Public Board Agenda

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

Date:    Wednesday 25 September 2019
Time:    12.30 – 15.20
Venue:   Boardroom, Gyle Square, Edinburgh
Contact: Pauline Symaniak
         boardadmin.his@nhs.net
         0131 623 4294

Note: the format of the Board agenda has been updated to align with the terms of reference for the Board, agreed in June 2019. This in turn aligns with the Blueprint for Good Governance.

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
<th>Agenda item</th>
<th>Lead Officer</th>
<th>Report</th>
</tr>
</thead>
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<tr>
<td>1.</td>
<td></td>
<td>OPENING BUSINESS</td>
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</tr>
<tr>
<td>1.1</td>
<td>12.30</td>
<td>Welcome and apologies</td>
<td>Chair</td>
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<tr>
<td>1.2</td>
<td></td>
<td>Register of interests</td>
<td>Director of Finance &amp; Corporate Services</td>
<td>BM2019/39</td>
</tr>
<tr>
<td>1.3</td>
<td>12.35</td>
<td>Minutes of the Board meeting held on 26 June 2019</td>
<td>Chair</td>
<td>BM2019/40</td>
</tr>
<tr>
<td>1.4</td>
<td></td>
<td>Action points from the Board meeting held on 26 June 2019</td>
<td>Chair</td>
<td>BM2019/41</td>
</tr>
<tr>
<td>1.5</td>
<td>12.40</td>
<td>Chair’s Report</td>
<td>Chair</td>
<td>BM2019/42</td>
</tr>
<tr>
<td>1.6</td>
<td>12.45</td>
<td>Executive Report</td>
<td>Chief Executive</td>
<td>BM2019/43</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>SETTING THE DIRECTION</td>
<td></td>
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<tr>
<td>2.1</td>
<td>13.00</td>
<td>Interim operating position for the Scottish Health Council: supporting public involvement in service change in Health and Social Care Partnerships</td>
<td>Director of Community Engagement</td>
<td>BM2019/44</td>
</tr>
<tr>
<td>2.2</td>
<td>13.25</td>
<td>Operational Planning Process 2020-21</td>
<td>Director of Finance and Corporate Services</td>
<td>BM2019/45</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>HOLDING TO ACCOUNT – including FINANCE AND RESOURCE</td>
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<tr>
<td>3.1</td>
<td>13.35</td>
<td>Organisational Performance Report including Finance, Workforce and Operational Risk Reports</td>
<td>Director of Finance &amp; Corporate Services</td>
<td>BM2019/46</td>
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<tr>
<td></td>
<td>14.05</td>
<td>Refreshment break</td>
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</tbody>
</table>
## INFLUENCING CULTURE

4.1 14.20  iMatter Update  
Associate Director of Workforce  
BM2019/47 Presentation

## ASSESSING RISK

5.1 14.30  Risk Management Strategy  
Director of Finance & Corporate Services  
BM2019/48

5.2 14.40  Risk Management Update: corporate risks  
Director of Finance & Corporate Services  
BM2019/49

## GOVERNANCE

6.1 15.00  Board and Governance Committee schedule of meeting dates 2020-21  
Director of Finance & Corporate Services  
BM2019/50

6.2 15.05  Audit and Risk Committee: key points from the meeting on 4 September 2019 and approved minutes from the meeting on 19 June 2019.  
Committee Chair  
BM2019/51  
BM2019/52

6.3  
Quality and Performance Committee: key points from the meeting on 15 August 2019 and approved minutes from the meeting on 22 May 2019.  
Committee Chair  
BM2019/53  
BM2019/54

6.4  
Scottish Health Council Committee: key points from the meeting on 27 June 2019 and approved minutes from the meeting on 23 April 2019.  
Committee Chair  
BM2019/55  
BM2019/56

6.5  
Staff Governance Committee: key points from the meeting on 29 August 2019 and approved minutes from the meeting on 14 May 2019.  
Committee Chair  
BM2019/57  
BM2019/58

## ANY OTHER BUSINESS

## DATE OF NEXT MEETING

8.1 15.20  The next meeting will be held on 4 December 2019 at 12.30pm in meetings room 6.4/6.5, Delta House, Glasgow.
SUBJECT: Register of Interests

1. Purpose of the report
To present the Register of Interests held at 18 September 2019 for Board Members and senior staff members within the organisation.

2. Key Points
Board members have a responsibility to comply with the HIS Code of Conduct. This requires Board members to review their entries in the Register of Interests and confirm compliance with the Code. The Register of Interests is a standing item on the Board public agenda. Board members and senior staff are asked to note that they have a duty and that it is their responsibility to ensure that any changes in circumstances are notified within one month of them occurring.

3. Actions/Recommendations
Board members and senior staff are required to confirm that their entry in the Register of Interests complies with the Code of Conduct and approve the Register of Interests as attached.

Appendix 1: Register of Interests (as at 18 September 2019)

If you have any questions about this paper please contact Pauline Symaniak, Corporate Governance Officer, p.symaniak@nhs.net, 0131 623 4294 ext 8505
## SUPPORTING INFORMATION

### RISK

<table>
<thead>
<tr>
<th>Do the key points represent a risk to the organisation?</th>
<th>If yes, has a risk been raised on the Compass Risk Management System</th>
<th>If yes, provide the risk number, risk description and risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>no</td>
<td>n/a</td>
<td>n/a</td>
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</table>

### OTHER CONSIDERATIONS

<table>
<thead>
<tr>
<th>How do the key points support the five priorities in the strategic plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enable people to make informed decisions about their own care and treatment;</td>
</tr>
<tr>
<td>• Help health and social care organisations to redesign and continuously improve;</td>
</tr>
<tr>
<td>• Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve;</td>
</tr>
<tr>
<td>• Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve;</td>
</tr>
<tr>
<td>• Make best use of all resources.</td>
</tr>
</tbody>
</table>

Compliance with the HIS Code of Conduct supports good governance which in turn ensures best use of resources.

| Resource Implications | No additional resource implications. |

| What engagement has been used to inform the work. | The Register of Interests does not relate to any policy or work programme that will impact on staff, volunteers or service users, and engagement is therefore not required. |

<table>
<thead>
<tr>
<th>What Equality and Diversity considerations relate to the work. Advise how the work:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• helps the disadvantaged;</td>
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<tr>
<td>• helps patients;</td>
</tr>
<tr>
<td>• makes efficient use of resources.</td>
</tr>
</tbody>
</table>

The Register of Interests does not relate to any policy or work programme that will impact on staff, volunteers or service users.
<table>
<thead>
<tr>
<th>NAME</th>
<th>CATEGORY</th>
<th>INTEREST</th>
<th>Date interest commenced (if in FY 2019/20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAIR</td>
<td></td>
<td></td>
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<tr>
<td>Carole Wilkinson</td>
<td>1</td>
<td>*Lay Member, General Teaching Council</td>
<td></td>
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<td></td>
<td>1</td>
<td>Board Member, Care Inspectoriate</td>
<td></td>
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<tr>
<td></td>
<td>1</td>
<td>**Ad hoc advice and consultancy work for David Nicholl, On Board Training</td>
<td>5/9/19</td>
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<tr>
<td>Note: *Remuneration relates to a daily rate payable / ** Remuneration is a small hourly fee</td>
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<tr>
<td>NON-EXECUTIVE BOARD MEMBERS</td>
<td></td>
<td></td>
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<tr>
<td>Jackie Brock</td>
<td>1</td>
<td>Chief Executive, Children in Scotland</td>
<td></td>
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<tr>
<td></td>
<td>7</td>
<td>*Spouse is Chair of Pagoda Public Relations Company</td>
<td></td>
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<tr>
<td></td>
<td>7</td>
<td>Chair, Independent Child Protection Advisory Group, Scottish Football Association</td>
<td>26/6/19</td>
</tr>
<tr>
<td>Note: * Pagoda Public Relations Company has recently completed a strategic communications plan for SHTG</td>
<td></td>
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<tr>
<td>Suzanne Dawson</td>
<td>7</td>
<td>Director and Charity Trustee, Eastgate Theatre &amp; Arts Centre</td>
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<td></td>
<td>7</td>
<td>Charity Trustee, Borders Further Education Trust</td>
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<td></td>
<td>7</td>
<td>Fellow of Chartered Institute of Marketing</td>
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<td></td>
<td>7</td>
<td>Member of Law Society of Scotland Admissions Sub-Committee</td>
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</tr>
<tr>
<td>Name</td>
<td>Interests</td>
<td></td>
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<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Zoë M. Dunhill MBE</td>
<td>1 Sole proprietor own Child Health Consultancy</td>
<td></td>
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<tr>
<td></td>
<td>1 Invited reviewer Royal College of Paediatrics and Child Health</td>
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<td></td>
<td>1 Professional Advisor CQC England in Paediatrics</td>
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<tr>
<td></td>
<td>7 Honorary Fellow Royal College of Paediatrics and Child Health</td>
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<td></td>
<td>7 Fellow of Royal College of Physicians of Edinburgh</td>
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<td></td>
<td>7 Director Children's Health Scotland</td>
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<td></td>
<td>7 Member British Medical Association</td>
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<td></td>
<td>7 Member of the Board of Governors of the Dean and Cauvin Trust</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>3 NHS Greater Glasgow and Clyde Consultancy Contract for redesign of specialist children's services</td>
<td></td>
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</tr>
<tr>
<td>Paul Edie</td>
<td>1 Chair of the Care Inspectorate</td>
<td></td>
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<tr>
<td></td>
<td>1 Non Executive Member of the Scottish Social Services Council</td>
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<tr>
<td></td>
<td>7 Member of the Scottish Liberal Democrats</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1 Proprietor of Edie Associates</td>
<td></td>
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<tr>
<td></td>
<td>1 Partner, The Place Store</td>
<td></td>
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<tr>
<td>John Glennie OBE</td>
<td>1 Non Executive Board Member, NHS24</td>
<td></td>
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</tr>
<tr>
<td>Gill Graham</td>
<td>No declared interests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhona Hotchkiss</td>
<td>No declared interests</td>
<td></td>
<td></td>
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<tr>
<td>Christine Lester</td>
<td>1 Commissioner, Audit Commission</td>
<td></td>
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<tr>
<td></td>
<td>7 Member, Lennox Community Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Volunteer Adviser, Citizens Advice Bureau</td>
<td></td>
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</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Kathleen Preston</td>
<td>1. *Honorary Contract with NHS Blood and Transplant (NHSBT) as a Lay Member of the Organ Donation Advisory Group (Kidney Advisory Group) 7 Member of the Law Society of Scotland 7 Member (Professional Associate) of the Health and Social Care Alliance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duncan Service</td>
<td>1. Evidence Manager, SIGN 7 Director and Company Secretary, SHU East District Ltd 7 UNISON Steward 7 Treasurer, Guidelines International Network (G-I-N)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robbie Pearson</td>
<td>1. Chief Executive, Healthcare Improvement Scotland 7 Sister-in-law is nurse at St Columba’s Hospice (regulated by HIS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sybil Canavan</td>
<td>1. Associate Director of Workforce 7 Member of Unite (Trade Union)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lynsey Cleland</td>
<td>1. Director of Community Engagement 3 June 2019 7 *Lay Member, General Teaching Council for Scotland 3 June 2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alastair Delaney</td>
<td>1. Director of Quality Assurance</td>
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**Note:** *No remuneration will be received other than payment of expenses*
<table>
<thead>
<tr>
<th>Name</th>
<th>Category Number</th>
<th>Category Type</th>
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<tbody>
<tr>
<td>Ruth Glassborow</td>
<td>1</td>
<td>Director of Improvement</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>GenerationQ Fellow with Health Foundation</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Member of Managers in Partnership (MiP) Union</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>*Current participant in Sciana Network</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Partner is a manager at NHS Tayside</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>In receipt of free coaching from Peter Hill, MD, Coaching for More Consulting Ltd</td>
</tr>
<tr>
<td><strong>Note:</strong> <em>Participation is fully funded by the Health Foundation and there is also potential to access further bursary funding.</em></td>
<td></td>
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</tr>
<tr>
<td>Ann Gow</td>
<td>1</td>
<td>Director, Nursing, Midwifery and Allied Health Professionals</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Member of Royal College of Nursing</td>
</tr>
<tr>
<td>Safia Qureshi</td>
<td>1</td>
<td>Director of Evidence</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Spouse is CTO and VP Technology Innovation, Innovation &amp; Technology Group, Leonardo MW Ltd</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>2 July 2019</strong></td>
</tr>
<tr>
<td>Maggie Waterston</td>
<td>1</td>
<td>Director of Finance and Corporate Services</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Member of Chartered Institute of Management Accountants</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Member of Healthcare Financial Management Association</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>*Strategic Finance Leaders Programme: Scottish Public Sector</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Member of Unison</td>
</tr>
<tr>
<td><strong>Note:</strong> <em>This is a joint programme between Scottish Government and Deloitte which is resourced by Deloitte with no charge to Healthcare Improvement Scotland.</em></td>
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**Explanation of Categories**

<table>
<thead>
<tr>
<th>Category Number</th>
<th>Category Type</th>
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<tbody>
<tr>
<td>1</td>
<td>Remuneration</td>
</tr>
<tr>
<td>2</td>
<td>Related Undertakings</td>
</tr>
<tr>
<td>3</td>
<td>Contracts</td>
</tr>
<tr>
<td>4</td>
<td>Houses, Land and Buildings</td>
</tr>
<tr>
<td>5</td>
<td>Interest in Shares and Securities</td>
</tr>
<tr>
<td>6</td>
<td>Gifts and Hospitality</td>
</tr>
<tr>
<td>7</td>
<td>Non-Financial Interests</td>
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</table>
MINUTES – Draft

Meeting of the Board of Healthcare Improvement Scotland
Date: 26 June 2019
Time: 12.30–3.30pm
Venue: Room 6.4/6.5, Delta House, Glasgow

Present
Carole Wilkinson, Chair
Dr Bryan Anderson, Non-executive Director
Jackie Brock, Non-executive Director
Dr Zoë M Dunhill MBE, Non-executive Director
Paul Edie, Non-executive Director
John Glennie OBE, 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
Alastair Delaney, Director of Quality Assurance
Ann Gow, Director of Nursing, Midwifery and Allied Health Professions (NMAHP)
Karen Ritchie, Acting Director of Evidence
Maggie Waterston, Director of Finance and Corporate Services
June Wylie, Head of Improvement Support (Deputy for Director of Improvement)

Apologies
Suzanne Dawson, Non-executive Director
Gill Graham, Non-executive Director
Ruth Glassborow, Director of Improvement

Committee 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.
## 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.

Apologies were noted as above.

### 1.2 Register of Interests

The Board received the current register of interests from the Director of Finance and Corporate Services.

The Board approved the register. 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.

John Glennie OBE declared an interest as a Non-executive Director of NHS24.

### 1.3 Minutes and Action Points of the Board meeting on 20 March 2019

The minutes of the public meeting held on 20 March 2019 were accepted as an accurate record.

The action point register was reviewed and accepted. All actions were noted as complete and there were no matters arising.

### 1.4 Chair's Report

The Board received a report from the Chair updating them on recent developments. The Chair added that she had attended a Quality Management System (QMS) learning session and that an introductory QMS session for the Board would be provided at the August Board seminar.

In response to a question from the Board about the remit of the Children and Young People Working Group, the Executive Team advised that it was a cross-organisational group set up to fulfil the organisation's corporate responsibilities for children and young people and to take forward related initiatives.

The Board noted the report.

### 1.5 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) There were several staff changes to note – Lynsey Cleland had joined as Director of Community Engagement; Safia Qureshi would join shortly as Director of Evidence; Angela Timoney had been appointed as the Chair of SIGN (Scottish Intercollegiate Guidelines Network). In addition, absences in the Corporate Governance Office had created capacity challenges.
b) The iMatter survey had achieved an excellent 90% response rate and results would be available shortly.

c) The independent review of the Monklands Hospital replacement options appraisal exercise would be published shortly and the Scottish Health Council report would follow thereafter.

d) The Value Management programme had received confirmation of funding.

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

e) The reviewer for the Death Certification Review Service (DCRS) was external. An increase in calls to the DCRS helpline had resulted in a decrease in the number of certificates being amended. This was welcome but had created additional pressures.

f) The NMAHP vision would link the Director’s internal and external roles with NMAHP employees to better deliver the work.

g) The HIS escalation process would be applied to NHS hospitals where there were instances of patient safety. There was a different process for concerns around Independent Healthcare.

It was agreed to reinstate the section regarding directorate challenges within the Executive Report for future meetings.

The Board noted the report.

2. STRATEGIC DIRECTION

2.1 Workforce and Development Plan 2019-2022

The Board received a paper from the Associate Director of Workforce providing the draft Workforce and Development Plan for approval and submission to Scottish Government. The Associate Director highlighted the following points:

a) The plan had been a significant piece of work by Ian Haxton supported by colleagues, in particular the People and Workforce Team and the Finance Team.

b) The plan had already been provided to the Staff Governance Committee and the Partnership Forum where it was positively received.

c) It was linked to the operational plan and the corporate strategy, whilst also including practical information, such as absence data and succession planning.

In response to questions from the Board, the following points were clarified:

d) The absence rate for mental health issues and stress reflected a similar pattern to the rate in territorial Boards where it had increased in recent years. Staff wellbeing was an area of focus in the action plan and would include support for staff.

e) The plan was integrated with the operational plan and the finance plan, therefore would be appropriately resourced. The staffing numbers took into account the additional funding allocations. The Executive Team were managing the low risk that recruitment would take place prior to the funding being received. If the additional funding was not received, the Executive Team would ensure that the organisation’s priorities were met.
f) Work was currently underway to improve clinical advice and leadership across the organisation and this would also consider how best to secure this clinical expertise.
g) Exit interviews were currently paper-based but improvements were being made to the process where we would move to an online, anonymised process.

The Board approved the Workforce and Development Plan.

It was agreed that the Staff Governance Committee would review progress with the action plan and that the Board would receive a progress report.

### 2.2 Proposal for Future Strategic Direction

The Chief Executive provided a paper setting out proposals to refresh the organisation’s strategy and highlighted the following points:

- a) The refresh would respond to shifting priorities as well as workforce and financial pressures, and would define how QMS aligns with the organisation’s work.
- b) The work would be delivered in Partnership.
- c) It was proposed to commence the refresh with a two-day strategy event in October 2019.

In the discussion that followed, the points set out below were made:

- d) There was a need to look at “business as usual” and work that might be divested.
- e) The work needed to take account of financial challenges and roles that were difficult to recruit to.
- f) It would be desirable to consider any intelligence from the Scottish Government about future policy whilst accepting that new commissions would continue to be received.

The Board approved the proposals.

### 3. GOVERNANCE

#### 3.1 Revised Governance Committee Terms of Reference

The Board received revised terms of reference from the Director of Finance and Corporate Services who highlighted the following points:

- a) The terms of reference had been revised to take account of the NHS Scotland Blueprint for Good Governance.
- b) The paper also made a change of name for the Quality Committee to the Performance and Clinical and Care Governance Committee.
- c) Terms of reference had been compiled for the first time for the Board and the Governance Committee Chairs’ meeting.
- d) The terms of reference would be incorporated into an updated Code of Corporate Governance.

In response to questions from the Board, the following additional points were made:

- e) Financial planning and forecasting would be added to the terms of reference for the Audit and Risk Committee.
- f) As previously agreed, a performance report was not provided to this meeting of the Board because a new style report was being developed by the performance reporting short life working group.
The Board approved the terms of reference subject to the comments noted above.

It was agreed that the approved terms of reference would operate for at least one year, pending any national work on terms of reference.

### 3.2 Governance Committee Annual Reports 2018-19

The Director of Finance and Corporate Services provided the Board with a paper summarising the themes and action plans from the annual reports for the Governance Committees. She stated that all Committees had met their remit and that the full reports were available on request.

The Board noted the paper.

It was agreed that the paper would be submitted to the next Governance Committee Chairs’ meeting and an update on the action plan would be provided to the Board in December 2019.

### 3.3 Raising Concerns

#### Sturrock Review Response

The Board received a paper from the Associate Director of Workforce setting out a draft organisational response to the Sturrock Review into allegations of bullying at NHS Highland. The response detailed a range of activity.

In the discussion that followed, the points noted below were made:

- **a)** The role of the Board and the Staff Governance Committee should be emphasised in the response.
- **b)** To enable Board members to be more visible, events could be better aligned with their attendance in the office, such as the staff huddle.
- **c)** Visibility was also required at sites out with Gyle Square and Delta House such as the DCRS offices and the Scottish Health Council local offices. A map of these offices would be circulated.
- **d)** Awards such as Making a Difference and the Margaret McAlees award support equality and diversity and upholding the organisation’s values.

The Board approved the response for submission subject to the comments above.

#### Whistleblowing Champion Annual Update

The Whistleblowing Champion, Dr Bryan Anderson, provided the following verbal update:

- **a)** There have been no instances of whistleblowing within HIS in the last 12 months.
- **b)** The Cabinet Secretary had advised that new whistleblowing champions would be appointed to each Board and would report to the new national whistleblowing officer. The detail of this was not yet available.
- **c)** Input had been provided to two consultations on the national whistleblowing champion and implementation of new standards in 2020. The standards would relate to the NHS and those
contracted by the NHS.

In the discussion that followed the points set out below were made:

d) The Sharing Intelligence for Health and Care Group relates to the NHS and Integration Joint Boards and it would review in future information on whistleblowing.
e) There would be a need to ensure that the organisational culture and its values and behaviours encourage people to speak up and raise concerns.

The Board noted the update.

### 3.4 Annual Report and Accounts 2018-19

[Pat Kenny, Deloitte, joined the meeting for this item]

**Annual Accounts 2018-19 including the Annual Performance Overview and ISA260 – report to those charged with governance**

The Board received this paper from the Director of Finance and Corporate Services who highlighted the following:

a) The Annual Accounts comply with the Government’s financial reporting manual.
b) The Governance Statement on page 37 set out the organisation’s governance framework.
c) The outturn for the year was noted on page 61 as an under spend of £257k which accords with the financial planning for 2018-19.
d) The Annual Accounts had been scrutinised in detail by the Audit and Risk Committee at its annual accounts workshop and at its Committee meeting. They had advised they were content that they had had sufficient time to scrutinise and understand the financial statements. In future, all Board members would be invited to attend the Annual Accounts workshop.

The Board received a report from Pat Kenny, Deloitte who advised that the External Auditors were content to provide an unqualified audit.

The Chair of the Audit and Risk Committee confirmed that the Committee were content to recommend to the Board adoption of the Annual Accounts for 2018-19.

The Board approved the adoption of the Annual Accounts for 2018-19.

The Board also noted the excellent work delivered by the Finance Team to ensure the Accounts were provided on time and to a high standard.

**Significant issues that are considered to be of wider interest**

The Director of Finance and Corporate Services provided this paper which set out the requirement for the Chair of the Audit and Risk Committee to report to Scottish Government any significant issues that may have arisen within the organisation up until the date of signing the accounts.

The Board confirmed that there were no significant issues to report and that the Chair of the Audit and Risk Committee should advise Scottish Government of this.
4. DELIVERING OUR CORPORATE PLAN

4.1 Financial performance report

[This item was taken out of order, before item 3.4]

The Board received a report from the Director of Finance and Corporate Services setting out the financial performance as at 31 May 2019. The following points were highlighted:

a) This was a high level report given the early point in the new financial year.

b) Table A set out the year-to-date position which was an under spend of £106k which was within the agreed tolerance.

c) Table C set out the additional allocations that were anticipated from Scottish Government during 2019-20.

d) The total anticipated additional allocations were £9,183,032 and work was ongoing with Scottish Government to agree which of these could move to baseline funding. This would improve the continuity of significant work and allow recruitment to permanent posts which would support retention of those skills which were difficult to recruit.

e) Table D set out savings to date which were £57k against a target of £1.2m. The internal change programme would secure recurring savings during the course of the next two years.

f) It was predicted that all of the financial responsibilities for the year would be met.

g) Budgets would be re-phased as part of the work by the Performance Reporting Short Life Working Group and this would be reflected in future financial reports.

In response to questions from the Board, the following additional points were made:

h) It was expected that there would be a shift over time to a more structured provision of additional allocations and new commissions in light of the Operating Framework with Scottish Government.

i) Changes within the Scottish Government health directorates had caused delays with receiving confirmation of funding and the organisation was firming up its approach to deadlines for these confirmations if work was to progress. Funding for mental health programmes was confirmed for 2020.

j) Clarification was provided regarding some of the allocations: there was an additional allocation of £1.1m for mental health work but £800k of that was transferred to NSS for services from ISD; and there was also budget for SPSP Mental Health. The total budget for mental health work would be examined in more detail at the Board’s strategy event in October.

The Board noted the financial performance.

4.2 Risk Management Update

The Board received a report from the Director of Finance and Corporate Services on the current status of risks and their management. This included all of the risks from the Corporate Risk Register and the very high risks from the Operational Risk Register.
The following points were highlighted:

a) The Board risk seminar in February 2019 found that there was one change in risk appetite – the compliance/regulatory category changed from minimalist to cautious. This change had been implemented on the risk database and was reflected in the reports presented.

b) Risks were considered by Committees for those assigned to them while the Audit and Risk Committee reviewed all risks.

c) Risk management was placed at the end of the agenda because this allowed a review of risk with the benefit of having already covered the other agenda items, discussion of which may have identified new risks, changes to risk ratings or risk closures.

In response to questions from the Board, the following points were clarified related to specific risks.

Risk 894 - Quality of Care Approach (QoCA)

d) The risk was raised following discussions at the Performance and Clinical and Care Governance Committee. It would be reviewed and raised to a red rating.

e) The QoCA Board level review of NHS Ayrshire and Arran had revealed that changes in the approach were required. The timescale for this was unclear pending consideration of the outcome of the external review but it would be done quickly.

Risk 891 - Independent Healthcare (IHC)

f) The risk has arisen because the number of clinics requiring to be registered was significantly higher than the planning predictions and continued to rise. There was therefore insufficient resource to deliver the work and this was being addressed.

g) A request for additional resource had been made and would help in the short term to move the work to a stable position. However additional plans were required to continue to deliver the work over the longer term by ensuring that costs invested early would be recovered.

h) The costs related to IHC would be included in future financial performance reports to ensure the Board were sighted.

i) There were a variety of ways that IHC clinics come to the attention of HIS but there is no single source to gather this information. Some clinics contact HIS directly as they recognise their legal requirement to register and are keen to display the HIS kitemark to the public.

j) There would be further challenges in the future related to internet-based services and potentially the regulation of private ambulances.

Risk 454 – Scottish Medicines Consortium (SMC) Product Assessment

k) The risk was related to the ongoing shortage of Health Economists. The mitigations had been deferring product assessments and increasing the contracting out of work.

l) SMC were looking at alternative assessment models but this work would be complex and require engagement with stakeholders.

Risk 818 – Focus on Dementia

m) The Focus on Dementia programme had moved internally within the Scottish Government and this had caused delays in approving
funding. A deadline for a response would be provided.

Risk 874 – ihub wide directorate risk
  n) It was noted that this risk was also reflected in the very high operational risks provided to the Board and was related to new commissions from the Scottish Government.
  o) It was agreed that the Chair and Chief Executive would raise the matter at the next quarterly strategic meeting with Scottish Government and thereafter a decision would be made if a new risk should be raised around new commissions.

Risk 697 - Brexit
  p) As part of the audit of the Annual accounts, Deloitte examined the organisation’s work towards an exit plan and assessed HIS as being reasonably well prepared for EU withdrawal.
  q) It was noted that there were broader implications of Brexit such as human resources.
  r) The risk would be kept under review as Brexit progresses.

The Board reviewed the risk registers and gained assurance that risks were being effectively treated, tolerated or eliminated.

5. ADDITIONAL ITEMS OF GOVERNANCE

5.1 Scottish Health Council Committee

The Board noted the key points report from the meeting on 23 April 2019 and the approved minutes from the meeting on 28 February 2019.

The Vice Chair of the Committee highlighted the following points on behalf of the Chair: the excellent work delivered by Sandra McDougall during her time as Acting Director of the Scottish Health Council, the work underway to address the capacity issues in the senior leadership team and the progress with the change implementation plan. The Board recorded their thanks to Sandra McDougall for her work as interim Director.

5.2 Performance and Clinical and Care Governance Committee

The Board noted the key points report from the meeting on 22 May 2019 and the approved minutes from the meeting on 27 February 2019.

The Chair of the Committee advised that they had received an update on the Quality of Care Approach and progress with the Growing Older in Scotland report. The Committee noted the need to use the Operating Framework with Scottish Government to manage the level of new commissions.

5.3 Audit and Risk Committee

The Board noted the approved minutes from the meeting on 6 March 2019.

The Chair of the Committee advised that they had scrutinised the Annual Accounts and had held a detailed discussion of risk management.

5.4 Staff Governance Committee

The Board noted the key points from the meeting on 14 May 2019 and the approved minutes from the meeting on 21 February 2019.
The Chair of the Committee advised that they had reviewed the Workforce Plan and the streamlining of reports. It had discussed whistleblowing and the workforce data report.

6. **ANY OTHER BUSINESS**

There were no items of any other business.

7. **DATE OF NEXT MEETING**

7.1 The next meeting would be held on 25 September 2019 in Gyle Square, Edinburgh.
# DRAFT ACTION POINT REGISTER

**Meeting:** Healthcare Improvement Scotland Board Meeting  
**Date:** Wednesday 26 June 2019

<table>
<thead>
<tr>
<th>Minute ref</th>
<th>Heading</th>
<th>Action point</th>
<th>Timeline</th>
<th>Lead officer</th>
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| 2.1        | Workforce and Development Plan 2019-2022    | Provide a review of progress on the action plan to the Staff Governance Committee and the Board. | SGC – 29 August 2019  
Board – 4 December 2019 | Associate Director of Workforce | SGC – complete  
Board – added to business planning schedule |
| 3.1        | Revised Governance Committee Terms of Reference | Financial planning and forecasting to be added to the terms of reference of the Audit and Risk Committee. | Immediate | Director of Finance and Corporate Services | Complete |
| 3.2        | Governance Committee Annual Reports          | To be submitted to the next Governance Committee Chairs’ meeting and an update on action plans to the December Board. | 21 August / 4 December 2019 | Director of Finance and Corporate Services | Governance Committee Chairs – complete / reviewed at meeting on 21 August 2019  
Board – added to business planning schedule |
| 3.3        | Raising Concerns – Sturrock Review           | The role of the Board and Staff Governance Committee to be emphasised in the response  
A map of Scottish Health Council offices to be circulated to Board members. | Immediate | Associate Director of Workforce | Complete |
| 3.4        | Annual Report and Accounts                   | All Board members to be invited to attend the Annual Accounts workshop. | June 2020 | Director of Finance and Corporate Services | Complete – added to Annual Accounts project plan |
| 4.2        | Risk management                              | Risk 894 Quality of Care Approach to be raised to a red rating.  
Risk 874 ihub wide directorate risk/new commissions to be raised at quarterly strategic meeting with Scottish Government. | 5 September 2019 | Chair/ Chief Executive | Complete, in line with Operating Framework |
SUBJECT: Chair's Report

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

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

3. Strategic issues
   a) NHS Scotland Board Chairs Group
      i) The Board Chairs group held its most recent meeting on 26 August 2019 where the focus for the meeting with the Cabinet Secretary was mental health. A paper was also presented that set out proposals for an aligned process for identifying and implementing good practice. The Director of Evidence in HIS will play a central role in this work going forward. I have also taken over the leadership for the Performance and Integration thematic group which will realign its work to focus on scale and spread of best practice. The first piece of work that the group will examine is the Hospital at Home programme.
      ii) I continue to act as a panel member for two Chair appointment rounds - NHS Tayside, which is in its latter stages, and NHS Highland, which is about to commence.
      iii) My individual meetings with NHS Board Chairs have continued with a visit to Dumfries to meet the Chair of NHS Dumfries and Galloway, and a meeting with the Chair of NHS Western Isles to understand their delivery priorities and how HIS might help. The visit to Dumfries was particularly informative, involving a full day's programme of meetings and visits. I was especially pleased to meet with the Scottish Health Council Local Officer and hear about her work.

   b) Adverse Events
      I had a telephone conversation on 5 September 2019 with the Cabinet Secretary, prior to her statement in the Parliament, about the expectations of HIS in responding to the Adverse Events report.

   c) HIS Board Strategic Event
      I am participating in the working group formed to design and deliver a two-day event in October which will provide an opportunity for the Board and Executive Team to work together on the initial stages of developing a new strategy for the organisation.
4. Stakeholder engagement

a) Joint Engagement with the Chief Executive

The Chief Executive and I have undertaken the following joint engagement:

i) The quarterly meeting with Scottish Government was held on 27 June 2019 and covered the Operating Framework as well as some key areas of our work. We also held a prioritisation meeting on 5 September 2019. This was an opportunity to discuss our most significant workstreams and gain a shared commitment and understanding of the workforce and resource implications.

ii) I continue to attend whenever possible the HIS Strategic Stakeholder Advisory Group meetings which provide valuable opportunities to meet and hear from our stakeholders. The latest meeting on 13 August 2019 focussed on primary care.

iii) A joint meeting with the Care Inspectorate Chair and Chief Executive was held on 27 August 2019. We discussed the Sharing Intelligence for Health and Care Group Annual Report, and the Audit Scotland scrutiny plan, in particular opportunities to develop it. We also shared our respective corporate plans and agreed to hold a joint Board event early in 2020.

iv) I attended the Policy Scotland Conference, Next steps for health and social care integration in Scotland, on 3 September 2019 at which the Chief Executive was delivering a presentation. The key messages from the event were the importance of relationships, leadership, agreeing shared goals and having an agreed strategic and financial plan.

b) Scottish Medicines Consortium (SMC) Meeting

I attended as an observer the SMC meeting on 2 July 2019. This was an excellent opportunity to understand more about their work and see first hand the challenges associated with medicines availability. I then joined an SMC evening reception as part of the Vancouver Group Meeting on 27 August 2019. This is an international forum for pharmaceutical regulation and it provided the opportunity to discuss the challenges shared by many countries around medicines availability and possible solutions.

c) Meeting with George Walker, Scottish Housing Regulator (SHR)

This meeting with my counterpart at SHR was held on 14 August 2019. The SHR Vice Chair and Chief Executive also attended. We discussed health and homelessness, and how we might work together as part of work underway to create a more proactive and joined up approach.

d) Leadership

I was delighted to join the Sharing Learning Event for the first cohort of leadership, the Project Lift development programme for aspiring executive leaders. The event provided an opportunity for networking and hearing from the collaborative teams which was very inspiring, in particular, the work with groups or organisations outside of the NHS and the focus on public health.
5. Our governance

a) Annual Review
Our Annual Review will be held on 21 November 2019 in Delta House, Glasgow. It will be non-Ministerial and led by the National Clinical Director. It is proposed that a largely similar format to previous years is followed, with some adjustments to ensure that the event is as engaging as possible and maximises opportunities to demonstrate impact.

b) Non-Executive Appointments
Planning is underway to fill the Board vacancy. The outline timetable indicates that we are likely to appoint a new Board member from March/April 2020. Recruitment for the new non-executive Whistleblowing Champion, appointed as part of a national exercise, is ongoing.

c) Governance Committees
   i) The Performance and Clinical and Care Governance Committee proposed at its meeting on 15 August 2019 to change its name to the Quality and Performance Committee.
   ii) Gill Graham will be Vice Chair of the Audit and Risk Committee following Bryan Anderson’s departure.
   iii) The Governance Committee Chairs met on 21 August 2019 and agreed that work will be taken forward to set up a Succession Planning Committee. This Committee will lead the process for Board appointments.

d) Board Seminar
A Board seminar was held on 21 August 2019 which brought the Board up-to-date on the Quality Management System and provided an opportunity for detailed discussions on the organisation’s approach to risk management.

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

*It should be noted that, with the introduction of the new Performance Report at the September Board meeting, updates on key achievements / challenges in relation to delivery of the work programme which may have previously appeared in this report are now included within the Performance Report.*

RECOMMENDATION

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

REPORT FROM THE CHIEF EXECUTIVE

Internal Improvement Oversight Board

In recognition of the opportunities for better cross organisational working to improve the quality and efficiency of our delivery, it has been agreed that an internal improvement programme should be established. There are many initiatives already underway within the organisation to improve internal efficiency and some are a direct consequence of implementing either the Finance Plan or the Workforce Development Plan.

In support of this an internal improvement oversight board is being established, co-chaired by the Deputy Chief Executive and Employee Director. The improvement programme will have three workstreams, as follows:

- People - Executive Lead: Associate Director for Workforce
- Process – Executive Lead: Director of Improvement
- Place - Executive Lead: Director of Finance and Corporate Services

Each workstream will be developed and delivered in partnership and Partnership Forum leads will be identified for each.
Revised leadership arrangements in the Quality Assurance Directorate

A shared leadership arrangement will be implemented on an interim basis for our operational assurance function. Ann Gow, Deputy Chief Executive / Director of NMAHP will take responsibility for inspection and regulatory activity. Ann will be supported by an Interim Chief Inspector.

Sandra McDougall will be appointed as Interim Director of Quality Assurance with effect from 1 October 2019, when Alastair Delaney departs from HIS. She will focus on the development of the methodology for quality of care reviews and other elements of external assurance including adverse events.

We will further strengthen our Senior Management arrangements in both the Quality Assurance Directorate and the Nursing, Midwifery and Allied Health Professionals directorate to reflect these changes. These arrangements were approved by the Executive Remuneration Committee at its meeting on 4 September 2019.

Director of Workforce

The Associate Director of Workforce post was established in April 2019. Due to the substantial contribution to date the role has made within HIS and at a national level, we will establish the role of Director of Workforce on a permanent basis, and work will begin to take forward the necessary recruitment process.

Medical Director

Following a recruitment process for the role of Interim Medical Director during June/July 2019, the conclusion was reached that as a key post within HIS in supporting clinical input and engagement in the development of our work, recruiting on an interim basis was not viable. The post of Medical Director has now been advertised on a permanent basis, with interviews to take place in December 2019.

Delta House accommodation

The lease for Delta House, Glasgow ends in March 2021 and work is now taking place to identify options for Glasgow accommodation following the end of the lease. We have made contact with Scottish Government property colleagues who will guide us to ensure that all protocols are met and to assist decisions to be made. Avison Young (property advisers) have been commissioned to search for commercial options and also to contact the landlord at Delta House to include the option of extending the current lease. NHS 24 are also looking to consolidate their property arrangements in the West of Scotland and contact has been made with them to explore any options that might suit us both. The steering group for this work comprises of the Chief Executive, Employee Director, Associate Director of Workforce and Director of Finance & Corporate Services. Discussions are taking place with the Partnership Forum and staff in Delta House will be formally contribute to this work by involving the Delta House Building User Group. Once options have been identified they will be considered by the Audit and Risk Committee prior to decisions being made by the Board.
Complaints reporting

The purpose of this section of the report is to update the Board on complaints received relating to the work of Healthcare Improvement Scotland (HIS).

Since the last report to the Board we have received and responded to two complaints, both in relation to our inspection of independent healthcare services. Both complaints were formally investigated at Stage 2.

The first related to the service provided by the HIS inspection team during the inspection process, however following the investigation no aspects of the complaint were upheld. In this case the investigation was not resolved within the 20 day timescale specified by the NHSScotland Model Complaints Handling Procedure; however the extension to the timescale was agreed with the complainant to allow for full consideration of the issues raised.

The second complaint also related to the inspection process and following the complaint investigation some aspects of the complaint were upheld. As a result of this, work will be taking place to review the quality assurance process for inspection reports and identified improvements will be implemented, and monitored via the Clinical and Care Governance Group. This complaint was resolved within the 20 day timescale.

A summary of all complaints received by Healthcare Improvement Scotland is formally reported in our Complaints and Feedback Annual Report, as submitted to the Performance and Clinical & Care Governance Committee.

DIRECTORATE ACHIEVEMENTS & CHALLENGES

This section provides Board members with key internal developments, achievements and challenges within directorates.

QUALITY ASSURANCE DIRECTORATE

ACHIEVEMENTS

Responding to concerns: implementation of our organisation-wide process

Healthcare Improvement Scotland has a duty to respond to potential concerns raised about the safety and quality of care, with the ultimate aim of helping make care better. In 2014, we established a process to manage concerns that were referred to us from the National Confidential Alert Line, and those raised with us directly by members of NHS staff under the protection of the Public Interest Disclosures Act. Over recent years, this process has been used to assess and manage concerns from a variety of other sources and we were also aware that concerns were being raised and dealt with directly by other parts of our organisation.
In April 2019, the Quality Assurance Directorate introduced the revised organisation-wide Responding to Concerns (RTC) process – a single, more structured and consistent approach across the organisation for how we respond to all concerns about the safety or quality of care. The principle of the new process is that regardless of the route through which we receive concerns, our process for managing these is the same and is applicable to all our work across Healthcare Improvement Scotland.

The new process is supported by an Internal Assessment Group with representation from across the organisation who use their expert knowledge and experience to support appropriate assessment of the concerns raised and make recommendations on next steps.

The implementation of this organisation-wide process has strengthened our approach to responding to concerns, ensuring that all concerns are managed consistently and considered by representatives from across the organisation. We are undertaking cross-agency assessment where appropriate to ensure robust management of concerns and the team is also establishing links and engaging with external stakeholders (e.g. Scottish Public Services Ombudsman, Scottish Government, Mental Welfare Commission and whistleblowing networks) to further develop and support the process.

CHALLENGES

Quality Assurance Directorate (QAD) work areas and staffing

There has been a significant increase in the workload in QAD due to new commissions such as the National Hub for Learning from Child Deaths, Adult and Support Protection and inspection of police custody suites. Consequently, QAD is in the process of filling 20 posts at various grades and types of contracts from a total compliment of approximately 70 staff in QAD. This is taking a considerable amount of management time to run assessment centres, make appointments and most importantly co-ordinate appointments across workstreams to ensure that we appoint the best candidates.

CORPORATE SERVICES DIRECTORATE

ACHIEVEMENTS

Culture survey

The culture survey has been launched within the organisation with colleagues invited to anonymously share their views in relation to their experience of working as part of Healthcare Improvement Scotland. It has been well received with 65% of staff sharing views on their wellbeing, fair treatment, management and career progression. This survey has been prepared specifically for HIS and its aim is to find out more information about what it is like to work in HIS. It should provide more information that will support an action plan that supplements the iMatter findings. There has been considerable interest from elsewhere within the NHS about our culture survey and it may be that other boards use this tool to assist them to understand their own environments better.
Operational Planning 2020-21

Planning for 2020-21 is now underway and a function leads event took place on 12 September which was well attended with very positive feedback. A planning week is taking place from 30 September to allow everyone time and space to build plans with teams and cross organisationally. A timetable for planning has been prepared to ensure that all timelines are met which include scrutiny by stakeholders and the Board prior to final sign off by the end of March 2020.

Skype for business

Internal improvement have been working with administrative staff and project officers (known as the Awesome Network) to introduce Skype for business within HIS. This has been well received and will enable better communications that support our agile working aspirations.

Mid-year financial review

Work has started with all staff to conduct a mid-year financial review. This will allow us to incorporate the financial costs of some changes to Directorates and is good base work for the budgeting exercise for 2020-21. A meeting took place with Scottish Government finance colleagues on 10 September and it was agreed to continue with our assumptions that no baseline funding increase will be incorporated within our financial planning. We confirmed that for 2019-20 we expect to reach financial balance.

CHALLENGES

Recruitment / staffing

There have been significant challenges around recruiting staff particularly within the Corporate Governance (CG) Team, IT and Finance. It is proving more and more difficult to recruit staff into these teams because of the demand for their skills within the open market. We have managed to bridge the gaps by using agency staff and some recruitment has now been made into finance and the CG team. I would like to thank all of the staff in these teams for going above and beyond what is required of them to cover these gaps during the intervening period.

Internal improvement work is being held back because the release of qualified Lean practitioners has not been forthcoming due to pressures of other work. We expect this to be addressed as part of the Internal Improvement Oversight Board where staff capacity will be considered which includes providing time to corporate improvement.
PEOPLE AND WORKPLACE

ACHIEVEMENTS

Job Train

The new NHS Scotland Recruitment system, Job Train, has been implemented within Healthcare Improvement Scotland on time and in line with the national project plan. As part of Phase 1 implementation for the programme, we have the opportunity to continue to contribute to the ‘lessons learned’ process for those following on after us, but a significant effort on the part of colleagues within the team.

Workforce Plan

With the sign off of the Workforce Plan, activity is underway to meet the actions to be completed, including the establishment of a ‘People’ work stream which will support the workforce plan, but also provide an essential focus for the people and workforce aspects of the internal improvement programme.

The HR team have also been part of the recent Operational Plan development session for the Senior Leadership Group to ensure they can support the necessary work within Directorates and service areas for the operational plan going forward.

Health and Safety

Recent interviews have identified a suitable candidate for the role of Health and Safety Advisor within the team and we hope to have a start date confirmed very soon. This is a positive step to further support the important work in the organisation regarding our Health and Safety responsibilities as an employer.

CHALLENGES

Staffing

We have had some staff turnover within the team to two key roles for the People and Workforce Team. In June we saw Fiona Murray, Team Lead, head off to pastures new in Dumfries and Galloway and at the end of September, we will see our HR Project Officer, Mark Bisset, move to a new Project Officer role within the ihub. Activity is underway to replace Mark and there are plans in the team to review the best way to replace the Team Lead role.

SCOTTISH HEALTH COUNCIL

ACHIEVEMENTS

New operating name

A decision was taken in July 2019 that the Scottish Health Council will operate as the Healthcare Improvement Scotland Community Engagement directorate from April 2020. The
legal entity will remain the Scottish Health Council, but the branding and operating name will become Healthcare Improvement Scotland - Community Engagement. This change is intended to make the role and purpose of the Scottish Health Council clearer to stakeholders and position it more visibly as part of HIS.

The April 2020 implementation date will allow the new operating name to be introduced as part of the wider package of changes currently being progressed, and will enable the practical steps that need to be taken to support the new name to be progressed in a co-ordinated way.

**SHC Committee Member Recruitment**

Work is underway to strengthen and seek to diversify the membership of the Scottish Health Council Committee through the recruitment of new committee members and the establishment of volunteer Public Partners roles within the Committee. Adverts to recruit 3 new Committee members were launched on 6 September on a mixture of popular online recruitment portals across health, care, and the third sector. The directorate is also spreading awareness about the vacancies through the local office network’s substantial stakeholder contacts, and via social media channels including Twitter. The information pack developed to support the recruitment emphasises that we welcome interest from people from all backgrounds, while also highlighting the importance of community engagement experience. Interviews for shortlisted applicants are planned for mid-November 2019, with a view to new Members commencing from 1 January 2020.

**Patient Participation Groups Mapping Exercise**

A mapping exercise has been carried out to find out how Patient Participation Groups (PPGs) across Scotland engage with their local communities. A report of this work was published in August 2019, describing the range of different ways PPGs operate and the diverse nature of activities they are involved in. The report also provides examples of current practice to help GP practices who are considering starting their own group, or looking for ideas on how to develop their existing group.

