NHS Grampian Board Paper - Grampian Operational Pressure Escalation System and Operation Iris

Appendix 1

Background

Business continuity and escalation planning has been central to our approach to winter planning for many years. Throughout the pandemic we have developed a number of new escalation models and systems to respond to the surges in COVID activity.

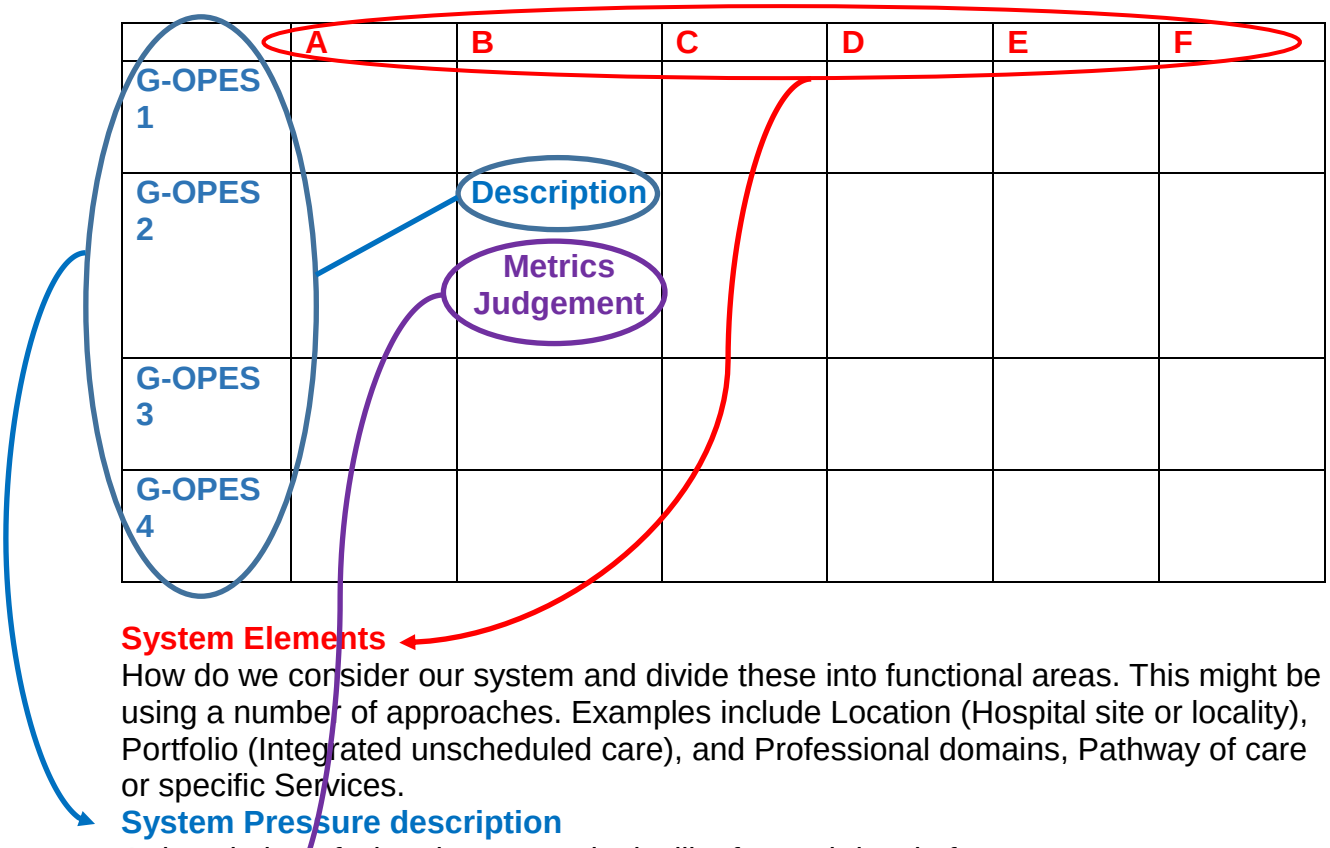
Operation Rainbow (March – June 2020) was almost entirely focused on responding to a COVID surge and brought in the concept of a 'Tactical Operating Model' that provided capacity ahead of demand. This was expanded to include consideration of additional winter pressures that see a predictable increase in all unscheduled activity and was refined in Operation Snowdrop (January – March 2021). This was again revised during the onset of the 'Third Wave' where unscheduled demand remained at usual winter levels with an increasing backlog of critical planned care and progressive workforce fatigue.

We have taken this learning into the development of a whole system escalation response model to manage the expected range of service pressures that will be experienced over the next six months (Operation Iris) whilst delivering our commitments in RMP4.

Consideration has been given to expected high levels of unscheduled care activity as well the specific surges in COVID, Respiratory Syncytial Virus (RSV) or other infections disease. It also accounts for the staffing and resource pressures that will threaten the delivery of both unscheduled and planned critical services at the specified protected level. It looks to be whole system in scope and to become aligned with the new Portfolio management arrangements and the System Leadership model. The intent is that it should form the basis of long term whole system pressure management.

Overall System Description
The G-OPES system starts with an agreed whole system pressure matrix with defined descriptions and measures:

G-OPES Whole System Pressure Grid and Levels



System Elements
How do we consider our system and divide these into functional areas. This might be using a number of approaches. Examples include Location (Hospital site or locality), Portfolio (Integrated unscheduled care), and Professional domains, Pathway of care or specific Services.

System Pressure description
A description of what the system looks like for each level of pressure.

Measures
The intelligence that will support the justification for each reported level. Ideally this is more objective that judgement but where judgement is required it is important to be clear who is making this. The metrics reflect the four main drivers of system pressure.

a. Activity / Demand
b. Activity/Demand : Capacity
c. Difficulty / Stress
d. Transition + Flow

Over and above this we may separately develop a set of whole system surrogate markers of pressure.

For each level of pressure with our system there should be pre-determined specific actions. Each must be deliverable by that element of the system and broad involved one of three types of action:

- Increase a capacity or resource
- Redirect one resource from one activity to another
- Change the usual operational rules through a derogation matrix

