Council Building
2 High Street
Perth
PH1 5PH

Friday, 23 November 2018

A meeting of the **Audit and Performance Committee of the Perth and Kinross Integration Joint Board** will be held in **the Council Chamber, 2 High Street, Perth, PH1 5PH** on **Friday, 30 November 2018** at **09:30**.

If you have any queries please contact Adam Taylor on (01738) 475163 or email Committee@pkc.gov.uk.

Robert Packham
Chief Officer

Members
Councillor Callum Purves, Perth and Kinross Council (Chair)
Councillor Eric Drysdale, Perth and Kinross Council
Bernie Campbell, Carer Public Partner
Jim Foulis, Associate Nurse Director, NHS Tayside
Robert Peat, Tayside NHS Board

Audit and Performance Committee of the Perth and Kinross Integration Joint Board

Friday, 30 November 2018

AGENDA

1	**WELCOME AND APOLOGIES**	
2	**DECLARATIONS OF INTEREST** Members are reminded of their obligation to declare any financial or non-financial interest which they may have in any item on this agenda in accordance with the Perth and Kinross Integration Joint Board Code of Conduct.	
3	**MINUTE OF PREVIOUS MEETING**	
3.1	**MINUTE OF MEETING OF THE AUDIT AND PERFORMANCE COMMITTEE OF 20 SEPTEMBER 2018** (copy herewith)	**5 - 10**
3.2	**ACTION POINTS UPDATE** Report by Chief Financial Officer (copy herewith G/18/202)	**11 - 12**
3.3	**MATTERS ARISING**	
4	**GOVERNANCE**	
4.1	**AUDIT & PERFORMANCE COMMITTEE - REVISED TERMS OF REFERENCE** Report by Chief Financial Officer (copy herewith G/18/205)	**13 - 18**
5	**ASSURANCE: INTERNAL CONTROL AND RISK MANAGEMENT**	
5.1	**RISK MANAGEMENT PROGRESS UPDATE** Report by Chief Financial Officer (copy herewith G/18/203)	**19 - 34**
5.2	**HM INSPECTORATE OF PRISONS FOR SCOTLAND - HMP PERTH INSPECTION** Report by Head of Health (copy herewith G/18/204)	**35 - 80**
6	**FOR INFORMATION / NOTING**	
7	**PRIVATE DISCUSSION**	

8 DATES OF NEXT MEETING / DEVELOPMENT SESSIONS

Tuesday 19 February 2019

AUDIT AND PERFORMANCE COMMITTEE OF THE PERTH AND KINROSS INTEGRATION JOINT BOARD

Minute of Meeting of the Audit and Performance Committee of the Perth and Kinross Integration Joint Board (IJB) held in Room 410, Fourth Floor, Council Building, 2 High Street, Perth on Thursday 20 September 2018 at 2.30pm.

Present: Councillors C Purves (Chair) and E Drysdale (both Perth and Kinross Council); J Foulis, Associate Nurse Director, NHS Tayside; and L Lennie, Carer Public Partner (substituting for B Campbell).

In Attendance: R Packham, Chief Officer; J Smith, Chief Financial Officer; D Fraser, E Devine, D Mitchell, S Gourlay and P Jerrard (all Perth and Kinross Health and Social Care Partnership); S Hendry, Democratic Services, Perth and Kinross Council; T Gaskin, Chief Internal Auditor, Perth and Kinross IJB; and J Clark, Chief Internal Auditor, Perth and Kinross Council; A Shaw and C Windeatt (both KPMG).

Apologies: B Campbell, Carer Public Partner and R Peat, Tayside NHS Board.

1. WELCOME AND APOLOGIES

Councillor Purves welcomed all those present to the meeting and apologies were submitted and noted as above. Councillor Purves thanked the previous Chair of the Committee, Councillor C Ahern, for his time as Chair and a member of both the Committee and IJB.

2. DECLARATIONS OF INTEREST

In terms of the Perth and Kinross Integration Joint Board Code of Conduct, Councillor E Drysdale declared a non-financial interest as Convener of Perth and Kinross Council's Audit Committee.

3. MINUTES OF PREVIOUS MEETINGS/MEMBERSHIP AND ROLE OF AUDIT AND PERFORMANCE COMMITTEE

3.1 MINUTES

(i) Minute of Meeting of the Audit and Performance Committee of 19 June 2018

The minute of meeting of the Audit and Performance Committee of the Perth and Kinross Integration Joint Board of 19 June 2018 was submitted and approved as a correct record.

(ii) Minute of Special Meeting of the Audit and Performance Committee of 18 July 2018

The minute of the special meeting of the Audit and Performance Committee of the Perth and Kinross Integration Joint Board of 18 July 2018 was submitted and approved as a correct record.

3.2 ACTION POINTS UPDATE

The Action Point Update (Report G/18/120) from the meeting of 19 June 2018 was submitted and noted.

3.3 MATTERS ARISING

There were no matters arising from the minutes of previous meetings.

3.4 AUDIT AND PERFORMANCE COMMITTEE MEMBERSHIP UPDATE

S Hendry reported that S Hay had stepped down as a member of the Tayside NHS Board and was therefore no longer Chair or a member of the IJB and Audit and Performance Committee. Tayside NHS Board would be filling this vacancy in due course. Councillor Purves and members of the committee thanked S Hay for his contribution to the work of the IJB.

3.5 ROLE OF AUDIT AND PERFORMANCE COMMITTEE MOVING FORWARD

J Smith reported that at the request of the then Chair of the IJB, S Hay, and Councillor Purves, the terms of reference for the Audit and Performance Committee were being reviewed, supported by relevant staff including Internal Audit.

Further to this, work was taking place across Tayside to look at clinical and care governance arrangements with Health and Social Care Partnerships. The Chief Officer would be attending an NHS Tayside wide meeting on 11 October 2018 to discuss this and the Audit and Performance Committee sought assurance that there would be sufficient representation from Perth and Kinross in terms of their position on clinical and care governance.

The committee noted the position.

4. GOVERNANCE

4.1 TRANSFORMING GOVERNANCE ACTION PLAN 2018/19

There was submitted a report by the Chief Finance Officer (G/18/121) providing an update on the progress of the Transforming Governance Action Plan 2018/19.

Resolved:

(i) The progress on the Transforming Governance Action Plan 2018/19, as set out in Appendix 1 of Report G/18/121, be noted.

(ii) The Chief Financial Officer to provide a further update at the next meeting of the Committee on further progress on the Transforming Governance Action Plan.

5 ASSURANCE: INTERNAL CONTROL AND RISK MANAGEMENT

5.1 ASSURANCES RECEIVED FROM PARTNERS

There was submitted a report by the Chief Financial Officer (G/18/122) providing an update on the assurances from NHS Tayside and Perth and Kinross Council regarding their governance arrangements, noting that Perth and Kinross IJB is reliant on both Partners to deliver the Integration Joint Board's overall aims and objectives.

Resolved:

(i) It be noted that the Integration Joint Board had issued confirmation of the adequacy and effectiveness of the governance arrangements in place within Perth and Kinross Integration Joint Board for 2017/18 to NHS Tayside and Perth and Kinross Council;
(ii) The position regarding confirmation of receipt of the assurance from Perth and Kinross Council be noted;
(iii) The status of the governance arrangements within NHS Tayside be noted;
(iv) It be noted that the status of assurances from NHS Tayside and Perth and Kinross Council is consistent with the contents of the Integration Joint Board's Governance Statement in the audited Annual Accounts for 2017/18.

5.2 RISK MANAGEMENT PROGRESS UPDATE

There was submitted a report by the Chief Financial Officer (G/18/123) (1) updating on risk management; and (2) to note and agree the next steps in respect of finalising the Health and Social Care Partnership (HSCP) Risk Profile.

Resolved:

(i) The progress made in respect of Risk Management, including the further four risk management sessions and the session with the Integration Joint Board, all to be held by the end of October 2018, be noted.
(ii) The refreshed Risk Management Framework/Process and risk escalation process to be approved at the next Audit and Performance Committee meeting.
(iii) It be remitted to the Chief Finance Officer to present the Strategic Risk Profile to the Audit and Performance Committee at its next meeting.

5.3 INTERNAL AUDIT PLAN 2017/18 PROGRESS

There was submitted a report by the Chief Internal Auditor (G/18/124) briefing the Committee on progress of the internal audit plan.

Resolved:

Updates to the 2017/18 Internal Audit Plan, as well as commencement of delivery of the 2018/19 plan, as outlined in Report G/18/124, be noted.

5.4 INTERNAL AUDIT PLAN 2018/19

There was submitted a report by the Chief Internal Auditor (G/18/125) seeking approval of the Annual Internal Audit Plan for Perth and Kinross Integration Joint Board for 2018/19.

Resolved:
The Annual Internal Audit Plan 2018/19, as set out in Report G/18/125, be approved.

5.5 AUDIT RECOMMENDATIONS UPDATE

There was submitted a report by the Chief Financial Officer (G/18/126) providing an update with progress on the implementation of all internal and external audit recommendations arising since the formal inception of the Integration Joint Board on 1 April 2016.

Resolved:
Progress made to date on implementing agreed recommendations, as set out in the Appendix to Report G/18/126, be noted.

6. ANNUAL ACCOUNTS

6.1 ANNUAL ACCOUNTS 2017/18

There was submitted a report by the Chief Financial Officer (G/18/127) presenting the Audited Annual Accounts for the period to 31 March 2018 for approval and submission to the Integration Joint Board.

Resolved:
The Audited Annual Accounts for 2017/18, appended to Report G/18/127, be approved for submission to the Integration Joint Board for final approval.

6.2 KPMG EXTERNAL AUDIT ANNUAL REPORT 2017/18

There was submitted a report by the IJB's External Auditors, KPMG, (G/18/128) containing the Annual Audit Report to the Members of Perth and Kinross Integration Joint Board and the Controller of Audit for the year ended 31 March 2018.

Resolved:
(i) The contents of the Annual Audit Report to the Members of the Perth and Kinross Integration Joint Board and the Controller of Audit for the year ended 31 March 2018 be noted;
(ii) The report to be amended to include a reference to the number of changes in Board membership since its inception in 2015.

6.3 LETTER OF REPRESENTATION

There was submitted and noted a copy of a letter by the Chief Financial Officer to KPMG (G/18/129) in connection with their audit of the financial statements of Perth and Kinross Integration Joint Board for the year ended 31 March 2018.

7 PERFORMANCE REVIEW

7.1 2018/19 FINANCIAL POSITION

There was submitted a report by the Chief Financial Officer (G/18/130) providing a summary of the issues impacting on the financial position of Perth and Kinross Integration Joint Board in 2018/19, based on the 4 months to 31 July 2018.

Resolved:

(i) The forecast financial position for 2018/19 and the potential implications for both NHS Tayside and Perth and Kinross Council, as set out in the Appendix to Report G/18/130, be noted.

(ii) The Chief Officer be instructed to seek formal agreement from Perth and Kinross Council and NHS Tayside on the risk sharing arrangements for 2018/19.

8 FOR INFORMATION / NOTING

No further business.

9 PRIVATE DISCUSSION

Any private discussion took place between members of the committee and the Chief Internal Auditor as required.

10 DATE OF NEXT MEETING / DEVELOPMENT SESSION

Tuesday 20 November 2018 - 1.00pm (Development Session)

Action Points Update 20 September 2018
Perth & Kinross IJB – Audit and Performance Committee

Report No. G/18/202

Ref.	Min. Ref.	Meeting	Action	Responsibility	Timescale	Revised Timescale	Update/Comments
27	4.1	06/03/18	Governance & Accountability Arrangements – Chief Officer to bring a paper to IJB setting out in detail the governance arrangements. The Audit & Performance Committee agreed for the report to come back in September 2018.	RP / JMS	November 2018	-	Development session scheduled for November wrapped around the IJB meeting which will tie together Governance and Risk.
29	4.1	19/06/18	Transforming Governance Action Plan Update – The Chief Officer to provide a further update at the next meeting on progress with a training and development plan and performance for IJB members.	RP	September 2018	November 2018	Chief Financial Officer to provide a further update at the next meeting of the Committee on further progress on the Transforming Governance Action Plan. Agenda item for 30 November 2018 meeting.
30	5.1	19/06/18	Audit Recommendations Update – A sub-committee of the Audit & Performance Committee to be established to replace the current remit of the Care & Professional Governance Forum. The Chief Officer to progress this.	RP	November 2018	-	Complete - This is an agenda item for the IJB meeting on 30 November 2018 where the IJB is recommended to approve the establishment of a Clinical, Care & Professional Governance Committee and to approve the Terms of Reference for this proposed Committee.
32.	4.1	20/09/18	Chief Financial Officer to provide a further update at the next meeting of the Committee on further progress on the Transforming Governance Action Plan.	JMS	November 2018	-	Agenda item for 30 November 2018 meeting.
33.	5.2	20/09/18	Risk Management Progress Update – The refreshed Risk Management Framework/Process and risk escalation process to be approved at the next Audit & Performance Committee Meeting. Chief Financial Officer to present the Strategic Risk Profile to the Audit & Performance Committee at its next meeting.	JMS	November 2018	-	Agenda item for 30 November 2018 meeting.

Action Points Update 20 September 2018
Perth & Kinross IJB – Audit and Performance Committee

Report No. G/18/202

Ref.	Min. Ref.	Meeting	Action	Responsibility	Timescale	Revised Timescale	Update/Comments
34.	6.2	20/09/18	KPMG External Audit Annual Report 2017/18 – Report to be amended to include a reference to the number of changes in Board membership since its inception in 2015.	JMS	September 2018	-	Complete.
35.	7.1	20/09/18	2018/19 Financial Position – The Chief Officer be instructed to seek formal agreement from Perth and Kinross Council and NHS Tayside on the risk sharing arrangements for 2018/19.	RP	November 2018	-	Letter sent to Perth and Kinross Council and NHS Tayside and response received.

AUDIT AND PERFORMANCE COMMITTEE

30 November 2018

AUDIT & PERFORMANCE COMMITTEE – REVISED TERMS OF REFERENCE

Report by Chief Financal Officer (Report No. G/18/205)

PURPOSE OF REPORT

The report details the revised Terms of Reference for the Audit & Performance Committee of the Integration Joint Board (IJB).

1. RECOMMENDATIONS

It is recommended that the Audit and Performance Comittee:

(i) Consider the revised Audit & Performance Committee Terms of Reference as detailed in Appendix 1.
(ii) Note that the revised Audit & Performance Committee Terms of Reference detailed in Appendix 1 are being considered for approval by the Integration Joint Board following this meeting.

2. BACKGROUND

The IJB is responsible for putting in place good governance arrangements, including proportionate audit arrangements and annual financial statements which are compliant with good practice standards.

In order to ensure this happens the IJB established an Audit & Performance Committee in 2016 and the remit, powers and membership of this Committee were agreed by the IJB on 1 July 2016.

In line with good governance a review of the Audit & Performance Committee Terms of Reference has taken place

3. CONCLUSION

The refresh of the Audit & Performance Committee Terms of Reference has been undertaken by Audit & Performance Committee members with guidance from the Chief Internal Auditor. It is recommended that the Audit and Performance Committee consider the refreshed terms of reference as detailed in Appendix 1 of this report.