**CHALLENGES**

**Staffing**

There are currently vacancies in the directorate senior management team. New posts have been approved as part of the new directorate structure and are being recruited to on a phased basis, starting with two new Head of Function posts which are currently being advertised. Interim management support has been put in place to provide some additional capacity until the recruitment of the senior management team is complete.
EVIDENCE DIRECTORATE

ACHIEVEMENTS

Use of Hospital Standardised Mortality Ratio in Quality of Care Reviews

In July 2019, HIS introduced a new approach for using the Hospital Standardised Mortality Ratio (HSMR) so that less emphasis is placed on this single indicator. HSMR is now one of a set of 22 indicators of quality of care that are reviewed for the purpose of learning and enquiring about the quality of care. HIS no longer routinely engages with NHS boards on the sole basis of a significantly high HSMR. Further testing and use of the set of 22 indicators will take place throughout 2019-2020.

Multimorbidity and clinical guidelines

SIGN is part of a collaborative project, led by Bruce Guthrie, Professor of General Practice, University of Edinburgh, to use epidemiology to quantify the applicability of trial evidence to inform guideline development. NICE and the guidelines developers for the European Respiratory Society are also involved. This study will compare how people eligible for trials differ from those not eligible in terms of comorbidities, coprescribing, frailty and risk of dying from other conditions. The aim is to develop a tool to interrogate epidemiological data to allow these differences to be considered during guideline development and when making recommendations for the wider population.

Horizon scanning

The Scottish Health Technologies Group (SHTG) is exploring new ways to identify health technologies of interest for Scotland. SHTG worked with the National Planning Board on horizon scanning sessions around cancer, heart disease and robotics. SHTG recently took on a governance role and gained access to HealthTech Connect database, a secure online system for identifying and supporting health technologies as they move from inception to adoption in the UK health and care system. It has been developed by NICE with funding from NHS England. SHTG also established an arrangement with colleagues in Wales and Ireland, whereby health-technology assessments can be shared and adapted.

CHALLENGES

Access to new medicines

In July 2019 SMC issued “not recommended” advice for two medicines for cystic fibrosis, Orkambi® and Symkevi®. On 12 September 2019 the Cabinet Secretary announced that a 5 year agreement with the company had been reached to make these medicines available. The Director General Health and Social Care has since advised Boards that these medicines should be prescribed under standard arrangements. The Government has also indicated that it plans to further develop policy options, in the context of improving access to new medicines that better enable the service to address affordability and SMC to respond to clinical uncertainty. These circumstances present several risks for the organisation in relation to
reputation and ongoing stakeholder engagement. A paper will be prepared for the Board in October 2019.

**EU withdrawal**

The anticipated exit from the EU is expected to present risks for the health technology assessment of new medicines. The majority of medicines regulation is currently conducted through the European Medicines Agency which will cease immediately in the event of the UK leaving the EU without a deal. As medicines regulation is a reserved function, the Medicines and Healthcare Products Regulatory Agency (MHRA) is likely to assume this function for the UK, with the potential for delays in licensing and patient access. SMC is engaging with MHRA colleagues in order that sufficient information is shared with SMC to allow workload planning and mitigate these risks.

**Innovation scale and sustainability**

The Evidence Director is working with NHS National Services Scotland colleagues to design and deliver an event for Board Chairs on developing a shared approach to the scale and spread of innovation. Work is also underway on a specific approach to the spread of innovation and improvement in collaboration with NHS Education and the Golden Jubilee National Hospital.

**NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONALS (NMAHP) DIRECTORATE**

**ACHIEVEMENTS**

**Growing Older in Scotland**

The *Growing Older in Scotland* report has been approved and now developed into design format. This will be presented to the Board with a view to publication following approval from HIS Board. This report is a narrative of health and social care services for older people in Scotland based on data held and work done by Healthcare Improvement Scotland. A reference group of external experts and public partners have contributed to the report working alongside internal teams.

**Care and Clinical Governance (CCG) Group**

The CCG Group is now well established and signed off its workplan and logic model at its last meeting. A reporting template for directorates to provide assurance that they are meeting requirements for Care and Clinical Governance is being tested within the QAD Directorate. A robust process is also in place to provide assurance that staff requiring a Nursing, Midwifery or AHP registration as part of their role are up to date with registration and revalidation.

**HIS Formal Risk Management Process (unregulated services)**

The Head of Nursing and Midwifery has been working on the development of risk management guidance to detail the steps that HIS will follow to implement its formal risk management and escalation process when concerns are identified within unregulated services.
provided by NHSScotland. The NMAHP Team have also produced an escalation process to support the implementation of this guidance.

New Head of Nursing

A new Head of Nursing has been recruited, Ruth McMurdo will join HIS from October. This post was developed as a succession planning opportunity for director and associate level nurses. The post holder will work with HIS until April and a further year at Scottish Government.

Public Protection

Public Protection systems and processes have been developed in line with current national legislation and guidance and are now available to all HIS staff via the intranet. There has been a good uptake of public protection training (both online and face to face) across the directorates. However there are challenges in influencing current practice and cross-organisational leadership is required to raise awareness and keep this issue on the agenda.

Children’s Health Services

Information has been gathered from all directorates detailing the range of work being carried out across the organisation in relation to working with children and young people. This information will be compiled and presented in report form as soon as possible.

CHALLENGES

Staffing

Due to the Head of Nursing and Midwifery role being recruited to on a secondment basis, there has been significant turnover of staff within this position over the last two years. This has caused challenges with continuity and support given both to the Director, NMAHP Team, and organisation as a whole.

Recruitment to key posts in the Healthcare Staffing Programme has also been slow which has caused delays to progressing work. With the exception of one staff member, all team members are on secondment due to the budget not being baselined.

iHub

ACHIEVEMENTS

Quality Management System (QMS) – Internal Collaborative

The collaborative entered its final stage of testing the draft QMS framework in June with the seven participating teams sharing their learning and reflections from applying the framework at the final learning session. A number of themes have emerged through the testing which have informed the development of the future organisational approach to spreading the approach beyond the initial test teams and the next iteration of the framework itself.
Coupled with the team level testing, the QMS Portfolio has supported the first of a series of board seminars to support HIS board members to build their knowledge and understanding of QMS and their role in creating the conditions to enable a consistent and coordinated approach to quality management across the organisation.

Preparations are underway to host a visit to the organisation in September as the Health Foundation’s Q Community Country Partner, with the theme throughout the day being QMS. Delegates from across the UK will be attending to hear about QMS and the work of the organisation to apply this approach both internally to how we manage our own work and externally to support better quality of care across Scotland.

**Framework for Community Health and Social Care Integrated Services**

The Director of Improvement recently met with Scottish Government colleagues leading work to develop a framework for community health and social care integrated services. The need to create stronger connections to the work of HIS, particularly in relation to our evidence, improvement support and community engagement offerings, was agreed.

**Nesta**

Over the past year, the ihub’s partnership with Nesta (an innovation foundation) has supported Midlothian Health and Social Care Partnership’s efforts to test ideas around improving mental health and wellbeing for children and young people through the implementation of the People Powered Results (PPR) ‘100 Day Challenge’ methodology.

The PPR process has now concluded, and we’re continuing to work together to understand the lasting impact of this approach in Midlothian. In addition, we’re exploring further opportunities to work in partnership, using the PPR approach and combining skills and knowledge from both organisations across health and social care in Scotland.

**Impact Report**

We’re publishing a series of case studies about the positive impact of our improvement work during 2018-19. You can read these on ihub.scot in the News & Events section.

**CHALLENGES**

**Vacancies and associate workload challenges**

Vacancies and turnover continues to be a challenge with particular pressure at the moment on project officers. At the end of August the ihub had 29 vacancies (17.5%) of which seven were project officers. Options for block recruitment for hard to fill posts are currently being explored.

Fourteen of these vacancies are associated with time limited new programmes of work such as Access QI, Value Management and Early Intervention in Psychosis. The current challenges in the system mean that we are increasingly expected to start new programmes of work before
staff have been recruited. Access QI and Value Management are both examples of this. This is placing particular pressure on the directorate at the moment.

Communication

We have a significant programme of improvement support working in a range of sectors and using a range of delivery models. This is presenting challenges internally around ensuring our offerings are joined up and co-ordinated. It is also presenting challenges with how we effectively communicate what we are doing in a concise and accessible format so that our delivery partners can better understand the full range of offerings.

EXTERNAL ENGAGEMENT

This section highlights a number of external meetings and events attended by the Chief Executive and Executive Team and hosted by HIS.

IHI National Forum

The IHI National Forum on Quality Improvement in Healthcare will be held on 7-11 December 2019 in Orlando, Florida. It has been agreed the organisation can support 5 attendees at the conference who will be delivering workshops or posters that have been successful in the IHI selection process. Ruth Glassborow, Director of Improvement will jointly present a Workshop on Big System Quality Strategy and Management with Jason Leitch, National Clinical Director, Scottish Government, and Ann Gow, Deputy Chief Executive and Director of NMAHP will jointly present a workshop on Workload, the final piece of the quality jigsaw? with the Deputy Chief Nurse for Scotland, sharing our work on healthcare staffing and excellence in care.

World Patient Safety Day (WPSD)

The World Health Organisation launched its inaugural WPSD on 17 September 2019. The ihub is marking the occasion through an internal and external social media-based campaign with a theme of ‘Why does safety matter to you?’.

NHS England Experience of Care Team visit to HIS

In October, the Person-Centred Health and Care Programme team will host a visit from NHS England and NHS Improvement’s Experience of Care Team.

During their two day trip, the team will visit The Royal Hospital for Children in Glasgow at the Queen Elizabeth University Hospital to learn about their collaborative work with parents and families to improve the care and experiences of children. They will also hear about their approach to using ‘What Matters to You?’ to shape ongoing care and support.

The following day, the NHS England team will meet with a range of staff from NHS boards, HIS, Scottish Government’s Person-Centred and Quality Team, and NHS Education Scotland to hear about approaches to person-centred care being applied in Scotland and to explore examples of where QI in care experience are being systematically applied.
HIS works in partnership with The Health Foundation to support the Q Community in Scotland. This is part of a wider Q network across the UK, which brings together improvement professionals and practitioners to share learning, enhance skills and make changes to services. Over the last 12 months, Q Scotland, working with colleagues from NHS Health Scotland, has been co-creating a sub-group on QI and Equity. This has representation from a wide range of stakeholders from both the QI community and the Public Health community.

On 16 July 2019, we hosted the group’s first webinar and were joined by more than 60 colleagues from across Scotland. Feedback from participants has been very positive and has reinforced the need to do more about this issue and suggested ways of continuing the work.

**HIS Strategic Stakeholder Advisory Group – Primary Care**

In August 2019 we held the fifth meeting of this group with a focus on HIS’ work in primary care. When the group was initially set up it allowed for both a core membership and a co-opted membership depending on the topic. For this meeting, as the topic was primary care, HIS invited a number of additional attendees along for their primary care subject matter knowledge and we were delighted that so many were able to attend. The outputs of the session are available on our website.

Key messages to HIS included:

- Strengthen joint working with delivery partners, including H&SCPs (Health and Social Care Partnerships), RCGP (Royal College of General Practitioners) and third sector.
- Provide stronger national leadership, including improved co-ordination of work across HIS and across other national boards.
- Strengthen your support for redesign and integrated working.
- Stronger focus on spread and scale-up, including sharing of learning.
- Quality assurance in primary care – needs to be accelerated.
- Strengthen and make more visible the role of evidence to ensure informing practice and improvement, including a focus on evaluation.
- Greater focus on working across full range of independent contractors, ie pharmacy, dentistry, optometry.
- Review and communicate how you set your priorities.
- Improve how you communicate your work.

There was lots of positive feedback at the end of the session, an example of comments made was: “Positive meeting – impression that HIS were listening and valued views/comments from participants”, “Focused discussion and sense we were being listened to”, “Group discussions – honesty and frankness around the table”, “The solution focused aspect”, “Thinking how quality can support integration”. Suggestions for improvement largely focused around ideas about how to expand membership of the group and how we enable topic focused discussions whilst still placing them in the context of the much wider whole system issues.
SUBJECT: Interim operating position for the Scottish Health Council: Supporting public involvement in service change in Health and Social Care Partnerships

1. Purpose of the report

This paper provides an update on the Scottish Health Council’s interim operating position for supporting public involvement in service change in Health and Social Care Partnerships, to take account of the current context and policy developments.

2. Key Points

Background

The Scottish Health Council has a statutory role to “support, ensure and monitor” the patient focus and public involvement activities of the NHS in Scotland.

Guidance produced by the Scottish Government - ‘Informing, Engaging and Consulting People in Developing Health and Community Care Services’ CEL4 (2010)¹ (referred to as ‘CEL 4’) sets out the process that NHS Boards must follow to involve people and communities in developing service change proposals. It also sets out the role of the Scottish Health Council to provide advice and support to NHS Boards in following the guidance, and in the case of service changes identified as ‘major’, to quality assure the engagement and consultation process to inform decision-making.

This guidance was produced prior to the establishment of Health and Social Care Partnerships and does not take account of services previously delivered by NHS Boards that are now planned and delivered through the governance structures of Integration Authorities.

The Scottish Health Council has been reviewing its role in supporting community engagement across health and social care services as part of a wider review of the Scottish Health Council’s role, structure and ways of working. While the review has been ongoing an interim operating position to support the development of a consistent approach to how the Scottish Health Council work’s with Health and Social Care Partnerships was agreed in May 2017.

In relation to general advice to Health and Social Care Partnerships on good practice engagement, the interim operating position stated that the Scottish Health Council would:

- Support Health and Social Care Partnerships to deliver effective and proportionate engagement and consultation in line with the integration planning principles set out in the Public Bodies (Joint Working) Scotland Act 2014, through providing advice and sharing experience.
- Develop general good practice guidance for engagement in service change, focusing on core principles for engagement that span across health and care services and promoting a clear robust process which is consistent with both CEL 4 (2010) and the integration planning principles.

With regard to the quality assurance/major change in relation to integrated service changes, the interim operating position stated;

In the case of changes involving social care services only, it would not be appropriate for the Scottish Health Council to provide a view on whether a proposed change should be identified as major.

In the case of proposed changes to services delegated to Partnerships involving NHS services, or both NHS and social care service, the Scottish Health Council will seek clarification from the Scottish Government about handling these requests and will not provide any views on whether proposed changes should be regarded as major or non-major until this clarification is received.

In June 2019 the Scottish Health Council Committee requested that this interim operating position be reviewed and submitted to the HIS Board for consideration to ensure our role is clear while other policy developments are ongoing.

**Current context**

In October 2018 the Scottish Health Council sought and received advice from Central Legal Office indicating that the statutory public involvement duties placed on NHS Boards transfer across to Integration Authorities for the delivery of health services. The advice highlights that this transfer of responsibility carries with it the Scottish Health Council’s role in “supporting, ensuring and monitoring” public involvement duties for health services within Integration Authorities. Consideration is therefore required on how the Scottish Health Council delivers its statutory duties when operating within Integration Authorities.

Scottish Government has stated the CEL 4 (2010) guidance does not apply to Integration Authorities and in October 2018, the Cabinet Secretary provided a response on the matter to the Health and Sport Committee stating that Scottish Government “do not feel that it is necessary to use a Ministerial power of direction to extend the processes around major service change set out in CEL 4 to cover Integration Authorities”.

In February 2019, the Joint Ministerial Strategic Group for Health and Community Care’s report on the progress of Integration of Health and Social Care highlighted a recommendation to develop revised statutory guidance on community engagement and participation for health and social care bodies.

In March, the Scottish Government and COSLA co-chaired group was convened to progress the Joint Ministerial Strategic Group recommendations relating to engagement and consider revised statutory guidance (CEL 4 (2010)). The Scottish Health Council has been involved in this group, with current timelines indicating the development of revised guidance for April 2020.

An area of significant consideration within current (‘CEL 4’) guidance focuses on the decision making requirements of ‘major’ and ‘non-major’ change, with major change requiring formal consultation and final consideration by the Cabinet Secretary rather than an NHS Board. With Integration Authorities set up to provide greater local autonomy in decision making this element provides a key consideration in the development of revised guidance, particularly in relation to health services delegated to Integration Authorities.

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2 Cabinet Secretary Response to Health and Sport Committee (11 October 2018): The Governance of the NHS in Scotland - Ensuring Delivery of the best Healthcare for Scotland. [pdf](http://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/20181011_Response_IN_from_Cab_Sec_re_NHS_Gov.lttr_of_02.10.18.pdf)

Work in partnership with the Care Inspectorate

Following receipt of our legal advice, and in parallel with the Scottish Government and COSLA work to develop new national guidance, consideration is being given to how the Scottish Health Council delivers its duties across NHS Boards and Integration Authorities.

While the Scottish Health Council has a legal duty to support, ensure and monitor the public involvement duties in respect of health services across NHS Boards and Integration Authorities, it has no legal duty in relation to social care services. However, it is recognised that this distinction may be easier to make in theory than in practice and we are aware that the integrated nature of service design and delivery will require close partnership working with the Care Inspectorate and other relevant authorities as this work evolves.

A proposed approach to supporting and assuring community engagement across health and care services that is aligned to the Quality of Care framework has therefore been co-produced with the Care Inspectorate.

A draft discussion paper on the proposal was presented to the Scottish Government and COSLA co-chaired engagement group to consider a way in which both organisations may deliver their duties for community engagement aligned to the Quality of Care approach. This proposal has received initial feedback from the group, but requires further development and discussion with key stakeholders and any proposed approach will need to take account of how the Quality of Care approach is used in other areas of Healthcare Improvement Scotland’s work.

Interim operating position

The Scottish Health Council continues to be actively involved in a wide range of changes progressing through Integration Authorities. This has mainly focused on supporting practice and providing advice; sharing practice from across the country; and elements of involvement within evaluation and feedback. This advice and support has been framed around the Scottish Health Council’s ‘Tips to Support Effective Engagement’, a document produced to outline practical steps to be considered when engaging people in change.

To date, the team has not undertaken formal quality assurance of any engagement or consultation activities progressing through Integration Authorities. This is something that will be informed by the development of a new operating framework.

In line with the operating position agreed in 2017, the Scottish Health Council has not provided views on whether proposed changes within Integration Authorities may constitute major service change.

The period until revised national guidance is produced and a new operating framework is developed presents an operating risk for the Scottish Health Council in relation to our role to ‘monitor’ public involvement duties for health services delegated to Integration Authorities, particularly in circumstances where there is public or political challenge to engagement and consultation activities.

It is therefore important that the organisation has a clear and up-to-date interim operating position with Integration Authorities during this time.

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4 Scottish Health Council Tips to Support Effective Engagement
http://www.scottishhealthcouncil.org/about_us/what_we_do/service_change/tips_for_engagement.aspx#W_WILD0rT1U
Taking account of the ongoing policy development work, it is proposed that the Scottish Health Council:

1. Continues to provide Integration Authorities with general good practice advice and support for engagement in service change, in line with the Scottish Health Council’s ‘Tips to Support Effective Engagement’ and best practice.
2. Commence involvement in formal quality assurance of engagement activities for health services that are delegated to Integration Authorities once the role is agreed through revised statutory guidance, in tandem with the development of a Quality of Care approach to community engagement.

An updated operational framework will be developed to support the consistent delivery of our role in the interim until revised statutory guidance is produced, and we will continue to work in partnership with relevant authorities across health and care.

It is also proposed that a public facing position statement be developed to provide transparency on our role, and our interim position.

**Actions/Recommendations**

To support the development of a consistent approach to working with Integration Authorities, the Board is asked to agree the following interim operating position:

1. The delivery of general good practice advice and support for engagement in service change to Integration Authorities, as outlined within the operational framework and in line with the Scottish Health Council’s ‘Tips to Support Effective Engagement’ and best practice.
2. Commence formal quality assurance of engagement activities for health services that are delegated to Integration Authorities once the role is agreed through revised statutory guidance, in tandem with the development of a Quality of Care approach for community engagement.
3. Produce a public facing position statement to provide transparency on our role, and the interim position.

If you have any questions about this paper please contact:
Lynsey Cleland, Director of Community Engagement/Chief Officer of the Scottish Health Council, lynsey.cleland@scottishhealthcouncil.org.
**SUPPORTING INFORMATION**

**RISK**

<table>
<thead>
<tr>
<th>Do the key points represent a risk to the organisation?</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Risk 778 (risk rating high/15): There is an operational and reputational risk to the Scottish Health Council’s role in supporting public involvement in service change because of the different governance structures progressing change through NHS Boards and Integration Authorities. This results in public uncertainty on the engagement process to be followed and challenge in the role of the Scottish Health Council.</td>
</tr>
</tbody>
</table>

**OTHER CONSIDERATIONS**

How do the key points support the five priorities in the strategic plan:
- Enable people to make informed decisions about their own care and treatment;
- Help health and social care organisations to redesign and continuously improve;
- Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve;
- Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve;
- Make best use of all resources.

The work relates to:

**Priority 2**: ‘Help health and social care organisations to redesign and continuously improve’ and;

**Priority 4**: ‘Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve’.

Resource Implications

The interim operating position will be developed within existing resources.

Resource implications for the formal support and monitoring of engagement activities for health services delegated to Integration Authorities will be scoped as part of ongoing work to develop a Quality of Care approach for community engagement.

What engagement has been used to inform the work.

Work is informed by engagement activity and a standing group of Healthcare Improvement Scotland Public Partners support the practice of the team.
<table>
<thead>
<tr>
<th>The development of a new operational framework will be developed in consultation with key stakeholder groups. Governance is provided through the Service Change Sub-Group of the Scottish Health Council Committee.</th>
</tr>
</thead>
</table>

What Equality and Diversity considerations relate to the work. Advise how the work:
- helps the disadvantaged;
- helps patients;
- makes efficient use of resources.

Practice has been supported through the HIS Equality and Diversity Officer to ensure Equality and Diversity considerations are fully considered.
SUBJECT: HIS Operational Planning Process 2020-21

1. Purpose

To provide the Board with an update on the arrangements for the operational planning process 2020-21. This includes the principles to be used and key dates.

2. Background

The operational planning process was led in 2019-20 by the Senior Leadership Group (SLG) who designed a new process for the development of the operational plan. This process will focus on increased staff engagement and input into the design and delivery of the plan. An after action review took place between the Executive Team (ET) and the Senior Leadership Group (SLG) to establish what worked well and what could be improved with the process. As a result, the following was agreed:

- The 2020-21 planning process should start as soon as possible.
- A planning group would be established with clear terms of reference and with the required staff and skills from finance, workforce, Organisational Development & Learning (OD&L), communications and the planning team. This group will be led by the Director of Finance & Corporate Services.
- Representation would still be required from the SLG to provide continuity into this process.
- The planning process would build on the Quality Management System (QMS) internal collaborative work to support embedding this approach in how we plan and deliver our work.
- Logic modelling would be used to support the understanding of the inputs, outputs and impact of our work and how these contribute to achieving longer term outcomes.
- The learning from the Primary Care cross organisational work would be shared and aligned with other large cross organisational topics.
- A significant and concentrated focus will be required by ET members to agree baseline funding instead of additional funding allocations wherever possible to provide a more certain future funding base for the organisation.
- The plan will be based on the national priorities and will incorporate measurement of the quality of what is delivered.
- A timetable will be agreed that includes stakeholder engagement including staff engagement.
- The 2020-21 planning process will run alongside the work that will take place with the Board in setting the strategic direction for the organisation with alignment incorporated when possible.
- There would be close links with the Internal Improvement Oversight Board to incorporate any impact on how we work.

3. Key Points

Progress to Date

The Operational Planning Group (OPG) has been established and has met regularly since August.

A function lead event took place on 12 September to introduce the planning process to staff and to set the direction. A dedicated planning page has been set up on the Source for staff to access at any time.

The OPG and ET have agreed that for 2020-21 the structure of the plan will be as follows:

- A high level operational plan will be prepared that will be based on a medium term planning cycle which will include horizon scanning. This will be produced as part of our contract with Scottish Government (SG) with the first year of the plan becoming the Operational Plan 2020/21. This will align with the strategic planning work that the Board is undertaking during the autumn of 2019.

- A more detailed plan that underpins the high level plan will be prepared. This will be measurable and will be built around logic models setting out clear outcomes, input and outputs for each of our programmes of work. These would be underpinned by detailed finance, workforce and performance information to ensure that the plan could be delivered sustainably over the medium term and progress can be measured.

- The priorities that were established for the 2019/20 plan will continue into the medium term ie:
  - Governance of the quality of care,
  - Mental Health;
  - Integration of health and social care services;
  - Access to care;
  - Primary Care;
  - Ensuring the effective engagement of people in the design and provision of care and;
  - HIS statutory duties to safeguard the public and provision of care.

The following principles have been agreed by the OPG and ET as fundamental to the development of the plan and these have been shared with Function Leads:

1. Collaboration is key to the delivery of the planning process. Directorates and teams will work together throughout this planning round, building on the learning and cultural changes made through the 2019-20 process and the learning from the Primary Care Cross Organisational Network. Function leads will be expected to work with their teams to embed this way of working. Collaboration and networking will be core to any of the staff engagement events.

2. The behaviours of everyone involved in the development of our operational plan are as important as the steps in the process. Focus on the priorities for Healthcare Improvement Scotland and the people of Scotland before individual team or directorates.
3. The decisions we make about our work programme must be transparent and robust, and should increase organisational resilience in terms of funding, workforce and our work.

4. We will focus on the value of our work. All of our work should be supported by appropriate project documentation, robust logic models and resourcing which include evaluation/impact assessments and realistic exit strategies where appropriate. We will aim to establish the value of the ‘HIS £’ (HIS pound) to the people of Scotland.

5. The process will ensure that we include the views of our main stakeholders. This will be achieved through existing programmes of direct engagement with key stakeholders including staff via function lead events and staff huddles. During 2020-21 further corporate level engagement will be undertaken through the ET geographical leads role and there are plans for a stakeholder event in autumn 2019. Early and continuous engagement with our Scottish Government sponsor team will also be maintained.

6. We will commit to the use of plain English throughout the process and development of the draft plan.

**Process for Approval of the Plan**

Appendix 1 details the timeline and milestones that will be met to ensure that the plan is approved by the Board by 31 March 2020. The timetable includes the opportunity to review the plan as it develops with appropriate oversight by the Board and Governance Committees.

Greater use of existing data will inform development of the plan. Significant work is being undertaken by the Planning, HR and Finance teams to enable measurement of the 2019/20 plan. This information will be used as a baseline to build discussions with teams on their input to the planning process for 2020-21 and to develop realistic logic models.

A successful function lead event took place on 12 September to share with staff the approach that is being taken to planning and to explain the input that is required from them. A planning pack has been developed and is being improved based on feedback from this event. The packs will be distributed from 19 September. The function lead events will continue throughout 2019/20.

A specific ‘planning week’ will take place from 30 September with all staff being committed to use at least one day to contribute to the process. They will be encouraged to attend workshops (finance, workforce planning and logic modelling), use information from the Source and create opportunities for cross organisational engagement and networking to develop their plans.

4. **Actions/Recommendations**

The Board is asked to:

- Note the update on the arrangements in place for the development and delivery of the operational plan 2020-21.

**Appendix:**

1. Delivery of 2020-21 Operational Plan process and milestones
**SUPPORTING INFORMATION**

**RISK**

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**OTHER CONSIDERATIONS**

How do the key points support the five priorities in the strategic plan:
- Enable people to make informed decisions about their own care and treatment;
- Help health and social care organisations to redesign and continuously improve;
- Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve;
- Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve;
- Make best use of all resources.

The Operational Plan is a key document to provide the Executive Team, the HIS Board and SG sponsors that our work is supporting improvements in the design and delivery of better care for the people of Scotland. The operational planning process enables all staff to participate in the design of the HIS work to ensure meeting national priorities and adding value.

Resource Implications

None

What engagement has been used to inform the work?

The process for the operational plan has been developed with input from the Executive Team, function leads and members of the Senior Leadership cohort.

What Equality and Diversity considerations relate to the work. Advise how the work:
- helps reduce health inequalities;
- helps people who are service users;
- makes efficient use of resources.

HIS has a statutory requirement to ensure its work reduces health inequalities and makes efficient use of resources. Our Equalities and diversity officer is a member of the Operational Planning group.
## Operational Planning Process 2020-21 – Timeline & Milestones

Item 2.2, Appendix 1

<table>
<thead>
<tr>
<th>Activity</th>
<th>Board/Governance Committees</th>
<th>ET</th>
<th>Function Leads</th>
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<tr>
<td>Function Lead Workshop</td>
<td></td>
<td>12th September 2019</td>
<td>12th September 2019</td>
<td>12th September 2019</td>
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<tr>
<td>Planning Pack Launch</td>
<td></td>
<td>18th September 2019</td>
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<td>18th September 2019</td>
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<td>Staff Huddles</td>
<td></td>
<td></td>
<td></td>
<td>17th &amp; 23rd September 2019 17th &amp; 23rd September 2019 21st &amp; 28th October 2019 16th &amp; 18th December 2019 2020 schedule (tba)</td>
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<td>Deadline for submission of Planning templates</td>
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<td>SG Engagement</td>
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<td>Planning Day – review of operational plan draft</td>
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<td>Final review of operational plan draft</td>
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<td>Planning Week</td>
<td>Audit &amp; Risk Committee</td>
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<td>Approval of draft plan by HIS Board</td>
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<td>Final Plan shared with SG</td>
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SUBJECT: Organisational Performance Report August 2019

1. Purpose of the report

To provide the Board with a detailed report showing the progress that Healthcare Improvement Scotland is making toward delivering its 2019/20 Operational Plan. This report includes detailed finance and workforce information and the high operational risks that relate to the operational plan. The report provides a significant amount of detail to provide assurance to Board members regarding progress that is being made.

2. Key Points

As part of the Governance Blueprint self – assessment that was undertaken by the Board in November 2018, it was identified that the performance reporting process that was in place was not meeting the needs of the Board to discharge its assurance duties.

It was agreed that a working group would be established to agree a revised process for performance reporting. This working group includes two members of the Board, staff from Planning, Finance and Workforce and is being led by the Director of Finance and Corporate Services.

At a function lead event in May 2019 an exercise took place to understand the information requirements of different audiences which included Function Leads, ET and Board members. The requirements of the Board were captured as follows:

- No surprises
- Major challenges / exceptions / what is not going well
- High level risks and mitigation
- Celebrations / highlights / what is going well
- High level workforce data
- Political analysis
- Financial effectiveness
- The ‘real’ position – not the rose tinted version
- Assurance

This information assisted with designing the reporting system. Various iterations of the revised report have been shared with ET, the Board representatives and the Quality and Performance Committee. The latest version was considered by the Quality and Performance Committee at its meeting on 15 August and it was agreed to proceed with that format and to prepare a version for the Board at its September meeting.

The report is separated into sections with the intention of making the complexity of the organisation’s work more easily understood. This should also assist the Board to understand the growth in short term commissions from Scottish Government as distinct from the ‘business as usual’ work of the organisation.

The format of the report is as follows:

- **Section 1** is the overview and provides more information about areas of work that the Board should be sighted on either because they are not proceeding as planned, they are new/challenging commissions, or are proceeding well. This draws on
information that is covered elsewhere in the report but is being brought to the Board’s attention.

- **Section 2** is a summary of progress being made to meet the priorities set out in the Operational Plan 2019/20. These priorities are achieved cross organisationally and where possible, the narrative considers impact as well as output.

- **Section 3** considers what might be happening politically or in the future that could impact on our work. This includes a table of possible commissions that we are currently discussing with the Scottish Government. These potential commissions are currently at an early stage and it is helpful to see them in one place to assist with discussions at a sponsor level and also to consider how they might impact on work that is currently in progress.

- **Section 4** sets out all of the work that HIS undertakes that is funded by the baseline allocation and which is therefore considered to be our core work or business as usual. This funding supports all of the organisation’s core functions. The tables in this section cover all of the work of the organisation and provides a status report regarding progress toward achieving our planned outputs.

- **Section 5** provides an analysis of the agreed short term (between 1 – 3 years) work commissioned by Scottish Government. This is often complemented by the core work of HIS.

- The **appendices** provide the most up to date information around finances, workforce and operational risks. These 3 appendices underpin all of the work that takes place within HIS and having all of this information in one place should provide a full picture of progress within one report. The Corporate/Strategic Risk register will continue to be considered as a separate item on the Board agenda.

The final report contains a significant amount of information. Feedback from Board members is welcome to enable the continuous improvement of the information that is received.

**Actions/Recommendations**

The Board are asked to:

1. Review the Organisational Performance Report and to ask any questions required for assurance.
2. To review the financial position of the organisation at 31 August 2019.
3. To feedback any comments about the report that could assist with improving it – eg what do you like/not like, is anything missing, should anything be removed.

**Appendix:**

1. Organisational Performance Report August 2019

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If you have any questions about this paper please contact Margaret Waterston, Director of Finance & Corporate Services margaret.waterston@nhs.net
SUPPORTING INFORMATION

RISK

<table>
<thead>
<tr>
<th>Do the key points represent a risk to the organisation?</th>
<th>If yes, has a risk been raised on the Compass Risk Management System</th>
<th>If yes, provide the risk number, risk description and risk rating</th>
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<tbody>
<tr>
<td>no</td>
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</table>

OTHER CONSIDERATIONS

<table>
<thead>
<tr>
<th>How do the key points support the five priorities in the strategic plan:</th>
<th>This report provides the Board with a significant amount of information to enable them to gain assurance regarding progress being made to meet these strategic priorities.</th>
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<tbody>
<tr>
<td>Enable people to make informed decisions about their own care and treatment;</td>
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<tr>
<td>Help health and social care organisations to redesign and continuously improve;</td>
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<td>Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve;</td>
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<td>Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve;</td>
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<tr>
<td>Make best use of all resources.</td>
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</table>

<table>
<thead>
<tr>
<th>Resource Implications</th>
<th>This report is still in development and improvements will be made based on feedback received</th>
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<tbody>
<tr>
<td>What engagement has been used to inform the work.</td>
<td>Staff, Board members and Governance Committees have been involved in the development of this work</td>
</tr>
<tr>
<td>What Equality and Diversity considerations relate to the work. Advise how the work:</td>
<td>The Operational plan is equality impact assessed and considers how the work of HIS can support patients and minority groups.</td>
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<td>- helps the disadvantaged;</td>
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<tr>
<td>- helps patients;</td>
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<tr>
<td>- makes efficient use of resources.</td>
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Organisational Performance Report – August 2019

Contents:

1. Overview p2
2. Operational Plan – Priorities 2019-20 p6
3. Horizon Scanning p17
4. Business as Usual p23
5. Short Term Commissions p35

Appendices:

1. Finance Report at 31 August 2019 p42
2. Workforce Report at 31 August 2019 p48
3. Operational Risk Register (at 17/09/19) p53
Section 1. Overview

Introduction

The objective of this report is to provide the Board with information about the progress of Healthcare Improvement Scotland (HIS) in delivering its Operational Plan 2019/20. The report includes a number of sections which aim to make the complexity of the work programme, including new commissions more easily understood and to assist the Board to gain assurance about the breadth and depth of work that is taking place and the progress that is being made.

This report includes finance, workforce and high operational risk information within the appendices. These three disciplines underpin delivery of all of the work of the organisation and complement earlier sections of the report.

This report should be read alongside the Executive Report to the Board in order to gain a full understanding of the activities taking place across the organisation, both internally and externally.

This overview aims to distil some of the highlights from the following sections to assist with understanding key issues around delivering the Operational Plan 2019/20. Sections 4 (Business as Usual) and 5 (Short Term Commissions) provide detailed information about all of the strands of work that are taking place and the outputs that they are planned to deliver. These are all broadly on track with some outputs being delayed and others exceeding planned delivery. A narrative is included to explain those outputs that are behind schedule.

Operational risks that are rated as high are shown in Appendix 3 and have been recorded in relation to Independent Health Care and the work of the Scottish Medicines Consortium.

The Board is asked to particularly note the following items:

Independent Healthcare (IHC)

HIS is responsible for regulating independent hospitals (including voluntary hospices), private psychiatric hospitals and independent clinics. The regulation began in April 2016 with inspection of clinics taking place from late summer 2018. This sector is in growth and is increasing in complexity which makes the definition and identification of an independent clinic difficult.

Risks have been identified and are recorded in the operational and corporate risk register – all rated as high/very high. A short life working group has been convened to address the risks and to review the future operating model. Oversight of this work is taking place by the Quality and Performance Committee and by the Audit and Risk Committee. Recruitment to fill additional posts to support IHC has gone well and should contribute towards dealing with the backlog of work and giving senior staff more space and time to work with others on the remodelling of the service and its financial and resource basis. The Quality and Performance Committee will continue to scrutinise this work and its progress.
Quality of Care Organisational Reviews

To date, three test, organisational-level, Quality of Care reviews have been undertaken in NHS Orkney, NHS Ayrshire & Arran and the Golden Jubilee National Hospital. A report of the NHS Orkney test exercise was published in August 2018.

An external review of the NHS Ayrshire & Arran Quality of Care review was commissioned and has led to a review of how we apply the quality of care approach to best effect in NHS boards. It is anticipated that this is likely to result in more targeted and focused reviews, which are linked more closely to available intelligence and evidence of the quality of care in NHS boards. Engagement is taking place with key stakeholders including Scottish Government about this proposed refocusing.

The final draft report of the review of the Golden Jubilee National Hospital has been shared with them for accuracy checking and is likely to be published in early October. We continue to work with NHS Ayrshire & Arran, and the Golden Jubilee National Hospital, to ensure the test organisational review processes are appropriately concluded, with any further learning identified.

Updates have also been provided at the most recent meetings of the Audit and Risk Committee and Performance and Quality Committee.

Adverse Events report and next steps

The Adverse Events team asked all 19 patient-facing NHS boards to submit a self-evaluation of their systems and processes for managing adverse events. This was followed up by teleconferences with those boards to better understand their submissions and address any gaps in the information supplied. The findings from this work are set out in the Adverse Events management: NHS Board Self-evaluation Report, which was published on 10 September 2019.

The findings highlight that the vast majority of boards report having policies, systems and processes in place that enable them to manage adverse events in line with the expectations in the National Framework. However, there are a number of key areas where improvement is required. The next steps that are set out in the report have been developed with these issues, and the earlier discussion of adverse events by the Health and Sport Committee, and Cabinet Secretary for Health and Sport, in mind.

In response to publication of the report, the Cabinet Secretary for Health and Sport wrote to the Chair of Healthcare Improvement Scotland setting out actions to be implemented by the end of this calendar year. These actions include: requiring all NHS Boards to notify HIS when they have commissioned a Significant Adverse Event Review for a Category I event and working with NHS Boards to standardise key terminology and definitions; in addition to better articulating the ways in which our scrutiny, assurance and improvement functions support continuous improvement where permanent harm has occurred. The letter has been published online via this link - https://www.gov.scot/publications/adverse-events-management-nhs-scotland

Work is now underway to take forward these actions. This work will include stakeholder engagement, establishment of an internal cross-organisational group and collaboration with NHS Education for Scotland.
On 27 August we published the fourth annual report from the Sharing Intelligence for Health and Care Group, setting out key messages about our work during 2018–2019.

For the first time the report includes observations on important issues that are relevant to the quality of care delivered for the people of Scotland, such as leadership, finances, workforce, performance and outcomes. This report is written with a broad audience in mind, including the public and healthcare professionals, and with the aim of stimulating constructive discussion and further action.

Death Certification Review Service (DCRS): Annual report for 2018-19

The DCRS Annual Report for 2018-19 was published on 19 September. The fourth annual report demonstrates that the Service has continued to effect improvement on the ‘not in order’ rate of Medical Certificates of Cause of Death (MCCD) as well as meeting service level agreement targets and continuing to provide educational support to NHS boards including reviewing performance and sharing examples of good practice.

New Spread Programmes

A number of new programmes have been launched that focus on scaling up good practice across Scotland. More information on these programmes is provided in section 2 with the exception of Value Management which is summarised below:

- Frailty at the Front Door Collaborative
- Practice Admin Collaborative
- Pharmacotherapy Collaborative
- Living and Dying Well with Frailty Collaborative
- Collaborative Communities

Value Management

The Value Management collaborative aims to test and spread an innovative model developed within NHS Highland that supports clinical, care and finance teams to apply quality improvement methods with combined cost and quality data at team level to deliver improved patient outcomes, experience and value.

The collaborative, led by Healthcare Improvement Scotland (HIS) working in partnership with NHS Education for Scotland (NES) and the Institute for Healthcare Improvement (IHI), will run until March 2022. Rolling out this approach was a commitment of Programme for Government, September 2019.

The overall approach has three core components:
- Creating the conditions for quality improvement through organisational culture, leadership and infrastructure interventions.
- Team, ward level quality and value improvement interventions and coaching.
- Quality improvement and coaching capacity and capability building.

Alongside continuing work with NHS Highland, we have recruited five NHS boards to work with us on this and the successful applicants are: NHS Forth Valley, NHS Greater Glasgow & Clyde, NHS Lothian, NHS Lanarkshire, and NHS Tayside
Financial Position

A detailed financial report is included in Appendix 1. The financial position at 31st August 2019 is within budget. The savings targets that were built into the financial plan are behind target with a shortfall in the proportion of recurring savings that have been achieved to date. The detail of this is explained in section 1.6 of Appendix 1. We are still waiting for the allocation of c£6.2m of additional funding to support some of the short term commissions.

Quarterly meetings are taking place with SG Finance Directorate. The most recent meeting was held on 11th September. Discussions took place around the future financial position and planning assumptions, allocation of outstanding funds for short term work and the requirement to baseline some regular short term funding streams e.g. Adverse Events, SAPG. SG Finance colleagues are actively following up the outstanding allocations.

It is expected that HIS will meet its financial targets for 2019/20 and will end the year in line with budget. A detailed half year review of the 2019/20 financial position is currently taking place to ensure that the financial planning assumptions that are in place will lead to the predicted outturn in March 2020.

Workforce position

Current workforce levels within Healthcare Improvement Scotland stands at 489 headcount (435.2 WTE), an increase of 13 staff (7.9 wte) since 1 April 2019. The contractual make-up of the workforce is currently 78% permanent, external secondees 10%, internal secondees 4% and 8% of the workforce are on fixed term contracts.

There have been 79 recruitment campaigns run since the start of the financial year and staff turnover is currently sitting at 5.7%.

Absence levels within the organisation are currently 3.7%, below the national target of 4%, slightly up on the same period from last year (3.4%). It is acknowledged that the primary reasons for absence are related to anxiety, stress or depression. Given this, specific activity relating to stress risk assessment is planned as an early activity for the newly appointed Health and Safety Officer for the organisation. Directorate level discussions are also planned to discuss activity at a local level to support staff.
Section 2: Operational Plan - Priorities 2019-20

This section provides detail about progress against the priorities set out in the Operational Plan 2019/20:

- Integration of health and social care services
- Mental health
- Primary care
- Governance of the quality of care
- Ensure the effective engagement of individuals in the design and provision of their care
- Access to care
- Statutory duties to safeguard the public and to provide high quality care

### Priority: Integration of health and social care services

**Overview:**

We are carrying out a wide range of activities designed to help achieve the ambition of an effective integrated health and social care system across Scotland. Essential characteristics of an integrated health and social care system include a stronger focus on involving people, their communities and their carers in the delivery and design of their care; delivering care closer to where people live, and to try and prevent illnesses and problems before they become more serious.

**Progress report:**

The new Director of Community Health and Social Care is now in post in Scottish Government bringing together Integration, Primary Care and Adult Social Care Support. There is a substantial programme of reform underway in these areas with the purpose of ensuring that more people enjoy health and care services at home or in a community setting. Significantly for HIS this includes:

- Strategic Planning (see update below)
- Reform of Adult Social Care Support (see update below)
- 2018 GMS Contract (see update on Primary Care)
- Health and Social Care Delivery Plan (see update on Mental Health)
- Meaningful engagement
- Nursing 2030 vision

**Report of the Ministerial Strategic Group (MSG) for Health and Community Care**

Since the publication in February 2019 of the MSG report reviewing progress with integration, extensive work has been underway to address all of the 25 proposals.

One of the recommendations was the development of a Framework of Community Health and Social Care Integrated Services, led by Scottish Government and due to be presented to the MSG this Autumn. Phase two of the work will then focus on developing the implementation support plan, which is likely to have an impact on the focus of the HIS improvement support offerings from 2020.

Another recommendation concerned reviewing the approach to inspection of adult service currently undertaken jointly by HIS and the Care Inspectorate (CI). Work is underway between the CI and HIS to develop a new approach that will extend the scope of these inspections beyond
commissioning arrangements to better focus on the outcomes of integration for communities and users of services. Proposals will be presented to the MSG in November.

The MSG also recommended that revised statutory guidance on community engagement and participation for health and social care bodies should be developed. The Scottish Health Council is a member of the Scottish Government/ COSLA co-chaired group convened to progress this recommendation. In tandem with this work to develop new statutory guidance, the Scottish Health Council is developing its approach to working with Integration Authorities.

**Strategic Planning**

HIS provides improvement support to Integration Authorities on the development of their strategic plans. The map below shows the variety of requests for strategic planning support and their development. The team have also developed a theoretical framework for strategic planning which is being tested with Integration Authorities.

![Strategic Planning Portfolio Projects](image)

**Reform of Adult Social Care Support**

The Reform of Adult Social Care Support work plan has now been published. HIS has been specifically commissioned for two programmes of work related to the work plan: Neighbourhood Care and Collaborative Communities, both of which sit as part of the Person Led Care Improvement Portfolio.

- The Neighbourhood Care programme has been awarded funding for Phase 2, to learn and further prototype an approach for Scotland.
- The Collaborative Communities programme, previously known as Outcome Based Commissioning, aims to ensure that health and social care organisations use collaborative practice and tools to facilitate real choice and control for people in their communities. It has 4 key work areas: commissioning support, widening the market (looking at new commissioning...
models including using the Health and Care Standards as part of the commissioning framework), community led support and Carer’s Act implementation.

**Transforming Local Systems Pathfinder Programme**
The Scottish Government TEC Pathfinder Programme has partnered with the ihub’s Transformational Redesign Unit to develop four local pathfinder sites which are focusing on technology enabled redesign of services. These sites are focusing on breathlessness, abuse survivorship and frailty.

**Priority: Mental Health**

**Overview:**
The Scottish Government’s Programme for Government for 2018–2019 sets out a clear priority for transforming services across Scotland for people with mental ill health – including children and young people. We are supporting this through our mental health access improvement support activities and our quality improvement safety programme focused on reducing harm in mental health settings.

**Progress report:**

**Mental Health Access Improvement Support Team (MHAIST)**
We are currently supporting the delivery of the national target that 90% of people requiring Child and Adolescent Mental Health Services (CAMHS) and/or Psychological Therapy (PT) Services will receive treatment within 18 weeks of referral to the service.

- We are leading a National Mental Health Access Collaborative to enable boards to make a positive impact on their access improvement priorities through the use of quality improvement methods along with collaborative sharing and learning across Scotland. Currently 29 teams from across both CAMHS and PT services are participating and the final learning session will take place on 8 November.

- We also provide in-depth support to services struggling to meet the 18 week standard to understand the key factors impacting access and then use this knowledge to develop and implement plans to address them. This work is being delivered in phases and we are currently providing support to four boards, NHS Forth Valley, NHS Grampian, NHS Lothian and NHS Tayside.

We have had requests for support in from a number of other NHS Boards but, due to capacity constraints, we are currently limited to working with the four boards identified above.

