Ref: GJF/2016/10/01

Unapproved Minutes
Board Meeting
Thursday 15 September 2016

Members

Stewart MacKinnon (SM)	Interim Chair
Jack Rae (JackR)	Non Executive Member
Mark McGregor (MM)	Non Executive Member
Maire Whitehead (MW)	Non Executive Member
Jane Christie-Flight (JCF)	Employee Director
Julie Carter (JC)	Deputy Chief Executive/ Director of Finance
June Rogers (JR)	Director of Operations
Mike Higgins (MH)	Medical Director
Anne Marie Cavanagh (AMC)	Nurse Director
David Miller (DM)	Interim Director of Human Resources

In Attendance

Sandie Scott	Head of Corporate Affairs
Margaret Duncan	Performance Manager, Scottish Government

Public Attendees

Paul McConville	Account Manager, EMIS Health

Minutes

Christine McGuinness	Communications Manager

1 Chair's Opening Remarks

1.1 SM welcomed members to the public session of the Golden Jubilee Foundation Board meeting.

1.2 SM welcomed Angela Harkness, Director of Global Development and Strategic Partnerships. Angela joins the Golden Jubilee with a wealth of experience in global development, strategic partnership acquisitions and management, marketing and capital campaigns within education, visitor attractions, charitable organisations and environmental projects. She was awarded the Freedom of the City of London in 2011, is Vice Chair of Keech Hospice, Luton, in 2015 gained a MA in Leading Innovation and Change, Robert Kennedy College, Zurich and York St John University.

1.3 SM advised that Safia Qureshi has been appointed as our new Director of Quality, Innovation and People. Currently the Project Director of the National Centre Project for the Scottish National Blood Transfusion Service, Safia has 15 years experience in senior management roles, and an experienced background in leading major change programmes, continuous improvement and innovation, as well as strategic collaborative working. She is very excited about joining our organisation and taking on this new role in January 2017.

1.4 SM thanked David Miller for his contribution as Interim HR Director. During his acting up period, David has ensured that we have a sustainable Human Resources portfolio. On behalf of the Board he thanked him for his hard work and ongoing leadershipof the HR team.

1.5 The Golden Jubilee Foundation welcomed members of the Scottish Parliament's Health and Sport Committee on Sunday 4 September. The Committee visited the hospital to find out about the work of the Golden Jubilee and its future plans for expansion. The Senior Management Team also led the Committee on a tour of the facilities, focusing on the life-saving, state-of-the-art, Cardiac Catheterisation Laboratories, Intensive Care Unit and Ward Areas.

1.6 The Golden Jubilee National Hospital is a finalist in the Employer of the Year (over 200 employees) category at the Icon Awards 2016 – the hospital was runner up in the Employer of the Year category last year. Jane Christie-Flight has also been named a finalist in the Uniformed Icon of the Year category – and the only NHS employee – for the second year running. Last year she was also the only female finalist.

1.7 97% of patients who responded to the recent Inpatient Experience Survey 2016 rated the Golden Jubilee National Hospital as "very good" for overall patient experience. The top results from these questions highlighted that:

- 100% of patients felt that the main ward or room they stayed, as well as bathrooms and toilets were clean.
- 100% of patients felt that their doctors knew enough about patients' condition and treatment.
- 100% of patients gave a positive rating to the overall hospital / ward environment.
- 99% of patients had enough privacy when their condition and treatment were discussed.

1.8 First Minister, Nicola Sturgeon, recently announced a £5 million investment to further expand services at the Golden Jubilee National Hospital as part of the £100m Capital Acceleration Programme. This investment brings forward elements of the planned expansion of the Golden Jubilee, which was announced as part of the NHS Elective Centres Project and will allow the Golden Jubilee to invest in:

- building prototype ophthalmology theatres and outpatient clinics to pioneer new models of care,;
- two state-of-the-art Magnetic Resonance Imaging (MRI) machines (one with cardiac capability), providing an additional 10,000 procedures a year;

- establishing a dedicated general surgery service, providing up to 2,100 procedures a year, increasing quality and continuity of care for patients and their families.