Author(s)

Name	Designation	Contact Details
Maggie Rapley	HSCP Service Manager Business Planning & Performance	m.rapley@nhs.net

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

Appendix 1

AUDIT & PERFORMANCE COMMITTEE

30 November 2018

TERMS OF REFERENCE

Introduction

1. The Audit & Performance Committee (the Committee) is identified as a Committee of the Integration Joint Board (IJB). The approved Terms of Reference and information on the composition and frequency of the Committee shall be considered as an integral part of the Standing Orders. The Committee shall be a standing Committee of the IJB.

Purpose

2. The Committee shall provide independent assurance on the adequacy of the risk management framework, the internal control environment, and the integrity of the financial reporting and annual governance processes. The Committee shall scrutinise performance and best value arrangements.

Authority

3. The Committee is a decision-making committee which will include the approval of the Annual Audit Plan. The Committee is authorised to request reports and to make recommendations to the IJB for further investigation on any matters that fall within its Terms of Reference.

Membership

4. The IJB shall appoint the Committee. Membership must consist of an equal number of voting members from Perth & Kinross Council (the Council) and NHS Tayside (the NHS). The Committee shall comprise two voting members from the Council, two voting members from the NHS and two non-voting members from the IJB. The Chair of the IJB cannot be a member of the Audit & Performance Committee.

5. Any member of the IJB can attend the Audit & Performance Committee.

6. Members of the IJB, or their proxies or substitute members, may substitute for members of the Committee who represent the same organisation or group.

Chair

7. The Chair of the Committee shall be a voting member nominated by the IJB.

8. In the absence of the Chair, the Committee shall elect a voting member as Chair for the purposes of that meeting.

Quorum

9. Three members of the Committee shall constitute a quorum. At least two members present at a meeting of the Committee shall be voting members.

Meetings

10. Meetings of the Committee shall be conducted in accordance with the Standing Orders of the IJB.

11. The Committee shall meet at least three times each financial year.

12. The Chief Officer, Chief Financial Officer, Chief Internal Auditor, Head of Health, Head of Adult Social Work and Social Care, Chief Social Work Officer, Associate Director/Mental Health Services, P&K HSCP Associate Medical Director and other professional advisors or their nominated representatives shall normally attend meetings. Other persons shall attend meetings at the invitation of the Committee.

13. The External Auditor shall attend at least one meeting per annum. At the end of each meeting of the Audit & Performance Committee there will be an opportunity on request for a private discussion with the external and Chief Internal Auditors without other senior officers present.

Reporting

14. The Committee shall provide the IJB with an annual report summarising its conclusions from the work it has done during the year and providing an opinion on the adequacy and effectiveness of the systems of internal control. The Committee shall review its own effectiveness yearly through self assessment against its duties and report the results to the IJB.

15. The Chair of the Committee, or, in his/her absence, a nominated member, shall provide updates on the work of the Committee at each meeting of the IJB.

Duties

16. The Committee shall review the overall internal control arrangements of the IJB and make recommendations to the IJB regarding signing of the Governance Statement.

17. It shall be responsible for the following duties:

17.1 Performance/Best value/Scrutiny

- To prepare and implement the strategy for Performance Review
- To ensure that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against set

objectives, levels and standards of service, to receive regular reports on these and to review progress against the outcomes in the Strategic Plan

- To monitor progress and review updates on various pieces of work across the Health & Social Care system on behalf of the IJB, particularly in relation to the Strategic Planning & Commissioning Board and its four underpinning Strategic Programmes of Care Boards (Older People and Unscheduled Care Board, Mental Health & Wellbeing Board, Primary Care Board and the Carers Board)
- To ensure that quarterly performance reporting to the Audit & Performance Committee from the Strategic Programmes Of Care Boards takes place utilising a core data set linked to the 6 Ministerial Steering Group (MSG) Performance Indicators and the 20 National Indicators
- To act as a focus for best value and performance initiatives and provide assurance on Best Value
- To scrutinise self evaluation documentation and inspection reports prior to submission to external inspectors
- To review reports of external inspections of health and social care services
- To maintain oversight of the Partnership's performance in statutory functions such as complaints handling, freedom of information and participation requests

17.2 Governance

- To review and approve the annual Internal Audit Plan on behalf of the IJB, receive reports and oversee and review progress on actions taken on audit recommendations and report to the IJB on these as appropriate
- To receive monitoring reports on the activity of Internal Audit
- To consider External Audit Plans and reports (including annual audit certificate/ annual report), matters arising from these and management actions identified in response
- To monitor the effectiveness of the control environment, including arrangements for ensuring value for money, supporting standards and ethics and for managing the Partnership's exposure to the risks of fraud and corruption
- To review on a regular basis the implementation of actions agreed by management to remedy weaknesses identified by Internal or External Audit
- To consider the effectiveness of the authority's risk management arrangements and the control environment, reviewing the risk profile of the organisation and assurances that action is being taken on risk-related issues, including partnerships and collaborations with other Organisations
- To ensure the existence of and compliance with an appropriate Risk Management Strategy
- To be satisfied that the Integration Joint Board's annual assurance statements, including the Annual Governance Statement, properly reflect the risk environment and any actions required to improve it and demonstrate how governance supports the achievement of the authority's objectives

17.3 Audit

- To consider the annual financial accounts and related matters before submission to and approval by the IJB
- To review the financial statements, external auditor's opinion and reports to members, and monitor management action in response to the issues raised by the external audit
- To be responsible for setting its own work programme, which shall include the right to undertake reviews following input from the IJB Committees and the Chief Officer, Chief Financial Officer and Chief Auditor
- In relation to the Partnership's internal audit functions:
    a) oversee its independence, objectivity, performance and professionalism
    b) support the effectiveness of the internal audit process
    c) promote the effective use of internal audit within the assurance framework
    d) To support effective relationships between external audit and internal audit, inspection agencies and other relevant bodies and encourage the active promotion of the value of the audit process
    e) To provide oversight of other public reports, such as the annual report

17.4 Standards

- To promote the highest standards of conduct and professional behaviour by IJB members in line with The Ethical Standards and Public Life etc (Scotland) Act 2000
- To assist IJB members in observing the relevant Codes of Conduct
- To monitor and keep under review the Codes of Conduct maintained by the IJB

AUDIT AND PERFORMANCE COMMITTEE

30 NOVEMBER 2018

RISK MANAGEMENT PROGRESS UPDATE

Report by Chief Financial Officer (Report No. G/18/203)

PURPOSE OF REPORT

The purpose of this paper is to present the Audit and Performance Committee with a Perth & Kinross Health & Social Care Partnership (PKHSCP) Risk Register and revised Risk Management Framework.

1. BACKGROUND

On 20 September 2018 a report by the Chief Finance Officer was presented at the Audit and Performance Committee (G/18/123) in respect of a Risk Management update. This report set out a proposal to undertake a series of risk workshops across the Perth & Kinross Health & Social Care Partnership Team to develop a refreshed Strategic Risk Resgister for consideration by the Audit & Performance Committee. . In addition it was agreed that an IJB Member workshop would be held on governance and risk in advance of the Audit & Performance meeting at the end of November

2. PROGRESS TO DATE

A series of risk management workshops have been held with members of EMT/IMT. A refreshed risk register has been developed and this is attached at Appendix 1. Risks to delivery of the strategic obkectives of the IJB change over time and therefore will be kept under regular review. A further EMT meeting in January provide the opportunity for a formal 3 Month Review and Update.

Our work with EMT ad IMT has provided a timely opportunity to review and update the IJB's Risk Management Framework. This is attached at Appendix 2. This includes a risk escalation process which has been agreed by PKHSCP to give clarity around risk escalation and ensure timely responses to allow risk mitigation. This has been implemented with immediate effect.

We have held two workshops with IJB Members in November covering the following:-

- Overview of IJB Governance Structure and routes for assurance
- Risk Management Training
- Review of refreshed Risk Register

To ensure that there is robust risk management and governance around each of the Strategic Programmes of Care to deliver on the Strategic Commissioning Plan a further set of risk workshops will be held with Boards by January 2019.

Work at Programme Board level to identify and develop individual risk profiles will be an early task for each Programme Board. Strategic Risks identified will be fed through into the PKHSCP Strategic Risk Profile and Operational Risk will be managed through the Service Managers. The Programme Boards will have oversight of Programme of Care risks.

3. NEXT STEPS

The risk management framework requires EMT to review red risks and their mitigation actions plans on a monthly basis. We are supporting managers with risks management expertise to develop the action plans and these will be considered by EMT in the first instance on 29 November 2018.

In parallel, we will work with each Programme Board to bring forward risks registers for review by EMT on a six weekly basis.

EMT will hold a full risk register review and update in January 2019.

4. CONCLUSION

This report sets out the progress in refsehing the Strategic Risk Register for PKHSCP and next steps.

5. RECOMMENDATION(S)

The Audit and Performance Committee are asked to:

(i) Approve the Strategic Risk Register.
(ii) Approve the refreshed Risk Management Framework.
(iii) Note the next steps including the development of action plans in realtion to red risks and the development of risk registers for each Programme Board.

Author(s)

Name	Designation	Contact Details
Jane M Smith	Chief Financial Officer	janemsmith@nhs.net

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

APPENDICES

1. Strategic Risk Register
2. Risk Management Framework

Perth Kinross HSCP Strategic Risk Register

				Inherent Risk					Residual Risk						
Risk Numbe	Category	Risk Description	Risk Owner	Impact Value	Probability Value	Inherent Score	Current Controls	Control Value	Impact Value	Probability Value	Residual Score	Treatment Actions	Risk Manager	Status	Due date
SR01	Strategic	**FINANCE** There is insufficient financial resources to deliver the objectives of the Strategic Plan.	Chief Finance Officer	5	5	25	1. Financial Planning Process 2. Enhanced Budget Negotiation Process (PKC & NHS) 3. Programmes of Care linking financial and service planning 4. IJB BRG Process 5. Financial Monitoring & Reporting 6. Eligibility Criteria	B C C B B A	5	5	25	1. All parts of Partnership have a 3 year financial plan. 2. To ensure that the budget negotiation process is agreed and understood and aligned to IJB 3. Enhance leadership and ownership in respect of Programmes of Care. 4. IJB / Elected Members awareness of financial process / pressures. 5. Review financial monitoring process	Stuart Lyall / Arlene Wood/ Hamish Dougall Rob Packham / Karen Reid / Malcolm Wright Rob Packham Rob Packham Diane Fraser/Evelyn Devine	Open	
SR02	Strategic	**WORKFORCE** There is a risk of an inability to recruit within some areas across the Partnership.	Chief Officer	4	5	20	1. Supplementary staffing and contingencies 2. Vacancy Management 3. Integrated Clinical Strategy Work 4. Maximising Marketing 5. Workforce Planning	C C C C B	4	4	16	1. Marketing / Workforce Planning and Joint Working Agreement based on agreed clear models of care - take into account recruitment and workforce issues. 2. Lobby NHS regarding Vacancy Management. 3. Build work force planning into management activity - Strategic Plan. 4. Clearly define Integrated Clinical Strategy model for P&KHSCP. 5. Develop a marketing plan through workforce group. 6. Continue to review HART recruitment issues. 7. Review role of transformation (praxtice development / education & training) 8. Review capacity issues	Diane Fraser/Evelyn Devine Rob Packham DF/ED ED / OPUSC Hamish Dougall Chris Lamont Paul Henderson Lead Professionals	Open	

				Inherent Risk					Residual Risk						
Risk Numbe	Category	Risk Description	Risk Owner	Impact Value	Probability Value	Inherent Score	Current Controls	Control Value	Impact Value	Probability Value	Residual Score	Treatment Actions	Risk Manager	Status	Due date
SR03	Strategic	**WORKFORCE** Lack of Joint Working Agreement	Chief Officer	4	3	**12**	1. Parent Bodies T&Cs 2. Protocol Proposal going to SP&R Committee and NHS Board 3.Parent Body HR Policies 4. Pan Tayside Group currently discussing and exploring agreement 5. Local Work Force Group for Partnership	A D A B C	4	3	12	1. Protocol proposal at SP&R - 28 November 2018 and NHST Board 6 December 2018. 2. Implementation of development plan and framework for Joint Working. 3. Pan-Tayside Group continue to work together. 4. Develop ToR for local workforce group to be signed off by IMT/EMT.	Pauline Johnstone (PKC)/ Chris Smith(NHS) Pauline Johnstone (PKC) / Chris Smith (NHS) Pauline Johnstone (PKC) / Chris Smith (NHS) Chris Lamont	Open	
SR04	Strategic	**COMMUNICATIONS & ENGAGEMENT** There is a risk that staff, stakeholders and communities will not support and buy-in to what we do.	Chief Officer	4	3	**12**	1. Strategic Planning and Commissioning Board 2. Individual Programme Boards 3. Communication and Engagement Plans 4. Corporate Communications 5. Programme Boards 6. Sub Groups 7. Stories of place and Local Action Partnerships	B B B B B B B	4	3	12	1. Review role of Boards in relation to Communication and Engagement. 2. Development of Communications and Engagement plans 3. Include Elected Members in Communication and Engagement	Diane Fraser Strategic Leads for Programme Boards EMT	Open	
SR05	Strategic	**GOVERNANCE** There is a risk of an unclear / cohesive Governance and Performance framework.	Chief Officer	5	4	**20**	1. Clinical Care and Professional Governance Forum; 2. Audit and Performance Committee; 3. BRG; 4. Strategic Commissioning Board; 5. EMT / IMT / IJB; 6. EOT / & Directors; 7. Purchase Service Board; 8. Quality Assurance Group; 9. OPSIG, Complex Care; 10. Strategic Programme Boards; 11. Care Inspectorate / HIS; 12. Annual Performance Report; 13. Chief Social Work Officer / NES; 14. Internal Audit / Professional Bodies (SSSC etc) 15. NHS Clinical Care Group	B B B B B B B B B C B B B B	4	3	12	1. Review CPGF Role / Remit. 2. Review APC ToR. 3. Review and agree the SCB ToR. 4. Explain Governance including relationships in a useful guide for all.	AMD / CSWO - Hamish Dougall / Jacquie Pepper Chief Finance Officer (JS) Head of Adult Care (DF) Business Planning & Perf Mgr	Open	