G-OPES Whole System Actions

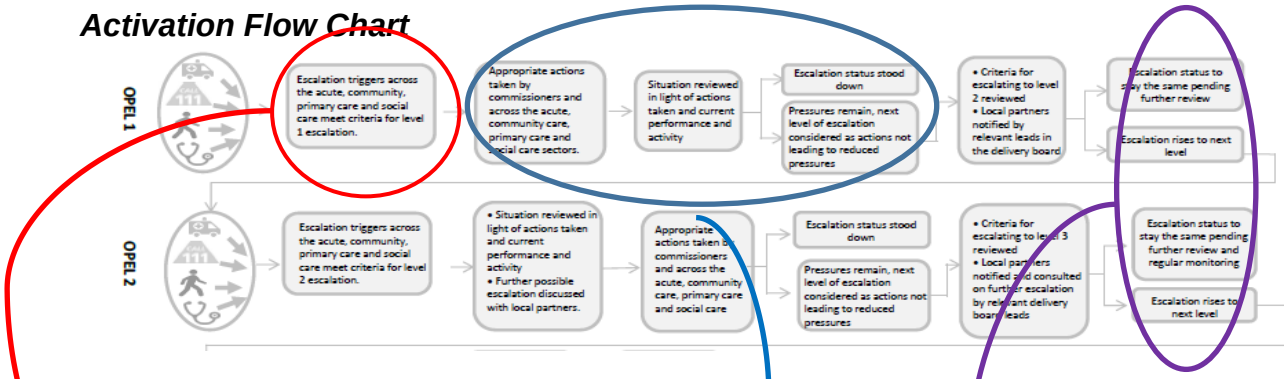
	A	B	C	D	E	F
G-OPES 1						
G-OPES 2		**Actions** Capacity Reallocate Change				
G-OPES 3						
G-OPES 4						

Actions

These actions will point to specific surge or business continuity plans that will detail what steps must be taken. The derogations described in these surge plans must be in line with the agreed organisational approach to derogation. Consideration must also be given to mutual aid where the action is directed to provide the support in another part of the system or within the sub element within one part of the system.

The operational activation will be established within the individual area management teams and across the whole system through the system connect decision making model.

Activation Flow Chart



The process of moving up and down through pressure levels is best described in a flow chart and needs to consider a number of steps.

Assessment and Activation

Where and how do elements of our system or the whole system come together to evaluate the metrics and intelligence around pressure

Delivery of actions

How to we ensure actions are progressed and managed. Do we consider actions against the highest pressure level in any part of the system, within the individual element or against an overall system wide aggregated pressure level?

Escalation and de-escalation

How do we escalate up to the next level? How do we de-escalate? How and when to we identify that the system needs further internal or external help? How do we communicate across our staff, patients and public?

System Components

Whole System Pressure Levels

The system uses four levels to describe pressure in any part of our system. The overall Board level description of how it feels and what is experienced at each level is set below.

Level 1

- The acute and community Health & Care system capacity is maintaining flow and are able to meet anticipated demand within available resources.
- Flow is supporting delivery of operating norms.
- The local system areas are taking any relevant actions based on their metrics to maintain this position and communicate this at daily cross-system huddles.
- Core critical business functions are operating with no known or anticipated issues that would adversely affect delivery of clinical and care pathways.
- Additional support is not anticipated to be needed to maintain operating norms.

Level 2

- The acute and community Health & Care system is exhibiting signs of pressure (e.g. staffing, demand/capacity, delays to admission and discharge).
- Insufficient discharges across the system to create capacity for predicted demand. Insufficient step down to support flow between acute and community.
- The local system areas will be required to take additional focussed actions in areas showing pressure to mitigate the need for further escalation.
- Enhanced co-ordination and cross-system communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible.
- Each area will agree their further actions being taken and any additional support requirements (e.g. mutual aid).

Level 3

- Actions taken in Level 2 have not succeeded to deliver capacity.
- The acute and community Health & Care system is experiencing major pressures compromising service flow, and these continue to increase (e.g. increase delays in admission and transfer pathways)
- Significant unexpected reduced staffing numbers in areas causing increased pressure on service flow.
- Significant delays in e.g. diagnostics, therapy assessment, discharge for acute and community.
- Further urgent actions are now required across the system by all partners (increased mutual aid across our whole system and partners)
- Each area has activated their specific actions to ensure clinical and care priorities are met (senior decision makers enhanced 24/7, cross-system operational Teams presence and communication, etc.)
- SLT made aware of the rising system pressure with the plan of action being undertaken. Additional support provided as deemed necessary.

Level 4

- Actions at Level 3 have not succeeded to deliver capacity and a decision to move the system to Level 4 will be discussed cross-system with CET.
- Pressure in the acute and community Health & Care system continues and there is increasing potential for clinical care and safety to be compromised.
- Care pathways are significantly disrupted due to capacity and demand not being able to be met.
- Decisive action must be taken collectively to recover capacity and ensure clinical care and safety.
- Enhanced system-wide arrangements agreed re operational and clinical and care leadership.
- If pressure continues for more than XX days all available escalation plans are revised, actions allocated and coordinated, external support considered.

These levels sit outside of any civil contingency response or major incident which both may be triggered by other internal or external events outside of normal operational business

System Operational Units

The system is complex and may be considered from a number of operational perspectives. These include hospital sites, specific services, and pathways of care, Health and Social Care Partnerships and Portfolios of Management. The expectation is that this will evolve particularly as Portfolio Leadership develops but the starting position with 10 Operational Units that will have their own escalation matrix is set out below. Furthermore dialogue is underway to include external agencies such as the local Scottish Ambulance Service (SAS) within our system.

- Aberdeen City Health and Social Care Partnership
- SOARS (Woodend, Rosewell, Ward 102, ARI)
- Royal Cornhill Hospital (CAMHS, Tertiary MHLD Services)
- Moray Health and Social Care Partnership
- Dr Grays Hospital Elgin (DGH)
- Primary Care and G-Med Services
- Aberdeenshire Health and Social Care Partnership
- Aberdeen Royal Infirmary (ARI)
- Royal Aberdeen Children’s Hospital
- Grampian Maternity Services (including Neonatal)

Operational Units Specific Pressure Level Descriptions

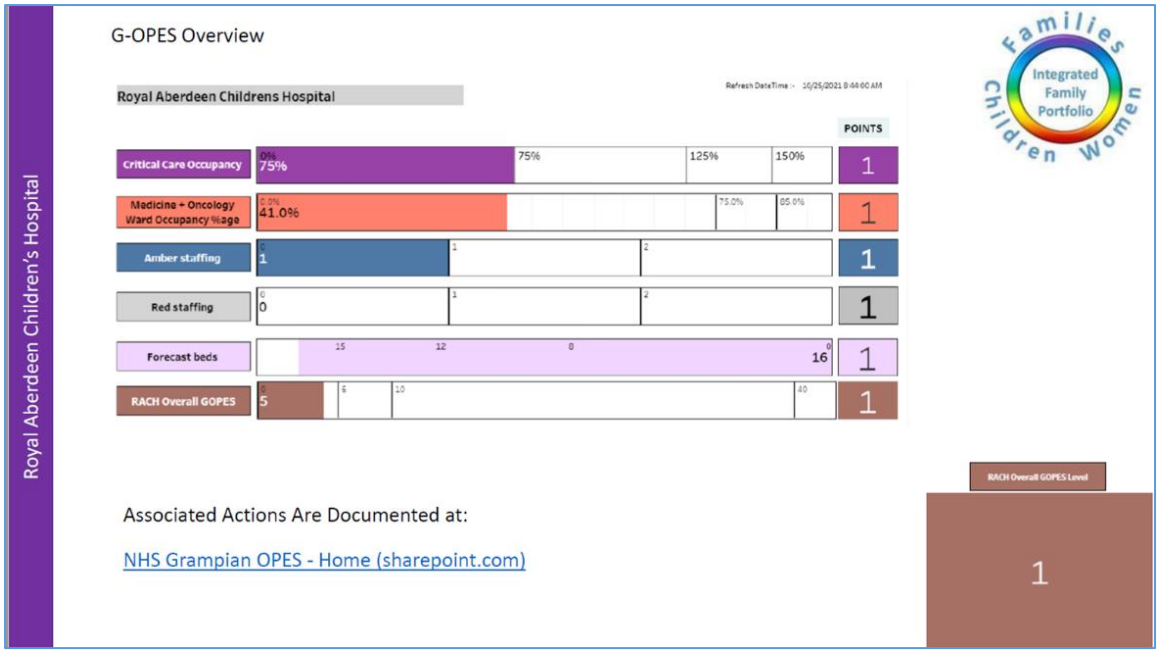
For each operational unit the teams have developed a local interpretation of the Board level descriptors set out above. An example for the Aberdeen City HSCP across levels 1 and 2 is set out below.

