partner	HR/Recruitment	NHS Borders	Both
Alison Holland	Nurse Bank Manager	Hiring Manager	NHS Borders	Both
Nicola MacDonald	Business Support Manager	Business/Hiring Manager	NHS Borders	Appraisal
Peter Old	Assistant Team Manager	Business/Hiring Manager	NHS Borders	Appraisal
Gail Russell	Partnership Project Lead	Staff Side	NHS Borders	Appraisal
Geraldine Bouglas	HR Manager/Business Partner	HR/Recruitment	NHS Borders	Appraisal
Philip Grieve	Operational Manager	Mental Health	NHS Borders	Appraisal
Sarah Martin	HR Administrator	HR/Recruitment	NHS Borders	Discovery

Lynne McCutcheon	Clinical Nurse Manager (BGH)	Hiring Manager	NHS Borders	Discovery
Euan Malcolm	Recruitment Assistant	HR/Recruitment	SAS	Both
Laura Howard	HR Administration	HR/Recruitment	SAS	Both
Deirdre Joy	Head of HR	HR/Recruitment	SAS	Appraisal
Denise Conlan	Business Manager	Hiring Manager	SAS	Discovery
Sheila Park	Recruitment Admin	HR/Recruitment	SAS	Discovery
Sandra Raynor	Senior HR Manager	HR/Recruitment	NHS Fife	Both
Alison McArthur	Recruitment Team Leader	HR/Recruitment	NHS Fife	Both
Karen Gray	Lead Physiotherapist	Hiring Manager	NHS Fife	Discovery
Andy Murray	Clinical Nurse Manager, Planned Care	Hiring Manager	NHS Fife	Discovery
Nicola White	Assistant Support Services Manager	Hiring Manager	NHS Fife	Both
Louise Noble	Partnership Co-ordinator	Staff Side	NHS Fife	Both
Anne Hamilton	HR Assistant	HR/Recruitment	NHS Fife	Discovery
Mark Stewart	Senior Specialist Lead	HR/Recruitment	NES	Appraisal
Tracey Cruickshank	Business Partner	HR/Recruitment	NES	Both
James McCann	Senior Officer	Staff Side	NES	Both
Leigh Willocks	General Manager	Service/Hiring Manager	NES	Appraisal
Priya Chamberlain	Senior Specialist Lead – HR	HR/Recruitment	NES	Discovery
Claire Blackburn	Senior Officer- HR	HR/Recruitment	NES	Discovery
Morag McDiarmid	Business Manager - Dental	Service/Hiring Manager	NES	Discovery
Morag McElhinney	Senior Specialist Lead – HR	HR/Recruitment	NES	Discovery
Niall MacIntosh	Lead Business Partner - Medical	Service/Hiring Manager	NES	Discovery
Miriam Reid	Business Partner – Finance	Service/Hiring Manager	NES	Discovery

Penny Crowe	General Manager - Dental	Service/Hiring Manager	NES	Appraisal
Neil Murray	Head of Recruitment Services	HR/Recruitment	NHS Lothian	Both
Susanne Newlands	Senior Recuruitment Manager	HR/Recruitment	NHS Lothian	Both
Patricia Nevin	Medical & Dental HR Manager	HR/Recruitment	NHS Lothian	Both
Kevin Alexander	Recruitment Team Leader (Medical & Dental)	HR/Recruitment	NHS Lothian	Appraisal
Hayley Wilson	Recruitment Administrator	HR/Recruitment	NHS Lothian	Appraisal
Denise Nasri	Nursing Workforce Manager	Service/Hiring Manager	NHS Lothian	Both
Reg Lloyd	Partnership Representative	Staff Side	NHS Lothian	Appraisal
Chloe McIntyre	Recruitment Administrator	HR/Recruitment	NHS Lothian	Discovery
Lynda Thompson	Recruitment Team Lead (General)	HR/Recruitment	NHS Lothian	Discovery
Marion Mackay	Medical Education Directorate Service Manager	Service/Hiring Manager	NHS Lothian	Discovery
Mary Purves	Pharmacy Administrator	Service/Hiring Manager	NHS Lothian	Discovery

Non-Financial Benefit Criteria

The table below shows the agreed benefit criteria and their descriptions for a regional recruitment service.

Benefit Criteria Theme	Descriptions
Standardise/Simplify and Share	• One NHS Scotland brand – promoting and marketing NHS Scotland as a world class exemplar employer that can hone campaigns to suit either local/national/speciality etc. on a Once for Scotland basis. • Once for Scotland i.e. Vision, National policy, process, IT system, data set, and SOPs for NHS Scotland recruitment promoting equity, effectiveness and branding of NHS Scotland as a world class employer • One collective HR resource - targeting the full weight of NHS Scotland's recruitment service where and when it is needed to optimise the service to customers, whether these are Boards, service users or applicants • Combined HR expertise, knowledge and skill leading to increased development and implementation of best practice across Scotland • Sustainable and resilient model of delivering an exemplar HR recruitment service. • Create a dedicated National Recruitment Service function with its own identity, which can optimise economies of scale and has an excellent customer care ethos with a primary focus n service quality
Efficiency and Effectiveness in Service Delivery	• Absolute Clarity: Rights, responsibilities and expectations of Boards/service users and the National Recruitment Service are clearly and consistently defined. • Service evolves to become a singular dedicated professional entity for recruitment on behalf of NHS Scotland. • Enhanced reporting and analytical capability, enabling improved performance management with KPIs and targets focussed on achieving value for money and customer satisfaction. • Service performance both improves against baseline and becomes more consistent, moving away from current high levels of variation across Scotland • Enhanced efficiency reduces duplication, streamlines and improves the quality, speed and cost of hiring. • Increased efficiency in the structure for managing recruitment across Scotland enabling Boards to focus on more effective local delivery of front line services • Increased collaboration between Boards to enhance innovation and encourage continuous improvement • National Recruitment Service transformation improves recruitment in "Difficult to recruit" specialties / occupations/areas across Scotland. • Increased/widen candidate talent pool.
Financial	• Move to the National Recruitment Service results in resource related financial saving in terms of both the time to hire, and the cost of recruitment events. • The enhanced quality improvements and efficiency releases staffing resources, to include hiring managers' time, which could be redirected to other areas of NHS activity. • Move to the National Recruitment Service results in non-labour related financial savings e.g. advertising/marketing/IT
Customer Experience	• One stop shop service that provides streamlined end to end recruitment and onboarding service to Managers. • Enhanced level of customer service to the hiring manager from the National Recruitment Service, to deliver the best services on a consistent basis across Scotland • Access to Centres of Excellence providing high level advice, guidance, and expertise to all service users across NHS Scotland • Easier to apply for posts e.g. One application form required for multiple posts across NHSScotland • Slicker, more efficient and bespoke targeted service that attracts high calibre applicants to the NHSScotland • The recruitment experience is enjoyable for applicants and our reputation is enhanced with positive downstream implications for staff retention
Recruitment Staff Experience	• Increased scale of new shared service creates increased potential for career structure and development in a shared service centre • Staff develop new skills and expertise in implementing the new service • Staff work more collaboratively to enable once for Scotland solutions on a continuous improvement basis.

Initial List of Model Options

1	Status Quo
2	Single Employer, Single Location, Split by Functions
3	Single Employer, Multiple Locations, Split by Functions
4	Multiple Employers, Single Location, Split by Functions
5	Multiple Employers, Multiple Locations, Split by Functions
6	Multiple Employers, Single Management, Single Location, Split by Functions
7	Multiple Employers, Single Management, Multiple Locations, Split by Functions
8	Single Employer, Single Location, Split by type of recruitment
9	Single Employer, Multiple Locations, Split by type of recruitment
10	Multiple Employers, Single Location, Split by type of recruitment
11	Multiple Employers, Multiple Location, Split by type of recruitment
12	Multiple Employers, Single Management, Single Location, Split by type of recruitment
13	Multiple Employers, Single Management, Multiple Location, Split by type of recruitment
14	Single Employer, Single Location, Split by specialist areas
15	Single Employer, Multiple Locations, Split by specialist areas
16	Multiple Employers, Single Location, Split by specialist areas
17	Multiple Employers, Multiple Location, Split by specialist areas
18	Multiple Employers, Single Management, Single Location, Split by specialist areas
19	Multiple Employers, Single Management, Multiple Location, Split by specialist areas
20	Single Employer, Single Location, Split by processing
21	Single Employer, Multiple Locations, Split by processing
22	Multiple Employers, Single Location, Split by processing
23	Multiple Employers, Multiple Location, Split by processing
24	Multiple Employers, Single Management, Single Location, Split by processing
25	Multiple Employers, Single Management, Multiple Location, Split by processing
26	Single Employer, Single Location, Split by Board
27	Single Employer, Multiple Locations, Split by Board
28	Multiple Employers, Single Location, Split by Board
29	Multiple Employers, Multiple Location, Split by Board
30	Multiple Employers, Single Management, Single Location, Split by Board
31	Multiple Employers, Single Management, Multiple Location, Split by Board

Initial Long List of Options

Option	Name
1.	Status Quo
2A	Hub & Spoke Model (Single Employer, Special Hub)
2B	Hub & Spoke Model (Single Employer, Process Hub)
2C	Hub & Spoke Model (Single Employer, Single Hub)
2D	Hub & Spoke Model (Multiple Employers, Single Management Structure, Special Hub)
2E	Hub & Spoke Model (Multiple Employers, Single Management Structure, Process Hub)
2F	Hub & Spoke Model (Multiple Employers, Single Management Structure, Single Hub)
3A	Single Consortium Service (Single Employer, One Location, Functional Split)
3B	Single Consortium Service (Single Employer, Multiple Locations, Functional Split)
3C	Single Consortium Service (Single Employer, One Location, Board Split)
3D	Single Consortium Service (Single Employer, Multiple Locations, Board Split)
4A	Single Management Structure (Multiple Employers, One Location, Functional Split)
4B	Single Management Structure (Multiple Employers, Multiple Locations, Functional Split)
4C	Single Management Structure (Multiple Employers, One Location, Board Split)
4D	Single Management Structure (Multiple Employers, Multiple Location, Board Split)

Scoring Rationale against Benefit Criteria

Single Employer		
Benefit Criteria	**Score**	**Rationale**
Customer Experience	High	• Single employer would enhance customer service as bigger scale to respond effectively. • Single employer would lead to consistency and clarity in roles and responsibilities. • Single employer would be able to deliver centre of excellence.
Efficiency and Effectiveness in Service Delivery	High	• Single employer would ensure consistency in systems and process and enable efficiencies in service delivery.
Standardise/ Simplify and Share	High	• Single employer means all working from the same page and be much more standardised. • Single employer will make it easier to ensure sharing of knowledge and skills. • Single employer will be easier to implement change and have one leading board that others can link to.
Recruitment Staff Experience	Medium	• Single employer will ensure transparency and priority in the recruitment team. • Single employer would provide collective identity to staff. • Single employer would ensure equality across recruitment teams.
Finance	High	• Single employer would have oversight and provide better financial control. • Single employer would lead to streamlining administrative function, processes, policies and procedures that would lead to saving. • Single employer lead to a reduction of management could lead to saving

Multiple Employers		
Benefit Criteria	**Score**	**Rationale**
Customer Experience	Medium	• Multiple employers would retain local knowledge and identity. • Multiple employers would not lose sight of local board priorities.
Efficiency and Effectiveness in Service Delivery	Medium	• Multiple employers would lead to conflict of interest and impact on service delivery. • Multiple employers would potential lead to no change and duplication.
Standardise/ Simplify and Share	Medium	• Multiple employers would give a slightly lower in standardised branding, ability to have collective resource.
Recruitment Staff Experience	Medium	• Multiple employers would result in little change for recruitment staff. • Multiple employers would allow staff to retain their current board identity.

Finance	Medium	No comment

Single Location		
Benefit Criteria	**Score**	**Rationale**
Customer Experience	Medium	• Local knowledge and relationship may be loss with single location.
Efficiency and Effectiveness in Service Delivery	Medium	• Being all together in one location is likely to deliver more efficiency as more collaborative working.
Standardise/ Simplify and Share	Medium	• Single location would reference standardisation. • Smaller number of sites would be better and easier to manage.
Recruitment Staff Experience	Medium	• Single location might affect staff retention. • Single location would lead to high skill mix, experience and collaboration.
Finance	Medium	• Single location more cost effective, dependence on location. • Need to take account of cost of relocation and loss of experience staff. • Single physical location does not achieve financial benefit with the technology available could allow the service to base anywhere.

Multiple Locations		
Benefit Criteria	**Score**	**Rationale**
Customer Experience	High	• Remaining in current geographical locations would ensure the retention of local knowledge, experience and relationship. • Localise location would provide a more customer focused service.
Efficiency and Effectiveness in Service Delivery	High	• Service delivery will be better processed in multiple locations. • Multiple locations is likely to maintain quality of service delivery.
Standardise/ Simplify and Share	Medium	• Retaining local officers so Boards have local knowledge and identity. • There will still be opportunity to share and standardise process through multiple employers and with the implementation of Jobtrain
Recruitment Staff Experience	High	• Multiple locations with the current base would be less stressful for staff and less resistance to change.
Finance	High	• Remain in current board locations would be more cost effective

Ranking and Weighting

Although all benefit criteria are important, they are not all equally important. To produce a scoring mechanism, participants were asked to rank and weight the benefit criteria. Ranking involved deciding the order of importance of the criteria (with 1 being the most important and 5 being the least). The weighting shows the relative importance of each of the criteria, by expressing each of the weights as a percentage so the total will equals 100%.

The table below show the agreed ranking and scoring of benefit criteria and the reasoning behind them.

Benefit Criteria	Ranking (Order of Importance)	Weighting (Relative Importance)	Reason
Customer Experience	1	30	Customer experience is the driver for service improvement and how it should be delivered.
Efficiency and Effectiveness in Service Delivery	2	25	This came a close second to customer experience in terms of ranking and weighting, with the reasoning that, that service efficiency and effectiveness would be defined and driven by achieving the best customer experience.
Standardise/Simplify and Share	3	20	Aiming to deliver an effective and efficient service would lead to standardising and simplifying process and documentations as well as the opportunity for collaboration and sharing of resources.
Recruitment Staff Experience	4	20	Recruitment staff experience would be an outcome of working in an effective, standardised and efficient service.
Finance	5	5	If the service is efficient, effective and standardise the financial benefits will follow.

Options Generation - Generate and Agreed Long List of Model Options

Participants worked in four groups to start to consider the different ways (options) recruitment services could be set up across the East Region, taking into account different recruitment services functions as well as how the service could be managed and delivered using the Service Model Development Framework (appendix 2).

A list of 31 model ideas were initially generated through the group work (see appendix 3) and through further full workshop group discussion, the following points were considered before arriving at an agreed Long List of model options:

- (29) "Multiple Employers, Multiple Location, Split by Board" considered to be closely similar to the Status Quo
- Multiple Management Structure should also be considered
- Increased complexity of model ideas due to the number of 'split by' variations (Function, Type of Recruitment, Specialist Areas, Processing, By Board)
- Consideration given to reducing complexity by grouping the following 'split by' variations together; (a) Functions & Specialist Areas and (b) Type of Recruitment & Specialist Areas.
- Consideration given to further simplifying the complexity of the model variations down further to focus on 3 main aspects;

Aspects	Description
1. Employer	The number of Boards employing the staff within the East Region Recruitment Service.
2. Management Structure	The line of accountability the recruitment service would be under.
3. Location	The number of locations where the recruitment service would be delivered out of, for the 6 Boards within East Region.

- **High Level results**

The table below shows the aspects and status quo results order of total combined individual scores.

Aspects and Status Quo (in result order)	Total Score
Multiple Locations	621
Single Employer	611
Multiple Employers	502
Single Location	427
Status Quo (baseline measure)	406

- Status Quo has the lowest score in comparison to the aspects; the remainder of the report will therefore focus on analysis of other aspects and model options.

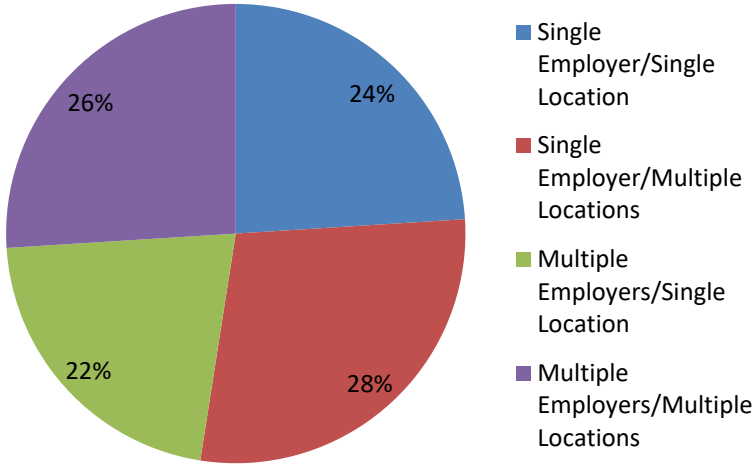
The table below shows the options results order of total combined individual aspect scores both unweighted and with weighting applied. It is important to note that all model options would be managed under a single line of accountability.

Model Options (in result order)	Total Score	Total Weighted Score
Option 3 - Single Employer/ Multiple Locations	1232	1324.4
Option 5 - Multiple Employers/ Multiple Locations	1123	1209.4
Option 2 - Single Employer/ Single Location	1038	1116.6
Option 4 - Multiple Employers/ Single Location	929	1001.6

- Option 3 had the highest score followed closely by Option 5 and Option 2.
- Option 4 had the lowest score.

The pie chart below shows the weighted score distribution between model options.

Weighted Score Distribution



- **Results by Benefit Criteria**

The table below shows the total (unweighted) score for each benefit criteria, with the aspect(s) that scored the highest highlighted in green and the option(s) that scored the lowest in red.

The highest possible score for each benefit criteria is 175 (35 participants X maximum score of 5).

Benefit Criteria	Single Employer	Multiple Employers	Single Location	Multiple Locations
Customer Experience	118	114	76	137
Efficiency and Effectiveness in Service Delivery	123	97	102	120

Standardise/ Simplify and Share	124	87	72	109
Recruitment Staff Experience	111	108	73	135
Finance	135	96	104	120

- Single Employer scored highest for three out of five benefit criteria, and second highest for the remaining benefit criteria.
- Multiple Locations scored highest for two out of five benefit criteria, and second highest for the remaining benefit criteria.
- Singe Locations scored lowest for three out of five benefit criteria, and second lowest for one of the remaining benefit criteria.
- Multiple Employers scored lowest (or equal lowest) for two out of five benefit criteria.

The table below shows the total (unweighted) score for each benefit criteria with the model option that scored the highest highlighted in green and the lowest option in red.

The highest possible score for each benefit criteria is 350 (35 participants x maximum score of 10).

Model Options	Customer Experience	Efficiency and Effectiveness in Service Delivery	Standardise/ Simplify and Share	Recruitment Staff Experience	Finance
Option 3 - Single Employer/ Multiple Locations	255	243	255	246	233
Option 5 - Multiple Employers/ Multiple Locations	251	217	216	243	196
Option 2 - Single Employer/ Single Location	194	225	239	184	196
Option 4 - Multiple Employers/ Single Location	190	199	200	181	159

- Options 3 scored the highest for all five benefit criteria.
- Option 4 scored the lowest for all five benefit criteria.

- **Individual Scoring - Mode (Range)**

The table below shows the mode (most frequent) individual score for each benefit criteria, in brackets, the range of individual scores.

Benefit Criteria	Single Employer	Multiple Employers	Single Location	Multiple Locations
Customer Experience	4 (1-5)	3 (1-5)	1 (1-4)	4 (1-5)
Efficiency and Effectiveness in Service Delivery	4 (1-5)	3 (1-5)	3 (1-5)	4 (2-5)
Standardise/ Simplify and Share	4 (2-5)	3 (1-4)	4 (1-5)	4 (1-5)
Recruitment Staff Experience	4 (1-5)	3 (1-5)	1 (1-4)	4 (2-5)
Finance	4 (1-5)	2 (1-5)	1 (1-4)	= 2 and 4 (1-5)
Total Score Mode	**20 (6-25)**	**14 (5-24)**	**10 (5-22)**	**18/20 (7-25)**

- The overall range of individual scores is close for all aspects.
- Single Employer and Multiple Locations have the largest mode of individual scores in total and across the majority of the individual benefit criteria.
- Single Location has the lowest mode of individual scores in total.

- **Individual Scoring – Rationale**

The tables below summarise the main rationales provided by participants for the scores they gave. For ease of reference, the total score (out of a possible 175) has been rated as high (117 or over), medium (59-116) or low (58 or less).

Single Employer		
Benefit Criteria	**Score**	**Rationale**
Customer Experience	High	• Single employer would enhance customer service as bigger scale to respond effectively. • Single employer would lead to consistency and clarity in roles and responsibilities.

		• Single employer would be able to deliver centre of excellence.
Efficiency and Effectiveness in Service Delivery	High	• Single employer would ensure consistency in systems and process and enable efficiencies in service delivery.
Standardise/ Simplify and Share	High	• Single employer means all working from the same page and be much more standardised. • Single employer will make it easier to ensure sharing of knowledge and skills. • Single employer will be easier to implement change and have one leading board that others can link to.
Recruitment Staff Experience	Medium	• Single employer will ensure transparency and priority in the recruitment team. • Single employer would provide collective identity to staff. • Single employer would ensure equality across recruitment teams.
Finance	High	• Single employer would have oversight and provide better financial control. • Single employer would lead to streamlining administrative function, processes, policies and procedures that would lead to saving. • Single employer lead to a reduction of management could lead to saving

Multiple Employers		
Benefit Criteria	**Score**	**Rationale**
Customer Experience	Medium	• Multiple employers would retain local knowledge and identity. • Multiple employers would not lose sight of local board priorities.
Efficiency and Effectiveness in Service Delivery	Medium	• Multiple employers would lead to conflict of interest and impact on service delivery. • Multiple employers would potential lead to no change and duplication.
Standardise/ Simplify and Share	Medium	• Multiple employers would give a slightly lower in standardised branding, ability to have collective resource.
Recruitment Staff Experience	Medium	• Multiple employers would result in little change for recruitment staff. • Multiple employers would allow staff to retain their current board identity.
Finance	Medium	No comment

Single Location		
Benefit Criteria	**Score**	**Rationale**
Customer Experience	Medium	• Local knowledge and relationship may be loss with single location.
Efficiency and Effectiveness in Service Delivery	Medium	• Being all together in one location is likely to deliver more efficiency as more collaborative working.

Standardise/ Simplify and Share	Medium	• Single location would reference standardisation. • Smaller number of sites would be better and easier to manage.
Recruitment Staff Experience	Medium	• Single location might affect staff retention. • Single location would lead to high skill mix, experience and collaboration.
Finance	Medium	• Single location more cost effective, dependence on location. • Need to take account of cost of relocation and loss of experienced staff. • Single physical location does not achieve financial benefit with the technology available could allow the service to base anywhere.

Multiple Locations		
Benefit Criteria	**Score**	**Rationale**
Customer Experience	High	• Remaining in current geographical locations would ensure the retention of local knowledge, experience and relationship. • Localise location would provide a more customer focused service.
Efficiency and Effectiveness in Service Delivery	High	• Service delivery will be better processed in multiple locations. • Multiple locations is likely to maintain quality of service delivery.
Standardise/ Simplify and Share	Medium	• Retaining local officers so Boards have local knowledge and identity.

		• There will still be opportunity to share and standardise process through multiple employers and with the implementation of Jobtrain
Recruitment Staff Experience	High	• Multiple locations with the current base would be less stressful for staff and less resistance to change.
Finance	High	• Remain in current board locations would be more cost effective

The following consistent comments made by participants were noted:

- There is a need to recognise and capture the potential benefits Jobtrain would incur across all criteria.
- Local knowledge, experience and relationship is noted to be a one of the key rationale for participants in terms of customer and recruitment staff experience.

Results by Board and Stakeholder Group

Individual total scores have been further analysed by Board (HIS, Borders, NES, Fife, Lothian and SAS) and stakeholder group (HR/Recruitment, Customer and Staff Side).

The table below shows the total model option score by Board, the highest score is highlighted in green.

Model Options	Borders	Fife	HIS	Lothian	NES	SAS
Option 2 - Single Employer/Single Location	262	139	177	214	163	83
Option 3 - Single Employer/Multiple Locations	306	147	221	258	202	98
Option 4 - Multiple Employers/Single Location	233	118	169	200	119	90

Option 5- Multiple Employers/Multiple Locations	277	126	213	244	158	105

- Option 3 has the highest score for five out of six Boards.
- One Board score Option 5 the highest and closely followed by Option 3 as the second highest.
- Two Board score Option 2 the second highest.

The table below shows the total model option score by stakeholder group, the highest score is highlighted in green.

Model Options	HR/Recruitment	Customer	Staff Side
Option 2 - Single Employer/Single Location	529	386	123
Option 3 - Single Employer/Multiple Locations	661	430	141
Option 4 - Multiple Employers/Single Location	507	316	106
Option 5- Multiple Employers/Multiple Locations	639	360	124

- All stakeholder groups scored Option 3 the highest and Option 4 the lowest.
- Customer score Option 2 the second highest.

Risk Score: Status Quo

Risk ID	Risk identified	Potential consequences/ Impact	Likelihood (1-5)	Impact (1-5)	Combined Score	Risk Level	Category	Mitigation	Likelihood (1-5)	Impact (1-5)	Combined Score	Risk Level	Rationale
1.1	There is a risk in not reacting to a need or perception to be a better service.	Lead to loss of innovation and wider collaboration opportunities.	4	4	**16**	High	Ops/HR	Jobtrain, regional meetings, understanding of processes and local systems, local QI projects, Shared knowledge and collaboration	3	3	**9**	Medium	Reduced likelihood due to work being done but still further improvements needed.
1.2	There is a risk that current processes are not sustainable i.e. Boards not have an electronic system.	Lack of electronic systems impacting on recruitment and reputational risks and is labour intensive	3	4	**12**	High	Ops/Strat	Jobtrain, some boards electronic but jobtrain means consistent service	2	3	**6**	Medium	Reduced likelihood and impact as system could still go down but have seen some improvements, not as labour intensive more the majority of boards but still intensive for boards in different ways.
1.3	There is a risk that the current service model does not meet the Scottish Government Once for Scotland agenda.	Non-compliance with Scottish Government Once for Scotland agenda (for recruitment this was to develop national strategic direction and regional service model).	5	4	**20**	Very High	Pol/Fin/Strat	Working together regionally - reduces risks, better communication across the East region. Aligning to standardisation work.	3	4	**12**	High	Reduced likelihood as more boards meeting up but this could be cancelled or not go ahead, no legal requirement to follow the agenda.
1.4	There is a risk of lack of governance around standardisation.	Leading to variance in interpretations around practice and process.	5	3	**15**	High		Oversight of groups, leads meeting up and communicating messages	5	3	**15**	High	Mitigation does not address risk. Not one policy, report back to Scottish Government however there are 6 different interpretations of guidance.

Risk Score: Option 3

OPTION 3: Single Employer/ Multiple Locations													
			Unmitigated Score						Mitigated Score				
Risk ID	Risk identified	Potential consequences/ Impact	Likelihood (1-5)	Impact (1-5)	Combined Score	Risk Level	Category	Mitigation	Likelihood (1-5)	Impact (1-5)	Combined Score	Risk Level	Rationale
3.1	There is a risk of lack of governance around standardisation.	Leading to variance in interpretations around practice and process.	3	3	9	Medium	Ops/Strat	Standarisation process, strong governance and holding reccruitment groups.	2	2	4	Medium	Governance brings risk lower
3.2	There is a risk that there could be a loss of internal peer support.	Leading to lack of interpersonal contact.	3	2	6	Medium	HR	Regular team meetings and regular leads meetings, recognising the risk and meeting and monitoring under a supervision framework.	2	2	4	Medium	If mitigation in place would reduce risks
3.3	There is a risk that there would be a lack of transparency around equal workloads, roles and responsibilities.	Leading to lack of equity across certain processes and workloads and across roles and bandings.	3	3	9	Medium	Ops/HR	Job description clarification, following structure, analysis of current roles and demand at eac level.	2	3	6	Medium	If mitigation in place would reduce risks
3.4	There is a risk that there could be inconsistent communication between locations.	Leading to single way of working & working individual individually at various locations.	3	2	6	Medium	Ops/HR	Share working practises, working to SOPs, clarify expectations of what is required, regular regional comms.	2	2	4	Medium	If mitigation in place would reduce risks
3.5	There is a risk that technology solutions to support any shared service model are not consistently available or resourced.	Inability to deliver a shared service across Board boundaries.	4	4	16	High	Ops/Strat/Pol/Tech	Jobtrain, shared technology brief, consistent comms platforms, introduction of Office 365 in future	4	4	16	High	Mitigation does not reduce risk. We can't score on future systems - may be delays with Ofice 365.
3.6	There is a risk of uncertainty for those with mixed job roles within a shared regional service.	Roles not appropriately resourced and impact on quality of service delivery.	4	3	12	High	Ops	Clarify job descriptions, clarity on structure and job expecatations.	3	3	9	Medium	Reduced likelihood as single employer will make it easier for clarity of roles.

Risk Score: Option 5

OPTION 5: Multiple Employers/ Multiple Locations													
			Unmitigated Score						Mitigated Score				
Risk ID	Risk identified	Potential consequences/ Impact	Likelihood (1-5)	Impact (1-5)	Combined Score	Risk Level	Category	Mitigation	Likelihood (1-5)	Impact (1-5)	Combined Score	Risk Level	Rationale
5.1	There is a risk of lack of governance around standardisation.	Leading to variance in interpretations around practice and process.	4	3	12	High	Ops/Strat	Standarisation group, governance within project, recruitment leads groupl	3	2	6	Medium	Mitigation reduces likelihood and impact.
5.2	There is a risk that there could be a loss of internal peer support.	Leading to lack of interpersonal contact.	2	2	4	Medium	HR	Regular team meetings across locations and rec leads, recognising risk and monitoring.	2	2	4	Medium	Mitigation does not reduce risk.
5.4	There is a risk that there would be a lack of transparency around equal workloads, roles and responsibilities.	Leading to lack of equity across certain processes and workloads and across roles and bandings.	4	3	12	High	Ops/HR	Job descriptions, structure, analysis of current jobs, estimate of what is required at each level, Leads meetings.	3	3	9	Medium	Mitigation reduces likelihood.
5.4	There is a risk that there could be inconsistent communication between locations.	Leading to single way of working & working individual individually at various locations.	4	2	8	Medium	Ops/HR	Working practises, following sops, clear expectaions, reg contact to discuss issues and experiences, approaches, consistent regional comms	3	2	6	Medium	Mitigation reduces likelihood.
5.5	There is a risk that technology solutions to support any shared service model are not consistently available or resourced.	Inability to deliver a shared service across Board boundaries.	4	4	16	High	Tech/Ops/Strat/Pol	Jobtrain, technology brief, ensure we all require jobrain email and telephone as minimumal, Office 365 introduction in future	4	4	16	High	Mitigation does not reduce risk. Still improvements for jobtrain and cant score on future improvements
5.6	There is a risk of uncertainty for those with mixed job roles within a shared regional service.	Roles not appropriately resourced and impact on quality of service delivery.	4	3	12	High	Ops/HR	Job descriptions, structure, clarity of roles,	3	3	9	Medium	Mitigation will reduce likelihood.
5.7	There is a risk that the governance of tasks will not be controlled.	Lose sight of workloads and could lead to conflict of duties	4	4	16	High	Ops	Job descriptions, structure, clarity of roles,	3	4	12	High	Mitigation will reduce likelihood.

Risk Score: Option 2

OPTION 2: Single Employer/ Single Location														
			Unmitigated Score						Mitigated Score					
Risk ID	Risk identified	Potential consequences/ Impact	Likelihood (1-5)	Impact (1-5)	Combined Score	Risk Level	Category	Mitigation	Likelihood (1-5)	Impact (1-5)	Combined Score	Risk Level	Rationale
2.1	There is a risk that there could be a loss of direct customer service.	This could lead to losing priorities in a wider/larger system and loss of local knowledge with geograhical constraints impacting customer service.	4	3	**12**	High	Ops/HR	Video conference use, Office 365 intro, strucure of service, educating managers, using staff knowledge, training structure,	3	3	**9**	Medium	Mitigation will reduce likelihood.
2.2	There is a risk that some boards may have "vested" interest in securing first recruitment of candidates.	This could lead to a loss of invested interests of candidates to roles within certain boards and the dominant stakeholder prioritised.	4	4	**16**	High	Ops/Strat	Governance - pre-advertising governance	2	4	**8**	Medium	Mitigation will reduce likelihood.
2.3	Financial risks: - Single location could be costly. - Redeployment/relocation to staff could be costly	Cost of single location unaffordable High cost of redeployment/relocation of staff unaffordable	5	5	**25**	Very high	Fin	More agile working, flexible working	5	5	**25**	Very High	Mitigation will not reduce risk. Difficult to implement across a regional service
2.4	Disruption to existing staff and team.	Disruption to staff routines, relocation and redeployment of teams that could lead to low staff morale.	5	4	**20**	Very High	HR/Ops	Clear comms through BC, change management, education workshops	4	4	**16**	High	Likelihood will reuce however human nature still to have anxieties even with introduction of mitigation.
2.5	There is a risk that technology solutions to support any shared service model are not consistently available or resourced.	Inability to deliver a shared service across Board boundaries.	4	3	**12**	High	Tech/Ops/Strat/Pol	Jobtrain, shared governance andknowledge, shared approach	3	3	**9**	Medium	Mitigation will reduce likelihood.
2.6	There is a risk of uncertainty for those with mixed job roles within a shared regional service.	Roles not appropriately resourced and impact on quality of service delivery.	2	3	**6**	Medium	Ops/HR	Clear job descriptions, shared governenace and knowledge	1	1	**1**	Low	This would take away the mixed role of risk would almost be negligable.

Capacity & Demand – Recruitment Sustainable Caseload Framework Appendix 9

A framework to agree a sustainable caseload for recruitment services staff was developed to support demand and capacity modeling. In this context ‘sustainable’ means an activity level that can be reasonably maintained and ‘caseload’ means processed tasks per hour.

It is recognised that there is no exact or ideal way to ‘match’ recruitment services capacity to demand and a sustainable caseload figure also needs to take account of:

Capacity considerations

- Recruitment Advisor & Assistants level of knowledge and experience
- ‘Hidden’ capacity from the use of overtime and temporary staff to cover vacancies
- Typical capacity loss (leave, absence, training)
- Potential economies of scale in larger teams

Demand considerations

- Range and complexity across and within NHS staff job families
- Varying rate of turnover in different staff groups

For the purposes of the Business Case, demand and capacity was considered in the following ways:

- Number of expected annual tasks
- Number of tasks processed per hour per WTE
- Annual Hours Required

It should be noted that East Region Consortium staffing figures below were correct at the time of modeling (January 2019).

Service Assistants	No. of expected annual tasks	No. able to be processed/hour	Annual Hours Required	No. of Staff Required	No. allowing for typical capacity loss*
General Client Enquiries (20% of vacancies)	1900	3	633.3	0.3	0.41
General Applicant Enquiries (5% of Applications Received)	4000	3	1333.3	0.7	0.85
General Panel Member Enquiries (10% of Shortlisted Jobs)	700	3	233.3	0.1	0.15
Vacancy preperation/system updating (i.e. inputting basic vacancy info onto JT?)	9417	2	4708.5	2.4	3.02
Customer Service Support			**6908.5**	**3.5**	**4.4**
Wider Functional Support (Service Management & Bespoke)			9750	5.0	6.3
Total Service Assistants			**16658.5**	**8.5**	**10.7**

Service Advisors	No. of expected annual tasks	No. able to be processed/hour	Annual Hours Required	No. of Staff Required	No. allowing for typical capacity loss
Triaged/escalated general enquiries (15% of above general enquiries)	1000	3	333.3	0.2	0.21
Vacancy checking/processing/advertising	9417	1	9417.0	4.8	6.04
Re-work/re-advertising required (changes on instruction from clients - i.e. 10% of vacancies advertised)	942	1	942.0	0.5	0.6
Incomplete/Late application enquiries & processing (5% of applications)	470.85	3	157.0	0.1	0.10
Setting Calendar Events (shortlists issued)	6776	3	2258.7	1.2	1.45
Invites to interview (including managing changes)	17253	3	5751.0	2.9	3.69
Conditional Offers Issuing	6604	2	3302.0	1.7	2.1
References issuing/receiving	8320	4	2080.0	1.1	1.3
Disclosure Scotland checks processing	3986	3	1328.7	0.7	0.9
Occupational Health checks processing	4439	4	1109.8	0.6	0.7
Sponsorship/Visa processing	15	2	7.5	0.0	0.0
Unconditional Offer Letters/Contracts issuing	6519	2	3259.5	1.7	2.1
General system updating across all stages (including notes)	9417	3	3139.0	1.6	2.0
Downloading/saving/sending all documentation to clients (pre-engagement/Offers/Contracts etc)	6519	1	6519.0	3.3	4.2
Client follow-up/engagement throughout process of live vacancies	9417	1	9417.0	4.8	6.0
Provide Supervisory & Events support					
Total Service Advisors			**49021.4**	**25.1**	**31.4**

Projected Supply and Demand

The table below indicates Projected Supply and Demand (WTE required for a given number of vacancies).

