**Public Board Agenda**

A public meeting of the Healthcare Improvement Scotland Board will be held on:

Date: 24 June 2020  
Time: 12.30 – 14.35  
Venue: MS Teams  
Contact: Pauline Symaniak  
boardadmin.his@nhs.net  
0131 623 4294

*Note: the format of the Board agenda aligns with the terms of reference for the Board, agreed in June 2019. This in turn aligns with the *Blueprint for Good Governance.**

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<td>7.1</td>
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<td>The next meeting will be held on 23 September 2020 at 12.30pm</td>
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Meeting of the Board of Healthcare Improvement Scotland
Date: 25 March 2020
Time: 13.00–15.00
Venue: Teleconference

Present
Carole Wilkinson, Chair
Jackie Brock, Non-executive Director
Suzanne Dawson, Non-executive Director
Dr Zoë M Dunhill MBE, Non-executive Director
Paul Edie, Non-executive Director
John Glennie OBE, Non-executive Director
Gill Graham, Non-executive Director
Rhona Hotchkiss, Non-executive Director
Christine Lester, Non-executive Director
Robbie Pearson, Chief Executive
Kathleen Preston, Non-executive Director
Duncan Service, Non-executive Director

In Attendance
Sybil Canavan, Associate Director of Workforce
Lynsey Cleland, Director of Community Engagement
Ann Gow, Deputy Chief Executive/Director of Nursing, Midwifery and Allied Health Professions (NMAHP)
Diana Hekerem, Head of Strategic Commissioning Support
Jane Illingworth, Policy and Governance Manager (up to item 2.1)
Lynda Nicholson, Interim Head of Communications
Sandra McDouggall, Interim Director of Quality Assurance
Safia Qureshi, Director of Evidence
Maggie Waterston, Director of Finance and Corporate Services

Apologies
Ruth Glassborow, Director of Improvement

Board Support
Pauline Symaniak, Governance Manager

Declaration of interests
Declaration(s) of interests raised are recorded in the details of the minute.

Registerable Interests
All Board members and senior staff are required to review regularly and advise of any updates to their registerable interests within one month of the change taking place. The register is available on the Healthcare Improvement Scotland website.
1. OPENING BUSINESS

1.1 Chair’s welcome and apologies

The Chair opened the meeting of the Board by extending a warm welcome to all in attendance and in particular to Kathleen Preston who was returning to the Board after an absence.

Apologies were noted as above.

1.2 Register of Interests

The Board received the current register of interests from the Chair.

Board Members and the Executive Team were reminded to provide any changes to the Corporate Governance Office within one month of them occurring. They were also reminded to declare any interests that may arise during the course of the meeting.

Dr Zoë Dunhill advised that her work with NHS Greater Glasgow and Clyde had ended and this should be removed from the register.

The Board approved the register.

1.3 Minutes and Action Points of the Board meetings held on 4 December 2019, 19 February 2020 and 18 March 2020

The minutes of the meetings held on 4 December 2019, 19 February 2020 and 18 March 2020 were accepted as accurate records.

The action point register was reviewed and accepted. There were no matters arising.

1.5 Chair’s Report

The Board received a report from the Chair updating them on recent developments. The Chair drew the meeting’s attention to the Annual Review letter from the Cabinet Secretary.

In response to questions from the Board, the following was clarified:

a) Before the COVID-19 situation developed, HIS was continuing to provide improvement support for CAMHS (Child and Adolescent Mental Health Services). There were pockets of good practice but capacity issues in the service impacted their ability to respond. The work is now paused.

b) Regarding Public Partners’ remuneration, this will be examined as part of the wider work stream looking at engaging people in the work of HIS.

The Board noted the report.

1.6 Executive Report

The Board received a report from the Chief Executive and the Executive Team providing information on headline issues and key operational developments.

The Chief Executive highlighted the following points:

a) The report had been prepared before the COVID-19 pandemic had started to impact the work of the organisation.
b) A very positive session had been held with the Executive Team and the Partnership Forum on 12 March 2020. The results of the Culture Survey were discussed and actions agreed. Reflections and learning from that will be provided to the Staff Governance Committee in due course.

c) The cross-organisational groups for Primary Care and Adverse Events had been very successful and the approach will be extended to the Dementia and Mental Health work.

The Board noted the report.

### 1.7 COVID-19 HIS Response

The Director of Evidence, who is the Executive Lead for the COVID-19 response, provided the following verbal update:

<table>
<thead>
<tr>
<th>a)</th>
<th>All HIS staff are successfully working from home from 19 March 2020, using Skype and remote access to the networks. The ICT and Planning Teams had been critical in making this happen.</th>
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<tr>
<td>b)</td>
<td>Staff are being supported to work from home with practical advice and there is daily monitoring of absences.</td>
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<td>c)</td>
<td>A daily communication is issued to staff which filters the key information that they should be aware of. This included a late evening message on the day the more stringent measures were announced by the Prime Minister.</td>
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<td>d)</td>
<td>A staff matrix has been developed to place staff in different categories to support redeployment.</td>
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<td>e)</td>
<td>Clinical staff in HIS have returned to their territorial Boards to support frontline services and 75 HIS staff had volunteered to train as call handlers with NHS24 to support the increased volume of calls. The NHS24 Chief Executive was very grateful for this.</td>
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<td>f)</td>
<td>Work is ongoing to rapidly adapt how HIS supports the health and care system in the current circumstances. Some of our work will be paused to relieve pressure on frontline services. Positive feedback has been received about how national Boards are adapting in this way to better support frontline services.</td>
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<td>g)</td>
<td>There were a range of functions that HIS delivers that must continue during the pandemic.</td>
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In response to questions from the Board, the following information was provided:

- h) The Service Level Agreements with SAS and NSS are being revisited to ensure they remained robust at this time.
- i) The NHS Scotland volunteering team have been working with Scottish Government to look at the co-ordination of volunteers in Scotland. The Scottish Health Council will contribute to that work.

The Board noted the update and were assured by the actions in place. They extended their thanks to all staff for adapting so quickly to a new way of working and for their work to support the system at this very challenging time.
## 2. SETTING THE DIRECTION

### 2.1 Strategic Priorities 2020-23 and Operational Plan 2020-21, Finance Plan and Workforce Plan

*Ian Haxton, Workforce Consultant, joined the meeting for this item.*

**Finance Plan**

The Director of Finance and Corporate Services provided a draft financial plan for 2020-23 for approval and delivered a presentation that covered the following key points:

- a) The Audit and Risk Committee reviewed the draft budget at their meeting on 18 March 2020 and their comments with answers provided are included the Board cover paper.
- b) Assumptions are included in the Board paper that a 2% uplift will be received each year for the next three years. The previous version of the budget which was provided to the Board at its seminar on 19 February 2020 had not included this assumption. However, it had been confirmed by Scottish Government that this should be included.
- c) The baseline allocation for 2020-21 is indicative at £27.1m, as per the Scottish Budget announcement 6 February 2020.
- d) There is £7m of additional allocations but it is assumed that approximately £2m of that will transfer to the baseline during 2021-22 for the Healthcare Staffing Programme and the Scottish Antimicrobial Prescribing Group.
- e) A savings target of approximately £2m per annum is embedded within the financial plan and was agreed by the Executive Team. It includes the creation of financial headroom for investment in HIS infrastructure to secure recurring savings and efficiencies.
- f) The capital budget is not yet approved but a £1.5m bid has been made for 2020-21 to support changes to the Glasgow office accommodation.
- g) No assumptions have been made regarding the impact of COVID-19, therefore this plan will be the baseline against which changes can be measured and reported.
- h) A five year analysis of past spend and recycling of funds supports the approach of embedding approximately £2m savings within the financial plan.
- i) Going forward savings targets will be allocated to directorates and this will support better financial planning.
- j) The Internal Improvement Oversight Board is now fully established and, although some of its work is diverted to support the COVID-19 response, there remains focus on the Place, People and Processes work streams.
- k) A structural change budget of approximately £0.3m is ring fenced to provide bridging funding for improvements to infrastructure, such as becoming a digitally enabled organisation.
- l) The budget requires approval by the Board and then submission to Scottish Government by 31 March 2020. Despite the uncertainties of COVID-19, a financial plan is required to secure budget.

The Chair of the Audit and Risk Committee advised that the Committee had examined the financial plan at its meeting on 18 March 2020 and were confident that the plan presented would secure a balanced budget.
In response to questions from the Board, the following points were confirmed:

m) The bridge funding is all revenue.

n) The financial plan is integrated with the workforce plan and this will take account of any workforce changes required and including within the Quality Assurance Directorate.

Workforce and Development Plan

The Director of Workforce presented the draft Workforce and Development Plan for 2020-23 and highlighted the following points:

a) The plan is similar to last year’s with the addition of analytics for supply and demand as there remained a challenging environment around specialist roles.

b) A review of recruitment and retention is underway.

c) There will be ongoing initiatives to nurture the organisation’s own talent.

d) It had been a challenging year with increased demand for workforce services, an increase in headcount and the introduction of Jobtrain.

e) Ongoing challenges are better line management involvement in sickness absences, using the functionality of Jobtrain and improved retention of employees.

The Board noted that the sickness absence rate for HIS is very good compared to other Boards. In response to questions from the Board, it was advised that work is underway to assess how HIS uses clinical expertise and this will be led by the new Medical Director who starts on 6 April 2020. There is also cohort of several hundred Scottish improvement leaders and work will be done to mobilise that talent.

Strategic Priorities 2020-23 and Operational Plan 2020-21

The Chief Executive introduced this item and highlighted the following points:

a) In light of the COVID-19 situation, the Board were being asked to approve the plan whilst taking into account that much of it would be impacted by the pandemic but to consider it alongside the Mobilisation Plan.

b) The operational plan would in effect provide a baseline against which performance could be reported and should be seen as the work that would have been delivered without COVID-19.

The Board examined the three plans and raised concern that the plans did not articulate the COVID-19 situation and therefore the organisation may be held to account for delivery of it in its entirety. It was agreed that an introduction would be added to the operational plan setting out that COVID-19 would impact its delivery.

Subject to the addition of this introduction, the Board approved the Finance Plan, the Workforce and Development Plan, and the Operational Plan.
### 2.2 Corporate Parenting and Children’s Rights Reports

The Director of Community Engagement provided two reports to the Board and highlighted the following:

a) The reports demonstrate the organisation’s progress and breadth of work in the last three years to deliver its duties under the Children and Young People Act.

b) The Children’s Rights report will be published every three years. This is the first report and requires to be published by 31 March 2020.

c) The Corporate Parenting Action Plan summaries the actions the organisation has taken in the last three years under its corporate parenting duties and sets out actions for the subsequent three years.

d) The work will build in the next three years to ensure that it is strategic and co-ordinated across all of the organisation.

e) Both reports had been considered and endorsed by the Scottish Health Council Committee.

The Board reviewed the reports and approved them for publication. The Board also welcomed the impact in this area and thanked the staff involved for this excellent piece of work.

### 2.3 Scottish Health Council – Change Implementation Update

The Director of Community Engagement provided this paper to update the Board and highlighted the following:

a) The Scottish Health Council’s change implementation programme was now complete and the new directorate will be launched on 1 April as Healthcare Improvement Scotland – Community Engagement.

b) The directorate is now a fully integrated part of HIS and will focus its efforts where it can make the most impact.

c) The new directorate structure is in place and there are revised governance arrangements for the Scottish Health Council Committee along with strengthened membership.

The Board wished to record their thanks to all the staff who had successfully delivered this significant change. The Board also extended their thanks to Jane Illingworth, Policy and Governance Manager, who has fostered productive relationships with the Health and Sport Committee clerks.

In response to a question from the Board, it was confirmed that the change implementation had addressed the concerns originally raised by the Health and Sport Committee.

The Board noted the update and the completion of the Scottish Health Council’s change programme.
3. HOLDING TO ACCOUNT – INCLUDING FINANCE AND RESOURCES

3.1 Organisational Performance Report including Finance, Workforce and Operational Plan Risk Reports

The Board received the latest performance reports.

**Organisational Performance Report**

The Director of Finance and Corporate Services highlighted the following key points:

a) Since the development of the new performance report, this was the first time it was presented in sequence with the Quality and Performance Committee having scrutinised it before the Board.

b) The report is comprehensive and includes overview sections for finance and workforce as well as the more detailed reports.

c) The various sections of the report are considered in detail by the relevant Committee – the Quality and Performance Committee examined the operational plan performance; the Audit and Risk Committee considered the finance report; and the Staff Governance Committee considered the workforce report.

In response to questions from the Board, the following additional information was provided:

d) The timelines for the report will in future be condensed by automation of the reporting system and this would allow more "live" reporting.

e) More information will be added to the business as usual section to highlight which of the pieces of work with a downward arrow, were the highest risk ones.

**Financial Report**

The Director of Finance and Corporate Services highlighted the following:

a) There would be a carry forward into 2020-21 of £300k, 1% of the budget. Scottish Government had advised that they were receptive to the organisation carrying forward more, if it became available.

b) Of the organisation’s contribution to the National Boards’ savings target, £70k has been returned and Scottish Government have agreed that can also be carried forward.

c) There will be further slippage of approximately £100k from the cancellation of events due to COVID-19 and Scottish Government are aware of this.

**Workforce Report**

The Director of Workforce highlighted the following:

a) The report included data on the workforce mix, staff changes, vacancies and recruitment.

b) Turnover had increased in 2019-20.

c) Sickness absence remains below the national NHS average but recording of absence reasons needs to improve.

d) Recruitment activity at all levels is now paused due to COVID-19.
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<th>Operational Plan Risk Report</th>
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The report provided to the Board set out the very high operational risks.

The Board examined the detail of the performance against the operational plan, the latest financial and workforce positions and the very high operational risks. They were content with progress reported, subject to the comments made, and to continue to receive the detailed performance report.

4. ASSESSING RISK

4.1 Risk Management: strategic risks

The Board received a report on the current status of risks on the strategic risk register and their management.

The following points were highlighted by the Director of Finance and Corporate Services:

a) The Audit and Risk Committee had received the audit report from the audit of risk management in the organisation.
b) A short life risk oversight group had been formed to oversee the resulting actions.

The Board considered the strategic risk register and gained assurance that the risks presented were being effectively treated, tolerated or eliminated. The Board requested that a strategic risk is raised to capture the possible impact of COVID-19.

5. GOVERNANCE

5.1 Succession Planning Committee: Proposals for membership and terms of reference

The Board received from the Chair a paper proposing the establishment of a Succession Planning Committee and providing outline membership whose main remit was to lead the process for non-executive recruitment.

In the discussion that followed, it was agreed that the terms of reference would be reviewed to ensure there was clarity about who the succession planning process applied to. Clarity was also sought on how the work of the succession planning committee linked to development for the whole Board and individual members. Revised terms of reference will be provided to the Board at a future meeting.

5.2 Scottish Health Council Committee: revised terms of reference

The Board received from the Director of Community Engagement revised terms of reference for the Scottish Health Council Committee which reflected the revised governance arrangements and the change of name for the Directorate to Healthcare Improvement Scotland – Community Engagement.

The Board approved the revised terms of reference for inclusion in the Code of Corporate Governance, subject to clarifying that the Committee received only the risk registers allocated to it.
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<td>Governance Committee Chairs</td>
<td>The Board noted the key points report from the meeting on 19 February 2020.</td>
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<td>5.4</td>
<td>Audit and Risk Committee</td>
<td>The Board noted the approved minutes from the meeting on 28 November 2019.</td>
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<td>5.5</td>
<td>Quality and Performance Committee</td>
<td>The Board noted the key points report from the meeting on 26 February 2020 and the approved minutes from the meeting on 6 November 2019.</td>
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<td>5.6</td>
<td>Scottish Health Council Committee</td>
<td>The Board noted the key points report from the meeting on 27 November 2019 and 27 February 2020, and the approved minutes from the meeting on 27 November 2019.</td>
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<td>5.7</td>
<td>Staff Governance Committee</td>
<td>The Board noted the key points report from the meeting on 4 March 2020 and the approved minutes from the meeting on 16 October 2019.</td>
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| 6.      | ANY OTHER BUSINESS                                  | The Chair advised that two presentations had been planned at the Board meeting but were postponed due to the meeting being held by teleconference:  
  a) The Margaret McAlees award winners – Standards and Indicators Team, and Graeme Morrison.  
  b) Anne Lumsden, who is retiring as Head of Organisational Development and Learning.  
Presentations will be re-arranged for a future date. |
| 7.      | DATE OF NEXT MEETING                                | The next meeting would be held on 24 June 2020.                                            |
| 7.1     |                                                      | Name of person presiding:                                                                  |
|         |                                                      | Signature of person presiding:                                                             |
|         |                                                      | Date:                                                                                     |
Extraordinary Meeting of the Board of Healthcare Improvement Scotland
Date: 27 May 2020
Time: 14.00-14.55
Venue: Microsoft Teams Videoconference

Present
Carole Wilkinson, Chair
Jackie Brock, Non-executive Director
Suzanne Dawson, Non-executive Director
Dr Zoë M Dunhill MBE, Non-executive Director
Paul Edie, Non-executive Director
John Glennie OBE, Non-executive Director
Gill Graham, Non-executive Director
Rhona Hotchkiss, Non-executive Director
Christine Lester, Non-executive Director
Robbie Pearson, Chief Executive
Kathleen Preston, Non-executive Director
Duncan Service, Non-executive Director

In Attendance
Sybil Canavan, Director of Workforce
Lynsey Cleland, Director of Community Engagement
Ann Gow, Director of Nursing, Midwifery and Allied Health Professions (NMAHP)
Ruth Glassborow, Director of Improvement
Sandra McDougall, Interim Director of Quality Assurance
Lynda Nicholson, Interim Head of Communications
Safia Qureshi, Director of Evidence
Maggie Waterston, Director of Finance and Corporate Services
Simon Watson, Medical Director

Apologies
None

Board Support
Pauline Symaniak, Governance Manager
1. **OPENING BUSINESS**

1.1 **Chair's welcome and apologies**

The Chair opened the meeting of the Board by extending a warm welcome to all joining.

1.2 **Minutes of the Extraordinary Board Meeting on 29 April 2020**

The minutes of the Extraordinary Board meeting on 29 April 2020 were approved as an accurate record.

1.3 **Action Point Register from the Extraordinary Meeting on 29 April 2020**

The Board received the action point register and were assured that all actions were complete.

2. **COVID-19 HIS RESPONSE**

2.1 **Latest Operational Update on HIS Response to COVID-19**

The Director of Evidence provided a paper setting out the latest position with the organisation’s response to COVID-19 and highlighted the following:

- a) Two teams had been created to support the response, one taking forward the practical steps and the other addressing staffing matters. The two teams continue to meet regularly, as does the Executive Team.
- b) The response has changed to meet requirements as they have evolved.
- c) Preparations have been made for the easing of lockdown along with plans for building adjustments, for example to enable social distancing. These are complete but on hold at the moment.

In response to questions from the Board, the following additional information was provided by the Executive Team:

- d) Regarding Community Engagement staff who are based in local offices, Service Level Agreements are in place with each Board and each staff member will be considered on a case by case basis. This will take into account the needs of HIS staff and also what use the local Board has for the space, particularly if this is for clinical practices.
- e) The return of staff to Delta House and Gyle Square will not be rushed and working from home will remain the default position for some time. The re-opening of these buildings needs to be considered alongside longer term aspirations for a more agile way of working and more flexible use of office space.
- f) The organisation’s Health and Safety Advisor is fully engaged in the home working arrangements and will be fully engaged in future plans to return to the offices.
- g) The recent staff survey about working arrangements provides insights from staff and this will be taken into account into any plans going forward.

The Board considered the latest update on the organisation’s response to COVID-19 and were assured by the actions in place to contribute to the national response and ensure the wellbeing of staff.
2.2 **Operational Planning Beyond COVID-19**

The Chief Executive referred to the paper circulated which set out various scenarios for reactivating the Operation Plan as well as an updated, draft Mobilisation Plan. The Chief Executive highlighted the following points:

a) The Mobilisation Plan in its draft format was not part of the public papers, pending approval by Scottish Government.

b) The paper should be read in the context of the different phases set out to ease the national lockdown which is in place as a response to COVID-19.

c) The first part of the paper sets out proposals under the assumption of a “moderate” scenario for the pandemic.

d) The second part of the paper considers what work HIS will reactivate through to August 2020 to help the health and social care system respond to COVID-19.

e) The paper sets out initial considerations for deciding which areas of the work programme will be reactivated.