Level 1	**Level 2**
1. Community capacity available across the system to focus on home-first principles. 2. Care at Home able to facilitate needs. 3. GP attendances within expected levels with appointment availability sufficient to meet demand. 4. Care & Residential Homes are 'green' and interim bed capacity. 5. Out of Hours (OOH) service demand is within expected levels 6. Sexual Health services have access to inpatient beds as required. 7. Care Management able to meet referral demand/lower waiting times. 8. Pharmacotherapy service being delivered at normal levels (as per 'allocation', taking account of planned leave). 9. Delivery of HSCP 'core' activities. 10. GP practice staffing is normal.	• Patients in community setting are waiting for community care capacity. • Some unexpected reduced staffing numbers. • GP attendances are higher than expected levels. • OOH service demand is above expected levels. • More than 50% of Care & Residential Homes are 'amber'. • Patients in Sexual Health may experience delays in accessing inpatient beds. • Care Management referrals are higher than average. • Unmet need list shows slight increase. • Waiting times above average. • ASP/VPD's above average. • Pharmacy: Staff levels are >=75% of expected daily establishment (including planned leave). Or: GP Practice staffing reduced, requiring adjustment of pharmacy team priorities.

Operational Units Specific Metrics and Visualisation

Each operational unit has evaluated the key metrics that relate to system pressure from their perspective and mapped indices to develop an objective scoring against each pressure level.

The example set out below is from the Royal Children's Hospital which uses 'Critical Care Occupancy', 'Ward Occupancy', 'Ward Staffing Pressures' and 'Forecasted Bed Balance' to drive their index of pressure which in this case is Level 1. This also gives an opportunity to understand relative pressures across the system when compared to other areas pressure level and helps facilitate balancing of risk.



All metrics will be collated on our data visualisation system (Tableau) with direct live access available to operational teams and eventually publication of daily status on our NHS Grampian Internet Site.

Operational Units Actions at each pressure level

Each operational unit has looked at describing the actions that they will take at each level of pressure aiming to improve capacity and flow such that the RMP4 objectives can continue to be delivered. These have initially be based on the current approaches taken by operational management teams but will be then revised to ensure they are goal orientated, actionable and link to a detailed operational protocol. An example of the current action set for the Royal Aberdeen Children's Hospital is set out below.

RACH Actions Level 1

1	Business as usual actions
2	Communication of internal capacity in the form of Sitreps to S&C at 0830 and 1600

RACH Actions Level 2

1	Actions will focus on individual areas of pressure but is not disruptive to normal patterns of activity
2	Plans in place to support areas under pressure such as additional capacity/staff redeployment/review of clinical activity
3	Increased reporting of Sitrep to S&C, divisional team 3x daily
4	Concentrated effort around flow within the hospital to ensure increase capacity and discharge planning. (Active prioritisation of scheduled activity, ward rounds to be conducted as early as possible by senior staff to maximise discharges)

RACH Actions Level 3

1	Surge beds in operation
2	Staff redeployed
3	Consideration and planning of cancellation of current planned activity, discharge of non-urgent patients and reschedule
4	Plan OPD activity postponement to support medical/ nursing/AHP decision making in all clinical departments and safe management of emergency patients
5	Plan use of non-front line facing clinical staff to be utilized across clinical areas ie PEFs/CNMs/Sp Nurses
6	Continue process of clinical prioritisation as at level 2.
7	Consider suspending educational activities.

RACH Actions Level 4

1	Cancel all non-urgent activity – theatres and outpatients
2	Discharge all non-urgent inpatients
3	Redistribute staff to ensure non-staffed surge beds are staffed safely
4	Significant redeployment of staff.
5	Consider approaches to neighbouring organisations (e.g. RGU, other NHS boards) for mutual aid.

The next development step will be to categorise actions into groups with a specified goal and an underpinning operational protocol (built on already established business continuity plans). These would be described at each level with the specified escalated details in the associated protocol.

Proposed Action Groups

- Managerial Oversight and Support Arrangements
- Flow Optimisation
- Increasing Pathway Capacity
- Portfolio Non Critical Service Step Down
- System Wide Activity Changes

Individual action will then be further reviewed to ensure they are Goal orientated and point to a specified action contained within either a business continuity plan or standard operating procedure. An example is set out below.

Example Goal Orientated Action

ARI Unscheduled Flow Optimisation Level1

Goal To reduce 'Clinically Fit for Discharge' count to below **xxx**

L1 Action: *AHP/Community review of all patients marked clinically fit for discharge or delayed discharges*
(Link to Flow ARI Protocol L1 level of activity) and discharge hub to ensure same day transport for all designated discharges

Goal To reduce 'Wait for Bed in ED' count to below **xxx**

L1 Action: *Direct Transfer Protocol for ED Patients to AMIA (Link to Flow ARI Protocol L1 level of activity)*

Due consideration must also be taken by the operational teams in progressing each action as specific circumstances may be at odds with the proposed action. At each level relevant teams should consider:

- Would this action support recovery in this instance?
- Would this action support recovery within the required timescale in this instance?
- Would the impact of this action (on staff, service delivery and support functions) be reasonable for the gain given either individually or as a collective set of actions (including mutual aid)?
- Does the action point to specific surge or business continuity plans and if so are any derogations within the action in line with the agreed organisational approach?
- Where derogation is applied have we completed local risk assessment and considered the ethical framework around decision making?

If actions are taken that are not part of the G-OPES framework the same consideration should be made along with an assessment that the level of disruption would be considered broadly equivalent to the agreed actions. If this action is considered likely to be repeated in future then consideration should be made to adding it to the G-OPES framework for future reference.