Vacancies	Staff WTE Required with varying demand		
	min	**likely**	**max**
0	0.0	0.0	0.0
1000	5.9	6.6	7.4
2000	11.8	13.1	14.8
3000	17.8	19.7	22.1
4000	23.7	26.3	29.5
5000	29.6	32.9	36.9
6000	35.5	39.4	44.3
7000	41.5	46.0	51.7
8000	47.4	52.6	59.0
9000	53.3	59.1	66.4
10000	59.2	65.7	73.8
11000	65.2	72.3	81.2
12000	71.1	78.9	88.5
13000	77.0	85.4	95.9
14000	82.9	92.0	103.3
15000	88.9	98.6	110.7

ADMINISTRATIVE

- Receipt of Vacancy
- Governance and QIA checks
- Processing Vacancies
- Liaise with redeployment
- Advertising
- Liaise with external agency (eg. advertising, job centre, headhunters)
- Process application
- Shortlisting
- Interview
- Offer & Pre-employment
- Onboarding
- Contracting
- Change of contract?
- Pay form processing
- Interview expense
- Relocation
- Induction?
- eESS/ Data input?

ADVISORY

(Self Service, Basic Level, Expert Level)

- Recruitment Portal (Internal/External)
- Service user enquiries (phone/email)
- International Recruitment
- Campaigns & Marketing
- PR (Social Media)
- Specialist/Bulk recruitment (e.g. winter)
- Assessment centre/Psychometric Assessment
- FOI

MANAGEMENT

- Recruitment Development
- Staff Development/Induction
- Relationship Management
- External Supplier & Contract Management/Service & Spend
- Activity planning & Change projects
- Performance & Quality (reporting /EO/ROI/management report)
- Complaints
- Redeployment

1. Short listed Options for Costing

As part of the non-financial option appraisal, the following options were short listed for costing:

Scenario	Description
Status Quo / Do Nothing Option 1	Multiple employers Multiple bases Existing staffing structure
Option 2	Single employer Multiple bases – retain existing bases Proposed new staffing model
Option 3	Multiple employers Multiple bases – retain existing bases Proposed new staffing model

2. Multiple and Single Employer Costs

No significant additional costs have been identified in relation to a single employer or a multiple employer service model.

3. Estates Costs

3.1 Current Estates Costs

Estates costs are not currently charged out by Health Boards to individual recruitment departments. Existing estates costs are sunk[6] as all Boards occupy properties alongside other departments. The removal of the recruitment team from one site would not result in the site becoming surplus property. There may be a reduction in hard Facilities Management (FM) costs such as heat, light and power but this is not possible to quantify at this stage and will likely be a minimal reduction.

3.2 Single Base Options

[6] Sunk costs are costs which have already been incurred and are irrevocably committed.

All options which included the sub-option to base employees at a single site were discounted from the short list of options. Prior to being discounted, the high level indicative costs of a single site were calculated and are included below for information.

3.2.1 Use of Existing NHS Estate

The use of existing NHS Estate would be contingent upon identifying a suitable site within the consortium which could accommodate the whole recruitment function for the East Region. Should a suitable site be identified, all estates costs would be sunk by applying the same logic stated in **section 3.1** above.

3.2.2 Use of Commercially Leased Property

This option refers to commercially leased property sites that are not within the East Region's existing estate. Advice has been sought from Healthcare Facilities Scotland (HFS), a division of NSS. High level indications of costs to occupy commercially leased premises range from an additional recurring revenue requirement of £300k per annum to £420k per annum. These costs include, amongst others, annual rental charges, buildings insurance, non-domestic rates and water rates, hard and soft FM. In addition, there will be a non recurring revenue requirement ranging between £250k and £600k. This includes accommodation furniture and fixtures fit out, IT equipment fit out and dilapidation costs[7].

3.2.4 Use of Purchased Property

This option refers to the purchase and refurbishment of an existing site or new build property that are not within the East Region's existing estate. Again, advise was sought from HFS on indicative costs for several areas within the East Region; Edinburgh City, West Lothian, Kirkcaldy, Dunfermline and North East Fife. High level indicative costs are shown in the table below.

	New Build Property	**Existing Property**
Non Recurring Costs	£	£
Capital Outlay	1m - 1.2m	550k - 650k
Non Recurring Revenue	90k - 125k	90k - 125k
Recurring Costs	£	£
Property running costs	140k - 170k	140k - 170k
Depreciation charge	20k - 24k	11k - 13k

[7] Dilapidation costs are the 'exit' costs to the tenant for putting the leased property back into repair and the removal of alterations on expiry of the lease.

There is no capital budget available to purchase a new site. The additional revenue requirements also result in a purchased site being unaffordable.

4. Staff Costs

4.1 All Options: Point on Scale

Staff costs (including employer 'on costs') have been costed at the mid-point of the pay band.

4.2 Proposed New Staffing Model: Salary Protection

A proposed new staffing model has been agreed by the East Recruitment Programme Board and the required posts and staffing numbers have been identified.

In line with Organisational Change policy, protection may apply to some existing employees' salaries under the proposed service model. This applies to both options 2 and 3.

Through initial inspection of current and proposed new bands and WTE, it appears that the following staff numbers may be eligible for salary protection:

Existing Band	New Band	WTE
8b	8a	0.4
6	5	0.15
5	4	2.19
2	2	1.11

Potential 'worst case' salary protection costs have been calculated on these numbers and do not make any assumptions in relation to individual staff members. These costs have been included on a recurrent basis for options 2 and 3.

The proposed staffing model would result in a reduction of 2.11 WTE within the recruitment service from 52.96 WTE to 50.85 WTE. There are currently 51.96 WTE employees within the current structure who are employed on a permanent basis[8]. WTE has been 'mapped' across from the existing staffing structure, resulting in 1.11 WTE surplus in band 2 employees. Costs for this post have been included throughout the life of the costing period. However, the employer would seek to redeploy staff members into another suitable post within the Health Board.

5. Costing Methodology

5.1 Worst Case Costing

There is a 'worst case' allowance for salary protection included in the costs. The actual cost of this will be dependent upon the new roles assumed by existing staff.

5.2 Staffing Models

Staff costs include all employers 'on costs' (basic salary, national insurance and superannuation contributions). Costs are based on an indicative banding exercise of the new roles. The NHS Agenda for Change Pay Deal for 2021-22 onwards has not yet been agreed. Staff costs are estimated, with a 3% uplift to base salaries applied per annum.

Year	Status Quo (52.96 WTE)	Proposed New Staffing Model (50.85 WTE)	Change
2021-22	1,884,486	1,868,934	↓ 15,552
2022-23	1,942,800	1,926,710	↓16,090
2023-24	2,002,862	1,986,219	↓16,643
2024-25	2,064,727	2,047,513	↓ 17,213
2025-26	2,128,447	2,110,647	↓17,800

The table above shows that the new proposed staffing model costs less than the status quo staffing model. However, additional costs are associated with options 2 and 3 which lead to an increase in revenue costs by the proposed new staffing model.

The drivers for these additional costs are as follows:

[8] 1 WTE band 4 employee is employed on a fixed term basis to March 2021. This is out with the costing period and has therefore not been included within the salary protection payment calculation

Option	Additional Costs
Option 2	£100k non-recurring transition costs in year one Salary protection payment (further detail provided in section 4.2)
Option 3	£100k non-recurring transition costs in year one Salary protection payment (further detail provided in section 4.2)

5.3 Recurring Recruitment Specific Costs

The routine costs of hire will sit with the recruiting board. Specific campaigns carried out by the recruitment service on the Board's behalf will be recharged to the employing Boards.

These costs are expected to reduce under options 2 and 3 due to the economies of scale and likely reduced duplication. However, it is not possible to quantify these potential savings with any accuracy at this point.

5.4 Recurring IT Revenue Costs

A 20% annual replacement allowance for ICT hardware and mobile phones has been included for all three options to ensure staff have suitable and reliable kit. There is an expectation that the staff within the future East Region Recruitment service will continue to use their existing kit where it is fit for purpose; however this will need to be assessed nearer the time to identify what the replacement requirements are.

In addition, the following recurring revenue costs have been identified. These are applicable to all three options.

Cost	2021/22 Annual Cost (£)
ICT Recurring Licences – ServiceNow, Microsoft	22,286
ServiceNow Annual Support	1,000

Jobtrain costs are fully funded by Scottish Government at the moment with no costs being recharged to Health Boards. This will be reviewed before expiry of the current contract (3 year term currently remaining). The cost will then potentially be recharged to Health Boards, however, this has not been agreed yet so has not been included in the costs.

5.5 Non-Recurring Revenue Costs

Transitional costs will be required in relation to all the short listed options, with the exception of the Status Quo option. Exact costs are unknown at this stage. A proxy figure of £100k for transitional costs has been included at this stage. Costs will become more apparent as the programme develops and requirements can be established.

Transitional costs are included to cover a range of requirements, including but not restricted to:

- Skills gap training
- Communications
- Change management
- Service improvement
- Staff security passes/ID badges
- IT system transitional costs (migrating data)
- IT system set up costs (helpdesk and telephone)

There is an expectation that the majority of HR, OD and project manager costs will be absorbed by the Single Employer board.

Target Operating Model (TOM) at a glance

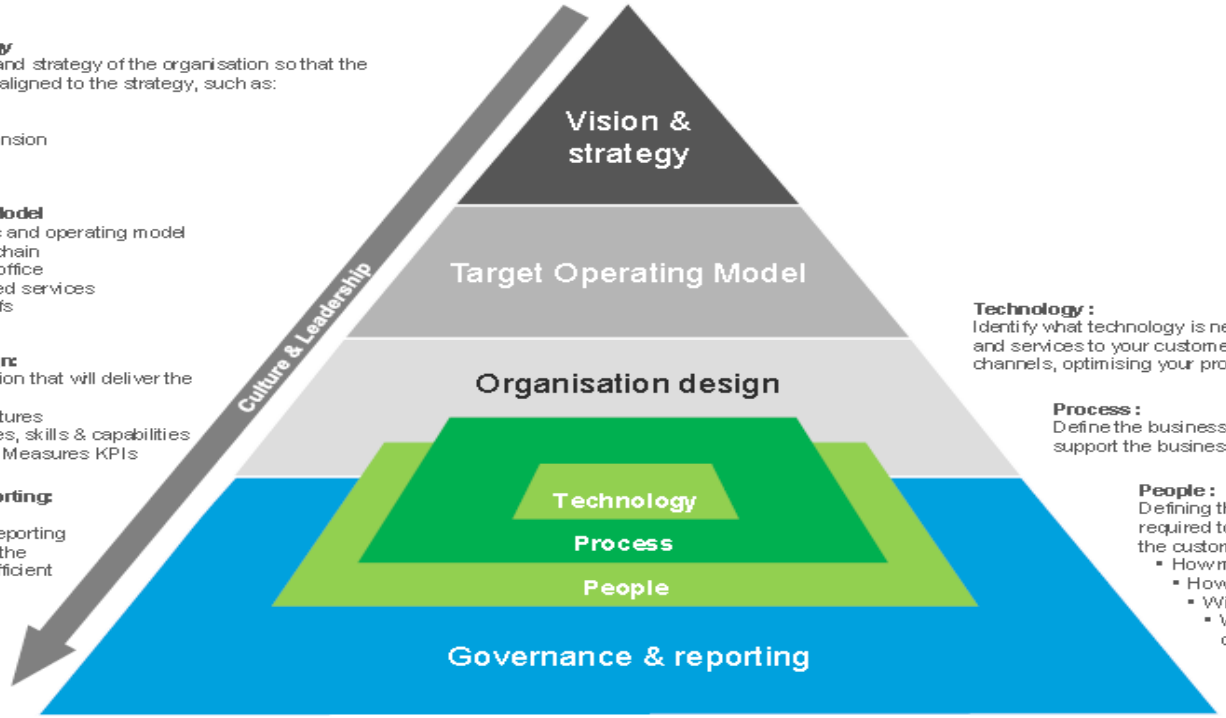
As illustrated below, the primary purpose of a TOM is to enable the application of a corporate strategy or vision to a business or operation. It is a high level representation of how a company can be best organised to more efficiently and effectively deliver and execute on the organisation's strategy. Moreover, it provides a common understanding of the organisation by allowing people to visualise the organisation from a variety of perspectives across the value chain as every significant element of business activity is represented. People, processes and technology are key components underlining any TOM and are critical to ensure its success.

Vision and Strategy
Analyse the vision and strategy of the organisation so that the business goals are aligned to the strategy, such as:
- Customer service
- Cost reduction
- International expansion
- Greater agility

Target Operating Model
Define the principles and operating model
- End to end value chain
- Front office/ back office
- Outsourcing/ shared services
- Interfaces/hand offs

Organisation design:
Define the organisation that will deliver the strategy:
- Organisation structures
- Role responsibilities, skills & capabilities
- Role Performance Measures KPIs

Governance & reporting:
Define governance arrangements and reporting requirements to run the organisation in an efficient and effective way



Technology :
Identify what technology is needed to deliver your products and services to your customers through your chosen channels, optimising your processes

Process :
Define the business and functional processes to support the business objectives

People :
Defining the level and capability of people required to meet the objectives and serve the customers:
- How many people do you need?
- How do you remunerate them?
- With what skills and knowledge?
- What ways of working and what culture do you need?

Brief Job Descriptions

Job Role	Indicative Banding	Brief Job Summary
Recruitment Services Assistant	3	The Recruitment Services Assistant is to provide day to day administration support to the Regional Recruitment Services. To answer basic enquiries that come into the recruitment service and provide advice where appropriate and under the supervision of Recruitment Services Advisor
Recruitment Services Advisor	4	The Regional Recruitment Services Advisor is responsible for carrying out the day to day recruitment activities. Provide recruitment advice and solutions to service users on a range of recruitment process and procedures related enquiries.
Recruitment Services Team Lead	5	The Regional Recruitment Services Team Lead is accountable for the day to day running and delivery of the region recruitment service activities.
Recruitment Project Manager	6	The Recruitment Project Manager is responsible for supporting the Senior Recruitment Services Manager with the delivery and implementation of agreed quality improvement and test for change projects across the Regional Recruitment Services.
Recruitment Services Manager	7	The Regional Recruitment Services Manager is accountable for managing the operational delivery and performance of the Regional Recruitment Services ensuring high standards is maintained.
Senior Recruitment Services Manager	8a	The Senior Recruitment Services Manager is instrumental in developing a holistic resourcing approach which anticipates the business's needs across all hire types within the Region, including experienced hire, senior/ exec hire and bulk recruitment.
Head of Recruitment	8c	The Head of Regional Recruitment Services is a senior Human Resources professional, who holds responsibility and accountability for the management and delivery of the Regional Recruitment Service and associated SLA.

Covid-19 Summary Feedback and Analysis

Information gathered through:

- Questionnaire "New Normal" issued to all 6 boards for completion
- Exploration and further discussion at Leads meeting 3.6.20

Summary Feedback

- The recruitment Leads for the 6 boards within the East Region (SAS, HIS, NES, NHS Borders, NHS Fife & NHS Lothian), completed a feedback questionnaire to identify the challenges and opportunities that were presented by the departments and their teams during the Covid-19 pandemic.
- The key challenges and outcomes were gathered from the feedback and discussed further during a Leads meeting on 3rd June 2020. This feedback and further analysis has helped potentially form a new way of working for the East Region recruitment service that incorporates more streamlined electronic ways of working, increasing efficiencies in time, resources and productivity.

BW 050620 v1.1

"New Normal" Summary Outcomes

- **Key Challenges**
- Mobilisation of home working (2-3 weeks, max of 200 users, insufficient laptops
- Obtaining references
- National Portal – nurses
- Online Disclosure checks (early stages/getting used to)
- OH Clearance
- PVG checks
- Electronic ID (selfie) & validity/tamper
- Unusual volumes (e.g health care support workers)

- **Key Outcomes**
- Online testing (freeing up time)
- Interviews – particularly for elsewhere in country/abroad
- Electronic ID (freeing time)
- Improved relationship with OH/Risk Averse
- Majority of people working from home (rota system for mail/non Covid pvg etc)
- Electronic PVG checks
- Microsoft Teams
- Shortened OH survey
- PVG Risk Assessment (signing disclaimer)
- Team working – professionalism & flexibility of team/proud of teams/local based knowledge helped
- Improved relationships – OH/Educational
- Emotional Wellbeing support in place – people have gone through the change curve
- Less requirement for site specific recruitment services due to flexible home working
- Team Development/Skills – band 3's helping band 4 work etc.

BW 050620 v1.1

What the Analysis tells us?

- The analysis from the gathered feedback demonstrates the power of technology and where this can improve the existing resources and current operating model within each board. It is evident that the requirement for a physical site (for projected numbers for the whole of the recruitment staff) are potentially not required as a future operating model in order for a future East Region Recruitment Service to be able to provide the required functionality and desired candidate experience. It is also evident that online ID checks, online PVG checks and interviews via Teams/online platforms have the potential to streamline and maximise efficiencies with no requirement for a single physical location to accommodate the whole of the East Region Recruitment Service.

BW 050620 v1.1

Recruitment Transformation Programme - Online Service Provider Recommendation

Background

NHS Lothian HR Enquiries service acts as a single point of contact for staff and managers to get advice on HR, OD & recruitment related enquires. NHS Lothian HR Enquiries currently do not have an online self-service enquiry platform. Enquiries are handled by email and telephone using Netcall 59R Contact Centre System.

Due to the expected growing demand within the service and to progress in line with technology and future innovation, it is important to explore the self-service desk option to support the future regional recruitment service to ensure the delivery of a high quality customer experience.

Service Now Online Platform

Payroll and eHealth currently use the self-service provider, Service Now. Service Now enables customers to self-serve, log and track enquiries and enquiry handlers can digitally manage and answer enquiries through the service platform. The system provides an overview of current enquiries and eases the management of caseloads and provides a high level large range reporting facility. The system can be securely accessed via mobile and outside the NHS network.

User Experience

Feedback was sought from existing users of Service Now (NSS, payroll, NHS Lanarkshire) for further consideration of alternative systems and current performance levels.

Alternative in house systems such as Zendesk were considered however it was left to the departments to build and configure & manage which greatly impacts time resources and skill sets. HR Connect was considered however this has limitations as public websites do not support at present.

EHealth use Service now in addition to Payroll & NHS Lanarkshire. Feedback from the service users has been very positive with the implementation of Service Now well supported from NSS as they have expert knowledge of the system and provide training to Super Users as part of the implementation process. The Service Now platform so far has not presented any issues with platform stability and is a service used widely outside the NHS. Within NHS Lanarkshire, all sub-sections within the HR Directorate with the exception of Staff bank and OD are using Service Now and NHS Forth Valley are currently trialling the system.

Costing

Costs for the introduction of Service Now quoted by NSS are logged in the table below. It should be noted that with more users it is expected that the license cost will reduce in price.

Basic Quoted Costs - 19.2.20					
Implementation	**Annual Support Costs - 20%**	**License Costs**	Projected Year 1 cost (Implementation)	Projected BAU Annual Cost from Year 2	Projected Total Costs over 5 years based on 59 licenses*
£5,000	**£1,000**	**£3.15 Per User**	£8230.20	£3230.20	£12,230.20

**This is an indicative number of licenses used solely for comparison purposes and the actual number of licenses required will be calculated by the relevant employer.*

Comparative costs are logged in the table below:

Comparative Costs for other service Users - 2019

	Set Up Costs	Annual Costs	License Costs	Projected Total Costs over 5 years based on 59 licences
Payroll – Service Now (Hosted by NSS)	£5,000	£3,000	£3.60 per month per user	£32,744
eHealth – Service Now (Hosted by NHS Lothian)	*Based on eESS service desk discussion no start up costs.*		£42 per month per user	£148,680
JIRA Service Desk – (Hosted by NES)	*None*	None	£25 per month per user	£88,500

It should be noted that comparative costs for Service Now were acquired in 2019 and that the annual and license costs quoted have reduced as the number of users has increased in 2020 and this is a trend expected to continue as per NSS expectations.

Recommendation

Taking into account cost projections and the feedback around existing systems that require a specific in house skills set to design and build and the time that this involves and the feedback provided by existing users, Service now provides a stable online self-service platform that can quickly be introduced to meet the needs of a regional recruitment service and provide service users with a high quality experience providing the required statistical reporting facilities that will continue to help the service to grow and evolve.

It is therefore recommended that Service Now (delivered through NSS) be the online self service enquiry system that the employer of the regional service introduces as part of the Transformation programme during phase 1 of the regional recruitment service.

Communications Plan

Appendix 15

Recruitment Transformation Programme.	**The overview, objectives and benefits of the programme. The key contact, timeframe and progress of programme workstreams.**	**Newsletter** **Staff meeting** **Minutes of Programme Board meeting**	**Quarterly** **As needed** **Monthly**	**Recruitment Staff Partnership HRDs Services Users**	**Members of the programme board**
Recruitment model option discovery and appraisal.	The objectives, outline and outcome of the option discovery and appraisal workshops.	Staff engagement session Workshop report	Pre workshop Post workshop	Recruitment Staff Workshop Attendees Programme Board Partnership	Programme Director/Recruitment Leads Project Manager
Keep staff and customers informed of new recruitment system launch and development.	The benefits of new recruitment system. Implementation and transition plan, change requirements and timescale.	Staff briefing Newsletter Userguide Global emails Training sessions FAQs Intranet Internet	In accordance to system implementation phase for each board	Recruitment Staff Partnership HRDs/CEO/DOF Service Users	Recruitment Leads System Project Lead Project Manager
Development of internet/intranet as a	Used to communicate a variety of key	Internet/Intranet	As needed	All stakeholders	Recruitment Leads Communications

powerful communication tool	programme development and messages	Web Banner Board team brief/newsletter			Representative Project Manager
Keep stakeholders informed of the recruitment transformation programme development.	Ad hoc messages	Staff meeting Minutes of meetings Emails	As needed Monthly As needed	Recruitment Staff	Recruitment Leads
Keep national steering group, regional workforce group and other regions recruitment transformation programme leads inform of East Region development and progress.	Key progress and development messages. Risk and issues arise.	Briefing note Fortnightly telephone conference Newsletter	Monthly Fortnightly Quarterly	National Steering Group Regional Workforce Group Regional Recruitment Transformation Programme Leads	Programme Director
Recruitment Model	The outline of new recruitment model; organisational change management process; model branding; discussion on recruitment service values/principles and identities.	Staff Engagement Workshops	Once	Recruitment Leads Recruitment Staff Partnership Service Users	Programme Team
Key Messages	Key messages from each stage of progress or meeting	Emails	As needed (circulate within 5 working days of agreement)	Recruitment Leads Recruitment Staff Partnership Service Users	Recruitment Leads Programme Board members Project Manager
Communication Log	To keep a communication log of all the communications and key messages that have	Log	As needed	Recruitment Leads Programme Board members	Project Manager

	been shared with stakeholders				

Technology and Equipment Costings (as of June 2020)

	£ Ex Vat	£ Ex Vat
Option	One Off	Recurring
a) HP Elitebook 840 14" Standard Laptop / Case (can work with docking station)	£525	
b) Dell Lattitude 3500 15" Thin Client Laptop	£310	
24" Monitor - standard	£100	
24" Monitor - integrated camera, Mike and Speakers	£130	
Laptop Docking station	£120	
Headset	£35	
Camera	£75	
Keyboard and Mouse	£8.5	
For new devices we charge:		
Initial Software bundle one off cost	£135	
Standard Software Bundle		£150 pa
MS Office (E1 Web Access)		£24pa
MS Office (E3 Full client Access - E1 +£120		£144pa

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**12 January 2021**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Author:	**Susan Fraser, Associate Director of Planning & Performance**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Discussion

This report relates to the:

- Annual Operational Plan (AOP), as impacted by the Joint Fife Mobilisation Plan (JFMP)

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report informs the Finance, Performance & Resources (FPR) Committee of performance in NHS Fife and the Health & Social Care Partnership against a range of key measures (as defined by Scottish Government 'Standards' and local targets). The period covered by the performance data is (with certain exceptions due to a lag in data availability) up to the end of October 2020.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board. It is produced monthly and made available to Board Members via Admin Control.

The report is presented at the bi-monthly meetings of the Clinical Governance, Staff Governance and Finance, Performance & Resources Committees, and an 'Executive Summary' IPQR (ESIPQR) is then produced as a formal NHS Fife Board paper.

The May meeting of the SG Committee was cancelled due to the pandemic, but 'virtual' meetings have taken place bi-monthly since July.

2.3 Assessment

The IPQR has been changed for FY 2020/21, to include improvement actions which reflect the challenges imposed by the COVID-19 pandemic. These reflect the spirit of the JFMP, where possible.

Performance, particularly in relation to Waiting Times across Acute Services and the Health & Social Care Partnership has been hugely affected during the pandemic, and recovery is being planned in stages. The Scottish Government have been provided with a plan which forecasts recovery trajectories in the period up to the end of the FY, and progress against this is included in the IPQR at Annex 1. The projections take account of additional funding provided by the Scottish Government.

The FPR aspects of the report cover Operational Performance (in Acute Services/Corporate Services and the Health & Social Care Partnership) and Finance. All measures apart from the two associated with Dementia PDS have performance targets and/or standards, and a summary of these is provided in the tables below.

WT = Waiting Times
RTT = Referral-to-Treatment
TTG = Treatment Time Guarantee (measured on Patient Waiting, not Patients Treated)
DTT = Decision-to-Treat-to-Treatment

Operational Performance – Acute Services / Corporate Services

Measure	Update	Target	Current Status
IVF WT	Monthly	100%	Achieving
4-Hour Emergency Access	Monthly	95%	Not achieving
New Outpatients WT	Monthly	95%	Not achieving
Diagnostics WT	Monthly	100%	Not achieving
Patient TTG	Monthly	100%	Not achieving
18 Weeks RTT	Monthly	90%	Not achieving
Cancer 31-Day DTT	Monthly	95%	Achieving
Cancer 62-Day RTT	Monthly	95%	Not achieving
Detect Cancer Early	Quarterly	29%	Not achieving
FOI Requests	Monthly	85%	Achieving

Operational Performance – H&SCP

Measure	Update	Target	Current Status
DD (Bed Days Lost)	Monthly	5%	Not achieving
Antenatal Access	Monthly	80%	Achieving
Smoking Cessation	Monthly	100%	Not achieving
CAMHS WT	Monthly	90%	Not achieving
Psy Ther WT	Monthly	90%	Not achieving

ABI (Priority Settings) [1]	Quarterly	80%	Not achieving
Drugs & Alcohol WT	Monthly	90%	Achieving

Finance

Measure	Update	Target	Current Status
Revenue Expenditure	Monthly	Break even	Not achieving
Capital Expenditure	Monthly	£15.471m	Achieving

[1] The NHS Fife fractionally missed the target for 2019/20, but this was due to the delivery of interventions in an A&E setting being paused during the pandemic – data collection for 2020/21 continues to be impacted, and there has been no guidance on expected achievement from the Scottish Government

2.3.1 Quality/ Patient Care

Refer to the Exec Summary for details on how the COVID-19 pandemic has affected service performance throughout NHS Fife.

2.3.2 Workforce

The report has been compiled by the Planning & Performance Team (PPT) with the support of Managers across the range of NHS Fife services.

2.3.3 Financial

Financial aspects are covered by the appropriate section of the IPQR.

2.3.4 Risk Assessment/Management

All current risks are related to the COVID-19 pandemic.

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

2.3.6 Other impact

None.

2.3.7 Communication, involvement, engagement and consultation

The NHS Fife Board Members are aware of the approach to the production of the IPQR since April.

Standing Committees and Board Meetings were cancelled in May, but restarted in July, and the December IPQR will be available for discussion at the round of January meetings.

2.3.8 Route to the Meeting

The IPQR was drafted by the PPT, ratified by the Associate Director of Planning & Performance and circulated to EDG members for consideration on 14 December. Following minor cosmetic changes, it was authorised for release to Board Members and Standing Committees.

2.4 Recommendation

The FPR Committee is requested to:

- **Discussion** – Examine and consider the NHS Fife performance, with particular reference to the measures identified in Section 2.3, above

3 List of appendices

None

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Fife Integrated Performance & Quality Report

Produced in December 2020

NHS Fife

Introduction

The purpose of the Integrated Performance and Quality Report (IPQR) is to provide assurance on NHS Fife's performance relating to National LDP Standards and local Key Performance Indicators (KPI).

A summary report of the IPQR, the Executive Summary IPQR (ESIPQR), is presented at each NHS Fife Board Meeting.

The IPQR comprises of the following sections:

I. Executive Summary

a. LDP Standards & Local Key Performance Indicators (KPI)

b. National Benchmarking

c. Indicatory Summary

d. Assessment

II. Performance Assessment Reports

a. Clinical Governance

b. Finance, Performance & Resources
   - Operational Performance
   - Finance

c. Staff Governance

Section II provides further detail for indicators of continual focus or those that are currently underperforming. Each 'drill-down' contains data, displaying trends and highlighting key problem areas, as well as information on current issues with corresponding improvement actions.

I. Executive Summary

At each meeting, the Standing Committees of the NHS Fife Board consider targets and Standards specific to their area of remit. This section of the IPQR provides a summary of performance against LDP Standards and local Key Performance Indicators (KPI). These indicators are listed within the Indicator Summary, which shows current, previous and (where appropriate) 'Year Previous' performance as well as benchmarking against other mainland NHS Boards.

The 2020/21 Annual Operational Plan (AOP) was produced before the COVID-19 Pandemic, and its content, both in terms of planned improvement work and performance improvement trajectories, was being discussed with the Scottish Government when the lockdown started. The suspension of many services means that the AOP cannot be reflected in the IPQR.

An alternative source for Improvement Actions in the 2020/21 IPQR, specifically for performance areas relating to Waiting Times, is the Joint Mobilisation Plan (JMP) for Fife. This has been produced at the request of the Scottish Government in order to describe the steps being taken by the Health Board and Health & Social Care Partnership to recover services which were 'paused' from the start of the COVID-19 lockdown.

As part of the JMP, a spreadsheet showing projected activity across critical services during the final 3 quarters of FY 2020/21 has been created and is being populated with actual figures as we go forward. In order to provide as up-to-date information as possible, some of the figures are initially provisional, and will be corrected if necessary the following month. The latest version of this is shown in Appendix 1.

Improvement Actions in the drill-downs carry a '20' or '21' prefix, to identify those continuing from 2019/20 and those identified as new for this FY. They are shaded in **BLUE** if they are assessed as being complete or no longer relevant.

a. LDP Standards & Key Performance Indicators

The current performance status of the 29 indicators within this report is 9 (31%) classified as **GREEN**, 4 (14%) **AMBER** and 16 (55%) **RED**. This is based on whether current performance is exceeding standard/trajectory, within specified limits (mostly 5%) of standard/trajectory or considerably below standard/trajectory.

There was notable improvement in the following areas during the last reporting period:

- FOI – achievement of the 85% target for closure within 20 days during 3-month period ending October
- Delayed Discharges – lowest number of patients in delay and bed days % lost due to delays since June

b. National Benchmarking

National Benchmarking is based on whether NHS Fife performance is in the upper quartile of the 11 mainland Health Boards (●), lower quartile (●) or mid-range (●). The current benchmarking status of the 29 indicators within this report has 7 (24%) within upper quartile, 18 (62%) in mid-range and 4 (14%) in lower quartile.

There are indicators where national comparison is not available or not directly comparable.

