NHS Board Accounts: 2014-15 questionnaire

NHS Tayside

Service development

1. Please give THREE examples of services that:

   (a) you plan to develop in 2014-15 (territorial boards should list local service developments, rather than national programmes)

Service	Expenditure 2013-14 £000	Planned expenditure 2014-15 £000
Maternity Service – effective change June 13	1100	1046
eRostering – effective implementation April 14	0	160
Nurse to Patient Ratios AMU – implementation April 14	0	1307

Answer to Question 1(a) –

Maternity Services
In January 2013, NHS Tayside began to develop a whole system review of maternity care to ensure delivery of the range of specific healthcare quality initiatives and policies relative to maternity care including:

- Standards of Maternity Care (RCOG 2008)
- Early years Framework (2008)
- Refreshed Framework for Maternity Care in Scotland (2011)
- Reducing Antenatal Health Inequalities (2011)
- Getting it Right for Every Child (GIRFEC) (2012)
- Reducing Sepsis Collaborative (2012)
- Family Nurse Partnerships (2012)
- Early Years Collaborative (2013)
- Maternity Care Quality Improvement Collaborative (2013)

A structural review was carried out to support the implementation of NHS Tayside Developing a Whole System Approach to Improvement in Maternity Care which aims to strengthen the multi-professional team to drive forward the current national initiatives detailed above ensuring that maternity care was person centred, safe and effective.

The structural change included enhancing the existing obstetric consultant workforce by 3.2 W.T.E. and a revised senior midwifery team structure (3 W.T.E. Midwifery Team Managers) and augmenting triage service with an additional 5.5 w.t.e posts and the appointment of a further 4 w.t.e senior midwives to support, co-ordinate and enhance capacity and flow within the different elements of hospital maternity care.

eRostering

NHS Tayside has invested £325k in the Allocate eRostering software package for a contract period of 3 years with option to extend for a further 2 years.

The implementation of an eRostering System will support the organisation by enabling more efficient management and deployment of staff on a prospective basis. It will also contribute to the quality and patient safety agenda through the consistent effective utilisation of substantive staff.

A summary of the specific objectives is as follows:

- Use data from system to inform plans for modernising the workforce and to aid management decision making on a prospective basis;
- Provide managers with more visible information relating to rosters to enable them to challenge and review practice in their area and manage risk. This information will be more visible to managers at the planning stage of rostering prior to any roster being worked and thereby managers have greater control over rostering decisions;
- Quality Improvements can be achieved through consistent effective utilisation of substantive staff;
- Provide a rostering tool to enable nursing & midwifery staff rosters to be developed in a more timely and efficient way which will release time for clinical care;
- Maximise the deployment of staff up to their full contractual working hours and to the shifts required;
- Reduce expenditure on supplementary staff;
- Effective use of information available within an eRostering system, managers can make decisions which will drive efficiencies in the organisation;
- Staff will benefit from the ability to view their roster remotely and to make requests electronically and remotely;
- Equal access for all staff to the requests process;
- Enhanced IT skills across staff groups who traditionally have not accessed IT in the workplace.

Nurse to Patient Ratios

The primary function of AMU is to assess to admit rather than admit to assess, and to treat acutely unwell patients with early intervention (investigation and treatment) ensuring good quality of care at the right time, in the right place by the right people. The philosophy of assessment rather than admission ensures appropriate use of capacity of tertiary care. This apart, Multidisciplinary assessment of patients at the “front door” of the hospital (AMU) helps to keep those patients in the most appropriate/desirable environment and to reduce the total length of stay in hospital.

During 2012 work was completed to revise the bed base and model of care within the two Acute Receiving Units within NHS Tayside (Ninewells and PRI) the revised models were implemented initially with the historical nurse staffing model. Therefore in 2013 in order to ensure that the units had the appropriate registered and unregistered nursing workforce to optimally support sustainable models of safe, effective and person centred care delivery it was considered essential to undertake a nursing workload and workforce planning exercise. To inform this process a review of relevant literature was carried out and the national nursing & midwifery workforce tools including professional judgement were applied.