Operational Units Operational Procedures and Business Continuity Plans

As part of regular winter planning all sectors are required to have business continuity plans and winter surge plans. These were tested in the run up to winter 2020 and supported by an overall winter surge plan submitted to the Board. It is recognised that these will need to be revised in line with this year's challenges and Operation Iris. They form the critical underpinning detailed plans that allow goal orientated actions to be taken by each area. The revision must take account of the transition into a Portfolio system of management and the specified derogations that are supported by the Board during this emergency situation. They also need to recognise a tiered approach based on the current pressure level and ideally be supported by a clear action card that facilitates deployment. All staff that are required to be involved in the delivery of these actions should be aware of their role ahead of time.

Cross System Working, Mutual aid and G-OPES
The overall intention is to develop a framework that supports the system leadership team to collaborate and balance support and resource across the whole system. There are three key opportunities to establish this:

- **System Connect Daily Meetings**
  These are the regular daily meetings that bring operational teams together under the direction of the Chief Officers and Portfolio leads. Where one area has relatively lower pressure than another it is possible to facilitate direct mutual aid.
- **Shared Goal Orientated Actions**
  Some goals should be shared across several areas and this offers the potential for mutual collaboration. An example would be a goal to reduce the number of hospital patients clinically fit for discharge who are stuck. This goal should appear in the action list of the ARI system as well as the Aberdeen City HSCP and Aberdeenshire HSCP. Together they will contribute different elements to meet the appropriate outcome.
- **Portfolio Management**
  The transition to Portfolio management offers the opportunity to reframe pressure systems and actions across pathways of care under single leadership. In some cases this would move us away from 'Hospital Site Management' to 'Pathway of Care Management'. A possible example would be reframing the ARI system as part of both the Unscheduled System and the Complex Planned Care System with full oversight of the 'Home to Home' pathways of care. This gives a real opportunity to balance the risks held in the planned and unplanned care services where traditionally unplanned care always displaces planned care even when the clinical urgency is equal.

Board Level Derogations from Normal Operational Protocols
During the first three COVID wave response (Rainbow, Snowdrop and 'Third Wave') derogations were considered across many areas of operational business and considered by our Silver and Gold commanders with an individual decision outcome. Many additional measures were also introduced at a National level and either associated with Professional Advice issued through the Chief Medical or Chief Nurse Offices or directly by Scottish Government. We also activated our Staff Policy in the event of a Pandemic which supported reallocation of staff to alternative duties where this was required for the maintenance of critical services. Most of these remain in place but we would like to describe the specific areas where we intend to use risk based derogations to support Operation Iris and G-OPES. These have all at times been considered when we have been working through a command and control approach but now need to be established as Board agreed frameworks for use within the systems leadership decision making approach described in Operation Iris and G-OPES. Specifically:

Increasing bed capacity within a hospital setting

- Identified potential additional bed capacity derogating from normal bed spacing Infection Prevention Control standards
  (*Bed spacing guidance from Health Protection Scotland and utilising Health Facilitates Scotland Health Building Note 00-03 and Scottish Health Planning Note 04-01 guidance. Supporting details in the National Infection Prevention and Control Manual*)

Increasing Flow on a pathway of care

- Agreed arrangements for temporary corridor waiting.
  (*Standards set out by Health Protection Scotland and Health Facilities Scotland. Supporting details in the National Infection Prevention and Control Manual*)

Derogations from Safe Staffing Levels

- Agreed derogations from standard ward based nurse staffing levels and the associated reduction in care provision
  (*Guidance for Workforce planning for midwifery services during Covid-19 (Scottish Government 2020), Real-time Staffing Resource (Adult Ward) (Scottish Government 2021), Real-time Staffing Resource (Adult Ward) (Scottish Government 2021), Real-time Staffing Resource (Adult Ward) (Scottish Government 2021) Guidance: Workforce Planning Mental Health and Learning Disability Nursing & Allied Health Professional Services during COVID-19 (Scottish Government 2020),* Critical Care Real-time Staffing Resource (Scottish Government 2021)).
- Agreed derogations from standard doctor staffing levels provision
  (*Professional view from Royal College of Physicians, London: Safe Medical Staffing Report 2018*).

Derogations from standard investigation and complaint processes

- Protocol prioritising complaint investigation
  (*Standards as set out by the Scottish Public Services Ombudsman*)
- Protocol prioritising incident investigation
  (*Standards as set out by Health Improvement Scotland*)

The approach to risk analysis, management and monitoring is set out in **Appendix 3** and the approach to ethical consideration and support in **Appendix 4**.

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Appendix 2 Progress Assessment G-OPES

(Executive Lead for G-OPES: Nick Fluck Medical Director and Organisation Lead Jenny Ingram, Associate Director of Quality Improvement)

This is a substantial piece of work and we have attempted to use a collaborative agile approach. Rather than waiting for completion before deployment we are seeking to go for early use with iterative improvement on a frequent basis. The current state of the system against each individual components is set out below. This does not include the Portfolio reframing work that needs early consideration by the respective Portfolio leads.

Overall RAG assessment of Progress

	Operation Unit Speciifc Descriptors	Operation Unit Level Metrics	Operation Unit Level Dashboard	Operation Unit Speciifc Actions	Operational Unit Actions Goal Orientated Revision	Operation Unit Surge + Business Continuity Plans	Revised G-OPES Specific Action Protocols	Goal Sharing Across Areas
Aberdeen City Health and Social Care Partnership								
SOARS (Woodend, Rosewell, Ward 102, ARI)								
Royal Cornhill Hospital (CAMHS, Tertiary MHLD Services)								
Moray Health and Social Care Partnership								
Dr Grays Hospital Elgin (DGH)								
Primary Care and G-Med Services								
Aberdeenshire Health and Social Care Partnership								
Aberdeen Royal Infirmary (ARI)								
Royal Aberdeen Children's Hospital								
Alled Health Professionals (Cross System)								
Grampian Maternity Services (including Neonatal)								

Operation Unit Level Specific Descriptors
This has been completed for all current units at all levels has been completed and published on the G-OPES SharePoint site (OPES - Level Descriptions (sharepoint.com).

Operation Unit Level Metrics
This has been completed for all current units at integrated into a Level specific scoring system.

Operation Unit Level Dashboard
Four units (Aberdeen Royal Infirmary, Royal Cornhill Hospital, Royal Aberdeen Hospital for Children and Aberdeen Maternity Hospital) have a live dashboard integrated into Tableau. (G-OPES METRICS: Views - Tableau Server).

Two units (Aberdeen City HSCP and Aberdeenshire HSCP) have detailed dashboards which are not yet integrated into the Tableau system. The remaining five units are progressing the development of their respective dashboards.

Operation Unit Level Specific Action
These have all been developed and are published on the G-OPES SharePoint site. (

Operation Unit Goal Orientated Action Review
All units have now started work on reviewing their actions to ensure they are clear, specific, and actionable and are goal orientated.