**Scottish Patient Safety Programme Mental Health (SPSP MH)**
SPSP MH aims to improve outcomes through a focus on reducing harm including restraint, violence, self-harm and seclusion, improving medicine safety risk assessment and safety planning at key transition points. To date this work has focused on adult acute mental health wards but we are currently developing the next phase of the programme which will focus on spreading the learning and support to all adult acute wards, as well as scoping broadening support to CAMHS and Peri-Natal in-patient wards.
Improving Observation Practice programme (SPSP-IOP) published new guidance in Spring 2019 which supports and challenges all mental health care practitioners to move away from the traditional practice of enhanced observation and work instead towards a framework of proactive, responsive, personalised care and treatment which puts the patient firmly at its centre. This guidance is based on work we have undertaken with services users and staff to develop and test new, ambitious and innovative ways of working. It represents a significant change in practice and we are now providing support to services to implement and embed this new person centred approach to observation practice.

Early Intervention in Psychosis (SPSP-EiP) is a new programme of work aimed at improving earlier intervention for patients with psychosis, which is characterised by hallucinations, delusions and disturbed thinking. We have recruited NHS Forth Valley and NHS Highland alongside their associated health and social care partnerships as initial test sites and following confirmation of funding are now recruiting the staff to support this work.

In addition we will establish a National Early Intervention in Psychosis Improvement Network (EIPIN). The ihub and Scottish Health Council are collaborating with third sector partners to ensure all work is co-designed and co-produced with those with lived experience. Further, SIGN will support the review and possible production of new guidelines to support the work.

Priority: Primary Care

Overview:

We will continue to build on our work within primary care and deliver targeted improvement support to optimise care and service redesign across primary care in Scotland. This work includes GP Cluster support and supporting improvement work within Integration Authorities as they develop new service models for primary care.

Progress report:

We continue to lead on supporting the development and implementation of work in Improving Together: A National Framework for Quality and GP Clusters in Scotland and the Memorandum of Understanding which details the agreed priorities for service redesign as part of the General Medical Services (GMS) contract.

Our work includes national improvement programmes that support the implementation of new ways of working. We have two new spread programmes directly supporting the implementation of new GMS contract:

- **Pharmacotherapy:** In recognition that multidisciplinary working is critical to reducing GP workload, the Memorandum of Understanding included an agreement that every practice would receive pharmacy and prescribing support which is referred to as Pharmacotherapy. We are currently in the final stages of recruiting 80 practices to an improvement collaborative focused on supporting the implementation of Pharmacotherapy Level 1 services within GP practice teams.

- We’ve also launched the Practice Administrative Staff Collaborative (PASC) Phase 2. The aim is to support practice administrative staff to develop their QI skills while improving key GP
practice processes around effective document and correspondence management and appropriate care navigation. This builds on the successful outcomes of PASC Phase 1, which saw a 44% average reduction of correspondence being reviewed by GPs, amounting to around 5,200 less documents per week. In one practice this led to a release of 5 hours of GP time per week.

We are also working with NES to develop a Primary Care Quality Improvement (QI) Faculty which over time, will provide responsive and planned quality improvement, coaching and mentoring support to GP Clusters across Scotland. We also deliver QI in Primary Care networking events and provide an online platform to share resources, key learning, relevant information and best practice though case studies and evaluations.

Community Treatment and Care Services (CTAC)
In spring 2019, we ran a 90 day learning cycle to pull together expert opinion and evidence to inform the design and development of CTAC services. We produced a report and held an event in June to share and discuss the findings and benefits in providing holistic community based patient care.

General dental practices
We are working with all general dental practices to deliver the safety climate survey supporting whole practice teams to better understand and measure their safety, and identify where improvements can be made.

The Scottish Health Council (SHC) has continued to support the establishment and development of Patient Participation Groups within general practice (supporting on average 20 per month) and during May 2019, sent a survey to all (944) general practices across Scotland asking for information on the types and methods of public engagement being carried out. There has been a 40% response rate and we will publish a report of the findings and develop tailored engagement tools and techniques.

The Quality Assurance Directorate is commencing a piece of work to develop and test a model for external quality assurance of primary care in H&SCPs, beginning with a scoping exercise to understand how the quality of care is currently monitored. Through this, we will identify current practice, areas of innovation, opportunities and constraints and will then work with 2-3 H&SCPs to develop and test the quality of care approach in primary care.

Our ongoing community and primary care assurance activity includes joint inspection of adult health and social care services, inspecting the care of older people in community hospitals and inspection of wholly private primary care medical and dental services.

Living Well in Communities
We have launched the Living and Dying Well with Frailty Collaborative to to improve how people aged 65 and over are supported to live and die well with frailty in the community. Twenty two teams from 19 health and social care partnerships across Scotland have been accepted on to the collaborative. In addition, scoping work is underway in collaboration with the Care Inspectorate to design the proposed Living and Dying in Care Homes Collaborative to take successful testing from the palliative and end of life care programme to scale across Scotland.

Focus on Dementia is working with three GP clusters across Scotland to test the relocation, or closer alignment, of post-diagnostic support (PDS) into primary care. This work involves 27 GP practices and each cluster has been encouraged to try new ways of working. This is enabling
earlier diagnosis and timely support to people and their families. To date, over 100 people have benefited from this support with the test sites seeing improvements including:

- One site is showing a 47% increase in uptake of PDS.
- Reduced waiting times for PDS in some cases from 12 months to 3 months.

The remaining year of the project involves working closely with external evaluators Blake Stevenson capturing and reporting on the impact of relocating PDS to primary care with the full report available in November 2020.

**The future of the British guideline on asthma**
SIGN is collaborating with the British Thoracic Society (BTS), and the National Institute for Health and Care Excellence (NICE) to produce a joint UK-wide guideline on diagnosis and management of chronic asthma in adults, young people and children chronic asthma. We are working together to develop a detailed scope, work plan and timeline for the collaboration.

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**Priority: Governance of the Quality of Care**

**Overview:**

Across Healthcare Improvement Scotland, we carry out a wide range of activities that are designed to help strengthen local governance arrangements for the quality of care. Our external quality assurance work continues to include a focus on the robustness of NHS boards’ governance structures, and their systems and processes to support staff to consistently deliver safe, effective, compassionate and person-centred care.

We are leading a national programme to improve the quality of nursing care through the development of indicators and tools to improve and assure the robust and reliable delivery of nursing and midwifery care across NHS boards. We are also supporting the introduction of new legislation to implement the necessary workforce tools and to monitor the provision of safe staffing in our healthcare facilities.

**Progress report:**

External quality assurance work increasingly focuses on governance. With the support of the Chief Nursing Officer of Scottish Government, the inspection of hospitals is being developed so that reports will include reference to governance and leadership where these have been a factor in either excellent practice or areas requiring improvement.

Whilst the methodology of organisation level reviews is being itself reviewed (see section 1), governance forms a part of the focus of these reviews. The forthcoming report into the Golden Jubilee National Hospital contains a specific section on governance. Lastly, joint inspections of adults and children’s services, conducted with the Care Inspectorate, consider governance particularly where this is a factor in either excellent or poor performance.

**Quality of cancer care in the North of Scotland: Pilot review of the North Cancer Alliance**

Healthcare Improvement Scotland is responsible for the external quality assurance of cancer services against tumour-specific quality performance indicators (QPIs). In a change to previous practice, these have included the effectiveness of the governance of the networks themselves as well as an examination of the cancer quality performance data. This is intended to ensure that we
are assured that the governance arrangements are sufficient to respond positively to the improvements required and identified through the data.

We piloted our approach, based on our Quality of Care approach and framework, with the North Cancer Alliance, and our report was published in August. The other two reviews have been completed and we are finalising the reports. After all three have been published we will write an overview report highlighting key issues across all three regional reports. This is the first time we have carried out quality assurance at a regional planning level.

**Healthcare Staffing Programme (HSP)**

The HSP, previously known as Nursing & Midwifery Workload Workforce Planning Programme (NMWWPP) transferred from Scottish Government on 1 April 2019. The new programme name reflects multi-professional working and the programme will support the implementation of the Health and Care (Staffing) (Scotland) Act which received Royal Assent in June. The following activities are underway:

- Confirmation of partial funding was received early September; agreement of a baselined budget for 2020-21 is required to allow substantive recruitment to progress.
- A Head of Programme has been appointed for the first year and policy links with Scottish Government are being established.
- Links to the Excellence in Care programme are being made.
- Education events for Board Workforce Leads and SSTS managers have been developed, with plans to evolve into a hub & spoke model.

**Excellence in Care**

The Excellence in Care programme aims to improve the nursing and midwifery care in all settings across Scotland. Core quality measures, which are applicable to all nursing and midwifery families, have now been agreed, along with the acute adult and paediatric measures. The remaining quality measures (mainly community nursing and midwifery) will be agreed by March 2020. Data submission plans from each NHS Board are in place to work towards full implementation of all quality measures during 2020. HIS will also have access to the Care Assurance and Improvement Dashboard (CAIR) by October 2019.

**Priority: Ensuring the effective engagement of individuals in the design and provision of their care**

**Overview:**

Through our Scottish Health Council local office network we are continuing our work to enable local communities to participate in the planning, development, and delivery of services. This includes leading on the national Our Voice Citizens’ Panel and providing advice and support to NHS boards and Health and Social Care Partnerships (HSCPs) on service change.

**Progress report:**

**Gathering Public Views**

Through our Scottish Health Council local office network have been supporting a number of requests to gather public views to influence national policy and direction. The following projects are currently being supported:
• Gathering views on user input to maternity services, including work to ascertain whether service users have a voice at a local and national level, and that there are good mechanisms to ensure they are aware of how to engage and to facilitate engagement with each other and at a national level.

• Gathering public views on ME Services on behalf of the Scottish Government has commenced with a stakeholder event involving third sector organisations who have been tasked with developing a set of questions around what a quality service for people with ME could look like. The Scottish Health Council will use these questions to gather feedback from the public.

• Gathering public views on shared decision making: on behalf of the Scottish Government, all local offices are gathering views about how to improve conversations between patients and healthcare professionals so that people can be as involved as they want to be in decisions about their care and treatment. The feedback will be used to inform national policy development and promotional activity around shared decision making.

Engaging people and communities in the design and delivery of primary care services
See under ‘Primary Care’ above.

Citizens’ Panel
The Citizens’ Panel, consisting of around 1,200 people who live across all NHS Board and Health & Social Care Partnership areas in Scotland, is used to get statistically robust and representative feedback on a wide range of health and social care topics. This year the panel has been refreshed and the next report will be published in October covering topics relating to Scottish Ambulance Service’s future strategy, Organ Donation and Excellence in Care (Nursing & Midwifery). A further two surveys are planned during 2019/20.

Citizens’ Jury
During autumn 2018 the Scottish Health Council and Scottish Government led on delivering the first Citizens’ Jury on a health and social care topic in Scotland. A diverse group of 24 Scottish citizens delivered 13 recommendations on shared decision making which the Scottish Government responded to in May 2019. The Scottish Health Council is currently evaluating the jury by analysing feedback from all the stakeholders involved in the jury process and will report on the learning and impacts from the jury towards the end of 2019.

Service Change
Advice and support on engagement in service change has been provided to 22 organisations (12 NHS Boards and 10 Health and Social Care Partnerships) on 37 active changes. A short animation to explain how impact assessment fits with wider planning, informing and engagement processes has also been developed to support NHS Boards and Health and Social Care Partnerships.

In addition, as part of the Scottish Health Council hosted webinar series, the ihub’s transformational redesign team delivered a session in August 2019 on the Scottish Approach to Service Design. This provided participants, including a range of staff from NHS Boards and Health and Social Care Partnerships, to learn more about the approach and its aim to empower and support the people of Scotland to actively participate in the definition, design and delivery of their public services.

Volunteering
The Volunteering Programme Team has been working with NHS Boards to develop case studies to showcase the positive impact that volunteering has on the service, on staff, on volunteers and on
We have also provided advice and guidance on volunteer management models, recruitment, engagement, policy development and risk management to support 15 Boards during the first quarter of the year.

**Priority: Access to care**

**Overview:**

Access QI is a new programme of work focused on supporting NHS Boards to deploy quality improvement (QI) expertise to meet the challenge of delivering sustainable improvements in waiting times while maintaining or improving the quality of care. The programme design was agreed in April 2019 with an agreement that it will work with NHS Boards to:

- Build the capability within teams and across pathways of care to deploy QI to improve waiting times.
- Provide support to ensure infrastructures and culture enable application of QI expertise to priority areas of work.
- Develop new and strengthening existing systems to share learning about what is and isn’t working.
- Work with the existing national programmes to ensure readily accessible information/guidance is available on High Impact Changes, Change Packages and Measurement.

**Progress report:**

Funding was confirmed on 26 July to enable the programme to run until October 2020 with an agreement that:

- With the resources available, the focus will initially be on three accelerator sites, though we will put in place a Scotland-wide learning system to ensure rapid sharing of learning more broadly.
- An extension beyond October 2020 is dependent on Scottish Government securing further funding.

Recruitment of the internal team that will support the delivery of this work has commenced. Three accelerator sites have been recruited and these are NHS Grampian, NHS Lothian and NHS Tayside. The three boards will receive intensive external support to demonstrate the impact of deploying QI approaches to reducing waiting times and provide accelerated learning that we can spread across Scotland. The first site visits to the boards will be held late September to commence the programme.

**Scottish Access Collaborative**

The Scottish Access Collaborative is a Scottish Government programme with the aim of sustainably improving waiting times for patients waiting for non-emergency procedures, through a series of focused “challenges”. One of these is EQuIP (Effective and Quality Interventions Pathways) which has been set up to identify appropriate alternative pathways to procedures that are less effective in the general population, with an initial focus on benign skin lesions, hernia, varicose veins and haemorrhoid surgery. We are exploring how the Evidence Directorate can support the collaborative with:

- identifying and understanding existing evidence
- developing explicit approaches to prioritisation
- using best evidence to inform pathway development
- sharing learning and experience of using consensus methodologies.

### Priority: Statutory duties to safeguard the public and to provide high quality care

#### Overview:

There are a number of activities that we are required to carry out by law. These include:

- advice on the clinical and cost-effectiveness of new and existing health and care technologies, and of all new medicines
- providing external quality assurance of the governance arrangements for the safe management of controlled drugs
- providing advice and support to NHS boards on involving patients and communities in service change processes (see earlier in report)
- helping to improve the quality and accuracy of death certificates, and giving public assurance around the death certificate process
- regulating independent healthcare services, with the aim of ensuring that independent clinics, hospitals (including private psychiatric hospitals) and hospices are maintaining high standards of care
- carrying out regulatory inspections to ensure safe care for patients, carers and staff who are exposed to medical ionising radiation in any NHS or independent service

#### Progress report:

**Advice on new medicines**  
This continues to be a challenging area, with considerable media and public interest and an update is included in the Executive Report to the Board.

**Death Certification Review Service (DCRS)**  
We help to improve the quality and accuracy of death certificates, and give public assurance around the death certification process. The 2018-19 annual report is being published in September (see section 1).

**Regulation of independent healthcare**  
A progress updated is provided in section 1 of the Performance Report in relation to the regulation of independent healthcare, which is an ever increasing area.

**Medical ionising radiation**  
This work is a developing area, as HIS has recently taken over full responsibility for this. It is a requirement that HIS is informed of any incidents related to this, and we have a programme of inspections about to start. Staff have recently been trained in England to develop their skills. This work also falls under the ongoing inspection of the UK by the IAEA of all nuclear work – our programme of work within this is very small but we have still been engaged in submitting a self-evaluation, and attended UK-wide briefings and preparatory workshops.

**Public Interest Disclosure Act (PIDA)**  
Healthcare Improvement Scotland has a duty to respond to concerns raised about NHS services by NHSScotland employees, or referred to us by another organisation, which may cause harm to patients and/or staff. One of the routes through which Healthcare Improvement Scotland is made aware of concerns is directly by a member of staff or group of staff under the Public Interest
Disclosure Act. The Executive Report to the Board details the new Responding to Concerns process for responding to all concerns about the safety or quality of care, including referrals via PIDA.

**Sharing Intelligence in Health and Care Group**
The work of the group identifies any legislative concerns about the work of NHS Boards across a wide range of agencies, and can be the basis for case conferences and subsequent action on a reactive basis. An update on the Group’s annual report is included in section 1.
Section 3: Horizon Scanning

A. Introduction

This section of the report is intended to provide a forward look in terms of what Healthcare Improvement Scotland (HIS) is being asked or may be asked in future to deliver — either as an extension of our existing work or as new work. It includes details of discussions with Scottish Government which may lead to the formal commissioning of work as well as a broader look at the legislative agenda and external political and policy environment.

B. Potential / emerging commissions from Scottish Government

The table below provides a summary of current areas of work which are at various stages of discussion with Scottish Government; some are formal requests currently undergoing scoping while others have been noted but may have had little formal discussion. When a formal commission including funding arrangements have been agreed, the work will move from this section and be included within the additional allocations section of the report where progress will be measured.
### SCOTTISH GOVERNMENT COMMISSIONS - HORIZON SCANNING

**Note re definitions:**
Level 2 - SG request for consideration
Level 1 - Emerging area, potential for formal request

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<td>Application of clinical standards for fracture liaison services</td>
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<td>Review of utility of best practice statement for physical examination of newborns</td>
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<td></td>
<td>Reprioritisation of existing work</td>
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</table>
C. Scottish Government priorities: Programme for Government 2019-20

On 3 September the Scottish Government published its Programme for Government 2019-20, *Protecting Scotland’s Future*, setting out its actions and priorities for the coming year and beyond, including the legislative programme.

Of the planned legislation, the **Forensic Medical Services (Victims of Sexual Offences) Bill** will underpin the ongoing work of the Scottish Government’s Taskforce for the Improvement of Services for Victims of Rape and Sexual Assault. HIS has previously published standards in support of this programme of work.

Chapter 3, Improving Outcomes through our Public Services, highlights key areas of focus in health and social care, building on the commitments in last year’s Programme for Government. There is an emphasis on upping the pace of improvement and change within health and social care services and improving access to services. There is reference to priorities focused on ‘the delivery of better patient care, better health and better value for the people of Scotland, so that we live longer, healthier lives at home or in a homely setting’.

The following extracts are intended to highlight the commitments which are likely to be of most relevance to Healthcare Improvement Scotland:

**Mental Health**
- investment in early years mental health including perinatal and infant mental health care
- taking forward the recommendations of the Children and Young People’s Mental Health Taskforce including investment in CAMHS
- delivery of waiting times improvements in CAMHS and psychological therapies
- establishment of a new Adult Mental Health Collaborative
- enabling the work of the independent reviews of the Mental Health Act and forensic mental health services
- investment in improvements to early intervention psychosis services
- driving implementation of the Suicide Prevention Action Plan – including to develop and promote best practice in local suicide prevention planning and learning reviews of suicides

**Learning disabilities, neurodiversity and dementia**
- continuing to increase the accessibility of diagnosis and support in primary care settings and testing integrated, intensive dementia home care
- engaging with stakeholders to develop the fourth National Dementia Strategy
- by the end of the year, to publish Scotland’s first ever National Action Plan on Neurological Conditions

**Integrated health and social care services**
With COSLA, taking forward actions to increase the pace and effectiveness of integration, based on the *Review of Progress with Integration*, including:
- developing new statutory guidance for community engagement and participation in the design and delivery of health and social care services
- developing a framework for community-based health and social care integrated services to help ensure that what works to improve outcomes in local community settings is shared and promoted across the whole system
- carrying out an audit of existing national leadership programmes and improving collaborative working with all health and social care partners, including the third and independent sectors
- improving strategic inspection by making sure it better reflects how different bodies need to work together to improve outcomes

**Providing the right healthcare and support when it is needed and at whatever stage of life**
- improving the primary care people receive in their communities, including local workforce planning, infrastructure development and patient engagement
- improving how pharmacists can provide personalised care
- the work of the National Out of Hours Oversight Group
- primary care reform, promoting innovation and co-produced local solutions, with a focus on rural and deprived communities
- considering the findings of the Health and Care Experience Survey

**Tackling cancer**
- changing national screening programmes where it is appropriate to ensure those in greatest need benefit fully
- supporting the dissemination of clinically-refreshed Scottish Referral Guidelines for Suspected Cancer
- taking account of the latest developments in cancer research, treatment and technology
- refreshing the cancer strategy and developing defined and consistent diagnostic and treatment pathways for different types of cancer

**Reducing waiting times**
- **delivery of the** Waiting Times Improvement Plan, working with partners to apply quality improvement expertise to help us to deliver sustainable improvements in waiting times whilst maintaining or improving the quality of care
- use of digital technology and ensuring that people are involved in the design of online services
- scale up of the Blood Pressure service for remote diagnosis and management of hypertension

**Workforce**
- improving the data, tools and methodologies available to help plan for the future including a common evidence base, to identify workforce gaps and develop new staffing models
- development of a positive working culture including strengthening policies and governance in relation to whistleblowing, bullying and harassment

**Adverse Childhood Experiences**
- development of Scottish standards for the Barnahus concept, publishing finalized standards in 2020

The Programme for Government covered a number of other areas of health and social care including public health improvement, harm associated with the use of illicit drugs and alcohol, development of a Women’s Health Plan, reform of social care, health and social care in prisons, the Independent Care Review and revision of National Guidance for Child Protection.
D. Scottish Parliament

Health and Sport Committee

The work programme of the Health and Sport Committee for 2019-21 includes the following areas:

- Primary Care – what should primary care look like for the next generation?
- Social prescribing of physical activity and sport
- Medicines
- Social Care capacity

The inquiry into Primary Care is currently underway and HIS submitted written evidence to the Committee. The Medicines inquiry is likely to take place in early 2020 and will include consideration of prescribing and cost-effectiveness.

The Committee has also been undertaking its annual pre-budget scrutiny for 2020-21 with a particular focus on integration authority budgets and will publish its report in the autumn.

Further details on the work of the Committee is included in the monthly Parliamentary Activity Briefing circulated to non-Executive Directors.

E. Other external / policy developments

Public Health Scotland

As noted in Programme for Government, a new national public health body in Scotland, to be known as ‘Public Health Scotland’, is being established to address the need to simplify and strengthen the public health landscape at the national level, ensuring better, more visible leadership and a stronger voice for public health.

A consultation on the proposals for the new body closed in June. HIS’ response to the consultation identified various interfaces between existing work in HIS and the proposed role and remit of Public Health Scotland and has highlighted the need to consider how the organisations can align and co-ordinate their work and collaborate where appropriate, to minimise the risk of duplication and the creation of a more cluttered and fragmented landscape.
Section 4. Business as Usual

Our core funded work covers most of the work of the organisation. The core budget is currently £26m and covers the core functions of HIS hence the title ‘business as usual’. This is the work that most external stakeholders will recognise HIS for and which underpins our reputation as an organisation that delivers and is high performing.

The table below details progress against the projects for Q1 (April – June) and has aligned work with the strategic priorities of Healthcare Improvement Scotland.

Project and Finance progress is presented using an arrow system:

- The project is performing to plan. All aspects of the project are within tolerance.
- The project is exceeding anticipated expectations.
- Represents there are significant issues and corrective action is required to meet business objectives. The project should be escalated and associated risks amended.

| Priority 1 - Enable people to make informed decisions about their own care and treatment |
|---|---|---|---|---|---|---|---|
| Directorate | Director | Cost Centre | YTD Budget | YTD Actual | Project | Output | Progress | Exception Narrative |
| Community Engagement | Lynsey Cleland | QF2010 | 137,544 | 124,017 | Community Engagement and Improvement Support | Promote public involvement in primary care with general practices being supported to improve their community engagement activities |  |  |
|  |  |  |  |  | | Provide support to NHS boards and Integration Authorities to improve their community engagement |  |  |
|  |  |  |  |  | | Provide training to individuals and local communities on community engagement (Voices Scotland, etc.) |  |  |
| ihub | Ruth Glassborow | QF8010 | 60,676 | 50,744 | Person Centred Health and Care Programme | One Person Centred network news letter published per quarter |  | Delay in meeting this KPI due to delay in SPO coming into post and priority given to learning sessions. KPI will be built into Nov network meeting planning |
### Priority 2 - Help health and social care organisations to redesign and continuously improve services.

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<th>Directorate</th>
<th>Director</th>
<th>Cost Centre</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
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<td>Hospital Standardised Mortality Ratio (HSMR)</td>
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<td>![Exception Narrative]</td>
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<td>Service Change</td>
<td>National and thematic Volunteer managers events (35 delegates)</td>
<td>![Progress Arrow]</td>
<td>![Exception Narrative]</td>
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<td>Case studies on volunteering published (film and written)</td>
<td>![Progress Arrow]</td>
<td>![Exception Narrative]</td>
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<td>QF7010</td>
<td>136,472</td>
<td>135,503</td>
<td>Service Change</td>
<td>Volunteering in Scotland Embedding of evaluation throughout volunteer engagement programmes workshops</td>
<td>![Progress Arrow]</td>
<td>![Exception Narrative]</td>
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<td>Support and advice provided to NHS Boards and Health and Social Care Partnerships on engagement in service change and to meet our statutory requirements.</td>
<td>![Progress Arrow]</td>
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<td>136,472</td>
<td>135,503</td>
<td>Service Change</td>
<td>Establishment of a Quality of Care framework to support the delivery of the organisations legislative and public involvement role within Health and Social Care.</td>
<td>![Progress Arrow]</td>
<td>![Exception Narrative]</td>
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<td>Quality of Care Improvement support provided to NHS boards and Health &amp; Social Care Partnerships on engagement</td>
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<td>Communicating key messages in Service Change Processes to support practice</td>
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<td>SPSP Acute Adult - All 15 boards submit quarterly progress reports against programme aims with analysis and feedback</td>
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<td>LWIC5 Core and Staff</td>
<td>Living Well in Communities 4 report to demonstrate portfolio impact</td>
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<td>Living well core and staff bundles published on website</td>
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<td>LWIC1 Living and Dying Well with Frailty</td>
<td>Living and Dying Well with Frailty learning session event (150 delegates)</td>
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<td>Living and Dying Well with Frailty putting improvement into practice. 10 Participating teams demonstrate tests of change</td>
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<td>SPSP Early Intervention Psychosis (EIP)</td>
<td>Early Intervention in Psychosis (EIP) - Improvement Network Launch event</td>
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<td>Early Interventions in Psychosis (EIP) Needs Assessment report</td>
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<td>Early Interventions in Psychosis (EIP) SIGN guideline revision - SPSP part of guideline development</td>
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Our QI Connect session planned in June was rescheduled to take place in July (Q2). This was due to the availability of the speaker.

25 April 2019: Session with Frank Federico. 219 people registered from 14 countries,
21 May 2019: Session with Brené Brown. 886 people registered from 19 countries.
We now have over 1100 organisations, including 85 colleges & universities from 62 countries.
<table>
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<tr>
<th>Project Code</th>
<th>Priority</th>
<th>Activity</th>
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<td>1</td>
<td>Multiple and Complex Needs</td>
<td>Primary Care Housing Film Launched</td>
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<td>QT0080</td>
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<td>Primary Care Improvement Programme Primary Care Dentistry</td>
<td>Primary Care Dentistry - Safety Climate Survey (SCS) Launch</td>
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<td>QT0057</td>
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<td>Quality Management System</td>
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<td>QT0021</td>
<td>1</td>
<td>Networks and Knowledge Exchange</td>
<td>Q Scotland Country Partner Events in collaboration with NES (350 delegates in total) (Including Visit and Webinar)</td>
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<tr>
<td>QT0050</td>
<td>1</td>
<td>Approaches to Transformational Redesign</td>
<td>Transformational Redesign final report on 100 day challenge with Midlothian HSCP to improve mental health and wellbeing for children and young people is delivered</td>
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*QT0037 - Ruth Glassborow*

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<td>Medical</td>
<td>Laura McIver</td>
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### Priority 3 - Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve

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<th>Cost Centre</th>
<th>YTD Budget</th>
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<td>Laura McIver</td>
<td>Q10171</td>
<td>12,681</td>
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<td>Scottish Mortality &amp; Morbidity Programme (SMMP)</td>
<td>Scottish Mortality &amp; Morbidity Programme Event (160 delegates)</td>
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<td>Medicines and Pharmacy Team (Chief Pharmacist)</td>
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<td>QAD</td>
<td>Alastair Delaney</td>
<td>Q10161</td>
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<td>Sharing Intelligence</td>
<td>Conduct 6 meetings of the sharing intelligence group to discuss intelligence from 18 NHS boards</td>
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<td>Management of Controlled Drugs</td>
<td>Management of Controlled Drugs - publish and update the Register of Accountable Officers for Scotland (as required)</td>
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<td>1,088,519</td>
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<td>SMC Advice</td>
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<td>Decisions explained documents are only provided for full and re-submissions</td>
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<td>SMC Publication of annual forward look report</td>
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<td>SIGN Chronic Pain Guideline</td>
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QD0032 189,446 177,781 SHTG Evidence Synthesis SHTG Evidence Synthesis reports for 6 technologies (Cancer waiting times) (Cochlear implants) (Closed system drug SHTG Advice) SHTG Advice on 5 technologies (Synovasure alpha defensin tests) (Hernia repair mesh) (Haematopoietic stem cell) SMC Publication of annual forward look report SMC Publication of update report

QD0050 241,816 244,046 SMC Horizon Scanning

SIGN Type 2 Diabetes Prevention Guideline SIGN Diabetes Type 1 Guideline SIGN Epilepsy in Children Guideline SIGN UTI Guideline SIGN Osteoporosis Guideline SIGN Chronic Pain Guideline SIGN Diabetes in Pregnancy Guideline SIGN Prophylactic Antibiotics SIGN Early Intervention Psychosis SIGN Eating Disorders Guideline SIGN Asthma Guideline SIGN Dementia Guideline
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<td>Collaborative Communities newsletter for CLS in Scotland published quarterly</td>
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<td>QT0001</td>
<td>159,113</td>
<td>157,786</td>
<td>Formal agreement was only reached in Q1 with 5 HSCPs to implement CLS in 2019/20 with activity due to begin now in Q2 instead. The first Collaborative Communities newsletter will be published in Q2 to provide details of this activity.</td>
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Section 5. Short Term Commissions

This section covers the work that is specifically commissioned and funded by Scottish Government. This generally relates to short term funding for projects which may then be absorbed into programmes or themes within Business as Usual in Section 4.

The table below details progress against the projects for Q1 (April – June) and is aligned with the strategic priorities of Healthcare Improvement Scotland.

**Project and Finance progress is presented using an arrow system:**

- The project is performing to plan. All aspects of the project are within tolerance.
- The project is exceeding anticipated expectations.
- Represents there are significant issues and corrective action is required to meet business objectives. The project should be escalated and Associated risks amended.

### Priority 1 - Enable people to make informed decisions about their own care and treatment

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<td>Living and Dying Well in Care Homes, ? Participating teams confirmed for the collaborative launch</td>
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<td>Living and Dying Well in Care Homes learning sessions event (40 delegates)</td>
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<td>Using observation to improve care for people with dementia: staff experiences from Balmore Ward, NHS Greater Glasgow and Clyde</td>
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<td>Primary Care GP Clusters - PASC 2 Regional Events (2 day x 3 region) 150 attendees each</td>
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<td>Develop a Quality of Care fully operational Professional Register and revalidation prompt</td>
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<td>Sign off of proposed Prioritisation Matrix by Cabinet Secretary for development of second generation tools</td>
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38
Priority 3 - Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve.

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<th>YTD Actual</th>
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<td>173,412</td>
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<td>Scottish Antimicrobial Prescribing Group</td>
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## Priority 4 - Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve.

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<td>27,892</td>
<td>National Hub Reviews/Child Deaths</td>
<td>National Hub Report publication on the findings from 3 pilot board reviews conducted order to test the processes for child deaths</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National Hub Report publication on the review of the current arrangements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>QE0062</td>
<td>0</td>
<td>38,807</td>
<td>Ionising Radiation (Medical Exposure) Regulations IR(ME)R</td>
<td>Ionising Radiation (Medical Exposure) Regulations 15 inspections including tests</td>
</tr>
<tr>
<td></td>
<td></td>
<td>QE0034</td>
<td>0</td>
<td>1</td>
<td>Adult Support and Protection Inspections</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Q10126</td>
<td>0</td>
<td>52,377</td>
<td>Management of Adverse Events</td>
<td>Management of Adverse Events baseline review report</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Management of Adverse Events scoping exercise to ascertain main themes recorded as category 1 events</td>
</tr>
<tr>
<td>Nursing</td>
<td>Ann Gow</td>
<td>QM0020</td>
<td>Used above</td>
<td>Used above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>-------</td>
<td>------------</td>
<td>------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Excellence in Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Produce 12 Core Excellence in care Indicators as agreed with Scottish Government</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Produce 12 Nursing and Midwifery specific Indicators as agreed with Scottish Government</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Publication of National Guidance for recording keeping (First of its kind for nursing)</td>
<td></td>
<td></td>
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<tr>
<td>Development of Excellence and Care Website</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disclosure Scotland Guidance</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Public Protection</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide quarterly reporting on public protection Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide Quarterly reporting on Prevent both Nationally and internally</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Priority 5 - Make best use of all resources**

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Director</th>
<th>Cost Centre</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>Project</th>
<th>Output</th>
<th>Progress</th>
<th>Exception Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>None to note this quarter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 1. Finance Report at 31 August 2019

Overview of Financial Performance

The August funding allocation letter from Scottish Government (SG) was received on 2 September 2019. This outlined a baseline recurring allocation of £26.425m (line A in Table A below). It also included a combined total of £2.829m (line B in Table A below) on additional allocations, resulting in a total revenue resource limit (RRL) for 2019-20 of £29.254m at August 2019.

All of the baseline recurring expenditure anticipated in the budget has now been received. With respect to additional allocations, in line with previous years the majority are outstanding, this equates to £6.216m (line C in table A below). The allocations still to be received and their associated risk rating can be found in Section 2 of this report.

Expenditure year to date is £1.295m overspent, this primarily relates to additional allocation funding not yet received. The underlying spend on baseline recurring allocations is underspent against budget by £0.133m.

The forecast outturn for revenue expenditure is break even, this assumes that our savings target of £1.4m will be fully met from a combination of staff turnover and cost efficiencies and that outstanding additional allocations will be fully received. To date we have identified £0.4m of savings and will engage a more detailed review of the forecast as part of the mid-year review which is scheduled to be completed early October. It should be noted that the 2018-19 surplus carry forward of £0.257m, which was received in August can be utilised to partially offset the remaining £1.0m.

Summary of Financial Expenditure:

<table>
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<tr>
<th></th>
<th>Budget Spend £000's</th>
<th>April - August Actual Spend £000's</th>
<th>Variance £000's</th>
<th>Full Year Forecast Spend £000's</th>
<th>Variance £000's</th>
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</thead>
<tbody>
<tr>
<td>Expenditure on Baseline</td>
<td>10,636</td>
<td>10,503</td>
<td>133</td>
<td>26,425</td>
<td>26,425</td>
</tr>
<tr>
<td>Expenditure on additional allocations -received</td>
<td>565</td>
<td>576</td>
<td>-11</td>
<td>2,829</td>
<td>2,829</td>
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<tr>
<td>Expenditure on additional allocations -anticipated</td>
<td>0</td>
<td>1,447</td>
<td>-1,447</td>
<td>6,216</td>
<td>6,216</td>
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<td>Revenue Resource Limit Expenditure (RRL)</td>
<td>11,201</td>
<td>12,526</td>
<td>-1,325</td>
<td>35,470</td>
<td>35,470</td>
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<tr>
<td>IHC Income</td>
<td>-285</td>
<td>-329</td>
<td>44</td>
<td>-684</td>
<td>-959</td>
</tr>
<tr>
<td>IHC Expenditure</td>
<td>285</td>
<td>299</td>
<td>-14</td>
<td>684</td>
<td>959</td>
</tr>
<tr>
<td>Net Deficit (Surplus)</td>
<td>0</td>
<td>-31</td>
<td>31</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Net Revenue Expenditure</td>
<td>11,201</td>
<td>12,496</td>
<td>-1,295</td>
<td>35,470</td>
<td>35,470</td>
</tr>
<tr>
<td>Corporate Savings target still to be achieved</td>
<td>0</td>
<td>-26</td>
<td>26</td>
<td>-689</td>
<td>-689</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>79</td>
<td>79</td>
</tr>
<tr>
<td>Baseline staff count (WTE)</td>
<td>380.8</td>
<td>380.7</td>
<td>0.1</td>
<td>375.8</td>
<td>375.8</td>
</tr>
<tr>
<td>Non recurring allocations staff count (WTE)</td>
<td>20.3</td>
<td>59.7</td>
<td>-39.4</td>
<td>93.4</td>
<td>93.4</td>
</tr>
<tr>
<td>IHC staff count (WTE)</td>
<td>12.5</td>
<td>13.3</td>
<td>-0.8</td>
<td>12.5</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Note: The year to date budget only includes additional allocations received to date. The full year budget includes anticipated allocations not yet received.
1. Baseline recurring spend

At 31 August the total baseline funding received is £26.425m. Of this HIS has spent £10.503m for the first five months which is £0.133m below budget. We are 42% of the way through the year with 40% of the baseline funding spent. Table B below outlines the baseline recurring spend position.

1.1. Financial position at 31 August 2019

Table B

<table>
<thead>
<tr>
<th></th>
<th>£000's</th>
<th></th>
<th></th>
<th></th>
<th>% of forecast spent as at August</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
<td>Budget</td>
<td>Forecast</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>349</td>
<td>315</td>
<td>34</td>
<td>943</td>
<td>943</td>
</tr>
<tr>
<td>Corporate Provision</td>
<td>97</td>
<td>92</td>
<td>5</td>
<td>-456</td>
<td>-456</td>
</tr>
<tr>
<td>Evidence</td>
<td>2,269</td>
<td>2,213</td>
<td>57</td>
<td>5,475</td>
<td>5,475</td>
</tr>
<tr>
<td>FCS</td>
<td>657</td>
<td>718</td>
<td>-60</td>
<td>1,742</td>
<td>1,742</td>
</tr>
<tr>
<td>Itub</td>
<td>3,079</td>
<td>3,010</td>
<td>69</td>
<td>7,910</td>
<td>7,910</td>
</tr>
<tr>
<td>Medical</td>
<td>296</td>
<td>293</td>
<td>3</td>
<td>1,010</td>
<td>1,010</td>
</tr>
<tr>
<td>NMAHP</td>
<td>131</td>
<td>133</td>
<td>-2</td>
<td>369</td>
<td>369</td>
</tr>
<tr>
<td>QAD</td>
<td>1,821</td>
<td>1,821</td>
<td>-1</td>
<td>4,497</td>
<td>4,497</td>
</tr>
<tr>
<td>SHC</td>
<td>1,143</td>
<td>1,109</td>
<td>35</td>
<td>2,970</td>
<td>2,970</td>
</tr>
<tr>
<td>People &amp; Workplace</td>
<td>250</td>
<td>246</td>
<td>4</td>
<td>663</td>
<td>663</td>
</tr>
<tr>
<td>Property</td>
<td>543</td>
<td>554</td>
<td>-11</td>
<td>1,303</td>
<td>1,303</td>
</tr>
<tr>
<td>Grand Total</td>
<td>10,636</td>
<td>10,503</td>
<td>133</td>
<td>26,425</td>
<td>26,425</td>
</tr>
</tbody>
</table>

The above 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 August were 381 vs. budget of 379. The forecast indicates that actuals will peak at budget level of 393 WTE in November and subsequently reduce to 376 WTE by March. The March position assumes that initiatives will have impacted as part of the strategic change program.
1.3. Directorate Pay Analysis

Key variances on year to date pay costs are:

- **Evidence** underspend of £35k primarily relates to Montgomery review which has been baselined by the Scottish Government. This is creating both a WTE and £ variance to budget.
- **QAD** overspend of £46k is a result of lower than anticipated cost being charged to additional allocations combined with higher than budgeted staffing. Whilst the volume of staff charged to additional allocations are in line with budget the grade and average cost is lower, this leaves a higher cost remaining in the baseline.
- **iHub** underspend of £15k, additional costs at Band 8D have been fully offset by lower costs across remaining bands.

The average baseline WTE to July was 363 WTE which increased to 381 WTE in August. This was principally a result of increased staff in QAD, Evidence and iHub.

1.4. Non pay costs

The non pay budget has now been reprofiled following meetings with Directorates In August. The graph below outlines the profile and compares this to prior year. Notable variances to prior year are in September, December and March. Further work will be undertaken by the Management Accountants as part of the mid-year review.
1.5. Directorate non Pay Analysis

Table D

Key variances on year to date non pay costs are:

- **Chief Executive** underspend of £22k relates to delayed prior year recharging of exhibition costs, creating a current year benefit.
- **Evidence** underspend of £22k, relates primarily to phasing on conferences within SIGN.
- **Finance and Corporate Services** overspend of £43k, relates primarily to under recovery of corporate overheads within additional allocations due to the additional allocation spend being behind the original budget profiling.
- **IHUB** underspend of £53k relates to unbudgeted income receipts of £12.5k plus slippage on films, consultancy and professional fees.
- **QAD** underspend of £45k relates to lower travel and subsistence costs and lower payments to other Boards.

1.6. Internal efficiency savings targets 2019-20

In order to achieve a balanced budget the financial plan was the subject of internal savings targets amounting to £1.2 m. This was to be achieved through strategic initiatives £0.5m and staff turnover during the year £0.7m. The budget also assumed a carry forward of £0.4m surplus, this contrast with an actual carry forward of £0.257m. This surplus shortfall has increased the target to £1.4m.

Table E below shows the current position as at 31 August 2019. This shows that savings of £0.4m have been achieved in the first five months of the financial year which represents 31% of the overall target for the year. It should be noted that £0.257m of prior year carry forward was received in August which could further reduced the savings target. This area will be a focus of attention during the mid-year review which will conclude in early October.

Table D

<table>
<thead>
<tr>
<th></th>
<th>April - August</th>
<th></th>
<th>Forecast as at March 2020</th>
<th></th>
<th>% of forecast spent as at August</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
<td>Budget</td>
<td>Forecast</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>57</td>
<td>36</td>
<td>21</td>
<td>181</td>
<td>181</td>
</tr>
<tr>
<td>Corporate Provision</td>
<td>70</td>
<td>63</td>
<td>7</td>
<td>-521</td>
<td>-521</td>
</tr>
<tr>
<td>Evidence</td>
<td>180</td>
<td>158</td>
<td>22</td>
<td>421</td>
<td>421</td>
</tr>
<tr>
<td>FCS</td>
<td>47</td>
<td>89</td>
<td>-43</td>
<td>262</td>
<td>262</td>
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<tr>
<td>IHUB</td>
<td>847</td>
<td>794</td>
<td>53</td>
<td>2,356</td>
<td>2,356</td>
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<tr>
<td>Medical</td>
<td>19</td>
<td>17</td>
<td>1</td>
<td>59</td>
<td>59</td>
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<tr>
<td>NMAHP</td>
<td>2</td>
<td>4</td>
<td>-2</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>QAD</td>
<td>132</td>
<td>86</td>
<td>45</td>
<td>423</td>
<td>423</td>
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<tr>
<td>SHC</td>
<td>96</td>
<td>80</td>
<td>16</td>
<td>267</td>
<td>267</td>
</tr>
<tr>
<td>People &amp; Workplace</td>
<td>15</td>
<td>11</td>
<td>4</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td>Property</td>
<td>543</td>
<td>554</td>
<td>-11</td>
<td>1,303</td>
<td>1,303</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>2,007</td>
<td>1,893</td>
<td>114</td>
<td>4,827</td>
<td>4,827</td>
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</table>

Table E

<table>
<thead>
<tr>
<th>Savings tracker</th>
<th>Target £000's</th>
<th>Achieved to date recurring £000's</th>
<th>Achieved to date non recurring £000's</th>
<th>Balance outstanding £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegated to Directorates</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3% Turnover</td>
<td>676</td>
<td>-208</td>
<td>-154</td>
<td>314</td>
</tr>
<tr>
<td>Held Centrally</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Change Pay</td>
<td>229</td>
<td>0</td>
<td>0</td>
<td>229</td>
</tr>
<tr>
<td>Strategic Change Non pay</td>
<td>229</td>
<td>0</td>
<td>-71</td>
<td>158</td>
</tr>
<tr>
<td>Prior year c/forward variance to budget</td>
<td>143</td>
<td>0</td>
<td>143</td>
<td></td>
</tr>
<tr>
<td>18/19 carry forward earmarked awaiting baselining</td>
<td>88</td>
<td>0</td>
<td>0</td>
<td>88</td>
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<tr>
<td>NMAHP v3 budget assumed income of £2022k, costs of £1977k</td>
<td>45</td>
<td>0</td>
<td>0</td>
<td>45</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>734</td>
<td>0</td>
<td>-71</td>
<td>663</td>
</tr>
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</table>
2. Additional Allocations non recurring spend

Table F below shows the details of the additional allocations received as at August. The budget value shown below is the approved budget value communicated to the Board in March 2019. The 19/20 allocation is the value confirmed in the latest SG allocation letter. Two of the allocations below, National Hub and Volunteer information system were classified as earmarked recurring in 2018-19 and are being quired with SG as to why they are not baselined in 2019-20.

Table F

<table>
<thead>
<tr>
<th>Allocations received</th>
<th>Future Funding category</th>
<th>Directorate</th>
<th>Budget</th>
<th>19/20 Allocation</th>
<th>19/20 Spend</th>
<th>Variance</th>
<th>20/21</th>
<th>21/22</th>
<th>22/23</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unbudgeted</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Professional Careers Programme salary contribution</td>
<td>Non Recurring</td>
<td>Evidence</td>
<td>0</td>
<td>10,000</td>
<td>0</td>
<td>10,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Funding for What Matters to You? Day 2019</td>
<td>Non Recurring</td>
<td>SHC</td>
<td>0</td>
<td>12,900</td>
<td>0</td>
<td>12,900</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Funding for transnics medical examinations</td>
<td>Non Recurring</td>
<td>Evidence</td>
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<td>25,745</td>
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<td>25,745</td>
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<tr>
<td>Barhamaus Standards</td>
<td>Non Recurring</td>
<td>Evidence</td>
<td>0</td>
<td>42,141</td>
<td>0</td>
<td>42,141</td>
<td>11,085</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Volunteering Systems</td>
<td>Baseline ?</td>
<td>SHC</td>
<td>0</td>
<td>22,600</td>
<td>0</td>
<td>22,600</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mortuaries</td>
<td>TBC</td>
<td>Evidence</td>
<td>0</td>
<td>25,000</td>
<td>0</td>
<td>25,000</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Adult Support and Protection Multi-Agency Inspection Programma</td>
<td>Non Recurring</td>
<td>QA</td>
<td>0</td>
<td>158,212</td>
<td>0</td>
<td>158,212</td>
<td>360,605</td>
<td>183,625</td>
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<tr>
<td>Access QI</td>
<td>Non Recurring</td>
<td>ihub</td>
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<td>482,806</td>
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<td>482,806</td>
<td>393,784</td>
<td>0</td>
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<tr>
<td>Neighbourhood Care</td>
<td>Baseline ?</td>
<td>ihub</td>
<td>0</td>
<td>37,000</td>
<td>0</td>
<td>37,000</td>
<td>0</td>
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<tr>
<td><strong>Budgeted</strong></td>
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<tr>
<td>National Review Panel</td>
<td>Non Recurring</td>
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<td>101,000</td>
<td>100,000</td>
<td>34,225</td>
<td>65,775</td>
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<td>Baseline</td>
<td>QA</td>
<td>71,253</td>
<td>261,515</td>
<td>27,932</td>
<td>233,623</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FOD - Care Co-ordination External</td>
<td>Non Recurring</td>
<td>ihub</td>
<td>114,952</td>
<td>70,048</td>
<td>13,129</td>
<td>56,919</td>
<td>67,248</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FOD - Diagnosis and Post Diag</td>
<td>Non Recurring</td>
<td>ihub</td>
<td>70,432</td>
<td>70,432</td>
<td>15,943</td>
<td>54,489</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Demenntia in Hospitals</td>
<td>Non Recurring</td>
<td>ihub</td>
<td>220,000</td>
<td>111,954</td>
<td>27,992</td>
<td>83,962</td>
<td>136,484</td>
<td>70,242</td>
<td>0</td>
</tr>
<tr>
<td>SARRs</td>
<td>TBC</td>
<td>Evidence</td>
<td>269,207</td>
<td>226,890</td>
<td>133,807</td>
<td>93,083</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>PNCP</td>
<td>Baseline ?</td>
<td>SHC</td>
<td>15,000</td>
<td>15,000</td>
<td>0</td>
<td>15,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IT Strategy</td>
<td>TBC</td>
<td>FCS</td>
<td>98,570</td>
<td>91,379</td>
<td>26,060</td>
<td>65,319</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Carry Forward</td>
<td>TBC</td>
<td>Corporate</td>
<td>400,000</td>
<td>257,000</td>
<td>0</td>
<td>257,000</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>MESH</td>
<td>Non Recurring</td>
<td>Evidence</td>
<td>54,344</td>
<td>1,500</td>
<td>7,655</td>
<td>6,155</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>NMAHP ****</td>
<td>Baseline confirmed</td>
<td>NMAHP</td>
<td>2,463,915</td>
<td>806,447</td>
<td>289,033</td>
<td>517,414</td>
<td>2,022,416</td>
<td>2,022,416</td>
<td>2,022,416</td>
</tr>
</tbody>
</table>

Total Allocations received

- 3,844,374
- 2,828,569
- 575,736
- 2,252,834
- 2,991,622
- 2,276,283
- 2,022,416

Table G shows the additional allocations still to be received and their associated risk rating. Two of the allocations below IRMER and Adverse Events were classified as earmarked recurring in 2018-19 and are being quired with SG as to why they are not baselined in 2019-20.

