National Services Division

Service agreement with:
NHS Tayside

For:
Advanced Interventions Service

2017-2018

1. Introduction

This agreement is between National Services Division (NSD), NHS National Services Scotland, as commissioner, for and on behalf of the Scottish Government, and NHS Tayside as provider of a service of the Advanced Interventions Service as identified below.

This agreement shall cover the period from 1 April 2017 to 31 March 2018.

The agreement is made under the provisions of Section 17A of the NHS (Scotland) Act 1978.

2. Objective

To provide a comprehensive service for patients with severe, chronic, treatment-refractory depression (TRD) and obsessive-compulsive disorder (OCD) who are residents of Scotland, including:

- Onward referrals for ablative neurosurgery (most commonly, Anterior Cingulotomy);
- specialist intensive psychological therapies for Obsessive-Compulsive Disorder at a national level in Scotland.

3. Definition of service

3.1 Service specification – General

The entry point for this service is:

- acceptance into the programme for assessment

The exit point is:

- discharge to local clinical teams after review of the outcome of neurosurgical interventions, or on completion of an intensive treatment programme for OCD

The service covers the assessment and treatment for severe and chronic treatment-refractory depression (TRD) and obsessive-compulsive disorder (OCD) including:

- comprehensive review of patient case notes;
- diagnostic psychiatric assessments;
- review of previous psychological treatments;
- advice to patients on future management strategies;
- ongoing treatment recommendations to referring Consultant Psychiatrists;
- suitability for ablative neurosurgery;

- intensive psychological therapies (in combination with pharmacotherapy) for obsessive-compulsive disorder for patients who have failed to respond to other treatments in secondary care mental health services.

Following acceptance of referral, the multidisciplinary team will undertake assessments comprising: detailed review of the patient's relevant case notes; extensive diagnostic psychiatric assessments; and the review of previous psychological therapies received by the patient.

During the assessment period the full implications of future management strategies, including any psychological therapies, drug treatments or neurosurgical interventions (where applicable) will be explained to the patient (including their family and/ or carers, where appropriate) prior to the offer of treatment.

All patients referred for ablative neurosurgery (at University College London Hospitals NHS Foundation Trust) will be reviewed by the Mental Welfare Commission (MWC) for Scotland in accordance with the requirements of the Mental Health (Care and Treatment) (Scotland) Act 2003. In England, the Mental Health Act (England and Wales) 1983 (part IV – section 57) applies and a referral to the Care Quality Commission will be required.

Links with the referring clinical team and the patient's GP will be developed to monitor the patients' progress prior to, and following intervention, and to deliver collaboratively a post-treatment clinical management plan.

The service will ensure that effective discharge planning arrangements are in place for patients undergoing either neurosurgery or intensive OCD treatment. Where appropriate, 'shared-care' models of treatment will be established, with collaboration between primary care, secondary care mental health services, and the patient and carers. Communication with GPs and referring clinicians will be continuous.

The team will issue post-intervention patient management recommendations to referring clinicians and will provide advice to the local services in delivering relevant treatment recommendations.

All patients proceeding to neurosurgical treatment will be subject to comprehensive clinical review at 12, 24 and 60 months post-surgery. Where clinically-indicated (and/ or requested by referring teams), patients may be reviewed in the interim.

Any major change in the way the service is to be provided must be discussed and agreed with the commissioner before implementation. Where changes to the senior clinical team are envisaged, the commissioner must be informed of the succession plan to be operated.

3.2 Intensive treatment programmes for OCD

Typical components of the intensive treatment pathway for OCD may include:

- Consultation-liaison with referring clinicians and teams;
- Provision of specialist training for psychological therapies for patients with OCD for teams who are delivering treatment for patients referred to the service. Training will be considered on a case-by-case basis;
- Supervision and support for teams delivering complex, multi-modal interventions for chronic, severe OCD;
- Intensive (and often inpatient) treatment programmes for individuals with OCD.