Indicator Summary

Performance
meets / exceeds the required Standard / on schedule to meet its annual Target
behind (but within 5% of) the Standard / Delivery Trajectory
more than 5% behind the Standard / Delivery Trajectory

Benchmarking	
●	Upper Quartile
●	Mid Range
●	Lower Quartile

Section	LDP Standard	Standard	Target 2020/21	Reporting Period	Year Previous		Previous		Current			Reporting Period	Fife		Scotland
Clinical Governance	N/A	Major & Extreme Adverse Events	N/A	Month	Oct-19	52	Sep-20	23	Oct-20	17	↑	N/A			
	N/A	HSMR	N/A	Year Ending	Jun-19	1.04	Mar-20	1.01	Jun-20	1.00	↑	YE Jun-20	1.00	●	1.00
	N/A	Inpatient Falls	5.97	Month	Oct-19	6.76	Sep-20	9.54	Oct-20	7.94	↑	N/A			
	N/A	Inpatient Falls with Harm	2.16	Month	Oct-19	1.17	Sep-20	2.12	Oct-20	1.68	↑	N/A			
	N/A	Pressure Ulcers	0.42	Month	Oct-19	1.00	Sep-20	1.44	Oct-20	1.04	↑	N/A			
	N/A	Caesarean Section SSI	2.5%	Quarter Ending	Jun-19	2.0%	Mar-20	0.9%	Jun-20	2.3%	↓	QE Dec-19	2.3%	●	0.9%
	N/A	SAB - HAI/HCAI	19.5	Quarter Ending	Oct-19	6.6	Sep-20	17.3	Oct-20	15.7	↑	QE Jun-20	6.3	●	20.3
	N/A	SAB - Community	N/A	Quarter Ending	Oct-19	8.5	Sep-20	7.4	Oct-20	10.6	↓	QE Jun-20	14.0	●	9.4
	N/A	C Diff - HAI/HCAI	6.7	Quarter Ending	Oct-19	14.2	Sep-20	9.3	Oct-20	9.2	↑	QE Jun-20	7.9	●	15.4
	N/A	C Diff - Community	N/A	Quarter Ending	Oct-19	2.1	Sep-20	6.4	Oct-20	3.2	↑	QE Jun-20	1.1	●	5.9
	N/A	ECB - HAI/HCAI	36.6	Quarter Ending	Oct-19	43.8	Sep-20	44.0	Oct-20	39.3	↑	QE Jun-20	36.4	●	39.7
	N/A	ECB - Community	N/A	Quarter Ending	Oct-19	43.7	Sep-20	38.2	Oct-20	34.0	↑	QE Jun-20	38.8	●	35.9
	N/A	Complaints (Stage 1 Closure Rate)	80%	Quarter Ending	Oct-19	82.8%	Sep-20	74.8%	Oct-20	79.8%	↑	2018/19	70.7%	●	81.5%
	N/A	Complaints (Stage 2 Closure Rate)	65%	Quarter Ending	Oct-19	60.8%	Sep-20	44.4%	Oct-20	32.5%	↓	2018/19	49.1%	●	53.7%
Operational Performance	90%	IVF Treatment Waiting Times	90%	Month	Oct-19	100.0%	Sep-20	100.0%	Oct-20	100.0%	↔	N/A			
	95%	4-Hour Emergency Access	95%	Month	Oct-19	92.7%	Sep-20	95.4%	Oct-20	94.1%	↓	Oct-20	94.1%	●	89.6%
	100%	Patient TTG (Ongoing Waits)	N/A	Month	Oct-19	90.5%	Sep-20	44.1%	Oct-20	54.9%	↑	Jun-20	32.1%	●	28.5%
	95%	New Outpatients Waiting Times	N/A	Month	Oct-19	92.4%	Sep-20	57.4%	Oct-20	59.3%	↑	Jun-20	37.4%	●	35.4%
	100%	Diagnostics Waiting Times	N/A	Month	Oct-19	99.0%	Sep-20	93.1%	Oct-20	94.3%	↑	Sep-20	93.1%	●	53.3%
	95%	Cancer 31-Day DTT	N/A	Month	Oct-19	98.1%	Sep-20	100.0%	Oct-20	100.0%	↔	QE Jun-20	96.3%	●	97.1%
	95%	Cancer 62-Day RTT	N/A	Month	Oct-19	91.0%	Sep-20	85.0%	Oct-20	81.7%	↓	QE Jun-20	77.7%	●	84.1%
	90%	18 Weeks RTT	N/A	Month	Oct-19	79.6%	Sep-20	59.7%	Oct-20	65.1%	↑	QE Sep-20	63.8%	●	67.3%
	29%	Detect Cancer Early	29%	Year Ending	Jun-19	27.2%	Mar-20	24.6%	Jun-20	23.5%	↓	2018, 2019	26.1%	●	25.6%
	N/A	Delayed Discharge (% Bed Days Lost)	5%	Month	Oct-19	6.4%	Sep-20	6.4%	Oct-20	5.2%	↑	QE Jun-20	4.6%	●	3.8%
	N/A	Delayed Discharge (# Standard Delays)	N/A	Month	Oct-19	64	Sep-20	48	Oct-20	35	↑	Oct-20	9.37	●	13.20
	80%	Antenatal Access	80%	Month	Mar-19	90.2%	Feb-20	84.1%	Mar-20	88.2%	↑	FY 2019/20	89.0%	●	88.3%
	473	Smoking Cessation	473	YTD	Aug-19	94.4%	Jul-20	38.6%	Aug-20	38.6%	↔	FY 2019/20	92.8%	●	97.2%
	90%	CAMHS Waiting Times	N/A	Month	Oct-19	62.5%	Sep-20	70.4%	Oct-20	76.5%	↑	QE Sep-20	63.9%	●	60.6%
	90%	Psychological Therapies Waiting Times	N/A	Month	Oct-19	64.2%	Sep-20	77.0%	Oct-20	64.7%	↓	QE Sep-20	76.6%	●	75.1%
	80%	Alcohol Brief Interventions (Priority Settings)	80%	YTD	Mar-19	66.1%	Dec-19	75.7%	Mar-20	79.2%	↑	FY 2019/20	79.2%	●	83.2%
	90%	Drugs & Alcohol Treatment Waiting Times	90%	Month	Jul-19	97.2%	Jun-20	93.4%	Jul-20	96.8%	↑	QE Jun-20	87.3%	●	95.3%
	N/A	Dementia Post-Diagnostic Support	N/A	Annual	2017/18	86.7%	2018/19	94.0%	2019/20	95.5%	↑	2017/18	86.8%	●	72.5%
	N/A	Dementia Referrals	N/A	Annual	2017/18	55.4%	2018/19	60.7%	2019/20	58.1%	↓	2017/18	55.3%	●	42.3%
	N/A	Freedom of Information Requests	85%	Quarter Ending	Oct-19	58.2%	Sep-20	81.5%	Oct-20	85.7%	↑	N/A			
Finance	N/A	Revenue Expenditure	£0	Month	Oct-19	N/A	Sep-20	+£1.859m	Oct-20	+£2.822m	↓	N/A			
	N/A	Capital Expenditure	£15.471m	Month	Oct-19	N/A	Sep-20	£3.323m	Oct-20	£3.789m	↑	N/A			
Staff Governance	4.00%	Sickness Absence	4.39%	Month	Oct-19	5.70%	Sep-20	5.69%	Oct-20	4.93%	↑	YE Mar-20	5.49%	●	5.31%

d. Assessment

Clinical Governance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
HSMR	1.00	N/A	N/A	YE Jun-20	1.00	YE Jun-20	
The HSMR for NHS Fife for the year ending June 2020 improved slightly in comparison to the year ending March 2020, and was equal to the Scotland average. The drill-down narrative provides a detailed explanation of the measure and limitations associated with it.							
Inpatient Falls (with Harm) Reduce falls with harm by 20% by December 2020	2.16	Oct-20	2.16	Oct-20	1.68	N/A	N/A
A small reduction in the falls with harm rate has been noted, and local focus continues to support consideration of practice to continue this trend. The COVID context remains the significant challenge in patient placement and e.g. PPE. Ward 41 at VHK (changed from a Stroke focus to general Medicine of the Elderly) is identified as having an upward falls trend, and work is already underway to change processes to mitigate this. Work is also underway to analyse the data from SACH, which shows a higher falls rate, albeit without a corresponding rise in the falls with harm rate.							
Pressure Ulcers 50% reduction by December 2020	0.42	Never Met	0.42	Oct-20	1.04	N/A	N/A
FHSCP hospital acquired pressure ulcers have increased slightly in Q3 from Q2 (from 13 incidents to 16), and the current rate of 0.60 is the highest since December 2019. ASD hospital acquired pressure ulcers have decreased slightly from Q3 from Q2, the current rate of 1.54 being the lowest since July. An improvement collaborative started on 24th September in three wards in the East Division, and no hospital acquired pressure ulcers were reported in these wards in September or October.							
Caesarean Section SSI We will reduce the % of post-operation surgical site infections to 2.5%	N/A	QE Jun-20	2.5%	QE Jun-20	2.3%	QE Dec-19	
Mandatory SSI surveillance has been paused since the starte of the Covid-19 pandemic, although Maternity Services have continued to monitor Caesarean Section SSI cases throughout the year. The performance data provided is non-validated and does not follow the agreed NHS Fife methodology, and there is currently no national comparison available beyond the final quarter of 2019.							
SAB (MRSA/MSSA) We will reduce the rate of SAB HAI/HCAI by 10% between March 2019 and March 2022	18.8	QE Oct-20	19.5	QE Oct-20	15.7	QE Jun-20	
Mandatory surveillance of SABs has continued throughout the COVID-19 pandemic. The NHS Fife HCAI rate was below National levels for Q2 2020, and also continues to be below the improvement trajectory; we are higher than the national average for community SABs. Surveillance has identified a cluster of unrelated SABs in ICU, partly related to post-COVID bacterial pneumonias. There have been just 4 PWID SABs so far in 2020, a marked improvement from 14 in 2019.							
C Diff We will reduce the rate of C Diff HAI/HCAI by 10% between March 2019 and March 2022	6.5	QE Aug-20	6.7	QE Oct-20	9.2	QE Jun-20	
CDI surveillance has continued throughout the COVID-19 pandemic. While NHS Fife remains below the national rates for both HCAI and CAI CDI, we are currently above the HCAI performance improvement trajectory. Recurrence of infection continues to be the ongoing challenge to address in reducing this rate to meet the reduction target by March 2022.							
ECB We will reduce the rate of E. coli bacteraemia HAI/HCAI by 25% between March 2019 and March 2022	33.0	QE Jun-20	36.6	QE Oct-20	39.3	QE Jun-20	
ECB surveillance has continued during the COVID-19 pandemic. NHS Fife achieved a rate below the national levels for Q2 2020 for Healthcare (HCAI) rates, although above for community ECBs. Whilst there has been a slight improvement in Fife's ECB rate from 2019, achieving the HCAI reduction target by March 2022 remains a challenge. Reducing urinary tract infections & CAUTIs remains the key to achieving this.							
Complaints - Stage 2 At least 75% of Stage 2 complaints are completed within 20 working days	N/A	Never Met	65%	QE Oct-20	32.5%	FY 2018/19	
Performance in closing complaints fell sharply during the early months of the pandemic, a common pattern across all Health Boards. We have been clearing the backlog of cases, expending particular effort on closing older complaints in October. The Patient Relations capacity to respond to complaints has been significantly impacted recently by the influx of complaints and calls relating to the Flu Vaccination Programme, while the hospital sites continue to be busy in responding to the Covid-19 pandemic, affecting the ability to respond to complaints within normal timescales.							

Finance, Performance & Resources Operational Performance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
4-Hour Emergency Access 95% of patients to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment	95%	Sep-20	95%	Oct-20	94.1%	Oct-20	●
The decrease in performance is reflective of the increasing capacity challenges the hospital is seeing and the lack of flow, especially early in the day. Attendances remain below the projected numbers which is supporting the improved performance on last year.							
Patient TTG (Ongoing Waits) All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat	100%	Never Met	N/A	Oct-20	54.9%	Jun-20	●
The number of patients waiting greater than 12 weeks decreased further in October (to 1,253, around 55% of the waiting list), with similar improvement in the % of patients waiting more than 18 and 26 weeks. Additions continue to increase (though still 33% below average), and this trend is expected to continue as routine outpatient clinics increase in line with plans. Activity delivered continues to increase in line with projections, however, elective theatre capacity reduced in November due to unscheduled care pressures. Additional in-house weekend activity funded by Scottish Government commenced in November and will enable a reduction in the backlog of routine procedures over the next 5 months. We are on course to deliver around 80% of the previous average level of activity by December 2020.							
New Outpatients 95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment	95%	Mar-20	N/A	Oct-20	59.3%	Jun-20	●
The number of patients waiting over 12, 18 and 26 weeks have been hugely impacted and are significantly higher as a % than they were before lockdown. The number of patients waiting greater than 12 weeks has improved slightly from a position of over 7,400 (50% of the waiting list) in August to just below 7000 (40% of the waiting list) in October. Referrals remain at 78% and activity remains at 74% of the average before lockdown resulting in an increase in the size of the outpatient waiting list. The activity delivered has been less than projected in some specialities due to challenges with the number of urgent review appointments and the impact of infection control measures. Unscheduled care pressures may also impact on outpatient capacity over the winter months. Efforts continue to find solutions to maximise the use of available clinical capacity. Additional in house and in-sourced activity has been delivered in November to reduce the backlog of routine referrals in a number of specialities and along with clinical validation of the waiting lists is beginning to reduce the number of patients waiting over 18 and 26 weeks.							
Diagnostics 100% of patients to wait no longer than 6 weeks from referral to key diagnostic test (scope or image)	100%	Apr-16	N/A	Oct-20	94.3%	Sep-20	●
The percentage of patients waiting less than 6 weeks for a diagnostic test has increased from to 78% in August to 94% in October following the increase in capacity in line with remobilisation plans. The percentage of patients waiting less than 6 weeks in endoscopy has risen from 41% in August to 59% in October. Capacity continues to be reduced by 30% due to physical distancing and infection control procedures. Capacity for routine endoscopies will be further reduced in November to accommodate the restart of Bowel Screening. Discussions around recovery plans have taken place with the SG, and funding has been agreed for some additional capacity which will be targeted at routine referrals. The percentage of patients waiting less than 6 weeks in radiology has risen from 87% in August to 100% in October due to increased activity and demand which is below that before lockdown. An increase in demand for inpatient diagnostic imaging in November will impact on performance in routine patients waiting over 6 weeks. Priority continues to be given to urgent referrals.							
Cancer 62-Day RTT 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral	95%	Oct-17	N/A	Oct-20	81.9%	QE Jun-20	●
Performance deteriorated in October, with the majority of breaches being seen in prostate due to the challenging pathway; improvement work in this area is delayed due to COVID. Delays at the start of the colorectal, lymphoma and upper GI pathways led to breaches in those specialties, while issues with PET reporting resulted in delay to MDT within the cervical pathway. Cancer patients continue to be prioritised and no breaches were as a direct result of COVID. Breaches ranged between 2 and 48 days, with an average of 24 days.							

Finance, Performance & Resources Operational Performance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
FoI Requests At least 85% of Freedom of Information Requests are completed within 20 working days	N/A	QE Oct-20	85%	QE Oct-20	85.7%	N/A	N/A
Work has continued at a positive pace within FOI, in NHS Fife with particular attention being paid to raising the level of compliance regarding responding to requests, ensuring AXLR8 is functioning well and looking ahead to the larger and more strategic next steps in bring NHS Fife up to full compliance under the Act.							
Delayed Discharge The % of Bed Days 'lost' due to Patients in Delay is to reduce	N/A	Jun-20	5%	Oct-20	5.2%	QE Jun-20	●
Bed days lost due to patients in delay icreased above the local target in late summer, after falling during the early months of the pandemic. However, this is now reducing and for October we are close to again achieving the 5% target. We have seen occupancy rise across our Acute and community hospitals, but LOS has been steadily reducing within our community hospitals, and this is supporting flow.							
Smoking Cessation Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas	100%	YT May-19	100%	YT Aug-20	38.6%	FY 2019/20	●
Staffing levels have been severely affected due to personnel taking up posts with Test and Protect, leaving the organisation or taking Maternity Leave. Recruitment has taken place, with new staff taking up post in December and January, and alternative arrangements put in place to support current clients has enabled continuity of care. The service has seen a drop in self referral to support over November which has allowed it to cope without having to create a waiting list. The Better Beginning work with pregnant mums has not progressed as expected as one staff member has been moved to work on other maternity priorities.							
CAMHS Waiting Times 90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral	90%	Sep-16	N/A	Oct-20	76.5%	QE Sep-20	●
Referral rates are marginally higher than those received at the same point last year however urgent presentations direct to CAMHS and via VHK have increased significantly over the past 3 months. This has resulted in increased capacity being targeted to respond to these presentations, drawing away staff from existing waiting list and longest waits. 'DNA's' and 'Treatment not required' continues to be a factor that effects performance and is under review by the service.							
Psychological Therapies 90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral	90%	Never Met	N/A	Oct-20	64.7%	QE Sep-20	●
As anticipated, the increase in clinical activity with the longest waiting patients has led to reduced performance on the target. The numbers waiting for PTs continues at present on a positive downward trajectory. Referrals, however, continue to rise and the demand/capacity gap remains significant in many areas of service.							

Finance, Performance & Resources Finance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
Revenue Expenditure Work within the revenue resource limits set by the SG Health & Social Care Directorates	Breakeven	N/A	Breakeven	Oct-20	+ £2.822m	N/A	N/A
The position to month 7 is an overspend of £2.8m; the forecast outturn to the year end is a potential worst case overspend of £9.5m. This assumes retention of our offsetting cost reductions (from pausing core services in the first half of the year) to contribute to our unmet savings; and recognises our current commitment to the IJB risk share as a potential cost to NHS Fife of £7.2m. The impact of Covid-19 on the financial performance is a key issue. Our initial allocation of Covid-19 funding is based on 70% of costs with a general 30% contingency retained by the Portfolio in recognition of the level of uncertainty reflected in financial assumptions. Scottish Government have indicated that a review of Boards' unachieved efficiency savings will be undertaken to inform a final allocation across Scotland. There is a level of risk in that final funding has yet to be confirmed across Scotland.							
Capital Expenditure Work within the capital resource limits set by the SG Health & Social Care Directorates	£15.471m	N/A	£15.471m	Oct-20	£3.789m	N/A	N/A
The total Capital Resource Limit for 2020/21 is £15.417m including anticipated allocations for specific projects. The capital position for the 7 months to October shows investment of £3.789m equivalent to 24.58% of the total allocation. The capital spend on the specific projects commences in earnest in the latter half of the financial year and as such is on track to spend in full.							

Staff Governance	Standard / Local Target	Last Achieved	Target 2020/21	Current Performance		Benchmarking Period and Quartile	
Sickness Absence To achieve a sickness absence rate of 4% or less	4.00%	Never Met	4.39%	Oct-20	4.93%	YE Mar-20	

Sickness absence levels continue to fluctuate, however it is positive to note that the trend improved for the first seven months of the year, albeit the rates BEING above 5% in July and September. Given COVID-19 and Winter pressures, we continue to anticipate that it will be challenging to maintain the current sickness absence performance levels. Business as usual Promoting Attendance activities in terms of Promoting Attendance Review & Improvement Panels and training have recommenced.

II. Performance Exception Reports

Clinical Governance

Finance, Performance & Resources – Operational Performance

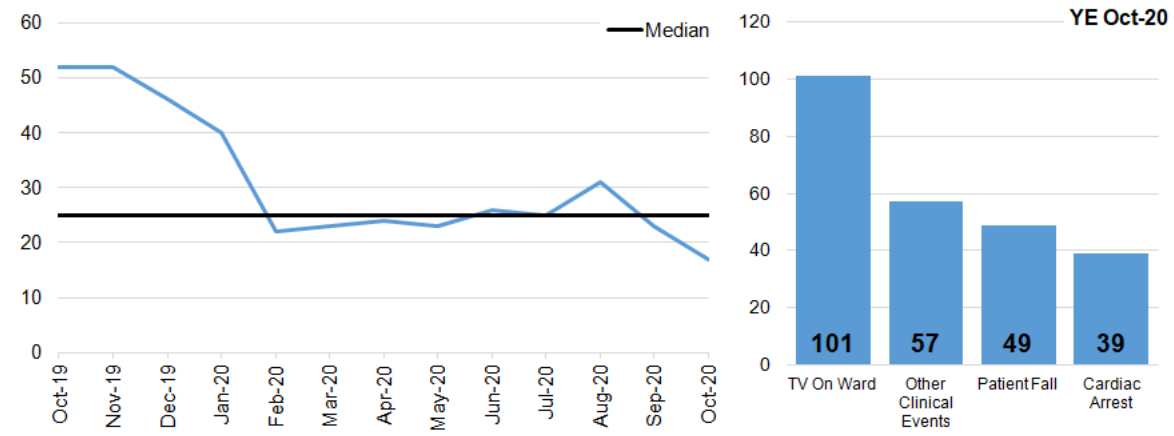
Finance, Performance & Resources – Finance

Staff Governance

Clinical Governance

Adverse Events

Major and Extreme Adverse Events



All Adverse Events

	Month	2019/20						20/21						
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
ALL	NHS Fife	1355	1358	1389	1397	1307	1119	891	1064	1122	1325	1238	1279	1322
	Acute Services	658	575	585	616	634	470	372	474	463	559	502	602	553
	HSCP	647	735	767	745	623	625	486	557	626	727	694	633	739
	Corporate	50	48	37	36	50	24	33	33	33	39	42	44	30
CLINICAL	NHS Fife	939	890	931	911	923	797	609	724	739	905	832	914	887
	Acute Services	592	534	527	556	572	438	343	431	421	513	465	554	504
	HSCP	321	339	393	337	333	344	248	278	298	371	351	341	371
	Corporate	26	17	11	18	18	15	18	15	20	21	16	19	12

Commentary

In January 2020, the reporting of tissue viability (on admission) adverse events changed, and this accounts for the reduction in major and extreme events as illustrated above.

In addition to this change, there have been changes and improvements made to the reporting pathway of unexpected death, specifically those within mental health and addiction services. These changes have become noticeable within the system from July onwards. This, along with natural variation in a system would explain some of the change evidenced in the reported numbers of major and extreme adverse events.

In March 2020, the configuration of services, including how services were offered and the numbers of people attending, changed significantly in response to the COVID-19 pandemic. This led to a reduction in the number of events reported across NHS Fife in Q2 of 2020. From July onwards, as services have resumed, the numbers of reported events has increased and is now in line with previous months.

Clinical Governance

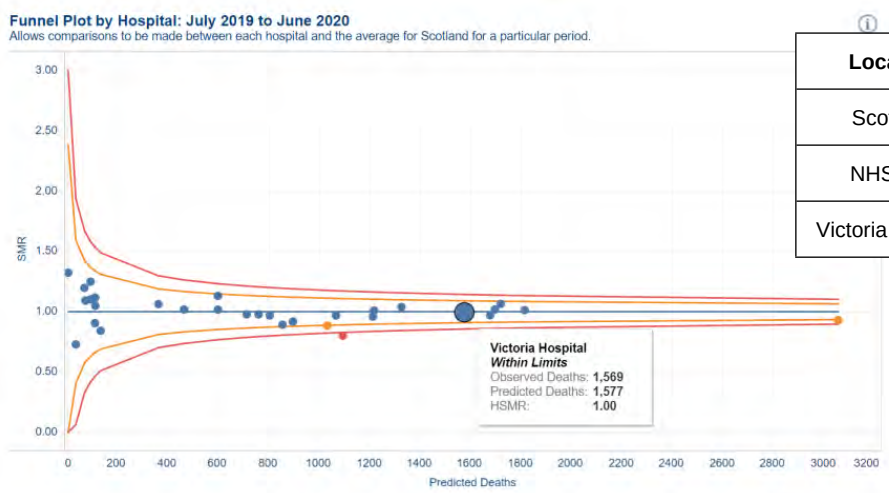
HSMR

Value is less than one, the number of deaths within 30 days of admission for this hospital is fewer than predicted. If value is greater than one, number of deaths is more than predicted.

Reporting Period; July 2019 to June 2020[p]

Please note that as of August 2019, HSMR is presented using a 12-month reporting period when making comparisons against the national average. This will be advanced by three months with each quarterly update.

The rates for Scotland, NHS Fife (as a whole) and Victoria Hospital as an entity in itself, are shown in the table within the Funnel Plot.



Location	HSMR
Scotland	1.00
NHS Fife	1.00
Victoria Hospital	1.00

Commentary

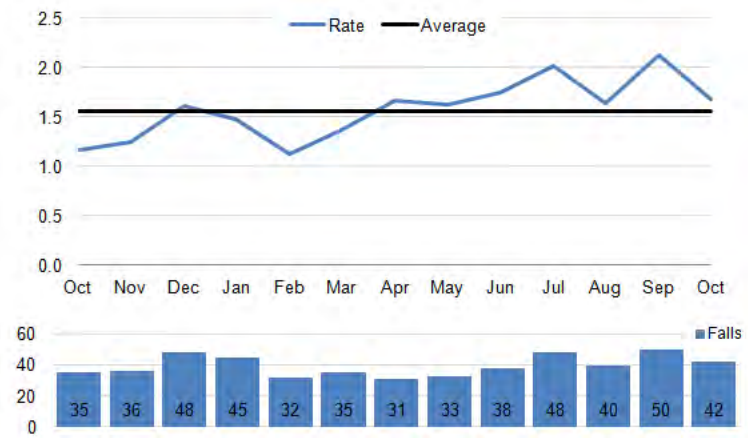
The annual HSMR for NHS Fife decreased during the second quarter of 2020, with both the actual and predicted number of deaths falling slightly in comparison to the previous 12-month period. This should be seen as normal variation, but we will continue to monitor this closely.

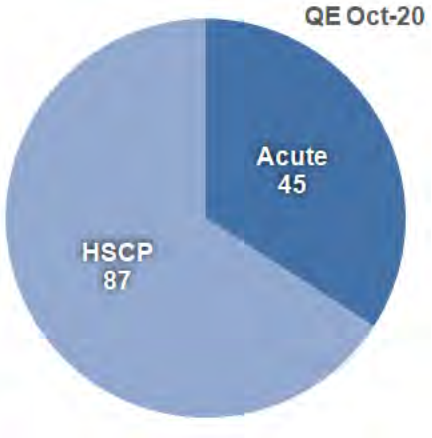
Clinical Governance

Inpatient Falls with Harm

Reduce Inpatient Falls With Harm rate per 1,000 Occupied Bed Days (OBD)
Improvement Target rate (by end December 2020) = ***2.16 per 1,000 OBD***

Local Performance





Service Performance

	Month	2019/20						2020/21						
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
WITH HARM	NHS Fife	1.17	1.24	1.61	1.47	1.13	1.37	1.67	1.62	1.75	2.01	1.64	2.12	1.68
	Acute Services	0.81	1.08	1.03	0.99	0.84	1.26	1.93	1.21	1.38	1.26	1.26	1.55	1.20
	HSCP	1.48	1.37	2.10	1.89	1.37	1.44	1.53	1.95	2.08	2.66	1.96	2.62	2.10

Key Challenges in 2020/21	The changes in service delivery due to the COVID-19 pandemic have changed clinical area function and this has been dynamic in response to the need for green and red capacity - this remains the same and in addition a number of key staff who support improvement activity are unable to commit the same focus in the current context. As previously noted a change in numbers of patients in ward footprints, the use of PPE and social distancing, and the resultant impact on the way that staff deliver care will be a focus of the revised workplan.

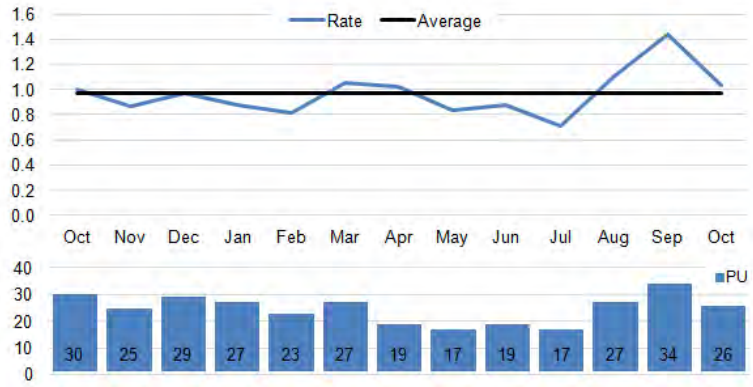
Improvement Actions	Update
20.3 Falls Audit *By Jan-21 (was Nov-20)*	Plans to complete the Falls audit have been delayed as a result of the ongoing situation but an adapted format is being developed and will be done as per audit. This is planned to begin before the end of 2020, recognising that a significant number of wards have changed function over this year.
20.5 Improve effectiveness of Falls Champion Network *By Feb-21 (was Nov-20)*	This work has been significantly delayed and is part of the draft refreshed work plan to consider. At initial consideration, there were only three wards noted not to have falls champions across in-patients settings. We require to review this in light of wards changing function and staff being redeployed to respond to COVID. There will be a reviewed focus on this in early 2021.
21.1 Refresh of Plans *By Jan-21 (was Oct-20)*	The refreshed workplan has been redrafted and is with the group members as part of a virtual discussion to finalise. This will be agreed in January.

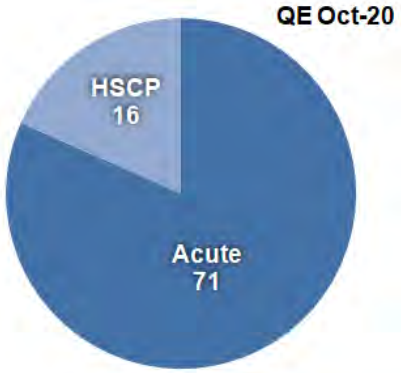
Clinical Governance

Pressure Ulcers

Achieve 50% reduction in pressure ulcers (grades 2 to 4) developed in a healthcare setting
*Improvement Target rate (by end December 2020) = **0.42 per 1,000 Occupied Bed Days***

Local Performance





Service Performance

Month	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	1.00	0.86	0.97	0.88	0.81	1.06	1.02	0.83	0.88	0.71	1.11	1.44	1.04
Acute Services	1.54	1.62	1.40	1.27	1.23	1.94	2.08	1.21	1.57	1.17	2.07	2.73	1.54
HSCP	0.55	0.25	0.62	0.55	0.46	0.46	0.42	0.53	0.26	0.31	0.30	0.32	0.60

Key Challenges in 2020/21	Analysing impact of COVID-19 on clinical pathway for handling Pressure Ulcers, and taking appropriate action to improve performance – this continues to require an agile response

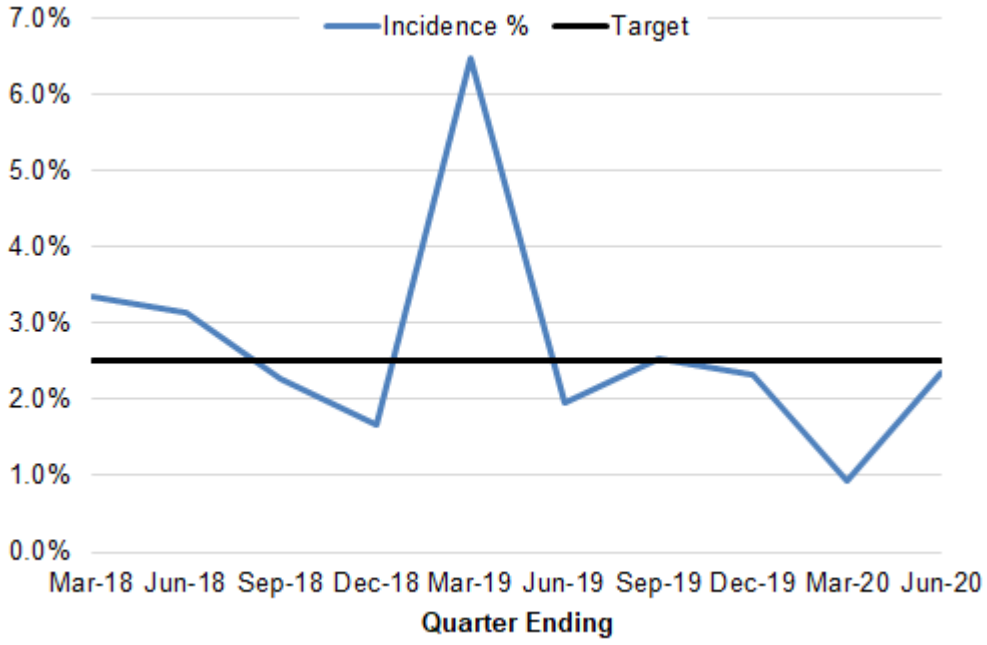
Improvement Actions	Update
20.4 Improve consistency of reporting	
20.5 Review TV Champion Network Effectiveness	Action closed – effectively superseded by new Action 21.2, below
20.6 Reduce PU development (initially by redesign of Quality Improvement model)	
21.1 Improve reporting of PU	Action closed – effectively superseded by new Action 21.3, below
21.2 Integrated Improvement Collaborative *By Feb-21*	An integrated improvement collaborative started in September, with three wards in the East Division participating. The collaborative aims to enhance comfort rounding and person-centred approaches in reducing patient falls and pressure ulcers, whilst also increasing knowledge and confidence in applying improvement methodology to measure outcome. ASD continue to progress quality improvement with specific wards for improvement, supported by ongoing QI education.
21.3 Implementation of robust audit programme for audit of documentation *By Jan-21*	A rolling programme of documentation audit is in development. This will be carried out by the Senior Charges Nurses within each ward area, supported by the senior nursing team. This will also incorporate assessment documentation for the prevention and management of pressure ulcers.

Clinical Governance

Caesarean Section SSI

*To reduce C Section SSI incidence (per 100 procedures) for inpatients and post discharge surveillance to day 10 to **2.5**% by March 2021*

Local Performance



Service Performance

Quarter	2017/18	2018/19				2019/20				2020/21			
Ending	Mar-18	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21
NHS Fife	3.3%	3.1%	2.3%	1.7%	6.5%	2.0%	2.5%	2.3%	0.9%	2.3%			
Scotland	1.6%	1.5%	1.5%	1.4%	1.6%	1.0%	1.2%	0.9%					

Key Challenges in 2020/21	NHS Fife SSI Caesarean Section incidence still remains higher than the Scottish incidence rate (no data for 2020 available at this stage)

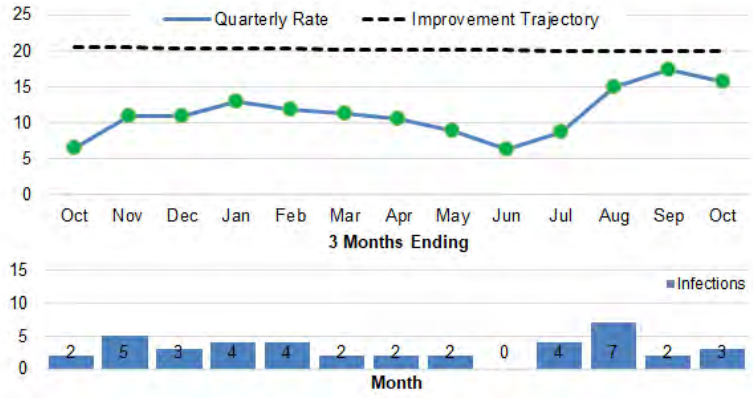
Improvement Actions	Update
20.1 Address ongoing and outstanding actions as set out in the SSI Implementation Group Improvement Plan *By Mar-21*	The SSI Implementation Group de-mobilised in early August as there were no outstanding actions, infection rates had improved and a robust system was in place for any major SSI review. If there are any further concerns, the group will re-establish. On resumption of the C-section SSI surveillance programme, we will continue to adopt the new methodology, which worked well previously in assessing SSI and type. Refresher training will be provided to staff to ensure awareness and understanding of the process. SSI incidence in the last three quarters has been calculated using raw data available from maternity services. This data is unverified with no National comparison, and should be interpreted with caution.
20.2 Support an Obesity Prevention and Management Strategy for pregnant women in Fife, which will support lifestyle interventions during pregnancy and beyond	

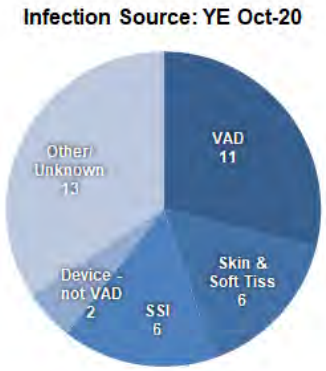
Clinical Governance

SAB (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending		2018/19		2019/20				2020/21
		Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	HCAI Infection Rate (per 100,000 TOBD)	17.8	14.1	13.7	15.5	10.9	12.5	6.3
Scotland		17.7	15.6	16.7	17.5	15.2	16.3	20.3

Key Challenges in 2020/21	Achieving a 10% reduction of healthcare-associated SAB by March 2022

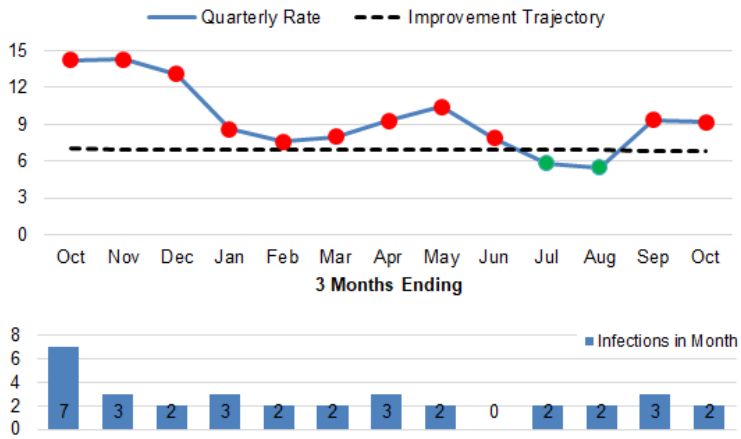
Improvement Actions	Update
20.1 Reduce the number of SAB in PWIDs *By Mar-21*	There have only been 4 PWID SABs so far in 2020, a marked improvement compared to the same period in 2019. Addiction services continue to be supported by the IPCT with the SAB improvement project, last meeting in September. Nurse prescribing of antibiotics by ANPs is being explored. The pandemic has made it especially challenging to see clients, with physical distancing reducing capacity in clinics. Despite an increased number of home visits, the total number of clients seen has reduced.
20.2 Ongoing surveillance of all VAD-related infections *By Mar-21*	Monthly charts distributed to clinical teams to inform of incidence of VAD SABs - these demonstrate progress and promote quality improvement as well as raising triggers & areas of concern. There have been no further SABs associated with the renal unit following a cluster in August.
20.3 Ongoing surveillance of all CAUTI *By Mar-21*	Bi-monthly meetings of the Urinary Catheter Improvement Group (UCIG) identify key issues and initiate appropriate corrective actions regarding catheter & urinary care. The group last met in October, and will meet again on 18th December. E-documentation bundles for catheter insertion and maintenance, to be added to Patientrack for Acute services, are still awaited.
20.4 Optimise comms with all clinical teams in ASD & the HSCP *By Mar-21*	Monthly SAB reports distributed with Microbiology comments, to gain better understanding of disease process and those most at risk, is continuing. This allows local resources to be focused on high risk groups/areas and improve patient outcomes. The Ward Dashboard is continuously updated, for clinical staff to access and also to be displayed for public assurance. Certificates for wards infection free period for SABs were distributed in October.

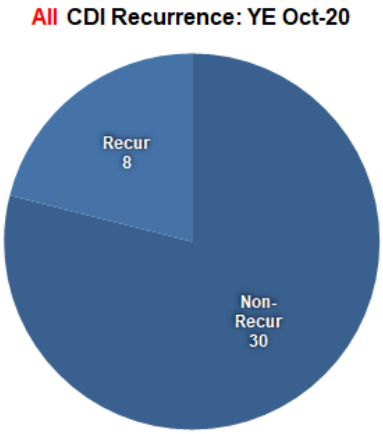
Clinical Governance

C Diff (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending		2018/19		2019/20				2020/21
		Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	HCAI Infection Rate (per 100,000 TOBD)	10.0	5.4	8.0	8.9	13.1	8.0	7.9
Scotland		13.8	11.8	12.3	13.7	15.1	13.6	15.4

Key Challenges in 2020/21	Reducing healthcare-associated CDI (including recurrent CDI) to achieve the 10% reduction target by March 2022

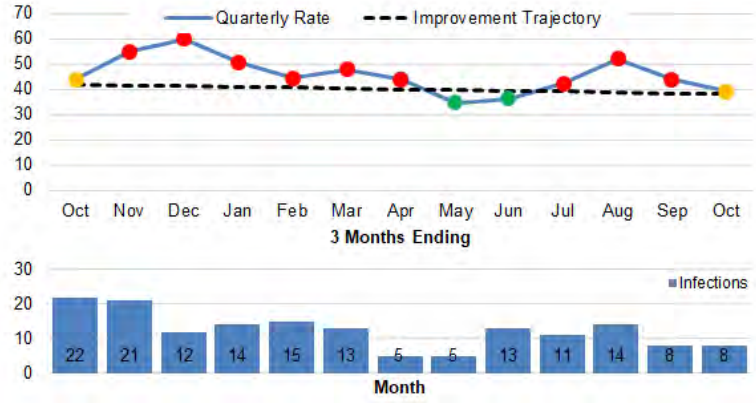
Improvement Actions	Update
20.1 Reducing recurrence of CDI *By Mar-22 (was Oct-20)*	To reduce recurrence of CDI Infection, 2 treatments are utilized in Fife: 1) Fidaxomicin is used for patients at high risk of recurrent CDI. 2) Bezlotoxumab is also used to prevent recurrence, whilst FMT (Faecal microbiota transplantation) is unavailable during the pandemic. It is obtained on a named patient basis on micro/GI request and needs approval by the clinical and medical director. [Bezlotoxumab is a human monoclonal antitoxin antibody that binds to Clostridioides difficile toxin B and neutralises its activity, preventing recurrence of CDI (BNF 2020).]
20.2 Reduce overall prescribing of antibiotics *By Mar-22 (was Oct-20)*	NHS Fife utilises National antimicrobial prescribing targets by NHS Fife microbiologists, working continuously alongside Pharmacists and GPs to improve antibiotic usage. Empirical antibiotic guidance has been circulated to all GP practices and the Microguide app has been revised.
20.3 Optimise communications with all clinical teams in ASD & the HSCP *By Mar-22 (was Oct-20)*	Monthly CDI reports are distributed, to enable staff to gain a clearer understanding of the disease process. ICN ward visits reinforce SICPs and contact precautions, provide education to promote optimum CDI management and daily Medical management form completion. This has continued throughout the pandemic. The Ward Dashboard is continuously updated, for clinical staff to access CDI incidence by ward and also to be displayed for public assurance. Certificates for wards infection free period for CDI were distributed to all wards within the Acute services in October.