Table G

<table>
<thead>
<tr>
<th>Anticipated Allocations</th>
<th>Directorate</th>
<th>Budget</th>
<th>Anticipated Allocation</th>
<th>Spend to Date</th>
<th>Risk</th>
<th>20/21</th>
<th>21/22</th>
<th>22/23</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Confirmed</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LW &amp; DW in Care Homes (previously Palliative Care)</td>
<td>Non Recurring</td>
<td>ihub</td>
<td>0</td>
<td>141,304</td>
<td>16,685</td>
<td>73,600</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>EIP (Early Invention Psychosis)</td>
<td>Non Recurring</td>
<td>ihub</td>
<td>0</td>
<td>130,000</td>
<td>0</td>
<td>260,000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OPAH</td>
<td>TBC</td>
<td>QA</td>
<td>0</td>
<td>167,000</td>
<td>0</td>
<td>Yellow</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td><strong>Budgeted</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPSP MOCQC</td>
<td>Baseline ?</td>
<td>ihub</td>
<td>41,496</td>
<td>44,000</td>
<td>22,676</td>
<td>Green</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Value Management</td>
<td>Non Recurring</td>
<td>ihub</td>
<td>548,841</td>
<td>627,000</td>
<td>46,269</td>
<td>Green</td>
<td>724,315</td>
<td>779,899</td>
</tr>
<tr>
<td>Collab Comm External</td>
<td>Non Recurring</td>
<td>ihub</td>
<td>300,000</td>
<td>300,000</td>
<td>85,381</td>
<td>Green</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental Health Access External</td>
<td>Non Recurring</td>
<td>ihub</td>
<td>1,178,774</td>
<td>1,215,264</td>
<td>545,918</td>
<td>Green</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GP Ousters</td>
<td>TBC</td>
<td>ihub</td>
<td>800,000</td>
<td>960,000</td>
<td>319,751</td>
<td>Green</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>SPSP Improving Obs Practice</td>
<td>Non Recurring</td>
<td>ihub</td>
<td>161,700</td>
<td>198,700</td>
<td>73,704</td>
<td>Green</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OI Board Development</td>
<td>Baseline</td>
<td>ihub</td>
<td>0</td>
<td>(70,000)</td>
<td>(19)</td>
<td>Green</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Off Label Cancer Medicines</td>
<td>Non Recurring</td>
<td>Medical</td>
<td>87,034</td>
<td>37,099</td>
<td>0</td>
<td>Green</td>
<td>89,024</td>
<td>51,931</td>
</tr>
<tr>
<td>NMAHP External</td>
<td>TBC</td>
<td>NMAHP</td>
<td>326,427</td>
<td>326,427</td>
<td>169,395</td>
<td>Yellow</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>NMAHP WPP</td>
<td>Non Recurring</td>
<td>NMAHP</td>
<td>492,000</td>
<td>Yellow</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NMAHG</td>
<td>Baseline confirmed</td>
<td>NMAHP</td>
<td>see**** above</td>
<td>1,171,169</td>
<td>Yellow</td>
<td>TBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRMER</td>
<td>TBC</td>
<td>QA</td>
<td>105,108</td>
<td>105,108</td>
<td>38,807</td>
<td>Green</td>
<td>TBC</td>
<td></td>
</tr>
</tbody>
</table>

Total Confirmed Allocations

3,549,370
3,645,065
1,318,584
4,526,481
1,146,399
831,830
-

<table>
<thead>
<tr>
<th>Unconfirmed</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SHTG External</td>
<td>TBC</td>
<td>Evidence</td>
<td>159,894</td>
<td>159,894</td>
<td>61,663</td>
<td>Yellow</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>SUDI</td>
<td>TBC</td>
<td>QA</td>
<td>68,513</td>
<td>68,513</td>
<td>14,304</td>
<td>Yellow</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Adverse Events</td>
<td>TBC</td>
<td>QA</td>
<td>143,230</td>
<td>143,230</td>
<td>52,377</td>
<td>Yellow</td>
<td>TBC</td>
<td></td>
</tr>
</tbody>
</table>

Total Unconfirmed Allocations

371,837
371,837
128,544
243,093
-
-
-

Total Anticipated Allocations

3,921,007
4,216,702
1,147,127
4,762,075
1,146,399
831,830
0

Total Additional Allocations

7,805,381
9,045,271
2,022,863
7,022,408
4,138,561
3,108,113
2,022,416

Risk Key | Definition
--- | ---
Red | No confirmation of funding received
Yellow | Confirmation received but value may be subject to amendment.
Green | Full confirmation received including value.
Outturn Prediction for 31 March 2020

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.

As noted earlier the full year forecast at August is assuming a break even position. Increased scrutiny on this position will be undertaken as part of the mid-year review which is due to conclude early October.
Appendix 2. Workforce Report at 31 August 2019

Headcount (HC) and Whole Time Equivalent (WTE) are referenced, along with comparisons to previous periods where appropriate. Terms used include ‘Payroll’ (HiS staff with permanent and fixed term contracts) and ‘Non-payroll’ (external secondees/associates from other NHS Boards). eESS is the primary source of workforce data unless otherwise stated (which excludes HiS employees seconded out to other organisations, agency and bank workers).

YTD month end: 31 August 2019
YTD Period: 1 April 2019 – 31 August 2019
Previous Year End: 31 March 2019

YTD workforce position

The current workforce as recorded by eESS, stands at 489 HC / 435.2 WTE in the organisation with 439 / 410.4 WTE being payroll staff and 50 HC/24.8 WTE non-payroll (see below for additional workforce not recorded on eESS).

Workforce YTD 2019/20 v 31 March position in Previous Years

<table>
<thead>
<tr>
<th>31-Mar-19 Total (HC)</th>
<th>23</th>
<th>91</th>
<th>41</th>
<th>129</th>
<th>42</th>
<th>10</th>
<th>74</th>
<th>61</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20 (YTD) Total (HC)</td>
<td>21</td>
<td>96</td>
<td>38</td>
<td>132</td>
<td>45</td>
<td>21</td>
<td>74</td>
<td>62</td>
</tr>
<tr>
<td>2019/20 (YTD) Payroll (HC)</td>
<td>20</td>
<td>88</td>
<td>36</td>
<td>131</td>
<td>40</td>
<td>10</td>
<td>71</td>
<td>62</td>
</tr>
<tr>
<td>2019/20 (YTD) Non-Payroll (HC)</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>11</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Current Directorate Headcount 2019 YTD v Start of Financial Year

<table>
<thead>
<tr>
<th>31-Mar-19 Total (WTE)</th>
<th>22.0</th>
<th>79.1</th>
<th>38.6</th>
<th>112.6</th>
<th>32.6</th>
<th>8.6</th>
<th>70.2</th>
<th>56.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20 (YTD) Total (WTE)</td>
<td>20.2</td>
<td>82.8</td>
<td>35.6</td>
<td>116.3</td>
<td>32.7</td>
<td>19.4</td>
<td>69.7</td>
<td>58.6</td>
</tr>
<tr>
<td>2019/20 (YTD) Payroll (WTE)</td>
<td>19.2</td>
<td>80.5</td>
<td>35.6</td>
<td>107.7</td>
<td>31.7</td>
<td>9.8</td>
<td>67.3</td>
<td>58.6</td>
</tr>
<tr>
<td>2019/20 (YTD) Non-Payroll (WTE)</td>
<td>1.0</td>
<td>2.3</td>
<td>0.0</td>
<td>8.5</td>
<td>1.0</td>
<td>9.6</td>
<td>2.4</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Source: eESS

*Additional workforce data (not recorded on eESS - provided by Finance):
Agency Workers: 12.9 WTE
Additional secondees: 6.2 WTE
Changes in Workforce since 1 April 2019:

The workforce across the organisation has changed by a total of +13 HC / +7.9 WTE since the beginning of the financial year (including payroll & non-payroll). At Directorate level, the main changes due to joiners, leavers and internal moves were within NMAHP (increasing by 11 HC) and Finance and Corporate Services decreasing the most in this period by 4 HC.

Source: eESS

The contract mix of the workforce reflects a slight rise in Non-payroll staff this month (i.e. Inward Secondees increasing by 2%) across the organisation.

Recruitment Activity (YTD)

Since 1 August, new recruitment campaigns have been processed via JobTrain, as a result the reporting for the fiscal year (YTD) incorporates data from two systems (as shown below).

In total 79 campaigns have been advertised since the beginning of the financial year (including 25 campaigns via JobTrain from 1st August). 7 are currently being advertised, 31 in total are at shortlisting/interview stage and 30 currently at offer/on-boarding stage. Out of the campaigns advertised year to date, 18 have been filled – 7 of these by internal staff.

RMS Campaigns up to 1 August

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Total Campaigns Advertised YTD</th>
<th>No. Currently at Advert Stage</th>
<th>No. currently at Shortlist Stage</th>
<th>No. Currently at Interview Stage</th>
<th>No. Currently at Offer Stage</th>
<th>Campaigns filled YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executives Office (Dir)</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Evidence Directorate (Dir)</td>
<td>10</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Finance &amp; Corporate Services (Dir)</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Improvement Support &amp; ihub (Dir)</td>
<td>22</td>
<td>1</td>
<td>2</td>
<td>11</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Medical Directorate (Dir)</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>NMAHP Directorate (Dir)</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Quality Assurance (Dir)</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Scottish Health Council (Dir)</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54</strong></td>
<td><strong>0</strong></td>
<td><strong>3</strong></td>
<td><strong>10</strong></td>
<td><strong>23</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

JobTrain Campaigns from 1 August - YTD

<table>
<thead>
<tr>
<th>Campaign Type</th>
<th>Total Campaigns</th>
<th>1. Advert</th>
<th>2. Shortlisting</th>
<th>3. Interview</th>
<th>4. Offer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent</td>
<td>11</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Secondment</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed-term/Secondment</td>
<td>11</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>25</strong></td>
<td><strong>7</strong></td>
<td><strong>8</strong></td>
<td><strong>10</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>
Recruitment Timelines

So far this year, the average time to reach offer stage was down to 32.6 days (compared to 42.5 days in 2018/19) and 75.5 days from advert to starting in post (compared to 75.3 days in 2018/19) as shown in the table below. Due to smaller sample sizes in the early part of the financial year, relatively small changes can result in larger variances which will smooth as the year progresses & sample sizes increase. As shown below, campaigns advertised since the start of the financial year did not result in staff appointments until the second period onwards (similarly, those progressing via JobTrain from August will take several weeks to complete their lifecycle).

Source: RMS/JobTrain

Staff Turnover (5.7% YTD)

Year to date, there have been 30 payroll staff who have left the organisation, the highest level of attrition was within the Improvement Support & ihub (8), Evidence Directorates (7) and the Chief Executive’s Office (7). This resulted in an overall turnover ratio of 7.2% since the start of the financial year. This is higher than the same period last year where the average turnover was circa 4.5% at this point. Turnover being cumulative throughout the year will be reported as a compound figure as the year progresses.

Source eESS

Sickness Absence Rate (3.7% YTD)

During this period, a total of 12,913 hours (1721 days) was lost due to sickness absence, representing 3.7% of the available workforce. 69% of sickness was attributed to long term conditions and the highest rate being within the NMAHP (11% of the available hours within the directorate).

Source eESS

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Sickness Absence YTD</th>
<th>Instances</th>
<th>Long Term</th>
<th>Short Term</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate %</td>
<td>Long Term</td>
<td>Short Term</td>
<td>Hours Lost</td>
</tr>
<tr>
<td>Chief Executives Office (Dir)</td>
<td>1.6</td>
<td>146.1</td>
<td>75.0</td>
<td>221.1</td>
</tr>
<tr>
<td>Evidence Directorate (Dir)</td>
<td>2.9</td>
<td>1132.8</td>
<td>417.8</td>
<td>1550.5</td>
</tr>
<tr>
<td>Finance &amp; Corporate Services (Dir)</td>
<td>4.9</td>
<td>790.1</td>
<td>316.9</td>
<td>1107.0</td>
</tr>
<tr>
<td>Improvement Support &amp; ihub (Dir)</td>
<td>2.5</td>
<td>1372.3</td>
<td>396.0</td>
<td>1768.3</td>
</tr>
<tr>
<td>Medical Director (Dir)</td>
<td>3.9</td>
<td>607.8</td>
<td>202.3</td>
<td>810.1</td>
</tr>
<tr>
<td>NMAHP Director (Dir)</td>
<td>11.0</td>
<td>654.2</td>
<td>52.5</td>
<td>706.7</td>
</tr>
<tr>
<td>Quality Assurance Directorate (Dir)</td>
<td>5.3</td>
<td>1247.4</td>
<td>1091.3</td>
<td>2338.7</td>
</tr>
<tr>
<td>Scottish Health Council (Dir)</td>
<td>4.3</td>
<td>1034.7</td>
<td>612.3</td>
<td>1647.0</td>
</tr>
<tr>
<td><strong>Organisational Total</strong></td>
<td><strong>3.7</strong></td>
<td><strong>6985.6</strong></td>
<td><strong>3163.9</strong></td>
<td><strong>10149.5</strong></td>
</tr>
</tbody>
</table>

Source eESS
Year to date, the sickness absence has remained fairly constant across the organisation with the exception of dropping in May to 3.15% as shown below. Overall the sickness absence rate is higher than the average last year but remains lower than the NHS benchmark of 4%.

Sickness Absence Main Reasons

Consistent with the previous reporting period, the main reason for sickness absence YTD remains ‘Anxiety/stress/depression/other psychiatric illnesses’ related with 4392 hours (585 days) lost, affecting 20 staff members. Other main reasons are shown below along with the numbers of staff impacted for each. Work is continuing to encourage managers to correctly categorise sickness absence and reduce those recorded as ‘Unknown/Other causes’.

Source eESS

Vacancy Position YTD*

Since the 1st April 2019, there have been 156 posts gone through the eRAF system for approval – 137 of these have been approved and the remaining 19 are at different stages as shown below. Improvement Support & ihub has had the most vacancies approved (44), followed by QAD (27) and Evidence (25) with other posts pending approval at different stages. The average time taken to approve an eRAF this period was 15.6 days.

<table>
<thead>
<tr>
<th>Posts</th>
<th>Approved</th>
<th>with Finance</th>
<th>with Unit Head</th>
<th>with Director</th>
<th>with ET</th>
<th>Not Commenced2</th>
<th>with HR</th>
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Source: eRAF
Since the start of the financial year, the majority of vacancies progressing through the eRAF system have been project related – 67 in total across Programme Manager, Project Officer & Administrative Officer roles. In addition, 13 National Clinical Leads/Advisors and 13 Improvement/Associate Improvement Advisors have been submitted, along with the others shown below.

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<td>Compliance/Regulatory</td>
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<td>904</td>
<td>Alastair Delaney</td>
<td>There is a risk that due to unpredictability of the sector and growth in the market in relation to regulation of independent healthcare services, this results in the current delivery model being unsustainable with HIS then being unable to meet its statutory obligations.</td>
<td>IHC Senior Inspectors currently review regulatory activity within the organisation with the programme manager on a weekly basis. This highlights any issues or areas of concern that we cannot deal with as a team and these items are then taken to the operational programme group of which IHC is a member for discussion and resolution, and if required to the QAD programme board. Established meetings with finance, HR and IT to discuss issues relating to the delivery model.</td>
<td>An internal group consisting of Senior QAD input, IT, Finance, HR, Planning and IHC representation has been established to fully assess the sustainability of the current model of regulation.</td>
<td>Currently IHC meets separately with all of the above directorates. A first meeting of the internal group has taken place and actions are being progressed. Sub-group meetings will take place in September and an interim report will go to ET and Audit and Risk Committee in October and November.</td>
<td>Very High - 16 Impact - 4 Likelihood - 4</td>
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<td>Operational SMC Product Assessment</td>
<td>454</td>
<td>Safia Qureshi</td>
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<td>There is a risk that SMC is unable to accept new medicines for use in a timely manner because of sustained volume of submissions, leading to political and/or public criticism and resulting reputational damage.</td>
<td>Horizon Scanning Schedule planning Published prioritisation criteria Workload reporting</td>
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<td>Medicine scheduling is monitored and both the Scottish Government and the SMC lead industry representative are updated monthly on the number of submissions awaiting assessment. Additional resource to support medicines assessment has been secured and an additional pharmacist and health service researcher have been recruited. As it has not been possible to recruit sufficient health economist expertise this has been escalated to the Director to consider how to underpin the team. An internal piece of work has begun to review (a) how SMC continues to deliver its remit to assess all new medicines/indications (b) whether new types of assessment may be appropriate for certain medicines and (c) the approach to scheduling submissions. Work on KPIs is ongoing with a view to demonstrating how the</td>
<td>Prioritisation criteria are used to schedule medicine submissions and manage workload. Scottish Government and Industry are kept informed of deferrals of submissions. There is some additional capacity in the assessment team which should reduce this risk but the gap in health economist resource is a rate limiting factor. The risk score has therefore been increased due to the number of submissions which are currently not able to be scheduled and have been deferred i.e. assessment not begun immediately on receipt but queued for assessment at a later date.</td>
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<th>Impact</th>
<th>Likelihood</th>
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<tr>
<td>Operational</td>
<td>SMC Product Assessment</td>
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</table>

| Operational | SMC Product Assessment | 480 | Safia Qureshi | There is a risk that the process changes required by the independent review into access to new medicines will lead to destabilisation of SMC with the potential for organisational failure and loss of reputation for Healthcare | Regular meetings with the Scottish Government Medicines Team are taking place. Regular SMC staff and exec meetings Director updates to CEO and Chair | Regular contact with SG Medicines Policy Team on capacity issues. SMC executive has oversight and ownership of proposed changes to methods. Discussions underway about solutions to underpin health economics resource in Evidence Directorate / organisation. | Implementation of SMC led recommendations have taken place. Other recommendations, yet to be implemented, led by other organisations could impact and destabilise SMC. SG has indicated (Sept 2019) a requirement for further changes to be implemented within short timelines. Ownership for these | Very High - 20 Impact - 4 Likelihood - 5 |
| **Improvement Scotland.** | SBAR prepared on potential options to secure ongoing statistician input. Changes to reduce the volume of submissions and 'stop' low value activities (e.g. paediatric abbreviated submissions) recommendations does not sit with SMC but their implementation will impact on SMC processes and therefore requires senior team involvement. |
SUBJECT: iMatter Update

1. Purpose of the report

The purpose of this paper is to:

- Provide an update and assurance to the Board that HIS is being proactive and effective in encouraging meaningful engagement of staff with the iMatter process. This is a key measure in monitoring our fulfilment of the Staff Governance Standard.
- Feed back the recommendations from the external evaluation, carried out by Strathclyde University, of the effectiveness of iMatter as a staff experience measurement and continuous improvement tool.

2. Key Points

HIS iMatter Board Report 2019 Headlines:

- Our **response rate** has **increased** by **4% from last year** to 90% (making this a 10% uplift from 2017). This suggests that as a board we are starting to appreciate the **iMatter** process more, and understand how it can be helpful.
- The overall **employee engagement index** has seen a **slight decrease of 2 to 78**. This is still high and could be an early indication that staff might be feeling more able to respond honestly.

Of the **28 Staff Experience Employee Engagement Components**:

- 2 are **level** with last year
- 8 have dropped by 1 point
- 6 have dropped by 2 points
- 9 have dropped by 3 points
- And **3 have dropped by 5 points**

The 3 areas which have dropped by 5 points are:

<table>
<thead>
<tr>
<th>iMatter Question</th>
<th>Staff Experience Employee Engagement Components</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>Change</th>
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<td>I have confidence and trust in senior managers responsible for the wider organisation</td>
<td>Confidence and Trust in my management</td>
<td>73</td>
<td>73</td>
<td>68</td>
<td>-5</td>
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<tr>
<td>I am confident performance is managed well within my organisation</td>
<td>Performance Management</td>
<td>67</td>
<td>66</td>
<td>61</td>
<td>-5</td>
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</table>
I feel involved in decisions relating to my organisation | Partnership Working | 66 | 65 | 60 | -5

- This year we encouraged smaller teams, (i.e. fewer than 4 people, and so requiring 100%) and we accepted the associated risk of there being a few more ‘No Reports’.

- From a total of 100 potential reports, we had 18 No Reports this year (up from 11 last year). 17 of these were from ‘small teams’ although it is worth noting that the collective response from all ‘No Report’ Teams did exceed 60%.

- At the other end of the spectrum, we had a significant increase in the number of teams achieving 100%, up from 36 last year to 51 teams this year.

**Team action plans**

Teams are currently meeting to discuss their team reports and to agree team action plans. These are due to be agreed and uploaded onto the iMatter system by 23 September.

**Team Stories**

As teams work towards completing their action plans we will be encouraging them to share their team iMatter stories – stories about the difference that iMatter has made to them as a team. The increase in iMatter stories is being monitored by Scottish Government. HIS submitted a team story from 2018, which was showcased (alongside three other stories) at the NHS Scotland Conference. The video of these stories can be found on the NHS Scotland Event 2019 website under mini-plenary 1 “People make change happen” or through clicking the link below:


The HIS story is the third one.

The Board Level iMatter Report is included in Appendix 1 and a summary comparison between the 2017, 2018 and 2019 Board iMatter Reports is included in Appendix 2.

**iMatter External Evaluation Recommendations**

The aim of the research was to provide evidence to support and inform ongoing work to ensure that there is a meaningful, effective and cost-effective approach to staff engagement in health and social care. A range of methods were used to collect the data including a range of desk research, semi-structured interviews and focus groups with staff, managers and stakeholders.

The full report is included in Appendix 3. It makes twelve recommendations around endorsing continuing practice and identifying areas for improvement. These recommendations are:

**Recommendation 1:** There was near unanimous support among staff, managers and stakeholders, including trade union and non-executive Board representatives, that iMatter is an effective model for capturing staff experience and promoting staff engagement. It is important that the iMatter approach is supported and resourced to build upon its successes to date. This should include continuing support to ensure access to information, coaching, training and learning for managers and staff involved in iMatter.

**Recommendation 2:** There would be value in some re-consideration of the two statements that appear to promote relatively greater confusion among respondents. Assessing
managerial visibility needs to be anchored both to clearer definition of who comprises ‘senior managers’ and to staff desires for visibility. There is also merit in anchoring the decision involvement question either specifically to Partnership working arrangements or to a specified level of organisational decision making.

**Recommendation 3:** There would be value in considering how best to build upon online resources and opportunities for face-to-face learning across teams on the Action Planning process and examples of good practice.

**Recommendation 4:** We recommend continuing the 60% threshold for iMatter reporting. However, we urge consistency in messaging to staff, so that their ownership of the iMatter process is reinforced. A shift in language among iMatter stakeholders – away from the negative connotations of receiving “No Report” – may also be helpful. Language differentiating a standard “iMatter Report” from an “iMatter Max Report” (provided when the 60% threshold is achieved) might be more helpful.

**Recommendation 5:** The iMatter national team should continue to work towards the development of an easy-to-read ‘Dashboard’ that presents top-line key indicators. Reporting should also employ statistical significance testing to indicate change and potentially (because of ‘big’ sample numbers) utilise the more robust analytical power of multivariate data analysis.

**Recommendation 6:** In its current form, D@W neither offers robust measures, nor appears to engage respondents in the process or in actions arising. It is difficult to see a strong analytical argument for, or widespread stakeholder interest in, continuing D@W in its current form. However, given the importance of the broader issue of dignity at work, there may be merit in adopting a similar co-created process as with the development of iMatter, with a view to identifying key issues, themes and robust questions; agreeing an appropriate vehicle and unit of analysis outside of iMatter for these questions (for example, through Pulse surveys); and developing action-oriented outcomes so that staff feel safe to speak up, and are confident that they will be listened to and their concerns acted upon.

**Recommendation 7:** There is a need for iMatter partners to continue to build on what is an effective online tool, for example by ensuring accessibility for all relevant groups and considering any possible upgrades based on feedback from staff.

**Recommendation 8:** iMatter stakeholders should work together to ensure that there are opportunities to share examples of good practice and facilitators of success in the delivery of iMatter across teams, Health and Social Care Partnerships (H & SCPs) and Boards.

**Recommendation 9:** It is essential that senior managers and leadership team members at all levels within participating H & SCPs and Boards take ownership of, and provide visible and committed leadership for, iMatter. Where this has not been the case, substantial challenges have arisen in embedding iMatter. It is crucial that embedding and supporting iMatter is seen as a key task and not an optional extra by senior management/leadership team members.

**Recommendation 10:** There may be benefit in further investment in server hosting facilities that would improve server capacity, memory and speed. Investing in improved, Cloud-based server capacity would allow access to additional flexible capacity as and when required, as well as mitigating any risks to data storage.

**Recommendation 11:** There is a need to take immediate steps to support IT integration (for example, linking iMatter with Turas and eESS systems) that has the potential to free up time
for Op Leads, managers and others, so that energies can be focused on Action Planning and delivering continuous improvement.

**Recommendation 12:** Progress should be made on the more extensive piloting of SMS and smartphone-friendly versions of the iMatter tool. Support should be provided for the development of an App-based version.

The conclusion highlights that iMatter has proved effective and has made substantial progress in achieving the original goals of the model.

### 3. Actions/Recommendations

The Board is asked to:

- consider the progress made within the organisation with iMatter and to continue to provide their encouragement and support towards full engagement.
- note that information from Directorate level reports will be used alongside other workforce information for Directorate reporting to the Staff Governance Committee on progress in implementing the Staff Governance Standard.
- consider the report and recommendations from the iMatter external evaluation and how this will continue to support and improve the way HIS engages with staff around staff experience.

**Appendices:**

- Appendix 1 - Board Level iMatter Report 2019
- Appendix 2 - A summary comparison between the 2017, 2018 and 2019 Board iMatter Reports
- Appendix 3 –University of Strathclyde Report on NHSScotland Staff Experience and Continuous Improvement Mode: Research Into Implementation

If you have any questions about this paper please contact:
Anne Lumsden
Head of Organisational Development & Learning, anne.lumsden@nhs.net
0131 623 4591
SUPPORTING INFORMATION

RISK

<table>
<thead>
<tr>
<th>Do the key points represent a risk to the organisation?</th>
<th>If yes, has a risk been raised on the Compass Risk Management System</th>
<th>If yes, provide the risk number, risk description and risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

OTHER CONSIDERATIONS

How do the key points support the five priorities in the strategic plan:

- Enable people to make informed decisions about their own care and treatment;
- Help health and social care organisations to redesign and continuously improve;
- Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve;
- Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve;
- Make best use of all resources.

iMatter is specifically designed to enable staff and teams to have a voice and to take ownership of influencing their experience at work.

iMatter encourages ownership of local actions, with a view to continuously improving the way teams work.

iMatter encourages teams to share their stories with a view to enabling others to learn and adopt practices that can improve experience.

iMatter is a continuous improvement model, designed to enable progress to be tracked over time and to create a culture in which any areas that might threaten sustainability can be highlighted at the earliest opportunity.

iMatter is all about making the best of our most important resource: our people and our teams.

Resource Implications

The resource implications of iMatter include:

Organisational Development and Learning (OD&L)
Board Administration (OD&L) – considerable especially at key points in the cycle such as agreeing Directorate team structures, and team confirmations.
The Board Ops lead (OD&L) is also responsible for monitoring, reviewing and reporting on the results. In addition there is a resource implication from OD&L and others in supporting teams to identify and then meet their development needs.

**Directors and Team Managers**

There is an investment required from team managers in checking and agreeing their team members details, preparing the ground with them for the survey, as well as monitoring and encouraging completion of it. Then, post survey, the manager must arrange to meet and discuss the report, with time and physical resource required to support the team to do so, and then to follow through on the actions agreed throughout the year.

**Staff Members**

Each staff member requires time to complete the survey (approx. 15 minutes), and to attend their team meeting to review, discuss and agree their actions. This might be achieved in one go but may need more than one session. They will also need support to implement and evaluate (and celebrate?) their actions throughout the year.

<table>
<thead>
<tr>
<th>What engagement has been used to inform the work?</th>
<th>iMatter has been discussed regularly at both Partnership Forum and it’s subgroup, the VBEC group.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Direct communications (usually email) have been issued throughout the year to all staff, highlighting the various stages of the process and to ensure everyone was aware of their role and responsibility.</td>
</tr>
<tr>
<td></td>
<td>Wherever possible, and appropriate, the concept of iMatter has been aligned to other activities such as ‘What Matters to You’ day, and the use of the IHI Improving Joy at Work Framework. The aim of this has been to convey that iMatter is not a separate ‘thing’: it is woven intrinsically into all we do, and one small action or change in one area could have significant impact on others.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What Equality and Diversity considerations relate to the work? Advise how the work:</th>
<th>iMatter is for ALL staff. Managers are encouraged to check to see if staff on long term absence or maternity leave etc wish to be included or not, but other than that no impact assessment has been carried out.</th>
</tr>
</thead>
</table>
Board Report 2019
Healthcare Improvement Scotland

**90%**
Response rate
Respondents: 429
Recipients: 479

**78**
Employee Engagement Index

### Staff Governance Standards - Strand Scores

<table>
<thead>
<tr>
<th>Strand</th>
<th>Weighted Index Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Informed</td>
<td>80</td>
</tr>
<tr>
<td>Appropriately Trained &amp; Developed</td>
<td>78</td>
</tr>
<tr>
<td>Involved in Decisions</td>
<td>75</td>
</tr>
<tr>
<td>Treated Fairly &amp; Consistently, with Dignity &amp; Respect, in an Environment where Diversity is Valued</td>
<td>78</td>
</tr>
<tr>
<td>Provided with a Continuously Improving &amp; Safe Working Environment, Promoting the Health &amp; Well Being of Staff, Patients &amp; the Wider Community</td>
<td>79</td>
</tr>
</tbody>
</table>

- **Strive & Celebrate (67 - 100)**
- **Monitor to Further Improve (51 - 66)**
- **Improve to Monitor (34 - 50)**
- **Focus to Improve (0 - 33)**
Experience as an Individual:
Number of respondents: 429

I am clear about my duties and responsibilities
I get the information I need to do my job well
I am given the time and resources to support my learning growth
I have sufficient support to do my job well
I am confident my ideas and suggestions are listened to
I am confident my ideas and suggestions are acted upon
I feel involved in decisions relating to my job
I am treated with dignity and respect as an individual
I am treated fairly and consistently
I get enough helpful feedback on how well I do my work
I feel appreciated for the work I do
My work gives me a sense of achievement

Average score
82
79
75
77
84
82
79
78
83
79
78
My Team / My Direct Line Manager:
Number of respondents: 429

- I feel my direct line manager cares about my health and well-being: 90
- My direct line manager is sufficiently approachable: 91
- I have confidence and trust in my direct line manager: 88
- I feel involved in decisions relating to my team: 81
- I am confident performance is managed well within my team: 78
- My team works well together: 81
- I would recommend my team as a good one to be a part of: 83

Average score:
- Strive & Celebrate (67 - 100)
- Monitor to Further Improve (51 - 66)
- Improve to Monitor (34 - 50)
- Focus to Improve (0 - 33)
My Organisation:
Number of respondents: 429

Overall, working within my organisation is a ....
Number of respondents: 429

Average score
7.13

Very Poor Experience... 0
1
2
3
4
5
6
7
8
9
Very good experience... 10

Thermometer

I understand how my role contributes to the goals of my organisation

I feel my organisation cares about my health and wellbeing

I feel senior managers responsible for the wider organisation are sufficiently visible

I have confidence and trust in senior managers responsible for the wider organisation

I feel involved in decisions relating to my organisation

I am confident performance is managed well within my organisation

I get the help and support I need from other teams and services within the organisation to do my job

I would recommend my organisation as a good place to work

I would be happy for a friend or relative to access services within my organisation

Strive & Celebrate (67 - 100)
Monitor to Further Improve (51 - 66)
Improve to Monitor (34 - 50)
Focus to Improve (0 - 33)
### EEI number for teams within the Board

<table>
<thead>
<tr>
<th>EEI Threshold</th>
<th>[67-100]</th>
<th>[51-66]</th>
<th>[34-50]</th>
<th>[0-33]</th>
<th>No report</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Teams</td>
<td>63</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>17</td>
<td>89</td>
</tr>
<tr>
<td>Percentage of Teams</td>
<td>70.8%</td>
<td>9%</td>
<td>1.1%</td>
<td>0%</td>
<td>19%</td>
<td>100%</td>
</tr>
</tbody>
</table>
iMatter 2019 Headlines
(extracted on 1 July 2019)

Yearly Response Rates

<table>
<thead>
<tr>
<th>Organisation</th>
<th>2017</th>
<th>Improvement</th>
<th>2018</th>
<th>Improvement</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>80%</td>
<td>↑</td>
<td>86%</td>
<td>↑</td>
<td>90%</td>
</tr>
</tbody>
</table>

EEI numbers and improvements from last year

<table>
<thead>
<tr>
<th>Organisation</th>
<th>2017</th>
<th>Improvement</th>
<th>2018</th>
<th>Improvement</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>80</td>
<td></td>
<td>80</td>
<td></td>
<td>78</td>
</tr>
</tbody>
</table>

No Reports by Directorate

<table>
<thead>
<tr>
<th>By Directorate</th>
<th>Total Number of teams</th>
<th>Total Number of No Reports</th>
<th>No Reports as a % of all</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIS (Evidence Directorate)</td>
<td>14</td>
<td>3</td>
<td>21%</td>
</tr>
<tr>
<td>HIS (Executive Directorate)</td>
<td>3</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>HIS (F&amp;CS Directorate)</td>
<td>7</td>
<td>1</td>
<td>14%</td>
</tr>
<tr>
<td>HIS (Improvement Support &amp; ihub)</td>
<td>20</td>
<td>3</td>
<td>15%</td>
</tr>
<tr>
<td>HIS (Office of Medical Director)</td>
<td>8</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>HIS (Office of NMAHP)</td>
<td>4</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>HIS (Quality Assurance Directorate)</td>
<td>23</td>
<td>11</td>
<td>48%</td>
</tr>
<tr>
<td>HIS (Scottish Health Council)</td>
<td>11</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>TOTAL FOR HIS</td>
<td>90</td>
<td>18</td>
<td>20%</td>
</tr>
</tbody>
</table>
### Team Sizes and Impact of Small Teams

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Teams/ Potential Reports</td>
<td>34</td>
<td>59</td>
<td>68</td>
<td>73</td>
<td>100</td>
</tr>
<tr>
<td>Number of 'Small Teams' (i.e. 4 team members or less)</td>
<td>5</td>
<td>15</td>
<td>18</td>
<td>23</td>
<td>46</td>
</tr>
<tr>
<td>'Small Teams' as a % of all Teams</td>
<td>15%</td>
<td>25%</td>
<td>26%</td>
<td>32%</td>
<td>46%</td>
</tr>
<tr>
<td>Teams achieving 100% response rate</td>
<td>17</td>
<td>19</td>
<td>23</td>
<td>36</td>
<td>51</td>
</tr>
<tr>
<td>Number of 'Small Teams' achieving 100%</td>
<td>5</td>
<td>11</td>
<td>19</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td>'Small Teams' as a Proportion of all Teams achieving 100%</td>
<td>30%</td>
<td>58%</td>
<td>82%</td>
<td>67%</td>
<td>88%</td>
</tr>
<tr>
<td>Number of No reports</td>
<td>-</td>
<td>6</td>
<td>8</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>Number of 'Small Teams' achieving No Report</td>
<td>-</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>'Small Teams’ as a Proportion of all Teams achieving No Report</td>
<td>-</td>
<td>100%</td>
<td>38%</td>
<td>82%</td>
<td>94%</td>
</tr>
<tr>
<td>Number of No Report Teams with Response Rate &gt; 60%</td>
<td>-</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Combined Response Rate of all Non Report Teams</td>
<td>-</td>
<td>58%</td>
<td>40%</td>
<td>59%</td>
<td>64%</td>
</tr>
<tr>
<td>Number of non-respondents causing No Report</td>
<td>-</td>
<td>8</td>
<td>27</td>
<td>27</td>
<td>38</td>
</tr>
</tbody>
</table>
## Board Yearly Components

<table>
<thead>
<tr>
<th>iMatter Questions</th>
<th>Staff Experience Employee Engagement Components</th>
<th>Average Response</th>
<th>Change from 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>My direct line manager is sufficiently approachable</td>
<td>Visible and Consistent Leadership</td>
<td>90 91 91</td>
<td>&gt;</td>
</tr>
<tr>
<td>I feel my direct line manager cares about my health and well-being</td>
<td>Assessing Risk and Monitoring Work Stress and Workload</td>
<td>88 91 90</td>
<td>-1</td>
</tr>
<tr>
<td>I have confidence and trust in my direct line manager</td>
<td>Confidence and Trust in my management</td>
<td>87 89 88</td>
<td>-1</td>
</tr>
<tr>
<td>I am treated with dignity and respect as an individual</td>
<td>Valued as an Individual</td>
<td>86 87 84</td>
<td>-3</td>
</tr>
<tr>
<td>I am treated fairly and consistently</td>
<td>Consistent Application of Employment Policies and Procedures</td>
<td>84 85 83</td>
<td>-2</td>
</tr>
<tr>
<td>I would recommend my team as a good one to be a part of</td>
<td>Additional question</td>
<td>84 85 83</td>
<td>-2</td>
</tr>
<tr>
<td>I am clear about my duties and responsibilities</td>
<td>Role Clarity</td>
<td>85 84 83</td>
<td>-1</td>
</tr>
<tr>
<td>My team works well together</td>
<td>Effective Team Work</td>
<td>83 84 81</td>
<td>-3</td>
</tr>
<tr>
<td>I feel involved in decisions relating to my team</td>
<td>Empowered to influence</td>
<td>82 81 81</td>
<td>&gt;</td>
</tr>
<tr>
<td>I understand how my role contributes to the goals of my organisation</td>
<td>Sense of Vision, Purpose and Values</td>
<td>82 82 81</td>
<td>-1</td>
</tr>
<tr>
<td>I get the information I need to do my job well</td>
<td>Clear, Appropriate and Timeously Communication</td>
<td>80 81 79</td>
<td>-2</td>
</tr>
<tr>
<td>I am confident my ideas and suggestions are listened to</td>
<td>Listened to and Acted Upon</td>
<td>81 82 79</td>
<td>-3</td>
</tr>
<tr>
<td>I get enough helpful feedback on how well I do my work</td>
<td>Performance Development and Review</td>
<td>79 80 79</td>
<td>-1</td>
</tr>
<tr>
<td>I would be happy for a friend or relative to access services within my organisation</td>
<td>Additional question</td>
<td>81 82 79</td>
<td>-3</td>
</tr>
<tr>
<td>I have sufficient support to do my job well</td>
<td>Access to Time and Resources</td>
<td>79 80 79</td>
<td>-1</td>
</tr>
<tr>
<td>I feel appreciated for the work I do</td>
<td>Recognition and Reward</td>
<td>80 81 79</td>
<td>-2</td>
</tr>
<tr>
<td>iMatter Questions</td>
<td>Staff Experience Employee Engagement Components</td>
<td>Average Response</td>
<td>Change from 2018</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2017</td>
<td>2018</td>
</tr>
<tr>
<td>I am confident performance is managed well within my team</td>
<td>Performance Management</td>
<td>79</td>
<td>79</td>
</tr>
<tr>
<td>My work gives me a sense of achievement</td>
<td>Job Satisfaction</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>I would recommend my organisation as a good place to work</td>
<td>Additional question</td>
<td>79</td>
<td>80</td>
</tr>
<tr>
<td>I feel my organisation cares about my health and wellbeing</td>
<td>Health and Wellbeing Support</td>
<td>77</td>
<td>78</td>
</tr>
<tr>
<td>I am given the time and resources to support my learning growth</td>
<td>Learning and Growth</td>
<td>76</td>
<td>76</td>
</tr>
<tr>
<td>I am confident my ideas and suggestion are acted upon</td>
<td>Listened to and Acted Upon</td>
<td>77</td>
<td>78</td>
</tr>
<tr>
<td>I feel involved in decisions relating to my job</td>
<td>Empowered to influence</td>
<td>78</td>
<td>77</td>
</tr>
<tr>
<td>I get the help and support I need from other teams and services within the organisation to do my job</td>
<td>Appropriate Behaviours and Supportive Relationships</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>I have confidence and trust in senior managers responsible for the wider organisation</td>
<td>Confidence and Trust in my management</td>
<td>73</td>
<td>73</td>
</tr>
<tr>
<td>I feel senior managers responsible for the wider organisation are sufficiently visible</td>
<td>Visible and Consistent Leadership</td>
<td>69</td>
<td>69</td>
</tr>
<tr>
<td>I am confident performance is managed well within my organisation</td>
<td>Performance Management</td>
<td>67</td>
<td>66</td>
</tr>
<tr>
<td>I feel involved in decisions relating to my organisation</td>
<td>Partnership Working</td>
<td>66</td>
<td>65</td>
</tr>
</tbody>
</table>
NHSScotland Staff Experience and Continuous Improvement Model: Research Into Implementation

Professor Colin Lindsay
Dr Robert Stewart
Professor Patricia Findlay
Professor Roma Maguire
Professor Dora Scholarios
Johanna McQuarrie
University of Strathclyde
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Executive Summary

Introduction and Aims

This research review of the implementation of iMatter was commissioned by The Scottish Government Directorate for Health Workforce, Leadership and Service Reform in conjunction with the Health and Social Care Analysis Division. The aim of the research was to provide evidence to support and inform ongoing work to ensure that there is a meaningful, effective and cost-effective approach to staff engagement in health and social care.

Staff experience and engagement have been central themes of policies developed by the Scottish Government in recent years to modernise NHSScotland and the wider public sector. Supporting engagement is a priority for NHSScotland and Health and Social Care Partnerships (H & SCPs), as a route to improving the experience of employees (for example, in relation to motivation, commitment and empowerment), contributing to organisational goals and delivering positive health and care outcomes for patients and service users.

iMatter has been developed since 2013 under the remit of the existing NHSScotland Scottish Workforce and Staff Governance (SWAG) Committee as a means of more effectively measuring the experience of staff working in health and social care. The further roll-out of iMatter to most H & SCPs in Scotland means that it is now also able to capture the experiences of local authority-employed social care and social work staff. iMatter has been designed to map onto and reflect NHS Staff Governance Standards. As we report below, iMatter is an effective means of capturing staff experience and engagement in line with these standards.

Key operational features of the iMatter model

- **iMatter is administered online or on paper**
- **Grouped into 4 factors mapped against NHSScotland Staff Governance Standards**
- **Teams develop and submit an Action Plan within a 12 week period**
- **Confidential** with protective controls to restrict access to data.
- **Anonymous** and does not collect demographic information.
- Data is **Managed** by an external independent Web service provider.
- **4 key performance indicators are used to evaluate iMatter**
  - Response rate
  - EEI Report
  - The level of No Report
  - Action Plan Rate
Our research also captured views of the NHSScotland Dignity at Work (D@W) Survey that was run in 2017. D@W was designed to bridge the gaps between the items in iMatter and the previous NHSScotland National Staff Survey by reporting experiences around bullying and harassment, as well as views on experiences of violence, whistleblowing and staff resourcing.

The research reported in this document sought to:

- consider validation and response rate issues associated with iMatter and D@W;
- review the presentation and utility of iMatter report data;
- gather and analyse evidence on the of acceptability of iMatter and D@W;
- gather and analyse evidence on facilitators of the implementation of iMatter and areas of best practice; and
- identify ongoing challenges and areas where more work is needed.

**Methods**

We used multiple methods of data collection at national and local levels, including analysis of the current literature on staff engagement and the relevant documentation covering the development, operation and output of iMatter; semi-structured interviews with 29 representatives of national and local stakeholders, with the latter drawn from 6 Boards (Geographic and National), selected by size and their iMatter experience in 2017; gathering the views of Health Board Chief Executives and senior Scottish Government personnel; and 12 focus groups/interview sessions with managers and staff across the 6 Boards. All data were analysed thematically according to the research objectives above.

**iMatter and Dignity at Work Validation and Response Rates**

iMatter has benefited from a robust validation process. The content of iMatter and the Employee Engagement Index (EEI) emerged from a process of co-production with staff rather than seeking to duplicate already validated engagement tools. The themes captured by the iMatter tool connect closely with measures and antecedents of engagement reported in the international research literature.

NHSScotland’s most recent D@W Survey’s nine item measures ask for binary responses (yes/no) and three Likert scale questions on issues related to bullying/harassment, experiences of abuse and violence, unfair discrimination, whistleblowing and job demands. Each of these has been conceptualised in the research literature as consisting of a number of underlying dimensions, suggesting that there is a risk that the D@W tool may not be suited to capturing the complexity of dignity at work challenges (especially given its reliance on binary responses for most survey questions). The D@W Survey was not independently validated.

A review of Annual Reports found that iMatter generated a relatively very high level of response in 2017 (63%) and in 2018 (59%). Although there was a small but significant decline in response over 2017-2018, the response still compares very favourably with most employee surveys where the response is typically between 30-40%.

While a national response rate of 59% is satisfactory, a number of Boards fell below the 60% response rate threshold and did not receive a full EEI Report. The slight increase in teams and Boards receiving ‘No Report’ is a matter of concern.