In recognition of the acuity and volume of patients admitted and discharged over a 24 hour period a staffing model was developed with a plan for phased implemented resulting in a combination of a 1:3 and 1:4 registered nurse:patient ratio with a skill mix of 70% registered nurses and 30% HCSWs, this required the level of investment detailed above

(b) you would like to develop if you had additional funding i.e. what is next on your list of priorities? (territorial boards should list local service developments, rather than national programmes)

Answer to Question 1(b)

If we had additional funding, particularly capital the next local priority would be upgrading our existing Theatre infrastructure on the Ninewells site ensuring our theatres meet the necessary compliance standard.

The Board is currently utilising three temporary theatres from Vanguard on the Ninewells site at a rental cost of £1.5 million per annum. The temporary theatres are assisting with a planned programme maintenance investment to ensure theatres meet minimal Scottish Health Technical Memorandum (SHTM) compliance standards as well as assisting with Treatment Time Guarantee targets.

(c) you plan to withdraw, restrict or reform in 2014-15 (please provide reason(s) and anticipated savings in 2014-15) (territorial boards should list local service developments, rather than national programmes)

Answer to Question 1(c)

The Board has undertaken an extensive consultation exercise that has resulted in a number of service transfers and a number of NHS sites declared as surplus to requirements. Disposal of the sites will see profit on the sale being utilised to repay brokerage received in 12/13 and 13/14 and through reduction in the overall footprint will see a saving on rates, overheads, carbon reduction and security costs as well as a reduction in backlog maintenance costs for former red risk properties identified in the State of the Estate report.

2. During 2014-15, do you plan to consult on the delivery of any specific services i.e. those resulting in significant service change?

During 2014/15 NHS Tayside will be considering significant redesign within medicine for the elderly, psychiatry and maternity services. In addition a surgical commission

is being undertaken which during 2014/15 will offer recommendations on surgical service provision within Tayside.

Perth and Kinross Dementia Strategy for future Dementia Care
The Perth & Kinross Dementia Strategy for future Dementia Care recently tested in the Strathmore Locality focussed on developing Community Based Dementia Services. Early indications through local evaluation are that the move from a ward based Dementia Service in Strathmore to a Community Based Service has reduced admissions to Psychiatry of Old Age (POA) hospitals from home and from care homes and that significantly more patients and carers are now receiving Dementia Care in terms of Post diagnostic support and earlier diagnosis and intervention within their own home environment.

There is an opportunity to further test and spread Community Based Dementia Services within the North Perthshire (Highland) Locality. Being able to inject highly skilled Dementia resource and capacity into the existing North Locality Older People's Mental Health Team will without doubt allow us to deliver quality community based services, such as those recently tested in Strathmore, with similar outcomes and results. There is also an established Integrated Care Team, inclusive of Local Authority and Third Sector, co-located within this Locality. Creating a larger North Perthshire POA Community Mental Health Team (CMHT) will further enhance the capacity and resource of the Integrated Care Team and encourage further generic support working. In light of other current service developments taking place in the North Perthshire Localities there is already an established Community Involvement and Engagement Programme which will allow support early dialogue with the Local Community around the requirement for service redesign and change.

Community Medicine and Rehabilitation Redesign Programme - Angus - Palliative Care and Medicine for Elderly - Day Treatment, End of Life, In-Patient Care
Angus CHP has been working to increase local access to End of Life Care in communities including admission capability and Day Treatment services. Plans include redesign of in-patient area in Whitehills, Forfar to provide Day Treatment via the peripatetic Palliative Care and Medicine for Elderly Teams, and similar for North East Angus in Stracathro Hospital. However the main project we would like to progress is in relation to Arbroath and the provision of two Palliative Care Hospice Suites and Day Treatment facilities for Palliative Care, Oncology, and Medicine for Elderly in Arbroath Infirmary.