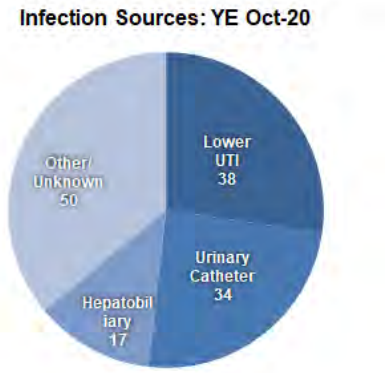
Clinical Governance

ECB (HAI/HCAI)

Reduce Hospital Infection Rate by 25% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending		2018/19		2019/20				2020/21
		Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	HCAI Infection Rate (per 100,000 TOBD)	49.2	39.2	42.1	31.0	60.0	47.9	36.4
Scotland		38.3	37.3	38.9	40.3	40.8	36.4	39.7

Key Challenges in 2020/21	Reducing CAUTI and UTI ECB in order to achieve overall 25% reduction in healthcare-associated ECB by March 2022

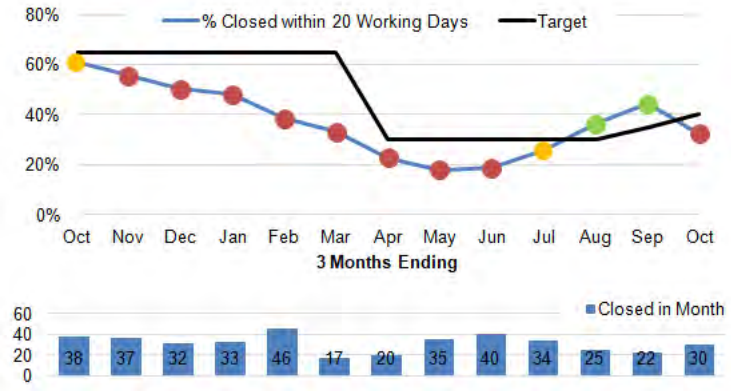
Improvement Actions	Update
20.1 Optimise communications with all clinical teams in ASD & the HSCP *By Mar-22*	Monthly reports and charts are distributed to key clinical staff across the HSCP and ASD. These demonstrate the underlying source of each ECB to raise awareness to clinical staff. Each CAUTI associated ECB is investigated in detail to better understand how the infection might have occurred, and any issues are raised with appropriate clinical teams. All CAUTI ECBs associated with traumatic insertion, removal or self removal are submitted to DATIX. There have been 3 trauma associated CAUTIs in 2020 - learning from these DATIX will be fed back to the Urinary Catheter Improvement Group.
20.2 Formation of ECB Strategy Group *By Mar-22 (was Mar-21)*	The ECB Strategy Group, initially looking at infections caused predominantly by urinary sources other than CAUTI, had been formed, but meetings have not taken place during the pandemic. The key issues identified by this group of addressing promotion of hydration and prevention of UTIs within the elderly population have now been incorporated within the UCIG by the Continence services. Further improvement work from the group will be reviewed in 2021.
20.3 Ongoing work of Urinary Catheter Improvement Group (UCIG) *By Mar-22 (was Mar-21)*	The UCIG last met in October, to review the following topics: • A CAUTI QI programme which started at Cowdenbeath GP practice • E-documentation bundles for catheter insertion and maintenance • Continence services continue to support all care/nursing homes across Fife to promote catheter care and adequate hydration • Continence/hydration folders in use at all care and residential homes • Education 'Top Tips' videos and newsletters published on BLINK Guidance on catheter maintenance solutions and Pathways for the management of difficult insertions have been completed.

Clinical Governance

Complaints | Stage 2

At least 75% of Stage 2 complaints are completed within 20 working days
*Improvement Target for 2020/21 = **65%***

Local Performance



Local Performance by Directorate/Division

3-Month Ending	2019/20						20/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	60.8%	55.6%	50.5%	48.0%	38.7%	33.3%	22.9%	18.1%	18.9%	25.7%	36.4%	44.4%	32.5%
Ack <= 3 Days (Monthly)	97.4%	89.2%	93.8%	93.9%	95.7%	94.1%	95.0%	97.1%	87.5%	97.1%	100.0%	95.5%	93.3%
ASD	60.5%	60.0%	57.1%	56.5%	49.4%	56.2%	55.2%	54.3%	53.5%	54.7%	55.3%	56.0%	55.1%
HSCP	57.6%	45.2%	33.3%	23.3%	9.7%	28.6%	28.4%	26.8%	25.7%	25.5%	26.9%	27.7%	26.5%

Key Challenges in 2020/21	Clearing the backlog of existing complaints Increase in complaints due to treatment delays (including diagnostics) General increase in complaints as we start to remobilise

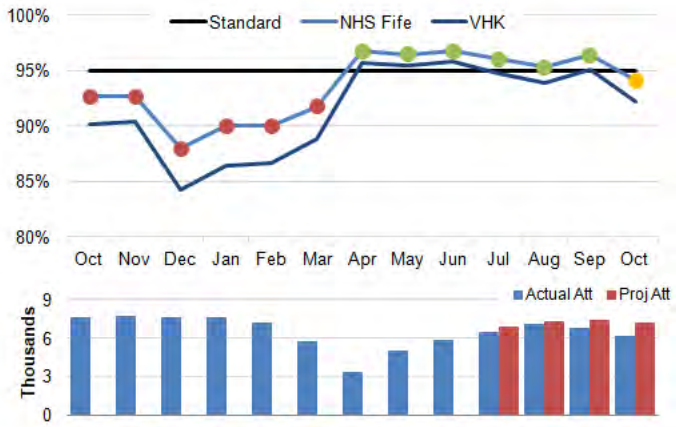
Improvement Actions	Update
20.1 Patient Relations Officers to undertake peer review	
20.2 Deliver education to service to improve quality of investigation statements	
20.3 Agree process for managing medical statements, and a consistent style for responses	
21.1 Agree process for managing complaint performance and quality of complaint responses *By Mar-21*	The PRT has changed the way they work in order to adapt to the 'new normal'. This includes changing meetings, reports and forms, with an aim of improving and sustaining consistency and quality. Part of this has been achieved via the development of the Complaints section of the new NHS Fife website.
21.2 Deliver virtual training on complaints handling *By Mar-21 (was Dec-20)*	This action has been identified as a replacement for previous action 20.2, with the aim being to improve overall quality. Sessions are currently being arranged. While some training has been delivered virtually, this is currently on hold due to the increase in the response to COVID-19.

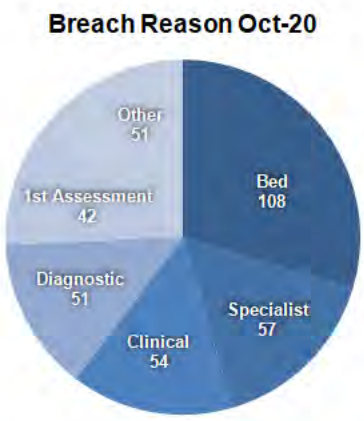
Finance, Performance & Resources – Operational Performance

4-Hour Emergency Access

At least 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for Accident and Emergency treatment

Local Performance





National Benchmarking

Month	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	92.7%	92.7%	88.0%	90.0%	90.1%	91.8%	96.8%	96.5%	96.8%	96.1%	95.4%	96.4%	94.1%
Scotland	88.0%	85.5%	83.8%	86.1%	86.4%	89.2%	94.9%	95.7%	95.6%	95.1%	92.9%	92.1%	89.6%

Key Challenges in 2020/21	Maintaining the reduction in numbers and the public using alternatives to emergency care Managing a department with red/green split during the return to normality, when injuries related to outdoor activity are likely to increase

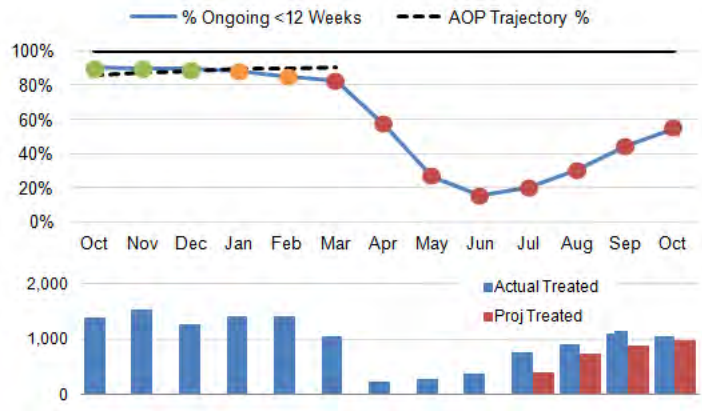
Improvement Actions	Update
20.1 Formation of PerformED group to analyse performance trends	
20.4 Development of services for ECAS	
20.5 Medical Assessment and AU1 Rapid Improvement Group	
21.1 Remodelling of Outpatient services *By Dec-20*	Outpatient activity continues on a limited face to face function and is balanced against the ongoing demands of the inpatient focus.

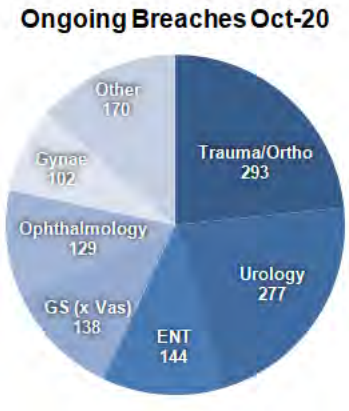
Finance, Performance & Resources – Operational Performance

Patient TTG

We will ensure that all eligible patients receive Inpatient or Daycase treatment within 12 weeks of such treatment being agreed

Local Performance





National Benchmarking

	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	90.5%	90.1%	89.7%	88.4%	85.4%	83.1%	57.3%	26.8%	15.4%	20.2%	30.0%	44.1%	54.9%
Scotland	69.7%	69.5%	67.0%	66.7%	66.3%	64.4%	46.6%	24.8%	17.3%				

Key Challenges in 2020/21	Recovery from COVID-19 Reduced theatre capacity due to increased infection control procedures and response to COVID-19

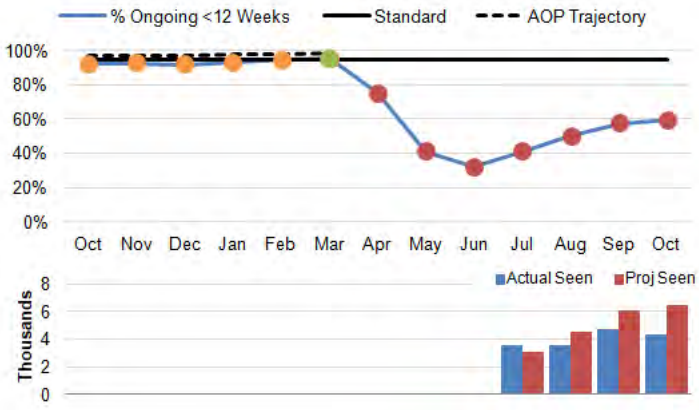
Improvement Actions	Update
20.2 Develop Clinical Space Redesign Improvement plan	
20.3 Theatre Action Group develop and deliver plan	
20.4 Review DCAQ and develop waiting times improvement plan for 20/21	
21.1 Develop and deliver transformation plan *By Mar-21*	This action is related to 20.2 and 20.3, above, but seeks to sustain delivery of improvements introduced during the pandemic
21.2 Review DCAQ in relation to WT improvement plan	
21.3 Undertake waiting list validation against agreed criteria	Action is complete, this is now an ongoing activity

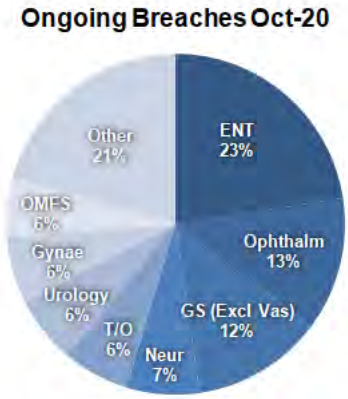
Finance, Performance & Resources – Operational Performance

New Outpatients

95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment

Local Performance





National Benchmarking

	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	92.4%	92.7%	91.8%	93.2%	94.7%	95.2%	74.8%	40.9%	32.0%	41.1%	50.0%	57.4%	59.3%
Scotland	73.3%	73.7%	73.2%	75.5%	75.1%	74.9%	57.8%	34.9%	28.5%				

Key Challenges in 2020/21	Recovery from COVID 19 Reduced clinic capacity due to physical distancing Difficulty in recruiting to specialist consultant posts

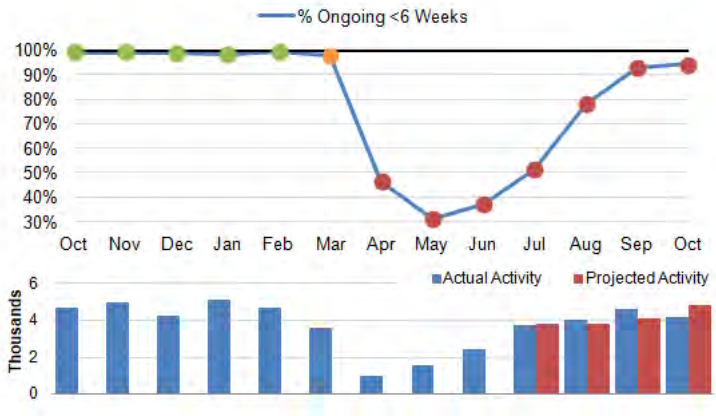
Improvement Actions	Update
20.1 Review DCAQ and secure activity to deliver funded activity in WT improvement plan	
20.2 Develop OP Transformation programme.	
20.3 Improve recruitment to vacant posts *By Mar-21*	Action continues – includes consideration of service redesign to increase capacity
21.1 Review DCAQ in relation to WT improvement plan	
21.2 Refresh OP Transformation programme actions *By Mar-21*	This action is related to 20.2, above, but seeks to sustain delivery of improvements introduced during the pandemic
21.3 Develop clinic capacity modelling tool	
21.4 Validate new and review waiting list against agreed criteria *By Jan-21 (was Nov-20)*	When the action is complete, this will be an ongoing activity

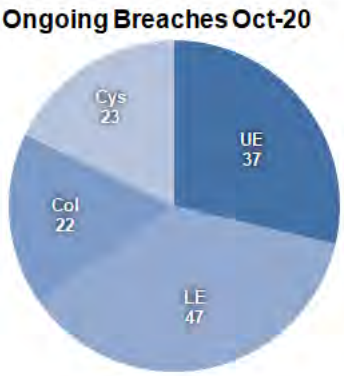
Finance, Performance & Resources – Operational Performance

Diagnostics Waiting Times

No patient will wait more than 6 weeks to receive one of the 8 Key Diagnostics Tests appointment

Local Performance





National Benchmarking

	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	99.0%	99.1%	98.6%	98.2%	99.5%	97.8%	46.3%	31.1%	37.4%	51.4%	78.3%	93.1%	94.3%
Scotland	80.8%	82.8%	79.5%	79.2%	84.7%	75.8%	28.4%	27.9%	35.4%	42.9%	49.3%	53.3%	

Key Challenges in 2020/21	Recovery from COVID-19 Reduced capacity due to physical distancing and infection control procedures Difficulty in recruiting to consultant and specialist AHP/Nursing posts Endoscopy surveillance backlog

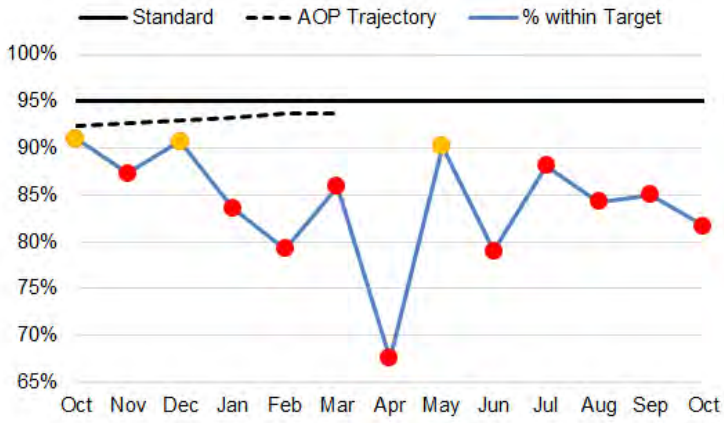
Improvement Actions	Update
21.1 Review DCAQ and develop remobilisation plans for Radiology and Endoscopy	
21.2 Undertake new and planned waiting list validation against agreed criteria *By Mar-21*	Complete for radiology and complete for new referrals for Endoscopy. Planned waiting list validation for Endoscopy is underway. When the action is complete, this will be an ongoing activity.
21.3 Improve recruitment to vacant posts *By Mar-21*	Action includes consideration of service redesign to increase capacity

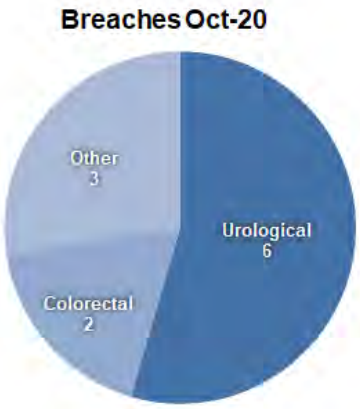
Finance, Performance & Resources – Operational Performance

Cancer 62-Day Referral to Treatment

At least 95% of patients urgently referred with a suspicion of cancer will start treatment within 62 days

Local Performance





National Benchmarking

Month	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	91.0%	87.3%	90.7%	83.6%	79.2%	85.9%	67.5%	90.2%	79.0%	88.2%	84.3%	85.0%	81.7%
Scotland	82.7%	81.9%	84.6%	83.6%	82.7%	86.1%	82.6%	83.8%	84.3%	87.1%	86.6%	86.5%	84.9%

Key Challenges in 2020/21	Recovery from COVID-19, by assessing affected components of the cancer 'journey' and reviewing capacity against expected demand. Identification of key improvement areas in view of the pandemic response and as screening programmes restart

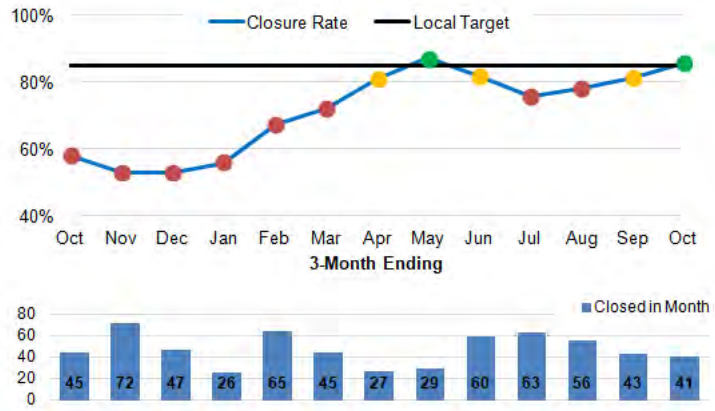
Improvement Actions	Update
20.3 Robust review of timed cancer pathways to ensure up to date and with clear escalation points *By Mar-21*	This will be addressed as part of the overall recovery work and in line with priorities set by the leadership team. DCAQ of cancer pathways delayed due to pandemic, but work is to restart.
20.4 Prostate Improvement Group to continue to review prostate pathway *By Mar-21*	This is ongoing work related to Action 20.3, with the specific aim being to minimise waits post MDT. Funding from Scottish Government has been secured to clinically review MDT and outcomes.
21.1 Establishment of Cancer Structure to develop and deliver a Cancer Strategy	
21.2 Cancer Strategy Group to take forward the National Cancer Recovery Plan *By Jun-21*	The National Cancer Recovery Plan is due to be published. The group have agreed to build on this to develop and take forward a NHS Fife Cancer Strategy.

Finance, Performance & Resources – Operational Performance

Freedom of Information Requests

In 2020/21, we will respond to a minimum of 85% of FOI Requests within 20 working days

Local Performance



Service Performance

Monthly	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Health Board	36.1%	49.3%	75.0%	52.4%	72.9%	76.9%	100.0%	81.8%	72.7%	72.0%	93.6%	82.1%	96.8%
IJB	77.8%	66.7%	14.3%	60.0%	83.3%	100.0%	100.0%	100.0%	60.0%	84.6%	66.7%	75.0%	50.0%

Key Challenges in 2020/21	Adequate resourcing to fully manage FOI Lack of FOI expertise and awareness within the organisation

Improvement Actions	Update
20.5 Refresh process with H&SC partnership for requests received that relate to their services	
20.7 Formalise long-term resource requirements for FOI administration	

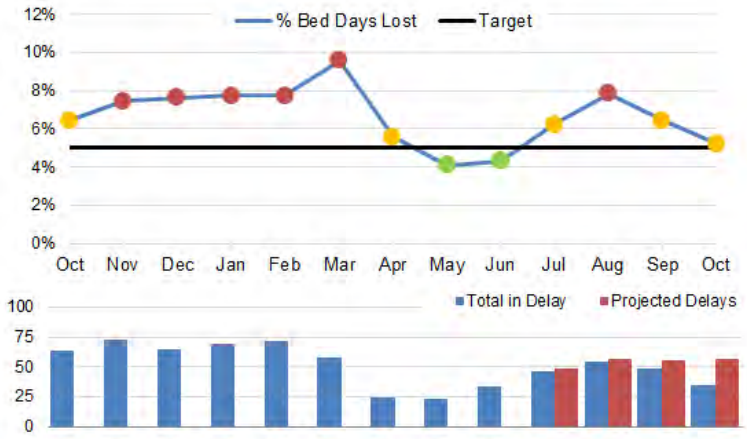
THERE ARE NO CURRENT SPECIFIC IMPROVEMENT ACTIONS. PERFORMANCE HAS IMPROVED SIGNIFICANTLY OVER THE LAST 3 MONTHS, AND THE AIM IS TO CONTINUE TO ACHIEVE THE 85% TARGET FOR CLOSURE WITHIN 20 DAYS OF RECEIPT

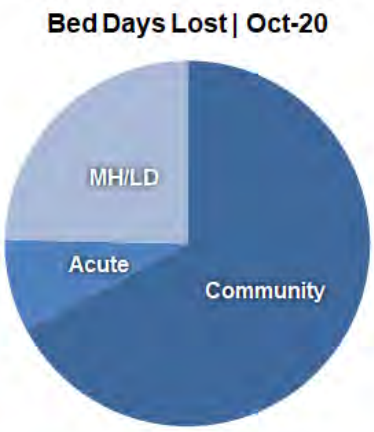
Finance, Performance & Resources – Operational Performance

Delayed Discharges (Bed Days Lost)

We will reduce the hospital bed days lost due to patients in delay, excluding Code 9, to 5% of the overall beds occupied

Local Performance





National Benchmarking

Quarter Ending		2018/19				2019/20				2020/21
		Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	TOBD	87,527	92,599	91,463	91,885	87,857	90,276	91,709	87,695	63,241
	Bed Days Lost	3,638	4,200	6,744	8,141	6,685	7,232	6,570	7,276	2,931
	% Bed Days Lost	4.2%	4.5%	7.4%	8.9%	7.6%	8.0%	7.2%	8.3%	4.6%
Scotland	TOBD	1,552,301	1,541,821	1,551,451	1,567,162	1,532,782	1,542,731	1,566,361	1,505,172	1,105,676
	Bed Days Lost	101,712	107,120	109,366	101,959	103,422	110,861	110,547	110,003	41,729
	% Bed Days Lost	6.6%	6.9%	7.0%	6.5%	6.7%	7.2%	7.1%	7.3%	3.8%

Key Challenges in 2020/21	Sustaining current performance as we return to 'normal' working Applying lessons learned during the pandemic, going forward

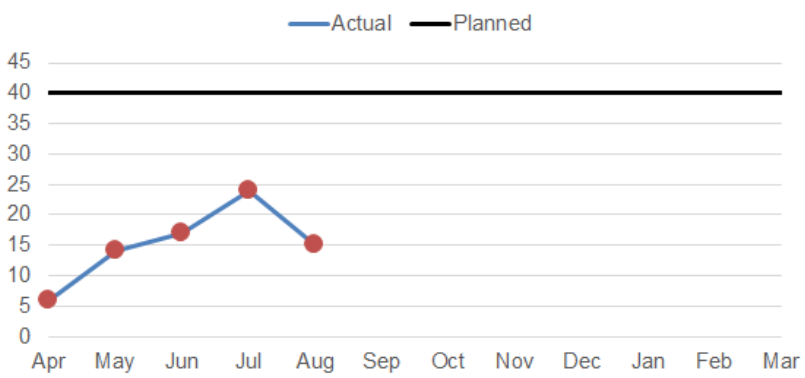
Improvement Actions	Update
20.1 Test a trusted assessors model for patients transferring to STAR/assessment beds	
20.3 Moving On Policy to be implemented *By Jan-21 (was Nov-20)*	The moving on policy will be reviewed by the HSCP Senior Leadership Team in December. This will further support new processes implemented as a result of the COVID-19 pandemic.
20.4 Improve flow of comms between wards and Discharge HUB	
20.5 Increase capacity within care at home	
21.1 Progress HomeFirst model *By Mar-21*	The working group continue to progress the actions to ensure 95% of all discharges occur safely and before 2 p.m. and to ensure assessments for LTC are not carried out within an Acute setting.

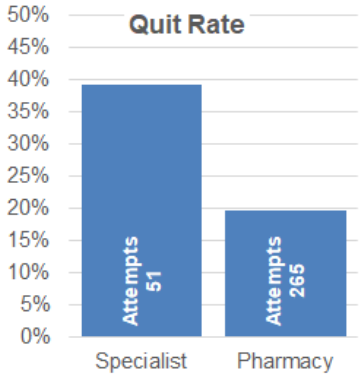
Finance, Performance & Resources – Operational Performance

Smoking Cessation

In 2020/21, we will deliver a minimum of 473 post 12 weeks smoking quits in the 40% most deprived areas of Fife

Local Performance





National Benchmarking

% Achieved Against Target		2020/21											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS Fife	Actual	6	14	17	24	15							
	Actual Cumul	6	20	37	61	76	76	76	76	76	76	76	76
	Planned Cumul	40	79	118	158	197	236	276	315	354	394	434	473
	Achieved	15.0%	25.3%	31.4%	38.6%	38.6%	32.2%	27.5%	24.1%	21.5%	19.3%	17.5%	16.1%
Scotland	Achieved												

Key Challenges in 2020/21	• Service Provision within GP practices, hospitals and community venues • Staffing levels • Unavailability of mobile unit (re-deployed during pandemic) • Inability to validate quits as part of an evidence based service

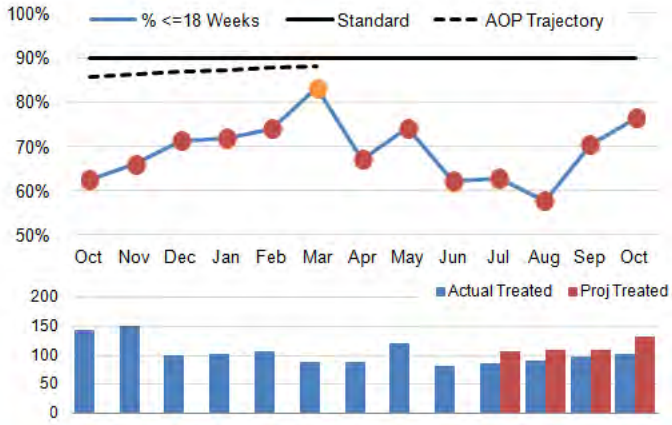
Improvement Actions	Update
20.2 Test Champix prescribing at point of contact within hospital respiratory clinic *By Mar-21*	The aim of this action is to test a model of delivery that allows a smoking cessation advisor sitting within clinic to enable direct access to Champix for patients attending clinic. This has been paused due to COVID-19.
20.3 'Better Beginnings' class for pregnant women *By Mar-21*	Limited progress due to COVID-19 but a couple of pregnant mums have requested support at this time. Initial outcomes (although small numbers) has shown positive outcomes to engaging with pregnant women.
20.4 Enable staff access to medication whilst at work *By Mar-21*	No progress has been made due to COVID-19
21.1 Assess viability of using Near Me to train staff *By Mar-21*	Near Me has the functionality to allow a few people to dial into a session, providing staff training which would previously have been done via 'shadowing' experience staff. We are currently asking patients if they have the technology and would be receptive to this option.
21.2 Support Colorectal Urology Prehabillitation Test of Change Initiative *By Mar-21*	Prehabilitation is a multimodal approach, which will minimise the risk of surgery being cancelled or SACT being delayed. Rehabilitation ensures patients are actively managed against the pathway, and this delivery model also improves quality outcomes for patients. Patients identified as smokers and interested in quitting will have rapid access to support.

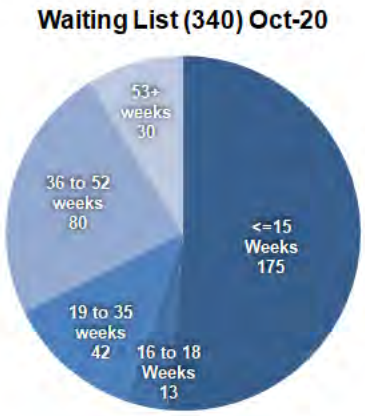
Finance, Performance & Resources – Operational Performance

CAMHS 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment

Local Performance





National Benchmarking

Month	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	62.5%	66.0%	71.3%	71.8%	74.1%	83.1%	67.0%	74.2%	62.2%	62.8%	57.8%	70.4%	76.5%
Scotland	64.6%	64.2%	71.5%	67.5%	63.8%	64.3%	74.0%	58.2%	50.5%	57.9%	57.2%	65.9%	

Key Challenges in 2020/21	Available resource to meet demand Impact of COVID-19 relaxation on referrals Change to appointment 'models' to reflect social distancing

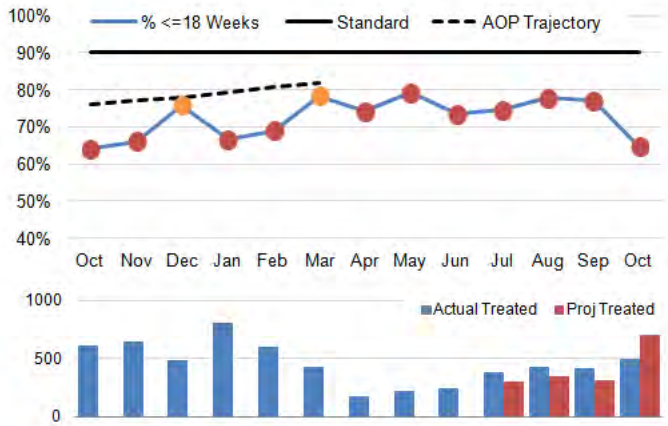
Improvement Actions	Update
20.1 Re-Introduction of PMHW First Contact Appointments System *By Dec-20*	Recruitment is underway to appoint to two existing vacancies, which occurred due to staff leaving to take up permanent positions. This impacts on the level of activity and ability to maintain a 2-4 week response time, which had been achieved during the third quarter of the year.
20.2 Waiting List Additional Staffing Resource	
20.3 Introduction of Team Leader Role	
21.1 Re-design of Group Therapy Programme *By Dec-20*	Due to COVID-19 restrictions, group-based face to face therapy work is not viable. Alternative delivery models of group therapy have been designed and will be rolled out from January 2021, focusing initially on Decider Skills Training and Anxiety Management.
21.2 Use Centralised Allocation Process *By Dec-20*	Revised administrative processes and clinical systems are in place to facilitate centralised screening and allocation of referrals. This ensures that appointments are identified and allocated quickly and equitably across clinical teams.
21.3 Build CAMHS Urgent Response Team *By Mar-21*	The plan to develop a CAMHS URT has been postponed due to the absence of key staff. The existing Self Harm Service has been maintained and supported to continue to deliver urgent assessments and interventions for children and young people who present with suicidal or self-harming behaviour, both through the urgent referral process and within acute hospital settings. The opportunity to redesign the service will be reviewed again in March 2021, giving consideration to staffing and the COVID-19 position.

Finance, Performance & Resources – Operational Performance

Psychological Therapies 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment for Psychological Therapies

Local Performance



National Benchmarking

Month	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	64.2%	66.0%	75.8%	66.6%	69.0%	78.4%	74.2%	79.2%	73.6%	74.5%	77.9%	77.0%	64.7%
Scotland	78.5%	77.8%	81.5%	75.8%	78.5%	78.8%	74.0%	76.5%	72.7%	74.1%	75.2%	75.8%	

Key Challenges in 2020/21	Predicted large increase in referrals post pandemic Identifying replacement for group therapies (no longer viable)

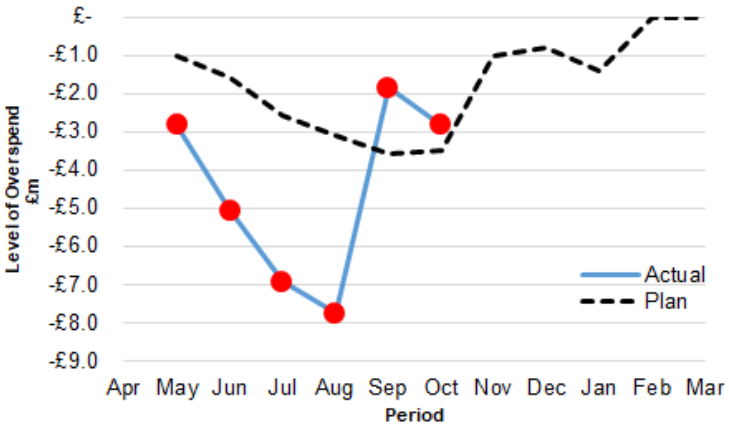
Improvement Actions	Update
20.2 Introduction of extended group programme in Primary Care	
20.3 Redesign of Day Hospital provision	Redesign has been implemented and developments are underway relating to therapeutic provision – action complete
20.4 Implement triage nurse pilot programme in Primary Care *By Jan-21 (was Dec-20)*	Staff in post in selected GP Cluster areas; service being well-utilised; positive findings from interim evaluation in September 2019; final evaluation was due this September, but has been delayed due to impact of COVID on data collection.
20.5 Trial of new group-based PT options *By Mar-21 (was Dec-20)*	Develop and pilot two new group programmes for people with complex needs who require highly specialist PT provision from Psychology service. Pilot of Schema therapy group underway. Very good participant retention rate to date. Very high intensity service; service capacity to run this specific group likely to be less than first anticipated. On-going development of Compassion Focused therapy group; anticipate pilot in New Year.
21.1 Introduction of additional on-line therapy options	
21.2 Development of alternative training and PT delivery methods	This action is to support care pathways for people with complex psychological problems within AMH Psychology and Clinical Health Psychology and for people with learning disabilities. Work to enable digital delivery of range of group programmes complete or nearing completion. Clinical delivery underway or planned for early 2021. Training programme to further develop capacity in MDT's underway. Action complete

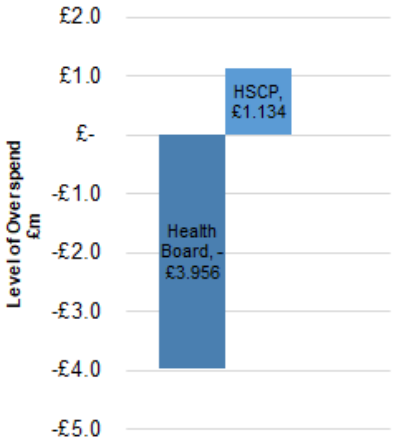
Finance, Performance & Resources – Finance

Revenue Expenditure

NHS Boards are required to work within the revenue resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

Local Performance





Expenditure Analysis

Memorandum	Budget			Expenditure			Variance Split By			
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Core Unmet Savings £'000	Net Core Position £'000	Covid Unmet Savings £'000
Health Board	420,887	448,120	247,275	251,231	-3,956	-1.60%	1,956	-1,073	883	-4,839
Integration Joint Board (Health)	357,254	376,583	216,845	215,711	1,134	0.52%	1,452	-43	1,409	-275
Risk Share	0	0	0	0	0	0.00%	0	0	0	0
Total	778,141	824,703	464,120	466,942	-2,822	-0.61%	3,408	-1,116	2,292	-5,114

Key Challenges in 2020/21	• Availability of Covid-19 funding (initial allocation received in September): to match our net additional costs; and costs associated with remobilisation plans – final funding allocation to be confirmed in January. • Our ability as a Board to regain traction in our savings and strategic plans in the context of the Covid-19 pandemic journey; and the implications of the funding decision yet to be made by SG on Boards' unmet savings • Informing a reliable and robust forecast position to the year end given the complexities of establishing the respective: core; Covid-19; remobilisation; and Test & Protect positions; and assessing the impact of the Winter flu campaign, the Redesign of Urgent Care Scotland-wide, the Covid-19 vaccination programme; and the identification of further financial flexibility mitigating opportunities • Ongoing discussions on potential risk share options with SG and respective partners – no IJB risk share has been built in to the in-year position, however £7.2m potential risk share cost (at October) has been reflected in our forecast outturn

Improvement Actions	Update
21.1 Local mobilisation plan *Ongoing throughout FY*	Partnering with the services to: • Identify additional spend relating to Covid-19 • Identify offsets against core positions • Understand and quantify the financial implications of remobilisation of core services across NHSF • Inform forecast outturn positions to the year end; in support of our statutory requirement to deliver a balanced RRL position • Capture the overarching Board-wide workforce plan and additional costs of the immediate significant additional resource for: Test and Protect; Urgent Care redesign; extended flu immunisation; and the Covid-19 vaccination programme
21.2 Savings	The total NHS Fife efficiency requirement for 2020/21 including legacy

By Jan-21	unmet savings was £20m. As part of the LMP, Boards were asked to provide an estimate of the impact of planned measures re Covid-19 on the delivery of planned Health Board savings. We anticipate achieving £11m of the target resulting in £9m underachievement of savings.