1.9 The Golden Jubilee National Hospital has become the first in the world to treat a patient with an Implantable Cardioverter Defibrillator (ICD) using a Magnetic Resonance Imaging (MRI) scan as part of the ground-breaking Ready MRI Study. The international study aims to test the safety and effectiveness of the Ellipse^{TM} ICD (developed by St. Jude Medical) in an MRI environment across 60 centres, with 165 patients taking part, and could improve the standard of care for patients at risk of Sudden Cardiac Arrest. The results could allow additional patients around the world to safely undergo MRI tests, which would traditionally, not be possible because of the strong magnetic fields involved. Specialists at Scotland's national hospital have been fitting patients with the revolutionary devices for the last 18 months, but this is the first time they have tested them in an MRI environment.

2 Apologies

2.1 The following apologies were noted:

Jill Young	Chief Executive
Phil Cox	Non Executive Member
Kay Harriman	Non Executive Member

3 Declarations of Interest

3.1 There were no declarations.

4 Minutes of last meeting

4.1 Minutes of the meeting held on 4 August 2016 were approved as accurate subject to the following amendments:

- P4, 7.1.3 – change 'on their 47th post op day' to 'who had an extended stay'
- P6, 7.3.3 – change to read 'but the Board is working towards every appraiser having 10 appraisees'
- P8, Divisional Update Surgical Services, last bullet point – remove 'anecdotally'
- P8, 8.1.5 – amend second sentence to read 'JR responded that we recently recruited Consultant Endoscopists but assured the Board that general surgery is an important issue for us.'
- P9, 8.1.8 – amend last sentence to read '...this is not giving any cause for concern'.

5 Actions and Matters Arising

5.1 Actions

5.1.1 All actions were closed with the exception of the following:

Action no:	040816/04
Action:	Check performance paper re 31-day thoracic pathway
Action by:	JR
Action status:	Closed
Action update:	JR gave a verbal update: There was a period of consultant unavailability at the end of May/June. When there is consultant absence, patients are offered another consultant, however, some choose to wait for their original consultant (probably due to the complexity of their condition). However, if the patient is on the 31-day cancer pathway, they are unlikely to wait. The patient advised unavailability numbers increase again in July and as we moved into August the numbers reduced week on week and this reduction continued into September. This is a typical trend over the summer holiday period when either the patient has a planned holiday or their family/carer may not be available to care for them when discharged post op.

Action no:	101215/04
Action:	Progress paper on Clinical Outcomes framework
Action by:	MH
Action status:	Ongoing
Action update:	Paper to 27 October 2016 Board meeting

5.2 Matters Arsing

5.2.1 There were no matters arising.

6 Person Centred

6.1 Partnership Forum

6.1.1 JCF provided an update on discussions at the Partnership Forum meeting which took place on Friday 2 September 2016.

Person Centred

- The updated Reserve Forces Training and Mobilisation Policy.
- The Spiritual Care Policy was also approved
- The Forum supported a proposal to work with See Me, an organisation which is funded by the Scottish Government and Comic Relief and managed by the Scottish Association for Mental Health (SAMH) and the Mental Health Foundation, which aims to tackle mental health stigma and discrimination, offering services to both employees and employers. The Occupational Health department will liaise with them to establish what services would benefit our

staff, and draft formal processes and guidance on how and when these should be used.

Safe

- The Forum was advised that work on the Compensatory Rest Policy is ongoing in relation to the National Organ Retrieval Service (NORS) and is being developed with extensive engagement from relevant trade unions, department heads and heads of service.
- The annual Health Promoting Health Service report, which we are required to provide to the Scottish Government, was presented but it was noted that some sections needed more content added.

Effective

- Members were asked to review and provide feedback on the draft PIN policy on additional employment.
- There was an update on the expansion plans, including the proposed two further MRI units and dedicated Ophthalmology Suite.
- An update was given on the Band 1 Review.

6.1.2 SM commented that there was a long discussion at the NHS Chairs meeting about the PIN policy on additional employment, noting that this also includes volunteering. JCF responded that this is one of several areas she is personally concerned about, and added that the policy is confusing and she is expecting there will be a lot of feedback on it. SM offered to raise any issues with the NHS Chairs group as they are keen that this is handled appropriately.

6.1.3 JackR asked if this policy only affected NHS staff. JCF confirmed that it is a Scottish Terms and Conditions Committee policy and added that there are lots of discussions going on nationally about how they are going to implement it.

6.1.4 JCF offered to circulate the consultation draft to Board Members so that they can contribute to the Board's response.