In response to questions from the Board about the organisation’s work in care homes, the following information was provided by the Executive Team:

a) HIS is unlikely to ever use its powers set out in the Coronavirus (Scotland) (No.2) Bill to take over the running of a care home. The inclusion of HIS in the Bill was queried and the advice was that all Boards were included in the Bill.

b) There has been a change in the job description for Nurse Directors to give them accountability for the healthcare provided in care homes and therefore consideration needs to be given to HIS’ role in this.

c) Support is also being provided by HIS through the Excellence in Care programme.

d) HIS has provided a number of staff to work with the Care Inspectorate on inspections. Those staff now have a caseload and have been asked to assist with on-site inspections. The work is covered by a Memorandum of Understanding between the two organisations and each person has roles and responsibilities for their deployment.

The Board asked a range of other questions and the Executive Team provided the additional information set out below:

e) The current situation provides an opportunity to reconsider the work programme and the Executive Team are committed to doing this. They will deploy their skills in a more co-ordinated manner and reinvigorate the geographical approach to the organisation’s offering.

f) Scenario modelling is being done with regard to workforce requirements. This takes into account the support being provided to the Care Inspectorate, the future requirements of the Quality Assurance Directorate and the announcement by the Cabinet Secretary that some hospital inspections will restart.

g) Guidance is being prepared for Independent Healthcare providers who will wish to restart their business as the phases of lockdown easing progress.

h) The organisation is also working with Her Majesty’s Inspectorate of Prisons to provide a healthcare focus to prison liaison visits. The methodology has been truncated to ensure staff are on site for as short a time as possible.
The Chair of the Care Inspectorate provided an update on how they had adapted working methodologies at the current time. He extended his thanks to the HIS staff who had supported the Care Inspectorate.

The Board considered the scenario planning and were supportive of the principles set out. The Board scrutinised the update to the Mobilisation Plan and were content to approve it.

3. ASSESSING RISK

3.1 Strategic Risk Management for COVID-19

The Director of Finance and Corporate Services provided the current strategic risk register and provided the following information in response to a question that was raised in advance of the meeting about risk 123, cyber security:

a) Cyber security is overseen by the Audit and Risk Committee. An update is scheduled for the Committee on the organisation’s IT systems and will be provided to its June meeting.

b) Any organisation is more vulnerable to a cyber attack during a pandemic and HIS is alert to this. It has passed successfully a recent audit of IT security and has up to date firewalls and remote patching.

c) The move to Office365 is currently being planned with a project team in place.

d) The Customer Management System is a vulnerable area because it is out of date but Office365 will also provide a solution for this. The organisation is working with NSS to agree the provision of this service.

e) The risk is rated at a realistic level given the firewalls in place.

The discussion then focussed on the following risks on the strategic risk register:

f) Risk 977, COVID-19. The Board noted that this risk reflected two different issues as result of the pandemic – the impact on the work programme and the impact on staff wellbeing. The Executive Team advised that the Staff Governance Committee that morning received a range of information to provide them with assurance on the initiatives to support staff within the organisation and those how had been redeployed elsewhere. It was agreed that the risk will be separated into these two different parts.

g) Risk 634, Workforce Strategy. The Board noted that the risk did not reflect the current position. The Executive Team advised that the Staff Governance Committee also noted this and the risk will now be refreshed.

The Board considered the strategic risk register and, subject to the comments above, were assured that the risks were appropriate and mitigations were effective.

4. AOB

The following points were highlighted:

a) The report from the Quality of Care Short Life Governance Group will be provided to the Board for its next meeting in June. It was considered by the Quality and Performance Committee at its
meeting on 13 May 2020.
  b) The Community Engagement Directorate are involved with supporting Volunteer Week, commencing 1 June 2020.

In response to a question from the Board, the Executive Team advised that HIS is providing practical support to Joint Integration Boards through bespoke support with commissioning which has continued throughout the COVID-19 pandemic. As part of the reactivation of work, consideration will be given to the organisation’s strategic planning role and work will be delivered to look at reducing the risks of infection in future pandemics.

5. DATE OF NEXT MEETING

5.1 The next meeting would be held on 24 June 2020.

Name of person presiding: Carole Wilkinson

Signature of person presiding:

Date:
<table>
<thead>
<tr>
<th>Minute ref</th>
<th>Heading</th>
<th>Action point</th>
<th>Timeline</th>
<th>Lead officer</th>
<th>Status</th>
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<td>25 March 2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Register of Interests</td>
<td>Dr Zoë Dunhill’s interest with NHS Greater Glasgow and Clyde to be removed from the register.</td>
<td>Immediate</td>
<td>Corporate Governance Manager</td>
<td>Complete</td>
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<tr>
<td>2.1</td>
<td>Strategic Priorities 2020-23 and Operational Plan 2020-21, Finance Plan and Workforce Plan</td>
<td>Introduction to be added to the operational plan setting out that COVID-19 would impact its delivery.</td>
<td>Immediate</td>
<td>Policy &amp; Governance Manager</td>
<td>Complete</td>
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<tr>
<td>3.1</td>
<td>Organisational Performance Report including Finance, Workforce and Operational Plan Risk Reports</td>
<td>More information to be added to the business as usual section of the performance report to highlight which of the pieces of work with a downward arrow, were the highest risk ones.</td>
<td>24 June 2020</td>
<td>Director of Finance and Corporate Services</td>
<td>Ongoing</td>
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<td>4.1</td>
<td>Risk Management</td>
<td>A strategic risk to be raised to capture the possible impact of COVID-19.</td>
<td>Immediate</td>
<td>Director of Evidence</td>
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### 27 May 2020

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<tr>
<th>3.1</th>
<th>Risk Management</th>
<th>Risk 923, Cyber security - An update is scheduled for the Committee on the organisation's IT systems and will be provided to its June meeting.</th>
<th>Director of Finance and Corporate Services</th>
<th>17 June 2020</th>
<th>Complete – presentation on agenda for 17 June meeting.</th>
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<tr>
<td></td>
<td>Risk 977, COVID-19 – Risk to be separated into two different parts, workforce impact and work programme impact.</td>
<td>Directors of Evidence and Workforce</td>
<td>Immediate</td>
<td>Complete – risk 977 closed and two new risks raised.</td>
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<tr>
<td></td>
<td>Risk 634, Workforce Strategy – Risk to be refreshed to reflect the current position.</td>
<td>Director of Workforce</td>
<td>Immediate</td>
<td>Complete – risk updated.</td>
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Agenda item 1.6
Board Meeting
24 June 2020

SUBJECT: Chair’s Report

1. Purpose of the report
   This report provides the Healthcare Improvement Scotland (HIS) Board with an update on key strategic and governance issues.

2. Recommendation
   The HIS Board is asked to:
   • receive and note the content of the report.

3. Strategic issues

   a) NHS Scotland Board Chairs Group

      i) Since my last report, two meetings have been held virtually, on 20 April and 18 May 2020. Both meetings have largely focussed on NHS Scotland’s response to COVID-19 but have included different aspects of the response, such as recovery phases and the governance during this period of significant change. Discussions have also extended to the COVID-19 outbreaks in care homes and the roles of NHS Boards, Local Authorities and Integration Joint Boards. The contribution of Hospital at Home and Near Me has been welcomed and there is a desire to maintain service improvements such as this beyond the response to the pandemic. We also received an update from the Reform and Innovation Group and an outline of their contribution to the recovery phase of the pandemic. The next meeting is on 22 June 2020.

      ii) The Chair of the Scottish Health Council and I have joined the other Special Board Chairs in meetings with Joe FitzPatrick MSP, Minister for Public Health, Sport and Wellbeing. These videoconference meetings have been held weekly since 16 April 2020 and have provided the opportunity for Special Boards to set out their contribution to the national response to COVID-19.

      iii) I took the opportunity to meet virtually in late April and early May with several newly appointed Board Chairs for NHS Orkney, NHS Ayrshire & Arran and the Interim Chair for NHS Lothian. This provided an opportunity to hear about their priorities and challenges, particularly in the current unprecedented circumstances, and to introduce them to the work of HIS.

4. Stakeholder engagement

   a) Joint Engagement with the Chief Executive

      i) The Care Inspectorate - The Chief Executive and I have held two of our regular keeping in touch meetings with our counterparts in the Care Inspectorate. These have again used virtual means and were held on 26 March and 28 May 2020. Our discussions have covered our joint work in the response to the outbreaks of COVID-19 in care homes, joint inspections and our respective roles as we move through the First Minister’s route map out of the pandemic.
ii) **Active Governance** – The Cabinet Secretary for Health and Sport has asked for work to be progressed in relation to active governance in NHS boards. This work builds on the direction set out in the National Blueprint for Good Governance. Healthcare Improvement Scotland and NHS Education for Scotland are providing support to this, with Robbie Pearson, acting as the Chief Executive Sponsor for this. I am sitting on the oversight group for this work. The Cabinet Secretary has asked for the focus to be on data and intelligence and the development of non-executives in fulfilling their scrutiny role. The Chief Executive and I have also joined a group with representatives from the Scottish Government and NHS Education Scotland to discuss agile governance.

**b) Meetings with Clare Marx, Council Chair, General Medical Council**

I had two very useful, virtual meetings with Clare Marx on 23 April and 16 June 2020. We exchanged information about each country’s response to the pandemic and discussed useful tools, such as their Ethical Hub and our work on Anticipatory Care Planning. We also discussed the impact of the pandemic in care homes and the progress with restoring non-COVID pathways of care. We talked about areas of good practice that had arisen through the pandemic response and recognised a shared desire to use the lessons learned as we move forward.

**c) Internal Engagement**

i) **Staff Huddles** - The Chief Executive and I joined the virtual staff huddles in May and June. I was able to update staff on the governance arrangements during the pandemic and share the Board’s gratitude for the ongoing hard work by staff during the challenging circumstances presented by the pandemic.

ii) **Meetings with staff** – I have held virtual meetings with several members of staff who have joined the organisation in the last few weeks to hear about their aspirations for their new jobs and what support they might need from the Board. I met Simon Watson (Medical Director), Sandra Flanigan (Head of Organisational Development and Learning) and Jenni Owens (Executive Assistant to the Chief Executive). I was also delighted to take part in the virtual retirement celebration for June Wylie, Head of Improvement Support.

5. **Our governance**

a) **End of Year Appraisals**

The annual appraisals for the Board’s Non-Executive Directors are in progress. The meetings are all being held virtually and follow the NHS Scotland format developed last year by the NHS Board Chairs group. I have also completed the annual appraisal for the Chief Executive.

b) **Public Appointments**

Due to the COVID-19 pandemic the interviews scheduled in March for the appointment to our vacant post on the Board, did not go ahead. The timescales are not currently known for rescheduling these interviews but I am speaking with the Sponsor Division to see if they might be progressed through virtual means.
There is also no indication as yet about the start date for the appointment round for the Board’s Whistleblowing Champion.

c) Governance Committees

Rhona Hotchkiss, Vice Chair of the Executive Remuneration Committee, will continue to act as the Interim Chair for this Committee. Regarding the Audit and Risk Committee, the Committee Chair and I had a virtual meeting to keep in touch with Evelyn McPhail, the Committee’s co-opted member who was appointed just before the COVID-19 lockdown began. This enabled us to keep her informed about recent developments and to maintain her connections with the Committee.

Carole Wilkinson
Chair
Healthcare Improvement Scotland
SUBJECT: Executive Report to the Board

PURPOSE OF THE REPORT

This report from the Chief Executive and Directors is intended to provide the Healthcare Improvement Scotland (HIS) Board with information on the following:

- key internal developments, including achievements and challenges currently facing the directorates
- external developments of relevance to HIS, and
- stakeholder engagement

This report is in the context of the organisational response to COVID-19 and should be read in conjunction with the latest COVID-19 Operational Update.

RECOMMENDATION

The HIS Board is asked to note the content of this report.

REPORT FROM THE CHIEF EXECUTIVE

Mobilisation Plan

At its Extraordinary Meeting on 27 May the Board received the latest high-level update to the Mobilisation Plan, which had been requested by Scottish Government, covering the next phase to the end of July 2020. This set out the current status of the work programme and provided a starting point for reactivation of work. It is anticipated that a further request will shortly be received from Scottish Government for a detailed Remobilisation Plan covering the remainder of the financial year. This will be developed using the approach to prioritisation presented to the Board at the May meeting. We are currently awaiting feedback from Scottish Government on the May update.

Staff Deployment Update

The table below provides an update on changes to staff deployment figures over the course of reporting to the Board to date. It indicates reductions in the numbers of clinical and non-clinical staff externally deployed from HIS. The Executive Team has begun to proactively progress discussions in relation to the return of externally deployed staff.
National Boards Collaboration – supporting NHS recovery

Healthcare Improvement Scotland has contributed to a paper setting out the key priorities for collaborative effort across the national boards to support NHS recovery. The paper recognises that while each of the national boards have specific contributions to make to the recovery and renewal phase, there are a number of areas of common interest where a continued co-ordinated and collaborative approach will deliver greater added value. These are as follows:

- winter planning and unscheduled care
- elective care
- mental healthcare
- community-led support
- intelligence

In taking this work forward the national boards will develop a wider strategic approach to renewal.

Internal Improvement Oversight Board

The Internal Improvement Oversight Board (IIOB) was established in 2019 to streamline and co-ordinate improvements in effectiveness and efficiency, to support the delivery of the strategic and operational plans for the organisation.

The IIOB is co-chaired by an Executive lead (the Deputy Chief Executive) and Partnership lead (Employee Director) and has three sub-groups: Process, Place and People. Each of these workstreams is co-led by an Executive Director and Partnership Forum lead and with an allocated non-executive director acting as a critical friend.

The formal Oversight Board was initially hibernated in response to the COVID-19 pandemic, as the Executive lead and programme lead were deployed outwith HIS. However work on a number of key elements has continued, for example in the Place workstream, the Glasgow Accommodation project and the Digital Office 365 work.

<table>
<thead>
<tr>
<th>Category</th>
<th>22 April 2020</th>
<th>21 May 2020</th>
<th>03 June 2020</th>
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<tr>
<td>Secondee returned to home board</td>
<td>53</td>
<td>49</td>
<td>38</td>
</tr>
<tr>
<td>Deployment of clinical staff to other organisations</td>
<td>37</td>
<td>41</td>
<td>29</td>
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<tr>
<td>Deployment of non-clinical staff to other organisations</td>
<td>13</td>
<td>22</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>103</td>
<td>112</td>
<td>82</td>
</tr>
</tbody>
</table>
The People workstream recommenced meeting on 29 May to begin the process of looking at new ways of working for the organisation, with a primary focus on the ‘Route map to recovery’ phasing requirements and organisational impact. The contribution of the ‘learning from COVID’ group and outputs from the health and wellbeing survey will be used to inform future developments.

It has now been agreed that the Oversight Board will be re-established with its first meeting due to take place on 1 July 2020. There will be a review of progress against the workplans of the three sub-groups and a prioritisation exercise to plan new work and understand how existing projects could be refocused in the current circumstances.

‘Shaping our future' staff survey

The ‘Shaping our future’ survey was commissioned by the Partnership Forum in recognition of the unprecedented circumstances we find ourselves in. The survey ran from 4-15 May 2020 and received a total of 334 responses. The results of the survey were reviewed at Partnership Forum on 11 June and shared with all staff and Board members on 15 June. The information provided will shape what we do to ensure our people are supported during this time, and into the future of living and working with COVID-19.

DIRECTORATE ACHIEVEMENTS & CHALLENGES

QUALITY ASSURANCE DIRECTORATE

Note: the Death Certification Review Service (DCRS) has now permanently moved from the Medical Directorate to the Quality Assurance Directorate.

ACHIEVEMENTS

The Quality Assurance Directorate responded rapidly to the challenges associated with COVID-19, with a high degree of flexibility and professionalism shown by staff.

- Deployed staff (20 clinical and one non-clinical) to NHS Boards and integration authorities to support the delivery of frontline health and care services;
- 8 staff volunteered to support NHS24 with call handler training;
- Worked in close collaboration with the Care Inspectorate as part of a whole system response to address the serious challenges which have arisen as a result of COVID-19 for those living and working in care homes. This has included gathering intelligence from care homes, joining Care Inspectorate colleagues to conduct unannounced inspections and agreeing scoping work on learning from ‘adverse events’ in the sector;
• Continued to meet our statutory obligations in terms of assuring the quality of healthcare services, whilst pausing routine inspections and reviews – this has included:
  ▪ continuing to respond to concerns raised by NHS employees; and facilitating the sharing of intelligence about the quality of care across partner organisations in Scotland;
  ▪ adapting our approach to regulation of independent healthcare services (i.e. independent hospitals, hospices and clinics) in line with Scottish Government guidance;
  ▪ making changes to the delivery of our DCRS, including a period of suspension of reviews, followed by recent resumption of reviews on a reduced basis, together with offering expert advice and guidance to certifying doctors;
• Commenced redesign of our inspection of NHS services. This will be intelligence led and focused on areas where we can make greatest impact in the current context;
• Worked in collaboration with HMIPS (HM Inspectorate of Prisons Scotland) to design a new programme of prison liaison visits;
• DCRS have increased the number of hybrid Level 1 reviews, from 4% to 8% of non-Procurator Fiscal reportable deaths as at 10 June 2020;
• Undertook internal development work across a range of wider programmes.

We have also made considerable changes to our approach to regulation of the independent healthcare sector. The key considerations were creating space to allow the sector to support the NHS and the national public health effort where they could, to not undertake activity that could spread the disease and to protect the health and safety of our staff. To this end we stopped proactive inspections and other face to face work prioritised work that would still provide assurance on quality of services but through digital means. We have continued to investigate complaints and respond to notifications.

Engaging with stakeholders
Technology has been used to engage with key stakeholders, particularly in the context of programmes which have required rapid development and adaptation. For example, regular meetings have taken place with the Care Inspectorate using MS Teams in respect of our collaborative working on care homes. Engagement with representative bodies in the independent healthcare sector also helped to inform guidance that we have produced for that sector. We have also used technology to support virtual meetings in the context of our regulatory role in respect of the Ionising Radiation Medical Exposure Regulations (IRMER) e.g. to facilitate a meeting between HIS, NHS Highland and the Care Quality Commission.
CHALLENGES

There have been new demands on the Directorate in respect of care homes and in reactivation of programmes in a rapidly evolving context. The demands of delivering new and adapted inspections has been a particular challenge, particularly at a time when some staff are deployed to other agencies or are limited by personal circumstances. New working practices and tools have required to be developed and implemented in tight timescales. Robust risk assessments have been required to ensure safety of our staff and the services we are working with. Capacity, particularly in relation to inspections, is currently very stretched, and resource and capacity planning is underway.

CORPORATE SERVICES DIRECTORATE

ACHIEVEMENTS

Glasgow accommodation / space planning

Following Board approval on 27 May 2020 to proceed with negotiations for a 10 year lease for Delta House, the next phase of the project is to develop outline space plans and designs to ensure that these are aligned with the proposed landlord technical works and meet with the expectations of staff. Work to finalise a space plan and fit out design is required to inform the final costs, affordability and programme management for the project. Due to the current restrictions, these costings are hard to predict given the availability of contractors and access to the building to provide estimated costs. Draft plans will be shared to test their appeal with staff and to help with finalising a fit-out design. A staff communication and engagement plan is under development as the project proceeds through the next phase and space plans are developed.

This work will be closely aligned with the IIOB People work stream in its review and development of flexible, agile and home working policies and the organisational response to the SG routemap responding to COVID-19 and lockdown restrictions.

Work is also underway to prepare the final business case to be approved by the Board prior to submission to Scottish Government for Ministerial approval to sign the lease and to release the required funding for the fit-out of the building.

At this stage it is difficult to provide accurate timescales and milestones for the project due to COVID-19 restrictions and implications. Work is progressing based on best estimates and information will be shared as soon as possible once it is available. The works that have been agreed to upgrade Delta House are significant and will be time consuming and disruptive. Options are being prepared to provide touch down space in Glasgow and Edinburgh as part of the route map for the easing of lockdown and this will feed into the plan for the redevelopment of Delta House.
Finance
This has been an especially busy period for the Finance team which has delivered the following:

- The Annual Accounts 2019-20 have been completed and audited with an unmodified opinion.
- The Annual Accounts Workshop was held on 4th June with all Board members invited and the accounts were reviewed and questions answered.
- A forecast to support the initial mobilisation plan was prepared. Financial planning is being prepared to support the latest version of the mobilisation plan and also the immediate additional resources required within Quality Assurance Directorate.
- The budget has been loaded and period 2 reporting is currently underway.

Corporate Governance
The Corporate Governance office has supported Board meetings on a monthly basis since the beginning of the pandemic and established regular briefings for non-Executives specifically in response to COVID-19. The team has also supported additional meetings of the Executive Team throughout (initially on a daily basis) and led on the development of two Mobilisation Plan updates. The team was also delighted to welcome Jenni Owens as Executive Assistant to the Chief Executive in April.