This is also a collaboration with Ninewells Oncology Unit to shift the balance of care towards local facilities, thereby improving the experience for local patients in the South Angus area as well as releasing space in Ninewells. This project is entirely in line with Locality modelling as part of Health & Social Care Integration and has good local support

Preventative spending

3. What specific preventative health programmes are included in your budget plans for 2014-15? (please give details of planned NHS board expenditure **over and above any ring-fenced allocations** in 2014-15 compared with 2013-14 within the categories shown)

Programme area	Expenditure 2013-14 £000	Planned expenditure 2014-15 £000
Smoking prevention/cessation		
Weight management (child/adult)		
Childsmile		
Keep Well		
Maternal and infant nutrition		
Blood borne virus prevention		
Immunisation programmes	440	540
Screening programmes		
Sexual health programmes		
Drug and alcohol programmes		
Other (please specify) – Equally Well	100	200

Answer to Question 3

Equally Well
Initially funded by the Scottish Government, the Equally Well test site in Dundee aimed to tackle health inequalities by improving community mental wellbeing. The process involved supporting changes in ways of working across services and piloting a social prescribing scheme in a GP Practice. The external evaluation showed positive results for service providers, patients and the community.

NHS Tayside Endowment Board of Trustees awarded c£204k to the transitional model for health equity, to roll out the Equally Well approach across Dundee for a year and subject to a successful evaluation would be rolled out in five Community Regeneration Areas and the social prescribing scheme was extended to a further three GP practices.

Recurring funding to support equally well across Dundee has been supported by the Board from the Civic Health earmark within the Strategic Financial Plan.

Extended Immunisation Programme
In response to the Joint Committee on Vaccination and Immunisation (JCVI) advice notified to Health Boards in December 2012 NHS Tayside has implemented the relevant new Immunisation Programmes. Costs have been incurred delivering the extended seasonal flu programme, the new Rotavirus immunisations and Shingles programme. Costs met from local resources included delivery of the programme (including some capital investment and one off costs) but not costs of vaccine. Costs for 2013/14 estimated at c£440k and budget for 2014/15 is estimated at £540k.

4. With regard to assessment of preventative spend programmes:

   (a) What savings do you anticipate that these preventative spend programmes will deliver over the next 5-10 years (please provide specific examples)

Answer to Question 4(a)

It is still too early to confidently predict the level of savings arising from the preventative spend programme.

The work being undertaken locally within the Integrated Resource Framework provides a greater understanding of the resource consumption within both Health and Social Care and this should help us achieve the following objectives:-

- The use of IRF as a mechanism to explore and analyse planning and investment for future patterns and profile of care delivery and resource use;
- Examine care pathways, improve equity, improve health and achieve better outcomes at lower cost.

Although no assessment has, as yet, been identified on what this means in financial terms, work is progressing with regards to developing commissioning strategies which, it is hoped, will see the development/enhancement of preventative services which in turn should place less reliance on institutional care (i.e. shift the balance of care). A modelling approach which is soon to be piloted is Programme Budgeting Marginal Analysis and it is hoped that this will enable partners to evaluate current activity against anticipated outcomes, prioritise options and consider areas for investment/disinvestment.

(b) Are the results of any such assessments reflected in your financial planning? (Please give any specific examples of how financial plans have been adjusted to reflect potential savings)

Answer to Question 4(b)

Financial Plan has not been adjusted to reflect potential savings as these cannot be quantified at this stage.

Change Fund/Integration Fund

5. With regard to the Change Funds:

(a) Please give examples of THREE services that will be funded using Change Funds in 2014-15? (please include details of Change Fund spending on these services in 2013-14 and 2014-15 and related outcomes)

Programme	**Expenditure 2013-14 £000**	**Planned expenditure 2014-15 £000**
Angus - Orthopaedic Pathway	20	20
Dundee - Carer Support	111	154
Perth - Perth Royal Infirmary/POA Liaison and Transitional Care	102	175

Answer to Question 5 (a)

Angus - Orthopaedic Pathway
Outcome Measures

- Average Length of Stay (Ninewells);
- Average Total Length of Stay (Ninewells & Stepdown);
- Transfer from Orthopaedic Ward to Angus Rehabilitation Unit;
- Re-admission rate within 28 days of discharge;
- Rate of Admission to Care Home.

Progress on Outcome measures
This patient centred pathway enables patients who have suffered a fracture to regain function as quickly as possible and return home when safe to do so with removal of delays and hand offs. All outcome measures were reviewed, documented and showed improvement after programme implementation**.**

Dundee - Carer Support
Outcome Measures

- Number of Statutory Carers Centres Assessments Completed;
- Increase in the number of carers reporting improved outcomes;
- Increase in the number of carers accessing therapies/activities/support funding;
- More knowledgeable and informed workforce.