6.1.5 MM commented that private sector organisations place restrictions on who else you can work for, but stated that the working hours is more of a concern, in particular when you consider the hours clinicians work.

6.1.6 MW commented that there is a distinction between paid employment and volunteering.

Action no: **150916/01**
Action: **Circulate PIN Policy Consultation Draft to Board**
Action by: **JCF**
Action status: **NEW**

Action no: **150916/02**
Action: **provide feedback on PIN Policy Consultation**
Action by: **All**
Action status: **NEW**

6.1.7 JackR commented that the Board does a lot to support staff in terms of mental health but expressed some concern about support for patients when we don't have mental health experience in the Board. MH responded that psychological support is provided to patients within the Scottish National Advanced Heart Failure Service.

6.1.8 JackR commented that there is a difference between psychological and psychiatric support and while it is not an issue here, it might be in general hospitals. AMC advised that there have been one or two issues in the past where patients needed more mental health support and this was provided through agency specialists or through an agreement with NHS Greater Glasgow & Clyde, depending on the need of the patient. AMC added that mental health teams report similar issues when their patients need moved to an acute care environment.

6.1.9 MW asked if the Dementia Nurses would be used to provide support. AMC responded that mental health professionals would be brought in. MH added that the need for psychiatric input is rare, and would be on a similar scale to neonatal.

6.1.10 MM asked if we have a formal arrangement with NHS Greater Glasgow & Clyde to provide mental health input. MH confirmed this and reassured the Board that the arrangement works really well.

6.1.11 The Board noted the update.

7 Safe

7.1 HAIRT

7.1.1 AMC presented the Healthcare Associated Infection Reporting Template for July 2016, highlighting the following:

- **Staphylococcus Aureus Bacteraemia** – One SAB was identified,
- **Clostridium difficile infection** – Nil to report, last case reported March 2014.
- **Cleaning and the Healthcare Environment Facilities Management Tool** – Housekeeping compliance 99.04% (up from 97.94%) and Estates Compliance 99.36% (down from 99.6%)
- **Surgical Site Infection** – All are within control limits.
- **Hand hygiene –** The bimonthly report from July indicates 98% compliance with Hand Hygiene. Medical Staff compliance has decreased slightly to 92%.

7.1.2 The internal 'ward view' system works hourly rather than day specific, so patients only identified when their 'day' kicks in, e.g. time of admission. System is being updated to be day-specific.

7.1.3 MM commented that it is always disappointing to see another SAB and highlighted that we used to be better than we currently are. AM responded that there is always a detailed investigation into each SAB.

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7.1.4 MM commented that it seems like we are spending an inordinate amount of time discussing a single case, but it can be a serious event for patients. MM further asked if patients refuse to be screened, do we just treat them as if they have MRSA? AMC responded that we would follow the usual precautions but the only difference would be in the antibiotic prophylaxis that is provided.

7.1.5 MW asked if we could screen the patients and just not tell them the results. AMC responded that this is not allowed.

7.1.6 JackR commented on the Chief Medical Officer's approach to only doing what is necessary, stating that this may be the right thing to do.

7.1.7 JackR asked about the Surgical Site Infection rates for Valve Replacement Patients, noting that this appears to be an increasing trend, and asked if this was related to increased activity. AMC responded that activity has actually reduced but assured the Board that this is being monitored, adding that no commonalities have been found to date.

7.1.8 MM asked what the best hospital in the world is in terms of SAB rates and whether there was a 'zero' rate hospital anywhere. AMC responded that it is common to have a zero rate for a few months in a row but would need to look into whether anywhere has maintained this for a longer time.

Action no:	**150916/03**
Action:	**Investigate whether any hospitals have sustained a zero rate for SAB**
Action by:	**AMC**
Action status:	**NEW**

7.1.9 MM commented that a zero rate for CDiff is achievable but this doesn't seem to be the case for SAB. AMC responded that SAB appears to be more common in the community.

7.1.10 The Board noted the update.

Action no:	**150916/04**
Action:	**Publish HAIRT**
Action by:	**AMC/ Comms**
Action status:	**NEW**

7.2 Silver Swan

7.2.1 AMC gave an update on Exercise Silver Swan – the National Exercise Programme managed by the Scottish Resilience Development Service (ScoRDS) to assess the preparedness and response of Scotland's local and national arrangements for an influenza pandemic over a prolonged period.