				Inherent Risk					Residual Risk						
Risk Numbe	Category	Risk Description	Risk Owner	Impact Value	Probability Value	Inherent Score	Current Controls	Control Value	Impact Value	Probability Value	Residual Score	Treatment Actions	Risk Manager	Status	Due date
SR06	Strategic	**GOVERNANCE** There is a risk of a lack of clarity around the roles and responsibilities of the IJB / Parent Bodies and HSCP.	Chief Officer	4	4	16	1. Government legislation / Scheme of Delegation 2. Corporate Governance structures 3. Service Plans in place 4. Financial Plans 5. Development sessions with Integrated teams 6. Self Evaluation and Regulated Evaluation 7. 'Directions'	B C B B C C B	4	3	12	1. Service Plans to be consolidated and support put in place to scrutinise and monitor. 2. Work collaboratively to shift the balance of care. 3. Better engage at all levels of staff. 4. Improvement plan developed in respect of Self-evaluation. 5.Communication of the 'Directions' and purpose to gain a better understanding.	IMT IMT/EMT IMT Diane Fraser Rob Packham	Open	
SR07	Strategic	**LEADERSHIP** There is a risk of a lack of a clear direction and Leadership to achieve the vision for integration.	Chief Officer / Chief Finance Officer	5	4	20	1. Chief Officer and EMT; 2. IMT / Locality Management Teams; 3. Strategic Plan; 4. Strategic Programme Boards; 5.Locality Team plans and Inpatient; 6. Governance: IJB, CPGC, A&PC, Risk Register; 7. Communications and Engagement Group 8. Links with Hosted Services	C B C C C B B B	5	4	20	1. Need to clearly define role and function of Senior Management Tiers. 2. Need to clearly define role and function of Senior Management Tiers. 3. Need to refresh the Strategic Plan and produce a ToR pf S.P.C.B and S.P.G. 4. Need to consolidate and complete the framework for Strategic Programmes of Care Boards. 5. Need to consolidate Locality Team Plans and put in a process for scrutiny and assurance. 6. Governance need demystifying and relationships explained. 7. Need to refresh the ToR/ Roles and Resp as part of workshop on 14 November 2018. 8. Create better links with Hosted Services	Business Planning & Perf Mgr. Business Planning & Perf Mgr. EMT EMT Heads of Health and Adult Care (ED/DF) Business Planning & Perf Mgr. Head of Adult Care (DF) Head of Health (ED) and Arlene Wood for MH	Open	

				Inherent Risk					Residual Risk						
Risk Numbe	Category	Risk Description	Risk Owner	Impact Value	Probability Value	Inherent Score	Current Controls	Control Value	Impact Value	Probability Value	Residual Score	Treatment Actions	Risk Manager	Status	Due date
SR08	Strategic	**POLITICAL** There is a risk of a lack of political continuity.	Chief Officer	5	4	20	1. IJB development sessions 2. Work with public partners / community planning 3. Community engagement project by project 4. Ambassador role of Chief Officer / Senior Leadership	B C C B	5	3	15	1. Project by Project inform Politicians. 2. Raise awareness with Elected Members / IJB Visits 3. Ensure timely response to PKC queries. 4. CO continue to meet with CEX / CEO of parent bodies every week and Chairs of Boards and Leaders. 5. Engage with communities / localities and Councillors		Open	
SR09	Strategic	**Technology / IT/ Data / Performance** There is a risk of a lack of a unified IT strategy.	EMT	3	5	15	1. IT Managers for HSCP across Tayside wide have been meeting to develop solutions; 2. Common log in platform and ability to view HSCP systems; 3. Joint SharePoint site; 4. Paper recording	C C C D	3	5	15	1. Regular updates to IMT/EMT on progress. 2. Develop a unified strategy 3. Develop SharePoint. 4. e-knowledge ???	S Strathearn / M Rapley A Taylor?? L Harris		

Appendix 2

Risk Management Framework

Risk Management

Risk management is an indispensable element of good management. As such, its implementation is crucial to the Perth and Kinross Health and Social Care Partnership (PKHSCP) and essential to its ability to discharge its responsibilities. It is about improving the PKHSCP ability to deliver outcomes by managing our threats, enhancing our opportunities and creating an environment that adds value and is a key part of corporate governance. Good risk management will help identify and deal with key risks facing the PKHSCP in the pursuit of its goals and not simply a compliance exercise.

As part of good corporate governance an organisation is required to demonstrate that risk management is an integral part of its activity. This requires risk management to be embedded within the culture of the Partnership.

The **Risk Management Strategy** presents a broad outline of the roles and agreed arrangements that are needed to ensure the effective management of risk across the Partnership.

The Risk Management Process

To allow the Partnership to meet their objectives, risk requires to be proactively managed. A typical risk management process will involve five stages:

- IDENTIFICATION - Recognise the risks and potential risks at all levels. Some of these risks will be immediately identifiable, others may be less recognisable.
- ASSESSMENT - Once the risks have been identified, the next stage is to analyse and evaluate those risks. Measurement is defined by how serious the risks are in terms of consequence and relative frequency of occurrence.
- PLANNING - The next stage is to determine the controls of those risks. This can include many actions such as the use of proactive measures, special training, new policy and procedures.
- IMPLEMENTATION AND MONITORING - The fourth stage in preparing and agreeing the risk management control plan is to ensure that an action plan is available to meet the impact of any proposed/additional actions and measures that have been identified in order to avoid the potential risks.
- CONTINUOUS IMPROVEMENT - The fifth stage is to establish a system where all the risks have a review process and defined reassessment timetable. This will ensure that the risk management process is dynamic and continuous. The review process includes the addition of new risks as they develop.

Stage 1

- **Recognise the risk**

This stage sets out to identify the risks facing the Partnership and to understand its unique risk position. When complete, this exercise will determine the broad risk areas, in terms of risk control and resource requirements .

- **Identifying the Context**

The starting point for risk management is a clear understanding of what the Partnership is trying to achieve and how this fits into the wider organisation or community. Risks will be considered under the following categories:

- Strategic: risks which potentially impact upon the Partnership ability to achieve its corporate objectives
- Programme / Project: those risks related to programmes of change and specific Transformation projects
- Operational: risks which impact upon the Localities to deliver its services and support functions in support of the Partnership strategic objectives

Risk management is about managing the threats that may hinder delivery of our strategic objectives and operational services, and maximising the opportunities that will help to deliver them. Therefore, effective risk management should be clearly aligned to the PKHSCP Strategic Commissioning Plan.

- **Identify key risks**

Leadership and direction is fundamental to the development of a risk management framework. The risk assessment will initially be a top down approach looking at the significant risks and controls at strategic level, then cascade through the Partnership. An individual may identify risks, but the assessment of any risk is a team or group activity – preferably at grass roots level. An important feature at this stage is to focus on the full range of risks across the Partnership objectives. This exercise will also identify current controls and present initiatives to examine the gaps and overlaps. Not every risk can be controlled at an acceptable level. The risks should be stated explicitly and must be communicated to Strategic Boards and relevant user groups.

The risk assessor must consider:

- The nature and characteristics of the risk
- The extent and category of the risk regarded as acceptable
- The likelihood of the risk materialising
- The Partnerships ability to reduce the impact and frequency on service delivery should the risk materialise
- The cost/benefit of controls in relation to identified risks

The activity, objective or outcome has to be assessed for risks that present as threats or opportunities with the aim of minimising threats and maximising opportunities. There are a number of different types of risks that the Partnership may face including financial loss, failure of service delivery, physical risks to people, and damage to the Partnerships' reputation. Whilst this list is not exhaustive, for the purposes of our Risk Management Framework, our most common risk factors relate to:-

- **Procurement & Commissioning**
- **Governance**
- **Public Protection & Political**
- **Environment**
- **Economy / Financial**
- **Partnership & Collaboration**
- **Communication and Engagement**
- **HR and Workforce**
- **Leadership**
- **Technology/IT/ Data & Performance**

Risks should be identified from the activities of the Partnership. For example, the risks should be considered and assessed across the potential impacts of:

- Failure to meet objectives
- Cost
- Service provision impact
- Schedule – result of operational delays
- Loss of reputation – accountability review

Describing the risk is equally important to ensure that risks are fully understood, and to assist with the identification of actions, the cause and effect of each risk must also be detailed. Typical phrases used to do this include:

Cause – is the source of the risk	**Risk Event is the area of uncertainty**	**Effect**
as a result of … due to … because of ...	Risk of … Failure to … Failure of … Lack of … Loss of … Uncertainty of … Delay in … Inability to … Development of … Damage to ...	may lead to … may result in …

Stage 2

- **Analyse the risks**

Having assessed our risk appetite and identified the risks, it is necessary to assess which are going to pose the greatest threat by considering the **likelihood (frequency)** of the risk actually happening and then identify the **potential consequences/impacts** this event would have on the Partnership, individual partners, service users and care providers and considering the proximity of when the event may impact producing the overall risk score.

These scores are not intended to provide precise measurements of risk but to provide a useful basis for identifying vulnerabilities to ensure that any necessary actions are undertaken. The Partnership has used a standard risk methodology to score risks and it is intended to help deliver consistent, meaningful scores that can be used to assess risks.

The risk management process requires each risk to be assessed twice – inherent and residual risk levels.

The **first assessment** (the 'inherent' risk level) is the exposure arising from a risk **before** control and action has been taken. It is assessed on the basis that there are no controls or action being taken to manage the identified risk.

The **second assessment** (the 'residual' risk level) considers the risk after the controls are applied. This provides a residual score that determines what further action, if any is to be taken.

- **Likelihood**

This will be based on the frequency of the event occurring, e.g. the probability/likelihood of the event. The likelihood score should be selected from the following table: (only one score may be selected) –

Score	Descriptor	Frequency of event occurring	Timescales Guide
1	Remote	Can't believe this event would happen	Unlikely
2	Unusual	Not expected to happen but might	Once a year
3	Possible	May occur occasionally	Quarterly or 6 monthly
4	Probable	Could occur several times	Monthly
5	Almost certain	Could occur frequently	Daily/weekly / happening

- **Consequences**

Once the likelihood is decided the consequences or impact on the Partnership must be determined. The establishment of accurate severity categories is fundamental to the risk management exercise. In identifying the score, the worst case scenario consequence will have priority.

A simple banding is explained in the following table: (only one score may be selected)

		← ***Consequences*** →				
Impact Score	**Descriptor**	**Objectives**	**Cost**	**Affect on Client Group or Users**	**Schedule**	**Reputation**
1 Green	***Negligible / insignificant***	Minimal Impact – no disruption	Minimal financial loss	None	Minimal	No interest to the Strategic Board
2 Green	***Minor***	Minor impact on provision	Moderate financial loss	Non permanent	Minor impact on project progress	Evoke some interest by the Strategic Board
3 Amber	***Moderate***	Objectives partially achievable – lost time	Possible significant financial loss	Semi permanent	Moderate impact on progress	Significant interest Strategic board Urgent inquiry by the Organisation
4 Red	***Major***	Significant impact on progress	Major financial loss	Extensive	Temporary halt	Loss of confidence in the Organisational lead. Executive interest.
5 Red	***Critical***	Unable to fulfil obligations	Severe financial	Major and unredeemable	Closure	Highly damaging adverse publicity. Major

			loss			loss of confidence in the Organisation. Possible Executive interest

- **Risk Exposure Rating**

The likelihood and consequences scores are multiplied together to give a figure that represents ***potential inherent risk exposure rating.*** This rating determines whether a risk is categorised as Red, Amber or Green.

Risk Scoring Grid						
Impact	**Critical**	**5**	**10**	**15**	**20**	**25**
	Major	**4**	**8**	**12**	**16**	**20**
	Moderate	**3**	**6**	**9**	**12**	**15**
	Minor	**2**	**4**	**6**	**8**	**10**
	Insignificant	**1**	**2**	**3**	**4**	**5**
		Very Low / Very remote	**Low / Remote**	**Medium / Possible**	**High / Probable**	**Very High / Almost Certain**
	Probability					

Risks are prioritised as to where they fall on the Risk Scoring Grid:

- **Priority 1** Risk remains extreme even after all identified controls and treatments have been applied. There are significant risks, which may have a serious impact on the Partnership and the achievement of its objectives if not managed. Immediate management action needs to be taken to reduce the level of net risk..
- **Priority 2** There are significant risks, which may have a serious impact on the Partnership or Service Delivery and the achievement of its objectives if not managed. Immediate management action needs to be taken to reduce the level of net risk.
- **Priority 3** Risk is manageable after controls have been applied. Although usually accepted, these risks may require some additional mitigating to reduce likelihood if this can be done cost effectively. Reassess to ensure conditions remain the same and existing actions are operating effectively.
- **Priority 4** Appropriate controls keep the risk low / negligible. These risks are being effectively managed and any further action to reduce the risk would be inefficient in terms of time and resources. Ensure conditions remain the same and existing actions are operating effectively.

Our tolerance toward risk in each of these areas in detailed by our Risk Appetite and any activity or objective should in the first instance be assessed against our risk appetite. Risk tolerance is the black line running through the matrix, where risks fall above this line consideration should be given to controls and contingencies required:

- **SUGGESTED APPETITE**

	Where risk management should focus most of its time
	Where risk management will ensure contingency plans are in place
	Basic mechanisms should be in place
	Where risk is so minimal it does not demand specific attention

Stage 3

The next stage of the process is to prepare specific responses to the risks to reduce the impact or likelihood of risks, not wholly to terminate or transfer.

It is important that a Risk Owner is identified along with the Risk Manager responsible for undertaking the responses to achieve the plan.

The Risk Control is completed and owned by the Risk Owner and updated with any Actions, Action owners and review date.

- **Risk Control**

Risk response options are one or a combination of the following:

Satisfactory / Take: Accept the risk as it is and take no further mitigation action(s)

Action required / Treat: Avoid a threat by taking action to remove the risk; Controls and actions will be put in place to prevent or reduce the likelihood of the risk materialising

Transfer: Transfer the liability for the consequence(s) of an event to another body, e.g. a contractor or purchase an insurance policy *(note that by transferring the risk only the financial impact will be covered, the risk may still occur!)*

Prevent / Terminate: Opt not to undertake the current or proposed activity because it is too risky

Where you have decided to **TREAT** a risk, you will have to identify all controls that are currently in place or that are required to mitigate the risk.

Consider how the control will affect the risk:
- ***Reduces impact of the consequences should the risk materialise***
- ***Reduces the likelihood of the risk occurring***

The effectiveness of the controls has to be rated to determine any further required actions(s)

The controls within each group should be explored using brief bullet point information. This will help you to determine how much control you have against each group across the following scale;

<table>
<tr><th></th><th colspan="3">Controls</th></tr>
<tr><td>D</td><td>Significant Controls do not exist or have broken down</td><td colspan="2">Will not achieve critical deadlines</td></tr>
<tr><td>C</td><td>Significant controls not operating effectively</td><td rowspan="2">May not achieve critical deadlines</td><td>Significant concern</td></tr>
<tr><td>B</td><td>Not all controls are fully effective</td><td>Watching brief</td></tr>
<tr><td>A</td><td>Controls are working effectively</td><td colspan="2">Will achieve critical deadlines</td></tr>
</table>

Stage 4

- **Action Plan for Improvement**

After considering actual control level you are now able to decide whether a targeted action is required i.e. are improvements necessary? If so, then decide the level of action that you need to achieve to arrive at the target control level.
The risk control planning process should also compare the risk exposure costs should the risk materialise with the cost of planned improvements to current controls. Capital and revenue, recurring and non recurring costs must also be considered and identified. It is possible that the impact in cost or resources required might outweigh the actual impact of the risk materialising on the Partnership. The Partnership can then prioritise the risks that require early attention on a cost and benefits basis and address them in the most effective way.