3.3 Staff and facilities

The provider will employ appropriately trained, qualified and where relevant, registered staff and ensure that such staff are enabled to develop skills and expertise relevant to the service.

All staff must be subject to the local occupational health policy which adheres to best practice.

Provision of clinical facilities, including operating theatres, at the time needed to deliver the service, is essential. The theatres will be provided with appropriate, agreed levels of staff with the required expertise and the necessary specialist equipment and other facilities.

Provision, at the time needed, for post-operative care of patients in medical and/or psychiatric intensive care beds/ high dependency beds with adequate levels of skilled nursing staff in collaboration with surgical, medical and mental health staff. These services will be accessible 24 hours a day, 365 days per annum, for the duration of the service agreement.

Patients receiving intensive treatment for OCD will have access to inpatient mental health facilities which are available 24 hours a day, 365 days a year.

The provider must adhere to the principles of HDL(2004)09 ‘Management of Intellectual Property in the NHS’ to ensure that there is effective management of Intellectual Property Rights which come into existence during the course of the performance of the Provider, with effect from the date of their creation.

3.4 Accommodation

The hospital environment will be clinically appropriate for the delivery of the interventions delivered by the service; attractive and clean, creating an atmosphere which is calm and welcoming to patients.

4. Activity levels

The agreed indicative annual level of activity for this service is:

Assessments	24
Follow-up visits	12
Intensive treatment programmes for OCD	4-6*
Referrals for ablative neurosurgery	3-5^^

* Number (and length) of programme will be dependent on individual need, and will be determined on a case-by-case basis.

^^All referrals for neurosurgery must be notified to NSD in a timely manner (post CQC approval).

The provider should advise the commissioner if it becomes apparent that activity targets cannot be met or will be exceeded.

5. Entry and Exit to the National Service

5.1 Referral

The service will only consider referrals from Consultant Psychiatrists, or from Psychiatrists where: an identified Consultant Psychiatrist is responsible for the care of the patient; has consented to the referral; and is in agreement to providing ongoing care following neurosurgery or other treatment.

Referrals are accepted on the understanding that the referring consultant retains overall clinical responsibility for the ongoing care of the patient, including the implementation of any treatment recommendations made by the service.

There will be tight referral criteria in place, including advice to referring clinicians on which other forms of treatment or medical therapy should have been pursued prior to assessment.

Referrals may be accepted from other parts of the UK, assuming that this does not disadvantage the service being offered to NHS Scotland. It is expected that most psychiatrists referring from other parts of the UK will be practising in specialist tertiary units or networks, or will have sought the expertise and advice of tertiary services prior to referral to the AIS. The provider should highlight UK activity levels in the service's reporting to the

Commissioner. The costs of assessment and treatment fulfilling the national service definition will be funded through this agreement.

Referred patients will be assessed by a Consultant of appropriate experience. The resultant opinion regarding clinical management will be provided promptly to the referring clinical team.

Recommendation 11.3.1 in the Report[1] sets out that the national service needs to continue to proactively communicate and engage with the clinical community in Scotland to ensure that it is appropriately meeting the true Scottish need for the service through distributing the service's referral criteria on an annual basis to the wider psychiatric community to support an increase in the referral rate into the service.

With regards to the intensive treatment pathway for OCD, suitable patients will typically have failed to respond to interventions within Steps 4 and 5 (Multidisciplinary care in primary or secondary care/ Multidisciplinary care with expertise in OCD/BDD) of the NICE guidelines (2006) for OCD (CG031). The target group will be: "*OCD…with significant comorbidity, or more severely impaired functioning and/or treatment resistance, partial response or relapse.*"

The specialist service, as funded, will be providing treatment within Step 6, as described by NICE: "*Inpatient care or intensive treatment programmes.*"

The service will not routinely offer specialist treatment for BDD (where this is the primary disorder), but will assess patients for their suitability for specialist treatment in units with expertise in the management of BDD. Advice on management (and onward referral) will be provided to the referring clinician.