- Silver Swan was delivered during the latter part of 2015 as a series of table top exercises. Following a wide-reaching programme of national events, the following key themes emerged for further action:
  - Pandemic planning and priority setting.
  - Coordination of the response.
  - Staff capacity and redeployment.

    - Public communications.
    - Supply chain interdependencies.
    - Mass fatalities – body storage and system capacity.
    - Antivirals.
    - Personal Protective Equipment.
- These are being taken into consideration and plans are currently being put in place to ensure these are programmed in an effective manner across the country. A progress review for all organisations, including the Scottish Government, will take place in November 2016.
- As a Board, we have reinstated Pandemic Flu meetings which have been titled “Silver Swan” and are reviewing these to ensure they are fit for purpose, and have have updated any plans which advised staff to report to their nearest hospital if they had any issues getting to their permanent work base in the event of a Pandemic.

7.2.2 SM asked if this connects to the winter plan. AMC confirmed this.

7.2.3 SM asked what RRPF is. AMC responded that this is the Regional Resilience Planning Forum, adding that although we are a category two responder, we sit on this to ensure we are linked in to what’s going on.

7.2.4 MM asked if the Golden Jubilee will be a resource for Extra Corporeal Membrane Oxygenation (ECMO) in the event of a pandemic flu outbreak given our ICU capactiy. AMC responded that this is still being discussed regionally and nationally as there would probably be a UK-wide approach. MH added that there is a very narrow window for ECMO being effective and in a genuine disaster scenario it is more about increasing the number of beds but there is a debate about what is achievable.

7.2.5 JackR asked if prevention and vaccination initiatives would only affect acute services. AMC responded that there is detailed work going on around this and advised that in this situation elective activity is generally cancelled, with cardiac activity being the last thing to be suspended.

7.2.6 The Board noted the update.

7.3 Health Promoting Health Service

7.3.1 AMC provided an update on the progress of the Health Promoting Health Service (HPHS), which has a vision for cultural transformation that ensures every healthcare contact is a health improvement opportunity.

- While the main focus of this is patients and visitors, the promotion of staff health and wellbeing is a core part of the HPHS vision.

- The demographics of patients treated at the Golden Jubilee is very different from other health Boards, providing mostly elective treatment for our inpatient admissions.
- However, to provide equity of access to health improvement support; to do so it may be necessary for us to offer targeted support that is specific to our clinical setting and patient demographics.

7.3.2 SM commented that the Chief Medical Officer is encouraging all Boards to get behind this.

7.3.3 MW asked about bicycles. DM responded that we have a cycle to work scheme as well as bikes were purchased for staff to use as part of the Cycle Friendly Employer initiative. The hotel also have bikes for guests to use.SM added that potentially more could be purchased and we could get an organisation to sponsor them.

7.3.4 MM commented that 12-hour shifts might get in the way of people exercising. AMC responded that the Nursing service has taken a more flexible approach with a combination of six, eight and 12-hour shifts, adding that there is a lot of evidence coming out about the impact of 12-hour shifts.

7.3.5 MM stated that the Step Count Challenge starts on 31 October and the organisation could speak to the organisers to get our own league table, adding that he is happy to pass on the contact details of the person who organised this for NHS Ayrshire & Arran. AMC responded that several teams took part last time and this had been really successful.

7.3.6 SM asked for HPHS to be a recurring agenda item. It was agreed that this should be provided on a quarterly basis or as necessary.

Action no:	**150916/05**
Action:	**HPHS update as regular agenda item**
Action by:	**AMC/ Comms**
Action status:	**NEW**

7.3.7 MW asked if we could explore getting more bikes. DM agreed to look into this.

Action no:	**150916/06**
Action:	**Explore purchasing more bikes for staff use**
Action by:	**DM**
Action status:	**NEW**

7.3.8 The Board noted the report.

8 Effective

8.1 Performance

8.1.1 JC presented the latest Board Performance report, highlighting areas of operational performance discussed at the July 2016 Performance and Planning Committee.

Safe

- The number of high/very high incidents continues to be low with only two high incidents reported in June
- The full quarter one position for SABs and clostridium difficile infections was reported as one SAB case, in June, and no cases of clostridium difficile.