Planning
Much of the Planning Team’s work has been refocused on supporting the work of the COVID-19 ‘Team A’ response, including development of a return to office environment checklist for Delta House and an Asset Register for equipment removed from offices to support staff to work from home.

Other activity has related to the HIS Pandemic Flu plan, systems development, specifically in relation to performance reporting and Evidence, and on the National Sustainability reporting tool.

Organisational Development and Learning
The team has delivered a range of activities to support the use of MS Teams since its introduction in early April. This includes 1-2-1 tutorial support, FAQs and fortnightly virtual Drop In Q&A sessions. A cross-organisational HIS Champions network has also been established to support learning and use of digital technology and this will be helpful as we progress to implementation of Office 365 (late summer / early Autumn). Plans are also in place to offer learning / training opportunities for staff to become more confident in the use of MS Teams, and specifically chairing / facilitating meetings or workshops – this will be an important skill as our use of digital communications technology is likely to increase.
The team supported the delivery of the ‘Shaping our future’ staff survey and its results, mentioned earlier in the report. Staff health and wellbeing has been identified as a priority, and the Head of Organisational Development and Learning has taken on the role of Wellbeing Champion for HIS, also representing the organisation on the national group led by Scottish Government.

In May, we participated in Mental Health Awareness week (18 – 24 May), promoting a range of learning and wellbeing opportunities to staff. Work is underway to identify and strengthen access to existing interventions and resources at an organisational and national levels.

**CHALLENGES**

The move to home working at the beginning of the pandemic was a key challenge across the organisation but particularly for the ICT team, which played a significant role in making this possible and in a short space of time. This led to an initial, large increase in helpdesk enquiries as staff adjusted, and the team also continued to support the IT arrangements for new members of staff. The ICT team has also supported the roll out of Microsoft Teams which is now used for the majority of HIS meetings, with 529 account details sent to staff, leading to 440 account set ups between 30 March and 3 April 2020.

The shift to remote working also presented challenges in relation to key deliverables within the Directorate, for example the ability to work closely and collaboratively on the annual accounts process. The team heads within the Directorate are considering the impact of the pandemic on ways of working and the learning that can be taken from this.

As noted previously in the report, the external deployment of the Internal Improvement Advisor and the hibernation of the Internal Improvement Oversight Board have had an impact on internal improvement activity, however we look forward to welcoming back this team member in the summer.

**PEOPLE AND WORKPLACE DIRECTORATE**

**ACHIEVEMENTS**

**Health and Safety**

The provision of effective Health and Safety support has been central to many aspects of our response to the COVID 19 pandemic. There has been a significant and ongoing level of Display Screen Equipment (DSE) assessment activity which has been responded to quickly and effectively across the organisation. There has also been a high level of activity in terms of risk assessment processes and an opportunity to reflect and adapt previous processes to be responsive to some of the more
challenging scenarios presented with our staff moving to support service activity in a number of external service areas. In consideration of the ongoing requirement for increased Health and Safety activity, the working arrangements for our service provision have been strengthened.

**Staff Deployment**

Following the decision to return HIS secondees to their substantive employers, the team responded quickly to ensure the appropriate governance and communication was in place to support this process. There has also been extensive activity to support the deployment of our own staff to other NHS Scotland boards, and again there has been a speedy response to ensure clarity of information to those staff involved and also ensure proper governance arrangements are in place to support those working elsewhere.

**Advice and Guidance**

The team has been central to the provision and ongoing updating of a range of advice and guidance to the whole organisation in relation to the people and workplace challenges that have arisen during the homeworking arrangements. We have continued to update and respond to enquiries in relation to new working arrangements and also have been close to the necessary planning in relation to any proposed return to our premises for both Delta House and the Gyle, but also for all of the Community Engagement Offices across Scotland. There has been ongoing planning and anticipation of a range of practical issues to enable the organisation to be able to respond to changes in the advice from Scottish Government and ensure we are ready and able to respond consistently as necessary.

**Confidential Contacts**

As part of the consideration of the overall wellbeing support to our staff, there has been active discussion with Partnership colleagues to agree the type of support that could be provided throughout the lockdown by the Confidential Contracts. From this the team have now supported the establishment of regular staff access and there have now been 2 cross-HIS Wellbeing Support Group meetings on Teams that have been well attended and proved very successful. These will be continuing on a weekly basis every Thursday afternoon.

**Pension Auto-enrolment**

Business as usual continues in the background and the HR Assistants have ensured completion of the internal processes required to support the pension auto-enrolment processes for Healthcare Improvement Scotland in line with the required timescales.
CHALLENGES

Remote Working

The move to working from home has presented its own challenges for the People and Workforce team who have always had a workload generated not only by scheduled activity but also through informal and ‘passing’ contact with colleagues. The team have had to adapt to the new way of working, and some have had their own challenges in terms of their home working set up and caring responsibilities. Daily teams sessions have ensured regular contact and an opportunity for individuals to share work, concerns and also have social contact on an ongoing basis which has gone some way to ensure resilience and continued effective team working in the current circumstances.

COMMUNITY ENGAGEMENT DIRECTORATE

ACHIEVEMENTS

Launch of Healthcare Improvement Scotland - Community Engagement

The directorate successfully launched its new operating name and website on 1 April 2020. Although planned events and awareness raising activities had to be postponed due to COVID-19, the launch was still marked with press and social media releases and correspondence to key stakeholders. The Directorate is currently refocusing its work programmes in the context of the pandemic and consideration will be given to alternative ways to mark the launch of Healthcare Improvement Scotland - Community Engagement and continue to promote our new aims and ways of working at an appropriate time in the future.

Gathering Views on ME

A gathering views exercise on ME was undertaken in early March 2020. The Directorate undertook a range of activities to elicit the views of people living with ME on the care and support they receive now and what they would like to see in the future. This included seven face-to-face group discussions, telephone interviews and an online survey that received 522 responses. Analysis work is nearing completion and a draft report is due to be shared with Scottish Government in early July, with the aim of publishing the final report in September 2020.

An action after review to understand the organisational learning from this work will take place in quarter 4 of 2020 to help inform a model of best practice for future Gathering Views exercises.
Volunteering in NHSScotland

Our Volunteering in NHSScotland programme team has been exceptionally busy providing dedicated advice and support to NHS volunteer managers since the start of the COVID pandemic. Their work has included producing guidance on the recruitment and developing roles of volunteers during the pandemic, and running virtual meetings and webinars to support Boards on a wide range of volunteering issues. The team has also worked with NHS Education for Scotland to produce an online induction scheme for volunteers via Turas Learn.

As part of Volunteers Week the team produced a short video to thank volunteers and published a number of blogs to highlight the invaluable contribution volunteers have been making during the pandemic and throughout the year.

CHALLENGES

The COVID pandemic has required the directorate to quickly refocus how it supports meaningful and inclusive community engagement in health and care services in the context of physical distancing requirements. The face-to-face engagement methods routinely deployed are not possible and work had been ongoing to develop tools and resources to support organisations engage differently.

The directorate is also considering how it supports and assures statutory duties for public involvement in response to the pandemic. We plan to work with Boards and Integration Authorities to help identify a new starting point for engagement activities in relation to urgent changes implemented during the initial emergency response, as well as proposed and future changes to health and care services at local, regional and national levels.

EVIDENCE DIRECTORATE

ACHIEVEMENTS

Evidence support to the Scottish Government Clinical Cell

Since April, HIS Evidence, particularly the SIGN team, has been supporting the Scottish Government’s COVID-19 Clinical Guidance Cell with the synthesis and publication of rapid clinical guidance on COVID-19 for health and care practitioners in Scotland.

The following publications are now available from the SIGN website:

- Pragmatic guide for diabetes services during the COVID-19 pandemic (published 8 April 2020)
- NHSScotland clinical guidance for TIA and stroke management during the COVID-19 pandemic (published 16 April 2020)
• Definitions of respiratory patients at high risk of COVID-19 infection, for shielding (published 30 April 2020)
• Assessment of COVID-19 in primary care (published 7 May 2020)
• Maternal critical care provision (published 19 May 2020)
• Prevention of thrombosis in RRT (published 27 May 2020)
• Presentations and management of COVID-19 in older people in acute care (published 29 May 2020)

Guidance is produced using a rapid development methodology. SIGN’s input is facilitating the development of rapid high-quality guidance, and the joint Scottish Government and SIGN branding gives authority to a Once for Scotland approach.

Antimicrobial Stewardship during the pandemic

The Scottish Antimicrobial Prescribing Group (SAPG) has developed pragmatic practical advice for clinical teams to support antimicrobial stewardship during the COVID-19 pandemic and minimise unnecessary antibiotic use that may drive increased antimicrobial resistance. This included advice on managing respiratory infections in hospitals and for frail older people in the community.

To evaluate the impact of COVID-19 on antibiotic use in hospitals, SAPG coordinated a point prevalence survey which eight boards participated in and this data is currently being analysed for a peer-reviewed publication.

SAPG is also working with colleagues in NSS to evaluate the impact of COVID-19 on antibiotic use in the community and this work will also be published in due course.

Access to new medicines with potential to treat COVID-19

RAPID C-19 is a UK-wide multi-agency initiative (involving NICE, the National Institute for Health Research (NIHR), NHS England, NHS Improvement, the Medicines and Healthcare Regulatory Agency (MHRA) and the devolved administrations) to expedite access to new medicines that may be beneficial in the prevention and/or treatment of COVID-19.

SMC (Scottish Medicines Consortium) is working with NICE to prepare briefings on medicines in clinical trials, including a summary of ongoing clinical trials and published evidence. The Chair and Chief Pharmacist of SMC are members of the Oversight Group that meets weekly to review briefings and monitor medicines that may be appropriate for expedited early access. An example of this is remdesivir which received an Early Access to Medicines Scheme (EAMS) scientific opinion from the MHRA at the end of May. The ADTC Collaborative and SMC worked at pace to ensure guidance was issued to health boards within 48 hours of the MHRA announcement. This medicine may be licensed by the European Medicines Agency in the near future.
Pre-Hospital Clinical Management Pathways

HIS Evidence has been invited to join a Scottish Government Short Life Working Group looking a pre-hospital clinical management pathways for COVID-19 patients. The role of the SLWG will be to make recommendations to the CMO around the value or not of introducing any new service.

CHALLENGES

The Mobilisation Plan identifies the need for SMC activities to resume as soon as practicable. HIS pharmacy staff who were deployed to support Health Boards will return by the end of June to allow new medicine assessments to take place. Progress is also reliant on the ability of clinicians to attend formal meetings such as the New Drugs Committee, Patient and Clinician Engagement (PACE) and SMC. Feedback from members indicates that most should be able to attend virtual meetings from June/July 2020 onwards. Most Boards are restarting ADTC meetings and will shortly be in a position to receive SMC advice. A New Drugs Committee will be held virtually in June and SMC should resume in August.

Whilst these practical steps are welcomed, resuming standard process according to conventional timelines is not a viable option. The current circumstances require SMC to take a pragmatic approach to allow advice to be issued in as timely a way as possible, with a view to the earliest decisions being taken for medicines expected to deliver greatest clinical benefit. The SMC executive team has agreed the principles of how this will work and a proposal will be submitted to the Scottish Government Health and Social Care Directorates in the next week or so.

Restarting National Screening Programmes

Plans for the recommencement of national screening programmes were recently approved by the Scottish Screening Committee. The arrangements required to address the backlogs from the period of suspension mean that resumed services are unlikely to meet all of the criteria in the relevant HIS screening standards. The Standards and Indicators team will identify those criteria which will need a temporary amendment until programmes are back on track. These amendments will be consulted on through the Screening Programme Boards and in consultation with the recently established National Screening Oversight Group.

NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONALS (NMAHP) DIRECTORATE

ACHIEVEMENTS

Gender-based Violence Policy

Gender-based violence (GBV) is a major public health issue which cuts across the whole of society. The interim GBV Policy was rapidly progressed by the public
protection team, HR and partnership colleagues at the beginning of COVID-19 and is now available to all staff. This policy brings us in line with national guidance and will be used as a stop gap until the Once for Scotland GBV guidance becomes available in 2021. The policy contributes to a safe working environment for those affected by gender based violence, raises awareness and promotes the welfare of all staff and ensures as an organisation we respond effectively to those affected both victims and perpetrators. Training is currently being developed at a national level and will be adapted for HIS shortly.

**NHS Orkney – Joint Inspection of Children’s Services (JICS) Report**

The NHS Orkney JICS report highlighted significant areas for improvement in both multi-agency and NHS child protection service, and as a result our Public Protection and Child Health Services Lead has been providing regular support since March 2019.

During this process we are maintaining good links with the Care Inspectorate, the Sharing Intelligence Group and Scottish Government to ensure a consistent approach to support being provided.

Improved links have also been made with NHS Grampian, the North of Scotland Managed Clinical Network for Child Protection and the Scottish nursing leadership for Child Protection. An improvement plan has been developed and includes actions around guidance, communication and awareness-raising.

**CHALLENGES**

NMAHP has a high number of clinical staff seconded to its programmes from NHS boards. These staff returned to their boards to support COVID-related work in mid to late March 2020. Communication regarding staff return has commenced however feedback suggests that a number of highly skilled staff might not be released to HIS to recommence secondments. Discussions have begun as to mitigating this issue and offer of permanent employment using monies baselined in 2020/21 is being considered for staff whose skills are necessary for the continued running of programmes.

**ihub DIRECTORATE**

**ACHIEVEMENTS**

The directorate led the rapid development and implementation of a number of new programmes to support the health and social care system in its response to COVID-19. A number of these, including Near Me, Inclusion Support and Person Centred Care Learning System, have been designed and delivered in partnership with other directorates and demonstrated in practice how a cross organisational approach can
enhance our impact. Designing new programmes from scratch, at the same time as staff were transitioning to full remote working, was only possible because of the commitment of a wide range of staff to work flexibly and at pace in a challenging context. As an example, Near Me roll out support to primary care started within 24 hours of initial agreement.

**NHS Near Me**

In response to the pandemic, HIS agreed in March 2020 to support the Scottish Government with the rapid implementation of Near Me across a number of key services including mental health, maternity, obstetrics, paediatrics and primary care. As a result, benefits have been highlighted including reduced attendance within outpatient departments, protecting the clinical and care workforce through reduced exposure to risk of infection, and increased resilience by enabling clinical support to be provided from different geographical locations.

**Impact**

Activity data reflects the 11 week period in which HIS has provided implementation support.

**Primary Care**

The current phase of implementation support within general practices has now concluded with:

- **652** practices across 10 NHS boards being supported to implement NHS Near Me.
- Across the 10 boards, **1,894** video consultations were undertaken for w/c 17 May over 55% of the total video consultations completed that week.

A primary care webex with over 480 attendees was also held to enable practices across Scotland to share their learning and consider the future role of video consultation within the primary care model.

**Obstetrics, Community Midwifery and Paediatrics**

HIS is supporting eight NHS boards to implement NHS Near Me across maternity and obstetric services with the current phase due to conclude by the end of June 2020. Video consultations undertaken within maternity services has increased by **247%** over the reporting period with **236** completed for week commencing 17 May.

Implementation of NHS Near Me within paediatric services was already underway prior to HIS commencing. Our role has been to support the development of national clinical guidance, patient facing information and to facilitate a broader learning system for teams across the country.
Mental Health

The support across mental health has focused within three key service areas – crisis, eating disorders and perinatal mental health support – alongside the National Deaf Mental Health Service. A brief case study of the support can be found here: https://tec.sct.org/wp-content/uploads/2020/05/Scottish-Mental-Health-Service-for-Deaf-People-200513-v1_0.pdf

All boards are now using NHS Near Me within mental health services and this phase of support is due to conclude at the end of June. Data demonstrate a significant increase of over 409% with 3,626 in Near Me consultations completed week commencing 22 May.

10 boards supported by HIS have demonstrated an increase of 1,031% in Near Me consultations since the commencement of support at the end of March 2020.

Evaluation

A small evaluation team was developed within the HIS capacity to capture:

- The internal learning for the organisation of responding within an emergency situation to deliver large scale change at pace and scale.
- Learning for both the SG National Near Me team and wider system on best practice in relation to implementing NHS Near Me.

The team has also been participating with a four country learning system led by the Health Foundation to capture and share experiences from the four nations.

Inclusion Support

The Connecting Scotland programme was initiated following discussions with the Scottish Government’s Office of the Chief Designer about how those who are digitally excluded might not be able to access digitally redesigned health and social care services (a long standing inequality issue). The initial work, supported by HIS’s ihub and Community Engagement Directorates, has now developed into a formal Scottish Government programme with £5m funding to enable the purchase and delivery of equipment, and support to people facing digital exclusion.

Supporting Person-Centred Care in Covid-19 Situations Learning System

Health and care staff are demonstrating new ways to communicate compassionately when the usual ways of interacting with patients, service users and their families, are not possible. The ihub, Community Engagement and Evidence directorates have developed a learning system to identify case studies that demonstrate how small acts of compassionate care make big differences to patients, service users and their families and, in turn, to health and care staff. An example is overcoming the communication barrier between COVID-19 patients and care staff wearing Personal
Protective Equipment. The associated webpage has consistently been one of the most viewed pages on the ihub website and there has been a good level of engagement on social media.

**Primary Care Resilience National WebEx Series: Connect, rebuild and move forward together**

The response to COVID-19 has led to a rapid change in how general practice operates. The Primary Care Improvement Portfolio is hosting a webex series to share the learning and reflect on what this could mean for the future of primary care. The series has also been picked up by colleagues in the Welsh Government who are looking to be involved as the series progresses. The first webex had over 480 participants joining us with lots of discussion generated in the chat box. You can find the recording of the webex and a copy of the slides on our ‘Primary Care Resilience’ webpages. The next session is planned for 25 June and will include discussion on relationships and collaborations between primary care services and care homes in Scotland.

**Health and Social Care Learning System**

The Scottish Health and Social Care system has been innovating at an unprecedented pace and scale to address the challenges presented by COVID-19. The Transformational Redesign Unit (TRU) has developed a systematic approach to identifying these innovations and capturing learning in the form of case studies, blogs and horizon scans. For example one of these stories is looking at a community approach to supporting mental health and wellbeing during COVID-19 and can be accessed at [https://ihub.scot/media/7150/20200420-hscp-learning-system-community-led-models-kinning-park-complex-v1.pdf](https://ihub.scot/media/7150/20200420-hscp-learning-system-community-led-models-kinning-park-complex-v1.pdf)

**Health and Social Care Partnerships Support (HSCP)**

We have adapted our bespoke support offer in relation to strategic planning and commissioning and are engaging with nine health and social care partnerships and one NHS board around COVID-19 resilience and recovery. An example is the work to support East Renfrewshire HSCP to develop a dashboard using demand and capacity information from across local care providers. Projects focusing on recovery and renewal in the context of COVID-19 relate to priority areas such as children and young people, mental health, and drugs and alcohol.

**National Organisations Integration Improvement Support Huddle**

One of the recommendations of the Ministerial Strategic Group’s review of integration in 2019 was that national improvement bodies must work more collaboratively and deliver the improvement support partnerships require to make integration work. We have led work to put in place a monthly huddle call to enable the key national organisations to share any key new developments in their improvement support offers
and identify any interface issues for collaboration. Attendance was expanded out to include Public Health Scotland in recognition of their key role in this space and Scottish Government Policy leads and Integration Joint Board Chief Officer representatives are also invited to attend. Starting in January 2020, these calls have continued throughout recent months with ongoing attendance from all the national organisations involved; an indication of the value of them. The huddle is also enabling the development of positive relationships, something evaluations consistently show is important for effective collaborative working.

**CHALLENGES**

**Capacity**

We are now in the process of reactivating a wider range of improvement support offerings in line with the priorities identified in the current HIS mobilisation plan which for improvement support are Access QI, Older People (including Hospital at Home), Primary Care, Mental Health, and Safety. It is vital that the national improvement support aligns with the current priorities of the health and care system. Therefore we are going through a process to understand priority needs against these key areas of work, reviewing:

a) Whether we need to develop new programmes.

b) Which of our hibernated programmes are still fit for purpose/still a priority and need to be reactivated.

c) How long any COVID-19 responses related to these priorities should continue for.

Doing all of this when we have staff externally deployed and many with significant caring responsibilities is challenging. In addition to the 16.4 Whole Time Equivalent (WTE) staff who are deployed in boards/HSCPs, we currently have 20.2 WTE vacancies across the directorate. Further, our Head of Improvement Support, June Wylie, has now retired and we are not currently in a position to replace her. In common with the rest of the organisation, line managers are also reporting significantly more time being spent in one-to-one conversations providing emotional support to staff.