5.2 Exit

The management of chronic, severe mental illness is complex and requires multi-disciplinary input. The Service will work with local and surgical providers so that efficient and patient-centred transfer of care is achieved, and that there is a clinically appropriate care plan in place. Usually, this can be best achieved by the AIS working closely with referring services, and UCL surgical services,for a short period of time. In some cases it is beneficial if members of a patient's local team can visit Dundee to work with the AIS prior to a patient's discharge.

Patients will exit the intensive treatment pathway for OCD when: a) they have completed the predetermined course of specialist treatment; and/ or b) when they no longer fulfil the descriptors for Step 6 treatments, as defined by NICE (2006). At the time of discharge, further treatment options will be discussed with the patient and referring clinician.

[1] Review of the Advanced Interventions Service, National Services Division (September 2011)

6. Quality

6.1 Statutory guidance

The provider will be expected to comply with all relevant guidance, legislation and statutory instruments. These must include, but are not limited to:

- Health & Safety Executive requirements
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Equality Act (2010)
- the EC Working Times Directive
- Modernising Medical Careers
- the recommendations of the Glennie Report
- Data Protection Act 1998
- Freedom of Information (Scotland) Act 2002

The Chief Executive of NHS Tayside is responsible for ensuring that all appropriate policies and procedures in relation to healthcare associated infection are in place.

6.2 NHS Tayside

Baseline quality standards, performance targets and indicators established by NHS Tayside will also be applied to the NSD service agreement. These will include:

- Building effective alliances to improve health: formal links should be nurtured to support the further benchmarking between the Advanced Interventions Service, the English OCD networks; and the two other services providing neurosurgery for mental disorder: the University Hospital of Wales, and Frenchay Hospital, Bristol. Where possible National Services Division should work in partnership with the service to support this work. The service should continue to: report extensively on service outcomes; develop the evidence-base by contributing to the worldwide literature; and develop systems to assist with international benchmarking.
- Increasing value-for-money by improving efficiency and effectiveness
- Delivering a person-centred service by providing patients and/or their carers the opportunity to influence planning and decision making and by ensuring that they receive services responsive to their needs
- Improving quality through the development and implementation of clinical care protocols, systematic monitoring of outcomes, and ensuring that strategies for research and audit are in place.

The following additional standards should be applied:

Waiting times

- The provider will work to minimise patient waits, and to ensure that it follows the principles of the Scottish Government's 18 weeks Referral to Treatment standard to ensure that patient waits are within national Scottish waiting time guarantees for outpatient appointments, diagnostic tests and inpatient admissions.[2]
- Where patients are referred from non-Scottish NHS organisations, all efforts will be made to see patients as soon as possible. However, since external funding is required for non-Scottish patients, there may be additional delays outwith the control of the Service or Provider.

General

- The service should have a caseload which should meet at least the minimum required necessary to ensure the provision and maintenance of appropriate diagnostic and therapeutic expertise
- Patients and their relatives or other carers will be treated with courtesy, professionalism and respect.
- Services should be provided irrespective of gender, race, religion, culture, or sexuality.

Discharge procedures

- There should be communication at an early stage with the NHS Board of residence and other appropriate agencies where patients are likely to require significant ongoing support on discharge.
- Discharge arrangements will be reviewed continually for their clinical appropriateness.
- Protocols for integrated care post-discharge will be shared with all professionals involved in the care of the individual.

Feedback from patients

- The provider will maintain effective arrangements for seeking and monitoring patient feedback during and after episodes of care.
- Regular surveys of patients' views and those of their relatives and other carers should be made in order to assess their perceptions of the quality of service provided.
- Summaries of these assessments and other quality audits should be made available to the commissioner and to the public.

[2] The 'clock start' for neurosurgical intervention commences from date of receipt of written confirmation of MWC authorisation (issue of certificate T1).