Additional information required to complete the risk control plan:

- The named risk owner – the person ultimately responsible for the risk
- The named risk manager – the person actually managing the risk
- The reporting arrangements for review – the review timescale and the person responsible for that are different from the risk owner. The risk control plans may also be reviewed by the Strategic Board
- Details of the person recording the information and the date
- Risk ranking – gives you a suggested order of priority in which to deal with your risks.

- **Risk Ranking**

This is calculated by the ***actual risk control level*** multiplied by the ***risk exposure rating*** (likelihood x consequence). The highest score should then be converted to first on the list and the lowest score last on the list.

Stage 5

- **Monitoring and Review**

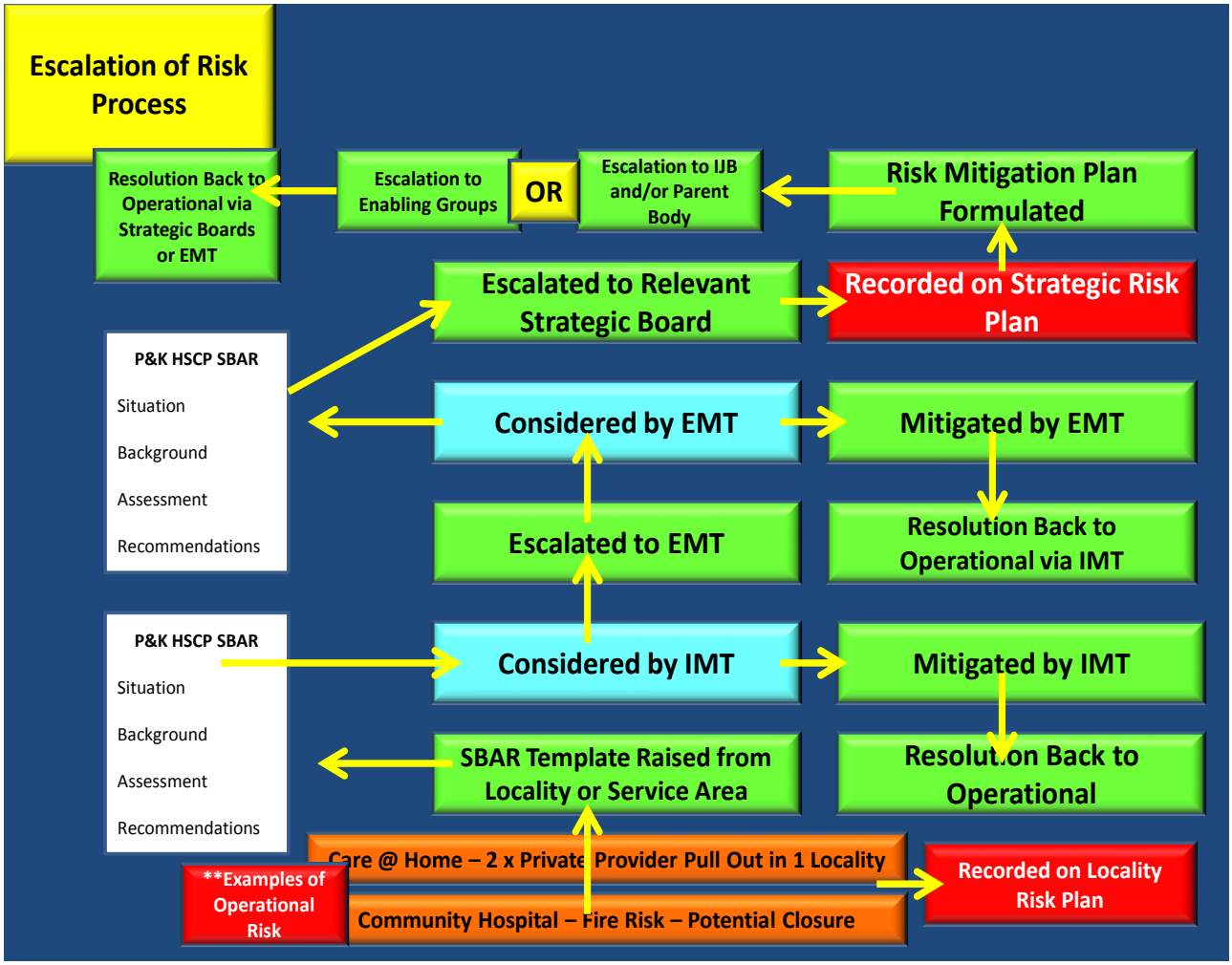
All identified risks and the associated actions must be monitored and reviewed on an ongoing basis. A risk control plan that does not change very often would probably indicate that risk is merely being identified, but not being managed or controlled.

A key element to ensure adequate follow up is a monitoring process which is able to provide reasonable assurance to the IJB / Partnership that there are appropriate control procedures in place for all significant risks and that these procedures are being followed. In addition, there should be formal procedures in place for reporting challenges and for ensuring corrective action.

Reviewing and Reporting Framework	
Risk Level and Score	**Frequency of Risk Reviews (applies to all Risk registers)**
Priority 1 **<16**	Risk remains extreme even after all identified controls and treatments have been applied. There are significant risks, which may have a serious impact on the Partnership and the achievement of its objectives if not managed. Immediate management action needs to be taken to reduce the level of net risk. **As a minimum review 2 weekly**
Priority 2 **10 - 15**	There are significant risks, which may have a serious impact on the Partnership or Service Delivery and the achievement of objectives if not managed. Immediate management action needs to be taken to reduce the level of net risk. **As a minimum review 6 weekly**
Priority 3 **6 - 9**	Although usually accepted, these risks may require some additional mitigating to reduce likelihood if this can be done cost effectively. Reassess to ensure conditions remain the same and existing actions are operating effectively. Risk is manageable after controls have been applied. **As a minimum review quarterly**

Priority 4 **1 - 5**	These risks are being effectively managed and any further action to reduce the risk would be inefficient in terms of time and resources. Ensure conditions remain the same and existing actions are operating effectively. Appropriate controls keep the risk low / negligible. **As a minimum review 6 monthly**

The escalation of risk process is shown below:



Risk Register example

				Inherent Risk				Residual Risk							
Risk Number	**Category**	**Risk Description**	**Risk Owner**	**Impact Value**	**Probability Value**	**Inherent Score**	**Current Controls**	**Impact Value**	**Probability Value**	**Residual Score**	**Risk Treatment**	**Treatment Actions**	**Risk Manager**	**Status**	**Due date**
SR01	Strategic	The potential for reductions in budget and increased wage settlements, creates a risk to our medium financial plan that may result in our ability to deliver core services	Chief Executive	3	3	**9**	Financial Plan BMIPs	3	3	9	Reduce				
SR02	Strategic	Failure to generate sufficient income creates a risk to the medium financial plan that may effect our ability to deliver services		4	3	**12**				0					

Risk Response Plan

RISK RESPONSE PLAN						
Risk ID	**Category**	**Date Raised**	**Status**	**Treatment**	**Date Due**	**Last Review date**
Risk Description						
Risk Owner						
Action	Description		Risk Manager	Date Due	Update	
1						
2						

AUDIT & PERFORMANCE COMMITTEE

30 November 2018

HM INSPECTORATE OF PRISONS FOR SCOTLAND – HMP PERTH INSPECTION

Report by Head of Health (Report No. G/18/204)

1. SITUATION AND BACKGROUND

The purpose of this report is to provide the Audit and Performance Committee with an update following an announced inspection by HM Inspectorate of Prisons for Scotland supported by Health Improvement Scotland (HIS) between 14 May and 1June 2018.

HM Inspectorate of Prisons for Scotland (HMIPS) has responsibility for inspecting care within prison establishments. The new Inspection and Monitoring Standards for Inspecting and Monitoring Prisons in Scotland were launched on the 14 May 2018.

The inspection and Monitoring Standards comprise of 9 standards:-

Standard 1 – Lawful and Transparent Custody
Standard 2 – Decency
Standard 3 – Personal Safety
Standard 4 – Effective, Courteous and Humane use of Authority
Standard 5 – Respect, Autonomy, and Protection against Mistreatment
Standard 6 – Purposeful Activity
Standard 7 – Transitions from Custody into the Community
Standard 8 – Organisational Effectiveness
Standard 9 – Health and Wellbeing

Each Standard has a number of Quality Indicators (QIs) which are graded individually to inform the overall grade for the Standard as a whole.

HMIPS is supported by Inspectors from Healthcare Improvement Scotland (HIS), Education Scotland, Scottish Human Rights Commission, Mental Welfare Commission and the Care Inspectorate.

The Prisoner Health Care team in HMP Perth is the first in Scotland to complete the “Health Improvement Scotland Prisoner Healthcare Quality of Care Approach Self Evaluation tool”. Devised by HM Inspectorate of Prisons for Scotland and supported by Health Improvement Scotland, the Perth team completed the self-evaluation in advance of the inspection supported by a significant quantity of evidence during the inspection.

The inspection took place between 14 and 18 May. The overall inspection team consisted of 18 inspectors which included 2 HIS inspectors and 4 clinical partners to inspect the healthcare service within HMP Perth using Standard 9. HIS inspectors subsequently revisited the establishment on 31 May and 1 June to follow up concerns raised at the time of the initial inspection

Since transfer of responsibility from SPS to NHS Tayside and P&K IJB, the leadership team across Prisoner Healthcare have been driving continuous improvement, proactively identifying and prioritising opportunities to modernise the services. Significant investment was made under the CHP to address historical patient safety concerns in the form of additional staffing resources.

The Prison Healthcare Patient Safety Collaborative was developed in partnership with NHS Tayside Patient Safety Team and uses an improvement approach to drive forward change within the service and is the first collaborative in Scotland which relates to prison healthcare. The team has been driving progress against a in the context of rising complexity across the prisoner population (substance misuse, mental Health issues and increasing frailty) and with significant constraints within workforce supply. A number of other material factors have affected the rate of transformation including staff performance, recruitment and retention challenges and average sickness absence.

There are three work streams across the collaborative

- Deteriorating patient
- Medicines safety
- Multidisciplinary communication.

Leadership and Culture is an underlying theme across each of the work streams.

2. ASSESSMENT

The service was inspected against Standard 9 Health and Wellbeing which consists of 17 Quality Indicators, 16 of which are applicable to HMP Perth. The report was published on the 10 October and a summary of the performance grading for standard 9 quality indicators are outlined in Appendix 1

The service has been working on developing an improvement plan to support the issues identified through the inspection as well as continue to progress with the ongoing work around wider service improvement. A full improvement plan (Appendix 2) has now been completed in response to the report and the actions required to continue to progress towards achieving the standards. There are likely to be significant cost implications which are currently being escalated. Progress has been made in relation to a number of the areas highlighted as areas of concern.

There is evidence of improvements made relating to assessment and coordinated care of people with physical healthcare care needs on admission and ongoing; the “Talk to Me” assessment is now being completed for people returning from court; the documentation in the Primary Care Team has been revamped based on the NHS Tayside District Nursing record and a revised MH team assessment has been implemented; regular professional and managerial supervision; relocation of the teams to a single office and relocation of the daily huddle which has improved communication between the SCNs and their teams. The introduction of care assurance walkrounds is a positive step which is being embraced by the SCNs and CNs and their governance role, but the scorecards are requiring a significant amount of time to manually populate and there may be a need to consider increased administrative support for this.

Each team now have up to date training plans which have been shared with them with SCNs working towards ensuring consistent planning for release of staff. The themes that emerged through the survey monkey undertaken by the Clinical Educator is being taken forward through the person centred culture programme.

There remain challenges with the ability of all teams to provide consistent clinic based activity due to the time taken to administer medications although there is evidence of improvement in this respect within Halls C3 &4. An action plan is in place to ensure ongoing monitoring of this issue, including SPS.

3. RECOMMENDATIONS

The Audit and Performance Committee is asked to

- Acknowledge the work undertaken to date
- Note the improvement plan was approved by Perth and Kinross Care, Clinical and Professional Governance Forum on 2 November
- Note and approve the improvement plan for submission to Health Improvement Scotland
- Note a mock inspection took place wk commencing 15 November
- Note HIS will return for 3 days on the 26 November for an interim inspection
- Note full HMIPS re-inspection will take place in approximately 12 months
- Acknowledge and support that the service will continue with the patient safety collaborative
- Acknowledge the service will continue working with wider healthcare services including public health, mental health and substance misuse and other partners including Criminal Justice, Police and Procurator Fiscal to develop new models of care which meet the needs of the population of both HMP Perth and HMP Castle Huntly.

4. REPORT SIGN OFF

Responsible Executive Director and contact for further information.

If you require any further please contact:

Contact for further information	Responsible Executive Director
Jillian Galloway	Robert Packham
Head of PHC, OOH, FMS	Chief Officer
jillian.galloway@nhs.net	robertpackham@nhs.net

Date: 15 November 2018

Additional supporting information

1. Summary table of graded performance against each quality indicator
2. Improvement plan for HIS
3. Clinical Governance and Risk Management Paper Update Summary for Prison Healthcare Patient Safety Collaborative

QI	Quality Indicator	Grading
9.1	As assessment of the individuals immediate health and wellbeing is undertaken as part of the admission process to inform care planning	Generally Acceptable
9.2	The individuals healthcare needs are assessed and addressed throughout the individuals stay in prison	Poor
9.3	Health improvement, health prevention and health promotion information and activities are available for everyone	Generally Acceptable
9.4	All stakeholders demonstrate commitment to addressing the health of inequalities of prisoners	Generally Acceptable
9.5	Everyone with a mental health condition has access to treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release	Poor
9.6	Everyone with a long term health condition has access to treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release	Unacceptable
9.7	Everyone who is dependent on drugs and/or alcohol receives treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release	Poor
9.8	There is a comprehensive medical and pharmacy service delivered by the service	Poor
9.9	Support and advice is provided to maintain and maximise individuals oral health	Satisfactory
9.10	All pregnant women, and those caring for babies and young children, receive care and support equitable to that in the community, and is supported throughout their stay in prison, on transfer and on release	N/A
9.11	Everyone with palliative care or end of life care needs can access treatment and support equitable to that in the community, and is supported throughout their stay in prison, on transfer and on release	Generally Acceptable
9.12	Everyone at risk of self-harm or suicide receives safe, effective and person centred treatment, and supported throughout their stay in prison, on transfer and on release	Poor
9.13	All feedback, comments and complaints are managed in line with the respective local NHS Board policy. All complaints are recorded and responded to in a timely manner	Generally Acceptable
9.14	All staff demonstrate an understanding of the ethical, safety and procedural responsibilities involved in delivering healthcare in a prison setting	Generally Acceptable
9.15	The prison implements national standards and guidance, and local NHS Board policies for infection prevention and control	Satisfactory
9.16	The prison healthcare leadership team is proactive in workforce planning and management. Staff feel supported to deliver safe, effective and person centred care	Poor
9.17	There is a commitment from NHS Board to the delivery of safe, effective and person centred care which ensures a culture of continuous improvement	Generally Acceptable