Operation Unit Surge and Business Continuity Plans
These are developed and reviewed on an annual basis and were last tested in the winter/surge 2020 table top exercise. They have been collated with the G-OPES SharePoint site and are currently under review.

Operation Unit G-OPES Specific Action Protocols
These will be developed alongside the revision of the specific actions and in light of the agreed frameworks of derogation.

Goal Sharing across the System
This is under discussion within the System Leadership teams to establish the way in which this could support internal mutual aid and risk sharing.

Regular updates on progress of G-OPES development and implementation are presented at the weekly System Connect Meeting and the Chief Executive Team meeting. A flash report format has been developed and is presented on the following page:

Grampian Operational Pressure Escalation System (G-OPES)

Executive Lead: Professor Nick Fluck * Improvement Lead: Jenny Ingram

Report Date:	22.11.2021
Owner:	Jenny Ingram

Programme Objectives

Aim:
To develop a standard whole system approach to defining levels of system pressure and linking this to clearly defined actions.

Objective:

To embed this as our standard approach moving us out of a civil contingencies response giving ownership back to operational teams.

Programme Scope

The system is complex and may be considered from a number of operational perspectives. These include hospital sites, specific services, and pathways of care, Health and Social Care Partnerships and Portfolios of Management. The expectation is that this will evolve particularly as Portfolio Leadership develops but the starting position with 10 Operational Units that will have their own escalation matrix is set out below. Furthermore dialogue is underway to include external agencies such as the local Scottish Ambulance Service (SAS) within our system.

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- Primary Care and G-Med Services
- Aberdeenshire Health and Social Care Partnership
- Aberdeen Royal Infirmary (ARI)
- Royal Aberdeen Children's Hospital
- Grampian Maternity Services (including Neonatal)

Workstream KPIs/Measures

SharePoint https://scottish.sharepoint.com/sites/NHSGrampianOPES

- Board Level descriptors for each Level 1-4. (Complete)
- Each Operational area will have:
  - Level descriptors for each Level 1-4 (complete)
  - Actions for each level (initial actions complete)
  - Metrics to determine G-OPES Level (in progress)
- All metrics will be collated on our data visualisation system (Tableau) with direct live access available to operational teams and eventually publication of daily status on our NHS Grampian Internet Site.

Workstream/Projects & Status

Work Stream/Project	Timescale	RAG
• Sharepoint Site built hosting all G-OPES information	Sept 2021	
• Board Level descriptors agreed	Sept 2021	
• All Operational Unit Level descriptors agreed	Sept 2021	

• Information Governance:
  • sign off for G-OPES Level to be displayed on intranet.. Will be on the internet when fully operational
  • Agreement that all staff with an Illuminate account can access G-OPES
	Oct 2021	

• Metrics:
  • RACH – Live
  • MH&LD – Live
  • Aberdeenshire H&SCP – Live with professional judgement
  • Moray H&SCP – Go Live 22nd Nov with professional judgement
  • AMH- testing phase
  • ARI – metrics well established but need to be calibrated to differentiate L3 and L4
  • Aberdeen City will go live using the professional judgement tool
  • DGH calibration required. Potential to go live with likely frequent initial override
  • SOARS as for DGH pathway
	Nov-Dec 21	

• Overall Dashboard in Tableau. Health Intelligence working with the HSCPs re dashboard metrics.	End Dec 21	
• Actions being reviewed under the proposed action groups and goals to facilitate a common cross system approach. System Wide Activity Changes • ARI have sub split actions into USC/Adult Medicine and Integrated Specialist Care Portfolios	Nov 21	
• Ask to review specified goals and an underpinning operational protocols/SOPs (built on already established surge nd business continuity plans). • Areas are reviewing this and are including relevant protocols/SOPs in their actions. • There may be others required as we determine the cross system actions required along with the Board Level Derogations from Normal Operational Protocols.	Dec 21	

Key Risks/Issues

- Change management is required for large parts of the system to move from Excel spreadsheets to electronic capture. However, the Partnerships will use a combination of system generated data, performance dashboard, other data from daily huddles to agree their overall G-OPES level on a daily basis.
- Education and information resources required to share across all teams re G-OPES aim, descriptors, actions, whole system approach and accurate data completion.
- The operational activation will be established within the individual area management teams. and across the whole system through the system connect decision making model. The aspect of how cross system activation will operate is being worked on, particularly when how the system responds to areas in Level 4 where sole actions will not reduce to Level 3.
- The actions will correlate with any relevant surge or business continuity plans that will detail exactly what steps must be taken. The derogations described in these surge plans must be in line with the agreed organisational approach to derogation. Derogations are currently being developed and approved by CET and the Board.

Next Steps

- User Manual Guide developed and shared with G-OPES Group and System Connect. This will support understanding of G-OPES and will be backed up by education/training.
- System understanding needs to be spread and shared with everyone expected to play their part in it. This will need to be cascaded through management structures with clear, shared understanding at each level.
- Continue weekly G-OPES connect meeting and review end of November 21.

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Appendix 3 - NHS Grampian Risk Approach and Application to G-OPES

(Executive Lead for Risk: Nick Fluck Medical Director and Board Risk Advisor Mike Sevenoaks)

Background

In the last 18 months a new approach to Risk Management in NHS Grampian has been under development. We have established a new Board Policy with an operational Risk Protocol and Standard Operating Procedure (SOP) supported by a suite of educational and training material. The initial focus was on operational risk management across our health and care system but has now moved to an enterprise risk management approach to include hazard management, assessment of assurance systems and corporate and strategic risk profiles.

Operational Risk Management

All system risks are hosted on a modified DATIX platform and have been reviewed and in the context of the new policy, procedure and SOP. All risks have been framed around the principle of 'Risk is the impact of uncertainty on our objectives' and detailed using a three part risk description (Cause, Event and Consequence). Live visualisation has been established with an Illuminate Tableau workbook that allows selection based on location, severity, consequence and linkage to key organisation hazards. The workbook can drill to full risk details and used to monitor progress of associated action plans.

Risk identification events are supported by the Board Risk Advisor and all new risks are reviewed at the weekly whole system 'Clinical Risk Management' meeting led by the Medical and Nurse Directorates. This information is considered alongside other critical system information such as adverse events, complaints, health and safety reports as well as workforce support and development activities. This meeting can escalate specific issues directly to the weekly Chief Executive Team meeting.