By comparison, D@W achieves a significantly lower response rate (36% in 2017), similar to the levels of response for the National Staff Survey in 2015 (38%) and 2014 (35%). Like iMatter, D@W response rates were significantly higher in the National Boards.
Action Plans are critical for the longer-term sustainability of iMatter as a continuous improvement model. In contrast to the response rate, there was a statistically significant improvement in teams completing Action Plans: from less than half in 2017 (43%) to nearly three-fifths in 2018 (56%). This represents a significant achievement by Boards: 77% increased their Action Plan rate with the largest shifts mainly occurring in geographical Boards.

Acceptability of iMatter: the views of staff and managers

iMatter was viewed overwhelmingly as an acceptable model of staff engagement by our national and local interviewees. There is a comprehensive recognition of, and commitment to, the principles of the iMatter model across all national and local stakeholder groups. The overwhelming majority of the respondents spoke very positively about the merits of the iMatter approach. The strengths identified as being associated with iMatter included:

- support for the team-based approach and data on staff working relationships;
- support for iMatter as a validated and credible measure of staff experience;
- the link from iMatter to recognised NHSScotland Staff Governance Standards;
- iMatter provides localised feedback that allows an Action Plan to be developed by teams and where progress can be reviewed, leading to better staff experience;
- iMatter is action-focused, goes beyond a ‘simple’ staff survey and is a tool with the potential to support team ownership, empowerment and problem-solving;
- iMatter generates significantly higher levels of staff response and data more representative of staff views;
- iMatter data can be used alongside other management tools and approaches; and
- benefits associated with the transferability of iMatter to settings outwith NHSScotland (e.g. to H & SCPs and Council staff, and to other public sector workforces in Scotland).

**Recommendation 1:** There was near unanimous support among staff, managers and stakeholders, including trade union and non-executive Board representatives, that iMatter is an effective model for capturing staff experience and promoting staff engagement. It is important that the iMatter approach is supported and resourced to build upon its successes to date. This should include continuing support to ensure access to information, coaching, training and learning for managers and staff involved in iMatter.

There was widespread acknowledgement of the key role played by Op Leads in “making things happen” where iMatter was performing well. Op Leads play a key role in raising awareness, keeping managers and teams informed of timescales and deadlines, delivering training, and offering encouragement, advice, coaching and support to staff and managers.

Research participants thought that the issues addressed by iMatter were valid and reflected many of the opportunities and challenges faced by NHS and H & SCP staff. Some isolated issues were raised regarding the wording of particular iMatter subject areas – e.g. a perceived degree of confusion related to an iMatter Tool statement centring on the visibility of senior managers (“I feel senior managers responsible for the wider organisation are sufficiently visible”) and on decision-making (“I feel involved in decisions relating to my organisation”).

**Recommendation 2:** There would be value in some re-consideration of the two statements that appear to promote relatively greater confusion among respondents. Assessing managerial visibility needs to be anchored both to clearer definition of who comprises ‘senior managers’ and to staff desires for visibility. There is also merit in anchoring the decision involvement question either specifically to Partnership working arrangements or to a specified level of organisational decision making.
The key benefits of iMatter are represented below.

**Use and Impact of iMatter by Teams and Leaders**

Most staff thought that Action Planning had been useful and were able to recount a range of actions undertaken by their teams, including: more proactive leadership and communication around CPD; raising training and development priorities and asking that managers seek additional training resources; action to schedule more time for developmental one-to-one conversations between staff and managers; creating clearer feedback opportunities between staff and managers; creating processes to support peer-to-peer feedback; and putting plans in place to improve the quality of supervision. The broader benefit of bringing together teams with a sense of purpose to spend ‘quality time’ was a recurring theme.

There was an acknowledgement among both managers and Op Leads that continuous training, coaching and sharing of good practice was required to maintain positive momentum around the Action Planning process. Our research provided the first opportunity for some managers to share insights about the process and content of Action Planning, an opportunity that they valued.

Our interviews and focus groups highlighted a number of challenges associated with effective team-based Action Planning, including substantial changes to team membership as a result of staff turnover or organisational change, and time and workload constraints.

There was generally a positive view of the online material available, and especially the growing Action Plan and ‘team stories’ resources, which provide excellent examples of the positive impacts delivered by iMatter. There was consensus on the need to continue to invest in dynamic, interactive and accessible online resources in order to share good practice.
Recommendation 3: There would be value in considering how best to build upon online resources and opportunities for face-to-face learning across teams on the Action Planning process and examples of good practice.

The need for a response rate threshold for reporting was accepted by all of our Board and most national staff-side respondents. Op Lead respondents were also particularly supportive of the need for current 60% threshold, as an effective aspiration that encourages high response rates. Nevertheless, some participants felt that the perceived imposition of this threshold from the top-down conflicted with the broader message that iMatter should be owned by teams.

Recommendation 4: We recommend continuing the 60% threshold for iMatter reporting. However, we urge consistency in messaging to staff, so that their ownership of the iMatter process is reinforced. A shift in language among iMatter stakeholders – away from the negative connotations of receiving “No Report” – may also be helpful. Language differentiating a standard “iMatter Report” from an “iMatter Max Report” (provided when the 60% threshold is achieved) might be more helpful.

Our interviews with managers and Op Leads suggested that there would be benefit in investing in further iMatter reporting functionality to provide a ‘Dashboard’ of key indicators and statistically significant inter-relationships. There was support for further efforts to build upon ongoing work to develop such Dashboard functionality.

Recommendation 5: The iMatter national team should continue to work towards the development of an easy-to-read ‘Dashboard’ that presents top-line key indicators. Reporting should also employ statistical significance testing to indicate change and potentially (because of ‘big’ sample numbers) utilise the more robust analytical power of multivariate data analysis.

The Distinctiveness of the iMatter approach

In discussing the strengths of iMatter, comparisons were invariably made with the previous National Staff Survey and with D@W. In terms of the former, most of our Board respondents described the National Staff Survey as a resource-intensive exercise that suffered from relatively poor levels of response and produced limited feedback for staff. Similar concerns were raised in relation to the most recent D@W Survey.

More generally, there was limited support for the D@W process, as it currently operates. It was argued that the focus should be on action on dignity at work – that resources should be targeted on ensuring that staff and managers have the information and processes that they need to deal with issues, and that training and CPD should embed a culture of dignity at work. Our review of the most recent D@W Survey also noted that its design (e.g. relying mainly on a binary question format) did not reflect best practice as identified by the research literature.

Recommendation 6: In its current form, D@W neither offers robust measures, nor appears to engage respondents in the process or in actions arising. It is difficult to see a strong analytical argument for, or widespread stakeholder interest in, continuing D@W in its current form. However, given the importance of the broader issue of dignity at work, there may be merit in adopting a similar co-created process as with the development of iMatter, with a view to identifying key issues, themes and robust questions; agreeing an appropriate vehicle and unit of analysis outside of iMatter for these questions (for example, through Pulse surveys); and developing action-oriented outcomes so that staff feel safe to speak up, and are confident that they will be listened to and their concerns acted upon.
IT Acceptability: User Interface

Our expert-led review of the usability of the iMatter online tool concluded that the design was clear and concise. Respondents are immediately aware of the purpose of the measure, the expected completion time, that questions are mandatory (except for optional questions on respondents’ staff groupings) and what will happen after completion. These design features are consistent with good practice in online surveys. The online tool may have limits around accessibility for people with sensory impairments or dyslexia. The tool’s accessibility needs to be reviewed regularly to ensure compliance with best practice. All staff and managers participating in our research were positive about the usability and ‘look and feel’ of the iMatter online tool.

Recommendation 7: There is a need for iMatter partners to continue to build on what is an effective online tool, for example by ensuring accessibility for all relevant groups and considering any possible upgrades based on feedback from staff.

Implementation Facilitators and Best Practice

There are a range of key facilitators associated with the effective implementation of iMatter, including: securing the visible leadership and buy-in of senior managers; senior management’s leadership of the dissemination of practical information about iMatter; support for the crucial work of Op Leads in delivering information, support and training; effective IT systems and electronic communications; and ensuring sufficient information and support was available during team confirmation and Action Planning processes.

There are also a range of best practice activities that have been important where iMatter has worked well: the importance of providing ongoing guidance on the iMatter process to line managers; the value of intensive communication and feedback during the data gathering and Action Planning periods; the use of social media to raise awareness; maximising staff access to IT to support higher response rates; and supporting staff and management choices on the formation of teams that are appropriate but maintain confidentiality in iMatter reporting.

Recommendation 8: iMatter stakeholders should work together to ensure that there are opportunities to share examples of good practice and facilitators of success in the delivery of iMatter across teams, H & SCPs and Boards.

Ongoing Challenges

Our research finally identified a range of ongoing challenges and areas for further action for iMatter. These included:

- crucially, the need to continue to encourage senior and line manager buy-in and leadership of the iMatter process – it was suggested that where iMatter has struggled to gain traction, this is often a symptom of senior leadership team members failing to take full ownership and provide visible and committed leadership;
- the need to continue to increase the number and quality of Action Plans;
- the need to address staffing pressures that limit the time and opportunity for staff to engage with iMatter, Action Planning and continuous reflection on staff experience;
- the need for continued work to support the establishment of iMatter teams that allow for effective Action Planning between line managers and staff;
- ensuring that staff and management changes are identified quickly and effectively;
- ensuring that managers have access to information, coaching and training in both the basics of the iMatter process and Action Planning.
**Recommendation 9:** It is essential that senior managers and leadership team members at all levels within participating H & SCPs and Boards take ownership of, and provide visible and committed leadership for, iMatter. Where this has not been the case, substantial challenges have arisen in embedding iMatter. It is crucial that embedding and supporting iMatter is seen as a key task and not an optional extra by senior management/leadership team members.

In terms of technology-related challenges, it was noted that where IT systems were slow or crashed, this caused additional work for managers and frustration. It was suggested that these problems are often rooted in NHSScotland legacy systems and limited server capacity.

**Recommendation 10:** There may be benefit in further investment in server hosting facilities that would improve server capacity, memory and speed. Investing in improved, Cloud-based server capacity would allow access to additional flexible capacity as and when required, as well as mitigating any risks to data storage.

There was strong support for further investment in IT integration work that would relieve some of the administrative burden associated with team confirmation and updating data. This would free up time to provide more support, training and coaching. The establishment of a ‘single sign-on’ linking iMatter and Turas and the integration of iMatter with eESS were identified as immediate priorities.

**Recommendation 11:** There is a need to take immediate steps to support IT integration (for example, linking iMatter with Turas and eESS systems) that has the potential to free up time for Op Leads, managers and others, so that energies can be focused on Action Planning and delivering continuous improvement.

A number of Board interviewees, staff and managers raised the potential benefit of an App-based version of iMatter. An iMatter App has the potential to deliver substantial benefits in terms of improved response rates and consistent access to information (and report data) for staff at all levels. Elsewhere, a recent test of change of an SMS version of iMatter produced generally positive results – building on this experience may also help to improve response rates and the reach of iMatter. Paper copies of iMatter have been costly to produce and have delivered significantly lower response rates. Further investment in App and SMS versions may prove to be a more cost-effective approach to improving the reach of, and response rates associated with, iMatter.

**Recommendation 12:** Progress should be made on the more extensive piloting of SMS and smartphone-friendly versions of the iMatter tool. Support should be provided for the development of an App-based version.

**Conclusions**

The key finding of this evaluation is that iMatter has proved effective and has made substantial progress in achieving the original goals of the model. It is important that investment and support for the iMatter process is maintained and strengthened so that the progress made on staff engagement is built upon and consolidated.

An additional key finding of this research is that staff and managers across a range of teams, H & SCPs and Boards find the current iMatter model and content to be relevant and useful in exploring staff experience, engagement and continuous improvement. There was also broad support for iMatter from trade union respondents and non-
executive Board members. There is a comprehensive recognition of, and commitment
to, the principles of the iMatter model across all national and local stakeholder groups.
For NHSScotland, it represents an effective means of capturing staff experience and
engagement in line with established Staff Governance Standards.

A number of further conclusions are clear from our research.

- iMatter benefits from being rooted in a process of co-production with staff and
  managers, so that its measures and processes are meaningful in context.
- While response rates vary, they compare positively with the preceding National Staff
  Survey and many other engagement exercises, and generally demonstrate a high level
  of acceptance of and engagement with the iMatter process. This was confirmed by our
discussions with staff and managers at various levels and across a range of Boards
and H & SCPs. There is consensus that the iMatter process is of value. This seems to
be due to the locally-relevant, team-based and action-focused approach of iMatter.
- iMatter is therefore an effective model for capturing staff experience and promoting
  staff engagement. It is important that it continues to be supported and developed.
- The visible leadership and encouragement of senior management teams for iMatter
  has been an important facilitator of success and should be strongly encouraged in all
  H & SCPs and Boards.
- The work of Op Leads/BAs and their teams was valued by managers implementing
  iMatter – they play a key role in informing and supporting both the iMatter process and
  Action Planning in response. It is important that this work continues to be resourced
  and further supported.
- While the content of iMatter appears to be appropriate and of value for staff and
  managers in reflecting on staff experience, there should be a continuing process of co-
  production and reflection on the content of the tool and how outputs are reported.
- There is strong support for the iMatter Action Planning process as a means of framing
  team-based actions. There is also awareness of challenges associated with limited
  time and resources and the need to maintain momentum on agreed actions. It is
  important that staff have time and resources for Action Planning and reflection. In the
  more immediate term, The work of Op Leads – or additional or alternative forms of
  support as appropriate – should be resourced to continue to assist teams to engage in
  Action Planning and continuous improvement.
- Resources are required to enhance opportunities to share good practice in Action
  Planning and outcomes across teams. This may involve further investment in a
  growing body of useful online materials, and/or creating opportunities for staff and
  managers to share practice in person.
- The design of the iMatter online tool works effectively for staff and is in line with good
  practice. There is an urgent need to explore technology-based solutions to maximise
  the reach of iMatter – this should involve investment in an App and/or the further roll-
  out of SMS versions.
- There is strong support for further investment in IT systems that streamline and
  integrate iMatter with other systems such as Turas and eESS. Such IT integration
  offers important opportunities to reduce the administrative demands of iMatter on
  managers and Op Leads/BAs, freeing them to concentrate on staff engagement work.
  Investment in such IT integration is both justified and urgently required.
- In conclusion, there is strong support for iMatter among staff, managers and other
  stakeholders, including trade union respondents and non-executive board members.
  iMatter has successfully rolled out a highly effective tool for capturing and reporting
  staff experience, and (crucially) informing actions on continuous improvement. It is
  important that the good practice associated with iMatter is shared and celebrated, and
  that there is renewed investment to build on this successful model, and tackle some of
  the continuing challenges identified in this report.
Part One: Introduction and Context

This research review of the implementation of iMatter was commissioned by The Scottish Government Directorate for Health Workforce, Leadership and Service Reform in conjunction with the Health and Social Care Analysis Division. Its key aim is to provide insight to maximise the current and future development and implementation of the iMatter model that measures staff experience and continuous improvement in the Health and Social Care (HSC) sector in Scotland. Although there is no consensus on the precise definition of staff engagement, it is accepted that this broadly concerns a chimera of workplace cultures, processes, policies and practices that seek to maximise the conditions for improving the experience of employees (e.g. in motivation, commitment, empowerment), the organisation (e.g. in productivity and performance) and delivering positive health and care outcomes for service users. It is within this broad framework that iMatter has emerged as the main NHSScotland standard measure for benchmarking staff experience.

Below we outline briefly the policy background to the development of iMatter in the context of NHSScotland, its links to wider debates on staff engagement, the main features of the iMatter model and a set of specific research objectives.

Staff Experience and Engagement in NHSScotland

Staff experience and engagement have been central themes of policies developed by the Scottish Government in recent years to modernise NHSScotland and the wider public sector. NHSScotland’s 2020 Workforce Vision for HSC commits to valuing and empowering everyone who works for NHSScotland and supporting them to work to the best of their ability (NHSScotland 2013). Supporting employee engagement has been a key theme in staff experience strategies for NHSScotland, reflecting an evidence base that engagement levels are linked to enhanced organisational performance (which in the context of NHSScotland connects to potential gains in health and care outcomes for service users/patients). Accordingly, a related NHSScotland Quality Outcome seeks that “staff throughout NHSScotland… feel supported and engaged, enabling them to provide high quality care to all patients and to improve and innovate” (NHSScotland 2013). NHSScotland’s Employee Engagement Index (now integrated within iMatter) has been specifically designed to provide evidence on the drivers and experiences of engagement, and draws on the range of current core Staff Governance Standards and Health Care Quality standards, as well as the evidence base highlighted by the UK Government-commissioned Engaging for Success report (McLeod and Clarke 2009). Employee engagement matters for organisational outcomes and is central to the success of efforts to drive change in public services (CIPD 2012). Defining and measuring staff engagement remain contested, however, and there remains a need to evaluate critically the evidence on potential drivers, outcomes and approaches to measuring employee engagement (Guest 2014).

Strong staff engagement mechanisms are also integral to the delivery of the Scottish Government’s current 2016 Health and Social Care Delivery Plan (HSCDP), which seeks to deliver better services with improved health outcomes for patients and better value within the emerging landscape of integrated HSC models. Scottish Government and NHSScotland’s shared aims in pursuing HSC integration include to produce better outcomes for people and support more responsive community services tailored to people’s needs. An additional and supporting outcome prioritised by the Scottish Government’s HSCDP is that “people who work in health and social care services feel engaged with the work they do and are supported to

1 These act as guidance to ensure that NHS staff are: well informed; treated fairly and consistently with dignity and respect in an environment where diversity is valued; are appropriately trained and developed; and, are involved in decisions.
continuously improve the information, support, care and treatment they provide”. Measures to ensure that NHS staff feel supported and engaged are key to HSC integration, and it is important that NHSScotland has a robust evidence base on the drivers and factors shaping staff engagement and continuous improvement.

Staff engagement is also central to the Scottish Government’s responsibility to monitor NHS Staff Governance Standards and iMatter provides a means of monitoring the governance framework, and assessing whether Boards are creating healthy organisational cultures. Improved staff experience and engagement is consistent with improved NHS patient/client care outcomes and is an integral part of Partnership working in NHSScotland. Staff engagement practices represent one important element of employee voice (a core element of Scotland’s Fair Work Framework), with the potential to support innovation and change at every level from immediate teams to Health Boards and the wider NHS, by harnessing views, opinions and behaviours that contribute to continuous improvements in practice. Engagement can also enhance staff perceptions of how they are valued, with implications for employee well-being. Consequently, this research will connect with, and reflect key priorities associated with, the wider public policy context on workplace issues, for example engaging with:

- the Fair Work Framework (2016), which sets out in detail the ambitious aspirations of Scotland to be the best Fair Work nation in the world by 2025 and what fair work means in and for Scotland. The Framework points to the important role of the public sector in supporting the delivery of fair work, and there is significant potential for any lessons learned from NHSScotland in relation to fair work (and specifically employee involvement, development, engagement and dignity at work) to prove highly influential in the wider development of fair work in Scotland;
- the pursuit of inclusive growth, at the heart of Scotland’s Economic Strategy since 2015, that focuses on combining increased prosperity with greater equality, opportunity and fairness. Fair work, as discussed above, lies at the heart of inclusive growth, with NHSScotland well placed to make a substantial contribution to this agenda;
- the importance of staff experience and engagement in line with Staff Governance Standards established since the National Health Service Reform (Scotland) Act, 2004; and
- Scotland’s broader public service reform and the workplace innovation agenda which, following the Christie Report (2011), has focused on four main areas to drive public service improvement and reform by supporting: a decisive shift towards prevention; greater integration at local level driven by better partnership; a clear focus on performance; and (crucially for the purposes of this study) workforce development.

The iMatter Model: Key Features

iMatter has been developed since 2013 under the remit of the existing NHSScotland Scottish Workforce and Staff Governance (SWAG) Committee as a means of more effectively measuring the experience of staff working in HSC. From 2002-2017 staff engagement was mainly measured by the National Staff Survey which generated both national and local Board level data. The National Staff Survey generated a relatively large volume of survey returns, and highlighted staff views on a range of issues, including data on sensitive areas such as whistleblowing, bullying and harassment, and the abuse of NHS staff by patients/service users. However, the National Staff Survey had a number of limitations. It was perceived by some as outdated, costly, based on a top-down approach to measuring staff experience, having typically poor response rates (between 28-35%) which raised questions about how ‘representative’ the data was of the wider population of NHS staff, and having a limited

2 Through existing NHS Scotland Partnership fora structures (i.e. SPF – the Scottish Partnership Forum and SWAG - the Scottish Workforce and Governance committee).
analytical and practical purchase in the sense that data were never provided below Directorate-level (and therefore offered no insights at team-level). Crucially, relying wholly on a single-point National Staff Survey had a very narrow utility for local and national NHS bodies between reporting cycles to act constructively on the survey outputs by delivering changed practice.

Concerns such as these have underpinned the development of iMatter and the pausing of the National Staff Survey in NHSScotland in 2016 (with the smaller-scale National Staff Survey derived D@W Survey operational alongside iMatter in 2017). Unlike these surveys, iMatter was co-produced with NHS staff (i.e. bottom-up), externally independently validated against NHS Staff Governance Standards and explicitly developed to address some of the analytical weaknesses of national surveys by being based on a team-model with a follow-up Action Plan component. Consequently, iMatter attempts to widen and deepen the measurement of staff experience by incorporating staff feedback into an Action Plan and using this as a mechanism to generate improvement/change. It is this multi-functional feature of iMatter that marks it out as a potentially significant tool for staff empowerment.

iMatter is still at a relatively early stage in its development and implementation in NHSScotland. It has been phased in operationally since 2015 across NHS Boards and more recently adopted in most of the integrated H & SCPs across Scotland. Since 2019, questions that will allow analysis of responses by staff grouping have been included. The key operational features of the model represented below.

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3 Currently, 23 of 31 H&SCP is in Scotland opted to participate in iMatter in 2018, with 12 of these also offering the tool to their Council-employed social care staff, helping to support the evolving integration agenda.
The introduction of iMatter as a new approach to continuous improvement has not been without challenges, as illustrated by the parallel streaming of the D@W Survey in 2017. D@W was designed to bridge the gaps between the items in iMatter and the previous National Staff Survey. The new online system (used to run both iMatter and D@W) also allows for further tailored ‘Pulse’ surveys to ask staff about other local and national issues (e.g. organisational change); it is anticipated that a suite of these will be developed and validated over the next few years. The results of the HSC Report for iMatter in 2017 showed the relative success of the model for benchmarking continuous improvement locally while still providing a national picture of staff experience across Scotland. Board level results have allowed SG and SWAG to assess levels of engagement and staff perceptions of progress in relation to the Staff Governance Standards.

Research Aims and Objectives

If iMatter is to be the preferred model of measuring staff experience, further evidence is needed of how it is being used and what is helping or hindering it being embedded as business-as-usual. Assurance is needed that staff in different roles, grades and places accept, understand and value their own participation in iMatter; feel empowered and are confident that the team and manager act on its findings; and that leaders in the wider organisation are using it to support transformational change. Consequently, the overarching aim of the research is to provide evidence to support and inform ongoing work by SWAG and others to ensure that there is a modern and meaningful approach for effective staff engagement at the core of continuous improvement and that this maximises improvements in staff experience and the cost-effectiveness of measuring employee engagement. More specifically, the research sought to:

- consider validation and response rate issues associated iMatter and D@W;
- review the presentation and utility of iMatter report data;
- gather and analyse evidence on the of acceptability of iMatter and D@W;
- gather and analyse evidence on facilitators of the implementation of iMatter and areas of best practice; and
- identify ongoing challenges and areas where more work is needed.

There a number of core questions connected to the evaluation. These were:

- how iMatter has been implemented across the NHSScotland and H & SCPs (has this been as intended; what factors have facilitated or challenged progress, including the model, IT infrastructure and extent of buy-in at all levels?);
- staff acceptance and views of iMatter, including whether there are differences between the health and social care sectors, and between roles, grades and locations, and the reasons for any variation;
- how teams are using the iMatter continuous improvement model to support their ongoing journey and what difference it has made to working at team, Directorate and organisational levels;
- if there are any features of the current model and process that should be changed or improved;
- how best practice in using iMatter continuous improvement model is being shared;
- how leaders are using iMatter to support improved staff experience;
- how managers are using the iMatter model linked to their own continuous personal development;
- how appropriate is the current approach to measuring employee engagement within iMatter;
whether the approach provides a sufficient measurement of the employee voice in assessing the implementation of the staff governance standard;
the approach to measuring staff experience of dignity at work issues;
how staff engagement encourages participation and delivers meaningful results on dignity at work issues; and
how ‘Pulse’ surveys could be used in the future.

Methods

The research used multiple methods of data collection. The range of information and sources provided system-wide and in-depth coverage of iMatter at national and local levels across stakeholders in HSC. Our sample selection was designed to reflect key variations that can illustrate how staff were engaged in different contexts by including NHS Health Boards that varied in terms of their relative employee size and whether they served populations based in urban, urban/rural and mainly rural areas (including islands). Our method ensured coverage across national NHSScotland Partnership structures by including the views of representatives of Scottish Government, employers and staff-side organisations.

Literature and Documentation: We collated a range of literature on the development, implementation and outputs of the iMatter model (including national and local iMatter reports in 2017 and 2018). This allowed us to map the development of iMatter, the main features of the model and analyse a range of key statistical information and outputs. We conducted desk-based, expert reviews of the development and validation of iMatter and the online tool used to capture most responses, and assessed in light of relevant contemporary research.

Semi-structured Interviews: These were mainly conducted by telephone (face-to-face when requested) with representatives of all the main NHSScotland partners at national and local levels, plus one H & SCP Chief Officer. We collated interview data from a number of sources: key Scottish Government representatives involved in iMatter and national staff-side representatives from the main trade unions; senior employer and staff-side representatives at the local level along with those Non-Executive Directors primarily responsible for staff governance on local NHSScotland Boards and the designated Operational Leads and Board Administrators (Op Leads/BAs) responsible for facilitating iMatter at the local level. We identified a purposive sample of six Boards (4 Geographic and 2 National) to provide a range of insights into iMatter practice and performance across Scotland. This included Boards of a similar size and geography that would provide points of contrast in their performance (based on their iMatter outputs) from the 2017 Annual Report. Boards 1 and 2 were based in large urban areas, and Boards 3 and 4 were based in geographically wide and dispersed rural

4 Including more informal interviews with the iMatter project team and Webropol.
5 Op Leads are dedicated staff roles with responsibilities for supporting managers to take ownership of iMatter including the administration of data and utilising iMatter as a team to improve staff experience and improved care. Op Leads are the main lead for implementation and governance; providing leadership; and updating their Board’s senior management team. Their tasks include building and maintaining the team structure in Boards, and the team confirmation tasks with managers. They also include education and awareness-raising about iMatter among staff and across Directorates, organising and delivering staff training events and the provision of ongoing training/guidance for managers, linking with Webropol over local IT system issues, collating and reporting on iMatter output data to managers, including reporting to Board Area/National Partnership Fora, and checking on Action Plans. In addition, they are required to link with the national iMatter SG Programme Lead and attend monthly national network meetings. Board Administrators support Op Leads in all of the above roles and functions. In Boards with H&SCPs there may also be Directorate Administrators who perform similar functions to Board Administrators.
settings. Boards 5 and 6 were operational National Boards. We use this numbering system in the text where relevant.

We also attended two meetings of the Op Leads national network group as observers. These provided an opportunity for the research team to understand better the operational issues involved in iMatter, to listen to the items that were being discussed and gain an understanding of the views of Op Leads on the common issues they faced across NHS Boards.

Individual interviews were carried out with 27 of the above NHSScotland partner representatives. In addition, we also conducted two additional interviews with representatives of Webropol, the IT provider responsible for administering iMatter. This provided an assessment of the electronic dimension of iMatter.

**Views of Chief Executives and senior Scottish Government staff:** We conducted a research exercise with all Health Board Chief Executives across Scotland and with senior key Scottish Government personnel. The aim was to gain a national system-wide senior view on iMatter. An e-mail was issued to 22 Board CEOs and 3 senior Scottish Government personnel asking for their views on iMatter in terms of its acceptability, implementation, impact and areas where further work was required. While the former were all asked for their response by e-mail reply/return, we offered to conduct individual interviews with two of the three SG senior personnel who were closest to the iMatter process. We received a total of 5 submissions from Board Chief Executives on these issues: 3 from Geographic and 2 from National Boards respectively. We conducted one telephone interview with a senior Scottish Government official familiar with the development of iMatter.

**Focus Groups with Staff:** In addition, in each of our six Boards (four Geographic and two National Boards), we also conducted two focus groups with staff: one group that included junior managers/team supervisors responsible for managing teams; and, one group that included staff who were part of teams that completed iMatter. These focus groups provided a diverse range of views across gender, age, management levels and staff grades based in a variety of locations and teams. Staff were recruited from one H & SCP area in each Geographic Board and the interviewees were recruited using the Op Leads to reflect iMatter experiences in a range of working HSC roles (i.e. staff working in Ancillary, Administrative, Clinical and Social Care roles). Where there were problems recruiting adequate numbers of participants, group numbers were supplemented by individual interviews with staff. Supplementary individual interviews were only required in two Boards in relation to four of the focus groups. Groups comprised between 4-10 participants. A total of 68 individuals attended focus groups and completed individual interviews.

All of the interviews and focus groups were digitally recorded (where consent was given), transcribed and analysed thematically according to our research aims. The findings are reported using this structure. All qualitative data sources were interrogated to deliver key findings. Notably, engaging with such a range of partner groups allowed for a more robust triangulation of data so that no one particular partner view dominated the analysis. The data as a whole allows us to provide a reliable and robust assessment of iMatter as a workplace approach that supports NHS Boards and H & SCPs to identify and progress their staff experience to ensure employee engagement, commitment, well-being and orientation to constructive change within NHSScotland.
A summary of our engagement with stakeholders is provided below.

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<th>Board/Interviewee Group</th>
<th>HR Director</th>
<th>Employee Director</th>
<th>Op-Lead</th>
<th>Non-Exec Board Member</th>
<th>Other experts (n)</th>
<th>Staff (n)</th>
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Part Two of this report outlines our findings in relation to the research objectives. Part Three offers concluding reflections on iMatter, addressing these research questions as well as offering recommendations for the future development of the iMatter model.
Part Two: Findings

We now present the main findings of the report, starting with an assessment of the validity of, and the validation process for, iMatter; followed by a discussion of the presentation and utility of iMatter report data; then our main fieldwork findings on views of the acceptability and benefits of the iMatter process; we then identify facilitators and examples of best practice; before finally discussing ongoing challenges.

iMatter and Dignity at Work Validation and Response Rates

This section evaluates the NHSScotland Bespoke Staff Experience Questionnaire and the Employee Engagement Index (EEI) (Snowden and MacArthur, 2013, 2014): developed through a rigorous piloting process of testing and assessment. The validation used data from Pilot 3 and demonstrated that iMatter “… is a robust, reliable, valid and popular measure…an excellent tool to measure improvement in staff engagement” (Snowden and MacArthur, 2013). The sample size used in the pilot means that iMatter is generalisable to all NHSScotland staff.

Boundaries of the Validation

iMatter is a reliable and valid subjective measure of staff engagement. Snowden and MacArthur (2013) examined the psychometric properties of the iMatter components and satisfactorily demonstrated the internal reliability of the questionnaire. The combination of a Rasch and factor analysis was used to confirm that the components reflected the four factors that underlie iMatter. The validity of iMatter and the EEI is founded on the robustness of the initial conceptual model and the process of co-production. iMatter can be used to represent the engagement of different subgroups in NHSScotland. Snowden and MacArthur (2013) comment that the scale is “theoretically grounded, developed by staff and modified through a process of consultation over a series of robust cycles” (pp.29-30). We consider these issues in more detail below.

The pilot study did not provide a confirmatory factor evaluation of any potential alternative underlying structures and the focus is on the quality of each individual item. The exploratory factor analysis results showed the effects of item placement (rather than latent factor structure). The pilot does not show the discriminant or convergent validity of the measure against other measures of positive psychological states (e.g. job satisfaction) or engagement; or any potential of the metric for the prediction of key outcomes (e.g. individual or team level task or extra-role performance). A comprehensive evaluation of the quality of this index, either as a more generalised measure of employee engagement, or as a way of identifying other factors which may enable or result from engagement, is beyond the scope of this review.

Conceptualising Employee Engagement under iMatter

iMatter represents Staff Governance Standards in their ‘simplest form to capture the essence of what staff experience means to its staff and the organisation.’ (National Staff Experience Project, 2013, p.8). The ‘MacLeod Enablers’ have also been analysed using more recent and extensive UK national datasets (e.g. Dromey, 2014). iMatter identifies change in staff experiences in relation to potential antecedents of engagement and the ‘enabler’ factors are consistent with those cited in conceptual models of engagement in the wider literature.

6 Based on 1,271 staff from 3 Boards: NHS Golden Jubilee, NHS Forth Valley and NHS Tayside.
7 For example, this would involve cross-validating with independent composite measures of staff engagement or measures of different facets (e.g., evaluating the items loading on to Factor 4 representing one’s team against an independent measure of team engagement).
For example, Bailey et al (2015) presented a systematic review of academic and practitioner outputs for the National Institute for Health Research (NIHR). They integrated a number of key studies aimed at identifying engagement factors useful for NHS practitioners. There was support for five factors driving high engagement: individual psychological states; experienced job-design related factors; perceived leadership and management; individual perceptions of organisational and team factors; and, organisational interventions or activities. While the iMatter questionnaire EEI is not a measure of individual psychological states, it does reflect how staff perceive the other four organisational factors which help enable engagement. Other NHS studies also confirm the importance of these same enablers; for example, leadership, trust in management, and well-functioning teams with clear objectives (Dawson et al 2011; Mauno et al 2007; West 2013; West and Dawson 2012; and West et al 2011). The EEI framework is consistent with current research on ‘enablers’ and important organisational and HR practices which are likely to shape individual employee engagement.

The validation is not necessarily intended to evaluate whether iMatter provides a measure of staff engagement consistent with other wider work in the field. The current literature is dominated by theory and models that treat engagement as a psychological activation, accompanied by positive affect or feeling, focused on one’s work role (Bailey et al 2017). The most common model is the ‘Utrecht Group’s’ notion of engagement as a psychological state of raised activation towards work tasks (Schaufeli et al 2002). The lack of psychological activation is not a concern for the theoretical grounding of the model nor its validity. There is still significant academic debate on the nature of employee engagement, including whether it represents another redundant concept in the same space as job satisfaction and organisational commitment (Bakker et al 2011; Christian et al 2011; Peccei, 2013). Instead, in iMatter, the explicit intention is to provide “a pragmatic tool for benchmarking engagement against other exemplar organisations” (National Staff Experience Project, 2013, p.16), and to provide value for managers and practitioners in evaluating workforce change. The intentional focus on enablers of engagement (e.g. leadership, engaging managers, employee voice) avoids debates on psychological conceptualisations and provides a tool with both practical utility (e.g. allowing disaggregation of results by teams) and staff support and buy-in.

In terms of the sufficiency of the EEI for capturing particular enablers, the index was not designed to represent a comprehensive measure of different dimensions. In the case of employee voice, for example, several items represent this component (e.g. 5 ‘Learning and Growth’, 6 ‘PDP/PDR’, 7 ‘Access to Time and Resources’, 15 ‘Consistent Application of Employment Policies and Procedures’ and 16 ‘Performance Management’). However, while it is not known whether these items taken together would represent an internally consistent, reliable measure of voice, the presence of these items in iMatter is critical. Evidence shows the positive effects of upward employee voice (e.g. through internal communication channels, or directly through a trade union) on employee engagement (Bryson, 2004; Holland et al, 2011). Holland et al’s (2017) study of Australian nurses showed that direct voice and supervisor support were positively associated with engagement.

Co-production of EEI

The development of iMatter and the EEI metric are co-produced and ‘bespoke’. This is significant for the validity of the model. Rather than consider its convergence by benchmarking against other well validated scales, the EEI was developed as a process of ensuring staff commitment to the process of conducting engagement surveys and acting on their findings. Bailey et al’s (2017) conclusion in their review of employee engagement studies is very significant:

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8 For example, the Utrecht Work Engagement Scale, or the 9-Item Intellectual, Social, Affective Engagement Scale (Soane et al 2012).
“Studies that apply and contextualize the more generic frameworks around employee engagement to particular organisational settings, including more multi-method, qualitative or ethnographic research that enables deep insights to be generated into the contextual aspects of engagement would be welcome. (p.39). There is much scope for further research that seeks to develop and extend current conceptualisations and theorisations of engagement through investigations that take greater account of the organisational and political contexts within which engagement is enacted and experienced” (p.163).

In other words, there is value in the use of the iMatter index as a tool in NHSScotland and in other settings if it has staff support, is viewed as action-oriented and is used in a way that acknowledges and is shaped by the context of staff engagement.

The EEI score is intended to provide a summary measure for comparative analysis. For any one team, the total score is calculated as the average of all individuals’ scores in that group. Given that the construction of the index was intended to follow the conceptual model (indicated above), it is not possible to consider separate scores for different underlying dimensions (e.g. the items representing employee voice). The index has not been validated for the underlying factor structure and while the items used may not be composite measures of each dimension, the validation study gives assurance of the value for the items treated as a whole as an indicator of staff engagement. The score is a shorthand, global indicator in teams, directorates, Boards and nationally, and should be interpreted as such for comparison.

Interpreting iMatter Response Rates

It is important to evaluate how generalisable and representative the achieved sample is of the target population, regardless of what tool is used. A response rate does not guarantee representativeness and there is no theoretical justification per se for 60% to be used as a benchmark in reporting, though there may be conceptual arguments to be deployed in its favour. The sought response rate in itself is not critical except in so far as this provides an incentive for higher numbers and a reporting rationale for team-level improvements by capturing most team members. For example, in random sample representative designs a response rate of 20% may be acceptable and provided the relevant ‘representative’ population dimensions are known, the data can be weighted. In contrast, ‘whole-population’ samples (like iMatter and D@W) require higher levels of response for generalisability. This is accentuated in NHSScotland because of workforce size, variation and expansion into an integrated HSC multi-employer landscape. The metric output is needed to detect change (large and small) over time in components and as the basis for devising Action Plans. To be more confident in the output, a strong team response is required. The higher the response the more likely it is to achieve an appropriately generalisable sample with a recognisable practical improvement output. For gauging engagement within small teams, a census (i.e. 100%) approach is essential to protect confidentiality.

9 Calculated as the proportion of the actual summed score on the 28 items (individually scored from 1-6) for each individual in relation the maximum possible score on the index (168): a global team engagement indicator.

10 Analysis of non-response bias should ensure that the responses are evenly spread among the entire population being captured. All teams (or other relevant groupings) should be responding at the same rate. Up until 2019, no representative type data are collected from respondents or used in iMatter reporting.

11 Where we would calculate the required sample size to ensure a robust level of statistical confidence and the degree of sampling error/accuracy.
D@W Survey

Dignity at work is a holistic concept which has been used, variously, to refer to the presence of good quality or decent work, fair pay, fair treatment or respect, autonomy and control at work, the absence of bullying or harassment, and employee voice (Anker et al 2003; Bolton 2007; Sayer 2007). A number of different questionnaires have been developed to measure these concepts: for example, the Decent Work Questionnaire, based on the ILO’s Decent Work agenda (Ferraro et al 2018); the Decent Work Scale (Duffy et al 2017), and the Quality of Working Life Systemic Inventory (Martel and Dupuis 2006). Others, such as the Workplace Employment Relations Survey (Van Wanrooy et al 2013) measure related concepts, such as participation and involvement, management relations, job control, and influence. Perceived fairness is embodied in the wider concept of organisational justice (Rupp et al 2017).

NHSScotland’s D@W Survey – which ran alongside iMatter in 2017 – addressed issues related to bullying/harassment, experiences of abuse and violence, discrimination and job demands. Each of these has been conceptualised in the wider literature as consisting of a number of underlying dimensions. The survey is neither a robust measure of these concepts, nor of the wider concept of ‘dignity’. Most of the items ask for binary responses (yes/no), although three items provide scope for variance using a Likert scale. None of the item measures have been validated in terms of any of the criteria discussed above that underpin iMatter. The 2017 D@W Survey retained some existing questions from the National Staff Survey, in an attempt to provide comparative data.

iMatter: Report Data

As part of our evaluation, we reviewed report outputs from the iMatter process. There are two iMatter Annual Reports (HSC Staff Experience Report 2017 and 2018). The 2017 report also provides data on D@W and where possible we compare these surveys on their KPIs. The reporting covers all HSC staff and the components are clearly mapped against three related staff experience frameworks. There is variation in KPIs across Boards (and change over 2017-2018). In addition, the 2018 report included softer qualitative exemplars (i.e. stories) of how different teams have been using iMatter. These give an insight into the efficacy of the model for stimulating continuous improvement.

In terms of the statistical KPI output from iMatter and D@W there are a number of identifiable trends evident in the KPI data in 2017 and 2018, outlined below.\(^\text{12}\)

- iMatter generated a relatively very high level of response in 2017 (63%) and in 2018 (59%). Although there was a small but significant decline in response over 2017-2018, this still compares very favourably with most employee surveys where the response is typically between 30-40%. Nevertheless, no national EEI was given for HSC in 2018.

- Responses in 2017 and 2018 are significantly higher in National Boards and reflect the relatively greater complexity of accessing staff in Geographic Boards (e.g. greater numbers of staff and multi-site spread). A similar picture is also evident in D@W in 2015 and 2017. In our interviews with local Board stakeholders there was a very strong

\(^{12}\) The figures span a period when many Boards have switched from staged or phased cohort data collection to single cohort (i.e. a full Board iMatter run). Also, Boards are not all at the same stage of development and many may still be in the process of optimising their team structures and models to ensure that iMatter teams reflect both line management arrangements and that staff identity with their team. Since iMatter is resourced by Boards, external budgetary constraints and internal processes of organisational change and its impact on structures, services and the staff composition of teams may all adversely impact on iMatter performance KPIs.
and consistent view that iMatter response rates (and completing Action Plans), were typically highest amongst staff in more senior roles (i.e. Corporate Services) and where workforces are large and ‘captive’ (i.e. primary care settings). They were likely to be weaker in more geographically-dispersed sections of the workforce, and those likely to be more ‘disconnected’ from the organisation (either in terms of their ‘identification’, their roles in specific operational settings, in solo or two-worker units, or in part-time roles) with less access to IT at work.

- While a national response rate of 59% is satisfactory it presents a utility issue for formal EEI reporting triggered by the 60% threshold for 40% of Boards (14% in 2017). No Board dropped below 51% (so that the majority responded, which compares favourably with many other staff surveys) and the ‘No Reports’ in nine Boards were mainly in mixed urban-rural and largely rural areas. Overall, only five Boards (4 non-Geographic) increased their response 2017-2018, two had no change, and while the rate declined in 68% of Boards, in only a third of these was this at 5% or more.

- By comparison, D@W achieves a significantly weaker response rate (36% in 2017), similar to the levels of response for the National Staff Survey in 2015 (38%) and 2014 (35%). Like iMatter, D@W response rates were significantly higher in the National Boards. More staff responded to iMatter irrespective of whether the distribution mechanism was electronic or paper. In general, electronic distribution was significantly higher than paper for both tools and at both time points. Board 1 and 2 respondents were also very clear that iMatter was relatively more successful in attracting a response among hard-to-reach manual NHS staff groups than either National Staff Survey or D@W (between 40-55% compared to around 15%).

- There is a range of factors behind a fall in the response rate for iMatter in 2018, although we can probably rule out timetable issues and problems incorporating H & SCPs. It may be more useful to look at external (i.e. budgetary constraints) and structural factors such as the change to single cohorts in 2018, the differential efficacy of the distribution mechanisms and possibly IT issues, as explanations for the drop in response.

- Consistent with the drop in the national response rate, the levels of ‘No Reports’ in teams increased from 33% in 2017 to 38% in 2018. Although there was no correlation between the number of teams in each Board and the levels of ‘No Report’, some of our staff respondents suggested that staff in ‘small’ teams, or those in which staff identify less with their team, or where managers are seen as less open to feedback, might be less likely to respond. For example, one staff member participating in our focus groups said that while they personally found team Action Planning within a small group useful, some colleagues appeared to feel that it offered little more insight than could be gleaned from one-to-one meetings with line managers. Elsewhere, however, a manager in one of our Geographic Boards noted that issues had been raised in small group Action Planning discussions that were not voiced in one-to-one meetings with staff.

- In terms of the utility and sensitivity of the iMatter model to flag up issues for improvement and change, of the 13 Boards that were issued with national reports in both 2017 and 2018, 7 have an EEI score in 2018 which is higher than in 2017; 5 had

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13 H&SCP response rates in both 2017 and 2018 in the four Geographic Boards that we focused on as part of our fieldwork tended to be higher than those in the NHS Boards.

14 Boards with a higher share of paper questionnaires were less likely to get a report in 2018. Only three Boards failed to reach the 60% threshold in terms of their online response. IT issues are recurring and are detailed in a later section.
no change; and one has a lower EEI score in 2018. The ability of the model to pick up variation was also evident in the iMatter component data. There was appreciable discrimination and variation in responses across factors and components at the national and Board levels, and the ‘traffic light’ system provides clear guidance on areas where improvement/change is required. The overall pattern tends to show that nationally, teams are largely in the ‘Strive and Celebrate’ and ‘Monitor to Improve’ categories with proportionally less in the ‘Improve to Monitor’ and particularly the red ‘Focus to Improve’ areas. The important point however, is that the model looks able to discriminate satisfactorily and highlight areas for change/improvement.

- The components that consistently attract the lowest levels of positive response (nationally and in Boards) are those organisational components in which staff may feel they exert the least control: Partnership Working15 and Visible and Consistent Leadership16. Both were most strongly correlated with Confidence and Trust in Senior Management. This data sends out a critically important message for all NHS senior-level partners: visibility, trust and confidence are important for staff. Interestingly, the theme of ‘visibility’ either in terms of its interpretation as a component measure or as an issue for staff, was a recurring theme in the local Board interviews and focus groups with staff, and we highlight this in later sections.

- Action Plans are critical for the longer-term sustainability of iMatter as a continuous improvement model. In contrast to the response rate, there was a statistically significant improvement in teams completing Action Plans: from less than half in 2017 (43%) to nearly three-fifths in 2018 (56%). This represents a significant achievement by Boards: 77% increased their Action Plan rate with the largest shifts mainly occurring in Geographic Boards.

- The national and Board reporting could make more positive use of the Action Plan data in the sense, that it is possible to obtain even a reliable proxy measure of the potential number of changes/improvements to staff experience generated by Action Plans. To take only one example, the Scottish Ambulance Service (SAS) had 395 teams in 2018 and 67% of these completed an Action Plan. This means (assuming a baseline rate of 1 change per Action Plan) that there were (at the very least) 265 changes/improvements potentially made by SAS teams in 2018 as a direct result of staff participation in iMatter.