Progress on Outcome measures

- There has been an increase in the number of carers assessments offered and accepted. A new carers assessment form which is outcome focussed has been developed, piloted and will be rolled out in early 2014/15;

- All carers receiving a carers assessment have reported improved outcomes. Measures linked to the projects within the carer Support project have shown significant improved outcomes for carers in both health and wellbeing and the ability to cope with the caring role;

- A number of new supports have been introduced including On the Spot Therapies (106 carers), Time for U Respite Care vouchers (35 people registered), all of which have produced positive results. The early intervention service has increased the number people who are carers and 59 carers have received 1:1 support; the majority have reported improved outcomes. 23 carers have received training in moving and handling; challenging behaviour and the changing relationship course. Further research is being undertaken to determining future models of respite care and support;

- Training delivered to a number of key groups including Community Support services and University Student nurse course.

Perth - Perth Royal Infirmary/POA Liaison and Transitional Care
Outcome Measures

- Improved access to POA Services;
- Reduction in patient waiting times;
- Earlier identification of patients in an acute environment with cognitive impairment;
- Timelier, effective discharge for patients;
- Reduction in delayed discharges;

- Improve patient's journey post discharge and reduce readmission rates;
- Improved awareness of dementia and delirium in an acute hospital;
- Improved quality of care for patients with a cognitive impairment.

Progress on Outcome measures

- Enhancement of team with employment of 1.0 WTE Band 7 RMN, 1.0 WTE Band 6 and 0.5 WTE Band 5. Single point of contact established within PRI. Referrals increased by 30%. 40% increase in the number of patients supported through the Psychiatry of Old Age Liaison Service (monthly).
- Majority of patients are seen within one day of referral to service
- Team attend daily ward rounds to identify patients earlier providing assessment, treatment and care and discharge planning support
- Reduction in the average length of stay by 3 days
- Improved discharge planning and co-ordination resulting in reduction in the number of patients experiencing a delay
- Transitional care provided by specialist OT on discharge from hospital resulting in a decrease in the number of readmissions within 28 days. This service has now been enhanced through the employment of 5 Social Care officers to provide short term intervention and support on discharge
- Dementia / Delirium training rolled out to multi disciplinary acute staff. Dementia Care mapping completed in acute wards PRI. Butterfly scheme implemented.
- Positive user and carer feedback. Dementia Care Mapping evidenced benefits of volunteer support on the wellbeing and mood of patients in acute care.

(b) Have these programmes/services been evaluated? (If so, please provide details)

Answer Question 5 (b)

Angus - Orthopaedic Pathway
This test of change has been fully evaluated using patient feedback and relevant data. It is now embedded in NHS Tayside's Steps to Better Health Care programme and NHS Tayside's Acute Older People's Collaborative. This Orthogeriatric model, tested in Angus, is now to be rolled out to cover all patients across Tayside with a similar joint care model to be tested in the surgery department.

Dundee - Carer Support
The programme is reviewed cyclically and outcomes monitored by the Dundee Change Fund Monitoring Group.

Perth - Perth Royal Infirmary/POA Liaison and Transitional Care
The liaison service is evaluated on an annual basis through the Partnerships Change Fund Executive Board. The Transitional Care element of the service has only just commenced on 3 March 2014.

(c) Do you plan to continue to fund these services in 2015-16 through the Integration Fund?

Answer Question 5 (c)

Angus - Orthopaedic Pathway
Yes

Dundee - Carer Support
Yes

Perth - Perth Royal Infirmary/POA Liaison and Transitional Care
Yes

6. Can you give examples of any specific services that you are developing with local authority and/or third sector parties as a result of the planned Integration Fund (please provide details of the service, along with planned investment by each partner)?

Answer to Question 6

All local Partnerships are in the process of reviewing and evaluating their existing Change Fund plans and will consequently review future commitments. At present, it is anticipated that some programmes (e.g. those listed in 5a and a number of other services) may well continue through the new Integration Fund. However the local Partnerships are still awaiting further national guidance regarding the Integration Fund prior to specifically developing services in response to the new Integration Fund.