Patient information

- Patients (or, if more appropriate, their carers) will have access to all information on their condition, the treatments or investigations to be provided and their ongoing care plan.
- Electronic information, including websites, must meet the recommendations for accessible communication set out in *Achieving Fair Access* [NHS Scotland and Disability Rights Commission, Apr 2007].
- General patient information should be available in a written format and/or in a format that takes account of physical, cultural, educational and mental health needs; however, person-specific communication will also be provided verbally by the relevant health care professional. It should, as a minimum, cover the following subject areas:
  - → diagnostic procedures
  - → treatment options and choices
  - → follow up care
  - → support and information services available at both local and national level
  - → practical arrangements
  - → the team who will provide their care.

Infection control

- An infection control policy which is regularly audited must be in place.

Health promotion and education

- The provider unit will incorporate health promotion and patient education into its daily activities. Particular attention should be given to appropriate advice to patients and carers, staff development, and to the evaluation of patient education prior to discharge.

6.3 National Services Division

The provider will use the quality dimensions, closely aligned with the NHS Scotland Healthcare Quality Strategy, to evaluate and report the quality of their service.

Quality dimension	Description
Safe	Avoiding injuries to patients from care that is intended to help them
Effective	Providing services based on scientific knowledge
Efficient	Avoiding waste, including waste of equipment, supplies, ideas, and energy
Equitable	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status

Timely	Reducing waits and sometimes harmful delays for both those who receive care and those who give care
Person – centred	Providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions

6.4 Audit and development of performance indicators

The provider will ensure and demonstrate the high quality of service and constantly seek improvement demonstrating this through systematic clinical audit.

Multidisciplinary quality assurance and audit processes will be in place. Aspects of care will be reviewed, deficiencies identified and corrective action put in place as part of a continuous rolling programme. These will be reported in the annual report.

Results of specific audit measures should include:

- An outline of the audit programme applicable to this service agreement;
- aggregated and anonymised data reporting clinical activity and outcomes;
- deaths related to clinical care;
- complications and critical incidents (to include significant events including any unplanned subsequent surgery);
- clinical complaints relating to all aspects of the service;
- anonymised summaries of regular clinical audit meetings including: the frequency of meetings; disciplines attending; clinical complaints; deaths and complications, and the changes recommended to improve clinical care;
- hospital acquired infections;
- patients referred but not considered appropriate for treatment (including reasons for non-acceptance);

The aim of applying outcome measures within the service agreement is to provide a proxy for the impact of intervention and will look at measures which cover all areas of care. The provider will measure specific areas of process and outcome as detailed in Annexes. These will be monitored on an ongoing basis by the commissioner who will reserve the right to question the result to anticipate changes to be effected from these results. The provider is also encouraged to develop other outcome indicators as appropriate.

This will include:

Referral

- Number of patients assessed
- NHS Board (or NHS Trust) of referrals
- A measure of the age of patients at referral (taking into account the need to maintain confidentiality)
- No. of follow-up patients
- No of patients referred and accepted for treatment

Treatment

- Length of in-patient stay
- Treatment type – list and numbers
- No. of patients undertaking the intensive OCD programme, along with lengths of stay.

Outcome(s)

- For neurosurgery, key outcomes will include changes in the severity of depressive and/ or OCD symptoms using relevant scales at 1, 2 and 5 year follow-up, for instance:
  - Hamilton Rating Scale of Depression (HRSD-17)
  - Montgomery-Åsberg Depression Rating Scale (MADRS)
  - Yale-Brown Obsessive Compulsive Disorder Scale (Y-BOCS)
- For intensive treatment programmes for OCD, key outcomes will be change in symptom burden measured using the Y-BOCS
- Mortality
- Quality of life assessments
- Numbers of patients going on to have further treatment within the Service.

Discharge

- Number of patients returned to referring team
- Follow up after discharge

Clinical audit will provide a basis for agreeing and establishing appropriate performance indicators for future service agreements.