Organisation Level Hazards

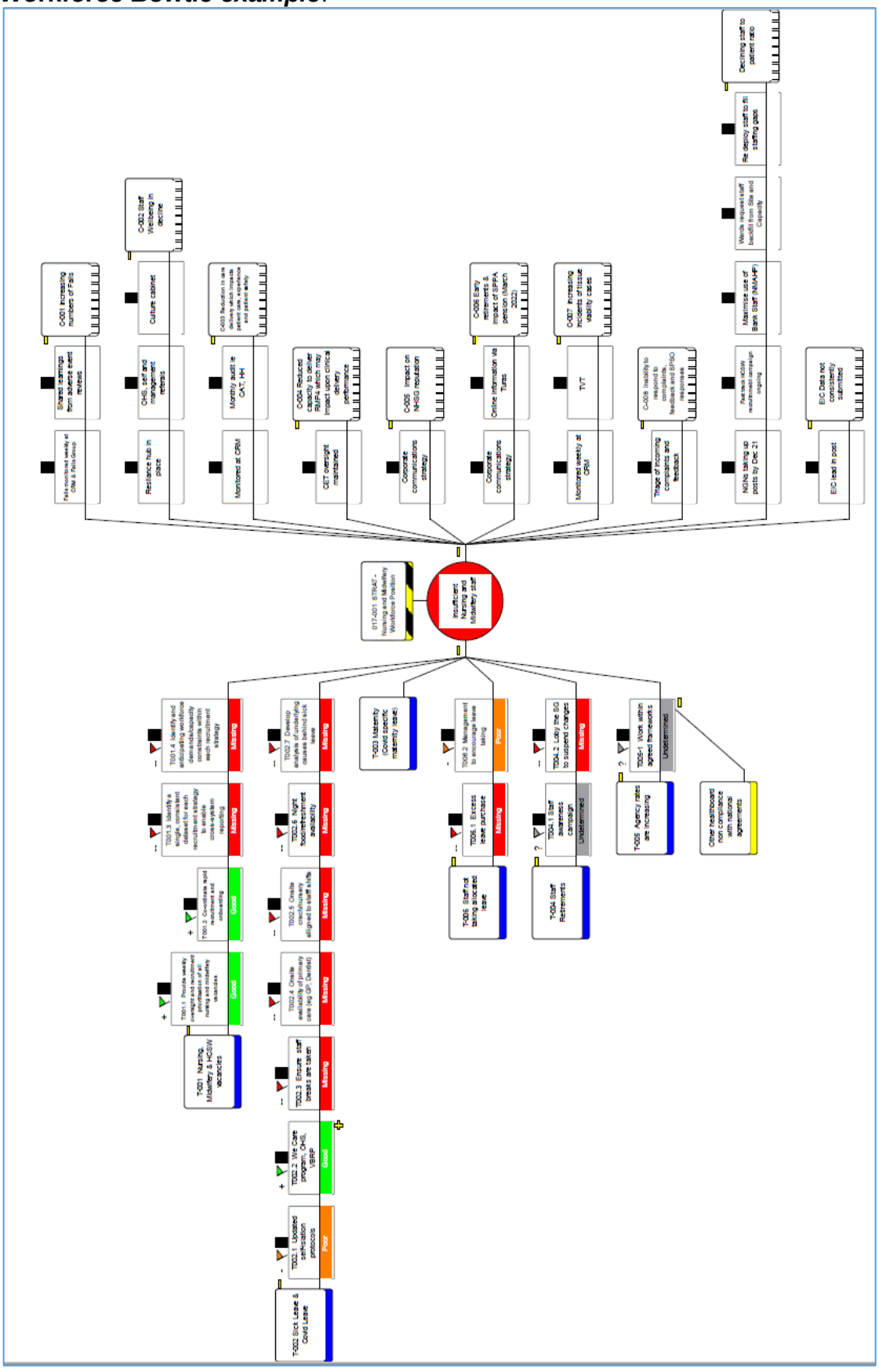
Our previous corporate risks which were aligned to assurance sub committees of the Board were more correctly seen as areas of Hazard. These were refined to seven key areas with four being aligned to the main assurance sub committees reporting to the Board.

Hazard Area	**Aligned Board Assurance Committee**
Quality + Safety of Clinical Care	Clinical Governance
Workforce	Staff Governance
Compliance	Performance Governance
Infrastructure	Performance Governance

Each Hazard area has also been aligned to an executive level group that considers all aspects of Performance, Assurance, Improvement and Risk within the scope of the Hazard. Supporting this work we have also introduced the **BOWTIE** method of Hazard analysis. This is a visual software tool that helps us consider analyse the

events that may be associated with these Hazards and then establish the threats that may lead to these events and the consequences that follow. By detailing the potential threat barrier and consequent barriers it is possible to evaluate the overall control we have for a given Hazard and the gaps that need to be managed. An example partial output the Workforce group analysis looking at shortage of nursing and midwifery staff is given on the following page.

Workforce Bowtie example:



This methodology lends itself to analysing complex risk situations and high risk services.

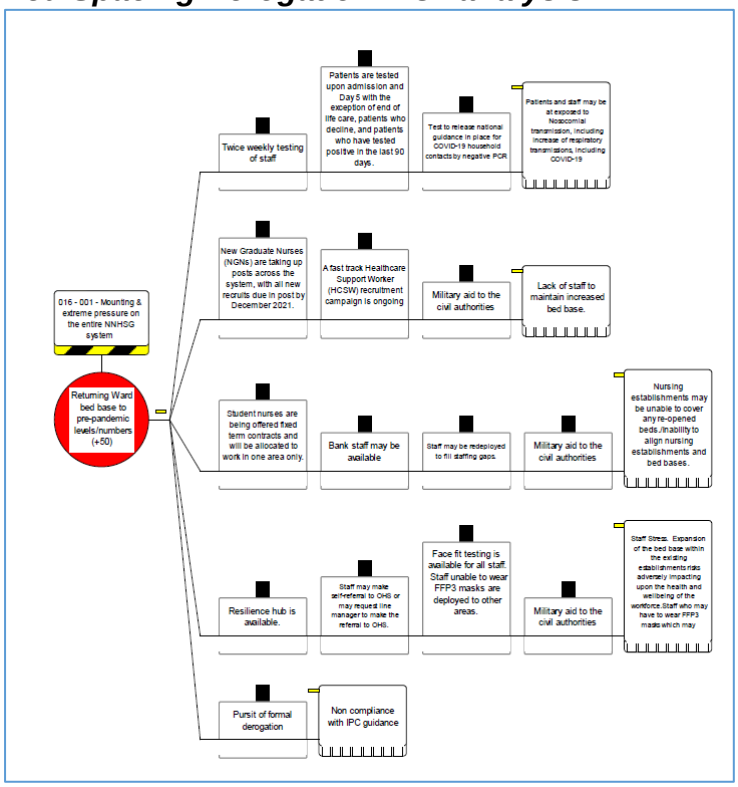
Corporate Strategic Risks

Using the enterprise risk approach we have started work on the Corporate Strategic risk profile and completed a number of sessions with the executive team. The principle is maintained in that the corporate strategic risks are related to the impact of uncertainty on our corporate and strategic objectives. This has not yet been fully completed but it is clear that the uncertain provision of health care capacity and workforce wellbeing are critical risks that make the delivery of RMP4 difficult. Our organisational plans which include Operation Iris and G-OPES are part of our mitigations to reduce this risk and avoid harm.