Reducing inequalities

7. What specific programmes are aimed at reducing inequalities? (please include details of THREE services in the format shown below)

Programme	**Expenditure 2013-14 £000**	**Planned expenditure 2014-15 £000**
Cash for Communities	313	838
Men Only Tayside – Improving HIV Prevention and Sexual health of Men who have Sex with Men(MSM)	156	184
Keep Well	628	748

Answer to Question 7

Cash for Communities
Outcome measures
The Cash for Communities programme was established to fund community inspired initiatives aimed at improving health and wellbeing. Applications from community groups, charities and social enterprises are invited and are assessed for their innovation, foundation, co-production and outcome. The expenditure figures represent committed rather than actual expenditure.

Progress on Outcomes
Each of the projects within Cash for Communities which has been funded from the Board's Endowment Funds is subjected to an evaluation focussed on the objectives set out in the initial bid.

Men Only Tayside
Outcome measures
- Increase in MSM accessing sexual health services;
- Uptake of HIV testing and re-testing;
- Positivity rate amongst those reporting unprotected anal sex in the last 3 months;
- Uptake of hepatitis B (HBV) testing and vaccination.

Progress on outcome measures
- Within one year the numbers of MSM attending Sexual Health Services has increased by 85%;
- 49% of men attending are new to services.
- 35% had no previous HIV testing history;
- High uptake (94%) of HIV/BBV screening;
- High prevalence (4.8%) in tested population;
- High uptake (70%) of HBV vaccination;
- 10 trained volunteers.

Keep Well
Keep Well in Tayside is targeting those aged 40-64 in SIMD Quintile 1 20% (most deprived), as well as the "vulnerable" groups identified as high risk of health inequalities by the Scottish Government; substance misuse (drug and alcohol), gypsy/travellers, prisoners, offenders, homeless, South Asian and Black Afro-Caribbean. Work to support all of these groups has continued in 2013-14 with an increasing resource invested in supporting those in the "vulnerable" groups. All 41 practices asked to support Keep Well in Tayside are now involved, with support to deliver the service in some cases from centralised teams based in each of the 3 CHP's.

As of the end January 2014 c2330 health checks have been delivered against the target of 2500.

The Scottish Government have five indicators Boards report on, focussing on process measures rather than outcomes.

Process Measures
The five high level key indicators within Keep Well are:-
- Number of people who attend appointments expressed as a percentage of the local target;
- Number of first health checks undertaken for carers, expressed as a percentage of the local target;
- Number of those attending for a health check with an ASSIGN risk score >=20%, expressed as a percentage of the first health checks;
- Number who have had at least one new chronic disease problem identified with 3 months of their most recent health check, expressed as a percentage of the total health checks;
- Number of patients referred at, or within 3 months, of attending their latest health check;

A range of complimentary evaluations have taken place or are currently being progressed, for example patient and staff experience supporting those in the "vulnerable" groups, self reported change for those seen for a repeat health check after 5 years, and assessment of change from those attending five year review from clinical data.

There is strong evidence that Keep Well is reaching people who would not have been seen otherwise and likely to be the 'unworried unwell.' Around 80% of those attending for health checks live in the 20% most deprived areas according to SIMD. Other non-geographically based groups are being targeted and have engaged e.g. offenders in prison and in the community, ethnic groups considered to be at high risk of cardiovascular disease, people who misuse substances and people who are homeless.

Progress on Process measures

- 9 out of 10 people having a health check had a risk factor that required clinical support or a lifestyle change
- 32.3% of the Keep well cohort had been recorded, for the first time, as having at least one of the following: Smoker, Cholesterol greater than 6mmol/l, BMI greater than 30, Positive FAST score, Hypertension, Global CVD risk score greater than 20%.
- Statin prescribing increased from 68.8 prescriptions/100 people/6 months to 177.2 prescriptions/100 people/6 months in those who attended a health check. In those who had not attended, statin prescribing increased from 53.9 prescriptions/100 people/6 months to 86.7 prescriptions/100 people/6 months over the same 2 year period
- Average blood pressure decreased among attendees against no change in non-attendees; those with higher blood pressure showed greater reductions
- Average total cholesterol:HDL ratio decreased in those who had a health check and increased among those who had not had a health check
- In the Tayside Keep Well cohort taking part in the Counterweight programme, the proportion of people having lost 5% weight is higher than indicated in the published data, suggesting better outcomes and greater economic benefits

An ongoing survey of people at five year review (a second health check) has revealed that, while 8% had accessed support from services to make lifestyle changes, 59% had made changes without support from services. 31% felt that these changes had improved their health. This highlights the information that is lost when tracking of people is not possible and that people make changes on their own after their health checks.