Holding staff through the uncertainty of redesign can be a challenge in normal circumstances and doing this when there is so much uncertainty in individuals’ personal lives increases the challenges further. However we have been able to draw on the learning from the development of the ihub directorate in 2015 and have a strong focus on being clear with staff around process, making sure there are effective mechanisms for involving staff and regular communication.
MEDICAL DIRECTORATE

ACHIEVEMENTS

‘Once for Scotland’ medicines work

In support of ‘Once for Scotland’ work around the safe and effective use of medicines and delivery of pharmaceutical care, we have developed a wide range of policies, guidance and advice for a number of specialties and settings including Prisons, Cancer, Primary Care, Palliative Care and Care Homes. This has involved collaboration with both internal (SAPG and SMC) and external pharmacy and medicines stakeholders. This work was developed in response to COVID-19 and therefore considered the need to reduce patient contact where appropriate, minimize risks associated with the use of medicines and support rapid changes in practice. Ongoing learning support systems are being put in place to continue to support this work.

Examples of work to date in support of COVID-19 are as follows:

Area Drug and Therapeutic Committee Collaborative (ADTCC)

- Patient Group Direction for paracetamol, to support community pharmacies to provide supplies during issues with availability of over the counter packs during COVID-19.
- Returning Medicines to Community Pharmacies during COVID-19 - guidance for patients on NHS Inform on how to safely return medicines to their community pharmacy.
- Palliative Care pack published.
  - Collaborative working between HIS, SG, National Services Scotland, Directors of Pharmacy
  - Single Nurse Administration of Controlled Drugs with the Nurse Directors - for implementation at NHS board level.
  - Patient Group Directions for Paracetamol, Morphine Oral Solution and Lorazepam (embedded in Palliative Care Toolkit).
- Advice on therapeutic substitution/switching Renal Dialysis/ Hemofiltration Fluids
- NHS Louisa Jordan support for medicines governance, Controlled Drug issues and discharge prescriptions.
- Pharmaceutical Care in Care Homes – establishment of Group to discuss medicine use in general in care homes.

Cancer
- Off label and SACT (Systemic Anti Cancer Therapy) Cancer medicines programme suspended since March, however cancer medicines guidance being developed in response to regional requests, with two already approved.
- Cancer Treatment Response Group Cancer Medicines Governance Framework approved and issued (Scottish Government).

Prisons
- Support medicine use in Prisons: Clinical Guidance, implementation and evaluation support on switching patients to Buvidal, scoping provision of Nyxoid and service planning for early release of prisoners.

Scottish Rheumatology Registry
We have worked in collaboration with a number of NHS Boards to support the development of a system to track the response to biological therapies for Rheumatoid Arthritis. This was designed to give better near real-time information on the benefits of these therapies, which come with clinical risks and significant costs. The new system has been of even greater benefit during the COVID-19 pandemic as it allows better monitoring of a group of people at higher risk of severe COVID-19, many of whom are shielding. It was co-developed with a number of NHS Boards using UK Health Foundation funding and roll out has accelerated during the Pandemic as part of a wider move to remote monitoring, which would complement a ‘Near Me’ consultation for people with Rheumatoid Arthritis.
1 minute Explainer Video: https://youtu.be/FF_VdTv8l0U.

The approach has the potential to be used in other situations where people rely upon therapies that maintain health by supressing the immune system which inevitably increases the risks of severe infections.

CHALLENGES
The Medicines team has also played a significant part in supporting NHS capacity and resilience through redeployment of staff to NHS 24 and Scottish Government.

The pace, complexity and sensitivity of the work by a reduced team has been a challenge.
STAKEHOLDER / EXTERNAL ENGAGEMENT

Communications team: reputation management – our contribution to COVID-19

One of the key ways we engage with stakeholders on our activity is through social media on the corporate HIS account, mainly Twitter. In the quarter March through May 2020, we have seen our rate of engagement triple through this medium, compared with our usual level (pre COVID-19). The table below highlights the main statistical changes.

This shows that stakeholders have turned to us as a trusted source of information and that there is a great interest in our contribution to the response to COVID-19. We have ensured a consistent approach to the quality of social media output. We have analysed the content of our outputs to show what is attracting the biggest interest, this shows to be the person-centred care stories which have been gathered by the national learning system. In addition, our output pointing to learning opportunities for health and care professionals has also proved most popular. We have also run a series of blogs highlighting individual contributions to the frontline during COVID-19 and these have frequently attracted engagement rates approaching the top end of the industry standard of good.*

For example: Our blog about supporting NHS Scotland’s response to COVID-19 featuring Jacqui Sneddon, SAPG lead, had 2,628 impressions, and 214 actual engagements which gives a rate* of 8.1%.

Taking February as a typical month, we can see March being a key month where the number of people following us on Twitter more than doubled, indicating they were turning to us as a key source of useful content. The benefit of this increased following means our social media output has reached a far greater number of stakeholders. This growth is shown in the final column.

We continue to attract new followers each month although the rate may start to taper off to pre-Covid rates as our output becomes more business as usual. Our challenge is to sustain increased followers and engagement rates over the longer term.

Key months of change highlighted in red.

<table>
<thead>
<tr>
<th>Month</th>
<th>New Followers</th>
<th>Likes</th>
<th>Retweets</th>
<th>No. of Accounts Reached (Impressions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb (pre- COVID)</td>
<td>240</td>
<td>286</td>
<td>197</td>
<td>81k</td>
</tr>
<tr>
<td>March</td>
<td>595</td>
<td>374</td>
<td>230</td>
<td>78k</td>
</tr>
<tr>
<td>April</td>
<td>413</td>
<td>972</td>
<td>769</td>
<td>154k</td>
</tr>
<tr>
<td>May</td>
<td>337</td>
<td>1,000</td>
<td>863</td>
<td>273k</td>
</tr>
</tbody>
</table>
[*An engagement rate between 0 and 2% is considered to be low. Engagement rates between 2% and 9% are considered to be good. An engagement rate between 9% and 33% is considered to be high.]
1 Purpose
To provide the Board with a briefing on the response to date of Healthcare Improvement Scotland to the COVID-19 pandemic and to inform Board members of the further measures being taken.

This is presented to the Board for:
- Awareness

This report relates to:
- Emerging issue

This aligns to the following HIS priorities(s):
- Safe, reliable and sustainable care

2 Report summary

2.1 Situation
At the time of preparing this paper, Scotland is in phase 2 of the Scottish Government’s route to recovery. Healthcare Improvement Scotland has developed a detailed re-engagement plan that allows us to respond safely to these changes.

The re-engagement plan maps our response to the phases detailed in the Scottish Governments route map to recovery. The re-engagement plan will be reviewed weekly at the Team A resilience meetings.
2.2 Background

- Remote working is fully established across the organisation. Our offices at Delta House and Gyle Square and our regional Community Engagement offices remain closed.
- Our Emergency Response Teams continue to meet regularly to cover resilience arrangements and our amended work programme.

2.3 Assessment

2.3.1 Quality/ Care

We continue to issue regular emails to staff containing advice on issues such as keeping safe, working practices, travel arrangements and Scottish Government guidance.

2.3.2 Workforce

The health and wellbeing of our staff remains a key priority. The Head of Organisational Development and Learning is leading work to respond to feedback from the recent staff survey. Our confidential contacts mutual support group continues to meet every Thursday.

There have been no confirmed cases of COVID-19 amongst our staff.

Further work has been undertaken to support the safe re-start of recruitment.

The COVID-19 group, via its connection to the national PPE (Personal Protection Equipment) oversight group, will become the link for monitoring PPE stock availability for staff inspecting care homes.

A Question and Answer paper about the new Test and Protect process has been developed and shared with all Healthcare Improvement staff.

We are working with the Partnership Forum to produce guidance for staff members who are balancing home-working with home-schooling and other caring responsibilities.

2.3.3 Financial

Financial appraisal is covered in a separate paper.

2.3.4 Risk Assessment/Management

There are two strategic risks in respect of COVID-19.

2.3.5 Equality and Diversity, including health inequalities

We remain sensitive to the issues facing staff in the current situation and the potential stresses, for example, of balancing enforced working from home with caring responsibilities of any kind, or with the need to self-isolate or shield. We continue to address these both with general advice and individual support as needed.

2.3.6 Other impacts

N/A
2.3.7 Communication, involvement, engagement and consultation

This update has not been shared externally with stakeholders. Regular staff communications on the latest position continue to be shared with all staff and on the organisation’s intranet.

2.3.8 Route to the Meeting

This update has not been previously considered by another group. The Executive Team meet regularly to review the latest operational position with COVID-19.

2.4 Recommendation

- Awareness – For Members’ information only.

3 List of appendices

None
Healthcare Improvement Scotland

Meeting: Board Meeting
Meeting date: 24 June 2020
Title: External Assurance: care homes, hospitals and independent healthcare
Agenda item: 2.2
Responsible Executive/Non-Executive: Ann Gow, Director NMAHP & Deputy Chief Executive/ Sandra McDougall, Interim Director of Quality Assurance
Report Author: Ian Smith, Head of Quality of Care

1 Purpose

This is presented to the Board for:
• Discussion and agreement

This report relates to:
• Emerging issue

This aligns to the following HIS priority:
• Safe, reliable and sustainable care

2 Report summary

2.1 Situation

Healthcare Improvement Scotland suspended all routine inspections, as part of its response to COVID-19, in order to support frontline services to focus efforts on service delivery in the context of the pandemic. This included; hospital inspections and the inspection of prisoner healthcare with HMIPS (Her Majesty’s Inspectorate of Prisons for Scotland) and all joint inspection activity with the Care Inspectorate. The organisation continued throughout the pandemic to respond to any emerging concerns and retained a small team for monitoring any issues in independent healthcare. In recent weeks the organisation has also been supporting the inspection of care homes with the Care Inspectorate following a high number of deaths in this sector.

A number of clinical Quality Assurance Directorate permanent inspection staff were deployed to territorial NHS boards, NHS 24 and the Care Inspectorate to support frontline healthcare and other activity in response to the pandemic. At 15 June 2020, all but seven inspectors, who are supporting the Care Inspectorate in its care home liaison work, have returned from their temporary secondments.
As the COVID-19 numbers decline, the country moves into a new recovery phase and intelligence is increasingly available about the effect of the outbreak on services, there has been a call to restart some hospital inspection activity. The reactivation and refocusing of our inspection programmes, at the same time as undertaking new inspection work in relation to care homes, has created a number of workforce pressures.

2.2 Background

Previous discussion at the Board about the Quality Assurance Directorate highlighted the challenges and the increasing complexity of quality assurance work for the organisation and the need to ensure resourcing and leadership of the directorate. An agreement was reached to recruit a Director of Quality Assurance. Interim leadership for the directorate would continue to operate jointly between the Interim Director of Quality Assurance and the NMAHP Director/ Deputy Chief Executive. Recruitment to the Director post and the vacant Head of Service post has been paused during the covid outbreak.

The covid pandemic has increased the need for assurance in respect of health and care services, given the harmful effect on people and services of the outbreak. Assurance and inspection activity is increasingly under public scrutiny in the immediate aftermath of the peak of the pandemic and carries high reputational risk for the organisation. This has highlighted the need for accelerated development in the leadership, support and operational delivery in the directorate.

2.2.1 Quality of Care Approach
A separate Board paper entitled Quality of Care Approach Short-life Governance Group – Progress and Next Steps Report sets out a range of recommendations for strategic development within the directorate, which provide an overarching framework and direction for all of our assurance work. Areas for development include:

- Strengthening the use of data and intelligence to guide our assurance programmes and enable more proactive, targeted and pre-emptive activity
- Development of skills and capacity to support more effective use of self-evaluation
- An updated learning and development plan for the directorate
- Revision of the Quality Framework
- Development of an engagement and communication plan for the Quality of Care Approach, as part of a wider communication strategy for the directorate.

That paper highlights the need for investment of resources to support the recommended strategic development. The immediate operational needs set out in this paper in respect require to be considered in that wider context.

2.2.2 Inspections
Hospital inspections including the Healthcare Environment (HEI) and Older People in Acute Hospital (OPAH), Prisoner Healthcare inspections and Independent Healthcare inspections were all suspended in March 2020 following a letter from NHS Scotland’s Director General to allow the NHS and public sector services to focus on managing the outbreak of COVID-19. As noted above, the organisation continued throughout the pandemic to respond to any emerging concerns and retained a small team for monitoring any issues in independent healthcare and in recent weeks has been supporting the inspection of care homes with the Care Inspectorate.
2.2.3 Hospital Inspections
HIS has been asked by Scottish Government to recommence unannounced inspections into those hospitals which have patients at significant risk due to COVID-19. This inspection activity requires to be informed by data, including data on areas which have had outbreaks of healthcare acquired COVID-19.

These inspections will use a new methodology, developed for these inspections, which will be a hybrid of the HEI and OPAH inspections.

We will be carrying out two inspections per month, which will require a senior inspector, two inspectors per inspection and support from a programme team of a programme manager, two project officers and an administrative officer. As these inspections are covid related, resource will be sought from the national covid budget.

2.2.4 Prisoner Healthcare Inspections
These inspections were not initially planned to restart until August, however, due to the legal requirement for HMIPS to monitor prisons, and the significance of healthcare within the prisons, HIS was asked to take part in a series of prison liaison visits commencing in June 2020. Once again, in response to the current situation we had to develop a new methodology for prison visits, which is now a combination of virtual and onsite monitoring.

This work requires a senior inspector and an inspector to carry out the visits, supported by a project team.

2.2.5 Care Home Inspections
The Scottish Government, in response to the mortality rates within care homes, has instructed HIS to provide expertise in the inspection of infection control practice to the care home sector, working alongside the Care Inspectorate. This is new work for HIS, and has involved us developing a complex methodology and appropriate systems of internal governance whilst carrying out the inspections together with the Care Inspectorate.

We have been asked to participate in up to 10 inspections per week, including weekend and evening inspections. To date we have been asking inspectors to volunteer to carry out these inspections at the weekends, as the inspectors’ contracts currently cover a Monday to Friday normal working pattern.

A short life working group with participation from partnership, union representation, human resources, as well as inspectors, has been established to work through issues such as the development of a memorandum of understanding with the Care Inspectorate and establishment of systems for staffing these inspections appropriately from our existing pool of inspectors.

2.2.6 Independent Healthcare
Routine independent healthcare inspections were also suspended, with monitoring and management of notifications and complaints only. However, as the country moves into the next phase of the pandemic, we expect to see an increase in the amount of independent health providers re-opening.

2.2.7 Returning to pre pandemic work programmes
A combination of expansion of current work, pre-existing capacity issues and adaptations for working in a covid environment have put significant pressure on the directorate. This is likely to
increase as services and assurance programmes re-open. Currently there is a significant risk that, without investment in and development of the directorate, delivery of pre-pandemic programmes will not be possible. The sponsor directorate and chief nursing officers’ directorate have been made aware of issues and resourcing discussions are underway. In the meantime, prioritisation of the mobilisation plan is underway and resources are being deployed from across the organisation to support the directorate.

2.2.8 Management of Risk in the Covid Environment
A number of measures have been put in place to reduce the risk to HIS staff of contracting covid due to exposure at work and reduce the risk to services being inspected of cross infection by HIS staff. These measures have been agreed in partnership and include:

- Minimising the time spent in situ on inspection
- Maximising the use of telephone, video and self-assessment materials off site
- Targeting inspection activity using intelligence
- Use of personal protective equipment for staff in line with national guidance
- Individual risk assessments for each inspector which take into account their health status
- Reducing the need for overnight stays
- Following national social distancing and hygiene guidance including no car sharing and social distancing on inspection where practicable
- Specific training on infection control and regulatory issues.

All of these measures have resulted in significant adaptation of previously normal ways of working particularly as staff are currently working from home. Measures are likely to remain in place until a vaccine is available or national guidance changes.

In addition to covid risks, individual risk assessments are taking place with staff which take account of colleagues’ caring responsibilities. Schools being unlikely to return to normal in the medium term, will further impact capacity.

2.2.9 Business Support
The complexity and need for growth in the range of programmes in the directorate, logistics of planning programmes, workload and deployment of staff for the whole directorate have highlighted an increased need for business support for the directorate. A further current pressure is an impending vacancy in terms of the directorate’s Operations Manager post, which has not yet been filled as a result of the recruitment freeze. A combination of increased covid related workload added to an already stretched capacity, has increased the demands on the current operational team.

Within the wider organisation there are business management units supporting the work of directorates centralising interactions with corporate teams, supporting planning and co-ordination within directorates, both of programme delivery and workload/workforce. This approach supports programme managers enabling them to focus on delivery and ensures a focus on planning and quality control within the directorate. It is proposed that the quality assurance directorate is resourced to develop a business management approach.

2.2.10 Workforce
Staff within the directorate have responded flexibly and swiftly to the pandemic. In response to the need to support the NHS they have variously been deployed across the NHS many in
frontline services. Internally staff have adapted to working from home focusing on responding to concerns, monitoring the system and recently in situ in care homes and prison inspections. Support to staff returning post deployment from high pressure frontline services is being offered and arrangements for ongoing professional supervision are underway.

Prior to the pandemic, work had commenced to support capacity and workforce planning in the directorate. This work was in response to feedback from staff that they were under capacity to deliver the previous programme of inspections. Current increased pressures on management time have resulted in stalling of this work at a time when it is most needed. The Executive Team have agreed to seek external support for capacity planning and internally staff from the healthcare staffing team will work to further develop capacity planning tools for the directorate to support development of a robust approach to planning in the medium to long term.

In the immediate term there are significant gaps exacerbated by the current covid situation. These include:

- **Inspectors**

  Currently there are significant problems in our ability to cover the required inspections. The reintroduction of hospital inspections will make staffing for inspections unsustainable and will require prioritisation with regard to which inspections we are able to take forward. This will be further impacted as independent healthcare providers move to re-open services. The Executive Team has agreed to support recruitment of additional inspectors to alleviate the pressures on the current teams, numbers needed and costs are currently being calculated.

- **Senior Inspectors**

  In recognition of current pressures, the Executive Team recently gave approval to recruit an 18 month secondment for a senior inspector/reviewer for the care homes inspections programme. The need for further senior inspectors will be scoped as part of the workload planning exercise.

- **Programme Staff**

  There are current vacancies for programme staff. Adult Support and Protection and Joint Children and Adult inspections programme staff have been deployed to work on the Care Inspectorate programme leaving gaps if we are asked to fully re-open these programmes. Programme support is being sought as a matter of urgency from across the organisation to respond to immediate needs while recruitment and further capacity planning is carried out.

- **Senior Management**

  The Director of Quality Assurance post is awaiting recruitment. There is also an existing vacancy for the Head of Service Review, which was impacted by the recent recruitment freeze and the impending retirement of the operations manager.
2.3 **Assessment**

2.3.1 **Quality/Care**
Inspection provides an important independent assurance mechanism in respect of monitoring and improving the quality of health and care services.

2.3.2 **Financial**
Financial implications are highlighted throughout this paper. Discussions are ongoing with Scottish Government regarding funding, including COVID-19 funding. Consideration is also being given by the Executive Team to what resource can be redirected to support this work internally.

2.3.3 **Risk Assessment/Management**
The care home programme is considered to be high risk and is on the risk register. We have increased the risk on the other inspections due to the COVID-19 situation. Ongoing assessment of organisational and individual staff risk is in place with mitigations being updated regularly in line with national guidance.

2.3.4 **Equality and Diversity, including health inequalities**
Impact on equality and diversity will be assessed as part of the ongoing work described above to support the directorate.

2.3.5 **Other impacts**
Lack of support and retaining the current state would impact on the ability to provide public transparent assurance of health and care services with particular impact on groups such as the elderly, those with cognitive impairment, prisoners, vulnerable adults and children in need of protection.

2.3.6 **Communication, involvement, engagement and consultation**
There is ongoing formal discussion with the following groups:

- Scottish Government sponsors and interested directorates
- Care Inspectorate senior executive teams and operational teams
- Her Majesty’s Inspectorate of Prisons
- Staff partnership – a working group has been established to support this work
- Health Protection Scotland - expert infection control advice
- HIS Staff

2.3.7 **Route to the Meeting**
Due to the short notice of the re-commencement of the inspections this paper has gone directly to the HIS Board with issues within having been discussed with the Executive Team.

2.4 **Recommendation**
It is recommended that the Board discuss the issues set out in this paper, and acknowledge the risks to Healthcare Improvement Scotland in respect of developments in our inspection programmes and supports the Executive Team in deploying resources to the Quality Assurance Directorate in seeking external funding for covid related programmes.
1 Purpose

This report is presented to the Board for:
- Discussion

This report relates to:
- HIS Strategic Direction

This aligns to the following HIS priorities(s):
- Safe, reliable and sustainable care

2 Report summary

2.1 Situation

This report provides an update on the work of the Quality of Care Approach: Short-life Governance Group (the Group). The Group was chaired by Zoë Dunhill and included Non-Executive Board members; relevant members of the Executive Team; and Public Partners.