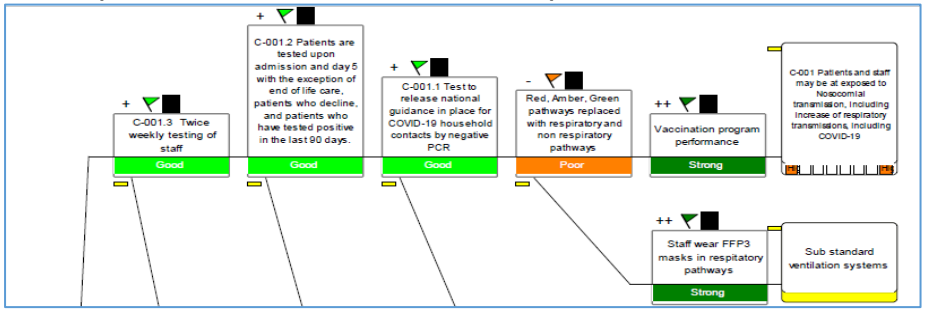
Risk approach to G-OPES and associated Derogations

Each derogation has be viewed from a risk analysis point of view using the Bowtie approach and specifically to carry out a risk and opportunity analysis. As an example the potential derogation to move away from bed spacing standards to increase available beds is on the following page:

Bed Spacing Derogation Risk analysis:

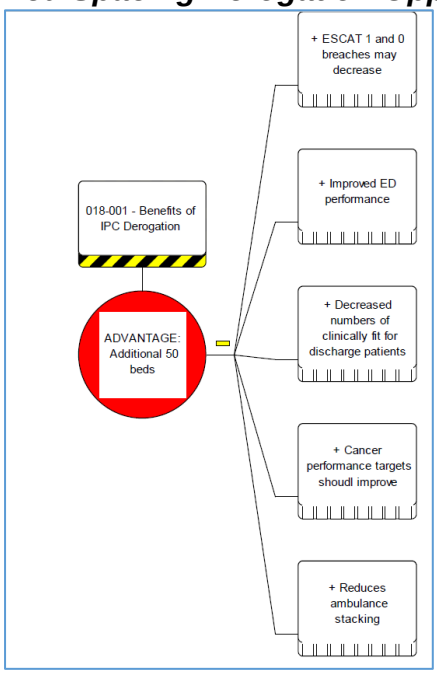


A further analysis of the controls that exist to prevent the consequence that have been identified can then be undertaken with consideration of their strength. The first consequent is shown here as an example.

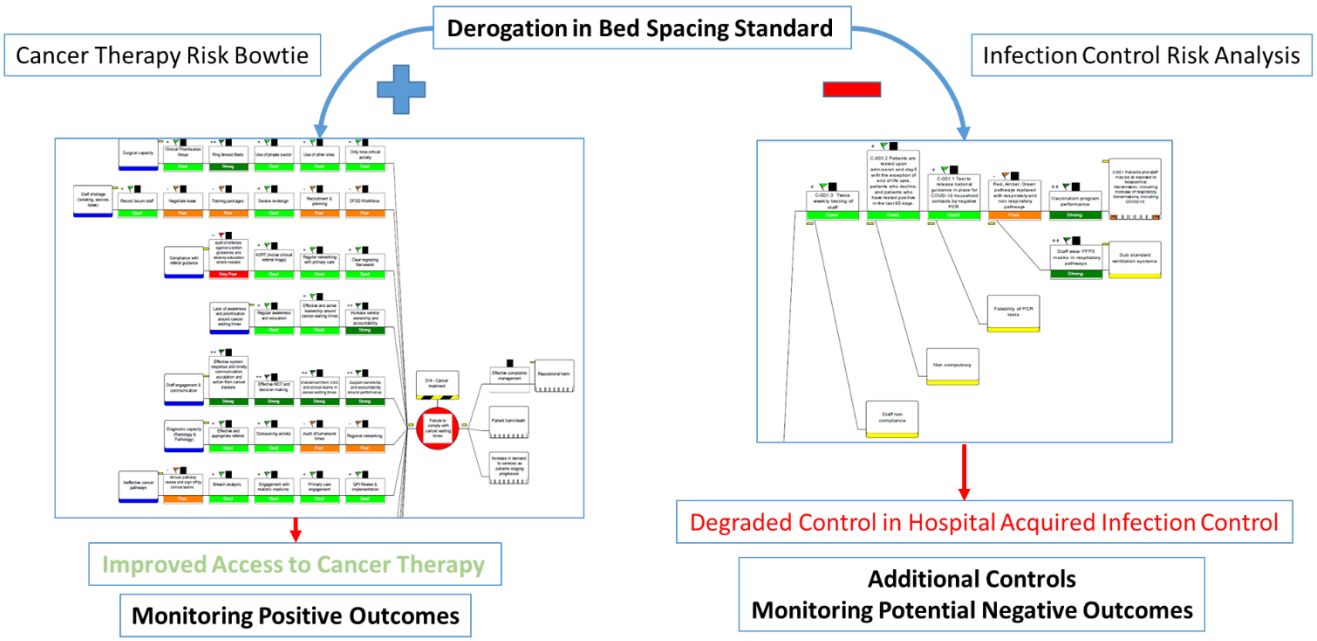


At the same time the introduction of additional beds brings some opportunities and opportunity analysis can be carried out in a similar way to risk analysis.

Bed Spacing Derogation Opportunity analysis:



Essentially this can then be brought together as a competing risk analysis where an individual action such as a derogation potentially improves one risk situation whilst at the same time reduces one of our controls for another risk or threat. The critical requirement is to evaluate this overall balance of risk, remember that its use should be specifically considered in each context and should be monitored. An example of this applied to capacity to treat cancer is set out below:



Further controls for G-OPES associated Derogations

Three additional considerations are important for the integration of derogations into G-OPES.

1. Each derogation needs to be consider at each level of escalation to match the associated risk of introducing that risk against the severity of the situation.

2. All Standard Operating Procedures that apply to a specific clinical area must be individually risk assess as the impact on infection prevention control may be very different in one environment verse another.

3. We need to embed monitoring of each mitigation into our whole system Clinical Risk Management process. This involves looking specifically at clinical events, adverse events, complaints and new risks against the positive changes to identify where the balance of risk has tipped against use of the mitigation.

NHS Grampian Board Paper - Grampian Operational Pressure Escalation System and Operation Iris

Appendix 4 - NHS Grampian Approach to Ethical Decisions

(Executive Lead Nick Fluck, Medical Director and Organisation Lead Luan Grugeon, Non-Executive Director and Chair of NHSG Ethical Advice and Support Group)

1. Background

The COVID Pandemic has highlighted the dilemmas clinical, health and social care decision-makers face. An early recommendation was to establish a Board level group to support all staff who may need advice beyond the normal experience of complex clinical, ethical, or logistical challenges and decisions that may result in moral injury.