Tayside Prison Healthcare Services

Her Majesty's Inspectorate of Prisons for Scotland

Inspection and Monitoring

Improvement Action Plan

Std 9	**All Prisoners received care and treatment which takes account of all relevant NHS Standards, guidelines and evidence based treatments. Healthcare professionals play an effective role in preventing harm associated with prison life and in promoting the health and well being of all prisoners**					
Quality Indicator 9.1 **An assessment of the individual's immediate health and wellbeing is undertaken as part of the admission process to inform care planning.** **Grading – Generally Acceptable Performance**						
Primary Care nurses to revert to managing the admission clinic	30 June 2018	Head of Nursing (HON)	Complete – Primary Care Team now assessing patients on admission to HMP Perth or on return to HMP Perth from Court using new Prison Healthcare traffic light assessment tool...	30 June 2018	• Vision Healthcare Records • Shift allocation sheet • Traffic light assessment tool	H&SC 1 H&SC 2 H&SC 3 H&SC 4 H&SC 5
Implement Opiate Withdrawal screening on admission	12 November 2018	Senior Charge Nurse (SCN) Substance Misuse	Plans underway for substance misuse duty worker to attend reception to conduct Clinical Opiate Withdrawal Assessment Scores on all patients identified as being at risk of opiate withdrawal.	In progress	• Vision Healthcare Records	H&SC 1 H&SC 2 H&SC 3

Implement the use of PGDs in the reception process	1 April 2019	Lead Pharmacist\ Specialist Clinical Pharmacist\ Lead Nurse\ Head of Nursing	PGDs from another NHS Tayside service have been identified for use within Prison Healthcare and are currently under review with a view to implementation in April 2019 due to current PGD requiring review by the service, approval from NHS Tayside PGD governance group and nurse PGD education Identified that NHS Tayside does not currently utilise PGDs for alcohol and drug detoxification treatment. Plan for these to be developed.		• Completed PGD • Vision Healthcare Records	H&SC 1 H&SC 2 H&SC 3

Ensure robust system is in place for sharing information with other health colleagues following admission to HMP Perth	31 December 2018	SCN Primary Care Team Substance Misuse Mental Health	• Traffic Light Assessment implemented for all individuals admitted to Prison which highlights specific individual needs • Team specific referrals are completed following admission assessment • NHS/SPS Night Report Updated to include all patients at risk, circulated to SPS Night Manager, SCN/CN for each nursing team/Pharmacy • Location changed of twice daily patient safety huddle • Relocation of all nursing teams into one central office space • Charge Nurse progressing Patient Safety test of change to improve quality of twice daily patient safety huddle	2 July 2018 30 June 2018 23 August 2018 12 October 2018 In progress	• Individual Health Care records • Night Reports • Observation of Practice • Test of Change for Safety Huddle.	H&SC 1 H&SC 2 H&SC 3 H&SC 4
Healthcare service information should be available in an easy read format and staff ensure appropriate translation services as accessed	31 October 2018	Health Centre Co-ordinator	Introduction of an easy read and colour Healthcare Patient Leaflet provided to all patients on admission starting from July 2018 Sourced easy read referral forms from other establishments and currently tailoring these for HMP Perth by 31 October 2018 HON memo to staff reminding of	30 June 2018 25 May 2018	• Patient Information Leaflet • Evidence of use of translation services within patient records • Posters in consulting rooms Translation Services.docx	H&SC 1 H&SC 2

			need to use translation services where appropriate.			
Update Substance Misuse Information Pack	30 December 2018	SCN Substance Misuse Team	Packs updated with new prints by 26 October 2018. Acknowledging that information in packs will need to be reviewed for easy read formatting	In progress	• Updated Substance Misuse pack.	H&SC 1 H&SC 2
Quality Indicator 9.2 **The individual's healthcare needs are assessed and addressed throughout the individuals stay in prison.** **Grading – Poor Performance**						
Review GP admission process to streamline appointments and reduce the waiting times for GP appointments	30 November 2018	Lead GP\ Health Centre Co-ordinator	Medical staff met and agreed new process for managing appointments and introducing stage 2 health assessments within 14 days of admission as per NICE Guidelines unless there is an acute need for medical review post admission to HMP Perth. Vision clinic profiles amended to include planned urgent and emergency appointment slots. Standard operating procedure for managing GP appointments written. Planned implementation date 19 November 2018.	13 September 2018 In progress	• Minutes from Meeting • Vision Clinic Profiles • Standard Operating Procedure	H&SC 1 H&SC 5
Improved record keeping and documentation for nursing staff	31 December 2018	Lead Nurse\ Head of Nursing	All nursing staff and pharmacy staff attended record keeping training in line with NMC and Healthcare Support worker	31 August 2018	• Audit Results • Training records • SCN/CNs challenging quality of	H&SC 1 H&SC 3

			Code and NHS Tayside record keeping policy. Revised Record Keeping Audit Tool implemented for all enhanced care records implemented 29 June 2018. NHS Tayside District Nursing documentation implemented for all active Enhanced Care patients (replaced hospital assessment documentation), implemented 31 August 2018. Third version audit tool implemented for new documents All Diabetes and Wound Care Plans transferred into electronic vision record Record Keeping Standards Reviewed in individual managerial\professional supervision with individual staff. Hosted first meeting of the newly established group through National Prison Healthcare Network reviewing documentation across all establishments. Continuing to contribute with a view to preparing standardised documentation for prison healthcare across all establishments, commenced 17 September 2018	29 June 2018 Ongoing 12 October 2018 22 October 2018 31 August 2018	information with PCT staff and individual improvement plans reviewed through supervision at least monthly. • Individual Staff Supervision Records	

Ensure robust system is in place for identifying patients with additional health and or social care needs	31 October 2018	SCN Primary Care Team	Traffic Light Assessment implemented for all individuals admitted to Prison which highlights specific individual needs using quality improvement methodology Admission Audit Tool redrafted and implemented following introduction of Traffic Light Assessment Traffic Light Assessment document uploaded to vision and records available in chronological order All patients on enhanced care caseload are assigned a named Primary care team Band 6 Associate Nurse in addition to a Band 5 Named Nurse with role and responsibilities clearly articulated and understood	2 July 2018 October 2018 September 2018	• Individual Electronic Health Care Records • Tests of Change • Audit Results  enhanced care document FINAL.doc  Traffic Light Assessment PDSA#1  Admission Audit.pdf  Enhanced Care PDSA#1.doc	H&SC 1 H&SC 3 H&SC 4
Implement a robust MDT process between NHS & SPS to ensure, a joint approach to meet the health and social care needs of individuals with complex needs throughout their stay in HMP Perth	30 November 2018	Head of Nursing	Primary Care Team introduced a weekly review meeting for those on enhanced care case load Joint NHS/SPS Hall specific Multi-disciplinary meetings planned for implementation 7 November 2018 Referral form agreed and implemented with SPS for requesting personal care	July 2018 Ongoing September 2018	• Agenda for Hall specific MDT meetings • Individual Patient Records • Person Care Referral form • Minutes of NHS/SPS Operational Meeting	

Improve access to self-referral forms in the residential halls and ensure they are available in an easy read format	30 October 2018	Health Centre Co-ordinator/SPS Unit Managers	Sourced easy read referral forms from other establishments and currently tailoring these for HMP Perth. Work with SPS to improve the availability of referral forms in the halls	In progress Ongoing	• Forms observed in Halls • Receipt of self referrals in Health Centre	H&SC 1 H&SC 3
Explore the potential of having a free phone number to the health centre to enable patients to call and make appointments	31 October 2018	Health Centre Co-ordinator/GiC	Governor in charge has agreed in principal to a phone line accessible for patients to be tested and implemented. SPS estates team exploring practicalities and cost of a freephone line to the Health centre.	In progress	• Emails Correspondence • Minutes from Prisoner Forum	H&SC 1 H&SC 2 H&SC 4
Improve access to health promotion/health improvement information in the halls	30 November 2018	Head of Nursing	New posters have been made available in hall areas promoting a range of health promotion initiatives (Smoking Cessation/Naloxone). Appointed 2.5WTE Health Improvement Advisors who will commence posts in November 2018. Community Harm Reduction Worker to be based in HMP Perth by 30 November 2018 for four sessions per week. Who will work with staff/patients to improve knowledge and access to health improvement information	October 2018 In Progress In progress	• Observation of Posters in Halls, • Observations of staff in post.	H&SC 3 H&SC 4
Improved access to Occupational Therapy assessments for people requiring cell functional	30 November 2018	Head of Nursing	Occupational therapist and physiotherapist attended HMP Perth to assess patients identified by inspectorate.	Complete June 2018	• Individual Electronic Patient Records	H&SC 1 H&SC 3 H&SC 4

assessments			Referral pathway agreed and implemented with community Occupational Therapy Service. Agreement reached with Perth and Kinross Joint Equipment store to supply stock of basic equipment within HMP Perth. Agreement arranged with SPS and Joint Equipment Store for delivery of larger equipment. Three Primary Care Nurses have attended training for assessing patient's needs for basic OT equipment. Joint NHS\SPS and community OT meeting to identify the requirements for upgrading a disabled cell with appropriate equipment, information supplied to SPS to aid business case preparations Falls coordinator and SCN have agree a modified falls assessment tool which is now in new record specific to Prison Healthcare, based on Forth Valley Prison healthcare Tool Falls coordinator additionally met with HoN and SPS 4/10/2018 to explore wider management of falls prevention in prisons and agreed actions which include awareness	Complete July 2018 24 October 2018 24 October 2018 24 October 2018 September 2018 Ongoing	• Referral Pathway • Email Traffic	
		Head of nursing/ Head of Offender Outcomes SPS				

			sessions for SPS Physical Instructors/Health Staff and discussion of indentifying those at risk of falls at SPS Nurse link worker meetings which are held monthly			
Quality Indicator 9.3 **Health Improvement, health prevention and health promotion information and activities are available for everyone** **Grading – Generally Acceptable Performance**						
Improve access to Naloxone kits on liberation	30 December 2018	SCN Substance Misuse	Casework Team Leader has planned visit to HMP Edinburgh to gain learning Posters placed in reception to highlight availability and how to refer as well as provided to each individual on admission in information pack along with harm reduction information. National Harm Reduction Sessions continue to be run by Caseworker for each new to prison admission. Lead Pharmacist is exploring legalities of providing patients with a GP10 on liberation for supply of naloxone, update expected 31 October 2018 Information posters provided to Unit Managers regarding naloxone availability to increase population awareness Meeting held 22 October 2018	In progress	• Visible of posters in halls • Copy of pack Copy of presentation	H&SC 1 H&SC 2 H&SC 3 H&SC 4 H&SC 5

			to review current naloxone issue process, actions to be progressed Meeting held with Chair of Tayside Drug Related Death Group and Tayside Chair of Blood Borne Virus Managed Clinical Network where it was agreed to introduce non fatal overdose pathway into Prison Healthcare, further meeting planned for November 2018			
Improve peer involvement around the use of Naloxone	1 January 2019	SCN Substance Misuse BBV & Sexual Health MCN Manager	Secured community harm reduction worker to commence 4 sessions per week (November 2018) to work in HMP Perth to support implementation of peer development Successful recruitment of 2.5 WTE Health Improvement Advisors to support public health initiatives including Peer support, expected to commence in post by end of November 2018	In progress		H&SC 1 H&SC 2 H&SC 4
Ensure information regarding harm reduction measures and managing an overdose is readily available in all residential areas	5 November 2018	SCN Substance Misuse	Harm reduction posters have been provided to residential managers to put up in halls. Joint NHS/SPS implementation, 1 October 2018, of Naloxone provision for Prison Officers administration. Standard Operating Procedure (SOP) developed, which incorporates collation of non fatal overdose information, 9 kits supplied to	24 October 2018 1 October 2018	• SOP • Naloxone Kits in Halls	H&SC 1 H&SC 2

			SPS			
Improved access to smoking cessation services	1 April 2019	Specialist Clinical Pharmacist/ Head of Offender Outcomes (SPS)	Successful recruitment into 2.5WTE Health Improvement Advisor Roles which are due to commence in November 2018. Two staff members completed two day smoking cessation training in July 2018. Two day smoking cessation training booked for new members of staff in November 2018. Group format for smoking cessation support implemented in each hall with the support of Public Health and Casework Team from 20 August 2018. Currently there are 76 service users engaged with smoking cessation services with no waiting list. All referrals appointed to a group within 7 days. Referral process developed and implemented for pharmacy team to see patients on a 1:1 basis. Identified pathway used within hospital services for engagement with community service that is currently being adapted for use within Prison Settings. This will allow individuals engage with the service to engage with their Community Pharmacy upon liberation. This process will be tested prior to the Smoke Free Prisons on 30 November 2018.	In progress	• TORT figures • Waiting List • Public Health data for number of quit attempts and success rate.	H&SC 1 H&SC 2 H&SC 3

Quality Indicator 9.4 **All stakeholders demonstrate commitment to addressing health inequalities of prisoners** **Grading – Generally Acceptable Performance**						
Quality Indicator 9.5 **Everyone with a mental health condition has access to treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release** **Grading – Poor Performance**						
Implement comprehensive range of low level psychological interventions and treatment for patients	30 April 2019 January 2019 30 December 2018	SCN Mental Health	Successful bid, Mental Health Strategy Action 15 Funding, for 2 WTE Nurse Therapists Band 7 Secured places on low intensity psychological therapy courses for December 2018 and January 2018 for 3 current mental health nurses Nursing staff have commenced NES online modules for low intensity psychological training	In progress	• Copy of bid • Emails • Learn Pro Dash Board	H&SC 1 H&SC 2 H&SC 3
Review the mental health nursing delivery model to increase clinic productivity and timely access following referral	30 November 2018 July 2018	SCN Mental Health	Temporary change to operating hours of team, team operating Monday – Friday 0700 – 1600 hours which supports a Registered Nurse to be on duty not involved in medicines administration Secured Contract with Agency to cover period of team vacancy (now filled) and long term	23 August 2018 July 2018	• Team Roster – SSTS • Test of Change PDSA • Waiting Times	H&SC 1 H&SC 2 H&SC 3

			sickness absence from July 2018 Utilising agency nurses for B Hall medication administration to release Mental Health nurses to run clinics, from mid October 2018 Exploring options for splitting B Hall medication administration, plan to test mid November 2018 Test of Change planned for mid November 2018 for early screening (within 72 hours of referral) of patients referred to service, this will test early intervention urgency of need	15 October 2018 In progress In progress		
Implement the use of a standardised and validated assessment/risk assessment tool in mental health nursing team	30 November 2018	SCN Mental Health Consultant Psychiatrists	Sourced validated risk assessment Currently training staff on use of Risk Assessment and plan to implement by 17 November 2018 Team currently introducing adapted Mental Health assessment tool, forms part of the vision electronic record but is separate to the above risk assessment, full implementation for all active case load patients by 30 November 2018	October 2018 In progress	• Individual Healthcare Records	H&SC 1 H&SC 2 H&SC 3
Ensure all patients have a personalised care plan and regular reviews	30 November 2018	SCN Mental Health	Recovery care plans now upload to vision and team progressing implementation for all active case load	In progress	• Individual Healthcare Records • Observation of Practice	H&SC 1 H&SC 2 H&SC 4