Effective

- Against the new job planning KPI and as of 31 July, 57.9% of Surgical Division's doctors had a signed, current job plan on the eJob Plan system. In RNM, however, while all doctors had a job plan uploaded to the system the sign off process was yet to begin. The Division is working hard with clinical leads to ensure job plans are signed off.
- As of the end of July all nurses due for revalidation had successfully completed the process during their allotted month.
- Bed occupancy was reported against the refreshed targets for 2016/17:
  - Critical Care bed occupancy decreased in both ICU wards in June by roughly 10% however overall HDU occupancy remained roughly the same.
  - Interventional Cardiology's occupancy was on target in June resulting in a green score but occupancy varied across the individual wards. While CCU achieved target during June, Ward 2C and Ward 2D were over occupancy.
  - Overall Acute Elective bed occupancy achieved amber with occupancy maintaining a broadly stable position during the first quarter of 2016/17. In the ward breakdown, however, there was a mixed picture. NSD was just below target at 85%, Orthopaedics delivered target occupancy and Cardiothoracic were below target.

Person Centred

- Three complaints were received during June returning a rate of 0.04%. Using the revised 2016/17 scorecard thresholds this meant performance returned to the green range.
- Sickness absence rose during June with performance of 4.46% delivered. This increase resulted in a red score for the month.

Divisional Update – Surgical Services

- Within Ophthalmology outpatient activity remains high, with an average of 550 new patients seen each month. Theatre activity is slightly behind target for the first quarter 2016/17 however sessions are continually being optimised with a view to recovering by August 2016.
- The Orthopaedic DoSA rate is rising with 49% achieved during June 16. Approximately 80% of pre-operative assessment patients are now seen by a Consultant Anaesthetists and anecdotally it is now being reported that a greater number of patients are being identified as suitable for DoSA.

Divisional Update – Regional and National Medicine

- The Cardiology waiting list continues to present a challenge. However it did reduce in the last two weeks of July largely due to increased coronary activity as part of Cath Lab 4 implementation. Close monitoring of the lists is in place.
- Transplant activity continues to exceed expectations with six transplants and six ECMO cases completed during 2016/17 as 31 July.
- The first of the two new SACCS consultants recruited started on 15 August 2016; the second has confirmed that they will take up post in early 2017. In

the interim the current SACCS team continue close monitoring of the waiting list to ensure that patients are seen in line with clinical priority.

8.1.2 MH provided an update on the process for moving to an electronic system for job planning, highlighting that this has been much more difficult than anticipated and has uncovered a few anomalies, including the fact that there are two different but equally legitimate ways of recording Programmed Activities (PAs) and that these need to add up to the same amount. All Consultants within Regional and National Medicine have their job plans online and these are just awaiting electronic sign-off. Surgical Specialties are at different points in the process in the different specialties but meetings have been scheduled over the next few weeks to get this moving.

8.1.3 JackR commented that this was a very helpful explanation and asked MH if he was content with this. MH confirmed this and added that the new system forces us to make sure that all of the job plans are signed off, assuring the Board that strict time limits are set for each part of the process.

8.1.4 JC commented that sickness absence was slightly up but this wasn't causing much concern. DM responded that this has come back down again.

8.1.5 MM commented that the report states that STEMI is the most serious type of heart attack (P12) but stated that mortality is the same for both STEMI and NSTEMI. It was agreed that this should be updated.

Action no:	**150916/07**
Action:	**Update Performance Report re STEMI mortality (Same as NSTEMI)**
Action by:	**JC**
Action status:	**NEW**

8.1.6 MM asked about the Day of Surgery Admission (DOSA) rate. JR responded that this is currently at 57% but work is being carried out in pre-operative assessment clinics and in the Booking Office to refine identification of DOSA patients and to determine what happens when they move from this. The aim is to get to 75% but we need to identify the right patients at the right time to make this happen. MH added that there has been an improvement. JR added that we currently have the lowest length of stay for hip and knee surgery despite the fact that some people are coming in the night before. MM added that this looks like something we could get even better at. JR and MH added that the recent peer review was a really good exercise and identified this issue. MH commented that there is an issue with making sure that patients have adequate time to make informed consent for their procedure. JR added that as DOSA increases, we may grow out of the current Surgical Day Unit.

8.1.7 JackR asked if the correct targets have been included in the KPI around incidents/tolerances (P7) and that the colours are transposed on the two charts on P16. JC responded that this should be the other way round, and that she will get this updated.