- The reporting data analysis also shows that Boards with the lowest percentage of teams with Action Plans includes seven of the nine Boards that did not get an EEI report in 2018, that teams with a higher response rate are more likely to have a higher proportion of Action Plans completed for 2018 and that completion of an Action Plan in 2017 helped to drive a higher response rate in 2018. In other words, iMatter is largely about commitment and having done so once, staff are more likely to do so again.

iMatter collates ‘big’ data: high numbers of responses across a defined set of components that discriminate Boards in terms of their staff experience and EEI components. Although there has been a slight but significant downward shift in response, this is accompanied by the significant upshift in Action Plan completion. The shift may reflect Board resources for iMatter and an increased focus on Action Plans. Although reporting on the iMatter model is still evolving we make only one critical observation on the presentation of the data, relating to the absence of an easy-to-read ‘Dashboard’ (i.e. a front page infographic that displays top-line KPI information and any other relevant key data indicators (e.g. change in the EEI since the previous survey). We note that progress is being made to develop such a Dashboard, and

15 “I feel involved in decisions relating to my organisation”
16 “I feel senior managers responsible for the wider organisation are sufficiently visible”
there is a need to continue to support this work. Reporting could also usefully employ statistical significance testing\(^\text{17}\) to indicate change and potentially (because of ‘big’ sample numbers) utilise the more robust analytical power of multivariate data analysis\(^\text{18}\). These provide for a more robust assessment of statistical outputs and findings. iMatter is a system with considerable as yet untapped analytical potential.

**Acceptability of iMatter**

A key theme for our engagement with staff, managers and stakeholders was the acceptability, adoption or and engagement with iMatter across team, H & SCPs and Boards.

While response and Action Plan rates may be general indicators of acceptability and support among staff, it is also notable that iMatter was overwhelmingly viewed as an acceptable model of staff engagement by national and local stakeholders. There is a comprehensive recognition of, and commitment to, the principles of the iMatter model across all of the national and local partner stakeholder groups. The overwhelming majority of the respondents spoke very positively about the merits of the iMatter approach and most contrasted the relative strengths of the model with the previous National Staff Survey and D@W. Compared to these single-point ‘snapshot’ surveys, iMatter was viewed as a more effective tool for staff engagement.

The range of strengths associated with iMatter are described below:

- support for the team-based approach and the ability to provide data on the experience of staff working relationships with their colleagues and supervisors/managers;
- support for iMatter as a validated bespoke instrument and measure of staff experience issues, where the components/items were generated by NHS staff - in other words, iMatter was viewed as a credible measure of experience because it was co-produced;
- the link from iMatter to recognised NHS Staff Governance Standards - iMatter is viewed as a measurement of these standards across the range of staff experience;
- iMatter comprises a localised feedback component that allow an Action Plan to be developed by teams to address issues raised by the component measures and where progress can be reviewed, leading to better staff experience;
- iMatter is action-focused and provides the basis for the continuous improvement of teams. It goes beyond a ‘simple’ staff survey and is a ‘tool’ with the potential for team ownership and empowerment, where problems can be resolved by teams rather than by management;
- iMatter has been able to generate significantly high levels of staff response and the data can be considered as more representative of staff views;
- iMatter is relatively quick to complete, the individual components are largely phrased in positive and/or neutral terms, and the components are largely easy to interpret;
- the utility of iMatter data to be used alongside other management tools and approaches (e.g. Quality Management, Leadership Development, Personal Development Plans and Annual Appraisals), and wider staff engagement or ‘cultural’ exercises or changes in Boards; and
- the transferability of iMatter to settings outwith NHSScotland (e.g. to H & SCPs and Council staff, and to other public sector workforces in Scotland).

\(^{17}\) To show whether any difference is meaningful and not simply due to chance. Significance testing is used to determine the importance of differences in statistical outputs between sample groups/populations.

\(^{18}\) For example, a stepwise regression method could be employed to determine the relative contribution of each of the four enabler factors that underpin iMatter to the overall EEI. This would allow the identification of stronger and weaker contributing factors and provide a robust basis for developing actions arising from the data to improve the EEI.
More specifically, there was near unanimous consensus among iMatter stakeholders, managers and staff participating in our research that there were important benefits associated with the iMatter focus on teams' experiences and actions at local level. The iMatter approach was seen as "creating a real sense of ownership among teams", which has contributed directly to the high response rates recorded for successive waves. Conversely, there was a recognition among stakeholders and Op Leads of areas of weaker response (and ownership) among staff in Boards: where organisational leaders and individual managers simply needed to take more responsibility for iMatter and deliver on staff experience for teams. Stakeholders and staff consistently described iMatter as "personalised", "localised", "team-focused", and "action-focused". Refocusing activity on engagement at the team level was also seen as generating a more positive sense of voice for staff. Stakeholders and Op Leads emphasised the need to continually promote the benefits of using iMatter as a measure of staff experience.

Line managers suggested that the bottom-up and co-produced nature of iMatter – "It was created by staff from the bottom-up, not from the top-down." – has been key to its success. The sense that iMatter is action-focused and owned by the teams that participate in the process was echoed by Scottish Government representatives and members of the iMatter national team.

There was widespread acknowledgement of the key role played by Op Leads in "making things happen" where iMatter was performing well. Op Leads play an important role in raising awareness, keeping managers and teams informed of timescales and deadlines, delivering training, and offering encouragement, advice and support to staff and managers. One manager welcomed regular email communications on iMatter but called for a "more personalised approach" that could be facilitated by further resourcing the time that Op Leads had to engage with managers on the ground.

Nevertheless, managers participating in our research spoke of the value of Op Leads’ coaching, advice and training, for example, on the Action Plan process. There was consensus on the need to continue to resource and further support the work of Op Leads.

Most of the staff and managers participating in the research were generally positive about the online and in-person information provided on iMatter, and many felt that they had a good understanding of the process. However, a number of managers suggested that there may be value in reinvesting and updating formal iMatter training that had been undertaken some time ago, and as a means of ensuring that new entrants to manager roles understood the system. Some stakeholders and Op Leads also pointed to the need to address an ambiguity among some teams about the content of Action Plans and a need to create access for teams to share practice on common issues.

There were few concerns among staff and managers, or other stakeholders, about the content of the iMatter tool. Interviewees and focus group participants thought that the issues addressed by iMatter were valid and reflected many of the opportunities and challenges faced by NHSScotland and H & SCP staff. As noted above, one or two issues were raised regarding the wording, clarity or usefulness of particular iMatter subject areas. One issue centred on a degree of confusion related to an iMatter component about the visibility of senior managers. While guidance as to the focus of this question is provided on the iMatter interface, many of our interviewees and focus group participants remained unclear as to how to action either positive or negative results. Similarly, some managers and other stakeholders felt that further guidance might be required on how to interpret and action concerns raised under the iMatter statement: "I feel involved in decisions relating to my organisation". Given that Action Plans (and the broader iMatter approach) focus on actionable activity at team level, there was some
discussion as to how best to respond to concerns about organisation-level communication and participation.

**Use and Impact of iMatter by Teams and Leaders**

There is still uncertainty at this stage among interviewees about how the iMatter Continuous Improvement model is being used by staff teams. However, we can highlight a number of areas that suggest that the utility of the model is emerging among staff in Boards. The majority of the Board interviewees were able to highlight:

- the emergence of ‘huddles' in Acute (involving Clinical, Domestic and SAS staff) and in Corporate settings, where teams regularly review events, priorities and progress; and
- the use of visual presentations of storyboarding (especially in Acute settings) as a means of sharing information, values or behaviours.

Most Board interviewees recognised that iMatter is one further tool within a wider framework of policies and initiatives on staff engagement and on health and well-being in the workplace. In this respect, many of these respondents felt that iMatter was starting to make a positive contribution and helping generally to facilitate better conversations between managers and staff and between team members. Interviewees were also able to highlight a number of compatible links between iMatter and other existing management and staff programs such as: Quality Management/Improvement; managerial leadership development/training initiatives; and can be used as part of individual Personal Development Plans (PDPs) and annual employee appraisals. Links were made between iMatter and work-life balance and well-being initiatives, while managers also expressed an interest in exploring how iMatter experience data can be linked to service and health outcomes for patients.

The latter point is critical: iMatter is not seen as a hermetically-sealed stand-alone ‘measure of engagement' and an improvement tool but is being developed and linked to other methods of engagement, and a wider interest in Boards about the importance and value of staff experience. In this respect, many interviewees noted that iMatter has to be viewed in the context of a broader ‘culture-shift' towards a much greater emphasis in Boards on ‘listening to staff’ and managerial cultures based on ‘collaboration and engagement'. There was a very strong and clear recognition by one of the staff-side respondents that managers who largely operated ‘command and control' staff approaches run a higher risk of being ‘exposed' by iMatter. In all of these respects, however, respondents pointed to a number of ways forward to develop iMatter in Boards so that it has a better chance of becoming ‘business-as-usual' practice and not a ‘tick-box initiative' being done to staff by managers, or as an HR-driven requirement of managers. Specifically, it was suggested that this required organisational leaders setting a strong tone about the importance of staff experience for Boards and individual managers taking greater responsibility for response and Action Plans (and their delivery). There was strong support among managers for resourcing for Op Leads (and/or other colleagues) to provide additional advice and support to ensure that the implementation of Action Plans and related actions was a year-round activity and to encourage further reflection and problem-solving activity among iMatter teams.

As we outlined earlier, there is clear evidence from the Board interviewees that the output KPI and component results of iMatter are being used to identify and address areas of low response and Action Plan rates. Scottish Government monitoring holds Boards accountable for their performance. There was also a recognition that at this stage of development, that assessments of iMatter still largely look at the model in terms of ‘input' and KPIs: and a recognition that more work may be required among managers and staff on the quality of the ‘output' from Action Plans and whether these are being delivered and delivering substantive
improvements for staff. Despite this view, all of the Board respondents provided anecdotal evidence that the feedback from managers and staff about the measure and about process was mainly positive and satisfactory. This was also the view of most of the national staff-side respondents and Non-Executive Directors. There was broad consensus that the content of Action Plans was satisfactory though more work may be required with managers/staff in some areas to improve their content and quality and a broader assessment on whether teams are delivering on Action Plans, what issues are being raised and what actions are being taken. Although all levels of management have access to this data (by consent), time and resource constraints seem to prevent comprehensive checks. On the basis of what checks are completed, it was thought that the actions outlined in plans are being addressed by teams to improve staff experience.

Scrutiny of Action Plans raises the wider question of Staff Governance of iMatter. The overwhelming majority of respondents raised no substantive governance issues: the development, implementation and the reporting output of iMatter is regularly discussed and scrutinised at Board-level and in local Partnership fora (i.e. Area and National Partnership structures). Where issues arose for a third of HRD stakeholders, these concerned access to those ‘red’ ‘Focus to Improve’ areas for teams and a feeling that repeated ‘red flags’ team reports and Action Plans need to be open to inspection irrespective of the confidentiality protections that teams have on accessing their data. It is important to note that these discussions appeared to reflect a genuine interest in gaining a better understanding of the issues behind red flags.

Practical Experiences of the iMatter Action Plan Process

Most of staff and managers participating in our research thought that Action Planning had been useful and were able to recount a range of actions undertaken by their teams, including: a desire for more visible and proactive leadership and communication around CPD opportunities; raising training and development priorities, and asking that managers seek additional training resources; action to schedule more time for developmental one-to-one conversations between staff and managers; creating clearer feedback opportunities between staff and managers; creating time and processes to support peer-to-peer feedback; and putting plans in place to improve the quality of clinical supervision.

Managers agreed with Op Leads that there were practical benefits associated with discussing specific challenges facing team members.

“iMatter just gives you the opportunity to have a conversation, a more structured conversation, around those key aspects of people’s roles.”

Op Leads and managers made a clear connection between the practical value provided by team Action Plans and positive attitudes towards iMatter among many staff.

“People are having a conversation… when it’s team level actions, they can see the benefit. they can see day-to-day how that’s changing.”

One staff member in our focus groups spoke of the benefits of Action Planning with their team that informed the arrangement of team-building training sessions.

“As a team, we chose, well, the three areas, main areas to work on, and then we discussed all things that we could do. The team building, we were so glad that we got the opportunity to say that we wanted to do that, and we had a good time doing that. Yes, I was really glad to be part of it. My manager didn’t just sit down and be like, “Right. These are the three areas. This is what we are going to do.” We all had a say. We all spoke about it.
We spent a good afternoon making an Action Plan... It was really good, really positive.”

The broader benefit of bringing teams together with a sense of focus and purpose to spend ‘quality time’ together was a recurring theme in our interviews and focus groups with both Op Leads and staff and managers.

“Actually, there is something about getting quality time in a room with people that do similar jobs, if not the same job, and actually just having the chance to sit and talk, to think of ideas.”

“I think, you know, sometimes again the team tend to forget about each other quite easily, and are very focused on the clients. Every now and again it is nice to just be like, “Let's bring the team in.” Our manager tends to see that, that we do need the time to come together and have more planning days, more training days where it’s just for staff, so that’s been good.”

It is worth reiterating that – while we acknowledge that our sample of staff research participants may not be typical – the views of staff across a range of job roles, H & SCPs and Boards were mostly very positive about iMatter. Indeed, we were struck by how views on iMatter generally, and Action Planning in particular, were broadly positive among the vast majority of staff. There were some mixed views in some groups and more ‘sceptical’ managers/staff who thought: iMatter added to workload pressures and focus on patient care; and was treated with scepticism by some staff because of the lack of delivery on Action Plans, especially in areas in which they had less control (e.g. the ‘visibility’ of senior leaders). There was an appreciation of managers who responded positively to feedback.

There was an acknowledgement among both managers and Op Leads that continuous training, coaching and sharing of good practice was required to maintain positive momentum around the Action Plan process. It is important that Action Planning and other aspects of iMatter do not come to be seen as aspects of procedural performance management rather than action-focused work around continuous improvement. Some of the managers participating in our research commended the support available from iMatter web-based resources and Op Leads/BAs, but argued for more one-to-one support and training around the Action Planning process. Op Leads/BAs and line managers agreed that additional support for training and coaching (both in refreshing knowledge of the basic processes of iMatter; and especially around Action Planning) would be helpful.

A challenge consistently identified by line managers and Op Leads related to arranging for Action Planning at times when colleagues working different shift patterns could interact.

There was also consensus that more time was needed offline for line managers and staff to support full engagement with the Action Planning process.

“We get enough information but not enough time. You need to create time offline and there is just not enough.”

Our interviews and focus groups highlighted a number of challenges associated with effective team-based Action Planning, including sometimes substantial changes to team membership as a result of turnover, organisational change, and time and workload constraints. Indeed, some managers worried that the “fluid and dynamic” nature of team-level change and the demands of operational roles in the NHS and H & SCPs meant that team Action Planning sessions sometimes responded to challenges “raised by other people” and events. Other
managers, however, took the view that the issues raised in iMatter results were worthy of discussion whether or not all respondents remained members of the relevant teams.

Many of those participating in our interviews and focus groups said that they would welcome the opportunity to share good practice and lessons (a) from the Action Planning process; (b) from Action Plans. This was a particular theme in managers' focus groups and our interviews with Op Leads – our research provided the first opportunity for some managers to share practice and insights about the process and content of Action Planning, an opportunity that they valued. Sharing practice on coaching and training in team building were seen as immediate priorities.

To this end, senior managers and Op Leads pointed to the growing online resource that is available on the iMatter website. There was generally a positive view of the material available, and especially the growing Action Plan and ‘team stories’ resources, which provide excellent examples of the positive impacts delivered by iMatter. There was consensus on the need to continue to invest in dynamic, interactive and accessible online resources in order to support the sharing of good practice and examples of effective Action Planning to drive change. The idea of increasing opportunities to share practice in the development and delivery of Action Plans was also strongly supported by managers.

In summary, the above discussion identifies a number of key benefits that have emerged from iMatter and that are represented in the figure below.
Reconsidering the 60% Response Threshold and 3-month Action Planning period

There are conceptual arguments that can be deployed to support and critique the 60% response reporting threshold, though it is unclear if these formed part of the original justification for setting the threshold. We also know that iMatter needs as high a response as possible for generalisability. In its favour, goal setting theory (Locke and Latham, 1990) strongly suggests that having clear and specific goals are a source of motivation that improves performance. Studies of communication, feedback and engagement (e.g. Bakker and Demerouti, 2008) also suggest that feedback is crucial to engagement, and that an insufficient ‘return’ from responding may undermine future employee response (Bakker, Demerouti and Euwema 2005).

The need for a response rate threshold was accepted all of the Board and most of national staff-side respondents. Op Leads were broadly supportive of the need for the current 60% threshold: as an effective and ambitious objective that encourages high response rates. Nevertheless, a number of potentially counter-productive issues appear to be associated with the current threshold. First, for some Board and national staff-side respondents the 60% threshold was thought to have a potentially detrimental impact on engagement among hard-to-reach groups such as Estates and Facilities staff, where response rates have typically more than doubled compared to the National Staff Survey (and D@W) but who still fall short of 60% and fail to get a full report. Second, when asked why they had participated in iMatter, a number of staff and managers referred to “strong encouragement” from management to help to achieve what was seen as an important objective. These concerns were amplified by some managers and staff who felt that the emphasis on driving participation to achieve the 60% response rate seemed to conflict with the broader message that iMatter should be owned by teams and that individual participation was discretionary. One line manager in a Geographic Board suggested that the focus on a percentage threshold risked encouraging managers and staff to focus on the “the process of ‘just get it filled in’ rather than the substance” of engaging with results and Action Planning. Some staff also expressed concern that if they or colleagues did not participate – and 60% was not reached – they would feel that they had “let colleagues down”. We noted that, among managers and some stakeholders, that the language of “No Report” was associated with a sense of failure in achieving an important objective.

Accordingly, there are reasons both to support an aspirational ‘stretch’ threshold objective of 60% and to have concerns about it. Those Boards receiving “No Report” in 2017 also received “No Report” in 2018, potentially suggesting a disincentive effect of previously having No Report. However, overall participation rates are relatively strong and show that the threshold can be achieved in Geographic and National Boards. During 2018 they rose in those Geographic Boards who received No Report in 2017, potentially pointing towards more positive outcomes of setting an ambitious (but not unrealistic) objective.

The Distinctiveness of the iMatter Approach

In discussing the strengths of iMatter comparisons were invariably made with the previous National Staff Survey and with D@W. In terms of the former, most of the local Board respondents described this as a resource-intensive exercise that suffered from relatively poor levels of response and produced limited feedback for staff because of a very narrow window between reporting feedback and the start of the next annual survey cycle.

The overwhelming number of stakeholders, line managers and staff who we engaged with considered iMatter to be a substantial step forward from the previous National Staff Survey that preceded it. Interviewees and focus group participants pointed to the substantially higher response rates recorded by iMatter when compared with the National Staff Survey. As noted above, the process of co-production that resulted in the emergence of the iMatter tool
statements was seen as producing a tool that better reflected staff views on engagement and workplace issues. Those involved in the development of iMatter also pointed to the manner in which the tool better connects to NHSScotland Staff Governance Standards.

Interviewees and focus group participants consistently pointed to the benefits of iMatter in providing team-relevant information and feedback that could inform actions – these features were not seen as relevant to the National Staff Survey. A number of interviewees and focus group participants across different Boards recalled the National Staff Survey as a “box ticking exercise” in comparison with an iMatter process that was much more clearly about informing action at the local level. As one NHS service manager noted:

“Compared to national survey, this is much more focused on the team. The feedback is more pertinent. It’s about a local focus, a team focus, not a big national picture that doesn’t tell us anything.”

Staff members participating in focus groups similarly saw a change from previous survey exercises that did not seem to focus on identifying actions to drive change.

“The national survey you just filled in your questionnaire and it went away. You didn’t have anything to action or anything. That was just easy. You didn’t have to do anything.”

An H & SCP staff focus group participant similarly compared iMatter favourably with previous local authority employee engagement surveys.

“Before, the engagement survey in the council, I remember, I am just thinking, it used to be on a Directorate wide, so it would have been for the whole of social care and wellbeing. So there were probably a lot more people in the scope, so it would probably be quite difficult to drill down to actually see what some of the challenges are. I guess in that respect, iMatter is good in that it goes to a smaller cohort of people, rather than being that top level… you can then start to see where there is potential challenges or support needed within teams.”

Similar concerns were raised by most Board respondents in relation to the current D@W Survey with the added proviso that this survey was also characterised by:

- measures that have not been validated with staff;
- use of defined terms (e.g. ‘discrimination’ and ‘whistleblowing’) that required further explanation and/or could otherwise be confusing;
- analytical/confidentiality limitations on the data which meant that results were only reported at the ‘Directorate’ level in Boards;
- raised issues (e.g. bullying and harassment) that were more sensitively covered by existing iMatter components (i.e. treated with dignity and respect); and
- concerns about the confidentiality of responses (i.e. the collection of demographic data in D@W) that could be used to link their D@W responses to their iMatter data (i.e. through the same QR codes on paper copies).

Accordingly, among our interviewees and focus group participants there was relatively limited enthusiasm for the D@W process, as it currently operates. D@W was seen by many as “a tick box exercise”, which fell victim to low response rates as a result of survey fatigue and because it was seen as a national data-gathering exercise rather than an action-focused exercise owned by teams (in sharp contrast to iMatter). During interviews and focus groups, some staff needed considerable prompting from the research team before eventually recalling that they had engaged with D@W, while a staff member noted that they were “not clear about the purpose” of D@W.
This is not to say that any of our research participants questioned the importance of the D@W agenda – they did not. But many thought that the current survey methods were not helpful, and that the emphasis should instead be on action. As one line manager summarised:

“Any avenue to report dignity at work issues is a good thing, but I would hope that people wouldn’t have to wait for a survey. It should be about actions. People should feel confident to raise an issue and that it will be actioned.”

Many other staff, managers and Board stakeholders also pointed to the importance of action on dignity at work issues – e.g. that resources should be targeted at ensuring that staff and managers have the information and processes that they need to deal with issues, and that training and CPD should embed a culture of dignity at work. Some managers pointed to the existing (and developing) processes and practices in place to support dignity at work (e.g. Whistleblowing) within NHS Boards and H & SCPs, and suggested that investment in these actions and services (and raising awareness of their availability) should be the key priority.

While managers participating in our research were wary of the idea of adopting a team-based ‘iMatter-type’ approach to D@W, which was seen as raising problems in terms of confidentiality, there was support for supporting a more action-focused approach to these issues.

Some of the national staff-side respondents (compared to their local Board counterparts who were on the whole more strongly in favour of iMatter) also mentioned the strengths of the National Staff Survey and D@W relative to iMatter. These concerned:

- the generation of longitudinal national and Board-level data and the ability to identify common national themes that need to be addressed (e.g. whistleblowing);
- response rates to National Staff Survey and D@W were appreciably high in some National Boards and reasonably representative of most staff in these settings; and
- the D@W data allowed Boards and NHSScotland to be held accountable for (albeit statistically low) levels of bullying and harassment, and for the physical abuse of staff at their place of work - these are all important issues for NHSScotland staff and loss of D@W may mean a lack of oversight on these issues.

In its current form, D@W neither offers robust measures, nor appears to engage respondents in the process or in actions arising. It is difficult to see a strong analytical argument for, or widespread stakeholder interest in, continuing D@W in its current form. There are, however, a number of possible avenues for the development of a new D@W approach. First, any new approach should take a broader conceptual view of dignity at work that captures and incorporates the key features of the existing current literature: utilising components that are presented in a fashion that is consistent with best practice in questionnaire design (i.e. the avoidance of binary response options and the use of Likert scales, and the use of neutral language in the design of individual measures) to produce a reliable and valid set of measures\(^{19}\). Second, unless an existing generalised measure is adopted, we would put a strong emphasis on the co-creation of D@W items with staff. This would give the questionnaire validity. Finally, a credible alternative to asking direct questions on the sensitive issues raised in the current D@W measure would be to develop action-oriented outcome measures (e.g. to

\(^{19}\) A number of reviews of good practice have highlighted a consensus around the benefits of 4, 5 or 7 point Likert scales in survey tools designed to capture the frequency (and in some cases impacts) of a range of aspects of bullying and harassment – see, for example, Cowie et al (2002); Einarsen et al (2011). Recent research by the Cabinet Office (2018) uses three point scales to capture the perceived frequency of bullying and harassment, and five point scales to assess staff views of organisational responses.
ask about staff awareness/use of individual Board policies/procedure in areas of bullying/harassment and discrimination). In our Recommendations that are presented in the Conclusions below, we suggest that these issues, along with the nature and frequency of any data gathering on dignity at work issues, should provide a central focus for the co-creation of a new approach to dignity at work.

**IT Acceptability: User Interface**

Our research involved a desk-based, expert-led review of the usability of the iMatter online tool, which was also discussed during our fieldwork research with staff and managers. Exploration and observation of the iMatter spec and online tool highlighted a number of strengths but also areas for development. The landing page is clear and concise. Respondents are immediately aware of the purpose of the measure, the expected completion time, that questions are mandatory (except for optional questions on respondents’ staff groupings) and what will happen after completion. These design features are consistent with good practice in the development of online surveys, resulting in higher response rates (Burns 2008). It does lacks personalisation, which has been demonstrated to enhance completion and response quality of responses (McPeak et al 2013) and may be a useful feature in future iterations.

The online tool incorporates a scrolling design (not screen by screen). This feature provides a richer context as most of the information is on one screen (Fan 2013). Questions are short and concise and less than the maximum recommended 20 words (Burns 2008). Completion time is minimal - 10 minutes. The majority of questions use a single statement format with agree/disagree answers selected by clicking a radio button which highlights the response. All are mandatory and forced. These types of question and modes of response are consistent with best practice: people are familiar with them and forced response eliminates the analytical problem of missing data. However, it may result in increased dropout rates and reduced data quality as people have plausible reasons for not wanting to answer a question (Decieux et al 2015). There were around 8,000 ‘abandoned’ completions of iMatter in 2018. There is no definitive answer to this conundrum in terms of best practice – the existing evidence suggests that there are benefits of forced response in terms of completeness, especially when used in relatively short online tools, but also warns against the potential for increased dropout (Steiger et al 2007). Given the relative brevity of the iMatter questionnaire, the current forced response format is the most appropriate design.

Of further note is that all iMatter statements are closed and there are no open-ended questions inviting textual comment. Our interviews and focus groups with staff and managers also occasionally highlighted the potential benefit of including text boxes so that respondents could expand and explain their views. Previous research on the use of online surveys has suggested that text options can be welcomed by respondents, but also throw up challenges in terms of the coding and analysis of data (Phillips 2015). Further feedback from iMatter respondents should be sought before making any changes that lead to the gathering of text-based data.

The navigation keys are coloured red, are positioned at the bottom of the screen, are easily identifiable and make it relatively simple for the user to navigate forward and back between pages. Overall there is very little ancillary functionality to confuse the user.

The final question consists of a visual analogue scale with a score from 0-10: a common question format with high levels of completion and response rates. Final submission entails the individual clicking a button with the text ‘submit my response’. The final page thanks the individual for participating and provides information on a web link to provide additional information. Both features are optimal for online survey design (Bataard 2012). Functionality could be improved by simply telling respondents that their response has been submitted – reducing ambiguity on behalf of the respondent.
The online tool may have limits around accessibility for people with sensory impairments or dyslexia. For example, the web pages, whilst having some bold text and highlighting features, overall lack colour, contrast and audio features. This may hinder people from completing the questionnaire or mean that some abandon the tool midway. This limitation should be addressed using accredited frameworks such as the Web Content Accessibility Guidelines (2018) to prevent response bias and enhance the quality of data being collected. All of the staff and managers participating in this research were positive about the usability and ‘look and feel’ of the iMatter online tool.

Implementation Facilitators and Best Practice

The early emphasis in Boards was on achieving buy-in (among senior managers and wider staff groups), getting structural supports in place and testing out the model. Embedding the model is still typically described in interviews as a ‘journey’: a recognition that implementing and embedding the model was an emerging and evolving process towards iMatter becoming business-as-usual. The Boards we spoke to typically have an implementation steering group (e.g. involving representatives from HR, senior management in Directorates and staff-side). All Boards also have designated Op Leads for iMatter. The early implementation process in most Boards was typically phased or staged. This involved ‘learning how to implement’. Early implementation typically began by using small-scale phased approaches (i.e. using discrete workforce groupings within a Board, or in specific cohorts and Directorates) and then applying any lessons learned from these approaches to the next cohort until all staff Directorates had been covered in a Board. Most Boards only switched over to whole-Board cohorts (i.e. covering all staff in the Board on a single iMatter run) in 2018 and the largest Boards still use phased or single-Directorate approaches as a means efficiently managing the process.

The table below summarises what the Board respondents identified as the key facilitators of implementing iMatter.

Range of Key Facilitators Associated with iMatter Implementation

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board-level iMatter return/buy-in (including Staff-side)</td>
<td>Securing buy-in and understanding of the process and output. Setting a leadership tone for the organisation by employer and staff-side partners</td>
</tr>
<tr>
<td>Senior Executives/Management Team</td>
<td>As above for Board with the aim of cascading support, awareness and buy-in further down management structures to team leaders/ supervisors</td>
</tr>
<tr>
<td>Operational Lead/Board Administrators/Directorate Administrators (or ‘Champions’)</td>
<td>Local support and delivery, and access to shared best practice at the national level</td>
</tr>
<tr>
<td>Implementation Steering Group</td>
<td>Local support and delivery</td>
</tr>
<tr>
<td>Team building and construction</td>
<td>Mapping line management structures and supporting appropriate team construction.</td>
</tr>
<tr>
<td>Electronic communications with staff</td>
<td>Building reliable points of contact with staff</td>
</tr>
<tr>
<td>Awareness-raising among staff</td>
<td>Securing buy-in and optimising response</td>
</tr>
<tr>
<td>Ongoing training/guidance systems for managers</td>
<td>Team confirmation, response and Action Plans, using the web interface and guidance for staff using iMatter</td>
</tr>
</tbody>
</table>

20 For example, using the user-interface and web service, accessing staff electronically and those in hard-to-reach staff groups, communications with managers and staff, and the timetabling of fieldwork.

21 This includes Scottish Government support for local Boards delivered by the iMatter team.
Facilitators were a mixture of actions and internal structural supports for iMatter which were also linked to similar aspects and to a range of operational best practices (see figure below). Discussions about facilitators and best practice were also used by interview respondents as part of the main reasons behind their levels of response and Action Plan rates (either compared to other Boards, or in internal comparisons between successive years of iMatter).

Our research also highlighted a range of best practice activities that have been important where iMatter has worked well. Managers and Op Leads pointed to, for example, the importance of providing ongoing guidance on the iMatter process to line managers, the value of intensive communication and feedback during the data gathering and Action Planning periods, the use of social media to raise awareness, maximising staff access to IT to support higher response rates, and supporting managers and staff to make appropriate choices around team formation.

Board and senior leadership behaviours were described as a strong facilitator of best practice by many respondents. Senior leadership is important in setting the culture and tone for behaviours in Boards by NHS managers and staff including the embedding of iMatter. In this respect, in Boards where response and Action Plan rates were weaker, this was partly linked to a lack of commitment, accountability and ‘ownership’ by managers to the iMatter process and model. We return to this issue in discussing the current ongoing challenges for Boards.

The support of Op Leads in the national network and their presence in Boards was a key facilitator of iMatter. As a national network they appear to operate as the primary source of shared best practice for iMatter and one of the main supports (and drivers) of embedding in local Boards. For the research team they provided an invaluable insight into the operational mechanics of implementation. We attended two network meetings as observers which gave us a valuable insight into ‘system-wide’ iMatter issues and practices. It was also clear that Boards placed a range of demands on Op Leads and that there seemed to be differences in the way that they were expected to support managers and staff. A common issue was that while Boards used Op Leads to ‘drive’ iMatter, this could also mean that senior managers and staff groups were failing to take on their own ‘ownership’, responsibility and ‘accountability’ for performance. Interestingly, the strongest individual Op Lead approach we encountered concerned being clear to senior managers in Board Directorates that they were primarily responsible for the performance of iMatter, and having the support and authority of senior HRD staff to be able to have ‘difficult conversations’ on performance with senior personnel. This point resonates with our earlier one about having the ‘right’ senior-level individuals driving iMatter in local Boards and that iMatter as a business-as-usual model will have to shift from being driven by HR to being driven by management/ staff teams.

Team building, construction and its ongoing maintenance was and still is a key task for Op Leads, not surprisingly for a model based on teams. Interviews with Op Leads stressed the repetitive and resource-intensive aspects of these tasks. It was clear from these interviews that team construction and maintenance remained an ongoing challenge in some of the Boards (e.g. because of organisational change, budgetary constraints, managerial and staff turnover, the timely response of managers to requests for information), where tasks like team confirmation were neither straightforward nor unproblematic for Op Leads and Boards. This is one area that potentially could be addressed through improved software supports to ease the administrative burden on OP Leads, allowing them to devote more time to supporting managers to use Action Plans and iMatter output as a management tool in Boards.

As a final point in this section we highlight ‘celebrating success’ as a key aspect of best practice. This should not be underestimated. The ‘softer qualitative’ parts of the national annual reports exemplify the practice of publicly demonstrating the output and value of iMatter in teams to the wider workforce. This was cited by many of the interview respondents as a way of building and embedding the credibility of local iMatter in Boards.
iMatter Best Practices

- Setting a visible leadership tone and accountability for the organisation by employer and staff-side partners
- Visible Board-level leadership, commitment & advocacy
- Visible Senior Executive/management Team: leadership, commitment and advocacy
- Cascading positive messages down management structures to team leaders/ supervisors
- Success stories as an example of how iMatter can work and how Action Plans can lead to change/improvements in teams
- Celebrating success/demonstrating value
- Advice from Operational Lead/Board & Directorate Administrators
- Practicing-sharing at the national level informs action within Boards
- Guidance on electronic submissions, completing the questionnaire, interpretation and Action Planning
- Ongoing guidance supports for iMatter (managers/staff)
- Team building and maintenance
- Supporting choices on appropriate membership and confidentiality for iMatter
- Regular e-mails to managers as a countdown to team confirmation and a 'live run', fieldwork and the 12 week Action Plan phases.
- Intensive communications strategies
- Awareness raising among staff
- Development and delivery of awareness raising materials. Use of social media such as Facebook and WhatsApp
- Encouraging managers and staff to complete an iMatter response and complete an Action Plan.
- Ongoing advocacy of iMatter
- Maximising access to IT for hard-to-reach and more 'disconnected' staff
- Reducing the levels of paper copies, and lower levels of response, by supporting IT access
Ongoing Challenges

Respondents reported a number of initial and very early challenges around iMatter. These included:

- involving hard-to-reach staff groups and how those with restricted or no access to IT in workplace settings would complete iMatter.
- how staff would find the time to complete an iMatter return;
- how staff likely to be more structurally ‘disconnected’ from the organisation (e.g. in solo or dual work units, or in part-time roles), or other staff (e.g. split shift patterns) could be linked to team structures;
- convincing staff who were described as being largely sceptical about staff engagement initiatives, or who didn’t see this issue as relevant to them, about the merits of a new staff experience measure;
- the potential of lower response among staff in ‘small’ teams where there are concerns about them being identified providing negative feedback to managers; and
- how iMatter would be implemented and whether the ‘right’ people (i.e. those with a measure of power and authority) would lead the implementation in Boards, and whether managers would ‘buy-in’ to a model being driven by HR staff.

As we shall see below, these initial challenges resonate in the views of some respondents on current implementation/embedding facilitators, best practices and challenges. It should be appreciated that we were not always able to get a clear linear timeline about the early, current and emerging challenges faced by Boards. Factors such as staff turnover and the proximity to the process by different individuals at different points in time prevent this. In addition, there is an axiomatic tension between facilitators and challenges in the sense that they are often one and the same issue: what facilitates iMatter are those aspects that help prevent a challenging issue arising. As a consequence, we discuss challenges in terms of ongoing issues faced by iMatter despite having facilitators in place and adopting shared best practice.

Engagement and Delivering iMatter

Broadly, those Boards with the lowest level of response, the highest number of ‘No Reports’ and lowest levels of Action Plans in 2017, tended to be those who reported greater numbers of challenging issues. Completing Action Plans, however, was a relatively common challenge across all of these Boards: they were generally all trying to increase their completion rates. A combination of team identification issues, external factors (i.e. budget pressures and incorporating new H & SCP staff), IT issues22, an uncertainty about whether the Board could reliably identify managers, the lack of training/induction supports and concerns about whether iMatter information was being shared by senior managers (in a ‘cascade’ downwards), were exclusively highlighted by respondents in those Boards performing poorly in 2017.

There was also a recognition across all Boards of areas of stronger and weaker responsibility, accountability and ownership among managers and staff, the difficulties of reaching staff (see previous Acceptability section) and ongoing workplace pressures on managers and staff. Crucially, there was a strong acknowledgement of the need to continue to encourage senior and line manager buy-in and leadership of the iMatter process — it was suggested that where iMatter has struggled to gain traction, this is often a symptom of senior leadership team members failing to take full ownership and provide visible and committed leadership.

22 For example: slow log-in and access, speed, ‘buffering’.
There was a general recognition that Boards should be doing more to tackle response and Action Plan levels and a range of actions offered by Board stakeholders to boost these rates. Actions to tackle the former mainly included more awareness-raising among staff, demonstrating the value of iMatter to build and embed credibility, and more visible/committed senior and managerial leadership. Actions to tackle the latter mainly were about ensuring greater managerial responsibility and accountability.

*Technology-related Challenges*

We have provided a positive evaluation above – based on our own analysis and staff views – of the usability and ‘look and feel’ of the iMatter online tool.

In terms of technology-related challenges, Op Leads and other stakeholders participating in interviews and focus groups were broadly positive about the technology of iMatter, although it was noted that where IT systems were slow or crashed, this caused additional work for managers and risked reputational damage to iMatter. There was acknowledgement – and a shared frustration – by Webropol that iMatter systems could sometimes appear slow to users. It was suggested that these problems are often rooted in NHSScotland legacy systems (with old operating systems affecting the usability of iMatter) or gateways/firewalls slowing data uploads, as well as limited server capacity.

More generally, there was an acknowledgment that the initial resourcing of iMatter systems was based on a ‘minimum viable product’ approach, and that further investment in IT should now play a crucial role in growing the reach and impact of iMatter.

There was strong support for further investment in IT integration work that would relieve some of the administrative burden associated with team confirmation and updating data:

> “Whilst the system is very user friendly, there are things that take me a long time to do. If we can continue to develop the system and invest in the system, and that will require a resource for it to continue to be an effective system to support the process… If we do that it frees up Op Lead time, it frees up administrative time within Boards, it frees up manager time, and it improves the overall perception of iMatter because people don’t separate the system from the process.”

Webropol described a positive and collaborative relationship with NHSScotland but also suggested that additional contact with, and support for, e-health Leads within Boards would be helpful to improve iMatter services. A clearer specification of commonly-required reports would help Webropol to build a more user-friendly dashboard allowing Op Leads/BAs and others more ready access to frequently-requested analysis (reducing delay and duplication in reporting).

There was also strong support among managers, Op Leads and iMatter stakeholders for further investment in, and the integration of, IT that would ensure that iMatter is able to ‘speak to’ HR interfaces. The establishment of a ‘single sign-on’ linking iMatter and Turas records was seen as an immediate priority. The integration of iMatter with eESS systems is another priority that has the potential to reduce significantly administrative demands on managers and Op Leads, and free up time and resources to engage in staff engagement work.

Webropol expressed an interest in dialogue on the closer integration of iMatter and NHSScotland/H & SCP systems, but also noted some of the challenges that IT integration can
throw up – it is important that the iMatter national team and partners work towards a clear specifications for systems integration and automation projects.

A number of Board interviewees, staff and managers raised the potential benefit of an App-based version of iMatter, which Webropol would be happy to support the development of, but which may raise issues in terms of staff access to smartphones and the need to update an App for one-off, annual use. An iMatter App has the potential to deliver substantial benefits in terms of improved response rates and consistent access to information (and report data) for appropriate staff at all levels.

Stakeholders involved in a recent test of change of an SMS version of iMatter were generally positive about its potential to improve usability and response rates, while acknowledging the need for the gradual, continuous testing and rollout of new technologies. There remains a wider question about whether staff should be asked to use their personal mobile phones and/or to share their numbers (though data is stored securely). However, there was again consensus that investment in both SMS and App-based approaches would add value in terms of improved reach and response rates (especially when compared with the resources currently spent on paper copy versions of iMatter that return a very low response rate). Other potential approaches to improving response rates might include the deployment of tablets with a pre-loaded iMatter tool - a popular idea among some of the Op Leads and managers in our research, and seen as a relatively easy-to-implement solution by relevant stakeholders.

There was also some support for the use of Pulse surveys as a means of testing progress on iMatter actions. Webropol explained that such tools could be developed relatively easily and deployed via email or SMS, and shared the view that this might help to create a more dynamic, continuous improvement focus for iMatter. However, both our engagement with stakeholders involved in iMatter implementation and evidence from examples of best practice suggest that it is important to guard against survey fatigue and to keep Pulse follow-ups short and focused.

Finally, there may be a need for further training for iMatter Op Leads on the use of IT systems. While sharing practice and ‘train the trainer’ approaches have been cost-effective in ensuring that relevant stakeholders understand the basics of iMatter systems, there was an acknowledged risk that out-of-date or inaccurate messages could be passed on.

Priorities for Future Work on iMatter

There remain areas for future work and development on iMatter and D@W.

iMatter Measures: As noted above, respondents to our research were largely satisfied with iMatter components with the exception of a recurring concerns about the interpretation of the statements about visibility of senior management and staff involvement in decision making. As we have suggested, there would be value in a co-produced review of the wording and content of all iMatter statements, and action taken to clarify unclear language to ensure a consistent response.

Generalisability of the iMatter Model: There was a general view that it was right to use iMatter in HSC: the efficacy of a team-based model in multidisciplinary, integrated settings could not be limited solely to NHSScotland staff. Further consideration is required to explore the opportunities for, and any challenges around, the generalisability of iMatter to other public service workplace contexts.

Continued development of iMatter coaching and support: We have noted above that the coaching, training and support work (mainly led by Op Leads) associated with iMatter has been effective and important to its success. There is therefore work to be done to continue to support and resource the work of Op Leads, further develop online learning resources, and
create opportunities to share practice and insights on the iMatter process, Action Planning and the impact of actions.

IT Development: We have noted that there was broad support among respondents for the development of an App to allow staff to complete iMatter more easily at work/home on smartphones, and for continued testing and (if appropriate) roll-out of SMS versions of iMatter. There is work to be done to arrive at a conclusion as to the best way to use smartphones to expand the reach of the iMatter tool.

We have suggested that, while the ‘look and feel’ and design of the current online interface is in line with good practice, there would be value in reviewing the design and accessibility of the iMatter tool.
Part Three: Conclusions and Recommendations

Staff experience and staff engagement have been central themes of strategies to deliver continuous improvement in health and social care. This is appropriate given that there is a strong evidence base that engaged employees are healthier and more productive, and that in the specific context of health and social care, there is a link between engagement and continuous improvement in services (and potentially positive health and care outcomes). Furthermore, NHSScotland’s 2020 Workforce Vision for health and social care commits to valuing and empowering everyone who works for NHSScotland and supporting them to work to the best of their ability.

iMatter has been developed as a means of more effectively measuring the experience of staff working in health and social care, and (crucially) as a means of supporting staff engagement and promoting continuous improvement.

The key finding of this evaluation is that iMatter has proved effective and has made substantial progress in achieving the original goals of the model. It is important that investment and support for the iMatter process is maintained and strengthened so that the progress made on staff engagement is built upon and consolidated.

Our review of the conceptual background to the iMatter tool noted that its measures have been validated, and that it connects with key themes in the international research literature on employee engagement and with NHSScotland Staff Governance Standards. Perhaps even more importantly, iMatter was co-produced with NHSScotland staff, and so reflects the understandings and priorities of health and social care employees (although, as noted in this report, there is a need for continuous reflection and co-production to ensure that all measures are meaningful).

An additional key finding of this research is that staff and managers across a range of teams, H & SCPs and Boards find the current iMatter model and content to be relevant and useful in exploring staff experience, engagement and continuous improvement. There was also broad support for iMatter from trade union respondents and non-executive Board members. There is a comprehensive recognition of, and commitment to, the principles of the iMatter model across all national and local stakeholder groups. For NHSScotland, it represents an effective means of capturing staff experience and engagement in line with established Staff Governance Standards.

As noted in this report, the evidence suggests that iMatter benefits from a number of strengths including:

- support for the team-based approach and the ability to provide data on the experience of staff working relationships with their colleagues and supervisors/managers;
- support for iMatter as a validated ‘bespoke’ instrument and measure of staff experience issues, where the components/items were generated by NHSScotland staff - in other words, iMatter was viewed as a credible measure of experience because it was co-produced;
- the link from iMatter to recognised NHSScotland Staff Governance Standards - iMatter is viewed as a measurement of these standards across the range of staff experience;
- iMatter comprises a localised feedback component that allows an Action Plan to be developed by teams to address issues raised by the component measures and where progress can be reviewed, leading to better staff experience;
- iMatter is action-focused and provides the basis for the continuous improvement of teams. It goes beyond a ‘simple’ staff survey and is a ‘tool’ with the potential for team
ownership and empowerment, where problems are potentially solved by teams rather than by management;

- iMatter has been able to generate significantly high levels of staff response and the data can be considered to be more representative of staff views;
- iMatter is relatively quick to complete, the individual components are largely phrased in positive and/or neutral terms, and the components are largely easy to interpret;
- the utility of iMatter data to be used alongside other management tools and approaches (e.g. Quality Management, Leadership Development, Personal Development Plans and Annual Appraisals), and wider staff engagement or ‘cultural’ exercises or changes in Boards; and
- the transferability of iMatter to settings outwith NHSScotland (e.g. to H & SCPs and Council staff, and to other public sector workforces in Scotland).

An additional finding is that the adequate resourcing of key support roles – in this case played by Op Leads – is essential to supporting the implementation of initiatives such as iMatter. We found that Op Leads play a key role in raising awareness, keeping managers and teams informed of timescales and deadlines, delivering training, and offering encouragement, advice, coaching and support to staff and managers. It is important that there is continued support and investment for this work.

As noted in this report: “Most of the employees and managers participating in our research thought that Action Planning had been useful...” while others also noted the broader benefit of bringing teams together to spend ‘quality time’ together and discuss shared issues and challenges. We again noted that continued investment in training, coaching and sharing of good practice was required to maintain positive momentum around the Action Planning process. It is important that resources to provide support, training and coaching in implementing iMatter and Action Planning at team level are maintained and are sufficient.

An important area of future development might involve the strengthening of opportunities for managers and Op Leads to share good practice and lessons from the Action Planning process; and the content of Action Plans. iMatter online learning and guidance materials are useful and will benefit from further development. Nevertheless, there is a need consider how best to build upon online resources and opportunities for face-to-face learning across teams on the Action Planning process and examples of good practice.

In comparison with iMatter, response rates and buy-in for the D@W Survey are clearly more disappointing. While all of our respondents strongly supported action on dignity at work issues, there was limited enthusiasm (including among staff and managers) for the current annual survey exercise. There was agreement that the D@W agenda needs to be made more action-focused. We recommend that NHSScotland and partners institute a process of co-production – much like the exercises that informed the development of the successful iMatter process – to arrive at a consensus as to what staff and managers want from the D@W process, and how best to take forward the D@W agenda.

Our expert-led review of the usability of the iMatter online tool concluded that the design was consistent with good practice in online surveys. All of the staff and managers participating in our research were positive about the usability and ‘look and feel’ of iMatter.