Commentary

The position to month 7 is an overspend of £2.822m. This comprises a run rate underspend position of £3.408m; unmet core savings of £1.116m (to be delivered over the remaining months of the year); and anticipated underachievement of savings of £5.114m due to our focus on the Covid-19 pandemic.

The impact of Covid-19 on financial performance is a key issue. The revenue position for the 7 months to 31 October reflects the initial Covid-19 funding received from SG; and match funds additional Covid-19 expenditure to October, with the exception at this time, of unmet efficiency targets; and offsetting cost reductions. These have been excluded from SG funding assumptions due to wide variation across Scotland and will be reviewed over the coming months. Our initial allocation of Covid-19 funding covers: Test and Protect; significant investment in equipment and digital; labs expansion; seasonal flu; Urgent Care redesign; staff health and wellbeing; and staff occupational health requirements. The allocation is based on 70% of costs with a general 30% contingency retained by the Portfolio in recognition of the level of uncertainty reflected in financial assumptions. Scottish Government have indicated that a review of Boards' unachieved efficiency savings will be undertaken to inform a final allocation across Scotland.

The forecast outturn to the year end is a potential worst case overspend of £9.492m. This assumes retention of our offsetting cost reductions (from standing down of core services in the first half of the year) to contribute to our unmet savings; and recognises our current commitment to the IJB risk share as a potential cost to NHS Fife of £7.229m.

The total Capital Resource Limit for 2020/21 is £15.417m including anticipated allocations for specific projects. The capital position for the 7 months to October records spend of £3.789m. The capital spend on the specific projects commences in earnest in the latter half of the financial year and as such is on track to spend in full.

Finance, Performance & Resources – Finance

1. Annual Operational Plan

1.1 As previously reported, the AOP process for the 2020/21 financial year was paused earlier in the year as Boards and Scottish Government prepared to respond to the Covid-19 pandemic. The revised AOP financial plan reflects both the mobilisation and the remobilisation plan high level impact on the financial position submitted at the end of July. As previously reported the initial Covid-19 funding allocation was made in the September allocation letter.

2. Financial Allocations

Revenue Resource Limit (RRL)

2.1 NHS Fife received confirmation of the October core revenue amount on 3 November. The updated core revenue resource limit (RRL) per the formal funding letter was confirmed at £815.385m. Anticipated allocations total -£0.016m.

Non Core Revenue Resource Limit

2.2 In addition, NHS Fife receives 'non core' revenue resource limit funding for technical accounting entries which do not trigger a cash payment. This includes, for example, depreciation or impairment of assets. The anticipated non-core RRL funding totals £9.334m.

Total RRL

2.3 The total current year budget at 31 October is therefore £824.703m as detailed in Appendix 1.

3. Summary Position

3.1 The revenue position for the 7 months to 31 October reflects an overspend of £2.822m.

3.2 Table 1 below provides a summary of the position across the constituent parts of the system for the year to date and includes both the core and savings positions. An overspend of £3.956m is attributable to Health Board retained budgets; and an underspend of £1.134m is attributable to the health budgets delegated to the IJB.

Table 1: Summary Financial Position for the period ended October 2020

Memorandum	Budget			Variance Split By			
	CY	Variance	Variance	Run Rate	Core Unmet Savings	Net Core Position	Covid Unmet Savings
	£'000	£'000	%	£'000	£'000	£'000	£'000
Health Board	448,120	-3,956	-1.60%	1,956	-1,073	883	-4,839
Integration Joint Board (Health)	376,583	1,134	0.52%	1,452	-43	1,409	-275
Risk Share	0	0	0.00%	0	0	0	0
Total	**824,703**	**-2,822**	**-0.61%**	**3,408**	**-1,116**	2,292	**-5,114**

Combined Position				Variance Split By			
	CY	Variance	Variance	Run Rate	Core Unmet Savings	Net Core Position	Covid Unmet Savings
	£'000	£'000	%	£'000	£'000	£'000	£'000
Acute Services Division	211,139	-8,090	-6.59%	-2,464	-803	-3,267	-4,823
IJB Non-Delegated	8,673	67	1.34%	86	-3	83	-16
Estates & Facilities	76,153	640	1.46%	644	-4	640	0
Board Admin & Other Services	65,961	416	1.01%	679	-263	416	0
Non-Fife & Other Healthcare Providers	90,973	1,030	1.94%	1,030	0	1,030	0
Financial Flexibility & Allocations	24,258	1,966	100.00%	1,966	0	1,966	0
HB Offsets	3,172	0	0.00%	0	0	0	0
Health Board	**480,329**	**-3,971**	**-1.48%**	**1,941**	**-1,073**	**868**	**-4,839**
Integration Joint Board - Core	417,410	1,041	0.42%	1,359	-43	1,316	-275
IJB Offsets	3,022	0		0	0	0	0
Integration Fund & Other Allocations	7,783	58	0.00%	58	0	58	0
Sub-total Integration Joint Board Core	**428,215**	**1,099**	**0.69%**	**1,417**	**-43**	**1,374**	**-275**
IJB Risk Share Arrangement	0	0		0	0	0	0
Total Integration Joint Board - Health	**428,215**	**1,099**	**0.69%**	**1,417**	**-43**	**1,374**	**-275**
Total Expenditure	**908,544**	**-2,872**	**-0.43%**	**3,358**	**-1,116**	**2,242**	**-5,114**
IJB - Health	-51,632	35	**-0.11%**	35	0	35	0
Health Board	-32,209	15	**-0.07%**	15	0	15	0
Miscellaneous Income	**-83,841**	**50**	**-0.10%**	**50**	**0**	**50**	0
Net Position Including Income	**824,703**	**-2,822**	**-0.61%**	**3,408**	**-1,116**	**2,292**	**-5,114**

3.3 The position at month 7 is a core net underspend of £2.292m; and unmet savings of £5.114m as a consequence of diversion of resources to deal with the Covid-19 pandemic.

3.4 Funding allocations of £8.972m and £4.506m have been allocated to HB and HSCP respectively to match April to October Covid-19 costs incurred. Further detail is provided in section 6 and later in Appendix 5.

4. Operational Financial Performance for the year

Acute Services

4.1 The Acute Services Division reports a **net overspend of £3.267m for the year to date**. This reflects an overspend in operational run rate performance of £2.464m, and unmet savings of £0.803m per Table 2 below. The overall position is mainly driven by pay overspend in junior medical and dental staffing of £1.342m. Additional non pay cost pressures of £0.816m relate to medicines within Emergency Care. Various underspends across other areas of Acute arising from vacancies have helped to offset the level of overspend. Budget rephasing has taken place to reflect the cost impact of the additional capacity required to catch up on postponed services which started to resume in October.

Table 2: Acute Division Financial Position for the period ended October 2020

Core Position	Budget			Expenditure			Variance Split By	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Core Unmet Savings £'000
Acute Services Division								
Planned Care & Surgery	70,359	72,017	39,105	39,455	-350	**-0.90%**	-167	-183
Emergency Care & Medicine	74,482	77,490	46,589	49,573	-2,984	**-6.40%**	-2,631	-353
Women, Children & Cinical Services	54,723	55,112	31,761	32,290	-529	**-1.67%**	-214	-315
Acute Nursing	607	627	367	342	25	**6.81%**	25	0
Other	1,990	1,982	1,062	491	571	**53.77%**	523	48
Total	**202,161**	**207,228**	**118,884**	**122,151**	**-3,267**	**-2.75%**	**-2,464**	**-803**

Estates & Facilities

4.2 The Estates and Facilities budgets report an **underspend of £0.640m** which is generally attributable to vacancies, catering, PPP and rates. These underspends are partly offset by an overspend in clinical waste costs.

Corporate Services

4.3 Within the Board's corporate services there is **an underspend of £0.416m**. Included within this position is a cost pressure of £0.069m relating to unfunded costs in connection with the significant flooding to the hospital and specific car parks in August. Further analysis of Corporate Directorates is detailed per Appendix 2.

Non Fife and Other Healthcare Providers

4.4 The budget for healthcare services provided out with NHS Fife is **underspent by £1.030m** per Appendix 3. Notwithstanding the in-year underspend, this area remains one of increasing challenge particularly given the relative higher costs of some other Boards, coupled with the unpredictability of activity levels and drug costs.

Financial Plan Reserves & Allocations

4.5 As part of the financial planning process, expenditure uplifts including supplies, medical supplies and drugs uplifts were allocated to budget holders from the outset of the financial year as part of the respective devolved budgets. A number of residual uplifts and cost pressure/developments and new in-year allocations are held in a central budget; with allocations continued to be released on a monthly basis. The financial flexibility of £1.966m released to the month 7 position is detailed in Appendix 4.

Integration Services

4.6 The health budgets delegated to the Integration Joint Board report an **underspend of £1.374m for the year to date**. The majority of underlying drivers for the run rate under spend are vacancies in sexual health and rheumatology, community nursing, health visiting, school nursing, community and general dental services across Fife Wide Division. Additional underspends are reflected in East following service redesign, and also against vacancies in community services and administrative posts.

Income

4.7 A small over recovery in income of £0.050m is shown for the year to date.

5. Pan Fife Analysis

5.1 Analysis of the pan NHS Fife financial position by subjective heading is summarised in Table 3 below (combined position).

Table 3: Subjective Analysis for the Period ended October 2020

Combined Position	Annual Budget	Budget	Actual	Net (Over)/Under Spend
Pan-Fife Analysis	**£'000**	**£'000**	**£'000**	**£'000**
Pay	397,727	231,561	232,267	-706
GP Prescribing	70,607	40,918	41,454	-536
Drugs	31,475	19,056	19,404	-347
Other Non Pay	388,900	227,768	224,844	2,924
Efficiency Savings	-12,205	-6,230	0	-6,230
Commitments	32,041	2,024	0	2,024
Income	-83,841	-50,976	-51,026	50
Net overspend	**824,703**	**464,120**	**466,942**	**-2,822**

Pay

5.2 The overall pay budget reflects an overspend of £0.706m. The majority of the overspend is within medical & dental staff with small offsetting underspends across other pay heads with the exception of personal and social care. Within Acute there are a number of unfunded posts including Clinical Fellows within Emergency Care.

5.3 Against a total funded establishment of 7,952 wte across all staff groups, there was an average 8,036 wte core staff in post in October. The additional staff in post represent staff cohort groups organised nationally to help support the Covid-19 activity.

Drugs & Prescribing

5.4 Across the system there is a net overspend of £0.883m on medicines. The GP prescribing budget is overspend in-year by £0.536m with a forecast overspend of £1m. The change from previous reporting is due to the retraction of budget in respect of Tariff reductions effective from April. Significantly higher drug prices are being experienced, likely exacerbated by the impact of Covid on supply and demand, raw material availability, transportation, and production. Opportunity to realise planned saving schemes have been lost as workforce is focused on Covid services and patient care. Implementation of Freestyle Libre (flash glucose monitoring system) continues to exceed original forecast and funding provided. £0.875m has been recharged to Covid whilst local and national work continues to establish the true Covid-19 impact on prescribing. An update will be provided when more information becomes available.

Other Non Pay

5.5 Other non pay budgets across NHS Fife are collectively underspent by £2.924m. This includes underspends across the system within sterile and diagnostics supplies, and travel and subsistence; and an updated position on the 2020/21 spend associated with the Royal Hospital for Sick Children which is significantly less than had been anticipated. As in every month, a detailed review of financial flexibility has been conducted.

6 Covid-19 Initial Funding Allocation

6.1 As previously reported, initial Covid-19 funding allocation was confirmed in September. The funding allocation has been made across Scotland on either actual costs or NRAC share, and excludes unachieved efficiency savings; and offsetting cost reductions. From this allocation we have fully match funded NHS Fife's additional Covid-19 costs (excluding unmet savings) for the 7 months to October. As previously reported SG have allocated 70% of total funding with a general contingency of 30% retained by the Portfolio in recognition of the level of uncertainty reflected in financial assumptions.

This carries a level of risk in that final funding has yet to be confirmed across Scotland. A summary of Covid-19 funding is attached at Appendix 5.

6.2 The funding received confirms £7.7m funding for elective/planned care activity which we had already anticipated and reflected in our financial reporting to date.

6.3 A separate allocation of £1.3m relating to payments to primary care for additional costs in responding to the pandemic has been received in the October allocation letter.

6.4 Whilst a SG decision has yet to be made on the treatment of unachieved savings; and offsetting cost reductions; there remains a risk that funding may be insufficient to cover additional costs which materialise as the year unfolds. This position will be kept under close review and highlighted in our regular SG reporting.

7 Financial Sustainability

7.1 The Financial Plan presented to Finance, Performance and Resources Committee in March highlighted the requirement for £20.015m cash efficiency savings to support financial balance in 2020/21. Whilst we had initially indicated an expected underachievement of savings of £14.2 via the Local Mobilisation Financial Template process; and a £5.8m efficiency savings target for NHS Fife; this has since been updated to reflect £11.2m expected achievement; and £8.8m anticipated underachievement of savings. SG plan to conduct a review of Boards' unmet savings to inform their decision on potential funding over the coming weeks to inform the final Covid-19 allocation. Table 4 summaries the position for the 7 months to October.

Table 4: Savings 20/21

Total Savings	Total Savings Target £'000	Forecast Achievement (Core) £'000	Forecast unmet savings (Covid-19) £'000	Identified & Achieved Recurring £'000	Identified & Achieved Non-Recurring £'000	Identified & Achieved to Oct £'000	Forecast / Unidentified to March £'000
Health Board	14,868	6,571	8,297	1,024	2,298	3,322	3,249
Integration Joint Board	5,147	4,675	472	2,520	1,969	4,489	186
Total Savings	**20,015**	**11,246**	**8,769**	**3,544**	**4,267**	**7,811**	**3,435**

8 Forecast

8.1 Based on the year to date position, and a number of high level planning assumptions as agreed by delegated budget holders, the year end run rate forecast is an underspend of £0.312m. Whilst we await SG decision on the treatment of offsetting cost reductions, there is a potential benefit of £6.194m if we can retain offsets. We would plan to use these offsetting cost reductions to mitigate some of the anticipated unachieved savings of £8.769m. If the aforementioned assumptions crystallise, the NHS Fife forecast RRL position would be an overspend of £2.263m. Further detailed review work will be undertaken to identify any further options and financial flexibility in an effort to deliver an improved position with a target balanced position.

8.2 There is however very limited assurance that NHS Fife can remain within the overall revenue resource limit if we are additionally required to cover the impact of the IJB risk share position of £7.2m. This therefore raises a concern that the Board cannot deliver on its statutory requirement to break even without additional funding. NHS Fife and Fife Council are currently reviewing the Integration Scheme and in particular the risk share agreement. The £7.2m is based on current arrangements.

8.3 The forecast outturn to the year end is a potential worst case overspend of £9.492m. The component parts which inform the forecast outturn are detailed in Table 5 and assumes retention of our offsetting cost reductions, to contribute to our unmet savings; and recognises our current commitment to the IJB risk share as a potential cost to NHS Fife of £7.229m.

8.4 For the purposes of reporting to Scottish Government in the Monthly Financial Performance Return (FPR) we have included the value of the risk share impact in the forecast; and are signposting a potential overspend of £9.492m. Dialogue is ongoing with Scottish Government colleagues to highlight the position and to discuss potential mitigating actions.

Table 5 – Forecast (modelling based on actual position at 31 October 2020)

Forecast Outturn	Run Rate £'000	Offsets £'000	Savings £'000	Risk Share £'000
Acute Services Division	-8,337	2,809	-8,264	0
IJB Non-Delegated	88	0	-33	0
Estates & Facilities	700	312	0	0
Board Admin & Other Services	1,007	51	0	0
Non-Fife & Other Healthcare Providers	604	0	0	0
Financial Flexibility	3,886	0	0	0
Miscellaneous Income	100	0	0	0
Health Board Retained Budgets	**-1,952**	**3,172**	**-8,297**	**0**
IJB Delegated Health Budgets	2,264	3,022	-472	0
Integration Fund & Other Allocations	0	0	0	0
Total IJB Delegated Health Budgets	**2,264**	**3,022**	**-472**	**0**
Risk share	**0**	**0**	**0**	**-7,229**
Total Forecast Outturn	**312**	**6,194**	**-8,769**	**-7,229**

9 Key Messages / Risks

9.1 The month 7 position reflects an overspend of £2.822m; which comprises a core underspend of £2.292m; and unmet savings of £5.114m as a consequence of diversion of resources to deal with the Covid-19 pandemic. All other additional Covid-19 costs for April to October have been match funded from the initial SG allocation received in September. There is the potential risk exposure if the Covid-19 contingency (second tranche funding) held by the Portfolio is insufficient to meet costs which materialise in the second half of the year.

9.2 At this point any potential implications of the IJB risk share have not been factored in to the in-year position; however the potential risk share cost assuming no change to the Integration Scheme would mean a full year forecast cost of £7.2m,.

9.3 Further work continues to identify any financial flexibility opportunities (further slippage on key projects/initiatives; review of revenue and balance sheet) which may improve the forecast overspend position.

10 Recommendation

10.1 Members are invited to approach the Director of Finance for any points of clarity on the position reported and are asked to:

- **Note** the reported core underspend of £2.292m for the 7 months to October
- **Note** that initial funding allocations for Covid-19 reflected in the month 7 position match fund additional costs to month 7
- **Note** the forecast outturn to the year end is a potential worst case overspend of £9.5m. This assumes retention of our offsetting cost reductions to contribute to our unachieved savings; and recognises our current commitment to the IJB risk share as a potential cost to NHS Fife of £7.2m.

Appendix 1: Revenue Resource Limit

		Baseline Recurring	Earmarked Recurring	Non-Recurring	Total	Narrative
		£'000	£'000	£'000	£'000	
Apr-20	Initial Baseline Allocation	701,537			701,537	Includes 20-21 uplift
May-20	Confirmed Allocations	-1,307		3,413	2,106	
Jun-20	Confirmed Allocations			-534	-534	
Jul-21	Confirmed Allocations			5,614	5,614	
Aug-20	Confirmed Allocations		9,474	1,547	11,021	
Sep-20	Confirmed Allocations	-69	56,750	32,764	89,445	
Oct-20	MPPP Respiratory projects 2			29	29	Specific Project
	Primary Care out of hours funding			340	340	Annual Allocation
	Preparing for Winter			661	661	Share of £10m
	Community Pharmacy Champions		20		20	Annual Allocation
	Mental Health Outcomes Framework		1,363		1,363	Annual Allocation
	Veterans First Point			116	116	Annual Allocation
	PfG School Nursing Service 2nd Tranche			69	69	Specific Project
	Covid-19 additional funding for GPs			1,325	1,325	Payments made to GP as per circular
	£20m (2018-19) tariff reduction to global sum		-1,142		-1,142	As per allocation letter
	£20m (2019-20) tariff reduction to global sum		-1,380		-1,380	As per allocation letter
	£20m (2020-21) tariff reduction to global sum		-1,723		-1,723	As per allocation letter
	6 Essential Actions			457	457	As per letter
	Redesign of Urgent Care			671	671	Share of £10m
	New Medicines Fund		5,390		5,390	Annual Allocation
	Total Core RRL Allocations	**700,161**	**68,752**	**46,472**	**815,385**	
Anticipated	Distinction Awards		193		193	
Anticipated	Research & Development		243		243	
Anticipated	NSS Discovery		-39		-39	
Anticipated	Pharmacy Global Sum Calculation		-204		-204	
Anticipated	NDC Contribution		-840		-840	
Anticipated	Family Nurse Partnership		28		28	
Anticipated	Golden Jubilee SLA		-25		-25	
Anticipated	Primary Care Improvement Fund		277		277	
Anticipated	GP pension		85		85	
Anticipated	COVID 19- GP Payments			233	233	
Anticipated	COVID 19 - 30%			1,370	1,370	
Anticipated	Top Slice NSS		-962		-962	
Anticipated	Cancer Strategy			-381	-381	
Anticipated	Capital to Revenue			6	6	
	Total Anticipated Core RRL Allocations	**0**	**-1,244**	**1,228**	**-16**	
Anticipated	IFRS			8,874	**8,874**	
Anticipated	Donated Asset Depreciation			132	**132**	
Anticipated	Impairment			500	**500**	
Anticipated	AME Provisions			-172	**-172**	
	Total Anticipated Non-Core RRL Allocations	**0**	**0**	**9,334**	**9,334**	
	Grand Total	**700,161**	**67,508**	**57,034**	**824,703**	

Appendix 2: Corporate Directories – Core Position

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
E Health Directorate	12,561	7,374	7,462	-88
Nhs Fife Chief Executive	206	120	163	-42
Nhs Fife Finance Director	6,420	3,734	3,421	313
Nhs Fife Medical Director	7,310	3,652	3,577	76
Nhs Fife Nurse Director	4,105	2,323	2,168	156
Legal Liabilities	8,093	6,367	6,415	-49
Early Retirements & Injury Benefits	814	475	448	27
Regional Funding	272	164	140	25
Depreciation	17,774	10,642	10,642	0
Nhs Fife Public Health	2,119	1,189	1,171	18
Nhs Fife Workforce Directorate	3,146	1,857	1,806	51
Nhs Fife Major Incident - Flooding			69	-69
Total	**62,820**	**37,898**	**37,482**	**416**

Appendix 3: Service Agreements

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	98	57	55	2
Borders	45	26	32	-6
Dumfries & Galloway	25	14	32	-18
Forth Valley	3,179	1,855	2,072	-217
Grampian	359	210	178	32
Greater Glasgow & Clyde	1,655	966	948	18
Highland	135	79	116	-37
Lanarkshire	114	67	144	-77
Lothian	31,518	18,386	17,136	1,250
Scottish Ambulance Service	101	59	60	-1
Tayside	41,096	23,971	23,707	264
	78,325	**45,690**	**44,480**	**1,210**
UNPACS				
Health Boards	10,627	6,199	6,528	-329
Private Sector	1,245	726	917	-191
	11,872	**6,925**	**7,445**	**-520**
OATS	711	415	77	338
Grants	65	65	63	2
Total	**90,973**	**53,095**	**52,065**	**1,030**

Appendix 4 - Financial Flexibility & Allocations

	CY Budget £'000	Flexibility Released to Oct-20 £'000
Financial Plan		
Drugs	2,869	0
CHAS	0	0
Unitary Charge	100	29
Junior Doctor Travel	35	12
Consultant Increments	23	13
Discretionary Points	205	0
Cost Pressures	3,342	1,152
Developments	4,498	758
Pay Awards	26	0
Sub Total Financial Plan	**11,098**	**1,964**
Allocations		
Waiting List	2,927	0
AME: Impairment	500	0
AME: Provisions	-130	0
Neonatal Transport	12	2
Cancer Access	301	0
Hospital Eye	193	0
Endoscopy	178	0
Advanced Breast Practitioner	31	0
ARISE	68	0
National Cancer Strategy	41	0
Covid 19	7,215	0
MPPP Respiratory Projects	29	0
Winter Funding	661	0
6 essential actions	457	0
Redesign urgent care	671	0
Capital to revenue	6	0
Sub Total Allocations	**13,160**	**2**
Total	**24,258**	**1,966**

Appendix 5 – Initial Covid-19 funding

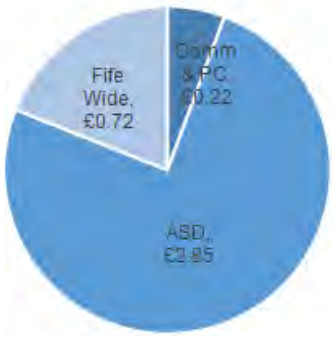
COVID funding	Health Board	Health delegated	Social Care delegated	Total	Capital	Primary Care Funding
	£000's	£000's	£000's	£000's	£000's	£000's
Allocation Q1 to Q4	22,540	6,546	4,458	33,544	999	1,559
Anticipated allocation	1,580		5,287	6,867		
Total funding	**24,120**	**6,546**	**9,745**	**40,411**	**999**	**1,559**
Allocations made for Apr to Oct						
Planned Care & Surgery	1,082			1,082		
Emergency Care & Medicine	1,952			1,952		
Women, Children & Clinical Services	860			860		
Acute Nursing	17			17		
Estates & Facilities	1,277			1,277		
Board Admin & Other Services	2,914			2,914		
Income	642			642		
Test and Protect	228			228		
West Division		1,560		1,560		
Pharmacy Division		65		65		
Fife Wide Division		1,202		1,202		
East Division		757		757		
Primary Care		922		922		1,559
Total allocations made to M6	**8,972**	**4,506**	**0**	**13,478**	**0**	**1,559**
Elective / Planned Care	7,724			7,724		
Capital					999	
Total	**16,696**	**4,506**	**0**	**21,202**	**999**	**1,559**
Balance In Reserves	**5,844**	**2,040**	**4,458**	**12,342**	**0**	**0**

Finance, Performance & Resources – Finance

Capital Expenditure

NHS Boards are required to work within the capital resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

Local Performance



Commentary

The total Capital Resource Limit for 2020/21 is £15.417m including anticipated allocations for specific projects. The capital position for the 7 months to October shows investment of £3.789m equivalent to 24.58% of the total allocation. The capital spend on the specific projects commences in earnest in the latter half of the financial year and as such is on track to spend in full.

Key Challenges in 2020/21	Overall programme of work to address all aspects of backlog maintenance, statutory compliance, equipment replacement, and investment in technology considerably outstrips capital resource limit available

Improvement Actions	Update
21.1 Managing expenditure programme within resources available *By Mar-21*	Risk management approach adopted across all categories of spend

Finance, Performance & Resources – Finance

1. Annual Operational Plan

1.1 The capital plan for 2020/21 has been approved by the FP&R Committee and is pending NHS Fife Board approval. NHS Fife received a capital allocation of £7.394m in the August allocation letter; an allocation of £0.999k for Covid equipment in the September allocation letter; an allocation of £0.381m for Cancer Waiting Times Equipment and is anticipating allocations of £4.5m for the Elective Orthopaedic Centre, HEPMA £0.025m, Lochgelly Health Centre £0.025m, Kincardine Health Centre £0.025m and Radiology funding of £2.068m. The total capital plan is therefore £15.417m.

2. Capital Receipts

2.1 Work continues on asset sales with a disposal planned :

- Lynebank Hospital Land (Plot 1) (North) – Under offer – however the sale of this land will not complete in the current financial year.

Discussions with SGHSCD will be undertaken to highlight the potential risk of non delivery of the sale of land.

3. Expenditure To Date / Major Scheme Progress

3.1 Details of the expenditure position across all projects are set out in the dashboard summary above. Project Leads have provided an estimated spend profile against which actual expenditure is being monitored. This is based on current commitments and historic spending patterns. The expenditure to date amounts to £3.789m or 24.58% of the total allocation, in line with the plan, and as illustrated in the spend profile graph above.

3.2 The main areas of investment to date include:

Statutory Compliance	£1.671m
Equipment	£0.780m
E-health	£0.642m
Elective Orthopaedic Centre	£0.582m

4. Capital Expenditure Outturn

4.1 At this stage of the financial year it is currently estimated that the Board will spend the Capital Resource Limit in full.

5. Recommendation

5.1 Members are invited to approach the Director of Finance for any points of clarity on the position reported and are asked to:

note the capital expenditure position to 31 October 2020 of £3.789m and the forecast year end spend of the total capital resource allocation of £15.417m.

Appendix 1: Capital Expenditure Breakdown

Project	CRL Confirmed Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2020/21 £'000
COMMUNITY & PRIMARY CARE			
Capital Minor Works	272	52	272
Statutory Compliance	150	102	150
Capital Equipment	31	31	31
Covid Community Equipment	26	26	26
Condemned Equipment	0	0	0
Total Community & Primary Care	479	212	479
ACUTE SERVICES DIVISION			
Statutory Compliance	3,189	1,509	3,189
Capital Equipment	549	108	549
Covid Acute Equipment	973	524	973
Minor Works	193	40	193
Cancer Waiting Times Equipment	381	0	381
Condemned Equipment	91	91	91
Total Acute Services Division	5,376	2,272	5,376
NHS FIFE WIDE SCHEMES			
Equipment Balance	235	0	235
Information Technology	1,041	642	1,041
Minor Works	33	0	33
Statutory Compliance	100	0	100
Contingency	0	0	0
Asbestos Management	85	0	85
Fire Safety	85	60	85
Scheme Development	60	8	60
Vehicles	60	9	60
Capital In Year Contingency (EDG)	1,220	0	1,220
Total NHS Fife Wide Schemes	2,919	719	2,919
TOTAL CONFIRMED ALLOCATION FOR 2020/21	**8,774**	**3,202**	**8,774**
ANTICIPATED ALLOCATIONS 2020/21			
Elective Orthopaedic Centre	4,500	582	4,500
Radiology Funding	2,068	0	2,068
HEPMA	25	2	25
Lochgelly Health Centre	25	2	25
Kincardine Health Centre	25	0	25
Anticipated Allocation for 2020/21	**6,643**	**586**	**6,643**
Total Anticipated Allocation for 2020/21	**15,417**	**3,789**	**15,417**

Appendix 2: Capital Plan - Changes to Planned Expenditure

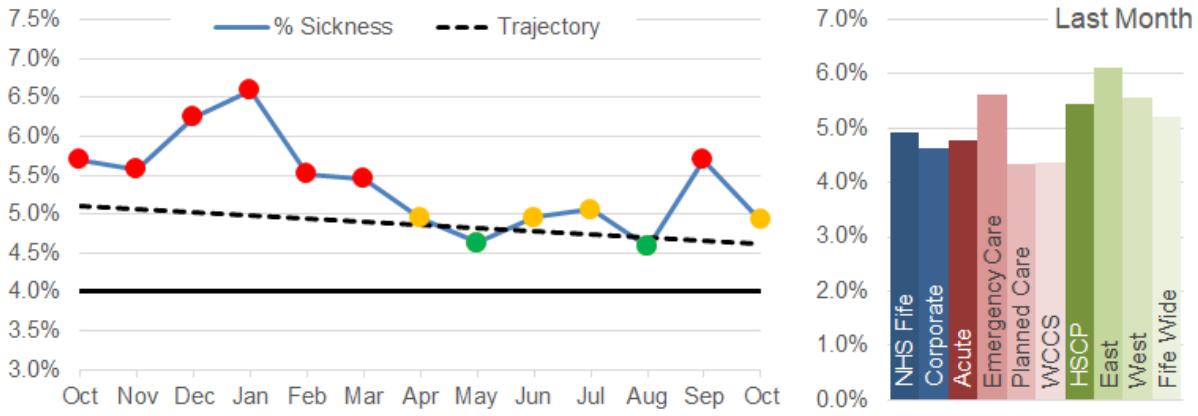
Capital Expenditure Proposals 2020/21 Routine Expenditure	Pending Board Approval £'000	Cumulative Adjustment to September £'000	October Adjustment £'000	Total October £'000
Community & Primary Care				
Capital Equipment	0	31	0	31
Condemned Equipment	0	0	0	0
Minor Capital	0	208	64	272
Covid Equipment	0	26	0	26
Statutory Compliance	0	150	0	150
Total Community & Primary Care	**0**	**414**	**64**	**479**
Acute Services Division				
Capital Equipment	0	549	0	549
Condemned Equipment	0	90	1	91
Cancer Waiting Times Equipment	0	0	381	381
Minor Capital	0	160	34	193
Covid 19 Acute Equip	0	973	0	973
Statutory Compliance	0	3,089	100	3,189
	0	**4,861**	**515**	**5,376**
Fife Wide				
Backlog Maintenance / Statutory Compliance	3,569	-3,469	0	100
Fife Wide Equipment	2,036	-1,800	-1	235
Information Technology	1,041	0	0	1,041
Minor Work	498	-367	-98	33
Fife Wide Contingency Balance	100	0	-100	0
Condemned Equipment	90	-90	0	0
Scheme Development	60	0	0	60
Fife Wide Asbestos Management	0	85	0	85
Fife Wide Fire Safety	0	85	0	85
Fife Wide Screen & Speech Units	0	0	0	0
Fife Wide Vehicles	0	60	0	60
Capital In Year Contingency	0	1,220	0	1,220
Total Fife Wide	**7,394**	**-4,276**	**-199**	**2,919**
Total	**7,394**	**999**	**381**	**8,774**
ANTICIPATED ALLOCATIONS 2020/21				
Elective Orthopaedic Centre	4,500	0	0	4,500
Radiology Funding	2,068	0	0	2,068
HEPMA	25	0	0	25
Lochgelly Health Centre	25	0	0	25
Kincardine Health Centre	25	0	0	25
Anticipated Allocation for 2020/21	**6,643**	**0**	**0**	**6,643**
Total Planned Expenditure for 2020/21	**14,037**	**999**	**381**	**15,417**

Staff Governance

Sickness Absence

To achieve a sickness absence rate of 4% or less
Improvement Target for 2020/21 = ***4.39%***

Local Performance (Source: Tableau, from December 2019)



National Benchmarking

Month	2019/20						2020/21						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
NHS Fife	5.70%	5.57%	6.25%	6.59%	5.51%	5.46%	4.95%	4.64%	4.96%	5.06%	4.58%	5.69%	4.93%
Scotland	5.69%	5.58%	5.83%	5.99%	5.27%	5.20%	4.57%	4.54%	4.49%	4.57%	4.64%	4.96%	4.93%

Key Challenges in 2020/21	Recovery from COVID-19 and repurposing Promoting Attendance activities to support business as usual

Improvement Actions	Update
20.1 Targeted Managerial, HR, OH and Well@Work input to support management of sickness absence *By Dec-20*	The Workforce Dashboard (delivered via Tableau) has been rolled out to circa 100 users within NHS Fife to date and roll out will continue on a planned basis. This provides Line Managers, Human Resources and Occupational Health staff with timely workforce information, which can be interrogated and drilled down in order to identify trends and priority areas. The Dashboards provide an additional resource to Promoting Attendance and Well@Work Groups, with Review and Improvement Panels utilising trend and priority indicators to target future interventions. Business Units are continuing to utilise trajectory reporting and RAG status reports. Bespoke training on the new Once for Scotland Promoting Attendance policy was offered in November, and will continue with short focussed sessions.
20.2 Early OH intervention for staff absent from work due to a Mental Health related reason *By Mar-21*	This has been in place since March 2019 and given the current COVID-19 pandemic situation, an additional Mental Health Nursing resource was secured within Occupational Health (OH) to provide support to staff who may be struggling with their mental health during the pandemic. This provides OH clinicians the option of referring employees for interventions which will help support them in the workplace. High level feedback is that all staff who have received support to date found it beneficial and some have found it helpful for them to return to work earlier and for others to remain at work. This is based on the number of staff who have completed the full journey. Funding has been secured to enhance the current OH staffing provision and will enable this service to continue on an on-going basis. Initial consideration of factors including general awareness raising of mentally healthy workplaces, support for managers to create mentally healthy and resilient workplaces and further awareness raising of support for staff was concluded in April 2020 and is an ongoing feature of the

Staff Governance	
	Promoting Attendance training and a foundation of the COVID-19 resources. This has been supplemented and complemented by the additional support and inputs via Psychology and other services during the pandemic and may be included in a much broader consideration and evaluation of staff support requirements being taken forward by the Staff Support and Wellbeing Sub Group of the Silver Command Workforce Group and their successors.
21.1 Once for Scotland Promoting Attendance Policy *By Mar-21 (was Dec-20)*	The purpose of this action is to provide training and support, in partnership, for managers and supervisors on the new policy and the standardised approaches within it, which was just being implemented at the start of the pandemic. Sessions were delivered across Fife when the policy was launched. Note - Having completed the action as initially set out, we can confirm that additional focussed sessions have been offered since November, via MS Teams, to support implementation of the policy. These will conclude in March 2021.
21.2 Review the function of the Promoting Attendance Group *By Dec-20*	The review of the function of the NHS Fife Promoting Attendance Group and associated supporting groups, to improve the governance arrangements of each group and how they interrelate, has commenced. The aim is to provide a Promoting Attendance framework with clear lines of reporting and escalation.
21.3 Restart Promoting Attendance Panels	

CAROL POTTER
Chief Executive
16th December 2020

Prepared by:
SUSAN FRASER

Staff Governance

Associate Director of Planning & Performance

Appendix 1: NHS Fife Remobilisation Activity to end of Nov 2020

Higher than Projected
Lower than Projected

		Quarter End	Month End			Quarter End	Quarter End
		Sep-20	Oct-20	Nov-20	Dec-20	Dec-20	Mar-21
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	2,040	974	1,066	1,004	3,044	3,220
	Actual	2,589	1,056	1,007	0		
	Variance	549	82	-59			
OP Referrals Accepted (Definitions as per Waiting Times Datamart)	Projected	14,042	7,386	7,520	7,659	22,565	21,906
	Actual	15,881	6,058	6,111			
	Variance	1,839	-1,328	-1,409			
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	13,602	6,466	6,997	7,166	20,630	22,208
	Actual	11,844	4,402	5,427			
	Variance	-1,758	-2,064	-1,570			
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,648	848	848	600	2,296	2,544
	Actual	1,110	420	462			
	Variance	-538	-428	-386			
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	10,074	4,000	4,000	3,450	11,450	10,850
	Actual	11,264	3,735	3,634			
	Variance	1,190	-265	-366			
A&E Attendance (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	21,495	7,190	7,180	7,335	21,705	21,810
	Actual	20,303	6,133	6,005			
	Variance	-1,192	-1,057	-1,175			
Number of A&E 4-Hour Breaches (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	775	280	300	420	1,000	985
	Actual	815	363	426			
	Variance	40	83	126			
Emergency Admissions (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	9,225	3,225	3,375	3,500	10,100	9,970
	Actual	8,755	2,931	2,875			
	Variance	-470	-294	-500			
Admissions via A&E (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	4,354	1,450	1,430	1,470	4,350	4,160
	Actual	4,467	1,492	1,364			
	Variance	113	42	-66			
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	Projected	2,195	690	700	750	2,140	2,320
	Actual	2,097	773	856			
	Variance	-98	83	156			
31 Day Cancer - First Treatment, Patients Treated (Definitions as per Published Statistics)	Projected	309	103	103	103	309	309
	Actual	291	91				
	Variance	-18	-12				
CAMHS - First Treatment, Patients Treated (Definitions as per Published Statistics)	Projected	325	132	135	89	356	295
	Actual	274	102				
	Variance	-51	-30				
Psychological Therapies - First Treatment, Patients Treated (Definitions as per Published Statistics)	Projected	970	702	715	539	1,956	1,985
	Actual	1,233	499				
	Variance	263	-203				

		Month End	Month End			Month End	Month End
		Sep-20	Oct-20	Nov-20	Dec-20	Dec-20	Mar-21
Delayed Discharges at Month End (Any Reason or Duration, per the Definition for Published Statistics) [1]	Projected	79	80	90	79	79	74
	Actual	75	65	98			
	Variance	-4	-15	8			

[1] The data required is the estimated number of people delayed at each census point (the snapshot figure). Baseline figures used are the census point figures as at the end of each month

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**12 January 2021**
Title:	**Internal Audit Annual Report 2019-20**
Responsible Executive:	**M McGurk, Director of Finance**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The purpose of this report is to present the final 2019/20 Annual Internal Audit Report to all Board governance committees. The report was considered and approved by the Audit & Risk Committee at its November 2020 meeting.