The Group:

- Assessed the progress made in the implementation of the Quality of Care Approach (QoCA), through a review of how it has been applied and implemented to date, and taking account of the evolving context for health and social care services
- Made recommendations about the future strategic direction of the QoCA, which are set out below
- Reported to the Quality and Performance Committee, which supported the Group’s recommendations at its meeting on 13th May 2020
- Identified a strategic risk to the implementation of its recommendations, linked to the impact of COVID-19.
2.2 **Background**

The quality of care approach was designed by Healthcare Improvement Scotland, in collaboration with key stakeholders, to guide inspection and review frameworks, in order to provide external assurance of the quality of health and care provided in Scotland. It seeks to ensure that any assessment of the quality of care is undertaken consistently and focuses on the achievement of the best possible outcomes for people using services.

The approach has three components:

- **the approach itself** – the methodology, and the principles that underpin it, that we use for all of our quality assurance work (published December 2017)
- **the Quality Framework** – this outlines the quality indicators used for self-evaluation and external quality assurance (published September 2018), and
- **our programmes of work** – the inspections and reviews (both planned and ad hoc) that we undertake to deliver on our strategic objectives.

The approach brings consistency to our quality assurance activity by basing this on a set of fundamental principles and a common Quality Framework.

2.3 **Assessment**

**a. Current context: the impact of COVID-19**

Since March 2020, HIS has been refocusing its work and its resources to support health and care services to respond to the COVID-19 pandemic. Non-essential work across the organisation has been significantly scaled back or suspended; staff have been redeployed to NHS boards and other organisations; and there have been radical changes in how people live and work. Whilst this position will be kept under review, it is currently unclear how long these arrangements, or other adaptations to ways of working, may require to be kept in place.

The unprecedented developments which have happened since March have meant that some work on the QoCA has not progressed as far as had been anticipated by this point in time, and there may also be limitations on how far the work that is planned can progress during 2020-2021.

**b. Use of the QoCA to date**

Since the QoCA was introduced in 2017-2018, following earlier design and testing, the approach has been used in various ways to guide and inform the development and delivery of a range of assurance programmes, such as:

- Joint inspections
- Regulation of independent healthcare
- Prisoner healthcare
- Cancer care
- Adverse events
- Ionising Radiation (Medical Exposure) Regulations – IRMER
- Test organisational reviews
- Responsive reviews (ongoing) – Tayside Mental Health Services; Beatson Institute review.

There are also plans for the approach to be used in hospital inspections, though this has been delayed due to capacity challenges in the inspection teams, and for the reasons outlined at (a) above.
Particular learning was identified as a result of the three test organisational reviews undertaken in:

(1) NHS Orkney  
(2) NHS Ayrshire & Arran (NHS A&A)  
(3) Golden Jubilee National Hospital (GJNH)

The aim of testing in these three boards was to enable the approach to be applied at a broader system level in very different settings, for example a small island board, a very large and more complex territorial board and a national patient-facing board.

Reports were published in respect of the test reviews in Orkney (August 2018) and the GJNH (October 2019). It was decided not to publish a report of the NHS A&A test review, as a number of significant weaknesses were identified in the process, the comprehensiveness of the evidence considered and conclusions which could be reached.

The NHS A&A process and draft report were also the subject of an independent external assessment by Professor Simon Mackenzie. It is evident that the scale and complexity of undertaking an organisational level review in a complex territorial board would require a different approach and much greater level of resource than could realistically be applied by HIS.

Consideration of the Mackenzie Report and discussions in the Group have led us to believe that more targeted intelligence-led, risk-based reviews, complementing our broader inspection and review programmes, would offer a better use of our resources than a rolling programme of organisational reviews such as was attempted in NHS Ayrshire and Arran.

It is also important to recognise the current context, and the work now being routinely undertaken by the Sharing Intelligence for Health and Care Group (SIHCG), which considers the data profiles of NHS boards in turn on a cyclical basis. The proposed approach would also be more in line with the underpinning principles of the QoCA.

Areas for improvement have been identified over time, and changes have been made to the methodology and underlying procedures to reflect these. Separate papers were considered by the Group on both the learning process and the development of a Standard Operating Procedure (SOP), which was designed to address some of the concerns that had been raised.

Leaving aside the particular challenges of the test organisational reviews, the experience of using the QoCA across a range of work programmes has been broadly positive and it has enabled greater consistency than would previously have been experienced across this range of assurance activity. The approach has also proven to be flexible and adaptable in different contexts.

Whilst the substance of the approach itself and the quality framework remain sound, the deployment of these would benefit from being further refined, as explained below.
**Recommendation 1**
*The QoCA should continue to guide quality assurance carried out by Healthcare Improvement Scotland (HIS), subject to the further recommendations made in this paper.*

c. Applying the principles of the QoCA
The Group recognised the importance of the following guiding principles which underpin the QoCA, and of demonstrating how we apply these in practice:

- **user-focused** – we put people who use services at the heart of our approach
- **transparent and mutually supportive, yet independent** – we promote and support a complementary approach to robust self-evaluation for improvement with independent validation, challenge and intervention as required
- **intelligence-led and risk-based** – we take a proportionate approach to inspection and review which is informed by intelligence and robust self-evaluation
- **integrated and co-ordinated** – we draw on the collective participation of relevant scrutiny bodies and other partners to share intelligence and minimise duplication of effort, and
- **improvement-focused** – we support continuous and sustained quality improvement through our quality assurance work.

Consideration as to how these principles have been applied has helped to identify areas to strengthen and further develop. It has also led to additional components being incorporated into the SOP to ensure that this supports the practical application of the principles, with further work being undertaken in key areas.

**Recommendation 2**
*The principles which underpin the QoCA, and the ways in which they guide the application of the approach in practice, should be explained more clearly in communications with stakeholders and this should also be evident in review reports.*

d. Strengthening the use of data and intelligence in our application of the QoCA
A key area of interest for the Group has been consideration of how data and intelligence informs, or could further inform, our assurance work. This included a presentation on this topic by the Director of Evidence and Head of the Data Measurement and Business Intelligence (DMBI) team.

Data and intelligence supports: the prioritisation and focus of quality assurance activity; the development of key lines of enquiry for inspections and reviews; and the triangulation and publication of findings.

In addition to the intelligence gathered through inspections and reviews, and the responding to concerns programme, the Quality Assurance Directorate (QAD) has two main sources of intelligence that are used to inform its work. These are:

1. intelligence obtained via the Sharing Intelligence for Health and Care Group, and
2. data and intelligence provided by the DMBI team, including HIS’s set of indicators (see Appendix 1).
To date, this intelligence has primarily been used to inform both planned and responsive inspections and reviews, with additional advice and input from the DMBI team.

Strengthening our use of data and intelligence would help to inform strategic decisions to be made about the focus of work. This could result in identifying particular themes to be built into our planned work or identifying whether a separate review is required for a service on a national, regional or local level.

It would potentially enable the organisation to take a more proactive, and pre-emptive, approach where there are signals in the evidence that suggest areas of care quality that would benefit from further enquiry. There are capacity and resource implications for this work, as it goes beyond what currently occurs.

**Recommendation 3**

*The use of data and intelligence in the application of the QoCA should be strengthened, building on the positive collaboration already established between the Quality Assurance and Evidence directorates of HIS. This should include development of mechanisms which would enable HIS to take a more proactive approach in the assurance of areas of care quality which are identified through analysis of data and intelligence.*

e. Supporting more effective use of self-evaluation by health and care providers

Robust self-evaluation should play a key role in the QoCA and, more generally, as part of the overall approach to quality management within a health and care system.

From the perspective of the QoCA, self-evaluation enables health and care providers to demonstrate their understanding and approach to improving the quality of care in relation to specified areas i.e. to ‘tell their own story’. Information provided through self-evaluation is considered alongside other sources of data and intelligence to enable the identification of areas requiring further enquiry and to inform the focus of any on-site visits.

This is an area that has proven to be challenging in practice, as service providers have sometimes struggled to carry this out effectively, and there is currently limited capacity to offer support or to build expertise within the directorate. Feedback from providers has highlighted that they have not always been clear about what was being asked for through the self-evaluation, and, linked to this, have found it time-consuming and burdensome. In some cases, providers already have existing mechanisms for self-evaluation which may not readily map across to the quality framework.

Some of the above concerns would be addressed through our smarter use of data and intelligence at an earlier stage, in order that requests for self-evaluation are more tailored to meet the identified need, with clearer rationales to explain these requests. This should in turn mean that self-evaluation is less time-consuming to complete, and improve the quality of the information provided.

Requests have also been received from service providers for support with self-evaluation, independently of existing assurance programmes.

There is significant scope to further develop how we promote and support the use of self-evaluation by service providers against the quality framework and relevant standards. This could support service providers to improve; and could also offer useful intelligence to inform internal/external assurance.
**Recommendation 4**
*There should be development of skills and capacity internally to support more effective use of self-evaluation by health and care providers, linked to smarter use of existing data and intelligence.*

**f. Systems and processes**
A key area identified for improvement as a result of the Simon Mackenzie report referred to above related to the need for clear, robust and more consistent systems and processes to support the delivery of the QoCA. This was another particular area of interest for the Group.

The Group agreed a proposed approach to development of a SOP to be used across the directorate. It was agreed that this should be developed with advice from Grant Thornton, internal auditors, in order to help provide independent assurance to the Group about its fitness for purpose.

In April, the Group was updated on progress with SOP development, setting out what has been achieved to date, and areas of planned further development, informed by an assessment by Grant Thornton (see Appendix 2). The SOP is being designed in an interactive handbook format, with links to relevant templates, policies and other related resources. It is important that this SOP is recognised as a live document and that it is kept updated through the processes established within the directorate.

Implementation of the SOP will be reviewed by Grant Thornton as part of the internal audit plan for 2020-21.

The Group felt that the approach taken in the development of this SOP might be useful in other areas of HIS practice.

**Recommendation 5**
*The SOP developed to underpin the implementation of the QoCA, with advice from Grant Thornton, internal auditors should be regularly reviewed and updated.*

**g. Learning and development – internally and externally**
Staff within QAD undertook a range of development activity, including training provided by Quality Scotland, when the QoCA was introduced. There is a need to produce an updated learning and development plan to support implementation of the recommendations in this paper. This should include ensuring that new starts to QAD receive the appropriate development support as part of induction planning.

**Recommendation 6**
*An updated learning and development plan for QAD is required to support implementation of the recommendations in this paper. This should be produced with support from the HIS Organisational Development & Learning team.*

The Group also discussed the importance of sharing learning following reviews and inspections, both with the individual services involved, and also more widely across health and care providers, in order to support continuous improvement of services. It was noted that the approach to this across QAD varies depending on arrangements for each programme, and that this could be done better and more consistently, in line with the ‘learning system’ envisaged by the Quality Management System.
Recommendation 7
An assessment of the effectiveness of mechanisms for identifying and sharing learning with health and care providers should be carried out across QAD work programmes, in order to identify how this can be improved.

h. Stakeholder engagement and communication
Engagement and communication relating to the revision of the quality framework should be part of a wider communication strategy about the QoCA; and how our assurance work helps to improve services and outcomes for patients and their families.

Work has begun on a QoCA engagement and communication plan. This requires to be completed and implemented with support from the HIS Communications team. It will be considered by the Quality and Performance Committee at its August meeting.

Recommendation 8
An engagement and communication plan is required to raise awareness of the QoCA, its key components and its impact on care quality. It should also address the issue of alignment with the QMS. This should be developed as part of a wider communication strategy for QAD, with support in its development and implementation provided by the HIS Communications team.

i. Alignment of the QoCA with the EFQM model and the Quality Management System
A key component of the QoCA is the quality framework. This is aligned to the 2013 European Foundation for Quality Management excellence model, known as EFQM. One benefit of this alignment is that EFQM is used across the public sector in Scotland, including by the Care Inspectorate and by local government. However, the quality framework has been designed specifically to be used within a healthcare context, with engagement in its development from key stakeholders to ensure appropriate fit.

The EFQM model has recently been updated and there is a need for our quality framework to be revised to ensure continued alignment. Some NHS boards have been looking at how they might use EFQM 2020 model and this reinforces the need to revise our own approach accordingly.

Recommendation 9
The quality framework should be revised to ensure alignment with the EFQM 2020 model. This will require engagement and communication with a range of stakeholders, internally and externally, and any relevant organisational development and learning needs should be clearly identified to support implementation of the revised quality framework.

Quality management enables us to reduce the risk of poor service delivery by planning quality into services. Our QMS illustrates a coordinated and consistent approach to managing the quality of what we do, and can be applied across the whole health and care system.
The QoCA offers one potentially valuable mechanism which supports both HIS, and health and care services, to implement a QMS which supports continuous service improvement. Given that the QoCA is designed to underpin all of our quality assurance activity, it is important that there is a shared understanding across HIS and our external stakeholders of how it supports the delivery of a QMS.

Work has commenced to develop a shared narrative that will set out the relationship between the QoCA and the QMS, though this has been delayed due to the impact of COVID-19.

**Recommendation 10: A shared narrative should be developed to set out the relationship between the QoCA and the QMS, using plain, accessible language.**

### 2.3.1 Quality/Care
Improving the quality of care and services is the aim of the QoCA. The recommendations in this paper are aimed at ensuring the QoCA remains fit for purpose, and enabling this to be delivered more efficiently and effectively.

### 2.3.2 Workforce
The review of the QoCA has benefited from regular input from partnership representatives, and has also involved feedback from staff that have experience of delivering the approach in different ways.

The development of a SOP has been welcomed by staff as a useful tool to support clarity and consistency in the delivery of work programmes.

Staff feedback has reinforced the need for learning and development to facilitate delivery of the QoCA and build skills and confidence, alongside recent initiatives such as Skills Frameworks which address the needs of particular staff groups.

Partnership representatives have particularly underlined the need for experiential forms of learning, recognising the diversity of roles and individual learning styles across the directorate. They have also noted the requirement for adequate resource to implement all of the recommendations effectively, in order to avoid placing additional pressure on staff who may already feel stretched.
2.3.3 Financial
The Group recognised that additional resource will be required within QAD to enable implementation of the recommendations in this paper, and that there will also be resource implications for others, including the DMBI team and the Communications team.

The need for additional resource to support development in QAD has been discussed by the Executive Team as part of its planning process for 2020-2021. It was also reflected in the draft Financial Plan 2020-2023 which was considered by the HIS Board at its March 2020 meeting. However, the costing of this work has not been completed, and it must be recognised that the timelines for progressing this work will be affected by the significant impact of COVID-19 on the work of both HIS and health and care providers.

**Recommendation 11:** The resourcing of the work outlined in this paper requires to be clarified, with support from the finance team, and the need for additional resource has been reflected in the HIS draft Financial Plan 2020-2023. However, it should be noted that the impact of COVID-19 on the feasibility of progressing aspects of the work during 2020-2021 is not yet known.

2.3.4 Risk Assessment/Management
The following risk number 986 was entered on the Risk Register on 24th April 2020, following discussion by the Short-life Governance Group:

“There is a risk that implementation of the recommendations made by the Quality of Care Approach Short-life Governance Group will be significantly delayed; because of the impact of COVID-19 on HIS’ work with health and care providers; resulting in both loss of momentum, and missed opportunities, to improve how HIS provides assurance about the quality of health and care in Scotland.”

This strategic risk is currently assessed as high, with a score of 16 (impact 4, likelihood 4).

2.3.5 Equality and Diversity, including health inequalities
A human rights based PANEL principles assessment was completed in November 2016 to inform development of QoC reviews.

An Equality Impact Assessment of the quality framework has also been undertaken and resulted in a number of recommendations for amendment to the framework to take account of equality protected characteristics. This assessment will be revisited when the quality framework is being revised.

2.3.6 Other impacts
Health and care service providers will be impacted by changes to the Quality Framework and in how we deliver the QoCA.

2.3.7 Communication, involvement, engagement and consultation
This work has involved learning from the experience of implementing the QoCA to date. Feedback obtained from NHS Boards in the context of particular work programmes, such as the test organisational reviews and the Cancer Quality Performance Indicator (QPI) Programme, has been considered by the Group to inform the recommendations.
Updates on the review of the QoCA have been provided to groups such as our NHS Liaison Co-ordinators Network and the Scottish Association of Medical Directors (SAMD).

Updates on the progress of this work have also been discussed with Scottish Government.

The Group benefited from having two Public Partner members who had experience of direct involvement in QAD work programmes, and offered constructive advice and challenge based on their own understanding of what matters most to patients and the public.

Further engagement and consultation is planned as this work develops, as reflected in recommendation 8.

2.3.8 Route to the Meeting
This paper has been developed by the QoCA Short-life Governance Group, which met following an initial planning meeting on three occasions between December 2019 and April 2020, before reporting to the Quality and Performance Committee in May 2020.

2.4 Recommendation
The Board is asked to discuss the recommendations set out in this paper, and summarised below, and the associated risk to implementation (see 2.3.4 above); and note that progress updates will be built into the Quality and Performance Committee’s business planning schedule:

1: The QoCA should continue to guide quality assurance carried out by Healthcare Improvement Scotland (HIS), subject to the further recommendations made in this paper.

2: The principles which underpin the QoCA, and the ways in which they guide the application of the approach in practice, should be explained more clearly in communications with stakeholders and this should also be evident in review reports.

3: The use of data and intelligence in the application of the QoCA should be strengthened, building on the positive collaboration already established between QAD and Evidence directorate of HIS. This should include development of mechanisms which would enable HIS to take a more proactive approach in the assurance of areas of care quality which are identified through analysis of data and intelligence.

4: There should be development of skills and capacity internally to support more effective use of self-evaluation by health and care providers, linked to smarter use of existing data and intelligence.

5: The SOP developed to underpin the implementation of the QoCA, with advice from Grant Thornton, internal auditors should be regularly reviewed and updated.

6: An updated learning and development plan for QAD is required to support implementation of the recommendations in this paper. This should be produced with support from the HIS Organisational Development & Learning team.
7: An assessment of the effectiveness of mechanisms for identifying and sharing learning with health and care providers should be carried out across QAD work programmes, in order to identify how this can be improved.

8: An engagement and communication plan is required to raise awareness of the QoCA, its key components and its impact on care quality. It should also address the issue of alignment with the QMS. This should be developed as part of a wider communication strategy for QAD, with support in its development and implementation provided by the HIS Communications team.

9: The quality framework should be revised to ensure alignment with the EFQM 2020 model. This will require engagement and communication with a range of stakeholders, internally and externally, and any relevant organisational development and learning needs should be clearly identified to support implementation of the revised quality framework.

10: A shared narrative should be developed to set out the relationship between the QoCA and the QMS, using plain, accessible language.

11: The resourcing of the work outlined in this paper requires to be clarified, with support from the finance team, and the need for additional resource has been reflected in the HIS draft Financial Plan 2020-2023. However, it should be noted that the impact of COVID-19 on the feasibility of progressing aspects of the work during 2020-2021 is not yet known.

Appendices:

**Appendix 1:** HIS briefing: A set of indicators about the quality of care

**Appendix 2:** Grant Thornton report: Internal Audit review of the development of a Standard Operating Procedure (SOP) for the Quality of Care Approach: Short-life Governance Group
A set of indicators about the quality of care

The Data, Measurement & Business Intelligence Team has developed a set of indicators (quantitative data). This is to help Healthcare Improvement Scotland colleagues/teams enquire and learn about the quality of care at ‘whole-system level’. We have recently started to test using these indicators within our organisation.

This briefing provides some information about this set of indicators, and how they might be useful to you and your team. If you’d like to access the analyses for these indicators, or find out more, please contact the Data, Measurement & Business Intelligence Team at hcis.DMBI-TEAM@nhs.net

Why did we develop these indicators?
Healthcare Improvement Scotland already uses a range of indicators/metrics, to support work such as quality improvement programmes and external quality assurance activities. However there was a risk that, by not looking at the most informative ‘whole system’ indicators, we might be missing important signals about the quality of care.

What are the indicators?
There are 22 indicators, covering early years, acute care, care of older people, mental health and workforce:

- Infant deaths
- Immunisation uptake
- Premature mortality
- Emergency admission
- Potentially preventable admission
- Hospital mortality
- Delayed discharges
- Inpatient/daycase waits
- Outpatient waits
- Waits for cancer treatment
- Experience of people using services
- Admissions for falls
- Inpatient falls
- Antimicrobial prescribing
- Care at home
- Last six months of life at home/community
- Access to Child & Adolescent Mental Health Services
- Access to psychological therapies
- Self-harm in acute mental health
- Consultant vacancies
- Nursing and midwifery vacancies, and bank agency use
How did we choose the indicators?
As recommended by Sir Harry Burns’ review of targets and indicators\(^1\), we developed our indicators in a way that was collaborative, pragmatic and iterative. This included a consensus study (Delphi methodology) to select the indicators. No indicator is perfect – but some are useful. We will continue to refine the set of indicators, through iterative testing and use.