Our research fieldwork identified a range of key facilitators associated with the effective implementation of iMatter, including:

- securing the visible leadership and buy-in of senior managers; senior management’s leadership of the dissemination of practical information about iMatter;
support for the crucial work of Op Leads in delivering information, support and training; 
effective IT systems and electronic communications; and 
ensuring sufficient information and support was available during team confirmation and 
Action Planning processes.

Our research finally identified a range of ongoing challenges and areas for further action for 
iMatter. These included:

• crucially, the need to continue to encourage senior and line manager buy-in and 
leadership of the iMatter process – it was suggested that where iMatter has struggled 
to gain traction, this is often a symptom of senior leadership team members failing to 
take full ownership and provide visible and committed leadership; 
• the need to continue to increase the number and quality of Action Plans; 
• the need to address staffing pressures that limit the time and opportunity for staff to 
engage with iMatter, Action Planning and continuous reflection on improving care 
• the need for continued work to support the establishment of iMatter teams that allow 
for effective Action Planning between line managers and staff; 
• ensuring that staff and management changes are identified quickly and effectively by 
iMatter systems; 
• ensuring that managers have access to information, coaching and training in both the 
basics of the iMatter process and Action Planning; and 
• the need to continue to support increasing participation in iMatter and Action Planning, 
and to ensure that Action Planning informs continuous improvement within teams.

In terms of technology-related challenges, while Op Leads and other stakeholders were 
broadly positive about the technology of iMatter, we conclude that further investment in server 
hosting facilities that would improve server capacity could help to resolve ongoing problems 
with data upload and storage.

There was strong support for further investment in the closer integration of iMatter with HR 
systems such as Turas and eESS, which might free up time for Op Leads, managers and 
others, so that energies can be focused on Action Planning and delivering continuous 
 improvement.

We also identified the potential benefit of App-based and SMS versions of iMatter in order to 
improve the reach of the tool to colleagues without ready access to IT.

A number of conclusions are clear from our research.

• iMatter benefits from being rooted in a process of co-production with staff and 
managers, so that its measures and processes are meaningful in context. 
• While response rates vary, they compare positively with the preceding National Staff 
Survey and many other engagement exercises, and generally demonstrate a high level 
of acceptance of and engagement with the iMatter process. This was confirmed by our 
discussions with staff and managers at various levels and across a range of Boards 
and H & SCPs. There is consensus that the iMatter process is of value. This seems to 
be due to the locally-relevant, team-based and action-focused approach of iMatter. 
• iMatter is therefore an effective model for capturing staff experience and promoting 
staff engagement. It is important that it continues to be supported and developed. 
• The visible leadership and encouragement of senior management teams for iMatter 
has been an important facilitator of success and should be strongly encouraged in all 
H & SCPs and Boards. 
• The work of Op Leads and their teams was valued by managers implementing iMatter 
– they play a key role in informing and supporting both the iMatter process and Action
Planning in response. It is important that this work continues to be resourced and further supported.

- While the content of iMatter appears to be appropriate and of value for staff and managers in reflecting on staff experience, there should be a continuing process of co-production and reflection on the content of the tool and how outputs are reported.
- There is strong support for the iMatter Action Planning process as a means of framing team-based actions. There is also awareness of challenges associated with limited time and resources and the need to maintain momentum on agreed actions. It is important that staff have time and resources for Action Planning and reflection. In the more immediate term, the work of Op Leads – or additional or alternative forms of support as appropriate – should be resourced to continue to assist teams to engage in Action Planning and continuous improvement.
- Resources are required to enhance opportunities to share good practice in Action Planning and outcomes across teams. This may involve further investment in a growing body of useful online materials, and/or creating opportunities for staff and managers to share practice in person.
- The design of the iMatter online tool works effectively for staff and is in line with good practice. There is an urgent need to explore technology-based solutions to maximise the reach of iMatter – this should involve investment in an App and/or the further roll-out of SMS versions.
- There is strong support for further investment in IT systems that streamline and integrate iMatter with other systems such as Turas and eESS. Such IT integration offers important opportunities to reduce the administrative demands of iMatter on managers and Op Leads, freeing them to concentrate on staff engagement work. Investment in such IT integration is both justified and urgently required.
- In conclusion, there is strong support for iMatter among staff, managers and other stakeholders, including trade union respondents and non-executive board members. iMatter has successfully rolled out a highly effective tool for capturing and reporting staff experience, and (crucially) informing actions on continuous improvement. It is important that the good practice associated with iMatter is shared and celebrated, and that there is renewed investment to build on this successful model, and tackle some of the continuing challenges identified in this report.

The evidence leads us to make the following Recommendations:

- **Recommendation 1:** There was near unanimous support among staff, managers and stakeholders, including trade union respondents and non-executive Board representatives, that iMatter is an effective model for capturing staff experience and promoting staff engagement. It is important that the iMatter approach is supported and resourced to build upon its successes to date. This should include continuing support to ensure access to information, coaching, training and learning for managers and staff involved in iMatter.
- **Recommendation 2:** There would be value in some re-consideration of the two statements that appear to promote relatively greater confusion among respondents. Assessing managerial visibility needs to be anchored both to clearer definition of who comprises ‘senior managers’ and to staff desires for visibility. There is also merit in anchoring the decision involvement question either specifically to Partnership working arrangements or to a specified level of organisational decision making.
- **Recommendation 3:** There would be value in considering how best to build upon online resources and opportunities for face-to-face learning across teams on the Action Planning process and examples of good practice.
- **Recommendation 4:** We recommend continuing the 60% threshold for iMatter reporting. However, we urge consistency in messaging to staff, so that their ownership of the iMatter process is reinforced. A shift in language among iMatter stakeholders –
away from the negative connotations of receiving “No Report” – may also be helpful. Language differentiating a standard “iMatter Report” from an “iMatter Max Report” (provided when the 60% threshold is achieved) might be more helpful.

**Recommendation 5:** The iMatter national team should continue to work towards the development of an easy-to-read ‘Dashboard’ that presents top-line key indicators. Reporting should also employ statistical significance testing to indicate change and potentially (because of ‘big’ sample numbers) utilise the more robust analytical power of multivariate data analysis.

**Recommendation 6:** In its current form, D@W neither offers robust measures, nor appears to engage respondents in the process or in actions arising. It is difficult to see a strong analytical argument for, or widespread stakeholder interest in, continuing D@W in its current form. However, given the importance of the broader issue of dignity at work, there may be merit in adopting a similar co-created process as with the development of iMatter, with a view to identifying key issues, themes and robust questions; agreeing an appropriate vehicle and unit of analysis outside of iMatter for these questions (for example, through Pulse surveys); and developing action-oriented outcomes so that staff feel safe to speak up, and are confident that they will be listened to and their concerns acted upon.

**Recommendation 7:** There is a need for iMatter partners to continue to build on what is an effective online tool, for example by ensuring accessibility for all relevant groups and considering any possible upgrades based on feedback from staff.

**Recommendation 8:** iMatter stakeholders should work together to ensure that there are opportunities to share examples of good practice and facilitators of success in the delivery of iMatter across teams, H & SCPs and Boards.

**Recommendation 9:** It is essential that senior managers and leadership team members at all levels within participating H & SCPs and Boards take ownership of, and provide visible and committed leadership for, iMatter. Where this has not been the case, substantial challenges have arisen in embedding iMatter. It is crucial that embedding and supporting iMatter is seen as a key task and not an optional extra by senior management/leadership team members.

**Recommendation 10:** There may be benefit in further investment in server hosting facilities that would improve server capacity, memory and speed. Investing in improved, Cloud-based server capacity would allow access to additional flexible capacity as and when required, as well as mitigating any risks to data storage.

**Recommendation 11:** There is a need to take immediate steps to support IT integration (for example, linking iMatter with Turas and eESS systems) that has the potential to free up time for Op Leads, managers and others, so that energies can be focused on Action Planning and delivering continuous improvement.

**Recommendation 12:** Progress should be made on the more extensive piloting of SMS and smartphone-friendly versions of the iMatter tool. Support should be provided for the development of an App-based version.
Acknowledgements

The research team is immensely grateful to all of the partners and staff in NHSScotland and in the Health and Social Care Partnerships who gave generously of their time in engaging with us on this research. We are also very grateful to the members of our Research Advisory Group who worked with us throughout this project, and to the Scottish Government iMatter Team who supported us in accessing documentation and people, and to the members of the Op Leads Network. We hope we have represented all of these voices appropriately. Any errors are, of course, our own.
References


SUBJECT: Risk Management Strategy

1. Purpose of the report

To provide the Board with a final draft of the revised Risk Management Strategy for approval.

2. Key Points

The risk management session at the Board seminar on 21 August 2019 explored the organisation’s risk management approach and undertook a self-assessment using the Audit Scotland Toolkit. A discussion also took place aimed at aligning the risk management approach with the Quality Management System. The self-assessment identified that risk management within HIS is largely of a good standard with the following areas identified for improvement:

- Risk management should be used to identify opportunities as well as risks
- Sharing risks with partners should be considered more closely as a form of mitigation
- Risk management could be better reported to stakeholders

A plan to implement improvements will be taken forward with the Risk Management Advisory Group.

During the seminar and subsequently, a number of questions were raised by Board members about clarifying the role of risk management within the organisation. These questions have been captured in Appendix 1 and a response has been provided for information. Where appropriate these questions have led to changes being made to the latest version of the draft Risk Management Strategy.

The final draft of the Risk Management Strategy is included at Appendix 2 and sets out the organisation’s approach to risk which is supported by the Compass risk database, a bespoke system developed by HIS in 2016. The revised Strategy was reviewed by the Audit and Risk Committee at its meeting on 4 September and the Committee was content to recommend its approval by the Board.

The revised Strategy is based on the latest BSI (British Standards Institution) standards for risk management – BS ISO 31000:2018. The key changes to the strategy following the Board Seminar are as follows:

a) The Corporate Risk Register has been renamed the Strategic Risk Register and it was agreed that this would be populated by the Board. To enable this to happen will require some time to be set aside with the Board.

b) The Operational Risk Register has been renamed the Operational Plan Risk Register to avoid confusion with the Operational category for risk appetite.

c) It is emphasised within the strategy that HIS have no tolerance for non-compliance with legal or regulatory duties and this includes breaches of health and safety regulations.

d) The risk appetite for the Workforce category was established as being cautious and this is included within the strategy. Work will take place to create this new category within the Compass system to allow reports to be drawn that match the strategy.

e) The roles of the Board and its Committees were discussed and agreed at the seminar and this is reflected in the strategy.
For the Board’s information, the management of risk within Healthcare Improvement Scotland will be the subject of a review by Grant Thornton as part of the Internal Audit Plan for 2019-20.

3. Actions/Recommendations

The Board is asked to:

a) Approve the Draft Risk Management Strategy (Appendix 2) for use by the organisation.

Appendices:

1. Feedback on Questions from Board Seminar
2. Draft Risk Management Strategy 6 September 2019

If you have any questions about this paper please contact Maggie Waterston, Director of Finance and Corporate Services, margaret.waterston@nhs.net, 0131 623 4608

<table>
<thead>
<tr>
<th>RISK</th>
<th>SUPPORTING INFORMATION</th>
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<tr>
<td>Do the key points represent a risk to the organisation?</td>
<td>If yes, has a risk been raised on the Compass Risk Management System</td>
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<tr>
<td>no</td>
<td>no</td>
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**OTHER CONSIDERATIONS**

How do the key points support the five priorities in the strategic plan:

- Enable people to make informed decisions about their own care and treatment;
- Help health and social care organisations to redesign and continuously improve;
- Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve;
- Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve;
- Make best use of all resources.

Effective risk management supports the achievement of all the organisation’s priorities, dealing with threats to successful delivery but also creating opportunities.

Resource Implications

The revised Risk Management Strategy will be embedded across the organisation by the Risk Management Working Group.

What engagement has been used to inform the work.

The risk register is an internal governance system which does not require external engagement. Engagement on the revised Strategy and corporate risk register has been undertaken with the Executive Team and the External Auditors.
<table>
<thead>
<tr>
<th>What Equality and Diversity considerations relate to the work.</th>
<th>There are no specific equality and diversity issues as a result of this paper. The corporate risk register outlines risks in relation to finance/resources.</th>
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<tbody>
<tr>
<td>Advise how the work:</td>
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<td>● helps the disadvantaged;</td>
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<td>● helps patients;</td>
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<td>● makes efficient use of resources.</td>
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Risk Management Approach – Feedback on Comments from Board Seminar

The table below captures the comments and questions raised by Board members on the revised risk management approach either at the Board Seminar on 21 August 2019 or via email. We have provided a response to each.

<table>
<thead>
<tr>
<th>Comments and Questions</th>
<th>Response</th>
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<tbody>
<tr>
<td>1 The name of the “corporate” risk register is confusing.</td>
<td>Agreed at Board Seminar to rename this the Strategic Risk Register.</td>
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</tbody>
</table>
| 2 Different risk appetites for different categories of risk are confusing.              | The NHS Scotland Blueprint for Good Governance states that the Board will set the organisation’s risk appetite. Within HIS, there is an established and embedded approach to risk that is based on assigning appetites to different categories of risk. This approach was arrived at with guidance from Internal Audit, alignment with the British Standard for risk management and the use of guidance from the Institute of Risk Management.

The Institute of Risk Management recognise that in all but the simplest businesses there is more than one appetite for risk and that the risk appetite has to be capable of being expressed differently for different categories of risk.

By assigning an appetite to categories will ensure that risks where the Board are most cautious will escalate to high risk more quickly than if the Board has a less cautious appetite. This enables identification of risks for priority review and action. |
| 3 What is the agreed appetite for the new Workforce category of risk?                    | The exercise at the Board seminar determined a “cautious” appetite for this category. This will be implemented and reviewed by the Board during 2020 alongside the review of the appetite for all categories.                                                                                                                                               |
| 4 Where do Health and Safety risks sit in the revised risk management approach?         | It was agreed at the seminar that these risks would be treated in the same way as legal and compliance risks in the Risk Management Strategy ie it is understood that there is no appetite to knowingly breach any health and safety requirements. The impact of a breach of any compliance requirements will determine the category that it is assigned to. |
| 5 The process for escalating risks is not clear.                                        | The tiered approach in the Compass risk system with risk managers, owners and directors ensures that there is oversight of risks across the organisation. The Compass system also enables risk managers to escalate to their director any risks that have increased suddenly.

The risk system is a live system and risks could be changed regularly. All risks are reviewed each month by the risk owner. The most recent assessments are escalated to ET monthly and to the Committees and Board for review depending upon the dates of meetings. |
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<tr>
<td></td>
<td>Each Committee provides a key points report to the Board and this should highlight any significant areas of risk that the Committee wish to escalate to the Board. Any Committee can ask for a more detailed review(s) of any risk within their remit and the Audit and Risk Committee can ask for a more detailed review of any area of risk that concerns them.</td>
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<tr>
<td>6</td>
<td>How do we ensure the Board’s ownership of risk?</td>
</tr>
<tr>
<td></td>
<td>The Board will continue to see all of the strategic risks and the high and very high risks from the operational plan risk register. They will also receive information about risks that have been escalated to the Board via the Committee structure. The role of the Board member is to gain assurance that the organisation is managing the risks that it faces by asking questions. They will review and challenge current risks and their ratings and identify new risks that require mitigation.</td>
</tr>
<tr>
<td>7</td>
<td>Risks are assigned to a Committee by the risk manager but how do we ensure Committees see all the risks relevant to their Committee?</td>
</tr>
<tr>
<td></td>
<td>When a risk is raised it is assigned to a Committee as part of the operation of the Compass system. This allows reports to be drawn from the system that are relevant to a particular Committee. The Audit and Risk Committee will maintain its role for the oversight of all risks while other Committees will review those within their remit. The Governance Committee Chairs meet regularly throughout the year to share updates on the business of their Committees. This is also an opportunity for a discussion around risk and to highlight any areas of risk common to more than one Committee and potentially risks to be considered in more detail by the Board.</td>
</tr>
<tr>
<td>8</td>
<td>Risk is not used to identify business opportunities.</td>
</tr>
<tr>
<td></td>
<td>This is an area for development and should be part of all risk discussions including by the Board and its Committees. It will also be taken forward as part of the work of the Risk Management Advisory Group.</td>
</tr>
<tr>
<td>9</td>
<td>There should be a thorough annual review (‘deep dive’) of the risk registers.</td>
</tr>
<tr>
<td></td>
<td>This has been added to the Board business planning schedule as an annual item and will incorporate a review of the risk appetite. Risk will be considered alongside the work to develop the organisation’s new strategy at the event in October.</td>
</tr>
<tr>
<td>10</td>
<td>The Audit and Risk Committee largely considers audit matters but does not consider risk in detail.</td>
</tr>
<tr>
<td></td>
<td>A fundamental role of the Audit and Risk Committee’s role is to review risks and risk management processes. The business planning schedule for the Audit and Risk Committee reflects the future business of the Committee and is reviewed at each meeting. We should explore further with the Committee Chair about the balance of audit v risk items on the agenda to ensure that the work of the Committee is appropriately balanced. The annual Internal Audit programme, agreed with the Committee, is based on the most significant risks identified in the risk registers. This work provides an independent review of the implications of the risks and should provide further assurances. The action plans resulting from the internal audit reviews are further mitigations of risk.</td>
</tr>
</tbody>
</table>
Draft Risk Management Strategy
2019-2021
6 September 2019
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Section 1 - Risk Management Overview

1. Introduction

Organisations of all types and sizes face internal and external factors and influences that make it uncertain about how they will achieve their objectives. The effect this uncertainty has on an organisation achieving its objectives is known as risk.

Healthcare Improvement Scotland’s approach to the management of risk is based on British Standards BS ISO 31000:2018 – risk management guidelines, which states that managing risk is:

- Iterative and assists organisations in setting strategy, achieving objectives and making informed decisions.
- Part of governance and leadership, and is fundamental to how the organisation is managed at all levels. It contributes to the improvement of management systems.
- Part of all activities associated with an organisation and includes interaction with stakeholders.
- Considers the external and internal context of the organisation, including human behaviour and cultural factors.

Assessing risk is a subjective exercise with some people being naturally cautious whilst others are risk takers meaning that there are likely to be differing opinions about risks and their ratings. The exercise is designed to provoke a thorough discussion of risks, their mitigations, impact and any potential opportunities that might arise and a difference of opinion should support these discussions.

Healthcare Improvement Scotland’s approach to risk management aims to be efficient, effective and consistent and is built on a review process with specific controls that are in place. This approach supports the Board to deliver its function in respect of risk management, as set out in the NHS Scotland Blueprint for Good Governance.

The Risk Management Strategy also recognises the diversity of work undertaken by Healthcare Improvement Scotland and the need to adjust the risk appetite accordingly.

2. Principles

The purpose of risk management is the creation and protection of value. It should improve performance, encourage innovation and support the achievement of objectives. The principles outlined in BS ISO 31000:2018 have been adopted by Healthcare Improvement Scotland. They provide guidance on the characteristics of effective and efficient risk management, communicate its value and explain its intention and purpose. They are set out as follows:
3. Framework

The effectiveness of risk management will depend on its integration into the governance of the organisation which includes decision-making. Healthcare Improvement Scotland uses a framework based on the British Standard to assist with integrating risk management into its significant activities and functions and is shown below. This requires support from the leadership team, staff and Board Members.

- **Leadership and commitment** – ensure risk management is integrated into all activities to assist with the achievement of objectives.
- **Integration** - dynamic and iterative process; customized to the organisation’s needs and culture via the Compass Risk Management system.
- **Design** – using the external and internal context; assigning and communicating roles, responsibilities and resources.
- **Implementation** – developing an appropriate plan; ensuring it is clearly understood and practised.
- **Evaluation** - periodically measure the performance of the risk management strategy.
- **Improvement** - continually improve and embed the process across the organisation using the Quality Management Approach.
A Risk Management Advisory Group has been set up with representatives from each directorate. They have a key role in embedding this framework and in spreading the learning from risk by agreeing and sharing best practice and by providing advice.

The role of the Board and the Governance Committees is set out fully in the NHS Scotland Blueprint for Good Governance and in the terms of reference for their operation in the HIS Code of Corporate Governance. The Board is responsible for providing leadership and commitment to the organisation around the management of risk. The Blueprint states that the role of the Board in assessing risk is to:

- 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.

The UK Corporate Governance Code states that the Board is responsible for determining the nature and extent of the significant risks that it is willing to take in achieving its strategic objectives. The Board should maintain sound risk management and internal control systems.

Within HIS, the escalation process for risk is routed through the Governance Committees to the Board.
Section 2 – Risk Management Process

This section sets out how the approach of BS ISO 31000:2018 is translated into the practical steps of managing risk within Healthcare Improvement Scotland where two risk registers are in place:

- Strategic Risk Register – risks which impact on the delivery of the strategic objectives of the organisation
- Operational Plan Risk Register – risks which impact on delivery of the operational plan

Project teams and business groups maintain their own risk systems to reflect those risks associated with work programmes. These should be continually reviewed and monitored as part of the programme management process to consider if they should be escalated to either the Operational Plan Risk Register (if the risk is sufficient to impede delivery of the Operational Plan) or the Strategic Risk Register (if the risk is significant or contributes to other risks that could impact on achieving the organisation’s strategic objectives).

There are three aspects to the risk management process: communication and consultation; scope, context and criteria; and the formal process of risk assessment.

a) Communication and Consultation

Communication and consultation with stakeholders should be held at every stage of the process in order to improve understanding of the risk and associated decision-making. Stakeholders are other people or organisations who may be affected by the risk or decisions made eg they may be external or internal, such as team members or other cross organisational staff.

b) Scope, Context and Criteria

When a risk is identified, consideration should be given to how it aligns to the organisation’s objectives which are set out in the Strategy and the Operational Plan. This enables a plan or mitigation to be agreed in order to manage the risk. The context of the risk must also be considered eg external factors could be national policy or stakeholder relationships and internal factors could be organisational structures and cultures.

NB. Underpinning any consideration of risk is the requirement that Healthcare Improvement Scotland will not knowingly breach any legal or regulatory requirements or duties. This includes adherence to health and safety standards.

Risk criteria relate to the amount of risk that the organisation has decided it will take in relation to different categories of risk eg reputational, delivery of corporate objectives, financial or workforce categories. This is called risk appetite and will be explained as part of the risk assessment process at stage 4b. The Board will decide the level of the organisation’s risk appetite and this will be reviewed regularly and updated on the Compass Risk Management System.

c) Risk Assessment

Risk assessment is the overall process for identifying, analysing and evaluating risk. The process is outlined below and support is available from the Risk Management Advisory Group to anyone who is uncertain about how to use the process.
All strategic and operational plan risks are recorded on the Compass Risk Management System which provides regular prompts to ensure that risks are properly recorded and reviewed.

Risk management roles and responsibilities are shown in Section 3 and a risk management process flowchart is available at Appendix 1. This should assist staff to apply risk assessment and review using the Compass Risk Management system.

The process of risk assessment within Healthcare Improvement Scotland incorporates the following stages:

<table>
<thead>
<tr>
<th>Stage in Process</th>
<th>Description</th>
<th>Further Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Risk Identification</td>
<td>The process of finding and describing a risk. This can be from a variety of sources eg discussions at meetings, horizon scanning, internal/external stakeholders, incidents etc.</td>
<td>The Compass Risk System has been developed by Healthcare Improvement Scotland to support delivery of the Risk Management Strategy and to assist staff to record and manage risk.</td>
</tr>
<tr>
<td>2 Risk Description</td>
<td>A clear description is required which also identifies the potential impact on the organisation should it materialise. The adopted protocol in HIS for describing a risk states the possible risk, the possible cause and the potential impact.</td>
<td>Example: ‘there is a risk of x because of y resulting in z’</td>
</tr>
<tr>
<td>3 Risk Analysis</td>
<td>This stage enables a better understanding of the nature of the risk and there are a number of actions (3a to 3d below) that support the analysis.</td>
<td></td>
</tr>
<tr>
<td>3a Assign a Risk Category</td>
<td>This requires a choice between 4 categories: Financial/Value for Money; Delivery of Corporate Objectives; Reputational/Strategic and Workforce.</td>
<td>See Table A below for a description of each category to assist with assigning the risk</td>
</tr>
<tr>
<td>3b Describe any controls that are in place</td>
<td>Controls are any operational process, policy, system or procedure that will be used when considering actions to reduce the possibility of the risk occurring</td>
<td></td>
</tr>
<tr>
<td>3c Describe the mitigations that will be put in place</td>
<td>Mitigations are the actions to be taken to manage or treat the risk. These could include: the actions to be taken; the timescale for implementation and any resource/budget requirements</td>
<td></td>
</tr>
<tr>
<td>3d Assign the risk to a Governance Committee</td>
<td>An integral part of the role of each Governance Committee is to review the risks within its remit at each of its meetings.</td>
<td>Table B below provides some guidelines to apply when choosing the appropriate committee</td>
</tr>
<tr>
<td>4 Evaluate the Risk</td>
<td>This stage incorporates a number of steps (4a to 4c below) to evaluate the risk which will support decisions to be made about treating the risk</td>
<td></td>
</tr>
<tr>
<td>4a Score the Risk</td>
<td>An estimate of the impact of a risk and the likelihood of it occurring need to be made in order to arrive at a score.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>The impact score</strong> is a rating of how significant the impact would be for the organisation, if the risk was realised. These range from negligible to extreme.</td>
<td><strong>Appendix 4</strong> provides guidance for the impact definitions against each category of risk.</td>
<td></td>
</tr>
<tr>
<td><strong>The likelihood score</strong> is the chance or likelihood of that impact occurring.</td>
<td><strong>Table C</strong> below describes the likelihood of the risk occurring</td>
<td></td>
</tr>
<tr>
<td><strong>4b Apply Risk Appetite</strong></td>
<td>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 appetites in use for HIS are open, cautious or minimalist and are applied automatically by the Compass Risk Management System. See Table D below. This will determine whether to rate the risk as very high, high, medium or low. A view can then be taken about whether or not the treatment of the risk is adequate.</td>
<td><strong>Appendix 5</strong> provides descriptors for appetite and also guidance for the risk appetite against each category of risk. <strong>Appendix 6</strong> shows the risk appetite matrices ie the risk outcome depending upon its score and the appetite of the category that it is placed into. <strong>Across all categories of risk it is understood that there is no appetite to knowingly breach any legal or regulatory requirements or duties.</strong></td>
</tr>
<tr>
<td><strong>4c Treatment</strong></td>
<td>If the risk is outwith the appetite and tolerances set by the Board the process of selecting and implementing measures to modify the risk takes place. Risk treatment can include the following: • Avoid the risk • Accept or increase the risk to pursue an opportunity • Remove the risk source • Change the likelihood of the risk occurring • Change the impact of the risk • Share the risk • Retain the risk by informed decision</td>
<td></td>
</tr>
<tr>
<td><strong>4d Escalation</strong></td>
<td>Significant risks are escalated to the appropriate person, group or Committee to review the decisions and actions that are being implemented to mitigate the risk. Reasons for escalation are varied and may be that a risk score has increased or a new risk has been identified that is very high.</td>
<td>All high and very high risks associated with the Operational Plan are considered by ET, Governance Committees and the Board. All strategic risks are considered by ET, the Audit &amp; Risk Committee and the Board.</td>
</tr>
<tr>
<td><strong>5 Monitor and Review</strong></td>
<td>The monitoring and review process assures and improves the quality and effectiveness of risk management.</td>
<td>This is an ongoing process that is embedded within the organisation and involves the review of risk at all levels ie team, directorate, ET, Governance Committee and Board.</td>
</tr>
</tbody>
</table>
Table A - Risk categories (Step 3a in process)

<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>

Table B – Assigning Risk to Governance Committees (Step 3d in process)

The following guidelines apply when assigning risks to a governance committee:

<table>
<thead>
<tr>
<th>Governance Committee</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit and Risk Committee</td>
<td>risks related to corporate governance, internal controls, audit and finance</td>
</tr>
<tr>
<td>Quality and Performance Committee</td>
<td>risks related to strategic objectives and corporate strategies covering the whole organisation</td>
</tr>
<tr>
<td>Staff Governance Committee</td>
<td>risks related to workforce, capacity and human resources</td>
</tr>
<tr>
<td>Scottish Health Council</td>
<td>risks related to the work programmes and resources of the Scottish Health Council</td>
</tr>
<tr>
<td>Executive Remuneration Committee</td>
<td>risks related to senior level posts in the organisation (these risks most likely to be raised by Chair of the Board, Chair of the ERC or the Chief Executive only)</td>
</tr>
<tr>
<td>Board</td>
<td>Strategic risks that are captured in the Strategic Risk Register and high risks identified from the Operational Plan Risk register</td>
</tr>
</tbody>
</table>
Table C – Score the Risk - Likelihood descriptions (step 4a in process)
(Guidance for impact definitions v category of risk can be found at appendix 2)

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Chance of occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rare</td>
<td>Very little evidence to assume this event would happen – will only happen in exceptional circumstances</td>
</tr>
<tr>
<td>2</td>
<td>Unlikely</td>
<td>Not expected to happen, but definite potential exists – unlikely to occur.</td>
</tr>
<tr>
<td>3</td>
<td>Possible</td>
<td>May occur occasionally, has happened before on occasions – reasonable chance of occurring</td>
</tr>
<tr>
<td>4</td>
<td>Likely</td>
<td>Strong possibility that this could occur – likely to occur</td>
</tr>
<tr>
<td>5</td>
<td>Almost certain</td>
<td>This is expected to occur frequently / in most circumstances</td>
</tr>
</tbody>
</table>

Table D – Risk Appetite - Descriptions (Step 4b in process)

<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, 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, 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>
</tbody>
</table>

NB: Across all categories of risk it is understood there is no appetite to knowingly breach any legal or regulatory requirement or duties.
Section 3 – Risk Management Roles and Responsibilities

Risk Manager
Definition: Team Leads/Line Managers – Programme/Projects/Operational. Managers will identify and be assigned to manage risk within their area of responsibility. The role includes:
- Responsibility to oversee all aspects of the risk(s) within their area of responsibility and identifying risk collaborators and reviewers
- Determining and/or authorising the actions needed to mitigate risk
- Ensuring that risks assigned to them are kept up to date
- Regular liaison and communication through the risk reporting process as required

Risk Owner
Definition: Function Leads. The risk owner is responsible for ensuring that risk is effectively managed across and within their specific areas of responsibility. The role includes:
- Responsibility to oversee all aspects of the risk(s) within area of responsibility including identifying risk managers
- Determining and/or authorising the actions need to mitigate risk
- Ensuring that risk management is integrated throughout their area of responsibility
- Regular liaison and communication through the risk reporting process as required

Risk Director
Definition: Risk director is the accountable officer within their area of responsibility. They also have a responsibility for organisational wide risk and so provide assurance to the Board and the Accountable Officer of the effectiveness of the risk control measures.

<table>
<thead>
<tr>
<th>Board</th>
<th>Audit &amp; Risk Committee</th>
<th>Other Governance Committees</th>
<th>Executive Team</th>
<th>Team Managers</th>
<th>All Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board will comply with the requirements of the Blueprint for Good Governance (page 5). They will assure and monitor risk management having received recommendations from the detailed scrutiny by the Audit and Risk Committee. Review all strategic and very high operational plan risks at every meeting.</td>
<td>Assure and monitor the effective development and operation of risk management. Review all Strategic and high/very high operational plan risks at every meeting.</td>
<td>Review strategic and high/very high operational plan risks within their remit.</td>
<td>Reviews strategic and operational plan risks monthly. Ensure risk management operates effectively.</td>
<td>Makes review of risk a standing item at Directorate Management Team meetings and unit meetings.</td>
<td>Consider and report all risks and incidents that could impact on their particular area of work. Ensure action is taken to manage risks.</td>
</tr>
</tbody>
</table>

The terms of reference for the Risk Management Advisory Group are attached at Appendix 5.
Appendix 1: Risk Management Process Flowchart for using Compass

Step 1 - Risk identification
Risks will most commonly be identified during discussions at team or management meetings, or with the directorate’s risk lead. Risks may also be identified when risk management is discussed at Board, Committee or Executive Team meetings. The most significant risks which could prevent the organisation delivering its key objectives are added to the Compass risk management system and a risk manager is assigned to the risk.

Step 2 – Risk analysis
The risk manager accepts or declines the proposed new risk on the Compass system. If the new risk is accepted, the risk manager analyses the risk by identifying controls and mitigations for the risk and considers the following information which is added to Compass – risk owner and risk director; governance committee; risk controls; risk mitigations; narrative update to describe the latest position of the risk. The risk manager also decides how the risk will be treated.

Step 3 - Risk evaluation
The risk manager assigns risk scores taking into account the mitigations. Scores are assigned for impact and for likelihood. These are multiplied and the risk appetite added automatically by Compass to give the final level of the risk.

Step 4 – Monitoring and review
Every month the risk manager receives via email a reminder to update their current risks. The risk manager should review all aspects of the risk including controls and mitigations as well as the narrative update and the score. The risk manager should also consider if the risk should be closed if it is no longer an active risk. The risk can be updated at any time between reminders by accessing the Risk Updates section on Compass.
Every month the risk owner and risk director will receive a reminder to review risks assigned to them. During the month consideration should also be given to project risks in case they require escalation to the Operational Plan Risk Register or the Strategic Risk Register on Compass.

Step 5 – Reporting and recording
During the course of the month reports of active risks will be extracted from Compass for discussion at Board, Committee, Executive, management and team meetings. During these discussions updates to current risks may be identified, new risks identified, escalation of risks or risk closures agreed.
## Appendix 2: Impact definitions v category of risk for guidance

<table>
<thead>
<tr>
<th>Impact Descriptor v Category of Risk</th>
<th>Negligible (1)</th>
<th>Minor (2)</th>
<th>Moderate (3)</th>
<th>Major (4)</th>
<th>Extreme (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operational (examples)</strong></td>
<td>Barely noticeable reduction in scope, quality or schedule.</td>
<td>Minor reduction in scope, quality or schedule.</td>
<td>Reduction in scope or quality of project; project objectives or schedule.</td>
<td>Significant project overrun.</td>
<td>Inability to meet project objectives; reputation of the organisation seriously damaged.</td>
</tr>
<tr>
<td></td>
<td>Interruption in a service which does not impact on day to day business activities.</td>
<td>Short term disruption with minor impact on business activities.</td>
<td>Some disruption in service with unacceptable impact on business activities.</td>
<td>Sustained loss of business services which has serious impact on day-to-day activities.</td>
<td>Permanent loss of core business services or facilities. Disruption to facility leading to significant “knock on” effect.</td>
</tr>
<tr>
<td></td>
<td>Small number of recommendations which focus on minor quality improvement issues.</td>
<td>Recommendations made which can be addressed by low level of management action.</td>
<td>Challenging recommendations that can be addressed with appropriate action plan.</td>
<td>Enforcement action. Low rating. Critical report.</td>
<td>Prosecution. Low rating. Severely critical report.</td>
</tr>
<tr>
<td><strong>Workforce (examples)</strong></td>
<td>Short term low staffing level temporarily reduces quality (&lt; 1 day).</td>
<td>Ongoing low staffing level reduces quality.</td>
<td>Late delivery of key objective / business activities due to lack of staff. Moderate error due to ineffective training/implementation of training. Ongoing problems with staffing levels.</td>
<td>Uncertain delivery of key objective/activity due to lack of staff. Major error due to ineffective training/implementation of training.</td>
<td>Non-delivery of key objective/activity due to lack of staff. Loss of key staff. Critical error due to ineffective training/implementation of training.</td>
</tr>
</tbody>
</table>
## Appendix 3: Risk appetite descriptor matrix for guidance

<table>
<thead>
<tr>
<th>Classification of Risk appetite</th>
<th>2 Minimalist</th>
<th>3 Cautious</th>
<th>4 Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward.</td>
<td>Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.</td>
<td>Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc).</td>
<td></td>
</tr>
</tbody>
</table>

### Category of risk

#### Financial/value for money

- Only prepared to accept the possibility of very limited financial loss if essential.
- Value for money is the primary concern.

- Prepared to accept the possibility of some limited financial loss.
- Value for money still the primary concern but willing to also consider the benefits.
- Resources generally restricted to core operational targets.

- Prepared to invest for reward and minimise the possibility of financial loss by managing the risks to a tolerable level.
- Value and benefits considered (not just the cheapest price).
- Resources allocated in order to capitalise on potential opportunities.

#### Operational

- Innovations always avoided unless essential.
- Only essential systems/technology developments to protect current operations.
- Close scrutiny by senior management.

- Tendency to stick to the status quo, innovations generally avoided unless necessary.
- Decision making authority supported by senior management.
- Systems/technology developments limited to protection of current operations.

- Innovation supported, with demonstration of commensurate improvements in management control.
- Systems/technology developments considered to enable operational delivery.
- Responsibility for non-critical decisions is devolved.

#### Reputation/credibility

- Tolerance of risk taking limited to those events where there is no chance of any significant repercussions for the organisation.

- Tolerance for risk taking limited to those events where there is little chance of any significant repercussions for the organisation should there be a failure.

- Appetite to take decisions with potential to expose the organisation to additional scrutiny but only where appropriate steps have been taken to minimise any exposure.

#### Workforce

- Close scrutiny by senior management.
- Only essential developments to protect current operations.
- Want to be very sure we would win any challenge.
- Zero tolerance for health and safety risks.

- Decision making authority supported by senior management.
- Developments limited to protection of current operations.
- Prepared to accept minimal, well managed H&S risks to achieve outcomes.
- Want to be reasonably sure we would win any challenge.

- New developments considered to enable operational delivery.
- Responsibility for decisions are devolved within agreed framework.
- Prepared to accept minimal, well managed H&S risks to achieve outcomes.
- Challenge will be problematic but we are likely to be successful and the gain will outweigh the adverse consequences.
## Appendix 4 – Risk appetite matrices

<table>
<thead>
<tr>
<th>OPEN</th>
<th>CAUTIOUS</th>
<th>MINIMALIST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Risk Assessment</strong></td>
<td><strong>Risk Assessment response</strong></td>
<td><strong>Net Risk Assessment</strong></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>16-25 – Very High</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>11-15 – High</td>
</tr>
<tr>
<td>8-12 – Medium</td>
<td>Acceptable level of risk exposure subject to regular active risk monitoring measures</td>
<td>6-10 – Medium</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>1 – 5 - Low</td>
</tr>
</tbody>
</table>
Appendix 5: Risk Management Advisory Group Terms of Reference

Aims
The aims of the Risk Management Advisory Group are:

- to support staff to understand the management of risk
- to assist staff with recording risks
- to implement, embed and improve risk management across their units/directorates
- to provide assistance with the review of risks at senior team meetings
- to lead regular reviews of the risk registers across their directorates
- to support the culture change required to communicate the benefit and impact of managing risk
- to promote how the intelligence from the management of risk can be used to support and improve governance and business priorities
- to provide a forum for sharing ideas, learning and best practice

Membership
The Advisory Group Membership is as follows:

- Director of Finance and Corporate Services (Chair)
- Head of Finance and Procurement, Operational Risk Lead
- Corporate Governance Manager
- Partnership Forum representative
- Representative(s) from each of the Directorates

Administration
Appropriate administrative support will be provided by the Corporate Governance Office to take notes of the meetings, collate and circulate papers and ensure follow up actions are delivered. Agendas will be circulated 7 days prior to the meeting and an action point register will be circulated within 7 days after the meeting.

Frequency
The Advisory Group will meet quarterly but will also convene between meetings where necessary.

Reporting arrangements
The Advisory Group will report, through the Chair, to the Executive Team.
DOCUMENT CONTROL SHEET

Title: Risk Management Strategy
Date of Issue: xx
Date Effective From: xx
Version/Issue Number: xx
Document Type: Policy
Document status: Draft
Author: Pauline Symaniak, Corporate Governance Officer
Owner: Maggie Waterston, Head of Finance and Corporate Services
Approver: Audit and Risk Committee/Board
Contact: p.symaniak@nhs.net

Revision History

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<th>Date</th>
<th>Summary of Changes</th>
<th>Name</th>
<th>Changes Marked</th>
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Approvals: This document requires the following signed approvals:

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<th>Title:</th>
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<tr>
<td>Executive Team</td>
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<td>Executive Team</td>
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<tr>
<td>Audit and Risk Committee</td>
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<td>Audit and Risk Committee</td>
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Distribution: This document has been distributed to:

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Linked Documentation:

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<tr>
<td>BS ISO 31000:2018</td>
<td>Available in hard copy only (copyright laws apply)</td>
</tr>
<tr>
<td>Training materials</td>
<td>Source</td>
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</table>

Dissemination arrangements:
Executive Team
Partnership Forum
Notification via Directorate management team/team meetings
Risk Management Working Group
Published via Source
Corporate induction
SUBJECT: Risk Management: Corporate Risks

1. Purpose of the report
To provide the Board with the corporate risk register to enable them to review risk across the organisation.

2. Key Points

a) 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 corporate risks as at 17 September 2019 (Appendix 1).

b) The very high operational risks were previously provided to the Board as part of this risk management update. However, they are now included as an appendix within the revised Organisational Performance Report at agenda item 3.1. This should allow the Board to review operational risks within the context of organisational performance.

c) Since the previous Board meeting in June, the Executive Team have undertaken a collaborative and detailed review of the corporate risk register and have individually reviewed the operational risk register. Appendix 1 reflects the updated corporate risks. The movement schedule at Appendix 2 shows the changes to corporate risks since the Board meeting in June, including risks that have been closed and any new risks that have been raised.

d) A grid showing the risk appetite and scoring is attached for reference at Appendix 3.

e) The Board is asked to refer to the paper provided at agenda item 5.1, the draft revised Risk Management Strategy, and to note that the new Strategy is not yet reflected in the corporate risk register presented at Appendix 1 or in the information in Appendix 3. Following approval of the Strategy by the Board, the Compass system will be updated to ensure alignment and future reporting will represent the revised strategy.

f) 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.

3. Actions/Recommendations
The Board are 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.
**Appendices:**
1. Corporate Risk Report
2. Movement Schedule
3. Risk Appetite Definition

If you have any questions about this paper please contact Maggie Waterston, Director of Finance and Corporate Services, [Maggie.waterston@nhs.net](mailto:Maggie.waterston@nhs.net), 0131 623 4608 ext 8580

## SUPPORTING INFORMATION

### RISK

<table>
<thead>
<tr>
<th>Do the key points represent a risk to the organisation?</th>
<th>If yes, has a risk been raised on the Compass Risk Management System</th>
<th>If yes, provide the risk number, risk description and risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OTHER CONSIDERATIONS

<table>
<thead>
<tr>
<th>How do the key points support the five priorities in the strategic plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enable people to make informed decisions about their own care and treatment;</td>
</tr>
<tr>
<td>• Help health and social care organisations to redesign and continuously improve;</td>
</tr>
<tr>
<td>• Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve;</td>
</tr>
<tr>
<td>• Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve;</td>
</tr>
<tr>
<td>• Make best use of all resources.</td>
</tr>
</tbody>
</table>

The risk register underpins delivery of the organisation’s strategy including these 5 priorities. Discussion of the risk register and its impact on delivery of the organisation’s plan is a key part of the assurance arrangements of the organisation.

### Resource Implications

The implementation, management and training of risk is being conducted on a team basis and forms part of management responsibilities. There are no additional resource requirements.

### What engagement has been used to inform the work.

The risk register is an internal governance system, which does not require external engagement.

### What Equality and Diversity considerations relate to the work.

There are no specific equality and diversity issues as a result of this paper.