While we cannot demonstrate an unequivocal causal relationship, the data for Dundee City, which was in Wave 1 of Keep Well, shows the following trends:

- Despite some fluctuations, for premature mortality from CHD, the absolute inequality gap between the most deprived and least deprived quintiles of deprivation for Tayside and Dundee City has narrowed
- The gap in Dundee City had narrowed by 36.9% pre-Keep Well but has narrowed by 61.6% in the five years since the start of Keep Well
- The absolute inequality gap in the age standardised rate of CHD hospital discharges for those aged under 75 years for Tayside and Dundee City has narrowed post-Keep Well

Trends for cerebrovascular disease mortality and morbidity are less pronounced, partly due to small number fluctuation. Nevertheless, the absolute inequality gap has narrowed between the most and least deprived quintiles over the Keep Well period.

Backlog maintenance

8. Please provide details of the THREE main actions in 2014-15 that will address backlog maintenance, providing:

The main actions that are planned to address backlog maintenance are direct expenditure on identified items with a specific focus on infrastructure, avoidance of expenditure by vacating and disposing of properties and addressing backlog issues where refurbishing projects are carried out.

(a) details of the action (investment/disposal etc.);

Answer to Question 8 (a)

(a) The Board plans to dispose of some 16 properties in 2014/15. These are either vacant or soon to be vacated properties. The significant properties comprise former mental health and community hospitals that have since been re-provided (Liff, Sunnyside, Ashludie, Irvine Memorial). Other properties include back office facilities where efficiencies in utilisation are being realised through re-positioning, mobile working and hot-desking in line with the Smarter Office initiative.

(b) planned expenditure/receipts from this action in 2014-15; and

Answer to Question 8 (b)

(b) Disposal receipts are anticipated to be around £8.5min 2014/15 of which £5m is the net book value of the properties. The actual receipts achieved will depend on market conditions. The Board capital plan topslices a capital budget of £1.4m for direct expenditure on backlog maintenance. In addition there are several major refurbishment projects planned that will also address in part backlog maintenance issues amounting to an estimated £4.6m. Therefore the total estimated spend on backlog maintenance is anticipated to be around £6m for 2014/15.

(c) the impact this will have on your overall level of backlog maintenance (high/medium/low risk)

Answer to Question 8 (c)

(c) In total the backlog maintenance avoided provided all projects and disposals are achieved will be around £6.4m in respect of 2014/15. In addition continued revenue spend of some £0.6m per annum will be avoided on disposed properties, which includes rates, repairs and other costs.

(d) what proportion does your planned spending on backlog maintenance in 2014-15 represent of your total capital budget?

Answer to Question 8 (d)

(d) The total backlog maintenance spend of £6m in 2014/15 represents 29% of the Board's net Capital Resource Limit.

Brokerage

9. (a) Did you have any brokerage in 2013-14?

Answer to Question 9 (a)

The Board received brokerage of £2.25 million in 2013/13 due to a delay in the sale of a major asset and down to lack of interest from building companies.

The Board repaid £0.25 million in 2013/14 with the balance of £2 million to be repaid in 2014/15 on completion of the missives by the successful developer.

The Board has received further brokerage of £2.85 million on the strength of planning delays around four major hospital sites that have already been declared as surplus and all services having being transferred to modern, fit for purpose accommodation.

Further brokerage was not anticipated at the start of 2013/14 but it became clear around October 2013 and discussions were held with SGHSCD colleagues. The brokerage will be repaid in 2014/15 £2.05 million and the balance of £0.8 million in 2015/16.

(b) If YES, was this brokerage anticipated at the start of the accounting period or did the requirement emerge during the year?

Answer to Question 9 (b)

Not applicable

10. (a) Do you anticipate the need for any brokerage in 2014-15?

(b) If YES, how much would you anticipate requiring and for what purpose?

Answer to Question 10

No further brokerage anticipated in 2014/15.

NRAC formula

11. What are your views on progress towards achieving NRAC parity?

Answer to Question 11

Board is adjudged to be c£9 million above parity and as such receives no additional uplift in respect of NRAC.