Action no:	**150916/08**
Action:	**Update P7 KPI – tolerances are wrong way around/ p16 charts – transpose colours**
Action by:	**JC**
Action status:	**NEW**

8.1.8 The Board noted the report.

8.2 Business

8.2.1 JR updated the Board on hospital activity to 31 July 2016.

- Activity for inpatients/day case procedures was behind plan by 4.1% for the month of July and ahead of the year to date plan by 0.3% when activity is adjusted to reflect complexity.
- Measured against a total activity projection of 37,871, the combined inpatient/day case and imaging activity at the end of July was 1.3% behind plan when adjusted to reflect complexity.

Current Situation

- Weekend general surgery lists were expected to continue until September. Whilst some of these were cancelled by the referring Boards, capacity was offered to other health Boards. We have also offered weekend ophthalmology theatre lists to support a referring Board who is experiencing challenges at the moment.
- Work has progressed on the Telehealth link pilot with NHS Fife to assess patients referred for cataract surgery, which will begin this month.
- There was a shortfall in Ophthalmic Surgery in the month of July. This was due to an equipment failure which resulted in patient cancellations. It is expected that we will be using an alternative provider in the near future.
- Delivery of the Plastic Surgery service remains an ongoing challenge due to the availability of Plastic Surgeons. We are in discussion with NHS Lothian to explore ways to improve this situation.
- The Recovery Group will continue to meet on a weekly basis to scrutinise theatre utilisation and address shortfalls in activity as they arise. The group will focus on recovering the shortfall experienced in Ophthalmology.

8.2.2 SM asked if there is only one surgeon doing foot and ankle surgery and for clarification on how many do joint surgery. JR confirmed that there are 14 who perform joint surgery and forefoot surgery; some do four joints and one minor procedure a day. JR confirmed that there is one foot and ankle surgeon who is very productive; he does all the complicated foot and ankle surgery. We are now thinking about the need for hiring a second foot and ankle surgeon and are talking to the team about their views on the use of laminar flow theatres for foot and ankle surgery.

8.2.3 MM commented that taking one day off the orthopaedic length of stay would save 10 beds.

8.2.4 MM commented that Electrophysiology (EP) doesn't ever appear to meet its target. JR responded that she is going to remove this as it isn't actually a target but used for internal planning purposes.

8.2.5 MM asked about EP studies and EP Consultants. JC responded that there is an unmet need but there is a capacity risk with promoting this service which has only two operators carrying out complex cases. MH added that this is a regional planning issue which needs to be addressed by the cardiology regional planning forum. MM added that these procedures can be transformative for this group of patients. JC agreed that this needs to be taken through the cardiology and cardiac surgery regional planning routes and work has been progressed previously to do this.

8.2.6 JackR asked about the cancelled weekend general surgery plans and what cost this incurred. JR responded that there were no costs because the lists were cancelled, but you begin to lose the goodwill of the staff who had agreed to cover them. MH added that the lists would have been carried out by visiting surgeons.

8.2.7 The Board noted the report.

8.3 Finance

8.3.1 JC updated the Board on the financial position at 31 July 2016.

- The year-to-date (YTD) results show a total surplus of £846k.
- The Revenue Year-end Forecast recognises that:
    - efficiency schemes are on track;
    - a re-phasing and review of identified potential cost pressures;
    - a robust view on income due based upon the agreed expansions and capacity;
    - recognition of non recurring slippage in quality bids and inflation assumptions; and
    - a general update on the financial planning assumptions.
- Recurring efficiency savings achieved were £1.138m against a plan of £871k.
- As a result of recent legislation, the Board is required to maintain a register for gifts and hospitality. Following initial review, the group has proposed that we prepare one register which takes into account all requirements for:
    - Ethical Standard in Public Life (Scotland) Act;
    - Public Services Reform Act;
    - Bribery Act; and
    - Association of British Pharmaceutical Industry requirements.

8.3.2 JackR commented on the strong financial position.

8.3.3 JackR asked about the positive impact of incremental drift within clinical support services. JC responded that this means someone has left who was higher up the pay band and has been replaced by someone lower down it. AMC and JC added that this was funded in some areas where this has been noticed as a recurring pressure.