2.2 Background

The report, with completed action plan, is considered as part of the portfolio of evidence provided in support of the Audit & Risk Committee's evaluation of the internal control environment. It provides details on the outcomes of the 2019/20 internal audit and the Chief Internal Auditor's opinion on the Board's internal control framework for the financial year 2019/20.

2.3 Assessment

Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2019/20 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

In addition, we have not advised management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work;
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected;
- The format and content of the Governance Statement in relation to the relevant guidance;
- The disclosure of all relevant issues.

Therefore, **it is my opinion** that:

- The Board has adequate and effective internal controls in place
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

We noted the following key themes:

- The opportunity to ensure that staffing reflects organisational priorities and the need for Board-level assurance that capacity and capability are sufficient to update and drive strategy, achieve transformation and deliver required savings
- Different ways of working due to Covid19 and the opportunities and challenges these present;
- The requirement to review and potentially revise the Board's overall Strategy and all supporting strategies and ensure they are widely known and understood;
- Ongoing developments in risk management;
- The requirement to finalise governance aspects of integration;
- Recognition of eHealth as an essential enabler for change and the implementation of governance arrangements for eHealth and Information Governance;
- Improvement required around implementation of internal audit recommendations.
- The importance of remobilisation to the transformation process is vital moving forward. Internal Audit have developed a set of remobilisation principles and will be reviewing the adequacy of actions taken by the Board against these principles, with a report to be considered at the January 2021 Audit and Risk Committee meeting.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.5 Equality and Diversity, including health inequalities

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit and shared with the Director of Finance and the Associate Director of Finance.

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager, reviewed by the Chief Internal Auditor and agreed by the Director of Finance. It has been discussed and approved by the Audit & Risk Committee at its meeting on 19 November 2020.

2.4 Recommendation

The Finance, Performance & Resources Committee is asked to:

- **NOTE** this report and its evaluation of the internal control environment, particularly its areas of findings relevant to the Committee's own remit.

3 List of appendices

The following appendices are included with this report:

- Annual Internal Audit Report 2019/20

FTF Internal Audit Service

Annual Internal Audit Report 2019/20

Report No. B06/21

Issued To: C Potter, Chief Executive
M McGurk, Director of Finance

C McKenna, Medical Director
L Douglas, Director of Workforce
H Buchanan, Director of Nursing
G MacIntosh, Head of Corporate Governance & Board Secretary

Audit and Risk Committee
External Audit

Contents

Final Report Issued	10 November 2020

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit and Risk Committee provides details on the outcomes of the 2019/20 internal audit and my opinion on the Board's internal control framework for the financial year 2019/20.

2. Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2019/20 Internal Audit Plan has been delivered in line with Public Sector Internal Audit Standards.

3. In addition, we have not advised management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work;
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected;
- The format and content of the Governance Statement in relation to the relevant guidance;
- The disclosure of all relevant issues.

ACTION

4. The Audit and Risk Committee is asked to **note** this report in evaluating the internal control environment and **report** accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2019/20 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the previous Director of Finance. The resultant audits ranged from risk based reviews of individual systems and controls through to reviews of strategic governance and the control environment.

6. The authority, role and objectives for Internal Audit are set out in Section 3 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

7. Internal Audit is also required to provide the Audit and Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit Committee should support the Accountable Officer and the Board by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of the financial statements and the annual report. The scope of the Committee's work should encompass all the assurance needs of the Accountable Officer and the Board. Within this the Committee should have particular engagement with the work of Internal Audit, risk management, the External Auditor, and financial management and reporting issues.

INTERNAL CONTROL

8. The Internal Control Evaluation (ICE), issued on 6 January 2020, was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Directors Group (EDG) and other papers. The ICE noted many actions taken by NHS Fife to enhance governance and achieve transformation and whilst it concluded that NHS Fife assurance structures were adequate and effective, there were 15 recommendations for improvement by the end of June 2020, eight of which were classified as significant. Four recommendations have been implemented, with two partially completed and nine still outstanding. Further details are included within each governance section.

9. In this annual report we have provided an update on progress to date and, where appropriate, built on and consolidated recommendations to allow revised completion dates to be agreed. The completion dates for seven actions have been extended, with the latest completion date now February 2021. Four remaining actions have previously been extended and remain outstanding. The following key findings from our ICE remain extant:

    - Sustainable financial balance will not be achieved without greater progress on transformation and the revision of the IJB risk share agreement
    - Information Governance assurances are insufficient
    - Although progress has been made, Integration Governance arrangements have still not been concluded
    - Actions to address the recommendations within Internal Audit Report B15/17 & B18/18 - Clinical and Care Governance Strategy and Assurance have not progressed as expected.

10. Covid 19 has clearly had a substantial impact on the organisation's priorities and ability to complete all of the agreed actions. However, it is our view that many of the original recommendations would not have been completed on time had the pandemic not occurred. The EDG should revisit these outstanding actions together with further required actions identified in this Annual Report to ensure the timescales for completion are appropriate, achievable and are afforded the requisite priority.

11. The ICE was our main piece of assurance work for 2019/20 and this Annual Internal Audit Report is therefore less detailed than in previous years. In addition to our ICE follow-up we have tested to ensure that there were no material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the impact of Covid 19 and the special governance arrangements put in place at the end of the year. Some areas for further development were identified and will be followed up in the 2020/21 ICE and, where applicable, our detailed findings have been included in the NHS Fife 2019/20 Governance Statement.

12. For 2019/20, the Governance Statement format and guidance included within the NHSScotland Annual Accounts Manual has been updated to include reference to the March 2018 SPFM Audit Committee Handbook and the Blueprint for Good Governance, issued in January 2019, albeit without specific reference to the associated Treasury Guidance on assurance mapping in the Audit Committee Handbook. Whilst Health and Social Care Integration is not specifically referenced, the guidance does make it clear that the Governance Statement applies to the consolidated financial statements as a whole, which would therefore include activities under the direction of IJBs. We are pleased to note that the NHS Fife Governance Statement does include reference to the key areas omitted from SGHSCD guidance.

13. The Board has produced a Governance Statement which states that:

    - *For 2019-20, 2595 individuals have exceeded the Treatment Time Guarantee to have their treatment provided within 12 weeks. A letter of apology was sent to each patient and every effort was made to treat patients in as short a time as possible. A Waiting Times Improvement Plan is being implemented and progress and improvement actions continue to be monitored through monthly performance reviews within the Acute Services Division.*
    - *An unannounced Healthcare Environment Inspection (HEI) was conducted at Glenrothes Hospital in March 2019, the Hospital having been last inspected in April 2014. The inspection reported on areas where NHS Fife was performing well and areas for improvement, identifying two areas of good practice and three requirements for improvement. During the visit the Board received positive feedback about the standards of cleanliness and staff knowledge of standard infection control precautions. It was, however, noted that not all staff were aware of and completed mandatory requirements for infection prevention and control education and that all patient equipment was safe and clean. An action plan was prepared in response to the areas for improvement identified, with all actions since completed. A further unannounced inspection of Glenrothes Hospital, by Healthcare Improvement Scotland, was conducted in July 2020, focused on Safety and Cleanliness and Care of Older People in Hospital; publication of the report is expected in September 2020.*
    - *There were 13 potential personal data-related incidents or data protection breaches reported to the Information Commissioner's Office (ICO) during the financial year ended 31 March 2020. Six related to personal data breaches, of which one report was rejected by the ICO as it pertained to a deceased person and one was subsequently withdrawn on investigation. Three breaches related to the unavailability of data (unplanned system outage) and four related to personal data breaches within GP Practices (NHS Fife is now joint data controller of data held within GP practices and provides Data Protection serves to GPs). None resulted in any patient harm or financial penalties being imposed. For ten of the reports submitted, the ICO took no further action, though made a series of recommendations. One report remains outstanding at the time of writing of this report.*
    - *During the 2019-20 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control.*

14. Whilst we are content that these disclosures are sufficient, members should be aware that the issues we have raised in relation to Information Governance could well lead to a disclosure in 2021-22 unless remedial action is taken as a matter of priority.

However, management have recently reviewed eHealth and Information Governance and are confident that the implementation of new governance arrangements will raise the profile of Information Governance at the Clinical Governance Committee and should address these issues.

15. Our audit has provided evidence of compliance with the requirements of the Accountable Officer Memorandum, and this combined with a sound corporate governance framework in place within the Board throughout 2019/20, provides assurance for the Chief Executive as Accountable Officer.

16. Therefore, **it is my opinion** that:

- The Board has adequate and effective internal controls in place;
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

17. Assurances have been received from all Executive Directors and Senior Managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility and that there are no known control issues, nor breaches of Standing Orders / Standing Financial Instructions.

Covid 19

18. On 17 March 2020 NHS Scotland was placed on an emergency footing under section 1 and section 78 of the National Health Service (Scotland) Act 1978, for at least three months. Boards were given instructions *'to do all that is necessary to be ready to face a substantial and sustained increase in cases of COVID 19'*. A subsequent Directive from Scottish Government to Health Boards made clear that where directions are issued on behalf of the Cabinet Secretary there was to be no local interpretation and that these must be implemented in full and without delay in order to maintain the resilience of the NHS.

19. In recognition of the challenges caused by the rapid mobilisation of services to address Covid 19, a letter was issued by the Scottish Government Director of Health Finance to Board Chairs dated 25 March 2020, providing approval to revise governance arrangements. Individual Health Boards were invited to submit their specific proposals for governance during the pandemic period to the Office of the Chief Executive and NHS Fife submitted it on 30 March 2020. On 8 April 2020 NHS Fife Board considered a paper outlining the Board's planned approach to governance while NHS Fife continued to deal with the Covid 19 pandemic, based on the principles contained in the submission made to the Scottish Government. The paper outlined aims: to ensure the Board could effectively respond to Covid 19 as well as appropriately discharge its governance responsibilities, maximise time available for management and operational staff to deal with the significant challenges of addressing Covid 19 demand within clinical services and minimise the need for people to physically attend meetings.

20. In addition, meetings between the Chair and Vice-Chair and members of the EDG have taken place on a weekly basis and the minutes have been circulated to Board members. The Chief Executive has issued a weekly Covid update to all staff.

21. To ensure good governance around the restart of clinical services, the Remobilisation Oversight Group (ROG) was established with a wide representation of clinical leaders, to oversee the restarting of health and care services in Fife. As reported to the July 2020 Board, the purpose of this group is to take forward the reintroduction of clinical services in a safe, measured and Covid 19 sensitive way. The ROG aims to oversee the

whole system restart to improve integrated pathways from primary care, community, social care and secondary care, adhering to governance arrangements with learning from the Covid 19 response. The latest iteration of the Remobilisation plan, to March 2021, was submitted to the Scottish Government on 31 July in line with the requirements of the Scottish Government.

22. The draft NHS Fife Governance Statement recognises that *"In light of the ongoing impact of Covid 19 on NHS Fife, it is anticipated that the Board's strategic framework will require to be reviewed, in tandem with reassessment of the transformation programme and its relationship to the remobilisation / redesign of key services. As part of that work, the strategies of the IJB will also need to be considered and it is expected that all of the Board's supporting strategies will require review, to appropriately reflect a post-Covid environment."*

23. It is clear that recovery and reconfiguration will be key throughout the remainder of 2020-21. Remobilisation activity and transformation will need to be considered together in parallel with the fundamental review and, if required, revision of the Board's overall Strategy and supporting strategies. Additional responsibilities have been placed on Boards in relation to care homes and these will need to be considered in the context of the recognised need to formalise and enhance clinical and care assurance processes.

24. NHS Fife has contributed to the national response to the pandemic by piloting the Scottish Test and Protect software and the testing of the effectiveness of a Covid 19 treatment.

Key Themes

25. During 2019/20 the Chief Executive's departure resulted in changes to the NHS Fife Executive and senior leadership team structure, including appointment of the then Director of Finance as Interim Chief Executive and the subsequent appointment of an experienced Director of Finance from another Health Board on an interim basis. Other appointments during the year included a new Director of Workforce, Chief Operating Officer, Director of Health and Social Care, although the Director of Strategic Planning post remains vacant. The necessary prioritising of Covid 19 duties had emphasised the urgency to put in place effective controls and in particular the need for the Board to seek assurance from the EDG to assure itself that it had sufficient capacity and capability to deliver long-term strategic change and develop sustainable models of care whilst delivering significant short-terms savings and continuing to deliver business as usual.
26. Over recent years the challenges facing all Boards have increased significantly and NHS Fife has been no exception. Controls within the Board have not kept pace with changes to the environment in which the Board operates and may not be sufficient fully to mitigate the risks facing the Board in the coming years. Systems of control continued to have challenges to adequately resolve long-standing information governance, IJB governance and transformation issues. Capacity issues, specifically the loss of a number of key finance staff, have contributed to a delay in submission of the annual accounts in line with the agreed timetable; the audit commenced in September and will conclude with the NHS Fife Board receiving the accounts for approval in November. Covid 19 and the consequent need to revisit the Board's overall and supporting strategies will create additional pressures going forward. The Board must assure itself that it has sufficient capacity and capability to review and, where necessary revise its

strategies, deliver transformation and reconfiguration, and achieve significant short-term savings whilst continuing to deliver business in extremely challenging circumstances at a time when staff have been under significant pressure over a long period.

27. Other key themes emerging from our ICE and other audit work during the year include:

- As with all other NHS Boards, the Board's overall Strategy and all supporting strategies will require fundamental review and potentially significant revision to take account of the impact of Covid 19 on population need, resource availability and the impact on modes of delivery as well as embedding potential for more rapid change. This will require considerable work to understand the impact of the pandemic and greater focus by Committees on the formation of supporting strategies and the monitoring their delivery as well as the delivery of transformation which will need both to accelerate and be genuinely transformative.
- Covid 19 will have a considerable impact on the Board's risk profile and, given the improvements still required, as reported in B13/20, there is an opportunity fundamentally to embed Risk Management processes, incorporating assurance mapping principles to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance. The revision of the Board's overall strategies provides an opportunity for fundamental review of the Corporate Risk Register to ensure it links risk to strategic objective, and to allow Board members to participate fully.
- Implementation of Internal Audit recommendations requires improvement with the vital support of EDG to ensure completion of actions. In particular, the completion of actions agreed within the ICE has been poor. Whilst some of this has undoubtedly been affected by Covid 19, we would anticipate that progress with actions will improve as staff return to their substantive duties. There is a need for more robust monitoring of ICE recommendations by officers and via the appropriate governance committees, who should reflect on any significant non-compliance in their year-end assurances.
- Digital and Information (eHealth) will be an essential enabler for transformation and remobilisation. Whilst there have been enhancements in the Digital and Information function, the overall governance arrangements and assurance reporting for Digital and Information, particularly for Information Governance, require substantial improvement to reflect their increasing importance and substantially increased risk profile.
- Following Covid 19, NHS Fife should establish clear and comprehensive Remobilisation principles which cover:
    - Learning lessons and identifying what did and did not go well, and thereby what changes and improvements can be instigated (noting that lessons learnt exercises have been undertaken with reporting to the Gold Command).
    - Where processes revised as a result of Covid 19 are proving more effective and efficient, these should be incorporated into Business as Usual and there should be no assumption of a reversion to prior models; the past should have no special place

- Data to evidence success and failure should be identified at the outset for both formal transformation projects and changes introduced as a result of the Covid 19 pandemic.

- It was already clear that services were not sustainable without substantial change and Covid 19 has increased the requirement for rapid transformation. Our Transformation Programme Governance Follow-up review (B15A/20) found that only one of the six recommendations from our report B10/18 had been fully implemented. Transformation work must be fully aligned with remobilisation activity and the organisation must seize the opportunity for rapid, sustainable change, in accordance with the actions agreed with Internal and External Audit over the last two years. This should be a central priority for both for the NHS Fife Board and particularly the Clinical and Care Governance Committee which has been delegated with responsibility for monitoring progress.

28. As a result of the Covid 19 pandemic, the Scottish Government delayed the requirement for comprehensive review of Integration Schemes. Whilst there has been progress, two key areas still need to be agreed including Clinical and Care Governance, which will now require particular attention. There is a commitment by management to reach agreement by 31 December 2020 in readiness for an approved Integration Scheme for the start of 2021-22.

29. The Board has been working in different ways as a result of the pandemic. Again, this provides an opportunity to reflect on its governance structures to ensure that they focus on the delivery of key organisational objectives, the mitigation of risk and effective assurance. This would also be a good time to refresh the understanding of the Board and Standing Committees on governance, culture and principles, ensuring that they are evident in all aspects of business. Whilst national initiatives such 'active governance' are expected to be introduced in 2020-21, we would expect the Board and Standing Committees to demonstrate:

- Clear expectations of acceptable progress and delivery, tempered with an understanding of risks and acknowledgement that risks may crystallise
- An expectation that officers will notify and address poor performance in a timely way
- A collective understanding from members that NHS Fife must deliver on realistic targets which requires the Board and its Committees to ensure that targets are meaningful and realistic and then to ensure that all possible actions have been taken to meet them
- Clear focus on priority areas including transformation, integration and information governance.

AUDIT PRODUCTS AND OPINIONS

30. During 2019/20 we delivered 34 audit products, including 9 from 2018/19. These audits reviewed the systems of financial and management control operating within the Board. Our reviews assisted the Board by examining a wide range of controls in place across the organisation.

31. Our 2019/20 audits of the various financial and business systems provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit and Risk Committee throughout the year.

32. A number of our reports, including reviews of areas such as eHealth Strategic Planning & Governance, Transport of Medicines, and Attendance Management (Workforce Planning) have been wide ranging and complex audits which have relevance to a wide range of areas within NHS Fife.

33. Board staff had previously maintained a system for the follow up of internal audit recommendations and reporting of results to Audit & Risk Committee. To improve the effectiveness of the Audit Follow Up system, a revised approach was adopted from October 2019 with Internal Audit conducting an exercise to identify all outstanding actions back to 2017/18.

34. Although the Audit & Risk Committee has acknowledged improvements in the quality of Audit Follow Up (AFU) reports since January, the AFU management response rate and the quality of responses still requires enhancement. Of the 177 recommendations made in the years 2017/18, 2018/19 and 2019/20, 74 have been reported as complete, 61 of which have been verified by internal audit (as at 22 June 2020). While progress with some of these actions has undoubtedly been affected by Covid 19, we would expect that as staff return to their substantive duties, there should be clear and significant evidence of progress.

ADDED VALUE

35. The Internal Audit Service has been responsive to the needs of the Board and has added value by:

- Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive Internal Control Evaluation which recommended remedial action to be taken in-year. This review made recommendations focused on enhancements to ensure NHS Fife has in place appropriate and proportionate governance, which supports and monitors the delivery of objectives and is commensurate with the challenging environment within which it is operating.
- Continuing to liaise with management and providing ad-hoc advice on a wide range of governance and control issues.
- Progressing the ongoing assurance mapping exercise to identify, assess, structure and develop assurances relating to key risks as well as those required from Directors. Internal Audit facilitated a joint approach across its four mainland clients as well as linking with national developments. In NHS Fife the Board Assurance Framework risk chosen for review was '*eHealth – Delivering Digital and Information Governance & Security*' which is described as '*There is a risk that due to failure of Technical Infrastructure, Internal & External Security, Organisational Digital Readiness, ability to reduce skills dilution within eHealth and ability to derive Maximum benefit from digital provision NHS Fife may be unable to provide safe, effective, person centred care*'. Work was progressing well, with very strong input from the Board Secretary, but was paused due to impact of Covid 19 and will continue as part of the 2020/21 Annual Internal Audit Plan.
- Continued participation in the development of information governance arrangements through attendance at Information Governance and Security Group and eHealth Board meetings and provision of support and advice on governance and assurance reporting.
- Detailed commentary on the developing Risk Management Framework.

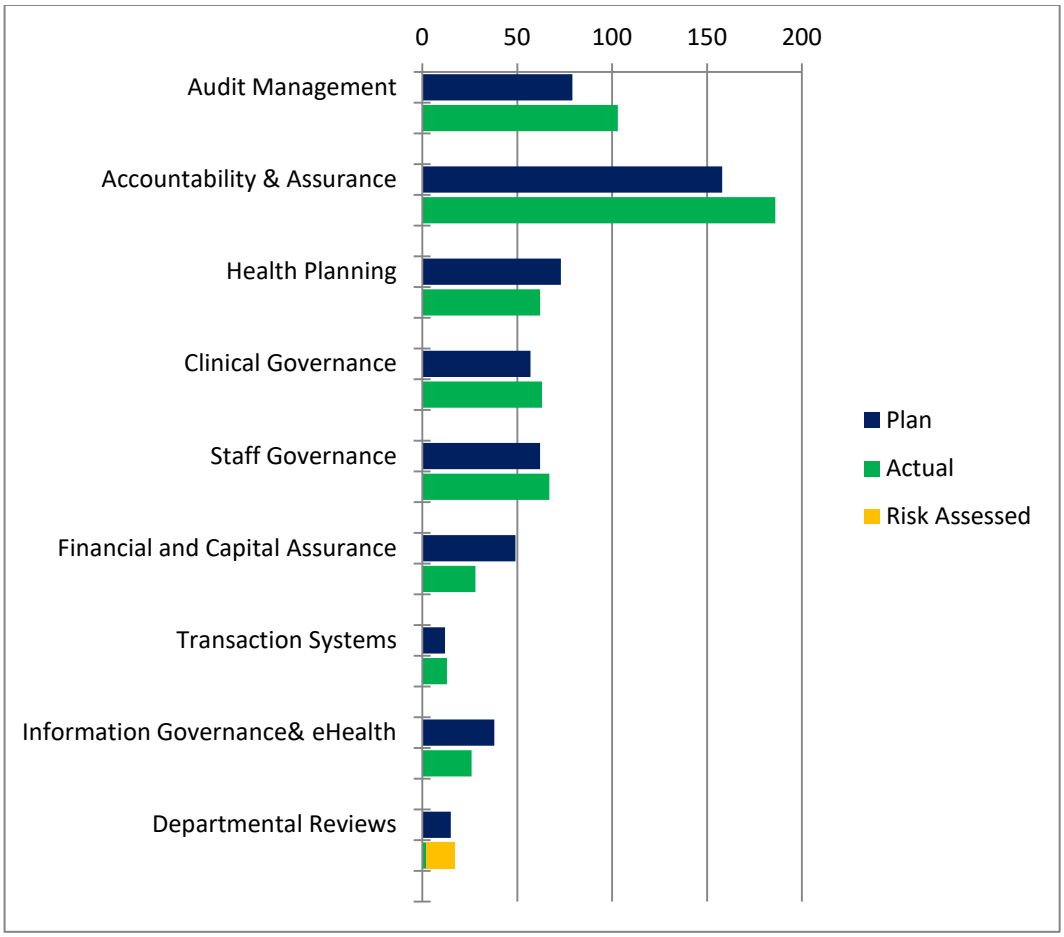
- The B21/20 Medicines Management review contributed to the broader Medicines Assurance Audit Programme by considering compliance with the controls included in the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP) regarding the movement and transportation of medicines to Community Hospitals. The audit found a number of lapses in expected controls and these were communicated at the Safe and Secure Use of Medicines Group and the Medicines Transport Project Group.
- The B23A/20 Attendance Management review provided assurance over the implementation of the attendance management policies and procedures and provided positive feedback that the training and awareness sessions were having a positive impact.

36. Internal Audit developed a governance checklist tool to capture evidence and provide assurance on areas of good governance and identify any gaps in arrangements to support the work of the NHS Boards during the pandemic. An abbreviated checklist was considered by the NHS Fife Standing Committees between June and July 2020 and Internal Audit will provide a review of these completed checklists early in the autumn. Internal Audit has also developed reconfiguration and remobilisation principles to assist management and to inform the 2020-21 audit process.

37. Internal Audit has continued to highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk and to advise on specific issues, as well as maintaining an awareness of the impact of the IJB control environment on NHS Fife and providing updated assurance principles for consideration by management.

INTERNAL AUDIT COVER

38. Figure 1: Internal Audit Cover 2019/20



39. Figure 1 summarises the 2019/20 outturn position against the planned internal audit cover. The Annual Internal Audit Plan was approved by the Audit and Risk Committee at its meeting on 20 June 2019. To date, we have delivered 550 days against the planned 543 days. Work is ongoing to ensure that the two remaining products from 2019/20 are completed by the September 2020 Audit and Risk Committee. All audit products required for External Audit and for year-end assurance have been delivered.

40. Following a recommendation from the External Quality Assessment carried out on Internal Audit in 2018/19, we continue with the agreed process of risk assessing outstanding 2019/20 audits for inclusion in the 2020/21 plan. Only one review, Recruitment and Retention, required risk assessment and has been included within the audit plan for 2020/21.

41. A summary of 2019/20 performance is shown in Section 4.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

42. The FTF Partnership Board has produced as annual summary of activity for the year:

FTF Partnership Board
Annual Summary 2019/20

1. Introduction

This report sets out a summary of Partnership Board meetings held in 2019/20.

2. FTF Partnership Board Meetings

Meetings were held on the following dates:

- 12 April 2019
- 13 November 2019

3. Attendance

The following individuals attended meetings in person or via teleconference:

Members:

- Scott Urquhart, Director of Finance, NHS Forth Valley (Chair)
- Carol Potter, Director of Finance & Performance, NHS Fife (now Chief Executive, NHS Fife)
- Frances Gibson, Head of Finance – Governance & Assurance, NHS Tayside / Robert MacKinnon, Associate Director of Finance

In Attendance:

- Tony Gaskin, Chief Internal Auditor FTF
- Jocelyn Lyall Regional Audit Manager FTF
- Barry Hudson Regional Audit Manager FTF
- Angela McEwan NHS Forth Valley (Minutes)

4. Business

The committee considered both routine and specific work areas during the year:
Key items discussed and outputs included the following:

- Review of External Quality Assessment (EQA) of FTF Internal Audit Service
- Health & Social Care Integration issues
- Internal Audit Shared Service Agreement 2018-2023 - update and review
- Internal Audit Service Specification – update and review
- Governance Issues including Governance Statement Guidance, Assurance Mapping and SGHSCD Assurance letters
- Review of budget performance 2018/19
- Approval of budget proposals 2019/20
- Review of Performance including KPIs and Balanced Scorecard
- Recruitment

5. Conclusion

As Chair of the Partnership Board I can confirm that the breadth of the business undertaken, and the range of attendees at meetings of the Partnership Board has allowed us to fulfil our remit.

Scott Urquhart
Chairperson, FTF Partnership Board

43. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the specification and the Public Sector Internal Audit Standards (PSIAS).

44. Internal Audit is compliant with PSIAS, and has organisational independence as defined by PSIAS, except that, in common with many NHSScotland bodies, the Chief Internal Auditor reports through the Director of Finance rather than the Accountable Officer. There are no impairments to independence or objectivity.

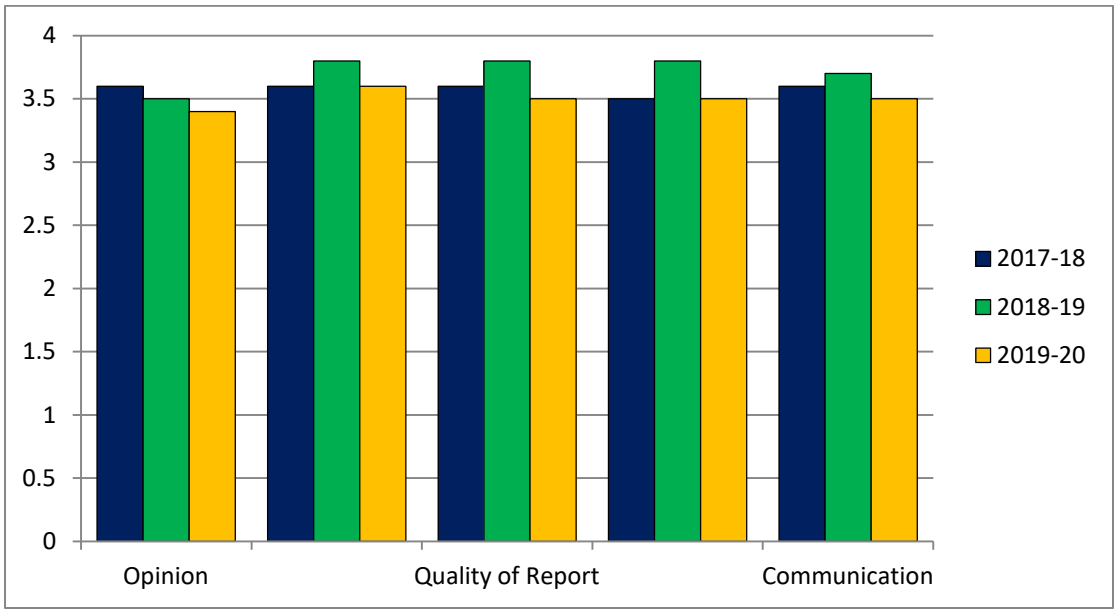
45. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

46. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent external assessment of the Internal Audit Service was presented to the Audit Committee on 9 June 2019 and concluded that *'following completion of the comprehensive External Quality Assessment (EQA) Checklist and, based on the work undertaken, it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* All actions are now complete and we are in the process of updating our self assessment of the EQA requirements. The outcomes will be reported to the FTF Partnership Board.

47. A key measure of the quality and effectiveness of the audits is the Board responses to our client satisfaction surveys, which are sent to line managers following the issue of each audit report. Figure 2 shows that, overall, our audits have been perceived as good or very good by the report recipients.

48. Figure 2: Summary of Client Satisfaction Surveys

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



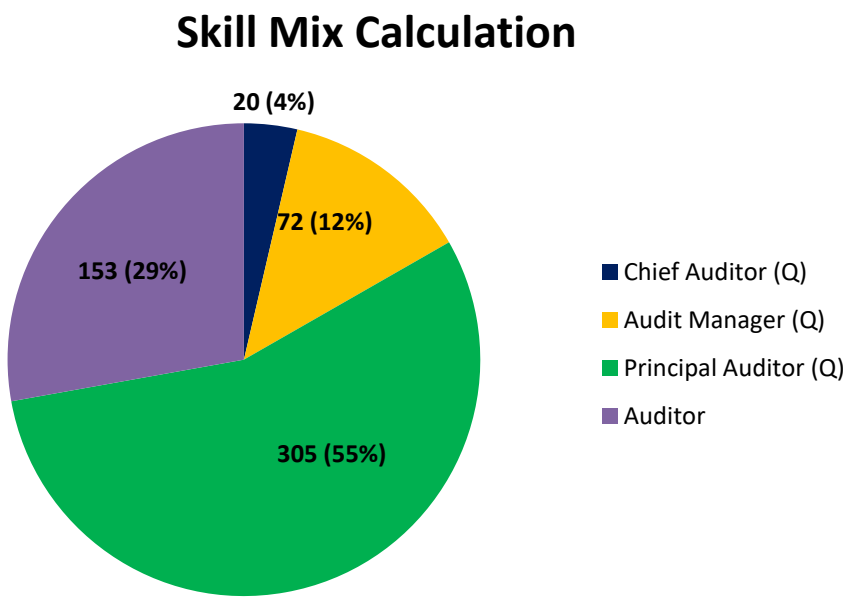
49. Other detailed performance statistics are shown in Section 4.

STAFFING AND SKILL *MIX*

50. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2019/20 the audit was delivered with a skill mix of **71%**, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

51. **Figure 3: Audit Staff Skill Mix 2019/20**

Audit Staff Inputs in 2019/20 [days] Q= qualified input.



ACKNOWLEDGEMENT

52. On behalf of the Internal Audit Service I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit.

53. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance, the Head of Corporate Governance & Board Secretary, and the Audit and Risk Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

Corporate Governance

Summary

The overall NHS Fife senior leadership structure and supporting sub structure should be reviewed and presented to the Board with clear assurance on capability, including Business as Usual arrangements, Strategy production, transformation and remobilisation. Assurance on the essential question of whether NHS Fife has the capacity and capability to deliver its operational and strategic objectives should be provided to the Board from the EDG.

Statements of Assurance

Assurance statements from Standing Committees include a Best Value Framework, which links to performance, governance and accountability as well as a separate section on risk management. However not all relevant key matters relating to governance, internal control and risk management were properly highlighted, including areas of significant concern which had already been identified by Internal and External Audit.