	15 November 2018		SCN attended Mental Welfare Commission National Session on Care Planning in Mental Health Settings (26 October 2018) and has shared knowledge with mental health team to aid effective care planning. SCN is in the process of setting set review clinics for specific Nursing Staff to support regular planned reviews in line with care plans	26 October 2018 In progress		
Improve joint working with substance misuse and mental health	31 October 2018	SCN Mental Health SCN Substance Misuse	Representation from each team now attending each teams weekly allocations meeting Three SCNs now sharing office and all nursing teams in one office	22 October 2018 October 2018	• Minutes from MHT MDT meeting • Substance Misuse Nurse attendance as required.	H&SC 1 H&SC 2 H&SC 3
Improve communication with patients on the progress with their referrals	30 December 2018	SCN Mental Health	Acknowledgment letters now sent on receipt of referral Progressing use of appointment cards	September 2018 In progress		H&SC 1 H&SC 2 H&SC 3 H&SC 4
Ensure waiting times info displayed in the health centre is accurate	30 October 2018	Health Centre Coordinator	SCN providing mental health waiting times to Health Centre coordinator for displaying	Ongoing	• Publicised Waiting Times	H&SC 1 H&SC 2 H&SC 3 H&SC 4
Quality Indicator 9.6 **Everyone with a long term health condition has access to treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release** **Grading – Unacceptable Performance**						

Establish long term conditions register	Commenced August 2017 at HMP Castle Huntly. Ongoing. Newly commenced at HMP Perth	Clinical Lead/GPs	Patients transferred to Castle Huntly have a medical indication listed for all medication. The new changes to the admission process at Perth mean that a disease register can be compiled. Data pulled from viison on numbers in HMP Perth with LTC such as Asthma, Epilepsy and Diabetes is assisting in giving priority to which conditions should be provided first	In progress		H&SC 1 H&SC 2 H&SC 3
Establish Long term condition clinics	March 2019 November 2018 November 2018	Clinical Lead/GPs/ Head of Nursing/ Specialist Clinical Pharmacist	With above data LTC clinics will be established in order 1. Asthma 2. Epilepsy 3. Diabetes 4. Thyroid 5. Hypertension 6. COPD Clinics will be established at Castle Huntly in Nov 2018 and systems tested before they are introduced in full to Perth Pharmacy Technician is planning implementation of Asthma clinics mid November 2018 SCN Primary Care SCN meeting with Epilepsy Nurse Specialist early November to establish training needs to allow nursing staff to run Epilepsy Clinic.	In progress In progress In progress		

			GP attended the epilepsy clinic plans to begin epilepsy reviews for more complex case by end of January 2019 Spirometer ordered to support COPD clinics and training to be arranged for nursing staff. Secured ISD support to complete week of care audit for PHC, audit planned for 26 November 2018	In progress In progress In progress		
Review admission process for GPs with a view to creating additional GP capacity for holistic health assessments within 2 weeks of being admitted to HMP Perth	30 November 2018	Clinical Lead and GPs	Clinic template agreed by GPs for new process as per QI 9.2	October 2018	 Enhanced Care PDSA#1.doc • Clinic template	
Develop improved documentation and care plans which are available on vision and in a chronological order	30 November 2018	SCN Primary Care Mental Health Substance Misuse	Nursing teams' assessments and care plans have been uploaded to vision, all active Primary Care enhanced care patients now have new electronic records (based on NHS Tayside District Nursing Documentation), mental health and substance misuse are progressing migration to electronic assessments and care plans. All new patient assessments are completed electronically. All Nursing staff have access to	Ongoing October	• Individual healthcare records  enhanced care document FINAL.doc	H&SC 1 H&SC 2 H&SC 3

			DOCMAN	2018		
Ensure training plans are in place and staff are release and supported to attend training to support their education and development	30 March 2019	SCN	Practice Educator and Practice Development Nurse completed a training needs survey monkey questionnaire for all nursing, case work and pharmacy staff Nursing and Case Work Teams have developed training plans specific to speciality and banding which are being shared with all staff. Person centred cultures programme will also focus on themes highlighted through survey monkey SCN are planning rosters to release staff to attend training sourcing supplementary staffing where required SCN have set a protected learning session each week for their specific teams., where they are focusing on completing training on new assessment documents and on-line training Substance Misuse and Mental health staff have commenced attending Trauma and Stabilization Training and NES online low level psychological intervention training which will support them to progress onto	Ongoing Ongoing Ongoing Ongoing	 MHT Training Plan (1).doc  SMT plan.doc  PCT Training Plan.docx  SBAR Perth Prison Nursing Team.docx • Team Rosters • Learn Pro Dash Board • Individual Staff members PDP	H&SC 1 H&SC 2

			further courses to deliver low intensity psychological interventions SCN have completed Leading Better Care self -assessments to identify gaps in knowledge, development is being monitored in managerial and professional supervision SCN planning 15 hours non-clinical time each week to undertake managerial duties, supported by contact with agency, this is review at weekly SCN huddle SCN getting opportunities to shadow peers in (2 days per week for 8 weeks) community and acute hospital settings to bring back learning of embedding governance/care assurance processes and additionally to increase awareness of wider NHS of PHC SCN/HoN supported and encouraged to attend external conferences, training and meetings to enhance networking and knowledge and promote growth HON supported to widen HON knowledge/experience by covering OOH/FMS 1 day per week for 3 month period	Ongoing Ongoing Ongoing In progress Ongoing October 2018	 Developing cultures of person centrednes	

Work with podiatry to include electronic documentation on vision of podiatry appointments	31 January 2019	Health Centre Coordinator	Agreement reached with podiatry that they will migrate to use of vision to support single patient record. Plan to meet in December 2018 to agree what health care templates are required to support migration	In progress In progress		H&SC 1 H&SC 2
Quality Indicator 9.7 **Everyone who is dependent on drugs and/or alcohol receives treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release.** **Grading – Poor Performance**						
Implement Opiate Withdrawal Tool (OWL) on admission			As per 9.1			H&SC 1 H&SC 3
Review Detoxification Pathway	April 2019	Consultant Psychiatrist Substance Misuse	Acknowledgment by team that this action directly relates to review of whole pathway and improved timely access to Opiate Replacement Therapy which would require additional access to non-medical prescribers In line with community substance misuse services in Tayside a review was completed of NMP workforce requirements within the prison setting Bid submitted to Alcohol and Drug Partnerships across Tayside for government funding, to secure additionally funding for 5.5 WTE Non-Medical	August 2018 September 2018 September 2018 - awaiting	• ADP Bid that includes workforce review figures	H&SC 1 H&SC 2 H&SC 3

			Prescribers (NMP) and additional funding for upskilling current band 5 substance misuse Registered Nurses as NMP to give the team the capacity to prescribe in addition to case management Work ongoing to draft and implement PGD for detoxification management to reduce reliance on medical staff to prescribe Commenced substance misuse quality improvement meetings reviewing prescribing pathway	outcome of bid In progress In progress		
Review Substance misuse pathway in order to improve access to appropriate timely assessment and ensure where possible it reflects the community model	30 April 2019	SCN Substance Misuse Team	Implementation of new referral process; patients can now be directly allocated to a Registered Nurse following referral for assessment rather than immediate allocation to Case Worker, allocation now based on needs of individual Currently reviewing role of substance misuse duty worker role to include assessment of patients following admission to establishment New substance misuse assessment sourced which team have reviewing and agreed as suitable Submitted bid for additional NMP workforce to allow additional clinical capacity as	September 2018 In progress October 2018 September 2018- await outcome of bid	• Individual Patient Healthcare Records	H&SC 1 H&SC 5

			above, await decision			
Improve standard of substance misuse assessments	31 December 2018	SCN Substance Misuse Team	Substance Misuse Team attended training session on pharmacology treatments for illicit drug use to improve knowledge base and support knowledge base for assessing patients New substance misuse assessment document sourced as above and due for implementation in November 2018 Consultant Psychiatrist has substance misuse assessment training planned from week beginning 22 October to enhance nursing staffs knowledge for completing comprehensive substance misuse assessments It is acknowledged by the team that a team specific audit tool will need to be drafted to monitor quality of assessments	October 2018 In progress In progress In progress	• Training plan • Draft assessment document	H&SC 1 H&SC 5
Work with SPS to improve the balance between recovery and harm reduction	30 April 2019	Head of PHC/GiC	SPS and NHS plan to reinvigorate joint recovery strategy on commencement of New Head of Offender Outcomes.	In progress		H&SC 1 H&SC 4 H&SC 5
Ensure robust individual care plans are in place with appropriate and timely	30 December 2018	SCN Substance Misuse team	Record Keeping audits implemented Electronic care plans	October 2018	• Scorecard • Record Keeping Audits • Individual Health Care Records	H&SC 1 H&SC 3

follow up			implemented team migrating from paper It is acknowledged by the team that a team specific audit tool will need to be drafted to monitor quality of care plans To improve regularity of reviews for those on active case load team are progressing test of change to reduce time spend administering medication, these tests are being progressed in conjunction with SPS and are supported by Patient Safety Quality Improvement Advisor	In progress Ongoing	• Test of Change – A Hall medication administration	
Improve discharge planning process	30 April 2019	SCN Substance Misuse	Team building on improving who they liaise with following a patients liberation, communication with harm reduction services, implementation of raising awareness of non-fatal overdoses during period in custody	In progress		H&SC 1 H&SC 4 H&SC 5
Quality Indicator 9.8 **There is a comprehensive medical and pharmacy service delivered by the service** **Grading – Poor Performance**						
Reduce the time taken to administer medications in the morning in order to reduce the impact on SPS regime and to increase capacity for nursing teams to deliver	As per Plan	Head of Prison Healthcare, Governor, Lead Pharmacist, Lead Nurse, Specialist Clinical	Medication SLWG established to identify ideas to improve timings for medication administration. Significant change in time taken in C3 &4. Other tests of changes are either ongoing or planned for other halls.	In progress	• As per plan • Test of Change data • Action Plan	H&SC 1 H&SC 2 H&SC 3

consistent clinic activity.		Pharmacist and Head of Nursing	Where other ongoing tests of change are planned for other halls there remain challenges in reducing the time taken to administer medications			
Establish a process for follow up reviews or assessments to ensure individuals are taking in possession medication correctly	April 2019	Head of Nursing Specialist Clinical Pharmacist	Ongoing medication spot checks in collaboration with SPS and MDT review of all these checks. Pharmacy Technician has commenced clinics reviewing those patients who are over-ordering their medications or are identified as having issues with managing their medications. Patient Safety Collaborative test of change involving a MDT review of all patients found to be under the influence of an unknown substance. MDT Review of all patients who are on pregabalin on gabapentin including SPS and NHS Tayside pain team in these reviews to commence 3 December 2018.	Ongoing September 2018 Ongoing In progress	• Individual healthcare records • Medication check data • Test of Change	H&SC 1 H&SC 3
Improve prescribing practice within HMP Perth	April 2019	Lead GP Specialist Clinical Pharmacist	Prison Healthcare has been invited to participate in NHS Tayside Prescribing Management Group. Work has been undertaken to improve formulary compliance resulting in a decrease in non-formulary compliance. Training has commenced for Senior Pharmacy Technician to undertake more in-depth poly-	November 2018 Ongoing Ongoing		

			pharmacy reviews. Lloyds Pharmacist is now undertaking key audits to look at key prescribing targets within HMP Perth. This has been highlighted by NPHN pharmacy group as good practice Ongoing work with reducing GP waiting times and appointment system will allow GPs within the service to carry out poly-pharmacy reviews. MDT review of all patients who are on pregabalin or gabapentin including SPS. This is due to commence in November 2018 and will be completed by March 2019. Prescribing benchmarking completed against other establishments. Monthly analysis has been commenced and first full report will be available by end of November 2018. Initial analysis shows that there has been reduction in the prescribing of; • Non-formulary non-steroidal anti-inflammatory drugs • Non-formulary topical preparations • Non-prescribable items within NHS Scotland e.g. Vaseline and Deep Heat • Oral Nutritional	Ongoing Ongoing In progress Ongoing		

			Supplementation • Pregabalin and gabapentin. The data also shows that whilst the Public Health data previously showed an ineffective smoking cessation service that patients were engaging with the service for their 12 week programme.			
Review of reporting of incidents through DATIX	Ongoing	Head of Nursing Specialist Clinical Pharmacist	All SCN's have undertaken a refresher course in DATIX verifier training delivered by Clinical Governance a Risk co-ordinator. DATIX incidents forming part of the team Scorecards. Monthly reports off all incidents within HMP Perth are reviewed by clinical teams to support learning and development from these incidents.	July 2018 September 2018 October 2018	• Score Cards • DATIX Reports	H&SC 1 H&SC 3
Quality Indicator 9.9 **Support and advice is provided to maintain and maximise individuals oral health** **Grading – Satisfactory Performance**						
Improve the provision of health promotion work for oral health	30 December 2018	Head of Nursing	Contact with Oral health team, work to be agreed and commenced	In progress		H&SC 1 H&SC 3
Quality Indicator 9.10 **All pregnant women, and those caring for babies and young children, receive care and support equitable to that available in the community, and are supported with their wellbeing throughout their stay in prison, on transfer and on release** **Not applicable**						

Quality Indicator 9.11 **Everyone with palliative care or end of life care needs can access treatment and support equitable to that in the community, and is supported throughout their stay in prison, on transfer and on release** **Grading – Generally Acceptable Performance**						
Review documentation for palliative care patients to ensure it meets the needs of a primary care environment	30 September 2018	SCN Primary Care Team	Palliative and end-of-life care needs are now assessed using the new prison specific electronic document and pathways. The document considers all aspects of daily living baseline 4AT, palliative care, wound management, MUST assessment and mobility. The document directs staff to follow direct pathways ie palliative care pathway	30 September 2018	• Palliative Care Pathway	H&SC 3 H&SC 4
Quality Indicator 9.12 **Everyone at risk of self harm or suicide receives safe, effective and person centred treatment and support with their wellbeing throughout their stay in prison, on transfer and on release** **Grading – Poor Performance**						
Ensure process in place to review all return from courts who have had a change in conviction status are reviewed on admission back to the establishment	30 May 2018	Head of Nursing	All prisoners who are returned from court with a change in circumstance are now assessed by a nurse as per Talk to Me.	30 May 2018	• Admission lists.	H&SC 1 H&SC 3 H&SC 4
Ensure all patients on Talk to Me are reviewed prior to case conference	30 September 2018	SCN Mental Health	Mental Health Team are endeavouring to see patients prior to the case conference and are working in collaboration with	30 September 2018		H&SC 1 H&SC 2 H&SC 3