The provider will collect information on the following:

- length of stay (ITU, HDU, Neurosurgical/surgical, Psychiatric ward)
- morbidity

Service specific

During the agreement period the provider will undertake to:

- Benchmark outcomes with similar units across the world, wherever possible;
- review patient information and supporting literature to ensure it is up-to-date.

Where possible, the commissioner will also monitor data on mortality at one month, one year and five years following surgery as available.

The provider will participate in UK and, where appropriate, international audit, and make available to the commissioner comparative information on results achieved.

The results of any studies undertaken during the agreement period should be shared with NSD as they become available. The objective of these studies is to improve the quality and effectiveness of the service.

6.5 Clinical governance

The Chief Executive of NHS Tayside will be accountable for the quality of the clinical service provided. NSD as the commissioner expects that robust mechanisms will be put in place to support clinical governance. Exception reports to the NHS Tayside clinical governance committee should also be provided to NSD.

7. Confidentiality

The provider will comply with the provisions of the Caldicott Report. In particular, patient-identifiable information will only be used in clearly-defined and monitored circumstances; only when absolutely necessary and should entail the use of the minimum necessary patient-identifiable information.

Access to patient-identifiable information will be on a strict need to know basis. Everyone in the organisation will be aware of their responsibilities with respect to patient confidentiality and the organisation will ensure that its use of patient-identifiable information is lawful.

NSD does not require returns to include patient-identifiable information; information on clinical activity required by NSD must be submitted in anonymised format.

8. Teaching and research

Within NHS Tayside, there are active programmes of teaching, research and development with both academic and NHS staff collaborating in these fields.

The provider will aim to continue this commitment to teaching and research in health-related areas in the future, although this remains outwith the funded value of this agreement.

The Review Report also sets out that the service indicated the desire to more proactively communicate with the UK Psychiatric Community by placing low-cost advertisements in the British Journal of Psychiatry and assessing its impact.

9. Financial arrangements

9.1 Agreement structure

This agreement takes the form of a cost and volume agreement under which the provider will be entitled to review a fixed sum, together with an amount on the actual activity achieved. Where it has been agreed that neurosurgery is necessary, pre-authorisation will be obtained from NSD.

9.2 Funded value of agreement

The indicative funded value of this agreement is agreed as:

£567,973

A full breakdown of this figure is available at Annex D.

9.3 Payment procedure

The agreement sum will be paid monthly in 12 instalments on or around the 15th day of the month. The month 12 payment will bring funding in line with agreed levels. Ablative surgery invoices will be paid by NSD – the patient initials, home Health Board, and date of surgical procedure will be notified in advance to NSD, by AIS, and an NSD authorisation code can then be issued to the supplier (normally UCL Hospital, London).

9.4 Basis of funding

The baseline value of the agreement shown above is based on expected price levels for 2015/16. This value will be reviewed throughout the agreement, with the intention of reconciling expenditure and funding, wherever possible.

Negotiations should, in normal circumstances, only be re-opened where it is apparent that the longer-term trends in service delivery differ significantly from the current plan. The commissioner does, however, reserve the right to re-open formal negotiations with the provider at any point during the term of the agreement if there are material changes in activity and/or expenditure.

(For the purpose of this agreement, material variations in activity and expenditure will be assumed as +/-10%, although breaching this threshold will not automatically trigger a re-opening of negotiations.)

Following receipt of the 9-month statement (see Annex B), the commissioner and provider will meet to agree a final funded value.

The value may also be increased if the commissioner receives additional funding in respect of:

- national pay awards and/or policy
- other statutory changes.

The value may be reduced if the provider is likely to be unable to achieve the indicative activity levels

9.5 Cost shifting and cross-subsidisation

The provider shall not take action to shift activity or costs to other budgets or to make agreements with other commissioners or providers without prior consent in writing from NSD.

The staff and facilities covered by the baseline funding of this agreement should not be used to cross-subsidise local services.