Who is the audience for the indicators?
The indicators are designed to be used within Healthcare Improvement Scotland. NHS boards are not asked to provide data for, or routinely respond to, this set of indicators.

What are the indicators used for?
The indicators can help us enquire and learn about the quality of care, and open up questions/discussions. The indicators do not provide definitive proof about the quality of care (good or poor), and should not be used to make judgements about quality/performance.

Where do the data come from?
The data for most of the indicators are available from existing Scotland-wide data sets. A main source of data is Discovery, an information system maintained by NHS National Services Scotland. If you would like to have direct access to Discovery then please contact the Data, Measurement & Business Intelligence Team.

How are the data analysed?
For each indicator, we look to see whether or not there is significant variation in the data over time, for example that might suggest things are improving or getting worse. We do this at Scotland-wide level, and also for different regions/organisations across the country. In addition, we look to see whether or not the data for particular regions/organisations are significantly different from the national average.

What are some of the key patterns at Scotland-level?
When looking at the data at Scotland-wide level, there are some patterns that could potentially be highlighting improvements being made. For example:

- The rate of infant deaths (within the first year of life) decreased by 15% between 2010 and 2016 (Source: National Records Scotland).

- The rate of prescribing antimicrobial items in primary care improved – decreasing by 10% between 2013 and 2015 (Source: ISD Scotland).

\(^1\) [https://www.gov.scot/publications/review-targets-indicators-health-social-care-scotland/]
For some indicators, the data have remained relatively stable.

- This is seen for potentially preventable admissions, although there are peaks during the winter months (Source: ISD Scotland).

Some of the indicators appear to be drawing attention to significant pressures within front line services.

- There are ongoing challenges with waiting times, such as the percentage of patients seen within 12 weeks for inpatient/day case treatment reduced by around 25% before levelling off (Source: ISD Scotland).

- There has also been an increase in the rate of consultant vacancies (15%) and nursing and midwifery vacancies (34%) over the last six years (Source: ISD Scotland).
Internal Audit review of the development of a Standard Operating Procedure (SOP) for the Quality of Care Approach: Short-life Governance Group

1. Purpose of the report

This paper is for consideration of the Quality of Care Approach: Short-life Governance Group in April 2020 and summarises the work we (internal audit) have done to date alongside HIS management to provide ongoing assurance to the group over the process adopted and development of the Standard Operating Procedure (SOP) to date.

2. Background

HIS established a Quality of Care Approach Short-life Governance Group to: assess progress made to date in the implementation of the quality of care approach; make recommendations for strategic development and delivery of the approach in the future; and to seek assurance that the systems and processes supporting delivery of the approach are clear, appropriate and robust. The main output from the short life governance group will be a paper setting out conclusions and recommendations for the Quality & Performance Committee of HIS to consider and approve at its meeting in May 2020.

The key aim for the quality of care approach is to agree a future strategic direction, which is flexible and adaptable, intelligence-led, risk based and forward looking, which would then be underpinned by HIS systems and processes within the Directorate to support delivery. A core area of delivery is the planned development of a SOP, to support how work is undertaken, recorded, and reported in a consistent way. It is intended that the SOP will take account of the recent revisions to the EFQM model, which the quality of care approach is based upon.

3. Scope and approach

Internal audit has engaged with HIS management and reviewed the SOP at varying stages of ongoing development in order to share recommended practice and provide constructive challenge, as the SOP is being developed. We have brought our wider knowledge of the HIS control environment alongside our relevant internal audit experience to consider how documentation standards are set out, how accessible and easy to follow the SOP is, and how effectively lessons learned have been embedded into the defined procedure. We have also considered the EFQM Model and ISO 9001 criteria for a quality management system when undertaking our work.
4. Observations and recommendations

The following internal audit observations and recommendations are based on the latest version of the SOP document provided, ‘20190812 QoC review procedures V0.8’

Structure and Format

- The format adopted appears to replicate that of a checklist, rather than a standard operating procedure which is typically not in tabular format.

  **Recommendation:** If not already undertaken, it is recommended that a cross-section of intended users of the document are consulted to determine if this format is appropriate and is user-friendly.

- We support the breakdown of stages and the indicative timescales in chronological order as this made most of the procedure easy to follow. This was not as clear in respect of stages 5 and 6 where the timescales appeared to be intertwined. There was also not a clear distinction between some tasks categorised as stage 5 (outputs and agree next steps) and 6 (report publication).

  **Recommendation:** Revisit stages 5 and 6 to determine if tasks can be sensibly grouped to align chronologically.

Content

- It is recognised that an introductory paragraph has been included in the draft SOP, however overall, there was limited front end guidance provided. This could include information such as:
  1. Purpose of the document
  2. Background/context
  3. Intended users of the document
  4. Roles and responsibilities of the key responsible persons involved
  5. References to any related documents/standards that should be referred to in conjunction with the SOP

  **Recommendation:** Consider including such additional information to expand the front-end guidance to provide greater clarity over its expected use and required users. This information could also include reference to the EFQM model adopted and in line with its rationale, highlight how the Quality of Care review process connects to the overall purpose and strategy of the organisation and how it contributes to creating sustainable value for stakeholders and delivering results. Including references to any other related documents within HIS will also support the objectives of the EFQM model by ensuring coordination and a holistic approach adopted across the organisation.

- It is noted in the introductory paragraph that the steps in the document are not prescriptive or mandatory. Rather, it is to be taken as the initial ‘default’ position for those who plan quality of care reviews. There could be a risk that this introduces too much judgment and subjectivity into the process (which was what the SOP was intended to mitigate) and therefore could compromise on consistency and quality going forward.
**Recommendation:** It is recommended that activities or controls that are considered key to the process (such as review and approval points) are identified, agreed and highlighted explicitly in the SOP to ensure a minimum level of quality and consistency across the reviews.

- One of the reports used to inform development of the SOP was the independent McKenzie review of the NHS Ayrshire & Arran operational review. It was observed that most of the relevant learnings from this review had been captured within the SOP. There were other recommendations which were not yet included but were intended to be added to the SOP upon completion of an ongoing learning exercise. Another of the recommendations from the McKenzie review was to identify who has authority to approve at key stages. Whilst there is reference in the SOP to sign off required throughout the process, this is predominately the responsibility of the Lead Reviewer. There appeared to be limited involvement of senior management and the Executive team where they receive sight of the draft report only (‘if appropriate’ in the case of the ET). There is a risk that without being more prescriptive over the role of the ET that this could become overly subjective and rely on individual judgement.

**Recommendation:** It should be considered if the oversight of senior management and the Executive Team as it is currently reflected in the SOP is appropriate and if these roles should be more prescriptive. It could add value to the review process to involve these parties at the outset for example, in agreeing the terms of reference, to ensure all relevant information is considered and incorporated at this stage. Outcomes from the learning exercises currently ongoing should be incorporated into the SOP as soon as they become available.

- There was an inconsistent level of detail provided for activities across the stages where some included more information than others. There is a risk that the method of undertaking the activity or the reasons for doing so will not be fully understood or consistently applied.

**Recommendation:** As a minimum, activity information should include what the task is, why it is required (its objective) and how it will be completed. For example, Stage 0 task “Review data from other inspection activity” could be expanded to read “Review data from other inspection activity from the sources referenced in the templates column to learn of any findings and recommendations that should be considered and built into the scope of the upcoming review.”

- There were a significant number of acronyms included throughout the procedure document. In line with the respective guidance on producing policies and procedures, it is suggested that the use of acronyms should be avoided, to make the document easier to understand.

**Recommendation:** As a minimum, any acronyms and abbreviations used should be referenced in a glossary included as an appendix to the document.
**Administration and other**

- It is acknowledged that the SOP is still currently in draft and as such there was no author/owner, published date, frequency of review and/or date of next review.

**Recommendation:** The final document should include this additional information and version control including the date of revision, summary of change and authorisation.

- There were no supplementary process flowcharts in place to visually represent the hand-in and hand-outs to and from responsible individuals, and to highlight any key controls/activities throughout the process.

**Recommendation:** The inclusion of flowchart(s) as an appendix should be considered to supplement the SOP and enhance understanding of the interrelationships among the various steps throughout the process. Flowcharts in this manner can also be used in training, to support teams in understanding the SOP and also as quick reference user guides.

5. **Conclusion**

It was evidenced during the review that the development of the SOP has been informed by various sources across the business as well as learnings from previous reviews, testing, and the EFQM 2020 model. There were good practices noted such as the breakdown of the process via grouping into key stages to make the SOP easier for users to digest and follow, and hyperlinks to templates included to provide guidance and promote consistency in activities undertaken across different reviews.

It is acknowledged that the SOP is still in the development phase and will be subject to further change in response to ongoing work, for example, learning exercises still underway.

To date we have highlighted a number of recommendations to support the continued development of the SOP and how it can be further enhanced. We are happy to re-look at the updated SOP and to continue to support the team through advice and guidance, as the SOP is further developed. Our input will allow developments to be built in now, before the SOP is finalised.

We would like to thank the staff at HIS for their cooperation throughout this work.
1 Purpose
To present the key points from the Governance Committee Annual Reports for 2019/20.

This is presented to the Board for:
• Awareness

This report relates to:
• HIS Strategic Direction

This aligns to the following HIS priorities(s):
• Mental health services
• Access to care
• Integration of health and social care
• Safe, reliable and sustainable care

2 Report summary

2.1 Situation
All Committees of the Board have prepared an annual report for 2019/20 which has been agreed by the Committee Chair and its members. The key points and future actions agreed by each Committee are set out in Appendix 1. These will be considered by the Board as part of the annual reporting cycle in June and progress reports will be received by the Board during the course of 2020-21.
2.2 **Background**
The Code of Corporate Governance requires that each Governance Committee produces an annual report which summarises its activities during the course of year, how it has met its remit and what future actions are proposed based on the learning of the Committee during the year.

2.3 **Assessment**
Key points from the 2019/20 annual reports are as follows:

a) The Committees all advised that they met their remit for 2019/20 and provided examples against each part of the remit, except where it was not applicable in 2019/20.
b) The Committees worked to their new terms of reference set out in the updated Code of Corporate Governance which was approved by the Board in December 2019.
c) The Committees have identified future actions to take forward in 2020/21 and these are set out in Appendix 1.
d) Each Committee reviewed throughout the year, the risks or issues within its remit.

2.3.1 **Quality/ Care**
In completing their annual reports, the Committees are considering their effectiveness throughout the year and the contribution which they make to good corporate governance. This in turn ensures the best outcomes for the services we deliver.

2.3.2 **Workforce**
The Staff Governance Committee considers matters concerning the health and wellbeing of staff. It has completed an annual report for 2019/20 setting out how it has met its remit.

2.3.3 **Financial**
The Audit and Risk Committee considers matters of financial performance. It has completed an annual report for 2019/20 setting out how it has met its remit.

2.3.4 **Risk Assessment/Management**
The strategic and high/very high operational plan risks assigned to each Committee are considered at each committee meeting. The annual reports set out the key risk areas that the committees have discussed.

2.3.5 **Equality and Diversity, including health inequalities**
The Staff Governance Committee considers matters concerning equality and diversity. It has completed an annual report for 2019/20 setting out how it has met its remit.

2.3.6 **Other impacts**
There are no additional impacts arising from this paper.
2.3.7 Communication, involvement, engagement and consultation
Each committee and its lead officer has considered its annual report for 2019/20. There is no need for any further engagement prior to this being provided to the Board.

2.3.8 Route to the Meeting
This has been previously considered by each Committee at its quarter 4 meeting and finalised electronically in light of the remote working in place to respond to the COVID-19 pandemic.

2.4 Recommendation

The Board is asked to:
• consider the actions identified in the 2019/20 annual reports
• note that copies of the detailed annual reports are available on request
• note that a report of progress against the actions will be presented to the Board during the course of 2020/21.

3 List of appendices

The following appendices are included with this report:

• Appendix No 1, Summary of Actions from the 2019/20 Committee Annual
## Appendix 1: Summary of key actions for 2020/21 from the Governance Committee Annual Reports 2019/20

<table>
<thead>
<tr>
<th>Committee</th>
<th>Action</th>
<th>Lead Officer</th>
<th>Due Date</th>
<th>Status (to be updated during 2020/21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit and Risk</td>
<td>Continue to oversee closely the achievement of savings targets to support the future financial sustainability of HIS.</td>
<td>Director of Finance and Corporate Services</td>
<td>31 March 2021</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue to oversee the financial arrangements to support Independent Healthcare.</td>
<td>Director of Finance and Corporate Services</td>
<td>31 March 2021</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue to oversee improvements to the management of risk across the organisation.</td>
<td>Director of Finance and Corporate Services</td>
<td>31 December 2020</td>
<td></td>
</tr>
<tr>
<td>Executive Remuneration</td>
<td>Review of the interim management arrangements for the Quality Assurance Directorate.</td>
<td>Director of Workforce</td>
<td>31 December 2020</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planned review of the end of year performance appraisals for Directors and the Chief Executive.</td>
<td>Director of Workforce</td>
<td>1 August 2020</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of the cross organisational objectives in place for 2019/20.</td>
<td>Director of Workforce</td>
<td>1 August 2020</td>
<td></td>
</tr>
<tr>
<td>Quality and Performance</td>
<td>Continue to highlight areas of risk to the Board, requesting external written evidence where this is necessary.</td>
<td>Medical Director</td>
<td>31 March 2021</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>Scottish Health Council</td>
<td>Continue to oversee the development of the directorate’s new ways of working and review the impact of the changes that have been made.</td>
<td>Director of Community Engagement</td>
<td>31 March 2021</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oversee the establishment of the mechanisms required to enable the Committee to gain assurance on the performance of all HIS directorates in relation to engaging people in the delivery of our work, including meeting our Duty of User Focus and equalities duties.</td>
<td>Director of Community Engagement</td>
<td>31 March 2021</td>
<td></td>
</tr>
<tr>
<td>Staff Governance</td>
<td>Given the current challenges and changes to working arrangements for the whole organisation, ensure an appropriate Staff Governance approach is maintained for the workforce, including continued scrutiny of health and safety arrangements, staff health and wellbeing and responding to the remobilisation arrangements for Healthcare Improvement Scotland.</td>
<td>Director of Workforce</td>
<td>31 March 2021</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As we move back into more of a business as usual approach, there will be an opportunity to continue the directorate based review of staff governance activity, supplemented by the additional focus described above.</td>
<td>Director of Workforce</td>
<td>31 March 2021</td>
<td></td>
</tr>
</tbody>
</table>
Healthcare Improvement Scotland

Meeting: Board meeting
Meeting date: 24 June 2020
Title: Financial Performance Report 31 May 2020
Agenda item: 3.3
Responsible Executive/Non-Executive: Maggie Waterston, Director of Finance & Corporate Services
Report Author: David Rhodes, Head of Finance & Procurement

1 Purpose

This is presented to the Board for:
• Discussion

This report relates to:
• Annual Operational Plan delivery
• Emerging issue
• Government policy/directive
• HIS Strategic Direction

This aligns to the following HIS priorities(s):
• Mental health services
• Access to care
• Integration of health and social care
• Safe, reliable and sustainable care

2 Report summary

2.1 Situation
The report at Appendix 1 sets out the financial position of Healthcare Improvement Scotland as at 31 May 2020. The financial report is considered by the Board at each of its meetings.
2.2 Background
The Financial Performance Report as at 31 May 2020 is set out in detail at Appendix 1. There is a comprehensive narrative that draws attention to the performance of the baseline budget and the budget for additional allocations.

The report measures financial performance against the budget that was approved by the Board in March 2020. Since then, significant change has taken place in terms of responding to the Coronavirus pandemic. The report captures separately the staffing costs that have been incurred to support the pandemic either by refocussing staff internally or by deploying staff to other areas of the health and care system. Further work will take place to capture the complete financial contribution that HIS have made to supporting the pandemic.

2.3 Assessment
The financial position at the end of May 2020 is broadly in line with the budgeted expectations. There is a slight over spend on the baseline budget which is largely a consequence of the budgeted savings being under achieved.

To date, we have received no additional funding allocations from Scottish Government. This is not unusual for this stage in the financial year and the attached report clearly states the expenditure that has taken place against the expectation of receiving the allocations as budgeted.

A revision of the financial plan will take place to support the remobilisation plan from August 2020 to March 2021. This will include redirecting resources to the work in the remobilisation plan and a review of the risks that surround the additional allocations. It will also include additional resources to support the Quality Assurance Directorate which we expect to finance from a bid for central COVID-19 funds. The revised financial plan will be shared with the Board.

2.3.1 Risk Assessment/Management
The financial plan for HIS will change rapidly as a consequence of the current operating environment. This is captured as a risk on the strategic risk register. Close monitoring of the financial position takes place between the management accountants and their designated budget holders.

2.3.2 Route to the Meeting
This has been previously considered by the Executive Team on 23 June 2020.

2.4 Recommendation
The Board are asked to consider this report for
- Discussion – Examine and consider the implications of a matter.
2 List of appendices

Appendix 1: Financial Performance Report at 31 May 2020
Overview of Financial Performance

The April funding allocation letter from Scottish Government (SG) was received on 13 May 2020. This outlined a baseline recurring allocation of £27.153m (line A in Table A below), which was in line with the assumptions within the budget approved by the Board in March 2020. The letter included no additional allocations or depreciation (line B in Table A below). Further notification on this is expected in the May letter anticipated to be received on 1 July 2020. The result is a total revenue resource limit (RRL) for 2020-21 of £27.153m at May 2020.

Overall, expenditure year to date is £1.047m over budget. Of this, baseline recurring allocations are overspent against budget by £0.031m with the balance relating to additional allocations and IHC where budgets have not yet been formally notified and are therefore not loaded. The baseline overspend reflects target pay savings across a number of Directorates being behind budget.

Whilst the annual operating plan has been modified to follow the mobilisation plan, the full year forecast anticipates a break even position against the budget approved by the Board in March 2020. However key risks against this assumption are that additional allocations are not fully funded and that income levels within Independent Healthcare are lower than budget following resumption of trading within the sector.

Summary of Financial Expenditure:

Table A

<table>
<thead>
<tr>
<th></th>
<th>Budget Spend £000's</th>
<th>April - May Actual Spend £000's</th>
<th>Variance £000's</th>
<th>Budget Spend £000's</th>
<th>Full Year Forecast Spend £000's</th>
<th>Variance £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Expenditure on Baseline (Including Savings Target)</td>
<td>4,287</td>
<td>4,318</td>
<td>-31</td>
<td>27,153</td>
<td>27,153</td>
<td>0</td>
</tr>
<tr>
<td>B Expenditure on additional allocations -received</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C Expenditure on additional allocations -anticipated</td>
<td>0</td>
<td>888</td>
<td>-888</td>
<td>7,657</td>
<td>7,657</td>
<td>0</td>
</tr>
<tr>
<td><strong>Revenue Resource Limit Expenditure (RRL)</strong></td>
<td><strong>4,287</strong></td>
<td><strong>5,206</strong></td>
<td><strong>-918</strong></td>
<td><strong>34,810</strong></td>
<td><strong>34,810</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>IHC additional allocations -anticipated</td>
<td>0</td>
<td>0</td>
<td>-448</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IHC Income</td>
<td>0</td>
<td>-9</td>
<td>9</td>
<td>-680</td>
<td>-680</td>
<td>0</td>
</tr>
<tr>
<td>IHC Expenditure</td>
<td>0</td>
<td>137</td>
<td>-137</td>
<td>1,128</td>
<td>1,128</td>
<td>0</td>
</tr>
<tr>
<td>Net Deficit (Surplus)</td>
<td>0</td>
<td>128</td>
<td>-128</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Revenue Expenditure</strong></td>
<td><strong>4,287</strong></td>
<td><strong>5,334</strong></td>
<td><strong>-1,047</strong></td>
<td><strong>34,810</strong></td>
<td><strong>34,810</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Baseline staff count (WTE)</td>
<td>369.8</td>
<td>379.1</td>
<td>-9.3</td>
<td>387.1</td>
<td>387.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Non recurring allocations staff count (WTE)</td>
<td>0.0</td>
<td>75.3</td>
<td>-75.3</td>
<td>0.0</td>
<td>88.0</td>
<td>-88.0</td>
</tr>
<tr>
<td>IHC staff count (WTE)</td>
<td>0.0</td>
<td>14.7</td>
<td>-14.7</td>
<td>0.0</td>
<td>18.0</td>
<td>-18.0</td>
</tr>
</tbody>
</table>
1. Baseline recurring spend

At 31 May the total baseline funding received is £27.153m. HIS has spent £4.318m of baseline funding for the first two months which is £0.031m over budget. We are 16% of the way through the year with 16% of the baseline funding spent. Table B below outlines the baseline recurring spend position.