While we commend the more detailed and reflective style of the Standing Committee Annual Statements of Assurance, disclosures included in the Board's Governance Statement were not highlighted as such within either the Annual Statements of Assurance or Executive Directors' Assurance letters. For example, while the HIS inspection reports of Glenrothes and Victoria Hospitals were not referred to in the Clinical Governance Committee Annual Statement of Assurance, nor in the relevant Executive Director's letter, these required disclosure within the Board's Governance Statement.

Integration Arrangements

The 'Review of Progress with Integration of Health and Social Care', published by the Ministerial Strategic Group for Health and Community Care (MSG) in February 2019, outlined 25 practical proposals for NHS Boards, Local Authorities and Integration Authorities, working with key partners including the third and independent sectors, to increase the pace and effectiveness of integration by February 2020. The Director of Delivery, Health & Social Care Integration has met with Fife IJB and HSCI to support the governance and integration arrangements.

Internal audit report B08/20 - Evaluation of Internal Control Framework (ICE) recommended that updates on HSCI should be provided to the Board. The integration scheme review, including the financial risk share, is being undertaken by NHS Fife in conjunction with Fife Council, and was due to be completed by April 2020 but has been delayed due to Covid 19. As a consequence the 'Integration Joint Board' BAF has still not been revised.

Audit Scotland issued a Section 102 report for Fife IJB on financial management and sustainability. Internal Audit had previously highlighted delays in progressing joint governance arrangements, transformation and best value. There has been improvement in financial management with a medium to long term Financial Strategy developed. However, the financial strategy will require further development to reflect the more challenging financial environment created by Covid 19.

Governance Arrangements

The Scottish Government issued a Director's Letter DL(2019)24 – Model Standing Orders -in December 2019, these were adopted by the Board for implementation effective from 1 April 2020. Internal Audit report B10/20 reviewed the Board's progress on the *'Blueprint for Good Governance*' issued by the Scottish Government on 1 February 2019, with one recommendation to address issues to enhance future reiterations of the action plan by 31

October 2020.

An Internal Audit Governance Checklist regarding preserving governance during the pandemic was considered helpful by all standing committees and will be used to inform the development of agendas moving forward so that no element of risk is missed. Internal Audit have now also developed Remobilisation/ reconfiguration principles which it is hoped will be similarly helpful.

Transformation and Remobilisation

The response by clinical services to Covid 19 has presented an opportunity to enhance the scale and pace of delivery of transformation. Audit Report B15A/20 Transformation Governance Follow Up reported limited progress has been made and Covid 19 has now provided the opportunity for transformation work to be fully aligned with remobilisation activity, along with a fundamental review of strategies. As above we would recommend the adoption and monitoring of a clear set of principles for remobilisation which ensure that services are transformed wherever possible and that the past has no special place.

In response to the emerging situation of Covid 19, NHS Fife submitted versions of the mobilisation plans to the Scottish Government, in line with SGHSCD requirements. A Gold, Silver and Bronze emergency planning command structure was implemented by the Board at the start of the pandemic and a Remobilisation Oversight Group (ROG) has now been established to oversee the remobilisation and reconfiguration of clinical services.

During 2019/20, the Chief Executive and the Director of Finance commenced a series of formal executive, general management and Board discussions on the medium-term financial position of NHS Fife. This focused on delivering transformation and securing a recurring balanced financial position. The importance of delivering "value" based health and social care services through effective resource allocation across the organisation was a key underpinning principle in this work. We also note that the use of Digital Technologies has the potential to transform how people access services and how health and care is delivered moving forward. A range of strategic areas to support evaluation and measurement of impact have been identified, with a proposed suite of key performance indicators.

Performance

The Chief Executive provided an overview of performance reporting to the 27 May 2020 Board meeting, where it was highlighted that Elective activity was paused due to Covid 19, with the exception of areas of highest clinical priority including cancer. This has impacted on normal performance metrics, where the 12 Week Outpatient Wait, Access to Psychological Therapies and 18 week referral to treatment had been improving up to end February 2020. Considerable challenges remain in continuing to improve performance against the key national targets as business returns to normal.

Operational Planning

The Board received confirmation from the Scottish Government that the approval process for the draft Operational Plan 2020/21 – 2022/23 is presently on hold. The document submitted in mid March was considered by the Board's governance committees and will be used to establish a recovery plan in relation to Treatment Time Guarantee and other routine performance targets.

Risk Management

Sections of the Board Assurance Framework (BAF) were reported to relevant standing committees throughout 2019/20, however we noted that many scores for target and current risk have not changed during the year, which may indicate insufficient consideration of the

risk profile possibly connected to the capacity and capability issues highlighted earlier. For example, the scores or recorded information within the Integration BAF have not changed despite specific action being agreed in response to Internal Audit concerns. Integration continues to be reported as a moderate risk despite significant known issues and the s102 report. We understand that it was decided that the risk would be reviewed once the integration scheme was updated.

Internal Audit Report B13/20 - Risk Management Framework, presented to Audit & Risk Committee in July 2020, noted the following :

- A risk management appetite has been agreed by the Board and key performance indicators agreed by the EDG, although the KPIs have not yet been reported formally.
- Delegation of functions to the IJB and the implications for risk management, governance and assurance and the treatment of residual risk, have not yet been clarified.
- The Risk Management Policy was due to be presented to the Audit and Risk Committee and the Board in January 2020 but was delayed further until approval by the September 2020 Audit and Risk Committee.

A process has been developed for identification, reporting, review and management of Covid 19 related risks. The format of the annual Risk Management report requires further enhancement and whilst Covid 19 has impacted on timing, it will need to be produced by June next year.

Clinical Governance

Clinical and Care Governance Strategy

The Clinical and Care Governance Strategy had a review date of April 2020 but should have been updated before that in line with actions agreed in two previous Internal Audit reports (Clinical Governance Strategy and Assurance B15/17 & B18/18). Despite this and the Strategy review date of April 2020, the NHS Fife Clinical Governance Committee (CGC) has not been updated regarding the status of the strategy review or provided with a revised date for its production and approval.

A Fife multi-agency Care Home Oversight Group has been formed following the Scottish Government decision to increase responsibilities for Health Boards in relation to assurance around care homes. A Fife Care Home Action Plan has been produced by the Health and Social Care Partnership. These increased responsibilities may exacerbate existing weaknesses in the Clinical and Care Governance Framework previously highlighted by Internal Audit.

We are aware of ongoing discussions regarding revising the Integration Scheme for Fife. Management have advised that these discussions have considered Clinical and Care Governance arrangements in Fife and that any changes would need to be reflected in a revised Clinical and Care Governance strategy. We therefore propose to amend the Annual Internal Audit Plan for 2020/21 specifically to consider Clinical and Care Governance arrangements and revisiting weaknesses highlighted previously, thereby superseding our previous reports.

Clinical Governance Committee Annual Statement of Assurance

Our B08/20 Internal Control Evaluation (ICE) included 2 action plan findings (ref 3 & 4) related to Clinical Governance neither of which have been addressed. The implementation dates for actions to address these findings have been extended due to Covid 19. There was no reference within the CGC Annual Statement of Assurance to non-completion of audit recommendations and the impact this had on the control environment.

The CGC acknowledged that there will be ongoing implications for the Board's clinical governance oversight processes and structures due to the pandemic, and that new responsibilities placed on the Health Board regarding public health testing and care home support would need to be incorporated in these new arrangements. The CGC assurance statement did not highlight the failure to implement key internal audit recommendations, that the Strategy had not been updated by its due date, or major issues in relation to transformation. Most importantly, the assurance statement conclusion did not specifically refer to known Information Governance issues despite an agreed Internal Audit action and the acknowledged major improvement required.

In May 2019 Healthcare Improvement Scotland (HIS) published their Unannounced Inspection Report – Safety and Cleanliness of Hospitals report regarding their visit to Glenrothes Hospital on 19 & 20 March 2019. The CGC has not received an update on actions to address the report findings since it was informed at its 4 September 2019 meeting that '*The HIS report included errors which the Director of Nursing is working with HIS to resolve*'. The report is included as a disclosure in the Board's Governance Statement along with further HIS unannounced inspection reports for Glenrothes and Victoria Hospitals.

Transformation and Remobilisation

Our Transformation Programme Governance Follow-up review (B15A-20) found that only one of the six recommendations from our report B10/18 had been fully implemented. The

subsequent impact of the Covid 19 pandemic on all aspects of NHS Fife's operational and strategic planning will mean that the planning of transformational work will be even more complex and the need for proper oversight and control becomes more urgent and more important. We would recommend that the CGC gives this area an appropriate level of oversight as well as ensuring that there is appropriate coordination and integration with remobilisation and reconfiguration activity. Consideration of Internal Audit's draft remobilisation/reconfiguration principles may be helpful to the CGC in assessing the Board's arrangements.

The Remobilisation Oversight Group is considering the balance between remobilisation of services and redesign/transformation. The role of the Integrated Transformation Board will be reconsidered to learn lessons from Covid 19 and is intended to evolve into a Strategic Planning Group with links with both the H&SCP and Local Authority and spans all business including financial planning, workforce planning, clinical strategy and eHealth. The Winter Plan will be included in the next version of the Joint Mobilisation plan.

NHS Scotland Resilience

The CGC considered the NHS Fife self assessment against the NHS Scotland Health Resilience Unit standards NHS Fife self assessment which were submitted the SGHSCD, updated to include reference to Covid 19, on the due date. We will be undertaking an audit of Compliance with NHS Scotland Resilience: Preparing for Emergencies Guidance and Covid 19 impact in 2020/21 (B15/21).

Staff Governance

Staff Governance Action Plan

A mid-year review of the Staff Governance Action Plan (SGAP) was reported to the Staff Governance Committee (SGC) in November 2019. No year-end review of the SGAP has been undertaken but the SGC have been informed that it will be updated to reflect the impact of Covid 19 and brought back to SGC in November 2020. Each SGC meeting during 2019/20 reviewed a particular strand of the Staff Governance Standard.

Workforce Planning

Revised Integrated Health and Social Care Workforce Planning for Scotland: Guidance published in December 2019 requires a revisit of NHS Fife's Workforce Plan and publication of a revised plan covering the period from 2021 to 2024 (with a deadline of 31 March 2021). The Workforce Planning Group has been reconvened and will review all required actions. The SGC were advised that 'normal' working arrangements for Workforce Planning have been paused and that the Strategy will require significant edits to take account of changes in service delivery, as a result of Covid 19, although we would highlight that it will also need to reflect changes to the Board's overall strategy. The annual Workforce Projections exercise was formally suspended by the Scottish Government due to Covid 19. Services are being supported to consider the workforce implications of changes arising from mobilisation.

Whistleblowing

Draft National Whistleblowing standards were issued by the Independent National Whistleblowing Officer to Boards in anticipation of these receiving parliamentary approval in summer 2020. The SGC was advised on 6 March 2020 that an implementation plan is to be developed to ensure full compliance with the standards, although a date for its completion is not yet noted. A new NHS Fife Whistleblowing Champion took up their position in April 2020. No Whistleblowing Report for 2019/20 has been presented to SGC.

TURAS - Staff Appraisal System

No year-end update on TURAS compliance in 2019/20 was provided to the SGC. TURAS compliance was 43% at 31 May 2020 (compared to 42% at 30 April 2019).

Attendance Management

The Sickness absence rolling 12-month average remains above the 4% target at 4.95% in 12 months to 30 April 2020).

Internal Control Evaluation

There were four recommendations in our B08/20 ICE audit relating to staff governance, one of which remains outstanding in that there has been no update to the SGC on action taken to address Audit Scotland's 'NHS workforce planning (part 2) – The clinical workforce in general practice' report. The related Primary Care Improvement Plan has not been provided to SGC to date.

Covid 19

The SGC was updated at its 18 June 2020 meeting on the current position regarding the pandemic and the planned arrangements for the remobilisation of NHS Fife's workforce.

Financial Governance

Structure of Finance Department

There have been a number of recent changes within senior management in the Finance Department including the previous Director of Finance moving to cover the Chief Executive role from February 2020, the interim appointment of a new Director of Finance from April 2020 (with some part-time cover during February and March, the secondment of the Assistant Director of Finance (Financial Services) to NHS Orkney and the departure of some senior financial and management accounting staff during January 2020.

The Director of Finance is currently progressing a restructure of the directorate, in line with the direction of travel identified for the department, with the intention of ensuring a focus on key priorities as well as ensuring consistent senior leadership for each of the critical functions and allowing for succession planning.

The restructure process was paused, partly due to Covid 19 and the need for HR support and will be consulted on with all parties (including Internal Audit) in the coming months, after which the Finance, Performance & Resources Committee (FP&RC) will be provided with assurances that capacity and capability are sufficient to provide appropriate financial support for strategy, transformation and business as usual.

The Director of Finance arranged for interim senior support from NHS Tayside from April 2020 to September 2020 for the Financial Services and Endowment areas; however this arrangement changed at short notice in July 2020 which impacted on capacity at that key time. Consequently, and also due to the impact on availability of staff working remotely during the pandemic, financial accounts were submitted to Audit Scotland beyond the financial accounts timetable deadline with the potential to delay the year-end timetable beyond the statutory deadline. The Director of Finance is working with Audit Scotland and Scottish Government to ensure the accounts are laid within the statutory deadline of 31 December 2020.

Anticipated Year-end Financial Position

As reported to the 27 May 2020 Board, the draft financial outturn position to 31 March 2020, subject to external audit review, was:

- Revenue Resource Limit (RRL) - ££780.531 million - target met with £0.060m under spend
- Capital Resource Limit (CRL) - £9.286 million - a resource budget for net capital investment - target met.

For 2019/20 the financial year end position for NHS Fife includes costs incurred for Covid 19 of £3.711m split £2.090m NHS Fife and £1.621m IJB which the Director of Finance stated is expected to be funded in full.

Efficiency Savings

For 2019/20 NHS Fife was required to make £17.333m of cash efficiency savings. Reported savings at year end totalled £10.154m of which £5,397m (53%) was non recurring. Therefore, there was £7m of unidentified savings and 73% of the overall savings target has not been met on a recurring basis. Internal and External Audit have previously reported the reliance on non recurring savings to achieve financial balance in previous years. For 2019/20 the delivery of savings in Acute Care was significantly short of the planned amount and this area should be a focus of attention for the FP&RC for 2020/21.

Financial Reporting

Financial reporting throughout the year was consistent, with a visible financial improvement at year end and the position was clearly presented via the Integrated Performance & Quality Report to the FP&RC.

The Director of Finance advised at the weekly meeting between the Chair and Vice Chair on 26 June 2020 that the revenue and capital plans drawn up originally in January/ February 2020 required full reassessment to reflect changed priorities as part of the remobilisation process. Updates will be provided to the EDG with further detail on the position, covering core spend and additional Covid 19 related costs.

The January 2020 FP&RC considered its self assessment and agreed that it was operating as per its Terms of Reference with positive assessments from its members and attendees and no areas of major concern identified.

Risk Management

The narrative within the Financial Sustainability BAF (FSBAF) recognises the ongoing financial challenges facing Acute Services as well as the pressures within the Health and Social Care Partnership in relation to social care budgets and the impact of potential amendment to the risk share arrangement. The report to the July 2020 meeting of the FP&RC highlighted concern over the financial position for the 2020/21 year and the planned savings for Acute Services where much more work is required. The FSBAF states that the impact of the Social Care overspend has been highlighted to Scottish Government within the monthly reporting template.

Internal Control Evaluation

The challenging financial position was highlighted within B08/20 Evaluation of Internal Control Framework (ICE). We strongly reiterate that financial balance during 2020/21 and beyond will be challenging unless the pace of transformation accelerates significantly; the savings within Acute Services are significantly improved and the resolution of the IJB risk share agreement.

The sole ICE recommendation relating to Value for Money has been partly implemented in that Management have started a process of utilising Audit Scotland Best value toolkits and other benchmarking tools (e.g. Discovery) but this has not been reported to the FP&RC which is therefore not in a position to be able to provide assurance on this area as required.

Information Governance

Year-end Assurances

Assurances provided to the NHS Fife Clinical Governance Committee (CGC) in 2019/20 were not sufficient to allow it to conclude accurately on the adequacy and effectiveness of Information Governance arrangements. Such assurances that were provided were delivered via minutes and annual statements of assurance from the Information Governance and Security Group (IG&SG), eHealth Board and the eHealth Performance Report. However, these did not provide assurance regarding compliance with Data Protection Act 18/GDPR, NIS Regulations, NHS Scotland's Information Security Policy Framework and the Cyber Resilience Public Sector Action Plan, all of which have significant gaps in control.

The IG&SG and eHealth Board Annual Statements of Assurance did not highlight significant matters of concern and were not considered and agreed by members prior to being presented to the CGC. Similarly, the relevant Director's annual assurance letter did not highlight these major concerns.

The conclusion at section 8.1 of the CGC Annual Statement of Assurance regarding adequate and effective governance arrangements being in place for the year does not specifically refer to Information Governance and we would have expected any conclusion on this area to contain significant caveats.

Competent Authority Audit – NIS Regulations

The outcome of the NIS Regulations/ISPF audit undertaken by the Competent Authority for Health, issued on 30 March 2020, has not been reported to a Standing Committee of the Board or considered for inclusion in the Board's Governance Statement. NHS Fife was assessed as being compliant with 53% of the controls. The report included 58 recommendations to address areas of non-compliance 18 of which were in the 'Red-Urgent' category. A draft remediation plan grouping the recommendations and proposed action by related topics has been prepared but needs to be finalised and approved. The CGC Annual Statement of Assurance also makes no reference to this important piece of assurance to the Committee.

Cyber Resilience

The IG&SG have been informed that '*the timeframe (31 October 2018) for gaining Cyber Essentials as required by PSAP has already passed and it should be noted that the scale and complexity of the IT estate and reliance in places upon legacy systems, remains a significant challenge' and the plan provided IG&SG with the key dates towards achieving 'alignment with ISPF/NIS whilst completing the requirements of the Public Sector Action Plan for Cyber Resilience*'. This information has not been explicitly conveyed to the CGC.

eHealth and Information Governance Arrangements

We raised a number of significant concerns over Information Governance and have been assured by management that changes to governance arrangements to be implemented following a very recent review of eHealth and Information Governance arrangements, reported to the CGC in July 2020, will raise the profile of Information Governance at the CGC and will address our concerns.

However, the July paper only provided a direction of travel and did not explicitly and overtly address a number of concerns raised by Internal and External Audit. We will review both the adequacy of the final agreed arrangements and their implementation in 2020-21.

Internal Control Evaluation

The following fundamental recommendations, some of which had also been highlighted previously, from the ICE report B08/20 are still outstanding:

- Information Governance arrangements currently operating in NHS Fife do not provide Fife NHS Board with sufficient assurance regarding compliance with its legislative requirements
- The management of information governance risks needs to be addressed so that Fife NHS Board is assured that all significant risks have been identified and that the mitigating actions in place or planned will be sufficient to reduce the risk to a level acceptable to the Board within an acceptable timescale
- Reporting to the Board and NHS Fife CGC on ISPF/GDPR/DPA 2018 and Cyber Resilience Public Sector Action plan has been minimal
- Reporting on the eHealth Delivery Plan to a standing committee only occurred once in 2019/20 and did not overtly link projects to relevant national and local strategies

As part of our ICE work we followed up on recommendations made in Internal Audit report B31&B32/19 and concluded that nine issues regarding assurances provided to the IG&SG had still not been addressed. At year-end, two issues had been partly addressed and seven were still unresolved. Overall it is not clear that these issues are being progressed with sufficient urgency; NHS Fife must prioritise these issues and actively monitor progress in much greater detail than previously.

eHealth Strategic Planning

We are aware that the reaction to the Covid 19 pandemic included accelerating and bringing forward elements of the NHS Fife Digital and Information Strategy Delivery Plan for example to allow clinicians to consult with patients remotely.

Action Point Reference 1 – Corporate Governance

Finding:

Over recent years the challenges facing all Boards have increased significantly and NHS Fife has been no exception. Controls within the Board have not kept pace with changes to the environment in which the Board operates and be sufficient fully to mitigate the risks facing the Board in the coming years. Systems of control continued to have challenges to adequately resolve long-standing information governance, IJB governance and transformation issues. Capacity issues, specifically the loss of a number of key finance, have contributed to a delay in submission of the annual accounts, in line with the agreed timetable. Covid 19 and the consequent need to revisit the Board's overall and supporting strategies will create additional pressures going forward. The Board must assure itself that it has sufficient capacity and capability to review and, where necessary revise its strategies, deliver transformation and reconfiguration, and achieve significant short-term savings whilst continuing to deliver business in extremely challenging circumstances at a time when staff have been under significant pressure over a long period.

Audit Recommendation:

The EDG should consider the specific issues highlighted in this report and other known issues and reflect on its structures and priorities and the resources required to deliver activity in a post Covid 19 environment while updating strategies, implementing savings and designing and delivering remobilisation whilst seizing the very limited opportunity for radical transformational change to ensure long-term sustainability of services. It should then provide overt assurance to the Board which should specifically comment on whether NHS Fife has the capacity and capability to deliver its operational and strategic objectives in the current circumstances and outline any changes required and how they will be subject to appropriate governance monitoring.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

Whilst a range of governance improvement activity was delivered during 2019/20 it is necessary to continue that work into 2020/21. By the end of 2020/21 we plan to have fully embedded many of the improvements in Information Governance including improving reporting and assurance to the Board. In terms of the IJB governance there has been significant process however this also needs to continue. Progress was also made in establishing the Programme Board to support and drive transformation however this was understandably paused at the onset of the pandemic. The capacity of the finance team was an issue during 2019/20 however the Director of Finance has been working to address this through a review of the finance structure, roles and responsibilities and capabilities required to deliver the service.

In developing the forward strategy and priorities for the organisation we will take

significant learning from the service redesign delivered in our initial and ongoing response to the pandemic. We are working to build the process to support a full review of our strategy underpinned by a formal strategic planning and resource allocation process.	
Action by:	**Date of expected completion:**
Chief Executive	**31 March 2021**

Action Point Reference 2 – Corporate Governance	
Finding:	
Our Internal Control Evaluation report (B08/20) issued in December 2019 included 15 Action Plan points, many of which were significant and all of which should have been completed by year-end. However, progress to date has been limited.	
Audit Recommendation:	
Our Internal Control Evaluation report is undertaken part way through the financial year in order to allow management time to address the findings prior to year-end. Whilst we recognise that the pandemic has been a disruptive factor it is not clear that this is the sole or even the main factor in their non-delivery. The EDG should consider why these recommendations have not been delivered, why this was not recognised earlier and produce an action plan for monitoring by the Audit and Risk Committee. Any such plan should take into account the issues relating to capacity and capability raised in recommendation 1.	
Assessment of Risk:	
Significant 	Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**
Management Response/Action:	
EDG will focus on ensuring that the report recommendations are delivered as soon as possible. The pandemic influenced delivery of many aspects of our EDG work however we will prioritise clearance of this issue, albeit in the context of the ongoing pandemic.	
Action by:	**Date of expected completion:**
Chief Executive	**31 March 2021**

Action Point Reference 3 – Corporate Governance	
Finding:	
Whilst the introduction of standard templates for standing committee assurances and Directors' assurances has improved the assurance process, not all relevant key matters relating to governance, internal control and risk management were properly highlighted, including areas of significant concern which had already been identified by Internal and External Audit.	
Audit Recommendation:	
All potential areas for inclusion in the Governance Statement should be clearly identified in both Executive Director and Senior Manager assurances and in Standing Committee annual assurance reports. The information within these sources of assurance should be triangulated to ensure all issues to be considered within the Governance Statement are clearly and consistently identified.	
Assessment of Risk:	
Significant 	Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**
Management Response/Action:	
This recommendation is fully accepted. Further work will be undertaken in the coming financial year to improve the completeness and consistency of assurance information provided in the Directors' letters, Standing Committee Annual Reports and final text of potential disclosures within the Governance Statement.	
Action by:	**Date of expected completion:**
Director of Finance and Board Secretary	**31 May 2021**

Action Point Reference 4 – Corporate Governance

Finding:

The IJB is undergoing a governance review which is supported by the Director of Delivery, Health & Social Care Integration from Scottish Government. However, whilst progress has been made, the review has not yet been fully completed due to Covid 19. There is a revised timescale for implementation which appears appropriate

We noted that the BAF for the IJB reported to the July 2020 NHS Fife Board and throughout 2019/20 has remained at a Moderate Risk and does not reflect the current risk profile.

Audit Recommendation:

Monitoring and consideration of the arrangements for HSCI including the recommendations of the MSG report, should reflect the strategic importance of the activities directed by the IJB.

Whilst we understand that the risk cannot be fully articulated until the Integration Scheme is updated, the BAF for the IJB should be reviewed and updated urgently to at least reflect the known key issues.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

The review of the Integration Scheme is continuing with partners. Regular meetings have been held over the last few weeks. It is anticipated this will be completed by March 2021

Following the completion of the review, the IJB will undertake a further review of its Governance Framework and structures

An initial development session for IJB members with the Director of Delivery, Health and Social Care Integration, Scottish Government was held in Nov 2019 and a programme of development days has been progressed since May 2020. Four sessions have been completed to date with further sessions planned. Topics covered include; Governance, Directions, Roles and Responsibilities, the IJB Annual Report, Remobilisation of Services, Leadership and Structures, Best Value and Performance

Regular updates continue to be provided to the IJB and its Governance Committees and EDG and SLT.

Action by:	Date of expected completion:
Director of Health and Social Care	**31 March 2021**

Action Point Reference 5 – Clinical Governance

Finding:

The Clinical and Care Governance Strategy should have been updated in line with actions agreed in two previous Internal Audit reports (Clinical Governance Strategy and Assurance B15/17 & B18/18). The agreed dates were not met, nor was the official Strategy review date of April 2020. The NHS Fife Clinical Governance Committee (CGC) has not been updated regarding the status of the strategy review or provided with a revised date for its production and approval.

We are aware of ongoing discussions regarding revising the Integration Scheme for Fife. Management have advised that these discussions have considered Clinical and Care Governance arrangements in Fife and that any changes would need to be reflected in a revised Clinical and Care Governance strategy. We therefore propose to amend the Annual Internal Audit Plan for 2020/21 specifically to consider Clinical and Care Governance arrangements and revisiting weaknesses highlighted previously, thereby superseding our previous reports.

Audit Recommendation:

The CGC should take ownership of this issue and ensure that the Clinical and Care Governance Strategy is reviewed and presented to Fife NHS Board for approval in an appropriate timescale.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

A review of the integration scheme is nearing a close, but the timeline for completion has been adversely affected by the global Corona virus pandemic.

Meetings to discuss and agree the clinical governance processes and linkages between NHS Fife Health Board and the Integrated Joint Board have been had; which have included the Medical Director, Nurse Director, Vice Chair of the Health Board and the Chief Officer and other key partners in the IJB.

The output of these meetings is in the final stages of agreement and will ensure robust clinical governance reporting via the NHS Fife Clinical Governance Committee for safety and quality of all NHS Fife services, while complying with the legislative responsibilities delegated to the IJB.

Once agreed by the group the proposals will be taken through the relevant governance routes of the IJB and Health Board for approval.

Action by:	Date of expected completion:
Medical Director	**31 March 2021**

Action Point Reference 6 – Clinical Governance	
Finding:	
Healthcare Improvement Scotland (HIS) published their Unannounced Inspection Report – Safety and Cleanliness of Hospitals report regarding their visit to Glenrothes Hospital on 19 & 20 March 2019 in May 2019. The CGC has not received an update on this report since it was informed at its 4 September 2019 meeting that '*The HIS report included errors which the Director of Nursing is working with HIS to resolve*'. The report is included as a disclosure in the Board's Governance Statement along with further HIS unannounced inspection reports for Glenrothes and Victoria Hospitals.	
Audit Recommendation:	
The CGC should actively monitor actions arising from all HIS and other external inspections and reflect on them appropriately in the preparation of their annual assurance statement.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The Director of Nursing reported to the Clinical Governance Committee in January 2020 that a formal meeting had been held with the Director of Nursing from HIS, who apologised for errors in the initial report. **HIS carried out an unannounced Inspection, again in Glenrothes Hospital, in July 2020; the Report was published on 15 September 2020. The Report and Action Plan will be presented to the Clinical Governance Committee by the Director of Nursing on 4 November 2020 for review and discussion.**	
Action by:	**Date of expected completion:**
Director of Nursing	**4 November 2020**

Action Point Reference 7 – Financial Governance

Finding:

For 2019/20 NHS Fife were required to make £17.333m of cash efficiency savings. Only £10,154m was delivered, over half of which was non-recurrent. In essence only 27% of the savings target was delivered recurrently and 40% was not delivered at all. In particular, the delivery of savings in Acute Services was significantly short of that planned. Internal and External Audit have repeatedly highlighted the reliance on non recurring savings to achieve financial balance, as well as the failure to deliver the transformational change required to deliver financial sustainability.

Audit Recommendation:

The Finance, Performance and Resources Committee workplan should include a series of focused deep-dives to understand the root cause of these issues, particularly within Acute Services and there should be congruence with the work of the CGC in assessing progress with Transformation.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

The key to ensuring recurring financial balance and effective resource allocation is delivery of service transformation. In Q1, 2020/21 the Director of Finance proposed and EDG approved a range of key workstreams to deliver the changes required, this work will have a 3-year timeframe linked to the Scottish Government Medium-term Financial Framework for Health and Social Care. In parallel work has begun on a benchmarking review of specialty costs and an assessment of the workforce requirements for service delivery, this remains a work in progress.

The focus will be developing financial planning for sustainable services, changing the narrative to focus on service transformation which is delivered through a strategic planning and resource allocation approach which integrates operational, workforce and financial planning, albeit with the context of managing through a global pandemic.

Action by:	Date of expected completion:
Director of Finance	**31 March 2021**

Action Point Reference 8 – Information Governance

Finding:

Action has not yet been taken to address the findings and recommendations included in internal audit report B08/20 Evaluation of Internal Control. A review of eHealth and Information Governance arrangements was reported to the CGC in July. We were advised by management that the implementation of new governance arrangements is expected to raise the profile of Information Governance at the Clinical Governance Committee and will address the issues raised by Internal Audit, although not all details of how this would be achieved were fully apparent in the July paper.

Audit Recommendation:

The CGC should monitor implementation of new governance arrangements for eHealth and Information Governance to determine whether they have addressed the issues in the narrative of this and the following reports:

- B31&32/19 Information Governance and eHealth – Action Plan Points 1, 2 & 3
- B06/20 Annual Internal Audit report – Action Plan Point 7
- B08/20 Evaluation of Internal Control – Action Plan Points 10, 12 & 15
- Competent Authority Report on Compliance with NIS Regulations – Recommendations 1.1.1 & 1.1.2

Revised governance arrangements should include providing the Clinical Governance Committee with explicit assurance regarding compliance with DPA 18/GDPR, NIS Regulations, NHS Scotland's Information Security Policy Framework and the Cyber Resilience Public Sector Action Plan and should result in more robust scrutiny of both Information and eHealth governance by the CGC.

Revised governance arrangements should be implemented at pace so that the CGC receives the required assurances regarding this critical area of governance in 2020/21.

Assessment of Risk:

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**

Management Response/Action:

The recommendations are accepted.

The Clinical Governance Committee was provided an update at its meeting on 4th March 2020, on the corporate governance review of Digital and Information (D&I), including Information Governance & Security (IG&S), and further supported the direction of travel at its meeting on the 8th July 2020.

Delays have been inherent whilst responding to the Covid 19 incident, but progress is currently being made.

Digital and Information Board

The Board workplan has been updated to include a standing item for 'Audit/Action plans', the delivery plan and 'project on a page' reporting provided. Points to escalate to the Clinical Governance Committee will be noted and actioned.

The 20/21 annual report/assurance statement will be more detailed and set the context going forward.

Information Governance & Security Group

A key component due to the inherent information risks to the organisation and recommendations within previous audits the IG&S Group is being reformed to act as a strategic oversight group supported by an Operational Group.

An IG&S Group meeting is scheduled for 15th October 2020 with the focus will be on providing whole system leadership, oversight and assurance to the organisation and will ensure the 'lens is maintained' on all aspects of IG&S. It will be a transition period in its early stages moving through implementation.

Similar to the D&I board the IG&S Group workplan has been updated to include a standing item for 'Audit/Action plans'. Points to escalate to the Clinical Governance Committee will be noted and actioned.

The 20/21 annual report/assurance statement will be more detailed and set the context going forward.