Clinical, health and social care decision-makers remain duty-bound to respect, protect and fulfil human rights, prevent discrimination, and ensure equality and human dignity are at the heart of clinical practice. There must be equity of access for people who could benefit from treatment escalation, and respect for autonomy and the right for people to be involved in decisions that affect them.

2. Fundamental principles

The Ethics Advice and Support Group developed a local framework, using the Scottish Government COVID-19 Guidance: Ethical Advice and Support Framework. This set out below:

Framework for Supporting Ethical Decisions

Fundamental principles:

- ✓ Everyone matters - this means that healthcare decisions should respect the principles set out in human rights and equality legislation
- ✓ Everyone matters equally – but this does not mean that everyone is treated the same
- ✓ Decision making processes should be fair and equitable, as well as transparent
- ✓ Decision makers need to be honest with patients and the public about how decisions are made, in a way that they are able to understand
- ✓ Decision makers at all levels should find out what matters to those that their decisions impact, including individual patients, healthcare staff and support them in playing an active role in the shared decision-making processes
- ✓ The harm that might be suffered by every person matters and so minimising the harm that a pandemic might cause is a central concern

Autonomy

Working together - Where possible, people should be actively involved in decisions about their health and wellbeing with full and accessible information. People's present and past wishes and feelings should be considered, so far as they can be ascertained, by any means of communication. Tailored support should be provided to those who need assistance to participate in decisions. All individuals have the right to change their minds about the care and treatments that they would choose, for example, patients may wish to review advanced decisions or care plans considering new treatment options. Practitioners should maintain confidentiality in line with regulators current guidance and document appropriately.

Beneficence

Where there are resource constraints, patients should receive the best care possible within those constraints and making use of the maximum available resources

Flexibility - As the clinical situation evolves both at the individual and population level, decisions will need to be kept under review with clear clinical pathway guidance at the national level.

Reciprocity - Wherever clinicians are expected or asked to take increased risks, they must be supported in doing so, for example there must be adequate supplies of appropriate PPE.

Justice

Any ethical decision should be considered as part of the wider context in society and must consider four main areas when evaluating justice: fair distribution of scarce resources, competing needs, rights and obligations, and potential conflicts with established legislation.

Respect - All patients should have access to good quality and compassionate care
Fairness - Patients should be treated as individuals, with respect for their autonomy, and not discriminated against. If there are changes to healthcare scope and delivery, decisions should be made fairly and equitably, and not impact any group disproportionately.
Capacity and Consent - The approach to assessing, supporting and recording decisions about capacity and consent remains the same during the COVID-19 pandemic. Clinicians should continue to apply the ethical, professional and legal frameworks in their interactions with patients.

Non-Maleficence

First do no more harm, Minimise the harm that medical intervention does to a patient while acting in the patient's best interests

Minimising Harm

Where there is a decision that a treatment is not clinically appropriate, there is not an obligation to provide it, but the reasons should be explained to the patient, or their attorney or guardian where appropriate, in a way that they are able to understand, and other options explored in accordance with the patient's wishes

No active steps should be taken to shorten or end the life of an individual, however the appropriate clinical decision may be to withdraw life prolonging or life sustaining treatment, or change management to deliver end of life care Clinicians are already familiar with the need to make ethically-based decisions where further treatment simply will not deliver medical benefit to the patient, and/or it runs the risk of being inhumane, degrading or violating fundamental human dignity

Where a treatment is likely to cause significant harm or have a limited chance of benefit, clinicians, in discussion with patients and those closest to them, may decide that this treatment or course of action is not in the patient's best interests. This could include deciding against transfer to hospital or admission to intensive care or may reflect a decision to a withdraw life prolonging or life sustaining treatment. In all circumstances, patients should continue to be provided with the best possible care, as close to their wishes as possible.

3 Application of our Ethical decision frame work in the development of G-OPES

Through the support of the Ethical Advice and Support group, we have established a three-level approach to support the development of Operation Iris.

Level 1 (Strategic)
The Ethical Advice and Support Group has reviewed and provided feedback on the overall approach to G-OPES in the context of Operation Iris, focusing on the specific derogations and the wider ethical considerations.

The ethos of this approach is ethical as when there is scarcity of resources, it seeks to ensure there is a fair and transparent process for prioritising resources, taking care to avoid disproportionate harm to any specific groups. This ethical intent should be explicitly stated in the G-OPES and Operation Iris communications. The report was not written in plain English and a short communication friendly version would be useful in engagement with wider stakeholders.

Increasing bed capacity within a hospital setting
The derogation from Infection Prevention Control recommendation will increase capacity to support continued fair and equal access to health care resource and minimise impact on any single group disproportionately.

The group supported

- An open, clear, accessible and honest communication with both healthcare staff and patients
- A commitment to active monitoring of positive healthcare outcomes as well as appropriate vigilance and investigation of healthcare-associated infections with rapid reassessment of the derogation as required.

Increasing Flow on a pathway of care

The derogation supports whole system approach to capacity and flow management but should be delivered ensuring dignity and compassion.
The group supported

- An open, clear, accessible and honest communication with both healthcare staff and patients
- Ensuring decisions are kept under regular review
- A recognition that this will require a balance of complex risks/benefits which may not always be easy to quantify. In these circumstances, decision making should use the best evidence available and seek to have collective decision making, ensuring the rationale for decisions taken are clearly recorded.

Derogations from Safe Staffing Guidance

The derogation supports whole system approach to capacity but should be delivered ensuring dignity and compassion and minimising harm.
The group supported

- An awareness of the potential moral distress and injury
- Ensure ongoing resources are available to support staff such as the Grampian Psychological Resilience Hub and direct access to the Ethical Advice and Support Group.

Derogations from standard investigation and complaint processes

The group supported an approach of open, honest, and clear communication, to manage expectations and keep the complainant updated and involved.

Level 2 (Operational)
The Ethical Advice and Support group will be available to provide local support and advise on local 'Standard Operating Procedures' that seek to apply derogations within the context of the G-OPES levels. The Group is keen to support a local tool to enable teams to follow an ethical approach but where assistance is needed teams can refer with an SBAR (Situation; Background; Assessment; Response Requested) to the group and be invited to join for active discussion and information sharing. Following the meeting a written response with advice from the group will be provided. The group will actively follow-up outcomes and ensure wider shared learning. Details can be found on the group website:
Supporting Ethical Decision Making Group (nhsgrampian.org)

Level 3 (Individual)
The Ethical Advice and Support group will be available to provide individual support for ethical issues that are encountered during the delivery of Operation Iris. Referrers will provide an SBAR (Situation; Background; Assessment; Response Requested) to the group and be invited to join for active discussion and information sharing.

Following the meeting a written response with advice from the group will be provided. The group will actively follow-up outcomes and ensure wider shared learning with consent of the referrer.
For the duration of Operation Iris the Ethical Advice and Support group will increase frequency of planned meetings as required with the option to call meetings at short notice to provide urgent advice.