9.6 Capital equipment

NSD receives a nominal capital allocation for equipment for specialised services. This does not cover buildings or infrastructure. NHS Tayside will therefore ensure that the service has a planned programme for the maintenance of the buildings and facilities.

Items of minor capital (under £5,000 including VAT, where appropriate) are considered revenue funding. All minor capital purchases not explicitly included in the indicative baseline should be agreed with the commissioner. Additional funding may be made available for this purpose.

9.7 Charging for other UK residents

Assuming that there is no diminution in the service made available to Scottish residents, UK residents may be treated under this agreement and their activity should be allocated against this agreement and a sum equivalent to the value of that income will be removed from the baseline funding provided by NSD.

The provider will ensure that all non-Scottish residents are charged at full cost-per-case rates, including fixed costs.

9.8 Other international patients

Treatment of EEA residents through reciprocal health arrangements is the responsibility of the host NHS Board and, as such, is excluded from the baseline of all national agreements. [Note: this includes the Republic of

Ireland and the Isle of Man, for whom NHS Tayside must make funding available.]

Anyone not covered by reciprocal health care agreements is considered a private patient and must provide / be able to provide proof of funding (either personal or from their own health system) before any referrals can be accepted. Again, these patients should be treated within the national service and the costs of their care reflected as income against the NSD-funded baseline.

In all cases, neurosurgical intervention will only be provided where it is considered appropriate to do so, and where post-operative arrangements are in place to ensure that there is adequate follow-up for the patient. It would be expected that a consultant psychiatrist (or equivalent) is able to provide ongoing care for the patient, and that they are in agreement with the referral to the service.

10. Performance monitoring

10.1 Information returns

The provider is responsible for the provision of information to the commissioner and for validity, accuracy and timeliness of all returns and data.

10.2 Right to visit

NSD retains the right to visit the unit at the provider's convenience and welcomes the opportunity for communication throughout the year.

10.3 Reporting timetable

The provider will supply the following reports on the progress of the service agreement:

Report	Date due	Format for report
Six month report	31 October	Annex A
Nine month report	31 January	Annex B
Annual report	31 May	Annex C

Reports should be emailed to NSS.nsd-reports@nhs.net)

It is the provider's responsibility to ensure that all reports are received within the agreed timescales. Failure to submit reports on time may impact on NSD's ability to reconcile funding to expenditure. Emailed reports must be sent to the address above and not to individual NSD staff.

10.4 Annual review

The service will be reviewed each year in late autumn following receipt of the previous year's annual report, the extent of the review depending on local circumstances.

NSD will assess the service's ability to achieve indicative activity levels. The review will consider variations required to the service agreement and agreement will be reached on any necessary adjustments to the final agreed activity levels and funded value of the agreement.

11. Variations to the agreement

11.1 Variations and notification times

Variations to the agreement will only be made at the annual performance review unless there are exceptional reasons for deviating from this procedure.

Either party will give:

- six months' notice of any proposed changes to the service which require a reduction in staffing;
- two months' notice of any other material changes.

Variations without notice will be considered in the event of unforeseen circumstances such as:

- the occurrence of a major incident;
- emergency treatment needs;
- a major outbreak of illness or infection;
- industrial action.

11.2 Sub-contracting

No sub-contracting shall be undertaken without the prior agreement in writing of NSD.

12. Resolution of disputes

The commissioner and the provider both resolve wherever possible to settle any disputes or disagreements in relation to this service agreement by negotiation.

In the unlikely event that these negotiations fail, the formal Disputes Procedure as detailed in NHS Circulars FIN (CON) (1992) 1 and FIN (CON) (1993) 4 will apply.

13. Distribution

A copy of this service agreement is to be held by the Service Director.