Action by:	Date of expected completion:
Director of eHealth and Director of Finance (SIRO)	31 March 2021

Section 4 Key Performance Indicators

Key Performance Indicators – Performance against Service Specification

	Planning	Target	2019/20	2018/19
1	Strategic/Annual Plan presented to Audit and Risk Committee by April 30th	Yes	No (June 20)	May 2019
2	Annual Internal Audit Report presented to Audit and Risk Committee by June	Yes	Yes	Yes
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	95%	78%
4	Draft reports issued by target date	75%	76%	65%
5	Responses received from client within timescale defined in reporting protocol	75%	57%	65%
6	Final reports presented to target Audit and Risk Committee	75%	76%	75%
7	Number of days delivered against plan	100% at year-end	101% at year-end	90%
8	Number of audits delivered to planned number of days (within 10%)	75%	76%	70%
9	Skill mix	50%	72%	74%
10	Staff provision by category	As per SSA/Spec	Pie chart	
	Effectiveness			
11	Client satisfaction surveys	Average score of 3	Bar chart	

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	1 (9)
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	6 (1, 2, 3, 4, 5 & 7)
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	2 (6 & 8)

Fife Health & Social Care Integration Joint Board

Supporting the people of Fife together

MINUTE OF THE FINANCE & PERFORMANCE COMMITTEE
FRIDAY 11TH SEPTEMBER 2020, 10.00AM
VIA MICROSOFT TEAMS

Present:	Councillor David Alexander Les Bisset, NHS Board Member Martin Black, NHS Board Member Councillor David Graham [Chair] Councillor Rosemary Liewald Margaret Wells, NHS Board Member
Attending:	Norma Aitken, Head of Corporate Service, Fife H&SCP Nicky Connor, Director of Health & Social Care Jim Crichton, Interim Divisional General Manager (Fife Wide) Scott Garden, Director of Pharmacy Fiona McKay, Head of Strategic Planning, Performance & Commissioning Audrey Valente, Chief Finance Officer
Apologies for absence:	Lynn Barker, Interim Associate Director of Nursing Claire Dobson, Divisional General Manager (West) David Heaney, Divisional General Manager (East) Dr Helen Hellewell, Associate Medical Director
In attendance:	Tim Bridle, Audit Scotland Tracy Hogg, Business Partner Avril Sweeney, Risk Compliance Manager Andrew Woodall, Project Support Secretary (Minutes)

NO	HEADING	ACTION
1.	**WELCOME AND APOLOGIES**	
	Cllr Graham welcomed everyone to the meeting and apologies were noted as above. DG informed members that the Echo pen was in use to aid with the minute of the meeting. DG extended his thanks to David Heaney and Claire Dobson for their efforts within the Health and Social Care Partnership (HSCP), acknowledging Claire moving on to a seconded post soon, and David announcing his retirement from the service. DG wished David and Claire well on behalf of himself and the Committee.	
2.	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
3.	**MINUTE OF PREVIOUS MEETING – 13 AUGUST 2020**	
	The Committee discussed the minute of the meeting of 13th August and the following point was raised:	

	• Addition *[Page 4, Para 5]*: MW would like the response to this question added to the minute because the answer that was given was that it is no longer an area of overspend because it was met at a budget setting meeting by Fife Council. MW felt this response is important to the record. AV clarified that the response to the question is "as part of the budget setting process we align budgets". AV continued that there was no mention of funding from Fife Council as this is not part of the budget setting process. MW requested the record include this was not included as an overspend because it was met through the budget setting process. **Decision** With this addition the Committee agreed the minute of the meeting of 13th of August as an accurate record.	
4.	**MATTERS ARISING / ACTION LOG – 13 AUGUST 2020**	
	DG noted that a number of the timescales on the Action Log are past due to the current pandemic situation, however there needs to be evidence to suit the new timescales when they are set. DG requested that all actions are added to the relevant committees as soon as they can be added on. **Decision** The Committee agreed for items on the Action Log to be brought to relevant committees with the timescales updated.	
5.	**FINANCE REPORT**	
	AV spoke to the Finance Report. DG referred to Adult Placements *[Page 17, item 5.5]* and asked AV if these projections are as accurate as they can be at this time. AV responded that this ties in with the next item, Financial Recovery Plan, as this involves looking at an escalation route because there is no delegated authority to overspend in the Partnership. In doing this, we need to understand the impact that having a multidisciplinary approach has on these additional packages. AV added that there is work ongoing and there are suggestions in the next paper that need to be piloted and brought to a future meeting. MW expressed concern that the issues with Adult Placements still aren't highlighted in the covering report as a key area of overspend. MW added that there is still no mention of consultation even though this was discussed at the previous meeting. MW queried how the Adult Placements financial position has shifted so significantly from £0.482m underspend in June to £3.404m overspend in July, a shift of almost £4m. AV informed members that in June both Partners presented information differently but we are now seeing a consistent approach; both	

	Partners are now including unachieved savings. This change is a result of the conversation at the previous committee meeting where it was agreed to include the unachieved savings so that we can continue to chase delivery of these savings. MB requested clarification that we were awarded £700k of the £1.7m which leaves a £1m pressure to be achieved by savings and this is to be added in to the savings just now, as if we can't achieve the savings as they are how can we achieve them if we add an additional £1m. AV confirmed that this would be added in; this is in discussions with the Scottish Government around including savings in local remobilisation plans. LB referred to the Social Care Other overspend *[Page 17, item 5.7]* of nearly £4.5m, stating that we asked for clarification at the last meeting around this and this has not been given in the paragraph in this report. LB requested that a separate, detailed paper or a lengthy paragraph be added to this report to be brought to the next meeting, explaining exactly what the risk share agreement is and what we're doing about it. LB referred to the Community Services underspend *[Page 16, item 5.1]* of £2.6m, stating that this has been a recurring theme for months and queried what is being done about it. LB added that we can't keep carrying this underspend to set against an overspend in other areas. AV agreed with LBs points and responded that the two are linked. AV continued that she is working with NHS Fife to realign their budget which will help with the wording in 5.7, however until this work is complete it will be difficult to present something with more clarity. LB acknowledged that this work won't be easy but highlighted that this has been an ongoing issue for at least a year, and there is now a degree of urgency about it now and requested an update be brought to the next meeting to show progress rather than just hearing that it is in discussion. AV agreed to bring an update on the progress to the next meeting. MB queried that with two Divisional General Managers (DGM) leaving, how are we setting budgets, who will be taking responsibility for this, and what are the timescales on these. AV clarified that it is not the DGMs that set the budgets but the budgets are set to be realistic for DGMs to achieve. NC added that an advert has been issued for Claire's post, and interviews will take place next week as it is a priority to ensure the stability of the Senior Leadership Team (SLT). **<u>Recommendations</u>** • The Committee **noted** the financial position as recorded at 31st July. • The Committee **noted and discussed** the next steps and key actions within the report.	**AV**
6.	**FINANCIAL RECOVERY PLAN**	
	AV spoke to the Financial Recovery Plan. DG asked, in relation to high reserves *[Page 26, table 1]*, what discussions are being had with people before proceeding with this. FM answered there is a	

	consultation plan for this, and a letter is ready to have this discussion with them. FM continued that everyone that gets a direct payment signs a contract and in the contract it states exactly what we will do. FM added that the contracts need to be reviewed and changed to reflect the reduction from 10 weeks to 4 weeks. These discussions have started with some people. DG queried how aligned this is with other IJBs in Scotland. FM explained that a scoping exercise had been undertaken to look at this and it found that a lot of Boards are moving to 4 weeks like we are. LB expressed his concern about the aspects laid out under Assessment *[Page 24]* as these were all reported by an external financial consultant two years ago. LB acknowledged that these are all commendable; however he would like see something that suggests we will be taking big steps forward. LB noted the current overspend highlighted under Assessment as £6.8m but Table 1 *[Page 26]* only identifies £1.1m for in-year recovery. LB requested more detail on how we will see the rest of this money being recovered in the current year. AV responded that the current position is £6.8m overspend but £6.5m of this is the unachieved savings, so if we take out the unachieved savings that we're hoping the Scottish Government will fund, we're only looking at around £0.5m overspend. AV agreed to bring a presentation of the savings and where we are to do with delivery of them. RL asked FM if there is any more detail with regard to how we will deal with respite care, and the funding in place for respite. FM responded that respite has been a challenge but the Government and Public Health signed off on the guidance last Monday to allow respite services to reopen, and we will be working with families to see what is available. FM added that we have a comprehensive database of everybody that has a self-directed support payment and what it is for; everybody will go to 4 weeks but we will recognise the people who have respite service and, if they receive a payment throughout the year, we generally know when they are going on a respite break so the money will go into their account before they go. MW referred to a sentence *[Page 23, para 4]* stating that the Partnership should not look to utilise any "windfall" or underspend as a result of the response to Covid-19; however in the following paragraph it says underspend must be used to mitigate against the increased costs identified. MW requested clarity that this means it is for the SLT to bring forward any proposals in relation to underspend arising due to Covid-19, rather than for Divisions to reabsorb and redirect funds. AV confirmed this is correct, and we need to offset as much of the Covid cost as we can. MB asked if the money being returned to accounts within two hours would be available 24/7 or if people would need to wait until Monday morning if it was needed over the weekend. FM responded that there would be planning so there wouldn't be a situation where urgent money is required to be paid in. **<u>Recommendations</u>** • The Committee **agreed** the recommendations on Page 26.	**AV**

7.	**WINTER PLAN**	
	NC, SG, and FM spoke to the Winter Plan presentation. NC agreed to send the presentation to members for their information. RL passed on her gratitude to the staff at ICASS for their great work, it is proving to be a great benefit to people receiving care in their own home. There were no further comments.	**NC**
8.	**ANNUAL REPORT ON OUTCOMES OF CARE INSPECTORATE INSPECTIONS**	
	FM spoke to the annual report from the Care Inspectorate inspections. MW asked FM for more information on Avenue Care Services (ACS) *[Page 35, Table 6]*; FM informed members that we are not placing with ACS at the moment, they are a Care at Home provider. ACS have had some significant issues with their management structure, and we have reduced some of the care packages they had and these have been recommissioned to other providers. FM added that ACS have started to turn a corner and we were meeting with them weekly, which has now been moved to fortnightly, to allow us to continue monitoring and see if we can them to a place where they are stable. FM informed members that, often, providers that are graded as 3 are larger providers and they are comfortable sitting at 3, even though we would aspire for them to improve their grade. MW queried if the ratings are based on inspections, how do we stay on top of any cause for concerns. FM responded that there is an intelligence group that meets with the Care Inspectorate regularly and they tell us what inspections are coming up, whether they are announced or unannounced which lets us know what their plan is. FM gave an example of inspections during Covid-19, stating that following an inspection by the Inspectorate they will email FM the results so that any issues are communicated immediately and these can be taken through the joined up huddle for actions to be agreed and taken on. FM continued that the intelligence group was only for Social Work so the plan is to have a group that encompasses everyone to look at the care facilities there are concerns about. MB asked if we can request core areas to look at in each home to ensure equality across all inspections. FM answered that the Care Inspectorate are the regulatory body so we have to adhere to them; but we work in partnership with them so they will tell us what areas they are going to look at and we can tell them areas that we have concerns about and they will incorporate these into their work plan. **<u>Recommendations</u>** • The Committee **noted** the content of the report. • The Committee **agreed** to add the report to the agenda annually.	
9.	**FIFE SUICIDE PREVENTION ACTION PLAN**	

	JC spoke to the Fife Suicide Prevention action plan. MW referred to the suspended training *[Page 46, Item 1]* and asked what is being done to get this back up and running. JC explained there has been an eLearning package developed which staff can access through TURAS, but the group have also started to look at how they can remobilise these training sessions in a safe way. RL asked, with pupils now back in school, is there going to be any additional input looking at how they have coped over the lockdown and not being in school. JC responded he is not aware of any additional input and agreed to ask the group this at the next meeting and bring an update to the next committee. NC added that the School Nurses have some drop in sessions that are specifically targeted towards supporting mental health; this is in place across all of the high schools in Fife. LB queried whether there was any plans to give specific training to staff within Primary Care as there have been studies that show giving intensive training to GPs and other Primary Care teams can make a difference. JC answered that the training delivered is generic. **Recommendations** • The Committee **noted** the content of the report.	**JC**
10.	**PHARMACY BUDGET – MOVE TO CORPORATE SERVICES**	
	SG informed members there is an error in the Governance route to IJB section *[Page 95]* of the paper. SG explained that the paper did not go to the NHS Fife Finance, Performance and Resources Committee on the 8th of September as it would be inappropriate for the first discussion not to be held at this Committee. SG spoke to the Pharmacy Budget paper. There were no comments from members on this paper. **Decision** • The Committee **accepted** the recommendations from the paper *[Page 96]*.	
11.	**COMPLAINTS REPORT**	
	FM spoke to the Complaints Report. DG referred to the compliments received *[Page 101, Table 1]* and asked FM if the West figure for July is supposed to be 0 or if this has been an omission. FM agreed to check this for the next meeting. There were no comments from members on this paper. **Decision**	**FM**

	• The Committee **noted** the content of the report.	
12.	**INTRODUCTION OF TECHNOLOGY ENABLED CARE – ASSESSMENT & REVIEW**	
	FM spoke to the Introduction of Technology Enabled Care (TEC) paper. RL queried how many clients were used in the trial for TEC. FM responded that this was not trialled; we have taken advice from other places that it has been rolled out. MB asked where all this information will be stored. FM explained that everything is taken on individual needs; the sensors only pick up movement which is sent to a central computer with Just Checking. The information is coded and non-identifiable. **Decision** • The Committee **noted** the content of the report.	
13.	**COMMISSIONING STRATEGY AND DIRECTIONS**	
	FM spoke to the Commissioning Strategy paper. RL requested the slides from the presentation be sent to members for the information; FM agreed to send these out. **Decision** • The Committee **noted** the content of the report.	**FM**
14.	**ANNUAL ASSURANCE STATEMENT 2019-2020**	
	There were no questions about the content of the Annual Assurance Statement. LB noted that the Director of Finance for NHS Fife is missing from Item 2.2 *[Page 113]*. DG agreed to add this in before signing the statement. **Decision** • The Committee **approved** the Annual Assurance Statement 2019/20.	**DG**
15.	**ANY OTHER COMPETENT BUSINESS**	
	There was no other competent business.	
16.	**DATE OF NEXT MEETING**	
	Tuesday the 6th of October 2020 10:00-12:00	

	Via Microsoft Teams	

Fife NHS Board
UNCONFIRMED

NHS Fife

MINUTES OF THE PRIMARY MEDICAL SERVICE SUB-COMMITTEE HELD ON TUESDAY, 1 DECEMBER 2020 HELD BY TEAMS CALL

PRESENT:
Mrs J Kelly (JK) (Chairperson)
Dr H Hellewell (HH) (deputising for Dr McKenna)
Dr S Mitchell (SM)
Dr P Duthie (PD)
Dr F Henderson (FH)

IN ATTENDANCE:
Miss J Parkinson (JP)
Miss D Watson
Mrs J Watson (JW)

NO	HEADING	ACTION

01/20 CHAIRPERSON'S WELCOME AND OPENING REMARKS

JK welcomed the Committee members to the first meeting of the Committee in 2020.

She advised the future of Committee was uncertain and would be discussed at the first meeting of the Primary Care Oversight Group (PCOG) next week. However as there were an agenda item that needed an urgent decision it was agreed to hold this meeting of the Committee.

02/20 DECLARATION OF MEMBERS' INTERESTS

There were no declarations of interest.

03/20 APOLOGIES FOR ABSENCE

Apologies were received from Dr C McKenna.

04/20 MINUTES OF PREVIOUS MEETING

The minute of the meeting held on 3 December 2019 was acknowledged and agreed as a true record of proceedings.

05/20 MATTERS ARISING – ACTION POINTS

a. Replacement meeting for PMSG

The Primary Care Oversight meeting will take over from PMSG.

b. Tracking of 2c practices overspend

To be discussed under item 06/20.

c. Primary Care input into new housing developments

Director of Estates to block any developments that do not provide Primary Care facilities.

06/20 PMS EXPENDITURE BUDGET

JW informed the Committee there had been a £17k underspend in 2019/20 for PMS.

JW advised the Group the budget for 2020/21 was £60m, an increase of £1.3m from the previous year.

There is currently an overspend of £89k. 2c practices are overspent by £159k, mainly due to staff and locum costs. The Direct Patient Service expenditure has increased by £77k in comparison to Apr – Oct last year. There is however an underspend of £85k on rates due to the revaluation of premises.

JW advised that the Enhanced Services are being paid an average based on the practices 2019/20 income, this includes flu.

PD informed JW that flu payments were to be discussed at a meeting later today and it could be decided to base the flu payments on the last three years. He agreed to notify JW of the decision of the meeting. **PD**

JW was advised that practices who did their own flu clinics should not get paid twice.

It was agreed that practices should be informed as soon as possible that they would not be getting an interim payment in December for flu, and also be updated on their COVID fund position. **JW**

07/20 RISK REGISTER

JK advised the Committee that the dates for the risks would be changed and asked if they felt there were any risks that needed to be added. The Committee did not have any additional risks for the Register. **JK**

HH advised that COVID was on the Partnership Risk Register and was happy to provide the Committee with a copy of the Register if requested.

08/20 IMPROVEMENT GRANTS

i) <u>Summary of Improvement Grants for 2019/20</u>

JP advised the final position of the budget for this year was an underspend of £25k, with some of the monies being accrued to 2020/21. The underspend went against the GMS bottom line as items such as enhanced services were over spent.

ii) <u>Summary of Improvement Grants for 2020/21</u>

JP advised the Committee the budget was currently £33k underspent.

She informed the Committee there were three applications from practices to create additional clinical areas and asked the Committee if they would consider the Pittenweem Surgery application to convert an office to a treatment room. This application was approved by the Committee. **JP**

JP to meet with Jim Rotheram on Thursday to discuss the ongoing work to identify accommodation requirements for the delivery of the GMS contract. They had also been invited to the GMS Implementation Group to discuss accommodation with the workstream leads. **JP**

It was hoped that a decision on the awarding of the back scanning contract would be made shortly. The would result in more improvement grants being requested by premises to convert rooms for clinical use.

09/20 APPLICATION TO EXTEND THE TEMPORARY CLOSURE OF TAYPORT BRANCH SURGERY
TAYVIEW MEDICAL PRACTICE, NEWPORT-ON-TAY

JP advised that she and Jim Rotheram had visited the practice last week to complete a risk assessment of Tayport which has been temporarily closed since March as the practice has applied to extend the closure period.

JP advised that Tayport could be made to work if required but it was not the best solution for COVID especially as the practice had purpose built facilities a few miles away where the COVID risks were minimal.

She informed the Committee the corridors were very narrow and that it was not possible to have a one way system as there was only one door suitable for patients. The receptionist had to open the door for every patient as there was no automatic door.

JP also informed the Group that the HSE had advised the first action to mitigate the risk of COVID would be to avoid risk in the first place. Face coverings could be used as a last resort.

PD advised he had spoken to one of the partners who had confirmed the practice want to retain the branch surgery but that they believed it could not function safely under COVID restrictions.

The practice advised they had not received any major complaints from patients, but that the Councillor had been making waves.

FH stated that the layout of Tayport was similar to her own practice at Ladybank and that they had managed to adhere to COVID restrictions. She also advised that the practice had installed a buzzer entry system.

JK advised the practice was still receiving rent for Tayport. The annual rent is £28,900.

It was agreed that Tayview practice could extend the closure of Tayport to the end of February when staff will have received the COVID Vaccination.. HH would advise CM of this decision before the practice was notified. **HH/JK**

It was also agreed that if they wished, they could visit Ladybank surgery to see the procedures they had put in place. **FH**

10/20 GP PREMISES FUNDING

The Committee noted the Scottish Government circular

11/20 GP PRACTICES – ADDITIONAL FUNDING – COVID 19 - UPDATE

JK advised that the above funding was available again to practices.

JW informed the Committee that she was currently collating the data PSD had up to July and the claims from the practice she had received subsequently. She also advised there was currently no allocation, but expected the Scottish Government would wait until year end.

HH confirmed governance for what the practices could claim for would be discussed at the PCOG.

12/20 ROUTINE REPORTING

Memorandum number PCD/PMSC/04/20 was enclosed for consideration. The Committee noted the content of the report.

13/20 AOCB

There was no AOCB.

14/20 DATE OF NEXT MEETING

JK asked that the Committee keep the 2 March 2020 in their diaries until the future of the Committee was decided.

FTF Internal Audit Service

Capital Management - NHS Fife Elective Orthopaedic Project

Report No. B25/20

Issued To: C Potter, Chief Executive
M McGurk, Director of Finance

H Buchannan, Nurse Director
J Owens, Nurse Director (Incoming)
B Johnston, Director of the Elective Orthopaedic Project (Incoming)

G MacIntosh, Head of Corporate Governance/Board Secretary

Follow-Up Co-ordinator

Audit and Risk Committee
External Audit

Clinical Governance Committee
Finance Performance and Resources Committee

Contents

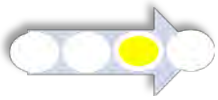
Draft Report Issued	30 September 2020
Management Responses Received	6 November 2020
Target Audit & Risk Committee Date	17 January 2021
Final Report Issued	**14 December 2020**

CONTEXT AND SCOPE

1. The NHS Fife Board Strategic Framework includes the objective of Clinical Excellence.
2. The NHS Fife Board Assurance Framework (BAF) describes the following risk which could threaten the achievement of this strategic objective – Strategic Planning '*There is a risk that NHS Fife will not deliver the recommendations made by the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost*.'
3. The current actions recorded in the BAF to mitigate this risk include:
    - *Leadership to strategic planning coming from the Executive Directors Group*
    - *Clinical Strategy workstream update has been produced to reflect progress against recommendations*
    - *Establishment of Integrated Transformation Board (ITB) should provide assurance to the committees and Board that the transformational programme has strategic oversight and delivery*
    - *Senior Leadership Team for Transformation through the ITB is provided by Chief Executive Officer's of NHS Fife and Fife Council*.'
4. The mitigation system has been identified within the strategic audit planning process as **Low.**
5. A strategy was developed for the re-provision of the elective orthopaedic service at Victoria Hospital, Kirkcaldy. The investment proposal was set out in an Initial Agreement and then within an Outline Business Case (OBC) to provide a standalone Fife Elective Orthopaedic Centre (FEOC). This will incorporate a three theatre surgical complex, inpatient and outpatient accommodation. The OBC has been further developed to include two radiography rooms. In line with the Scottish Government Investment Manual the Fife Elective Orthopaedic Project is published on the NHS Fife website for public awareness.
6. This audit has evaluated the design and operation of the controls over the governance arrangements, reporting arrangements and project methodology and has specifically considered whether:
    - Appropriate and adequate governance arrangements are in place over the Fife Elective Orthopaedic Centre project;
    - Sufficient reporting arrangements are in place for appropriate monitoring of risks, progress, quality and financial commitments of the project;
    - An appropriate project methodology is used to ensure that the inherent risks of the project are mitigated i.e. budget overspends, project scope, expected outcomes and timescales.

AUDIT OPINION

7. The Audit Opinion of the level of assurance is as follows:

Level of Assurance		System Adequacy	Controls
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.

A description of all definitions of assurance and assessment of risks are given in Section 4 of this report.

8. Our review of the Fife Elective Orthopaedic project concludes that:

- There are appropriate and adequate governance arrangements in place as follows:
  - gateway reviews of key milestones of the project with oversight by the Scottish Government Social Health Directorate Capital Investment Group;
  - a Project Board for the Fife Elective Orthopaedic Project (FEOC) with members from diverse areas of expertise and experience including a Non Executive Director and
  - an approval process of key milestones of the project through the NHS Fife Standing Committees, including the Finance, Performance and Resources, Clinical Governance Committee and the NHS Fife Board. The Fife Elective Orthopaedic Project Board reports to the NHS Fife Capital Investment Group and thereafter to the Executive Directors Group (EDG).
- Reporting arrangements are in place for the monitoring of progress, quality and financial commitments of the project. We evidenced regular reporting to the Finance Performance and Resources Committee, Clinical Governance Committee and the NHS Fife Board;
- The Scottish Capital Investment Manual (SCIM) methodology has been used for the project which is based on best practice from across the UK and globally and mandated through NHS CEL 19 (2009) Scottish Capital Investment Manual for NHSScotland. SCIM is required for all infrastructure and investment programmes and projects by NHS Scotland bodies and therefore is an appropriate methodology for this project;
- The Initial Agreement and the Outline Business Case documents are aligned to the '*Summary of Stages'* within the SCIM methodology;
- The update paper to the May 2020 Board meeting highlighted that the project has successfully remained in line with the timeline per the agreed programme, which in our opinion, is a significant achievement with the challenging circumstances associated with the current climate of the COVID 19 pandemic. However, the latest position presented to the September 2020 meeting of the

Finance Performance and Resources Committee highlighted that the project is currently showing 2 weeks behind on the main programme due to having to adapt ways of working during the COVID 19 pandemic.

We identified the following areas for improvement:

- As defined within the governance arrangements within the OBC, the Project Board reports to the Fife Capital Investment Group and then to the Executive Directors Group. We noted that the key milestones of the project were considered & discussed at these groups but formal approval of support for the documents to progress to the next level of governance was not recorded within the minutes. Action point reference 1 on page 5 has addressed this issue;

- In line with the SCIM risk management process, the Fife Elective Orthopaedic Project has an autonomous risk register in place. The Project Director advised that it is updated on a monthly basis and is provided to every Project Board meeting. We noted that the FEOC Project risk register includes identified risks, risk rating, mitigating actions and risk owner. However there is further scope to improve its effectiveness by including the action date, closed out date and any comments that would provide additional information or escalation of the risk if required.

9. Detailed findings/information is included at Section 3

ACTION

10. The action plan at Section 2 of this report has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

11. We would like to thank all members of staff for the help and co-operation received during the course of the audit.

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1

Finding:

Governance arrangements have been recorded within the Outline Business Case (OBC) for the Fife Elective Orthopaedic Project. The diagram within the OBC shows reporting from the Project Board to the Fife Capital Investment Group, then on to the EDG and subsequently on to the Finance Performance and Resources Committee and the NHS Fife Board. We noted that the key milestones of the project were considered at these groups but formal approval was not recorded within the minutes.

The timing of the submission to the SGHDCIG also impacted the formal approval process of the Fife Capital Investment Group, as the OBC was sent out to the group and approved virtually but we were unable to verify the formal record of support to progress the document to the next stage.

The OBC was included on the agenda to the EDG on 14 October 2019; however we were unable to validate the approval to support the progress of the document from the Executive Directors Group due to no formal record of the meeting retained at that time. We note that the EDG has changed the administration process and as of 24 February 2020, the formal monthly meeting is minuted.

Audit Recommendation:

We recommend that, going forward, the governance arrangements are reviewed for the Fife Elective Orthopaedic Project, to assess the balance of control with the efficiency and timing of the project to ascertain if formal approval of key milestones of the project is required by all the groups outlined within the OBC or whether some of these groups are informed rather than approving key milestones. (RACI can be a useful tool to ascertain the reporting framework, which groups are: Responsible; Accountable; Communicated to; Informed, for assessing this). The key milestones of the Fife Elective Orthopaedic Project should be scheduled through the governance processes to allow for the required groups and standing committees to formally approve in the required timescales.

Assessment of Risk:

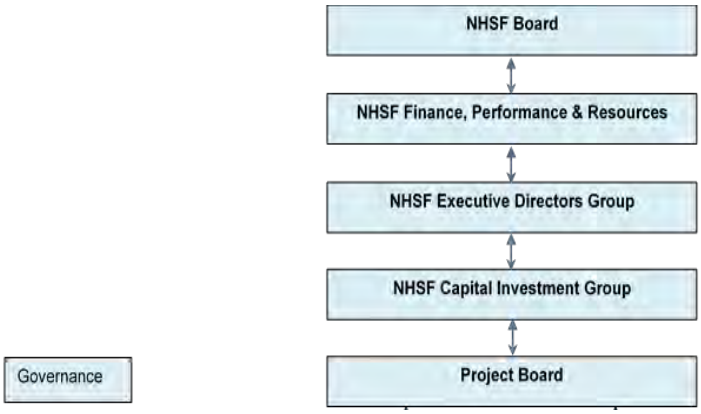
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:	
Due to the tight timelines of this project it was agreed by Executive Directors Group that some of the governance approvals would need to be run in parallel to achieve agreed construction programme with contractor. Future projects will clearly set out what committees are to approve the future business cases and what committees will receive it for information and these will clearly be shown in the project execution plan and agreed by NHS Fife's Capital Investment Group.	
Action by:	**Date of expected completion:**
Project Director	**31 January 2021**

Action Point Reference 2	
Finding:	
In line with the SCIM risk management process, the Fife Elective Orthopaedic Project has an autonomous risk register in place. The Project Director advised that it is updated on a monthly basis and is provided to every Project Board meeting. We noted that the FEOC Project risk register includes identified risks, risk rating, mitigating actions and risk owner. However there is further scope to improve its effectiveness by including the action date, closed out date and any comments that would provide additional information or escalation of the risk if required.	
Audit Recommendation:	
We recommend that the risk owner, action date, closed out date and if appropriate, any further comments to provide further clarity on the position or escalation of the risk if required, are included within the FEOC risk register.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The FEOC risk register is managed by the Project Manager under the Framework 2 process, therefore it may not be possible to include this information. However, consideration will be taken to including further comments if this is possible.	
Action by:	**Date of expected completion:**
Project Director	**31 January 2021**

Control Objective 1- Appropriate and adequate Governance arrangements are in place over the Fife Elective Orthopaedic Centre project.

1. Appropriate governance arrangements are in place to monitor, oversee and implement the NHS Fife Elective Orthopaedic Project (NFEOP) and these have been recorded within the Outline Business Case (OBC). The Scottish Government Health Directorates Capital Investment Group (SGHDCIG) has monitored and overseen the project, with gateway reviews as part of the checks and balances. The SGHDCIG have approved the Initial Agreement Document and the Outline Business Case for the Orthopaedic Elective Project. The next stage will be the submission and approval of the Full Business Case (FBC) which is planned for September 2020.
2. In line with the Scottish Capital Investment Manual (SCIM) an Initial Agreement Document was produced for the NFEOP and was considered and approved at the March 2018, NHS Fife Board meeting as part of the NHS Fife Capital Investment Programme.
3. Subsequent to the approval of the Initial Agreement, an OBC was developed. The diagram within the OBC shows reporting from the Project Board to the Fife Capital Investment Group, then on to the Executive Directors Group (EDG) and subsequently on to the Finance Performance and Resources Committee and the NHS Fife Board.



4. The OBC includes a comprehensive diagram of the governance arrangements with the purpose of each group and role. The remit of the NHS Fife Project Board for the Elective Orthopaedic Centre Project states its purpose is '*to provide strategic direction and leadership.*' Furthermore, the remit states, the '*Project Board will direct and lead the development for the Elective Orthopaedic Centre (EOC) ensuring that NHS Fife complies with its legal and financial responsibilities and that all actions are progressed in a timely manner and within budget*.' We noted that in practice, the OBC was considered by the Project Board and discussed. However, there is no formal recording of the Project Board agreement of the project key milestones such as the OBC in line with the governance arrangements set out for the project. We have discussed this with the Project Director and any further key milestones i.e. the Full Business Case and any other key issues will be noted and approval recorded within the Project Board minutes.
5. The Project Board referred to within the OBC provides named person, project role, responsibilities and experience. The Clinical Governance Committee minutes of November 2019 reported that the Nurse Director and the Medical Director were invited to become members of the Project Board to ensure there is Board level oversight on the project in terms of infection control issues and looking at clinical models. This will help towards mitigating any clinical risks of the project and help avoid the issues that have been experienced within other projects such as the New Children's Hospital in NHS Lothian and the Queen Elizabeth Hospital within NHS Greater Glasgow and Clyde. We

further noted that there is appropriate reporting and escalation arrangements recorded within the OBC.

6. The Project Board membership includes the Nurse Director as the Senior Responsible Officer, a Non-Executive Director and several other Directors which bring a wide spectrum of expertise, skills and experience to the Project Board.

Derogations of the Project

7. Derogation is defined within the Business Dictionary as the non application of a rule or reduction in its stringency, usually for a specific period and in specific reasons. The Derogations Schedule was approved at the 16 March 2020 FEOC Project Board. The Derogation Schedule is included within the OBC which has been approved by the SGHDCIG. The Director of the Project has advised that the Derogation Schedule will continue to be updated and approved at key stages of the project.

Approval of Key Milestones and Stages

8. The timing of the submission to the SGHDCIG has impacted on the formal approval process of key documents by the Fife Capital Investment Group. For example, the OBC was sent out to the group and approved virtually as it had to be submitted to the SGHDCIG, but we were unable to verify the formal record of approval collectively by the group. We recommend for future milestones and key stages of the project, such as the Full Business Case, that the document is presented with sufficient time to allow for formal recorded approval.
9. The OBC was included on the agenda to the EDG on 14 October 2019; however we were unable to validate the approval from the Executive Directors Group due to no formal record of the meeting retained at that time. We note that the EDG has changed the administration process and from 24 February 2020 it now records the EDG formal monthly meeting. This should ensure that the key milestones reported to the EDG are formally approved and retained.
10. The Clinical Governance Committee approved the OBC at its 6 November 2019 meeting. The minute of this meeting reported that the timeline required that after the OBC was considered through the Project Board, it was subsequently progressed to the Finance Performance and Resources Committee at the 5 November 2019 meeting, where it was considered in preparation for NHS Fife Board approval.
11. The OBC was submitted to the SGHDCIG in parallel, to the approval by the NHS Fife Board at the 27 November 2019 meeting. The paper presented to the Finance Performance and Resources Committee reported that the SGHDCIG were made aware that they received the Business Case subject to formal approval by the NHS Fife Board.
12. The Nurse Director and Project Director attend the National Elective Centre Programme Board which allows Sharing of information.
13. As detailed within the OBC, the project is being delivered using HFS Frameworks Scotland 2 (FS2) which operates using the NEC3/ECC3 form of contract. This type of contract is unique as it offers complete end-to-end project management solution for the entire project life-cycle: from planning, defining legal relationships and procurement of works, all the way through to project completion.
14. The contract was procured under Frameworks Scotland. The Consultants, have expertise in Project Management and in particular NEC3 & 4 and have been engaged to manage the project. In addition, an external contractor has been engaged as the Joint Cost Advisor. The utilisation of experienced experts within these areas provides further assurance over these processes.

Control Objective 2 Sufficient reporting arrangements are in place for appropriate monitoring of risks, progress, quality and financial commitments of the project.

15. There has been regular and appropriate reporting on the FEOC to the NHS Fife Board, the Finance Performance and Resources Committee (FP&RC) and the Clinical Governance Committee.

16. Presentation of the Initial Agreement to the FP&RC meeting in February 2018 was also provided and a presentation of the proposed design and project to the Board Development Session meeting in August 2019.

17. A paper on an introduction to the Scottish Capital Investment Manual (SCIM) was provided to the September 2019 NHS Fife Board meeting and a presentation provided to the November 2019 meeting of the FP&RC outlined the guidance on the cyclical process of project development from inception at the service planning stage, to post project evaluation of service benefits realised once a new building is occupied.

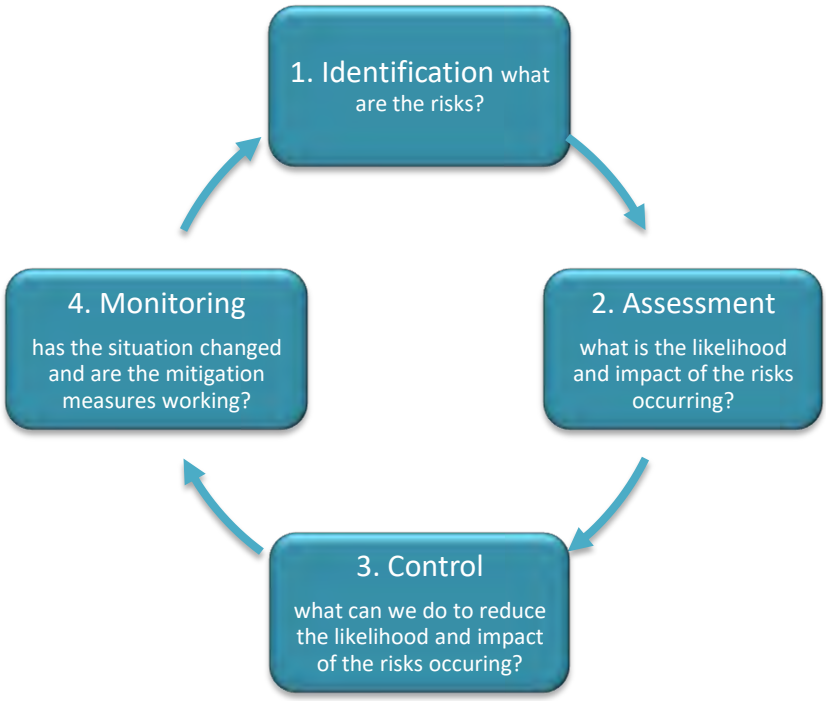
18. The FEOC project is using the SCIM methodology; this includes the Planning Stage outlined within the Initial Agreement, the Monitoring and Evaluation Plan, outlined within the OBC and the Full Monitoring and Evaluation Plan outlined within the Full Business Case which is planned for September 2020. These documents provide assurance through the governance processes on the progress, quality and financial commitments of the project. This is further detailed in the section below.

Risk Management

19. In line with the SCIM risk management process, (as depicted below) the Fife Elective Orthopaedic Project has an autonomous risk register in place. The Project Director advised that it is updated on a monthly basis and is provided to every Project Board meeting. We noted that the FEOC Project risk register includes identified risks, risk rating, mitigating actions and risk owner. However there is further scope to improve its effectiveness by including the action date, closed out date and any comments that would provide additional information or escalation of the risk, if required. The Project Director advised that the Project risk register is managed by the Project Manager and it is a Framework 2 process, therefore consideration will be given to making the enhancements but it may not be possible due to the design of the risk register.

20. We are advised by the Project Director that risks identified from the project risk register which require escalation are considered on the organisational risk register, a recent example is the COVID 19 risk. This risk was identified on the project risk register and escalated to the organisational risk register.

SCIM Risk Management



Financial Planning

21. The Capital Investment Programme (CIP) 2018/19 – 2022/24 includes the Fife Elective Orthopaedic project, with approval by the FP&RC at the 27 February 2018 meeting. The CIP was previously considered by the NHS Fife Capital Investment Group on 6 February 2017 and the Executive Directors Group on 19 February 2017.

Control Objective 3: An appropriate project methodology is used to ensure that the inherent risks of the project are mitigated i.e. budget overspends, project scope, expected outcomes and timescales.

Project Methodology

22. The Scottish Capital Investment Manual (SCIM) has been used which is based on best practice and mandated through NHS CEL 19 (2009) Scottish Capital Investment Manual for NHSScotland. The SCIM is used for all infrastructure and investment programmes and projects by NHS Scotland bodies and therefore is an appropriate methodology for this project. There is a web based SCIM tool, which includes a '*Summary of Stages'* and we have used it to measure compliance of the project on the Initial Agreement and the OBC and concluded that they are in both line with the SCIM processes.

23. Project Management Consultants were appointed by NHS Fife through Frameworks Scotland to manage the project scope, budget and expected outcomes of the project. The Project Manager has NEC3 Accredited Project Management Status.

24. An appropriate evaluation toolkit Achieving Excellence Design Evaluation Toolkit (AEDET) has been used which is in line with the NHSScotland Design Assessment Process under NHS CEL 19 (2010). The AEDET process, which involves scoring around three main criteria, (Functionality, Build Quality and Impact) has been undertaken and the outcomes have been included within the OBC.

Controls on overspend of the Project

25. The Initial Agreement outlined the construction costs only. The Financial Case is within the OBC and it provides a Financial Model of costs and associated funding and key assumptions for the project. The capital costs have been estimated by an independent cost advisor. In addition, assurances have been provided to the November 2019 FP&RC, that a cost plan has been produced and agreed with the Principal Supply Chain Partner to provide assurance on the affordability of the project. The OBC includes a detailed Financial Case which outlines the affordability of the scheme and sets out all associated capital and revenue costs. The Financial Case also states a preferred option, with consideration to the implications on NHS Fife's finances.

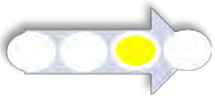
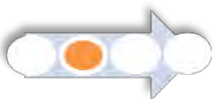
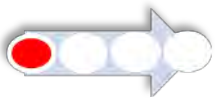
Monitoring of the Progress of the Project

26. As this is a £34m capital project, gateway reviews against key milestones are carried out by the SGHSCD Capital Investment Group. This has and will provide future oversight and monitoring of the progress of the project. In addition, update papers on progress are provided by the Project Director and Senior Lead Officer regularly to the FP&RC and the Board.

Section 4 Definition of Assurance and Recommendation Priorities

Definition of Assurance

To assist management in assessing the overall opinion of the area under review, we have assessed the system adequacy and control application, and categorised the opinion based on the following criteria:

Level of Assurance		System Adequacy	Controls
Comprehensive Assurance		Robust framework of key controls ensure objectives are likely to be achieved.	Controls are applied continuously or with only minor lapses.
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses.
No Assurance		High risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

Section 4 Definition of Assurance and Recommendation Priorities

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	None
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Two