The Board is not anticipating NRAC monies during the five years of the Strategic Financial Plan.

Equalities

12. Please provide up to THREE specific examples of how the use of an equality and diversity impact assessment has influenced budget decisions.

Answer to Question 12

Smoking Cessation
The NHS Tayside Smoking Policy included an EQIA which has been through the Workforce and Governance Committee.

Sexual Health/BBV
The needs of specific at risk populations, has been the driving determinant in the way in which investment in sexual health and Blood Borne Virus (BBV) has been progressively realigned in recent years. Poor sexual health and BBV is strongly associated with deprivation and also disproportionately affects specific groups within the population, most notably Men who have Sex with Men (MSM), vulnerable young people, people who inject drugs, and certain minority ethnic groups. Needs assessment was undertaken, which included a review of the evidence base and, where available health economic data, as well as engagement with the respective populations, to provide a sound basis on which to inform local service planning and investment decisions. This resulted in a shift in investment not only towards early intervention and asset-based approaches but to greater targeting and investment for those populations in greatest need. Examples of this include:

- social marketing campaign to encourage uptake of testing, vaccination and reduce stigma; commissioning outreach health promotion/behaviour change and peer-led educational interventions for MSM and the creation of dedicated community and specialist sexual health and HIV clinical service for MSM;
- extensive outreach BBV testing in at risk populations, including Hepatitis C testing in mosques to reach people of Pakistani origin;
- investment in a catch up campaign and a programme to increase uptake Hepatitis B vaccination;
- creation of dedicated sexual health clinics for young people and people with learning disabilities and a sexual health screening and contraception clinic in drug treatment services;
- creation of dedicated online resources for MSM and the development of an app for young people;
- the Healthy Community Collaborative working with communities where teenage pregnancy is highest to develop shared solutions has led to small scale investment support for community-led interventions and in social enterprises;
- investment in evidence based parenting programmes, with a focus on working with kinship carers and parents of children with learning disabilities; and
- investment support for the Family Nurse Partnership.

Men Only Tayside
Men who have Sex with Men (MSM) continue to be at high risk of acquiring HIV, hepatitis B and other serious Sexually Transmitted Infections (STIs) and make up the largest proportion of individuals diagnosed and living with HIV.

An estimated 5-7% of the population are MSM. In contrast to other areas of Scotland, especially the cities of the central belt, there has been very limited service provision for MSM in Tayside and no dedicated MSM or men only clinic within the Sexual and Reproductive Health Service.

In recognition of the limited understanding of the local MSM population health needs, the Sexual Health and BBV MCN commissioned a needs assessment to inform future planning, investment and service delivery. The needs assessment included a stratified examination of population need, a review of evidence-based interventions as well as the effectiveness of existing service provision, Plans were developed in conjunction with local men to establish a new joint NHS and third sector service: Men Only Tayside – MOT, which aims to address both prevention and treatment and care. Additional resources were identified through virement within the Effective Prevention bundle.

Sustainable development

13. Please provide up to THREE specific examples of how the NHSScotland sustainable development strategy has influenced budget decisions.

Answer to Question 13

There are several examples of projects that have been influenced by the NHSScotland sustainable development strategy, and many come under the remit and actions required to comply with the principals of the Good Corporate Citizenship Model such as Buildings, Travel, Procurement, Facilities Management both Hard and Soft and Community Engagement and are reflected within the PAMS document:

Carbon Reduction and Efficiency:
Specific funding is available for a number of projects that will reduce carbon emissions. These include voltage optimisation, biomass boilers and conversion to LED lighting. In addition the Board is exploring the re-provision of heating and power plant along with associated infrastructure through the Carbon Efficiency Fund. All new projects have an objective to achieve BREAAM excellent status to ensure maximum sustainability.

Space Utilisation:
The Board is achieving reduction in space usage through increased utilisation through the Smarter Office initiative, allowing property to be vacated and disposed and enhanced utilisation of the facilities that remain.

Community Engagement:
NHS Tayside actively supports and engages to ensure communities are considered as part of the day to day service process. A recent example was the joint arrangement between NHS Tayside and Dovetail as part of the Supported Business initiative for the supply and installation of fire doors across Tayside.