For and on behalf of The Scottish Government	**For and on behalf of NHS Tayside**
Signature …………………………………	Signature …………………………………
Block Capitals ………………………………	Block Capitals ………………………………
Designation ………………………………	Designation ………………………………
National Services Division	**NHS Tayside**
Date …………………………………	Date …………………………………

Signature ……………………………

Block Capitals ……………………………

Lead Clinician

Date …………………………………

Annex A

Provider: **NHS Tayside**

Service: **Advanced Interventions**

Report format: **Six month report**

1. Report of actual against planned activity:

Information on referrals and admissions for surgery/treatment must be broken down by NHS Board of residence.

	actual	*planned*
Assessments	xxx	xxx
Referrals for Ablative neurosurgery	xxx	N/A
Follow-up	xxx	xxx
Intensive treatment programmes for OCD		

Comment on significant variances from activity

In addition, the provider should include detail on:

- NHS Board of residence (or other UK region) for all referrals and surgical patients
- length of stay (Psychiatric ward, ITU, HDU, Neurosurgical/surgical ward)

2. Clinical outcomes

Provide detail on clinical outcomes, risks and clinical governance over the reporting period, including information on:

- clinical adverse events
- hospital acquired infections
- wound infections
- re-admission to ITU and/or HDU within inpatient stay
- second and subsequent procedures during the same inpatient stay
- all deaths within 30 days of intervention and all hospital deaths related to this service irrespective of the timing.

3. Notification of anticipated problems.

Identify any issues in relation to **<u>any</u>** of the following areas which may be impacting on the performance of the service:

Resources; Workforce; KPIs; Waiting Times; Response Times; Audits; Clinical Outcomes; Risks; Clinical Governance issues; and Adverse Events, etc.

4. Potential developments in future years with financial implications.

Service to indicate developments with potential financial implications for future years.

5. Financial report (as below):

This section should detail expenditure to date against funded value and explain any significant variances from planned including year end financial outturn.

	Agreement value to 30 September	*Actual expenditure to 30 September*	*Projected outturn to 31 March*
Costs as per Annex D			
Total			

Annex B

Provider: **NHS Tayside**

Service: **Advanced Interventions**

Report format: **Nine month report**

Financial projections

	Agreement value to 31 December	***Actual expenditure to 31 December***	***Projected outturn to 31 March***
Costs as per Annex D			
Total			

Comment on any material variances from planned expenditure

Forward year baseline

	Current NSD funded value	***Proposed baseline***	***Variance***
Costs as per Annex D			
Total			

All variances must be fully explained.
Developments not previously agreed with NSD must be supported by a full business case.

NB *Developments highlighted at this late stage will not normally be considered for funding from 1 April of the following year*

Annex C

Provider: NHS Tayside

Service: Advanced Interventions

Report format: Annual report

Section A GENERAL DESCRIPTION OF SERVICE / PROGRAMME

A1 Title/ Name of Service Programme/Year of Report
A2 Aim / Purpose / Mission Statement/Date of Designation
A3 Description of Patient Pathway
a) Target Group Service or Programme
b) Abbreviated care pathway

Section B QUALITY DOMAINS
B1 Efficient
a) Actual v Planned Activity
b) Resource Use
c) Finance & Workforce
d) KPIs & HEAT Targets
B2 Effective
a) Clinical Audit Programme
b) Clinical Outcomes/complication rates/external benchmarking
c) Service Improvement
d) Research
B3 Safe
a) Risk Register
b) Clinical Governance
c) Healthcare Associated Infection (HAI) & Scottish Patient Safety Programme(SPSP)
d) Adverse Events
e) Complaints & Compliments
B4 Timely
a) Waiting/Response Times
b) Review of Clinical Pathway
B5 Person Centred
a) Patient/Carer/Public Involvement
b) Better Together Programme
c) User Surveys/Action Plan
B6 Equitable
a) Fair for All: Equality & Diversity
b) Geographical Access

Section C LOOKING AHEAD / DEVELOPMENTS

Section D SUMMARY OF HIGHLIGHTS (Celebration and Risk)