			SPS to ensure this, as not always possible due to time constraints in particular if patient needs reviewed prior to leaving establishment to attend court in the early morning			
Quality Indicator 9.13 **All feedback, comments and complaints are managed in line with the respective local NHS Board policy. All complaints are recorded and responded to in a timely manner** **Grading – Generally Acceptable Performance**						
Ensure robust process is in place to reduce the response time to complaints	January 2019	Health Centre Coordinator	Reviewed and implemented revised triage process Implemented reminders sent to stage 1 investigators prior to deadline, which has reduced number of which that are escalated to stage 2 Onsite support of (1 day per week) of Complaints and Feedback Coordinator to assist with stage 2 responses and adherence to NHS Tayside policy Commenced drafting local Standard Operating Procedures for the onsite managing of complaints and feedback, which include contingency planning for periods of leave Successful recruited to a Patient Relations Administration Assistant, anticipated start date of December 2018	August 2018 August 2018 Ongoing In progress In progress Ongoing	• Datix reports of complaints received and action	H&SC 1 H&SC 3

			Commenced Healthcare forums with patient population and staff to support engage, effective communication and quality improvement	Ongoing		
Complaints awareness training for staff	30 December 2018	SCN Primary Care Team Substance Misuse Team Mental Health Team	Training plans now incorporate learn pro complaints module for all staff which are being progressed Training plans for band 6/7 staff include complaints investigation training which are being progressed	Ongoing	• Learn Pro Dash Board • Team Training Plans	H&SC 3 H&SC 4
Quality Indicator 9.14 **All NHS staff demonstrate an understanding of the ethical, safety and procedural responsibilities involved in delivering healthcare in a prison setting** **Grading – Generally Acceptable Performance**						
Implement a paper light documentation system to support all clinical and admin teams	30 November 2018	Health Centre Coordinator Head of Nursing	4 additionally DOCMAN scanners ordered to increase access to hardware Primary Care Team have progressed to Vision electronic patient records, reducing paper documents Substance Misuse and Mental Health Teams are currently migrating to vision electronic records Letter templates uploaded to Vision, for general correspondence to patients	October 2018 September 2018 In progress Ongoing	• Observations of Practice	H&SC 1 H&SC 3

Access to SCI Gateway for referrals to secondary care	30 December 2018	Health Centre Coordinator	Testing sending referrals out to secondary care was successful however a problem remains with information on return, IT continuing to seek a solution	in progress		
Review administrative support provided to clinical teams	30 December 2018	Health Centre Coordinator	Successfully recruitment for administration support for Head of Nursing Review completed 22 October 2018 where it was agreed that administration support would be allocated to substance misuse nursing team with immediate effect to support processing of all referrals, appointing patients previously only available for Case Work team for ISD purposes Review planned for early November to establish administration needs of mental health team, to support referral management, appointment patients and minutes taking Plan agreed for induction of new administrative staff	October 2018 In progress October 2018		
Quality Indicator 9.15 **The prison implements national standards and guidance, and local NHS Board policies for infection prevention and control** **Grading – Satisfactory Performance – not actions required**						
Quality Indicator 9.16 **The prison healthcare leadership team is proactive in workforce planning and management. Staff feel supported to deliver safe, effective and person-centred care**						

Grading – Poor Performance						
Ensure training plans are developed and staff are released for training to support their learning and development	30 March 2018	All	As per 9.6	Ongoing		
Ensure staff within SM have access to appropriate training	30 March 2018	SCN Substance Misuse Team	As per 9.6	Ongoing		
Review workforce plan and explore the options of rotational roles to improve retention of staff	30 March 2018	Lead Nurse Head of Nursing	Initial discussions commenced between Lead nurse and Head of Nursing to explore services to be included.	In progress		
Review skill mix within the primary care nursing team	30 March 2019	Head of Nursing	Meeting held to review needs of team and agreed as band 6 posts become vacant to recruit to Senior Community Nurse, Practice Nurse and Emergency Practitioner Nurse. Currently progressing recruitment of a Senior Community Nurse as a test Consideration being given to service redesign	In progress		H&SC 1 H&SC 3
Ensure all staffs mandatory training is up to date and completed	30 November 2018	SCN's	As per 9.6 Reported monthly on team scorecards	Ongoing	• Scorecards	
Ensure all staff have PDP and annual appraisal	30 March 2018	SCN Head of Nursing Specialist Clinical Pharmacist	Dates set for appraisals and staff are currently inputting PDP on to electronic system	Ongoing	• TURAS and LearnPro Scorecards	

Relocate the patient safety huddle and handover	30th August 2018 30 November 2018	SCN Primary Care Substance Misuse Mental Health	Patient safety huddle board has been relocated from stair well to nursing office. Charge Nurse progressing Patient Safety test of change to improve quality of twice daily multi-disciplinary huddle.	30th August 2018 Ongoing	• Observation of Practice • Test of Change Paperwork	
Implementation of team scorecards	30th September 2018	Head of Nursing\ Specialist Clinical Pharmacist	Use of monthly care assurance scorecard for each of the nursing teams and Pharmacy team have been implemented. Scorecards forming basis of collating information for the Service Performance Framework. Nursing Teams continuing to improve quality of scorecards. Specialities attending business meeting quarterly to present care assurance updates.	30th September 2018 Ongoing Ongoing Ongoing	• Team scorecards • Minutes of Business and Clinical Governance meeting. • Performance review dashboard • Team Scorecards  SCN_Scorecard August 2.doc  8. PCT August 18 scorecard.docx  MHT SCORE CARD AUGUST 2018.docx  8. SCN Walkround Care Assurance Tool.	

					8. SCN Walkround Care Assurance Tool.	
Implement a robust MDT process between NHS & SPS to ensure, a joint approach to meet the health and social care needs of individuals with complex needs throughout their stay in HMP Perth	30 December 2018	Head of Nursing	Primary Care Team introduced a weekly review meeting for those on enhanced care case load Joint NHS/SPS Hall specific Multi-disciplinary meetings planned for implementation 31 October 2018 Referral form agreed and implemented with SPS for requesting personal care	July 2018 In progress October 2018	• Agenda for Hall specific MDT meetings • Individual Patient Records • Person Care Referral form • Minutes of NHS/SPS Operational Meeting	
Ensure appropriate clinical supervision is in place for both mental health and substance misuse nursing teams	31 December 2018	Head of Nursing\ SCN Primary Care Substance Misuse Mental Health	Registered Nursing staff are all in receipt of managerial/professional supervision at least bi monthly Mental Health team have commenced value based reflective practice with an external facilitator. Substance Misuse Team currently sourcing value based reflective practice from an external facilitator. Progressing Charge Nurse and Senior Charge Nurse forums in collaboration with the Out of Hours and Forensic Medical Service.	Ongoing Ongoing In progress In progress		

Quality Indicator 9.17 **There is commitment from the NHS Board to the delivery of safe, effective and person centred care which ensures a culture of continuous improvement** **Grading – Generally Acceptable Performance**						
Patient Safety collaborative Work	1 April 2019	Head of Service	Secured 2 days per week of dedicated Quality Improvement advisor to support programme of work, she works alongside staff on site which has supported engaging staff in programme Notice Boards within health centre are plentiful of PDSA and charts plotting progress Patient Safety Programme threads thought all of the ongoing quality improvement work in the department support staff engagement and involvement in changes implemented	Ongoing/ in progress	• Patient Safety Programme improvements • Notice boards	
Implement Person Centred Care Practice Development	30 December 2019	Head of Nursing	Joint programme of work agreed between NHS and SPS to embark on a one year programme to embed person centred cultures within Prisons in Tayside Secured Senior Practice Development Nurse secured to lead programme, who is working nationally on Person Centeredness Cultures Initial meeting completed introducing model of programme		• Information Leaflet • Bid  Developing cultures of person centrednes	

			facilitated which was positively received Successful, Scottish Government, bid for funding to support programme of work including releasing Head of Nursing to undertake co-facilitator role for programme to support sustainability follow end of formal programme Initial 3 Day Practice Development School planned for 3-5 December 2018 where approximately 20 NHS/SPS participants will participate in person centeredness culture work			

Links to Standards

Health & Social Care Standards (H&SC)

Chief Officer, Perth Health and Social Care Partnership

Signature _____

Full name _____ Date _____

Perth and Kinross Health and Social Care Partnership

PRISON HEALTHCARE PATIENT SAFETY COLLABORATIVE PROGRESS REPORT

29 October 2018

SITUATION

The purpose of this report is to provide an update relating to the work undertaken within Prison Healthcare as part of the Prison Healthcare Patient Safety Collaborative.

BACKGROUND

Using the Institute for Healthcare Improvement Breakthrough Series Collaborative Model; a tried and tested change model designed to help organisations achieve sustainable change in specific topic areas, the NHS Tayside Prison Healthcare Patient Safety Collaborative was launched in August 2017 as an 18-month collaborative between NHS Tayside and the Scottish Prison Service (SPS), with an overall aim to provide safe and effective care to the patient population of HMP Perth and HMP Open Estate (Castle Huntly) by December 2018.

Three key workstreams were formed to help achieve this aim; deteriorating patient, focussing on clear pathways of care of the deteriorating patient in a safe effective and timely manner; medicines, focussing on safe and effective medicines management in prison healthcare, and multidisciplinary team working, focussing on safe and effective person centred communication.

The collaborative, supported by subject matter experts and the patient safety team, has held two learning sessions to date (August 2017 and March 2018), where attendees from both the NHS and Scottish Prison Service have been provided with a structure to build capacity and capability in improvement science and engage in learning and action periods to aid staff in making real system level change to lead to improvements in prison healthcare.

ASSESSMENT

Good progress has been made with each of the workstream teams despite a few busy and challenging months, particularly in the lead up to and following the announced HM Inspectorate of Prisons for Scotland visit. It proved difficult for staff to be released for a third learning session due to other competing priorities for both NHS and SPS staff. Instead, an engagement session was held in September 2018 in HMP Perth, which provided an opportunity for NHS and SPS to showcase the work they had undertaken to date. This proved to be successful and upon further reflection by the collaborative faculty members, agreement was reached that this model will continue to be used in place of learning sessions.

Work has continued to focus mainly around medicines administration times, which has to some extent slowed the pace of potential improvements in other workstreams.

An overview of some of the work undertaken to date, work in progress and some of which has been completed, is contained within the attached appendices; Appendix A (Medicines), Appendix B (Deteriorating Patient) and Appendix C (Multidisciplinary Team Communication).

RECOMMENDATION

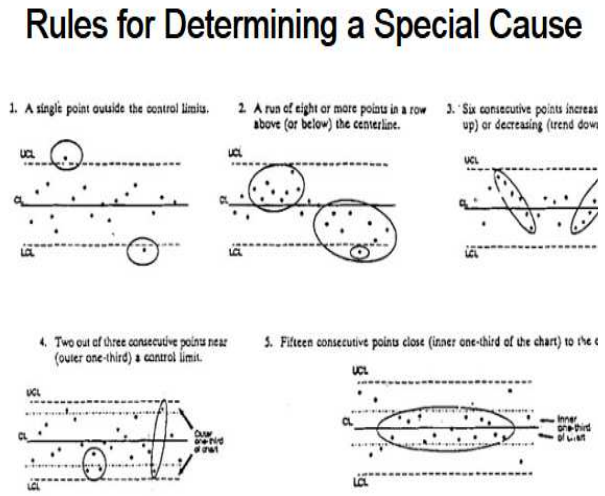
- Note the current level of activity, including successes and challenges across each of the workstreams

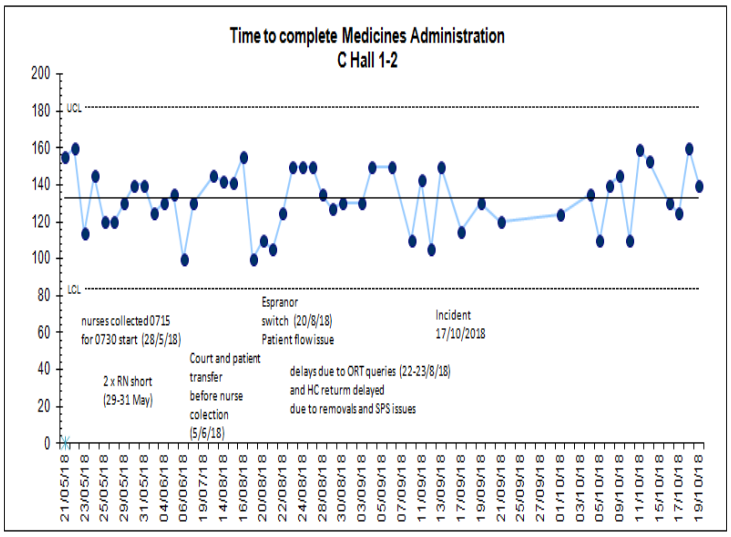
Prison Healthcare Patient Safety Collaborative
29 October 2018

Medicines Administration (supervised)

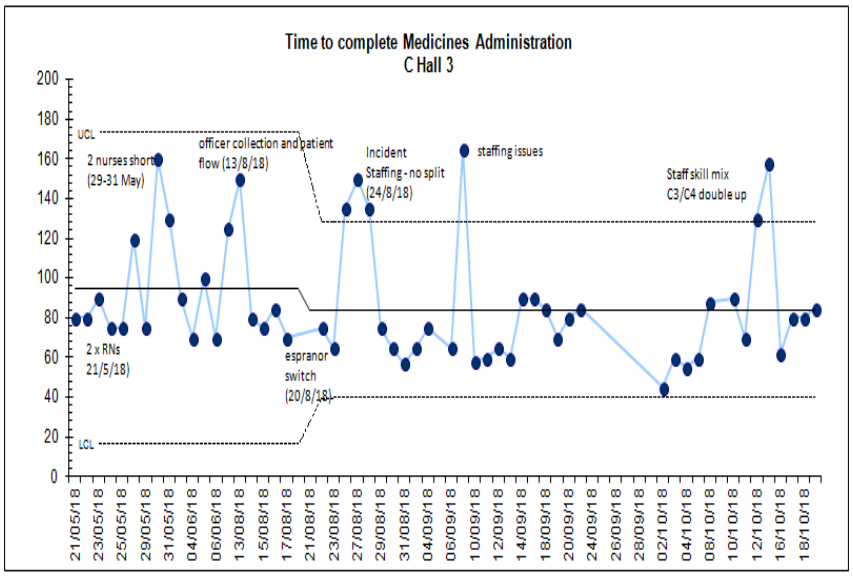
Aim: to ensure that supervised medicines are completed within 75 minutes (completed by 0845 hours) to allow nursing staff to commence specialist nurse clinics by 0930 hours, and allow the SPS route to move by 0845 hours.

Given the amount of data now available, I-charts (individuals charts) have been constructed to determine whether there is any common cause or special cause variation with the time to complete medicines administration across each of the flats within C Hall.