8.3.4 JackR commented that the Board doesn't have a lot of Perfusionists. JCF responded that this will be a pressure as a result of an aging workforce, as about one third of the team are planning to retire in the next five years, and there are no trainees in the system. JC added that this is a national pressure area. DM added that this is being considered as part of the longer term workforce planning programme, adding that the age profile of staff is mostly between 30 and 40, although there are still 20% in the 50+ group. JackR added that the key is looking at the pinch points. AMC added that this work has started with the group of Advanced Nurse Practitioners.

8.3.5 SM commented on the healthy financial position.

8.3.6 The Board noted the report.

8.4 Board Risk Register

8.4.1 JC presented the updated Board Risk Register.

- The Audit and Risk Committee made some minor changes to the descriptors, and nurse and medical validation has been included in the descriptor of the risk HR1.
- Board members noted that, it would be useful to include a strategic risk cluster for each risk and to realign the order of the risk register in line with the 2016/17 objectives.
- It was agreed at the July Senior Management Team (SMT) meeting that an additional risk for the adverse effects of the UK's referendum decision to leave the European Union. This is considered a low risk at this early stage. The key risks around this are:
    - **Strategic:** the Board vision in leading quality, research and innovation will continue to be pursued, with no significant risk at this stage.
    - **Financial:** restricted access to European Union Markets could reduce revenue or increase costs. The income for the Hotel could also reduce, as Europe is a key target market. There may be some impact on Research income due to changes in University research grant funding, however this is not a major source of funding for the Board. While it is possible there may be increases in costs to goods and equipment, these are negotiated nationally so may be minimized.
    - **Reputation:** there are potential risks to our Research reputation as our current model cites EU law, and not being a part of this may be seen as a disadvantage as many organizations have their headquarters in Europe. However, companies are more likely to use organizations that have a track record of meeting research targets, which we do, so this impact may be minimal. We will continue to progress our innovation role and build up strategic relationships in Europe going forward.
    - **Workforce:** Reduced access to the EU workforce could result in the inability to fill vacancies. In reviewing the Board's workforce more generally, 7% of the workforce, for which a nationality is known, are from EU countries although we only have a nationality recorded for 21.5% of the WTE staff, so this is likely to be understated. This is another risk that will need to be monitored closely, however given the Scottish Government position this may actually attract more staff from

the rest of the UK so difficult at this stage to identify as a significant risk.

- **Operational delivery:** There are no specific issues identified at this stage. It was proposed that this is added to the Board Risk Register. Finally, as part of the Board rollout of the Enterprise Risk Framework there was a dedicated SMT workshop in August to discuss this, work is also ongoing to appoint the Chief Risk Officer on a part time basis.

8.4.2 MW asked if we have considered the number of EU nationals within our staff as part of the Brexit work. JC responded that we know 7% of staff are EU citizens but recognised that we need to keep an eye on the situation.

8.4.3 SM commented that there is a large group that we don't know the citizenship status of. DM responded that the HR team are tidying up this data by going through all appointments over the past six years, but assured the Board that the numbers are very small as we only receive a limited number of work permits each year.

8.4.4 MM commented that we could struggle to recruit if Britain becomes a hostile environment for immigrants and noted his concerns about currency fluctuations where equipment has to be purchased in Euros.

8.4.5 SM commented that it could be a big issue if people from EU countries don't apply for jobs in the UK. JC commented that we are not seeing that yet. DM added that it is a fear, but assured the Board that the recruitment team have been attending events across the UK and Europe to raise the profile of the Board and that the team are working to future-proof the organisation so that we can be self-sufficient over the next five to 10 years; this work is already a few years in and we are starting to see the benefits already.

8.4.6 JackR asked about the distribution of EU citizens across staff groups. DM advised that this is primarily medical staff but will get some more data on this.

Action: **150916/09**
Action: **Check split of EU citizens across staff groups**
Action by: **DM**
Action status: **NEW**

8.4.7 SM commented that it was interesting to see how everyone focussed on Brexit and that this is well placed on the risk register, adding that he is pleased with the direction of travel for the enterprise risk model. JC added that the SMT approved the enterprise risk model and an update will be provided at the next Audit and Risk Committee.

Action:	**150916/10**
Action:	**Update on Enterprise Risk Framework (after Audit and Risk Committee)**
Action by:	**JC**
Action status:	**NEW**

8.4.8 The Board noted the report.

9 AOCB

9.1 There was no other business to discuss.

10 Date and Time of Next Meeting

10.1 Thursday 27 October 2016, 9.30am