1.1. Financial position at 31 May 2020

<table>
<thead>
<tr>
<th></th>
<th>£000's</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
<td>Forecast</td>
<td>% of forecast spent as at May</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>143</td>
<td>131</td>
<td>12</td>
<td>1,010</td>
<td>1,010</td>
</tr>
<tr>
<td>Corporate Provision</td>
<td>44</td>
<td>39</td>
<td>5</td>
<td>235</td>
<td>235</td>
</tr>
<tr>
<td>Evidence</td>
<td>928</td>
<td>922</td>
<td>6</td>
<td>5,953</td>
<td>5,953</td>
</tr>
<tr>
<td>FCS</td>
<td>243</td>
<td>280</td>
<td>-37</td>
<td>1,687</td>
<td>1,687</td>
</tr>
<tr>
<td>ihub</td>
<td>1,246</td>
<td>1,219</td>
<td>27</td>
<td>7,718</td>
<td>7,718</td>
</tr>
<tr>
<td>Medical</td>
<td>144</td>
<td>162</td>
<td>-18</td>
<td>908</td>
<td>908</td>
</tr>
<tr>
<td>NMAHP</td>
<td>87</td>
<td>94</td>
<td>-7</td>
<td>515</td>
<td>515</td>
</tr>
<tr>
<td>QAD</td>
<td>660</td>
<td>683</td>
<td>-23</td>
<td>4,360</td>
<td>4,360</td>
</tr>
<tr>
<td>Community Engagement</td>
<td>457</td>
<td>453</td>
<td>4</td>
<td>2,759</td>
<td>2,759</td>
</tr>
<tr>
<td>People &amp; Workplace</td>
<td>102</td>
<td>104</td>
<td>-2</td>
<td>606</td>
<td>606</td>
</tr>
<tr>
<td>Property</td>
<td>233</td>
<td>231</td>
<td>3</td>
<td>1,401</td>
<td>1,401</td>
</tr>
<tr>
<td>Grand Total</td>
<td>4,287</td>
<td>4,318</td>
<td>-31</td>
<td>27,153</td>
<td>27,153</td>
</tr>
</tbody>
</table>

The variances are explained in more detail in section 1.3 and 1.5.

1.2. Pay costs

Baseline staffing WTE levels at the end of May were ahead of budget, 379 vs. budget of 370. Staffing levels at the end of March 2020 were 383.
### 1.3. Directorate Pay Analysis

### Table C

<table>
<thead>
<tr>
<th>Category</th>
<th>WTE</th>
<th>£000's</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April-May</td>
<td>Budget</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>14.8</td>
<td>14.5</td>
</tr>
<tr>
<td>Corporate Provision</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Evidence</td>
<td>81.4</td>
<td>82.9</td>
</tr>
<tr>
<td>FCS</td>
<td>80.5</td>
<td>80.7</td>
</tr>
<tr>
<td>Hub</td>
<td>100.2</td>
<td>98.5</td>
</tr>
<tr>
<td>Medical</td>
<td>10.6</td>
<td>12.9</td>
</tr>
<tr>
<td>NMAHP</td>
<td>6.0</td>
<td>7.1</td>
</tr>
<tr>
<td>QAD</td>
<td>59.0</td>
<td>61.8</td>
</tr>
<tr>
<td>Community Engagement</td>
<td>55.8</td>
<td>58.4</td>
</tr>
<tr>
<td>People &amp; Workplace</td>
<td>11.5</td>
<td>12.4</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>369.8</td>
<td>370.1</td>
</tr>
</tbody>
</table>

All the key variances on year to date pay costs are the result of pays savings targets, which are still to be achieved in certain Directorates:

- **Medical** overspend of £13k, also includes £4k Chief Pharmacist additional hours
- **QAD** overspend of £28k, reflecting higher staffing in baseline than originally planned.

### Categories of Baseline Pay £3.6m

### Categories of Additional Allocation Pay £0.8m

### 1.4. Non pay costs

The graph below outlines the non pay expenditure and budget profile and compares this to prior year.
1.5. Directorate Non Pay Analysis

<table>
<thead>
<tr>
<th></th>
<th>£000's</th>
<th>Budget</th>
<th>Actual</th>
<th>Variance</th>
<th>Forecast</th>
<th>Budget</th>
<th>Forecast</th>
<th>Variance</th>
<th>% of forecast spent as at May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>19</td>
<td>7</td>
<td>11</td>
<td>114</td>
<td>114</td>
<td>0</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Provision</td>
<td>32</td>
<td>26</td>
<td>6</td>
<td>163</td>
<td>163</td>
<td>0</td>
<td>16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence</td>
<td>94</td>
<td>87</td>
<td>6</td>
<td>469</td>
<td>469</td>
<td>0</td>
<td>19%</td>
<td></td>
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</tr>
<tr>
<td>FCS</td>
<td>-21</td>
<td>17</td>
<td>-38</td>
<td>49</td>
<td>49</td>
<td>0</td>
<td>34%</td>
<td></td>
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</tr>
<tr>
<td>ihub</td>
<td>351</td>
<td>312</td>
<td>39</td>
<td>1,981</td>
<td>1,981</td>
<td>0</td>
<td>16%</td>
<td></td>
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</tr>
<tr>
<td>Medical</td>
<td>5</td>
<td>1</td>
<td>-4</td>
<td>21</td>
<td>21</td>
<td>0</td>
<td>19%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NMAHP</td>
<td>21</td>
<td>15</td>
<td>5</td>
<td>300</td>
<td>300</td>
<td>0</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Engagement</td>
<td>28</td>
<td>5</td>
<td>23</td>
<td>206</td>
<td>206</td>
<td>0</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People &amp; Workplace</td>
<td>5</td>
<td>6</td>
<td>-1</td>
<td>41</td>
<td>41</td>
<td>0</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property</td>
<td>233</td>
<td>231</td>
<td>3</td>
<td>1,401</td>
<td>1,401</td>
<td>0</td>
<td>16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>764</td>
<td>712</td>
<td>52</td>
<td>4,772</td>
<td>4,772</td>
<td>0</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key variances on year to date non pay costs are:

- **FCS** underspend of £38k relates partly to the corporate services charge to additional allocations, which reflects budget timing.

- **ihub** underspend of £39k, due to £16k over accrual for income which will be reversed in P3 and travel costs which are being assessed as potential savings against budget. The remaining variance is due to budget phasing.

- **Community Engagement** underspend of £23k, due to various Non-Pay underspends in Local Offices. An assessment is to be made to establish whether the underspend can be taken as savings.

1.6. Internal efficiency savings targets 2020-21

In order to achieve a balanced budget the financial plan was the subject of internal savings targets amounting to £2.022 m. This was to be achieved through directorate savings targets based on historical underspends of £1.318m and staff turnover during the year of £0.704m. The budget also assumed a carry forward of £0.242m surplus from 2019/20 which has been exceeded and is planned to be utilised as bridge funding to assist with structural improvement.

Table E shows the current position as at 31 May 2020. This shows that net savings of £0.415m have been achieved in the first two months of the financial year. It is anticipated that a carry forward surplus of £0.527m will be notified in the allocation letter in due course.
## 2. Additional Allocations non recurring spend

Table F below shows the details of the additional allocations. The budget value shown below is the approved budget value communicated to the Board in March 2020. No additional allocations have been formally communicated in the April allocation letter.

### Table F

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Confirmation Status Tab</th>
<th>Anticipated Allocation £</th>
<th>Spend to Date £</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Budgeted</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAPG</td>
<td>Evidence</td>
<td>Budgeted</td>
<td>236,533</td>
<td>36,658</td>
</tr>
<tr>
<td>National Review Panel - NRP</td>
<td>Medical</td>
<td>Budgeted</td>
<td>51,351</td>
<td>9,109</td>
</tr>
<tr>
<td>Off-Label Cancer Medicines - OLCM</td>
<td>Medical</td>
<td>Budgeted</td>
<td>89,024</td>
<td>14,313</td>
</tr>
<tr>
<td>HSP - Internal</td>
<td>NMAHP</td>
<td>Budgeted</td>
<td>1,168,968</td>
<td>135,986</td>
</tr>
<tr>
<td>19-20 Carry Forward</td>
<td>Corporate Provisions</td>
<td>Budgeted</td>
<td>527,000</td>
<td>0</td>
</tr>
<tr>
<td><strong>EiC-External</strong></td>
<td>NMAHP</td>
<td>Budgeted</td>
<td>278,000</td>
<td>35,864</td>
</tr>
<tr>
<td>HSP - External</td>
<td>NMAHP</td>
<td>Budgeted</td>
<td>853,448</td>
<td>0</td>
</tr>
<tr>
<td>SHTG - external</td>
<td>Evidence</td>
<td>Budgeted</td>
<td>209,918</td>
<td>37,621</td>
</tr>
<tr>
<td>Volunteering Information Systems</td>
<td>Community Engagement</td>
<td>Budgeted</td>
<td>20,400</td>
<td>1,145</td>
</tr>
<tr>
<td>Palliative and End of Life Care Clinical Leadership</td>
<td>ihub</td>
<td>Budgeted</td>
<td>73,606</td>
<td>8,064</td>
</tr>
<tr>
<td>Value Management</td>
<td>ihub</td>
<td>Budgeted</td>
<td>675,661</td>
<td>35,607</td>
</tr>
<tr>
<td>GP Clusters</td>
<td>ihub</td>
<td>Budgeted</td>
<td>750,000</td>
<td>87,125</td>
</tr>
<tr>
<td>SPSP Improving Observation Practice (SPSP IOP)</td>
<td>ihub</td>
<td>Budgeted</td>
<td>99,557</td>
<td>9,510</td>
</tr>
<tr>
<td>Dementia in Hospitals</td>
<td>ihub</td>
<td>Budgeted</td>
<td>115,858</td>
<td>16,091</td>
</tr>
<tr>
<td>Post-diagnostic Support</td>
<td>ihub</td>
<td>Budgeted</td>
<td>35,216</td>
<td>18,290</td>
</tr>
<tr>
<td>Care Co-ordination External</td>
<td>ihub</td>
<td>Budgeted</td>
<td>62,700</td>
<td>24,304</td>
</tr>
<tr>
<td>Access Qi</td>
<td>ihub</td>
<td>Budgeted</td>
<td>393,284</td>
<td>180,915</td>
</tr>
<tr>
<td>WMTY SG</td>
<td>Community Engagement</td>
<td>Budgeted</td>
<td>12,900</td>
<td>624</td>
</tr>
<tr>
<td>PNCP</td>
<td>Community Engagement</td>
<td>Budgeted</td>
<td>15,000</td>
<td>0</td>
</tr>
<tr>
<td>ICT Strategy</td>
<td>Finance &amp; Corporate Services</td>
<td>Budgeted</td>
<td>91,379</td>
<td>10,126</td>
</tr>
<tr>
<td>SUDI</td>
<td>QAD</td>
<td>Budgeted</td>
<td>52,195</td>
<td>10,789</td>
</tr>
<tr>
<td>Adverse Events</td>
<td>QAD</td>
<td>Budgeted</td>
<td>204,759</td>
<td>10,722</td>
</tr>
<tr>
<td>TBQG</td>
<td>QAD</td>
<td>Budgeted</td>
<td>43,373</td>
<td>1,173</td>
</tr>
<tr>
<td>QA Primary Care</td>
<td>QAD</td>
<td>Budgeted</td>
<td>118,654</td>
<td>17,794</td>
</tr>
<tr>
<td>Adult Support and Protection Inspections</td>
<td>QAD</td>
<td>Budgeted</td>
<td>284,586</td>
<td>37,375</td>
</tr>
<tr>
<td>National Hub</td>
<td>QAD</td>
<td>Budgeted</td>
<td>249,372</td>
<td>58,851</td>
</tr>
<tr>
<td>MCQIC external</td>
<td>ihub</td>
<td>Budgeted</td>
<td>44,000</td>
<td>9,148</td>
</tr>
<tr>
<td>Early Interventions in Psychosis (EIP)</td>
<td>ihub</td>
<td>Budgeted</td>
<td>283,485</td>
<td>23,952</td>
</tr>
<tr>
<td>Mental Health Access Improvement Support Team</td>
<td>ihub</td>
<td>Budgeted</td>
<td>418,000</td>
<td>38,322</td>
</tr>
<tr>
<td>Barnahus standards</td>
<td>Evidence</td>
<td>Budgeted</td>
<td>11,085</td>
<td>6,615</td>
</tr>
<tr>
<td>Collaborative Communities (External)</td>
<td>ihub</td>
<td>Budgeted</td>
<td>188,000</td>
<td>12,706</td>
</tr>
<tr>
<td><strong>Total Additional Allocations</strong></td>
<td></td>
<td></td>
<td><strong>7,657,314</strong></td>
<td><strong>887,540</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Key</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Red</strong></td>
<td>No confirmation of funding received</td>
</tr>
<tr>
<td><strong>Yellow</strong></td>
<td>Confirmation received but value may be subject to amendment.</td>
</tr>
<tr>
<td><strong>Green</strong></td>
<td>Full confirmation received including value.</td>
</tr>
</tbody>
</table>
3. COVID -19 Mobilisation spend

Table G below outlines the year to date pay costs across activities.

<table>
<thead>
<tr>
<th>Category</th>
<th>£000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A-refocusing work (COVID-19 resilience offerings)</td>
<td>1,354</td>
</tr>
<tr>
<td>2B-secondee returned to home board</td>
<td>316</td>
</tr>
<tr>
<td>2C-deployment of clinical staff to other organisations</td>
<td>465</td>
</tr>
<tr>
<td>2D-deployment of non-clinical staff to other organisations</td>
<td>254</td>
</tr>
<tr>
<td>HIS Planned work</td>
<td>2,036</td>
</tr>
<tr>
<td>Total</td>
<td>4,425</td>
</tr>
</tbody>
</table>

Table G

4. Outturn Prediction for 31 March 2021

In compliance with Scottish Government guidance, HIS has the ability to break-even over a three-year period, enabling it within any year to under or overspend by up to one per cent of annual resource budget. In HIS’s case this reflects circa +/- £0.3m.

The full year forecast anticipates a break even position, this is subject to additional allocations being funded in line with the March 2020 budget assumptions and no significant deterioration in income from the Independent Healthcare sector following resumption of trading activity in the sector.

5. Financial Outlook

The current mobilisation plan (25 May 2020) was prepared for the immediate term until end of July 2020. A remobilisation plan will now be prepared to cover the period from the end of July until March 2021. As part of this work a review of the original budget will take place which will incorporate a review of additional allocations and the likelihood or not of the work proceeding as originally planned and therefore the funding being received. The revised forecast will also incorporate the savings gap and represent the use of the bridging fund to achieve sustainable improvements to the way that we work and to the future financial sustainability of HIS.
Healthcare Improvement Scotland

Meeting: Board Meeting
Meeting date: 24 June 2020
Title: Risk Management: strategic risks
Agenda item: 4.1
Responsible Executive/Non-Executive: Maggie Waterston, Director of Finance and Corporate Services
Report Author: Pauline Symaniak, Corporate Governance Manager

1 Purpose
To provide the Board with the latest information on the strategic risk register.

This is presented to the Board for:
• Discussion

This report relates to:
• Annual Operational Plan delivery
• Emerging issue
• HIS Strategic Direction

This aligns to the following HIS priorities(s):
• Mental health services
• Access to care
• Integration of health and social care
• Safe, reliable and sustainable care

2 Report summary

2.1 Situation
The risk reporting system (Compass) has been created to support the Risk Management Strategy and to enable review of risk across the organisation. The Board is asked to review all of the strategic risks held on Compass (Appendix 1) as at 10 June 2020.
2.2 **Background**

The Board’s role for assessing risk is set out in the NHS Scotland Blueprint for Good Governance as follows:

- Agree the organisation’s risk appetite.
- Approve risk management strategies and ensure they are communicated to the organisation’s staff.
- Identify current and future corporate, clinical, legislative, financial and reputational risks.
- Oversee an effective risk management system that assesses level of risk, identifies mitigation and provides assurance that risk is being effectively treated, tolerated or eliminated.

2.3 **Assessment**

The movement schedule at Appendix 2 shows the changes in strategic risks since the previous Board meeting on 27 May 2020. A grid showing the risk appetite and scoring is attached for reference at Appendix 3.

2.3.1 **Quality/ Care**

The risk register underpins delivery of the organisation’s strategy and effective risk management ensures the best outcomes from our work programmes. Discussion of the risk register and its impact on delivery of the organisation’s work plan is a key part of the assurance arrangements of the organisation and in identifying opportunities.

2.3.2 **Workforce**

There is no impact on staff resources, staff health and wellbeing as a result of this paper. Relevant workforce risks are recorded on Compass and presented to the Staff Governance Committee.

2.3.3 **Financial**

There is no financial impact as a result of this paper. Relevant financial risks are recorded on Compass and presented to the Audit and Risk Committee.

2.3.4 **Risk Assessment/Management**

Strategic risks and their mitigations are set out in the report.

2.3.5 **Equality and Diversity, including health inequalities**

There are no equality and diversity issues as a result of this paper. An impact assessment has not been completed because this is an internal governance paper.

2.3.6 **Other impacts**

There are no additional impacts arising from this paper.
2.3.7 Communication, involvement, engagement and consultation
The risk register is an internal management tool and therefore no external consultation has been undertaken in preparing this paper.

2.3.8 Route to the Meeting
This has been previously considered by the following groups as part of its development.
- Audit and Risk Committee, 17 June 2020. The Board’s strategic risk report is the same report that was considered by the Committee.
- Extraordinary Board meeting, 27 May 2020. The Board received the strategic risk report at that time.

2.4 Recommendation
The paper is presented for discussion.

The Board is asked to review the attached papers to:
- Assure themselves that the risks presented are recorded and mitigated appropriately.
- To identify and agree any new risks that ought to be raised.
- To identify any opportunities that arise from the risk reports presented.

3 List of appendices
The following appendices are included with this report:
- Appendix 1, Strategic Risk Register
- Appendix 2, Movement Schedule
- Appendix 3, Risk Appetite Matrix
## Appendix 1 Strategic Risks (at 10/6/20)

<table>
<thead>
<tr>
<th>Category</th>
<th>Project/Strategy</th>
<th>Risk No</th>
<th>Risk Director</th>
<th>Risk Description</th>
<th>Current Controls</th>
<th>Current Mitigation</th>
<th>Current Update</th>
<th>Last Reviewed by Committee</th>
<th>Current Risk Level</th>
<th>May - 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reputational/ Creditly</td>
<td>COVID-19</td>
<td>950</td>
<td>Robbie Pearson</td>
<td>There is a risk that the delivery of our annual work programme will be adversely affected for a significant period of 2020 due to the health, societal and economic disruption at national and international level caused by the COVID-19 pandemic and the mitigation taken by the UK, Scottish and Scottish governments to delay the progression of the virus. A review programme to allow maintenance of statutory obligations, pause work dependent on clinical input and review on meeting immediate needs of system. Regular review of short-term covid-19 focused work through “Team B” resilience team. Co-ordinate response in line with recovery and renewal work of National Boards Collaborative work.</td>
<td>Develop and implement mobilisation plan. Minimise the pressure on both frontline healthcare and our own staff by re-focusing work programme. Consider pause as an opportunity and develop process for active consideration and prioritisation of restart of work. Ensure good communication with staff.</td>
<td>A mobilisation plan was prepared detailing the alterations to the operational plan for 2020-21 as a result of Covid-19 and has been reviewed by the Board and the Q&amp;PC. A framework for reactivating work by HIS was approved by the Board on 27 May 2020. An updated mobilisation plan was submitted to Scottish Government on the 25 May 2020.</td>
<td>Audit and Risk, 17 June 2020</td>
<td>Very High</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Financial / Value for Money</td>
<td>Finance Strategy</td>
<td>635</td>
<td>Margaret Waterson</td>
<td>There is a risk of instability with the budget for 2020-21 because of national funding diversion for COVID19 requiring changes to the priorities around our workplan and resulting in difficulties in managing a 12 month budget, particularly additional allocations in accordance with Scottish Government guidelines. A revised budget/forecast is being approved by the Board in March 2020. A weekly budget/forecast is being reviewed with budget holders and with HIS policy leads to determine current status. A review of all costs associated with baseline budget and additional allocations is taking place to understand the movement from original budget to mobilisation plan.</td>
<td>Weekly updates being provided to HIS finance colleagues showing impact of COVID19 on financial projections - to date IPCC £3.2m loss of income. Close contact with HIS policy leads to confirm additional allocations and their use. Review of the work programme for HIS to ensure that work is prioritised based on current knowledge. Learning from current agility of working to be assessed for inclusion as future ways of working eg use of technology, successful collaborations, home working which support efficiencies</td>
<td>A financial forecast was prepared to support the detailed mobilisation plan and was considered by the Board at its meeting in April 2020. Close contact is being maintained with SG finance colleagues and financial risks are being negotiated with them. The reactivation of work for HIS will be dependent on having the capacity, skills and finances required to deliver the work successfully.</td>
<td>Audit and Risk, 17 June 2020</td>
<td>High</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Reputational / Creditly</td>
<td>ICT Strategy</td>
<td>923</td>
<td>Margaret Waterson</td>
<td>There is a risk that our ICT systems could be disabled because of a cyber security attack resulting in staff being unable to deliver our work and causing reputational damage. Controls that are in place include: no direct connection to the internet and two Dali Sonicwall firewalls between the WAN network (external) and HIS network (internal) blocking incoming and outgoing traffic. These provide the following safeguards: block network attacks, intruder prevention and gateway anti-spyware anti-virus. Network traffic is segregated with VLANs and Sophos filters website traffic by blocking or allowing websites or categories. Sophos Anti-Virus has been deployed across domain which includes malware detection and blocks the latest threats.</td>
<td>All users complete modules on Data protect, Information Security and Freedom of information before being allowed access to HIS computers. User also sign the acceptable use policy. Avant port control blocks unauthorised removable media and Sophos policy scans on read access to alert to issues. We use WSUS (Windows Server Update Server) for security patch deployment. A patching schedule is in place where new security patches released are to be deployed within four week of release. There is a standard build to all new equipment with the latest security patches applied. Only the Alerts are sent nationally whenever any suspicious activity takes place outside NHSScottish or the public sector. The Director of Finance &amp; Corporate Services and the Head of ICT at SAS are on call for major incidents which are all handled centrally, HIS will undertake a self-assessment audit as part of the national resilience work to ensure that the controls that are in place are adequate to protect the organisation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
including ransomware, exploit-based attacks, and server-specific malware. We proactively search for issues, understand how attacks take place. Sophos sandstorm provides the organization with an extra layer of security against ransomware and targeted attacks. Healthcare improvement Scotland gained Cyber Essentials accreditation October 2018 members of the ICT team have privilege accounts for the domain. The ICT manager and Senior ICT Support Analyst are notified automatically when changes occur. ICT team monitor and receive alert from the firewall, server, anti-virus and proxy server logs. Daily backups of all data.