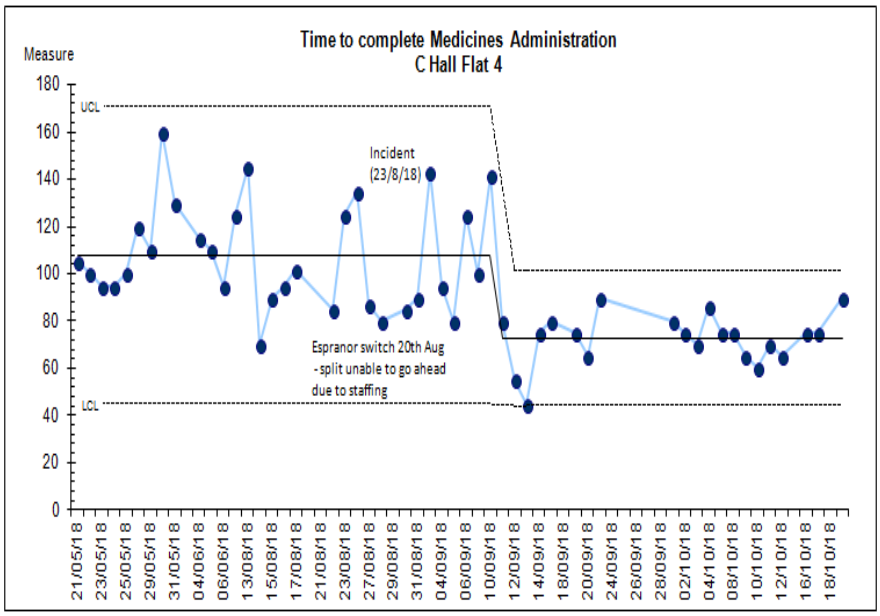




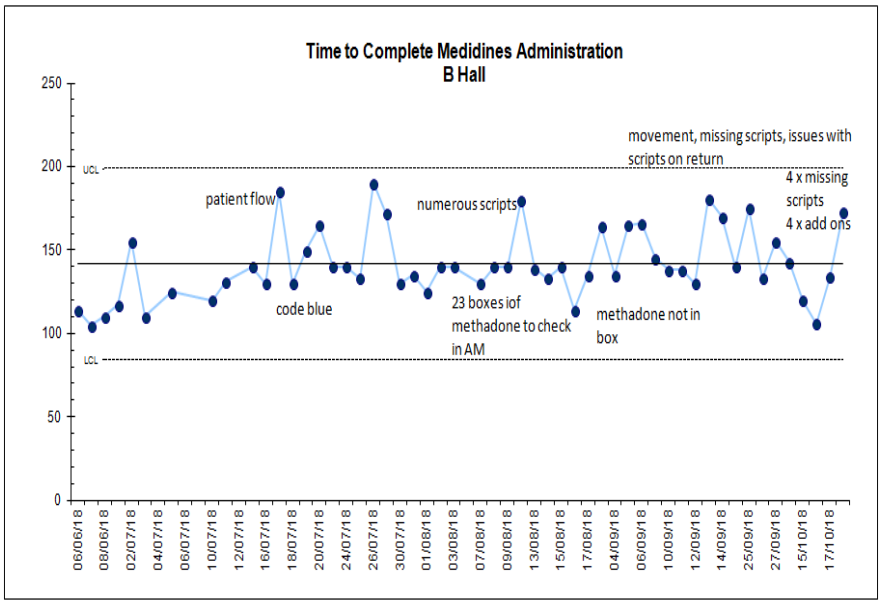
As can be seen from the data available for Flats 1 and 2 within C Hall, only common cause variation is evident with each of the data points falling in between both the upper and lower control limits. Unlike Flats 3 and 4 as described later, the switch to Espranor seems to have had little effect on the timings of medicines administration within Flats 1 and 2. The current average time to complete medicines administration is 133 minutes. The goal remains for medicines administration to be completed within 75 minutes. Consideration should be given to further tests of change which can be undertaken to help in achieving this goal.



The baseline average (mean) time to complete medicines administration in Flat 3 was 94.7 minutes. This has been recalculated after 20 data points and following the switch to Espranor on 20 August 2018. There are 5 points outwith the upper control limit between 24 August and 15 October, most of which have been attributed to staffing issues, which clearly affected the times to complete medicines administration. The revised mean now sits at 83.8 minutes demonstrating improvement from baseline.

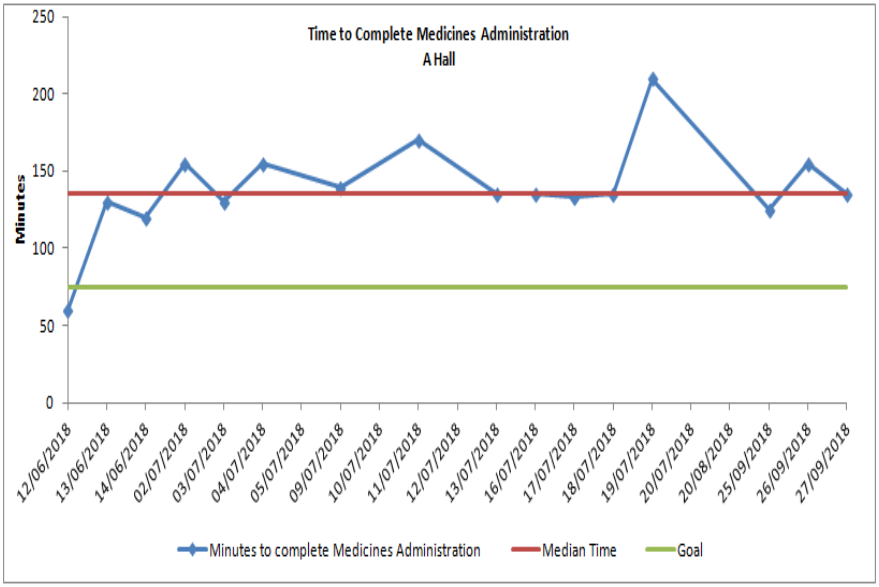


The baseline average (mean) time to complete medicines administration in Flat 4 was 107 minutes. There has been a clear reduction in the time to complete medicines administration from 11 September and the control limits have been adjusted to reflect the average time reducing from 107 minutes to 72 minutes.
Reduced variation is evident between 1-17 October with 12 consecutive data points close to the centreline, although fifteen would be required to evidence special cause using the rules to determine special cause.



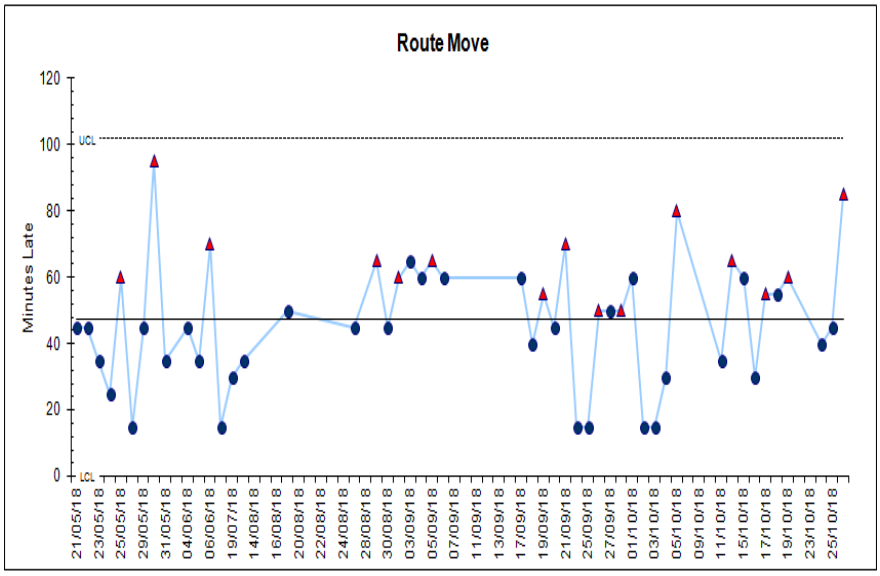
The mean time to complete medicines administration in B Hall is 141 minutes. Only common cause variation exists with this data.
An exercise has recently been undertaken to gauge an understanding of medicines breakdown within the hall, which includes identifying polypharmacy, and co-administering. This data is being explored further with the Mental Health Nursing Team to identify where potential improvements can be made.

A Hall



There is not yet enough data available for A Hall to construct a control chart. The current median time to complete medicines administration is 135 minutes.
A test of change is taking place week commencing 29 October which will see methadone administered in the afternoon as opposed to the morning. This is expected to show a reduction in the time taken to administer medicines in the morning, a reduction in the number of 2-3pm medicines and freeing up nursing time for clinics each morning. Data will be collected throughout the period of testing and the chart updated accordingly once this is available.

Route Move



Challenges remain with the route moving by the required time 0845 hours each morning. The current average time of the route moving late is 47 minutes.
It is of note that more than half of the data points above the average relate to days of the week when weekly medicines take place (highlighted as red triangles)
Daily exception reports have been reviewed (where available) to help gain a better understanding of reasons for delay, but on the whole, these days correlate with staffing shortages/incidents.

Management of an Offender at Risk due to any Substance (MORS)
Pharmacy staff are working closely with the Substance Use Nursing Team to enhance communication within the prison healthcare teams, with a view to identifying and being notified of all patients being managed under MORS. The aim of this work is to ensure that patients being managed on MORS policy are not inadvertently supplied with weeklies/supervised medicines. Early testing has included the use of a MORS folder within Pharmacy where patient scripts are placed following confirmation of the patient being placed on MORS. In addition to this, pharmacy staff will now attend both morning and afternoon patient safety huddles where all patients on MORS will be identified. Baseline data is available from an earlier test of change and this requires to be updated taking into account the subsequent tests of change undertaken.

C Hall Evening Medicines Administration
A test of change is to be commenced looking to improve the issuing of evening medications in C Hall with an aim of reducing nursing administration time and demonstrate if this has any impact on the SPS time off duty. This test will involve 1 nurse and 1 competent witness administering evening medications initially in Flat 3. Patients from Flat 4 will then move to Flat 3 to receive their medication. Medicines will also be administered in Flat 2, with Flat 1 patients moving to Flat 2 on completion. This test of change is expected to reduce the time spent by nurses administering medicines to each flat separately and reduce the movement of nursing staff between each flat.

Issue of Weekly Medicines (completed)
The goal for this improvement work was to achieve 95% compliance with the issuing of weekly medicines, thereby reducing the number of weekly medicines returned to the health centre for PM issue, which caused additional stress and workload for both SPS and NHS staff. Through continued tests of change, this process seen a decrease in the time taken to issue medication from 75 minutes to a median time of 20 minutes, together with process reliability of >95% for morning issue of weekly medicines.

Availability of Prescription Charts (completed)
This was a short term improvement project aiming to ensure the availability of patient prescription charts at GP clinics within the establishment. A number of tests of change were undertaken, leading to 100% compliance with availability of prescription charts compared to 40% availability from baseline data.

Under the Influence Safety Bundle Checklist
The overall aim of this work is to improve the recognition, assessment and review of patients who present as under the influence, through a consistent approach by NHS and SPS staff. The goal is for 95% of patients who have been identified as 'under the influence' to have been managed appropriately using a safety bundle checklist. This bundle contains a comprehensive list of expected actions to be undertaken following the identification of a patient being at risk due to substances, including triage, assessment, patient review and MDT review. This bundle has been tested on a couple of occasions to date and refinements have been made to the checklist as appropriate. Since the last changes were made, there have been no patients under the influence to test the bundle on (as at end of October). A data collection toolkit has been developed to allow teams to track progress with the outcomes of this work.

Management of Acute Illness
The aim of this work is to improve the management of acute illness to ensure that patients who require to see a GP urgently are triaged in a timely manner. This involves nurses identifying patients with acute illness during medication rounds. These patients are subsequently seen in the health centre the same morning. Early evaluation indicates that this process is working well. As a next step, data will be collected to evidence the impact this change is making, e.g. % of inappropriate referrals, number of unused appointments which were subsequently used for waiting list patients (thereby reducing wait list time), and increased patient satisfaction/staff satisfaction.

Promoting Timely Patient Safety Assessment to Identify Potential Physical Health Needs
Work had previously been progressed to ensure timely patient assessment to help identify potential physical health needs, through the use of the NHS Tayside Traffic Light Assessment. Currently this is done for each patient on admission to HMP Perth, however, feedback from nursing teams suggest that this process can feel rushed, resulting in a less comprehensive assessments being undertaken. Staff had suggested testing carrying out the assessment during the nurse clinic the day following admission. It was felt that this would allow ample time for each patient assessment to be undertaken, thereby improving patient safety. This test has not been progressed due to limited availability of clinic rooms within the Health Centre. A further suggestion has been put forward to test a joint GP/nurse assessment clinic (day following admission). This will require to be explored further with the GP and nursing staff. Consideration will require to be given to the availability of clinic rooms.

Holistic Approach to Complex Care Delivery
Work was being progressed to improve communication across the multidisciplinary team for patients on enhanced care. This is being progressed through testing a multidisciplinary team meeting, which includes a core group; a GP, nurse in charge and named nurse, with engagement from SPS officers where necessary to ensure joint case management. These meetings have an aim to review all patients requiring enhanced care on the active caseload of the primary care team. This piece of work will rely on the reliable undertaking of the traffic light assessment process and these will be monitored closely together.

Improving Communication between the Health Centre and Patient Population at Castle Huntly
Members of the MDT workstream based at Castle Huntly have been actively working to improve patient experience by enhancing and promoting an environment which actively supports health and wellbeing information to the patient population.

The team sought the views from patients through the use of a patient questionnaire to obtain a baseline on how communication from the health centre is rated, and importantly, to help identify where improvements can be made. Questionnaires were completed, returned and analysed, and improvements have been identified. This includes utilising NHS noticeboards with certain health topics, utilising TV screens within the Links Centre to display healthcare related information, inclusion of NHS Health Centre overview as part of the induction programme (including overview of medication ordering, supply and collection which was highlighted as a concern by patients).

Work continues to progress and links are being formed between the healthcare teams across both establishments to ensuring partnership working.

A key piece of this work is the involvement and collaboration with two prisoners/patients, in taking forward some of the improvements identified.

Reducing Complaints relating to Self-Referrals
Members of the NHS healthcare Team and the Scottish Prison Healthcare have been part of the first cohort of the Tayside Quality Improvement Programme. This seven month programme has been designed to build capacity, capability and confidence for improvement for staff. While the programme acknowledges a variety of improvement approaches and methodologies, it is founded in the Model for Improvement, data for improvement and Lean.

The team have learned a number of key technical skills, including process mapping, root cause analysis, pareto analysis, constructing aims, driver diagrams and project charters.

Each team within the cohort were tasked with identifying a project to work on during their involvement in the programme. The team had set out with an aim of reducing complaints relating to self-referrals and although this not been achieved given the short duration of the programme, the learning that the team have generated has been evidential and they will have no issues with applying the theory and technical skills in their workplace in the future.

Availability of GP Summaries
Exploratory work is in the early stages to ensure that GP summaries are received in a timely periods for patients being admitted to the establishment. HMP Kilmarnock has had good success with this and it is hoped to learn from their processes to replicate this at HMP Perth.

Appointment Booking System (completed)
Tests of change were undertaken to reduce the time taken to process appointments by at least 15% in both Health Centres. In order to achieve this, a test was undertaken to inform patients of their appointments using appointment cards rather than typed letters in Vision. Following three tests of change, there was an overall reduction of 50% in processing time by administration staff. This process has now been fully implemented.

Update provided on behalf of the Prison Healthcare Patient Safety Collaborative
29 October 2018