Reputational / Credibility Information Governance Strategy 759 Safia Qureshi There is a risk of reputational damage through failure to demonstrate compliance with the General Data Protection Regulation resulting in reduced stakeholder confidence in the organisation. Ongoing monitoring and advice staff training, records retention policy, data protection policy, information security policies, technical security controls, Cyber security certification; data processor contractual arrangements, improved implementation of retention schedules. Ongoing advice and guidance is being provided as required in relation to project work which has not been paused. Ongoing development work relating to the auditing of compliance will proceed as possible based on the availability of Information Governance Group members.

Operational Making Care Better Strategy 2017-2022 901 Robbie Pearson There is a risk that we are not providing sufficient time to delivering existing programmes of work because of the level of requests from Scottish Government to scope and design new programmes of work resulting in a failure to deliver within the operational plan. Operating Framework Further development of the new commissions process to include new arrangements for the lead officer in Scottish Government to confirm what funding is available before scoping work is started. Development of capacity planning approaches to include explicitly identifying time for scoping and designing new programmes of work. Where requests for scoping/designing new programmes exceeds available capacity agree with SG lead and sponsor approach to take forward including, where appropriate, additional resources to support the scoping and design stages, Internal improvement oversight board and its programmes will consider options in the process improvement and people work streams to better balance existing and emerging planning of work. The Operating Framework between our organisation and Scottish Government is a key mechanism for managing the demands on the organisation. There has been very close working with our sponsors in Scottish Government in relation to our response to COVID-19, including the re-profiling and pausing of significant aspects of our work and they have been helpful in ensuring a shared understanding amongst SG policy leads in relation to our role and contribution at this time.

There will be further discussion with Scottish Government about the implications of the development of the mobilisation plan and the reactivation of aspects of our work. This will also include the implications of work that has been paused.

Operational Making Care Better Strategy 2017-2022 883 Margaret Waterston There is a risk that the lease for Delta House Glasgow, will expire in March 2021 before we have secured a long term alternative due to the delays now being caused by COVID19 with gaining access to Delta House for structural surveys resulting in short term arrangements that may be costly and which may not suit the needs of our workforce. Weekly property calls with property adviser, structural engineer, O&G, NSE facilities and space planning experts to progress all aspects of the project that are possible. Property adviser (Avison Young) leading discussions with the landlord to negotiate acceptable terms and performance requirements. Negotiation with landlord to agree a short term extension to current lease to allow longer term lease to be agreed Discussions with SG Capital Investment colleagues to arrange sign off of the Final Business Case for 10 years using delegated authority powers rather than waiting for Ministerial Approval Agreement with SG Capital Heads of Terms have been agreed. Board approval was given on May 27th to proceed with the legal negotiations to finalise the lease. These negotiations are proceeding well along with the space planning work which will follow the alterations to the building. Weekly calls are in place with O&G and the property adviser to ensure we understand the implications of the process and that the process is moving forward as required.
Reputational / Credibility

QAD wider directorate risks

996
Sandra McDougall

There is a risk that implementation of the recommendations made by the Quality of Care Approach - Short term Governance Group will be significantly delayed, because of the impact of COVID-19 on HSC work with health and care providers, resulting in both loss of momentum, and missed opportunities, to improve how HSC provides assurance about the quality of health and care in Scotland.

Corporate systems for responding appropriately to impact of COVID-19 including Mobilisation Plan QoCA Work Plan including development of Engagement and communication plan QAD Performance monitoring and reporting, including regular oversight by QAD DMT Scheduled progress updates to Quality & Performance Committee

Clearly delineated QoCA Work Plan which sets out work that can continue to be progressed internally, plus areas of work which have dependencies re external engagement.

Opportunities to maximise engagement through existing mechanisms and networks rather than as a separate initiative will be identified where possible. Additional costs of this work have been recognised in HSC Financial Plans for 2020-21

Recommendations made by the QoCA SLG were supported by the Quality & Performance Committee when it met on 13 May 2020. An update will also be provided to the Board. The paper containing the recommendations set out the potential impact of COVID-19 on work to date, and on work requiring engagement with stakeholders during 2020-21. The Committee noted the uncertainty with regard to the extent of the impact of COVID-19, alongside the need to make progress with this work, and requested a further paper on communication and engagement at its next meeting.

Audit and Risk, 17 June 2020
High - 15
Likelihood - 3
Impact - 40

Operational

QAD wider directorate risks

929 Robbie Pearson

There is a risk of disruption to the activities of the quality assurance directorate arising from changes in the leadership arrangements which will impact delivery of work.

Actions agreed by the Executive Remuneration Committee to establish interim leadership arrangements in house capacity. External Recruitment. Workplan known.

Sandra McDougall assumed the role of Interim Director of Quality Assurance. Ann Gow assumed leadership responsibility on an interim basis for inspections and regulatory activity. Additional leadership support has also been provided by Donna O’Boyle for inspection activity. Sandra McDougall is providing leadership for the directorate, whilst a wide range of aspects of work are paused arising from COVID-19 response. Further clinical support is being provided by the Medical Director and the NMAHP Directorate. Ann Gow has now returned to the organization and has resumed joint leadership responsibility. Donna O’Boyle however has been recalled to Scottish government to work on their Covid response. It has also been decided to proceed with recruitment for the Director of Quality Assurance. A paper will be presented to the Executive Remuneration Committee in July 2020 outlining the recruitment process.

Audit and Risk, 17 June 2020
High - 15
Likelihood - 3
Impact - 40

Reputational / Credibility

Regulation of Independent Healthcare

890 Ann Gow

There is a risk that HIS may not be able to pursue enforcement of unregistered independent healthcare services because of a lack capacity resulting in both reputational risk to HIS and a potential public safety risk.

We have enforcement policies and procedures for unregistered services. In addition, we have a list of services which have told us they do not require to register with us and a list of services we have had no response.

We had produced a business case for an additional 0.8 WTE band 7 Programme Manager to undertake this work along with other pieces of work. Without this additional post, we will be unable to pursue these services.

We believe there are currently at least 29 unregistered services that require to be registered and a number of unregistered training providers using live models that make them providers of an independent healthcare service.

We have filled all the vacant posts in the IHC establishment currently and have one post on hold due to COVID-19. Both our programme managers are working, although COVID-19 is impacting on the work patterns of these staff. Once we have dealt with COVID-19 priorities and lockdown is...
There is a risk to the organisation being able to deliver the total requirements of the mobilisation and operational plan for 2020/21 based on the number of Healthcare Improvement staff currently working outside the organisation to support the wider NHS Scotland system as part of our organisational support to the impact of COVID-19. Some individual boards may feel unable to support our request to return staff at the point they are required to return to support our service delivery and some individuals may not wish to return based on their experiences elsewhere, which could leave gaps across some parts of our workforce.

As part of the COVID-19 ERT arrangements, the Team B group have developed a detailed process to support the planned and supported return of individual HIS staff members to the organisation. This includes appropriate discussions with both individual boards and also the individual staff members to put in place mutually agreed arrangements for return. This process should also enable early escalation of any staffing 'gaps' to enable an appropriate response to provide cover or identify alternative action required, e.g. recruitment to vacant roles. This process requires close monitoring and overview to allow HIS to respond quickly.

Following secondment of staff, there has been an ongoing process of line managers maintaining contact with individual members of staff from a health and wellbeing basis. There has also been a review date built into all those seconded out from our organisation to ensure the opportunity to review the continued requirement for individuals to be working elsewhere. All individuals who have moved externally to HIS have received individual communication from the organisation at the start of these arrangements to ensure due governance of the process.

Audit and Risk, 17 June 2020

High - 15
Impact - 5
Likelihood - 3

Activity and progress monitored quarterly via Staff Governance Committee. Further scrutiny and service focus takes place through the People work stream of the internal improvement programme which has focused on outstanding actions to facilitate and support their delivery.

Over we will start to progress the unregistered services work again.

There is a risk that we may not have the right skills at the right time to deliver our work because of a skills shortage or lack of capacity resulting in a failure to meet our objectives.

Workforce Plan agreed for 2020-23. Workforce plan provides detail on current and planned service arrangements within the organisation and includes a detailed action plan describing necessary actions to be implemented in 2020 & 2021.

Audit and Risk, 17 June 2020

High - 15
Impact - 5
Likelihood - 3
1. Strategic Risks

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Category</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>989</td>
<td>Workforce Strategy</td>
<td>There is a risk to the organisation being able to deliver the total requirements of the mobilisation and operational plan for 2020/21 based on the number of Healthcare Improvement staff currently working outwith the organisation to support the wider NHS Scotland system as part of our organisational support to the impact of COVID 19. Some individual boards may feel unable to support our request to return staff at the point they are required to return to support our service delivery and some individuals may not wish to return based on their experiences elsewhere, which could leave gaps across some parts of our workforce.</td>
<td>Newly raised risk.</td>
</tr>
<tr>
<td>990</td>
<td>COVID-19</td>
<td>There is a risk that the delivery of our annual work programme will be adversely affected for a significant period of 2020 due to the health, societal and economic disruption at national and international level caused by the COVID-19 pandemic and the mitigations taken by the UK and Scottish governments to delay the progress of the virus.</td>
<td>Newly raised risk</td>
</tr>
</tbody>
</table>

Risks that have left the report since May

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Category</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>977</td>
<td>COVID-19</td>
<td>There is a risk that both the health and safety of HIS staff and the delivery of our annual work programme will be severely and adversely affected for a significant period of 2020 due to the health, societal and economic disruption at national and international level caused by the COVID-19 pandemic and the mitigations taken by the UK and Scottish governments to delay the progress of the virus.</td>
<td>Risk closed – two new risks raised, 989 and 990.</td>
</tr>
</tbody>
</table>
Risk appetite definition

The risk appetite of the organisation is set by the Board and is the amount of risk that we are prepared to take, tolerate or be exposed to at any point in time. A range of appetites exist for different risks and these are regularly reviewed.

The current risk appetite categories are:

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Description (can include but not limited to)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial/value for money</td>
<td>• risks which impact on financial and operational performance (including damage / loss / fraud).</td>
</tr>
<tr>
<td>Operational</td>
<td>• risks which impact on the ability to meet project/programmes objectives (including eg impact on patient care)</td>
</tr>
<tr>
<td></td>
<td>• risks which could impact on the availability of business systems and therefore the organisation’s ability to perform key functions (technological)</td>
</tr>
<tr>
<td>Reputational/ Credibility</td>
<td>• risks which have an impact on the reputation/credibility of the organisation.</td>
</tr>
<tr>
<td></td>
<td>• could also include uncertainties caused by changes in health policy and government priorities.</td>
</tr>
<tr>
<td>Workforce</td>
<td>• risks which impact on the implementation of staff governance</td>
</tr>
<tr>
<td></td>
<td>• employee relations issues</td>
</tr>
<tr>
<td></td>
<td>• risks relating to staffing capability and capacity; issues of retaining, recruiting and developing staff with the required skills</td>
</tr>
<tr>
<td></td>
<td>• risks which lead to incidents or adverse events that could cause injury</td>
</tr>
</tbody>
</table>

The Board considers its risk appetite against these categories of risk. The current risk appetite, by risk category, has been agreed by the Board of Healthcare Improvement Scotland (21 August 2019), as follows:

<table>
<thead>
<tr>
<th>Risk Appetite Classification</th>
<th>Description</th>
<th>Category of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open</td>
<td>Willing to consider all options and choose the one that is most likely to result in success, while also providing an acceptable level of benefit</td>
<td>Operational</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reputational/ credibility</td>
</tr>
<tr>
<td>Cautious</td>
<td>Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for benefit.</td>
<td>Financial/value for money</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workforce</td>
</tr>
<tr>
<td>Minimalist</td>
<td>Preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited benefit.</td>
<td>No categories are currently assigned this appetite</td>
</tr>
<tr>
<td>Net Risk Assessment</td>
<td>Risk Assessment response</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>20-25 – Very High</td>
<td>Intolerable level of risk exposure which requires immediate action to be taken to reduce risk exposure</td>
<td></td>
</tr>
<tr>
<td>16-25 – Very High</td>
<td>Intolerable level of risk exposure which requires immediate action to be taken to reduce risk exposure</td>
<td></td>
</tr>
<tr>
<td>15-25 – Very High</td>
<td>Intolerable level of risk exposure which requires immediate action to be taken to reduce risk exposure</td>
<td></td>
</tr>
<tr>
<td>13-19 – High</td>
<td>Significant level of risk exposure that requires constant active monitoring and action to be taken to reduce exposure</td>
<td></td>
</tr>
<tr>
<td>11-15 – High</td>
<td>Significant level of risk exposure that requires constant active monitoring and action to be taken to reduce exposure</td>
<td></td>
</tr>
<tr>
<td>8-14 – High</td>
<td>Significant level of risk exposure that requires constant active monitoring and action to be taken to reduce exposure</td>
<td></td>
</tr>
<tr>
<td>8-12 – Medium</td>
<td>Acceptable level of risk exposure subject to regular active risk monitoring measures</td>
<td></td>
</tr>
<tr>
<td>6-10 – Medium</td>
<td>Acceptable level of risk exposure subject to regular active risk monitoring measures</td>
<td></td>
</tr>
<tr>
<td>4-7 – Medium</td>
<td>Acceptable level of risk exposure subject to regular active risk monitoring measures</td>
<td></td>
</tr>
<tr>
<td>1 – 7 - Low</td>
<td>Acceptable level of risk exposure on the basis of normal operation of controls in place.</td>
<td></td>
</tr>
<tr>
<td>1 – 5 - Low</td>
<td>Acceptable level of risk exposure on the basis of normal operation of controls in place.</td>
<td></td>
</tr>
<tr>
<td>1 – 3 - Low</td>
<td>Acceptable level of risk exposure on the basis of normal operation of controls in place.</td>
<td></td>
</tr>
</tbody>
</table>

**Likelihood Matrix**

<table>
<thead>
<tr>
<th>OPEN</th>
<th>CAUTIOUS</th>
<th>MINIMALIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
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<tr>
<td>3</td>
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<td>10</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

**Impact Matrix**

<table>
<thead>
<tr>
<th>OPEN</th>
<th>CAUTIOUS</th>
<th>MINIMALIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>
Healthcare Improvement Scotland

Meeting: Board Meeting
Meeting date: 24 June 2020
Title: Review of Governance Arrangements during COVID-19
Agenda item: 5.1
Responsible Executive/Non-Executive: Carole Wilkinson, Chair
Report Author: Pauline Symaniak, Governance Manager

1  Purpose
To review the organisation’s interim governance arrangements that were put in place at the start of the disruption to normal working as a result of the COVID-19 pandemic.

This is presented to the Board for:
- Decision

This report relates to:
- Emerging issue

This aligns to the following HIS priorities(s):
- Mental health services
- Access to care
- Integration of health and social care
- Safe, reliable and sustainable care

2  Report summary

2.1  Situation
A paper was presented to the April extraordinary meeting of the Board setting out proposals for interim governance arrangements. Those arrangements sought to ensure that there was sufficient staff capacity to respond to the emergency while securing appropriate governance for the actions taken by HIS. It was agreed at the April meeting that the arrangements would be reviewed at the June meeting of the Board.
2.2 Background
The COVID-19 pandemic continues to cause significant disruption to the HIS work programme and NHS Scotland remains on an emergency footing at the direction of the Cabinet Secretary. There continues to be an additional burden on the Executive Team as they continue to evolve the organisation to respond to the pandemic and identify appropriate opportunities to deploy staff to frontline services. The Executive Team also needs capacity at this stage to lay plans for when the work programme can be restarted and staff can return to the offices. At this time, all staff and Board members continue to work from home with face-to-face meetings replaced by virtual solutions.

2.3 Assessment
At its extraordinary meeting on 29 April 2020 the Board approved the proposal for the interim governance arrangements as follows: Minimal changes to the arrangements with Board and Committees meeting to focus on the urgent and important matters, including the HIS response to COVID-19.

These proposals were shared with Scottish Government and no changes were made to the Code of Corporate Governance because these interim arrangements could be accommodated within the current Code. By the time of the Board meeting on 24 June 2020, all of the Committees will have held their 2020-21 Quarter 1 meetings and addressed the essential business at this time. However, there has been no change to the significant disruption and additional burden caused by the pandemic or to the requirements for home working.

Therefore, it is proposed that the current interim governance arrangements continue but are reviewed at the Board’s next formal meeting on 25 September 2020. Although the Board has met monthly during the peak of the response, it is also proposed that an extraordinary Board meeting is not needed in July 2020. Therefore the next Board event would be the Board seminar on 26 August 2020.

2.3.1 Quality/ Care
There is no impact on the quality of services as a result of changing the governance arrangements as essential matters will continue to be addressed. Many HIS services have been paused or refocussed to support the frontline. The Board has already approved the Annual Operational Plan and the HIS Mobilisation Plan.

2.3.2 Workforce
The Staff Governance Committee met in Quarter 1 to seek assurance that appropriate staff governance arrangements are in place during COVID-19.

2.3.3 Financial
There is no financial impact in changing the governance arrangements at this time.
2.3.4 Risk Assessment/Management
There is a risk of over-burdening the Executive Team and governance support staff if adjustments are not made to the governance arrangements. This in turn could divert focus from the COVID-19 response and adversely impact staff health and wellbeing. Risks related to the COVID-19 pandemic are set out in the strategic risk report at agenda item 4.1.

2.3.5 Equality and Diversity, including health inequalities
There is no impact from changing the governance arrangements and staff governance matters will continue to be considered by the Staff Governance Committee.

2.3.6 Other impacts
Revised governance arrangements, whilst covering the essential business, have created a delay to non-essential business such as the Board would cover in seminar or development sessions.

2.3.7 Communication, involvement, engagement and consultation
The Chair has ongoing engagement and communication with the NHS Board Chairs group whose recent focus has been governance arrangements during COVID-19. The Chair also updated staff about the governance arrangements at recent staff huddles.

2.3.8 Route to the Meeting
This paper has not been considered by any other meetings.

2.4 Recommendation
It is recommended that:

- The interim governance arrangements agreed by the Board at its meeting on 29 April 2020 continue and are reviewed by the Board at its next formal meeting on 25 September 2020.
- An extraordinary Board meeting is not needed in July 2020.

The Board is asked to approve these proposals.

3 List of appendices
None