- helps reduce health inequalities;
- helps people who are service users;
- makes efficient use of resources.
### Item 5.2 Appendix 1 – Corporate Risks (at 16/9/19)

<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>Date Risk Last Reviewed by Committee</th>
<th>Current Risk Level</th>
<th>Aug - 2019</th>
<th>Jul - 2019</th>
<th>Jun - 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational</td>
<td>Business</td>
<td>908</td>
<td>Safia Qureshi</td>
<td>There is a risk that HIS doesn’t have a system for systematically reviewing the quality of key national metrics/indicators (eg access, harm) which could mean that our quality assurance and quality improvement work is not sufficiently informed. This could result in the potential to miss the early signs of a serious service failure.</td>
<td>Data comes from established sources and is quality assured. Indicator review group reviews and signs off. Escalation options encompass the responding to concerns process, the role of SIHCG and access to national data and our MOUs with other organisations.</td>
<td>Key metrics selected will be reviewed over the next two cycles. The analysis will be shared at the internal sharing meetings, with the Quality of Care organisational reviews and the emerging concerns team.</td>
<td>The first meeting to consider patterns in key metrics for all NHS boards took place on 24 July 2019 with colleagues from NSS Information Services Division. The metrics were considered to be fit for purpose although the group will review this after the next meeting in October including whether community care is sufficiently represented. DMBI considered on 13 Sept 2019 whether this should continue to be a risk and agreed it’s still open until our transition year is complete.</td>
<td>Audit &amp; Risk, 6/9/19</td>
<td>Low</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Financial / Value for Money</td>
<td>Finance</td>
<td>635</td>
<td>Margaret Waterston</td>
<td>There is a risk of not meeting our delivery commitments because of changing and competing priorities around our workplan due to the significant amounts of additional short term financial allocations resulting in difficulties in managing a 12 month budget in accordance with Scottish Government guidelines.</td>
<td>Regular Management Accounts information prepared with the support of budget holders, Sharper focus during 2019-20 on initial budget phasing leading to monthly forecasting based on interpretation of monthly spend patterns, commitments raised and understanding of changes to workplan. Monthly information will be a mix of narrative and graphical to assist with understanding.</td>
<td>Training for all new budget holders and refresher training for all existing budget holders Timeous financial information to be available for ET to consider Financial position to be a regular item on DMT agenda Management Accountants to attend DMT meetings.</td>
<td>The 2019-20 budget challenges are well understood and documented within the financial plan 2019-22. Work is underway to manage all commissions from SG via the operating framework whilst aiming to incorporate as many additional allocations as possible into our baseline funding. An internal change programme has been instigated to improve efficiency and to enable achievement of recurring savings to ensure longer term sustainability.</td>
<td>Audit &amp; Risk, 6/9/19</td>
<td>Medium - 10</td>
<td>Impact - 5</td>
<td>Likelihood - 2</td>
<td></td>
</tr>
<tr>
<td>Reputational / Credibility</td>
<td>ICT</td>
<td>923</td>
<td>Margaret Waterston</td>
<td>There is a risk that our ICT systems could be compromised because of a cyber security attack resulting in staff being unable to deliver our work and causing reputational damage.</td>
<td>Controls that are in place include: no direct connection to the internet and two Dell Sonicwall firewalls between the Swan 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</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. Avanti 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.</td>
<td>Alerts are sent nationally whenever any suspicious activity takes places across NHSScotland 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>n/a – new risk</td>
<td>Medium - 12</td>
<td>Impact - 4</td>
<td>Likelihood - 3</td>
<td></td>
</tr>
</tbody>
</table>
### Operational Credibility

<table>
<thead>
<tr>
<th>Information Governance Strategy</th>
<th>Safa Qureshi</th>
<th>759</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>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 schedule, internal permissions audit, ongoing monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Corporate privacy notices and the data protection policy have been updated and approved by policy sub-group and will be reissued to all staff. An online disposal register for asset owners and administrators to complete at the time of record disposal is in testing phase prior to an end of year call for destruction action. Ongoing monitoring is illustrating a need for concise reminders regarding data protection guidance which will be delivered via the Intranet.</td>
</tr>
<tr>
<td>Audit &amp; Risk, 5/9/19</td>
<td>Medium - 9</td>
<td>Impact - 3</td>
<td>Likelihood - 6</td>
</tr>
</tbody>
</table>

### Operational Learning from Adverse Events

<table>
<thead>
<tr>
<th>Learning from Adverse Events</th>
<th>Alastair Delaney</th>
<th>903</th>
<th>There is a risk that HIS will not play an effective role in improvement of adverse events management in NHS Scotland; because of staff changes and associated loss of expertise, combined with uncertainty about the focus of future work and resourcing of same; resulting in negative impact on key stakeholder relationships combined with missed opportunities to improve practice by NHS Boards which would benefit patients and their carers/families.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Self-assessments submitted by NHS Boards of their performance against the National Framework for Adverse Events. Baseline evaluation providing an overview of NHS Boards’ self-assessments of performance will be ready for publication in September. This provides an evidence base to inform future activity. Boards are required to submit notifications of suicide reviews to HIS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Communication clarifying HIS position in respect of baseline evaluation report sent previously to sponsor team by Chief Executive. Discussions ongoing with Openness &amp; Learning team and NHS Education for Scotland to agree focus of future work. Focus of this to be announced by Cab Sec upon publication of baseline report on 10 Sep.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Following a number of recent meetings, HIS and NHS Education for Scotland (NES) have been invited by Scottish Government to submit joint proposals to streamline the ways in which NHS Boards review and learn from incidents where something has gone wrong, and/or harm or death is caused. This proposed joint commission would facilitate a positive collaboration between HIS and NES, drawing on the strengths and expertise of both organisations to combine support offered to NHS Boards for a shared purpose and increased impact.</td>
</tr>
<tr>
<td>Audit &amp; Risk, 6/9/19</td>
<td>High - 16</td>
<td>Impact - 4</td>
<td>Likelihood - 4</td>
</tr>
</tbody>
</table>

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**Notice:** The table includes risks and likelihoods assessed using a matrix. Categories are as follows:

- **Likelihood:** Low, Medium, High
- **Impact:** Low, Medium, High
- **Action:** Ongoing monitoring, forthcoming action, etc.
| Operational | Making Care Better Strategy 2017-2022 | 901 | Robbie Pearson | There is a risk that we are not committing 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 * HIS new commissions process | * Further development of the new commissions process to include requirement 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. | Current financial situation means we are likely to see a natural reduction in requests for funded new programmes of work. However this increases the need to be clear on potential funding streams before starting any scoping work as increases the potential of considerable work being undertaken to design a new programme when there is no identified source to fund. | Audit & Risk, 6/9/19 | High - 16 Impact - 4 Likelihood 4 | - 0 | - | - |

| 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 made alternative arrangements due to the expectations of the Shared Services Estates planning work that is in its early stages resulting in short term arrangements that may be costly and which may not suit the needs of our workforce. | Currently working with SFT and National Boards programme to understand alternative options Contacting current landlord to understand potential for various types of lease extension and associated cost Working with National Boards on potential consolidation of office space in Glasgow and associated co-location opportunities and potential impact. | Work is underway to look at alternatives. This should provide sufficient time for options appraisals and decision making to allow an orderly transfer of staff to alternative accommodation. | Discussions are taking place between national boards, particularly NHS24 and NES who also have lease expiry during 2021/2022 to understand potential options. Avison Young have been commissioned to research potential options for HIS. Contacts have been made with Scottish Government surveyors who are guiding us through the process and capital investment protocols. An options appraisal will be prepared for the autumn which will include the potential to extend the lease at Delta House should a solution not materialise. | Audit & Risk, 6/9/19 | High - 15 Impact - 5 Likelihood 3 | High - 15 | High - 15 | High - 15 |

| Reputational / Credibility | Quality of Care Reviews | 899 | Alastair Delaney | There is a risk that the HIS QoC approach and methodology cannot be appropriately applied to the diversity/complexity of larger NHS organisations which could result in reviews that are not sufficiently robust impacting negatively upon the reputation of the organization and undermining interdependencies across HIS. | The after action review process will identify changes required to the methodology. No further board level reviews will be undertaken until new proposals accepted by ET. | A wider after action review of internal and external stakeholders will allow HIS to reflect and improve our methods. An external review of Ayrshire and Arran process has been undertaken with lessons to be learnt. Both these reviews will be used to identify proposals for change which will be taken to ET for approval in advance of any further reviews. Non Executive Directors will form a sub-group of PQG to assist in consideration of this review. | In deploying the approach to board level reviews undertaken in NHS Orkney to NHS Ayrshire and Arran it became apparent that there were significant issues. These related to the processes and procedures used and the reliability of evidence to form judgements. A number of immediate lessons have been learned for the ongoing review into Golden Jubilee Hospital. A review of the methodology is being led by the Depute Director of QAD. The risk is very high due to the fact that until the nature of the changes required become clear, they could impact on the timetable for delivery of the next board review, or ultimately require | Audit & Risk, 6/9/19 | Very High - 20 Impact - 5 Likelihood 4 | Very High - 20 | Very High - 20 | Very High - 20 |
changes that will mean changes to staffing or resources. A paper outlining how QAD intend to review the approach was approved by ET on 6 August. Paper approved by Q&P Committee on 15 August. Discussed at ARC on 4 September. Golden Jubilee report was approved by ET and was sent to the board for accuracy checking on 4 September. Publication expected on 7 October.

Reputational / Credibility  
Regulation of Independent Healthcare  
890  
Alastair Delaney  
- 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 who have told us they do not require to register with us and a list of services we have had no response.

  - We have 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.

  - Executive Team have agreed to IHC recruiting a 1.0 Programme Manager and a 1.0 Inspector to assist with work. The Programme Manager post has been filled with the existing post holder who was on fixed term and covering a maternity leave. The Programme Manager returning from maternity leave will not do so until January 2020, we are currently looking at backfill within QAD. The inspector post has been offered and we are awaiting recruitment checks.

  - Paper going to ET requesting two new additional f/t inspectors for 2 years.

Operational  
Workforce Strategy  
634  
Sybil Canavan  
- 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 2019-22. 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 2019 & 2020 and are underway.

  - Detailed action plan describing high and medium priority activity during 2019/10 which is underway. Activity and progress monitored quarterly via Staff Governance Committee. Further scrutiny and service focus will also take place through the 'People' workstream of the internal improvement programme which will focus on actions outstanding and also updating of plan on an ongoing basis.

  - The Workforce Plan 2019-2022 includes mitigating actions for this risk. It includes better workforce planning regarding succession planning and hard to find skills. It also includes a move to better cross organisational working and capacity planning around generic posts. These actions are being led and implemented by the Associate Director of Workforce.

  - Audit & Risk, 6/9/19  
  - Medium - 10  
  - Impact - 5  
  - Likelihood - 2
| Operational | Quality Assurance Directorate | 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 will assume the role of Interim Director of Quality Assurance. Ann Gow will assume leadership responsibility on an interim basis for inspections and regulatory activity. Alongside this, strengthening of leadership arrangements will take place including the appointment of an Interim Chief Inspector. | Members of QAD are being kept informed of developments. An all directorate meeting took place on 17 September 2019 which was led by CEO and which took the form of questions and answers. The CEO is working in partnership with the Employee Director to enable stability, transparency and openness and to ensure that any issues are brought to light and managed well during this transition period. | - | - | - | Very High - 20 | Impact - 5 | Likelihood - 4 | - | - | - |
## Corporate Risks

### New risks on the report since June

<table>
<thead>
<tr>
<th>Risk Number</th>
<th>Risk Description</th>
</tr>
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<tbody>
<tr>
<td>890</td>
<td>Regulation of Independent Healthcare</td>
</tr>
<tr>
<td>899</td>
<td>Quality of Care Reviews</td>
</tr>
<tr>
<td>901</td>
<td>Making Care Better Strategy 2017-2022</td>
</tr>
<tr>
<td>903</td>
<td>Learning from Adverse Events</td>
</tr>
<tr>
<td>908</td>
<td>Business Intelligence Strategy</td>
</tr>
<tr>
<td>923</td>
<td>ICT Strategy</td>
</tr>
<tr>
<td>929</td>
<td>Quality Assurance Directorate</td>
</tr>
<tr>
<td>Code</td>
<td>Area</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>10</td>
<td>Strategy 2017-2022 Making Care Better</td>
</tr>
<tr>
<td>246</td>
<td>Workforce Strategy</td>
</tr>
<tr>
<td>454</td>
<td>SMC Product Assessment</td>
</tr>
<tr>
<td>693</td>
<td>Data Measurement &amp; Business Intelligence</td>
</tr>
<tr>
<td>697</td>
<td>Strategy 2017-2022 Making Care Better</td>
</tr>
<tr>
<td>721</td>
<td>Strategic Delivery Plan: Medicines</td>
</tr>
<tr>
<td>737</td>
<td>Making Care Better Strategy 2017-2022</td>
</tr>
<tr>
<td>872</td>
<td>Workforce Strategy</td>
</tr>
<tr>
<td>874</td>
<td>ihub directorate wide risk</td>
</tr>
</tbody>
</table>
and the delivery of current programmes of HIS work resulting in a negative impact on organisational reputation.

| 891 | Regulation of Independent Healthcare | There is a risk that due to unpredictability of the sector and growth in the market in relation to regulation of independent healthcare services, this results in the current delivery model being unsustainable with HIS then being unable to meet its statutory obligations. | Closure agreed at Executive Team risk workshop |
| 894 | Quality of Care Reviews | There is a risk that the HIS QoC approach and methodology cannot be appropriately applied to the diversity/complexity of larger NHS organisations which could result in reviews that are not sufficiently robust. | Closed to be replaced by risk 899 |
Risk appetite is the amount of risk we are prepared to accept, tolerate or be exposed to at any point in time. To facilitate this, we must take balanced decisions which weigh the long term rewards against any short term costs.

Below are the risk appetite classifications that will be used to help identify and define our response to risk that is proportionate to our risk profile and business objectives.

### Risk appetite (classification)

<table>
<thead>
<tr>
<th>Classification</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open</td>
<td>Willing to consider all options and chose the one that is most likely to result in success, while also providing an acceptable level of reward.</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 reward.</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 reward.</td>
</tr>
</tbody>
</table>

Periodically (at least annually), the Board will consider its risk appetite against different categories of risk that it is exposed to. The current risk appetite, by risk category, has been agreed by the Board of Healthcare Improvement Scotland (November 2015), as follows:

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Description (can include but not limited to):</th>
<th>Risk appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational</td>
<td>• risks which impact on the ability to meet project/programmes objectives (including impact on patient care)</td>
<td>Open</td>
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<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>
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<td></td>
<td>• risks which impact on the implementation of staff governance.</td>
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</tr>
<tr>
<td>Financial/value for money</td>
<td>• risks which impact on financial and operational performance (including damage / loss / fraud).</td>
<td>Cautious</td>
</tr>
<tr>
<td>Reputational/ credibility and Strategic</td>
<td>• risks which have an impact on the reputation/credibility of the organisation.</td>
<td>Open</td>
</tr>
<tr>
<td></td>
<td>• Could also include uncertainties caused by changes in health policy and government priorities.</td>
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<tr>
<td>Compliance/ regulatory and legal requirements</td>
<td>• risks which impact on achieving compliance with legislation, regulation, legal requirements.</td>
<td>Cautious</td>
</tr>
<tr>
<td></td>
<td>• risks which lead to incidents or adverse events that could cause injury (health and safety)</td>
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</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>16-25 – Very High</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>11-15 – High</td>
</tr>
<tr>
<td>8-12 – Medium</td>
<td>Acceptable level of risk exposure subject to regular active risk monitoring measures</td>
<td>6-10 – Medium</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>1 – 5 - Low</td>
</tr>
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**OPEN**

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<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Impact</th>
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<tr>
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<td>4</td>
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<td>8</td>
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<td>5</td>
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**CAUTIOUS**

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<td>5</td>
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**MINIMALIST**

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<td>4</td>
<td>8</td>
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<td>5</td>
<td>10</td>
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SUBJECT: Board and Governance Committee Schedule of Meeting Dates 2020-21

1. Purpose of the report

To present the proposed schedule of Board and Governance Committee meetings for 2020-21.

2. Key Points

The Code of Corporate Governance includes the Standing Orders for the regulation of the business and proceedings of the Board of Healthcare Improvement Scotland. To support this process, regular meetings of the Board and its Governance Committees are scheduled throughout each financial year. A proposed schedule of meetings for 2020-21 is attached at Appendix 1.

All of the proposed dates have been agreed in advance with Board and Committee Chairs and Lead Directors. They take account of known dates for the NHS Chairs and Chief Executives meetings and business critical requirements throughout the year.

3. Actions/Recommendations

The Board is asked to approve the schedule of Board and Governance Committee meeting dates for 2020-21 and ensure that these dates are scheduled in diaries.

Appendix 1: Schedule of Board and Governance Committee meeting dates 2020-21.

If you have any questions about this paper please contact Maggie Waterston, Director of Finance and Corporate Services, Maggie.waterston@nhs.net, 0131 623 4608.
SUPPORTING INFORMATION

RISK

<table>
<thead>
<tr>
<th>Do the key points represent a risk to the organisation?</th>
<th>If yes, has a risk been raised on the Compass Risk Management System</th>
<th>If yes, provide the risk number, risk description and risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>no</td>
<td></td>
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</table>

OTHER CONSIDERATIONS

How do the key points support the five priorities in the strategic plan:
- Enable people to make informed decisions about their own care and treatment;
- Help health and social care organisations to redesign and continuously improve;
- Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve;
- Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve;
- Make best use of all resources.

Board and Governance Committee meetings ensure effective planning and delivery against all the strategic priorities and provide appropriate levels of governance, ensuring best use of resources.

Resource Implications

There are no additional resource implications.

What engagement has been used to inform the work.

The meetings schedule has been developed through consultation with the Chair, Governance Committee Chairs and Lead Directors. It is not subject to public consultation. The schedule will be published on the staff intranet and dates of the public Board meetings will be advertised on the website.

What Equality and Diversity considerations relate to the work. Advise how the work:
- helps the disadvantaged;
- helps patients;
- makes efficient use of resources.

There are no additional Equality and Diversity impacts.
## BOARD AND GOVERNANCE COMMITTEE MEETING DATES FOR 2020/21 v0.4

*GS = Gyle Square, Edinburgh; DH = Delta House, Glasgow*

### 2020

<table>
<thead>
<tr>
<th>Month</th>
<th>Board</th>
<th>Audit and Risk Committee</th>
<th>Quality and Performance Committee</th>
<th>Staff Governance Committee</th>
<th>Executive Remuneration Committee</th>
<th>Governance Committee Chairs</th>
<th>Scottish Health Council Committee</th>
</tr>
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<tbody>
<tr>
<td>April</td>
<td>Board Development 29 April, DH</td>
<td></td>
<td></td>
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<td></td>
<td>29 April GS</td>
<td>23 April DH</td>
</tr>
<tr>
<td>May</td>
<td></td>
<td>13 May GS</td>
<td>27 May GS</td>
<td></td>
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<tr>
<td>June</td>
<td>Board Meeting 24 June, DH 4 June workshop, DH 17 June meeting, GS</td>
<td></td>
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<td>3 June GS</td>
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<td></td>
<td>2 June Development DH</td>
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<td>July</td>
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<tr>
<td>August</td>
<td>Board Seminar 26 August, GS</td>
<td></td>
<td>19 August DH</td>
<td>6 August GS</td>
<td></td>
<td></td>
<td>26 August GS</td>
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<tr>
<td>September</td>
<td>Board Meeting 23 September, DH</td>
<td>2 September DH</td>
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<td>30 September GS</td>
<td>10 September DH</td>
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<td>October</td>
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<td>28 October GS</td>
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<tr>
<td>November</td>
<td>Board Development 18 November, GS</td>
<td>19 November GS</td>
<td>25 November GS</td>
<td></td>
<td></td>
<td></td>
<td>18 November DH</td>
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<tr>
<td>December</td>
<td>Board Meeting 9 December, GS</td>
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<td></td>
<td></td>
<td>8 December GS</td>
<td></td>
</tr>
</tbody>
</table>

### 2021

<table>
<thead>
<tr>
<th>Month</th>
<th>Board</th>
<th>Audit and Risk Committee</th>
<th>Quality and Performance Committee</th>
<th>Staff Governance Committee</th>
<th>Executive Remuneration Committee</th>
<th>Governance Committee Chairs</th>
<th>Scottish Health Council Committee</th>
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</thead>
<tbody>
<tr>
<td>January</td>
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<tr>
<td>February</td>
<td>Board Seminar 24 February, DH</td>
<td></td>
<td>10 February DH</td>
<td></td>
<td></td>
<td></td>
<td>24 February DH</td>
</tr>
<tr>
<td>March</td>
<td>Board Meeting 24 March, GS</td>
<td>10 March DH</td>
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<td></td>
<td>17 March GS</td>
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</table>

*Item 6.1, Appendix 1*
SUBJECT: Audit and Risk Committee: key points

1. Purpose of the report
   This report provides the Healthcare Improvement Scotland Board with an update on key issues arising from the Audit and Risk Committee 4 September 2019.

2. Recommendation
   The Healthcare Improvement Scotland Board is asked to receive and note the key points outlined.

   a) Finance Report
      A revised finance report was shared with the Committee. The report separates the use of baseline funding from the use of additional/short term allocations. It also separates expenditure between pay and non pay. The pay information is fully reconciled with the workforce information that is provided to the Staff Governance Committee. The Audit and Risk Committee welcomed this additional information and provided some suggestions to further improve the presentation and understanding of the information provided. It was agreed to provide the Board with the financial information presented in this way.

   b) Additional Allocations
      The Committee considered in detail the expenditure profile of the additional funding received from Scottish Government. Concern was expressed about the number of short term employment contracts and secondment arrangements that are entered into to fulfil the work that is funded by the allocations. The risks are recognised and are included within the risk registers which were discussed in detail.

   c) Risk Management
      A final draft of the Risk Management Strategy was considered by the Committee. Changes to the strategy reflected comments from Board members at the Board Seminar and a schedule was provided that responded to specific questions and comments. The Committee were content with the revised strategy and agreed that it should be put to the Board for approval. The Committee also reviewed the corporate risks and the very high and high operational risks. It was suggested that some of the risks could be consolidated as there were similarities that cut across the organisation and were not always specific to one directorate.

John Glennie
Chair, Audit and Risk Committee
MINUTES – Approved

Meeting of the Healthcare Improvement Scotland Audit and Risk Committee at 10.30
19 June 2019
Boardroom, Gyle Square, Edinburgh

Present
John Glennie OBE Board Member (Committee Chair)
Kathleen Preston Board Member
Bryan Anderson Board Member
Gill Graham Board Member

Healthcare Improvement Scotland Officers
Robbie Pearson Chief Executive
Maggie Waterston Director of Finance and Corporate Services/Lead Officer
Karen Ritchie Acting Director of Evidence
Ian Smith Head of Quality of Care (Deputy for Director of Quality Assurance)
Diana Hekerem Head of Strategic Commissioning (Deputy for Director of Improvement)

In Attendance
Joanne Brown Grant Thornton
Kate Morgan Grant Thornton
Pat Kenny Deloitte
Conor Healey Deloitte
Paul Wishart Finance Manager
David Rhodes Head of Finance & Procurement

Committee Support
Pauline Symaniak Committee Secretary

Apologies
Rhona Hotchkiss Board Member
Alastair Delaney Director of Quality Assurance
Ruth Glassborow Director of Improvement
Sybil Canavan Associate Director of Workforce
Ann Gow Director of NMAHP
Lynsey Cleland Director of Community Engagement
1. **WELCOME AND APOLOGIES FOR ABSENCE**

   1.1 All present were welcomed to the meeting.
   
   John Glennie declared an interest as a Non-executive Director of NHS24.
   
   1.2 Apologies were noted as above.

2. **MINUTES OF PREVIOUS MEETING/ACTION REGISTER**

   2.1 Minute of Audit and Risk Committee meeting on 6 March 2019
   
   The minute was approved as a true and accurate record of the meeting.
   
   2.2 Review of action point register of Audit and Risk Committee meeting on 6 March 2019
   
   The Committee reviewed the action point register and noted that all actions were complete.
   
   There were no matters arising.

3. **COMMITTEE GOVERNANCE**

   3.1 Business Planning Schedule
   
   The Committee reviewed the Business Planning Schedule, presented by the Director of Finance and Corporate Services.
   
   The Committee noted that there were several internal audit reports for review at the meeting and requested that the submission of future reports is more evenly phased.
   
   The Committee were content with the Business Planning Schedule.

   3.2 Review of Gifts and Hospitality Register
   
   The Director of Finance and Corporate Services presented the gifts and hospitality register covering the period 2018-19.
   
   In response to a question from the Committee, it was confirmed that there were no incidents during the year of sponsored travel being declared.
   
   The Committee noted the information provided on the register and approved the register for publication on the HIS website.

4. **ANNUAL ACCOUNTS**

   4.1 Audit Assurance Reports
   
   The Director of Finance and Corporate Services referred to the Audit Assurance Reports provided and confirmed that there had been no changes since the reports were reviewed by the Committee at its Annual Accounts workshop on 6 June 2019. For the IT services audit an executive summary only had been provided to the Committee with the full report being available on request. The executive summary included all of the risk areas that were reviewed which included the action plan from NHS NSS.
The Committee noted the importance of assurance around the organisation’s IT services to minimise the risk of fraud and maintain effective cyber security.

The Committee confirmed that they were content to accept the audit assurance reports.

### 4.2 Governance Readiness Report

The Director of Finance and Corporate Services presented the report and advised that there had been some changes since the Annual Accounts workshop. She highlighted that the readiness report was not a statutory obligation but was used by HIS to assist the Board to gain assurance that the governance statement is a true representation of the governance framework and its application within HIS.

The Committee noted the report.

### 4.3 Report to those charged with governance (ISA 260)

The Committee received the report from the External Auditor who noted that the report was largely the same as when it was reviewed by the Committee at the Annual Accounts workshop with only two minor changes.

A transcription error was noted on page 35 in the management response and this would be corrected.

In response to a question from the Committee, the External Auditor confirmed that there were no significant issues to report and that the audit opinion was favourable for HIS.

The Committee accepted the report.

### 4.4 Annual Report and Accounts 2018-19

The Director of Finance and Corporate Services presented this paper and highlighted the following points:

- a) An updated movements schedule had been provided setting out the changes since the Annual Accounts workshop.
- b) The Performance Report had been fully revised as advised at the workshop.
- c) Four areas of significant risk or issue had been added – financial sustainability, workforce planning, risk management and the NHS Scotland Blueprint for Good Governance.

The Internal Auditors presented a report setting out their audit opinion and noted the following:

- d) The report summarised the internal audit work over the course of the year which had included the production of six internal audit reports.
- e) Their conclusion was to provide reasonable assurance, confirming that no material issues had been identified that required inclusion in the governance statement.

The Committee noted there were some typographical errors which would be corrected before submission to the Board.

Subject to the corrections, the Committee agreed to recommend adoption of the Annual Report and Accounts to the Board at its meeting on 26 June 2019.

### 4.5 Letter of Representations

The Director of Finance and Corporate Services referred to the Letter of Representations issued with the papers and advised that this would be signed by the Chief Executive at the Board meeting on 26 June 2019.
4.6 Significant issues that are considered to be of wider interest

The Director of Finance and Corporate Services referred to the letter issued with the papers and highlighted the following points:

a) The letter would be signed by the Chair of the Audit and Risk Committee at the Board meeting and at the same time that the Annual report and Accounts were signed.

b) The paper asked the Committee to consider if any disclosure of fraud or a significant issue required to be made to Scottish Government.

c) The Director gave assurance that there were no significant issues of fraud and no significant problems had been identified which may have wider implications within Healthcare Improvement Scotland during 2018-19.

The Committee confirmed that they were content for the letter to be signed.

In closing the discussion of the Annual Accounts, the Committee Chair thanked the Finance Team for their excellent work.

5. CORPORATE GOVERNANCE

5.1 Information Governance update

The Acting Director of Evidence presented this paper and highlighted the following points:

a) The Internal Audit report on GDPR and Information Governance would be covered later in the agenda.

b) The issues raised by the departure of the Senior Data Protection Officer (DPO) were being mitigated in several ways including use of the Information Governance Coordinator (who was also trained in data protection), additional support from other national Boards, and use of a specialist adviser.

c) The work plan had been revised in light of the DPO’s departure.

d) Mandatory training compliance was showing an improvement. However, there remained some areas of poorer compliance which would be addressed.

e) Information governance incidents were detailed within the report.

In response to questions raised by the Committee the following points were clarified:

f) There were a high number of incidents due to selecting the incorrect email recipient and this was mostly due to the email system automatically filling email addresses. The function had been disabled in sensitive areas of work and most have been of a trivial nature.

g) The rating of corporate risk 759, related to the Information Governance Strategy, had been reduced. This would be reviewed, given the departure of the DPO.

h) Spam emails were only recorded when action was required as most were eliminated by the email system.

The Committee were content with the information provided in the report.

5.2 Non-competitive Tender Log

The Head of Finance and Procurement presented this paper and confirmed that there had been no instances of the use of non-competitive tenders since the previous Committee meeting in March.

The Committee noted the report.

5.3 Financial Performance Report to 31 May 2019

The Director of Finance and Corporate Services presented this paper and highlighted the following points:
a) The year-to-date variance was an over spend of £555k but taking into account additional allocations yet to be received, the position was an underspend of £106k.
b) Regarding additional allocations, spend to date was £662k and the allocations had been graded according to their stage of confirmation. There was a risk for the organisation in spending against unconfirmed allocations but this is being managed by the Executive Team with our Scottish Government sponsor.

In response to questions raised by the Committee the following additional information was provided:
c) The difficult financial climate had resulted in lack of clarity on timescales for receiving those unconfirmed additional allocations. It would be discussed as soon as possible with the Scottish Government sponsor division to secure progress.
d) The unconfirmed allocations for the ihub in respect of Improving Observation Practice and Mental Health Access were significant but funding for mental health had been assured for 2019-20. The funding position for 2020-21 and thereafter was not known. £800k of the mental health funding was transferred to ISD for data analysis.
e) The best overall position would be to move to a more stable financial platform with additional allocations moved into baseline.
f) The savings table reflected only two months of savings which were largely attributed to staff turnover.
g) The budgets were being re-phased and Key Performance Indicators created as part of the performance reporting review.
h) The non-pay savings target of £229k related to the internal change initiative.
i) It was anticipated that there would be a balanced budget at year end.

The Committee noted the update and were content with the information provided.

5.3 Business Resilience – National Fraud Initiative

The Director of Finance and Corporate Services presented a paper providing an update on business resilience. The following points were highlighted:
a) There had been several developments - a self-assessment of the organisation’s business resilience had been undertaken, an action plan was provided to the previous meeting and the Counter Fraud annual report had been received. The latter would be shared with the Committee.
b) The organisation had undertaken the data matching exercise as part of the National Fraud Initiative. Whilst most Boards only reviewed a sample of matches where fraud was suspected, HIS checks all of the matches as this also supported good management of the purchase ledger.
c) There were a higher number of matches compared to previous years due to improvements in the process for identification. However, many could be quickly discounted as not being fraud.

The Committee noted the update.

6. INTERNAL AUDIT

6.1 Internal Audit Actions Progress Tracker

The Director of Finance and Corporate Services presented this paper. She advised that actions were taken from the Internal Audit assurance reports and placed onto the actions tracker. They were then provided to the Committee until management and the Internal Auditors were in agreement that the action was complete and there was evidence to support that.

In response to a question from the Committee, it was advised that actions which were closed were embedded into working practices and any subsequent failures would be picked up in
future audits.

Grant Thornton highlighted that only one action was breached because it was awaiting a national solution.

The Committee noted the update and were content with the progress on the audit actions.

<table>
<thead>
<tr>
<th>6.2 Internal Audit Assurance Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant Thornton presented the audit assurance reports and highlighted the points detailed below.</td>
</tr>
</tbody>
</table>

**Communications**

- (a) The audit had examined the new communications strategy and how communications were embedded in the organisation.
- (b) The audit had been delivered in January but the report was deferred to allow the new Interim Head of Communications to understand how to address the actions that were identified.
- (c) There was one high risk finding - a resource model and work programme should be developed to support the communications strategy.

In response to questions from the Committee, the Executive Team clarified the following points:

- (d) The new Head of Communications was progressing the OASIS model for communications which set out a more structured approach. This would also support a greater pace to enhancing communications.
- (e) There would be more opportunities created to enhance the visibility of Non-executive Directors and the Executive Team such as engagement events, walk rounds and staff huddles.
- (f) Finding 3 in the report highlighted that better evaluation of individual pieces of work was required.

**Workforce**

- (a) The audit had examined recruitment practices and the flexible working model employed in the Quality Assurance Directorate.
- (b) Recruitment practices were given a partial assurance with findings around retention of documents, interview processes and the recruitment and selection policy which was out of date.
- (c) The trial of a flexible working model received a significant assurance with findings around time recording and considerations related to expansion of the model across the organisation.
- (d) Regarding recruitment practices, the Chief Executive advised that a new Associate Director of Workforce had been appointed and was already addressing a number of strands of work.

**GDPR/Information Governance**

- (a) The audit had examined compliance with GDPR and wider information governance arrangements, and had provided a partial assurance.
- (b) There were findings related to mandatory training completion rates, resource requirements for ensuring compliance, streamlining the information governance group meetings and updating of policies and processes.

**Strategic Planning**

- (a) This audit examined the refreshed approach to strategic planning and gave a partial assurance.
b) The findings related to corporate documents aligning to the strategy, early commencement of the following year’s operational planning, plans for efficiency savings and improving performance reporting through development of key performance indicators.

In response to questions from the Committee, the Executive Team provided the following information:

c) The new planning approach had used a subgroup of the Senior Leadership Group and an after action review had been held. Planning was already underway for 2020/21.

d) Individual strategies and plans had not been removed from the website because they still had a purpose. The need was to ensure they aligned to the organisational strategy.

e) There were several strands of work which would support the achievement of financial sustainability, including repositioning of the leadership of internal improvement and the appointment of a Deputy Chief Executive.

f) The central governance group that would look at securing efficiency savings would be in place before 31 July.

The Committee noted the reports and, subject to the comments above, were content with the information provided.

### 6.3 Internal Audit Annual Plan 2019-20

Grant Thornton presented this paper and highlighted the following points:

a) There had been two changes since the Committee received the draft plan at their March meeting and these had been agreed with the Chief Executive. These were holding the audit of the Quality of Care Approach in 2020/21 and a reduced number of days for the Brexit audit.

b) Risk management had been proposed for July 2019 but a delay would be considered to after the Board’s risk workshop in August.

The Executive Team highlighted two areas:

c) The annual internal audit plan was based around the risk register.

d) The audit of financial controls would include the Operating Framework with Scottish Government.

It was agreed that the Annual Plan would be circulated to the other Governance Committee Chairs and that in future they would receive the draft plan at one of their meetings.

The Committee approved the plan.

### 7. EXTERNAL AUDIT

#### 7.1 External Audit

Deloitte advised that they had no further information to present in addition to that provided for the Annual Accounts.

### 8. STANDING BUSINESS

#### 8.1 Risk Management

The Director of Finance and Corporate Services presented two papers and highlighted the points detailed below.

**Risk Appetite Update**

a) The paper provided the output report of the risk appetite workshop in February 2019.
b) There was one change to risk appetite with the compliance/regulatory and legal requirements changing from a minimalist to cautious appetite. This change had been made on Compass, the risk database.

c) Averse events related to health and safety moved from the operational category to the compliance/regulatory and legal requirements.

d) A cautious risk appetite for compliance matters still provided for safe delivery options.

e) Classifications would be further scrutinised at the Board’s risk workshop in August. Meantime, information would be sought on the categories that other Boards use.

The Committee noted the paper but requested that the appetite for compliance risks and the risk categories be re-considered at the Board’s risk workshop in August.

Risk Management Update

a) The Corporate Risks and the Operational Risks rated as high and very high were provided in the report and any changes since the previous meeting were shown on the movement schedule.

b) Risk Management was placed at the end of the agenda to allow review of risk with the benefit of having already covered the other agenda items.

In response to questions from the Committee about the corporate risk register, the following points were clarified:

c) Risk 874, ihub directorate wide risk - related to pressures from Scottish Government to deliver the access programme, a Cabinet Secretary priority, and in particular to move forward the three accelerator sites. There had been no funding to deliver this.

d) Risk 759, information governance - reflected that it was not possible to achieve 100% compliance due to staff turnover, long term sick leave and maternity leave. Low compliance areas were being targeted for action.

e) Risk 454, SMC Product Assessment - had an increased risk rating due to a very high number of submissions and a shortage of health economists which were difficult to recruit.

f) Risk 891, regulation of independent healthcare (IHC) - raised to reflect the unpredictability of the registration numbers which had been much higher than anticipated and the challenge to allocate resources. A working group was being created to mitigate the capacity issues in the short term and to reconsider the longer term delivery model for the regulation of independent healthcare because the original assumptions had changed significantly due to changes in the market. The higher number of registrations had resulted in the current resource being insufficient to service the scale of operations and this was being addressed. The income for IHC is recorded separately and it was agreed that for 2019-20 IHC would be reported as a separate financial entity which would assist with setting the future level of continuation fees. There was also a reputational risk because the number of inspections of independent clinics would be significantly higher than those for NHS hospitals.

It was agreed that a report on progress with managing the risks associated with the IHC sector would be provided to the next meeting and that a risk related the Quality of Care Approach would be raised on the corporate risk register.

In response to questions from the Committee on the operational risk register, the following points were clarified:

g) Risk 887, Death Certification Review Service – mitigations were in place and both the Senior Medical Reviewer and the Chief Executive were working with NHS24 to resolve matters.

h) Risk 854, Evidence and Evaluation for Improvement Team – work was ongoing with the HR function to retain specialist resource.
i) Risk 818, Focus on Dementia – this was one of several risks related to funding. This would be examined as part of the internal audit of the Operating Framework with Scottish Government.

The Committee were assured that risk was being effectively treated, tolerated or eliminated.

### 8.2 Board Report 3 key points

1. Internal Audit reports for Communications and Strategic Planning  
2. Independent Healthcare  
3. Risk appetite - compliance category and definitions of categories

### 8.3 Feedback session

Committee members were requested to send any feedback from the meeting to the Committee Chair.

### 9. ANY OTHER BUSINESS

### 10. DATE OF NEXT MEETING

Wednesday 4 September 2019, Delta House, Glasgow
SUBJECT: Quality and Performance Committee: key points

1. Purpose of the report

This report provides the Healthcare Improvement Scotland Board with an update on key issues arising from the Quality and Performance (formerly the Performance and Clinical and Care Governance) Committee meeting on 15 August 2019.

2. Recommendation

The Healthcare Improvement Scotland Board is asked to receive and note the key points outlined.

a) External Review of the NHS Ayrshire and Arran Quality of Care Review Report

The Committee received a summary of an external review of the NHS Ayrshire and Arran Quality of Care (QoC) review report carried out by Professor Simon McKenzie. Professor McKenzie highlighted key themes including:

- lack of clarity about the purpose of the review
- the quality of the report
- lack of triangulation of evidence
- lack of alignment of the review to the quality framework
- lack of internal systems and processes to support the review team and provide consistency of approach
- issues with the roles and responsibilities of external reviewers and the review team.

The Committee heard from the Director of Quality Assurance that overall to date the QoC approach had been used well but there had been problems applying it at the organisational level. A working group led by the Deputy Director of Quality Assurance reporting to this Committee will be set up to take work forward to address the key points of the report and design a standard operating model. The Chief Executive has written to his counterpart in NHS Ayrshire and Arran to request their participation in an after action review.

The Committee expressed their concerns and requested that an update be provided at the next meeting.

b) Operational Plan Performance Reporting

The Director of Finance and Corporate Services provided this paper and delivered a presentation which highlighted the following key areas:

i) The work to refresh performance reporting had arisen as an area for improvement from the Board's self-assessment against the NHS Scotland Blueprint for Good Governance.

ii) To develop a report which provides assurance to the Board, a logic model approach had now been developed which would report on short term outputs and longer term outcomes.

iii) The work had been delivered by a short life working group supported by two of the non-executive directors and informed by a function leads event in May.

iv) The new report will provide information on short term commissions as well as business as usual activities. It will include horizon scanning and workforce and finance data. An executive summary will cover key points.
v) There would be further refinement prior to providing the report to the Board meeting on 25 September 2019.

The Committee welcomed the report and endorsed the proposed content, noting the excellent progress that had been made. The importance was noted of the performance report in support of discussions with Scottish Governments around the Operating Framework.

c) **Proposal to Change the Name of the Committee to the Quality and Performance Committee.**

The Committee received and agreed a proposal to change the name of the Committee to the Quality and Performance Committee.

Dr Zoë M. Dunhill
Committee Chair
MINUTES – Approved

Meeting of the Performance and Clinical & Care Governance Committee
Date: Wednesday 22 May 2019
Venue: Boardroom, Gyle Square, Edinburgh

Attendance
Zoe Dunhill
Jackie Brock
Bryan Anderson
Suzanne Dawson
Gill Graham
Duncan Service
Board Member, Chair
Board Member, Vice Chair
Board Member
Board Member, Chair of the Scottish Health Council
Board Member
Board Member

Present
Robbie Pearson
Alastair Delaney
Ann Gow
Jane Illingworth
Alexandra Jones
John Kinsella
Alan MacDonald
Sandra McDougall
Karen Ritchie
Iain Robertson
Andrew Seaton
Maggie Waterston
June Wylie
Chief Executive
Director of Quality Assurance
Director of Nursing, Midwifery & Allied Health Professionals (Lead Director)
Policy and Governance Manager (minutes)
Public Partner
Chair, SIGN
Chair, SMC
Acting Director, Scottish Health Council
Acting Director of Evidence
Chair, SHTG (by telephone)
Chair, SAPG
Director of Finance and Corporate Services
Deputy for Director of Improvement

Apologies
Sybil Canavan
Ruth Glassborow
Laura McIver
Susan Siegel
Associate Director of Workforce
Director of Improvement
Chief Pharmacist
Public Partner
1. OPENING BUSINESS AND COMMITTEE GOVERNANCE

1.1 Welcome

The Chair welcomed everyone to the first meeting of the Performance and Clinical & Care Governance (PCCG) Committee and asked members to introduce themselves. It was noted that it was the last meeting of Professor Kinsella as SIGN Chair and the Chair thanked him for his contribution to the organisation over the last 6 years.

1.2 Apologies for absence

Apologies were noted as above.

1.3 Declarations of interest

All present were reminded to declare interests either at the start of the meeting or at any point during the meeting.

1.4 Minutes of the Quality Committee meeting held on 27 February 2019

The minutes of the meeting held on 27 February were approved subject to the following minor amendments:
- Page 3 – the report on the National Hub for the Review of Child Deaths would be brought to the Committee in November 2019.
- Page 6 – a penicillin prescribing (not de-labelling) steering group was set up; correction of SPAG to SAPG.

1.5 Review of action point register: 27 February 2019

The Chair noted that all actions have been completed.

1.6 Proposed changes to membership, name of Committee and revised Terms of Reference

The Chair highlighted the change in the Committee’s name to better reflect its remit, however would be open to suggestions for a more concise title. The updated Terms of Reference for the Committee will be presented to the Board in June and reflect the drawing together of a range of responsibilities. Given the number of new Committee members, it is proposed that it would be helpful for one non-executive member to attend each of the groups which report to the Committee, to build connections with the wider organisation.

1.7 Business Planning Schedule

The Director of NMAHP introduced the business planning schedule. No comments or questions were received.

1.8 Annual Report 2018/19

The Director of NMAHP introduced the report of the predecessor committee, which had been developed by the previous Chair and lead Director. She highlighted two areas of work which would continue with the present committee:
- scrutiny of the Operational Plan on a 6 monthly basis
- work to identify areas of overlap and common interest with Scottish Health Council Committee

One amendment to the report was noted: terms of reference for the Clinical and Care Governance Group (not Committee) were signed off. The report was approved for submission to the June Board meeting.

2. DELIVERING OUR OPERATIONAL PLAN

2.1 Operational plan: performance reporting

Performance overview of 2018-19

The Director of Finance and Corporate Services introduced the performance overview for 2018-19. She reminded the Committee that a review of performance reporting to...
the Board is being taken forward as one of the actions arising from the Blueprint for Good Governance. In the meantime the report circulated had been prepared for the annual accounts and was also intended to provide a year-end report on performance. Further work is planned to incorporate some graphs and visuals in the next iteration. The following points were noted during discussion:

- There was a request that paragraphs are numbered in this type of report for ease of reference.
- There is scope to refer more closely in the report to the organisational priorities and progress against these. It was noted that this is dependent on how the Operational Plan is written.
- The challenge in summarising the work of the organisation in 10-15 pages was noted and it was felt this had been done well. It may benefit from a greater emphasis on the shift in the organisation’s activities towards social care and the integrated space.
- The risks faced over the previous year were not particularly prominent in the report but it was noted that there is a separate section focused on risk elsewhere in the annual accounts.
- There are some typos on page 8 which Gill Graham would share.

Scottish Government commissions
The Director of Finance and Corporate Services introduced the new report in the context of the recently approved Operating Framework with Scottish Government, noting that HIS has a range of relationships which extend beyond the sponsor division to a number of policy areas. The report is intended to support the direction of new work through a single route as set out in the Operating Framework. It will also support improved horizon scanning and better conversations with Scottish Government about prioritisation.

The Chair welcomed the report which is a new development. It was noted that the report is a live document and subject to regular change. The following points were noted in discussion:

- Scottish Government has now provided additional funding in relation to the Barnahus standards. The relationship between additional funding and additional staff resource was discussed. This depends on the area of work – in this instance fixed term contracts would be extended. The Director of Finance and Corporate Services advised that the Workforce Plan would seek to support a more flexible approach to deploying staff across HIS as well as develop succession planning.
- The newborn screening work relates to a previous NHS QIS Best Practice Statement on newborn screening which has not been maintained. Discussions are underway with Scottish Government as to how best to take this work forward, potentially as part of a suite of screening standards which would require discussion with National Services Scotland. The use of NHS England standards was also being looked at although there are complexities around that.
- The spreadsheet in its current form was felt to be confusing to read and definitions were unclear. It would be helpful to highlight the challenges and progress in further iterations. The Policy and Governance Manager advised that the report is under development but that it was shared with the Committee at an early stage.

The Committee very much welcomed the information contained and it was noted the format would be developed further. Any additional comments should be sent directly to the Policy and Governance Manager.

The Chair welcomed Jackie Brock to the meeting.
### 2.2 Growing Older in Scotland Report

The Director of NMAHP introduced the report noting that the overall approach had previously been discussed at a Board seminar. The cover sheet highlighted the next steps and planned changes to the report. While a report would not usually be shared at this draft stage, it is a new approach for the organisation and therefore high-level feedback and approval for the direction of travel was sought from the Committee, prior to final sign off by the Board.

Members provided the following comments:

- It is difficult to pick out the key messages in the report; while it is intended for both the public and professionals it is rather dense and not very accessible for the former. The intention to publish an ‘easy read’ companion document as well as to develop infographics was noted.
- The inclusion of key messages / conclusions and recommendations was discussed. It was acknowledged that there would be an issue with HIS making recommendations for other organisations but there would be recommendations for HIS. There was encouragement for HIS to be confident in setting out the organisation’s own role and implications for its longer-term contribution to improving care for older people. It was suggested that the Executive Team spend some more time considering this aspect of the report.
- Some further context around the call from the Board in recent years for the organisation to set out the ‘state of the nation’ was provided by Jackie Brock who welcomed the report and the focus on a complex area.
- There was some discussion about HIS’ authority to look at the whole system. It was suggested that the contribution of the third sector could be more strongly reflected. The Chief Executive noted that it was important to stay within HIS’ competence to comment.
- The proposal for a foreword from the Chief Executive was welcomed; this would provide an opportunity for greater context and an acknowledgement of the impact of issues broader than health and social care e.g. transport, the economy, without straying into comment on areas outwith HIS’ scope.
- The SAPG Chair agreed to provide wording on antimicrobial resistance for inclusion in the report. It was also agreed that Realistic Medicine would be referred to.
- The SIGN Chair welcomed the inclusion of hyperlinks to source material and endorsed this direction of travel more generally for HIS reports.
- Broader stakeholder engagement with the report was discussed and the August meeting of the Strategic Stakeholder Advisory Group was suggested as an opportunity for this. It was noted that other organisations whose published data has been included in the report are already sighted.

Broadly the report was welcomed and acknowledged as an important first for the organisation, but the need for a careful approach, in order to build HIS’ authority to undertake further work of this nature, was agreed. The Chair congratulated the team on getting the report to this stage.

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<td><strong>The Director of Quality Assurance gave a presentation on progress to date and challenges faced.</strong> The Chair declared an interest given her previous involvement in Care Quality Commission (CQC) inspections and noted the rigour of their processes, suggesting that HIS may benefit from the participation of other UK systems in its work.</td>
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<td>- The importance of data, for example on mortality and morbidity, in driving improvement; this should be available in advance of inspections.</td>
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- The need for the Directorate to identify and evaluate the risks highlighted in the presentation e.g. in relation to recruitment and processes

The Director of Quality Assurance expanded on the cultural issues referred to in the presentation, noting different ways of working within the Directorate and efforts to move away from silos towards a more flexible, cross-Directorate approach.

The Director of Quality Assurance was asked to clarify the ask of the Committee members and he noted that there may be implications around the timescales for further delivery of board-level reviews and the need for understanding that this area is a work in progress. It was noted that this reflects a broader dilemma for HIS of political pressure versus the ambition to transform.

It was noted that an external advisor is currently considering the challenges and will be making recommendations; this, along with an articulation of the risks in the corporate risk register, will help to clarify the support and advice needed from the Board. In the meantime there would be a ‘pause’ while the Directorate determines next steps and that a maximum of 3 board level reviews would be undertaken in this business year. Issues around capacity were also noted with the Directorate currently being at capacity but ideally would be operating below this in order to remain responsive. It was agreed it will be important to manage Scottish Government expectations during this time.

The cross-Directorate engagement between the Quality Assurance Directorate and the Scottish Health Council was welcomed. It was agreed that this had worked well but that it also raised some questions for the Scottish Health Council, both in terms of capacity and also what makes for meaningful engagement (i.e. ‘broad brush’ versus targeted).

The Chief Executive advised that terms of reference are now in place for the work of the external advisor and that when the report is available it will follow HIS’ governance processes.

The Chair asked for any further reflections to be sent directly to her copied to the Policy and Governance Manager. This topic would be on the August meeting agenda.

### 3. CLINICAL AND CARE GOVERNANCE

#### 3.1 Report from the Clinical and Care Governance Group

The Director of NMAHP introduced the report and highlighted the 7 key principles of HIS’ Clinical and Care Governance Framework. An internal group had been set up to embed this within HIS. An initial action had been for Directorates to undertake a self-assessment exercise which has highlighted some gaps, for example around public involvement, and a general understanding about what clinical and care governance means for HIS. The Group is now taking forward a number of priority areas of work in response to these findings. It was agreed that it would report on a twice-yearly basis to the Committee.

#### 3.2 Health Technology Group updates

The Acting Director of Evidence highlighted the following points from the papers which had been circulated:

- SIGN - a new Chair has been appointed: Angela Timoney, currently Director of Pharmacy in NHS Lothian, and she is expected to take up post in July.
- SAPG – Jackie Sneddon has visited Ghana as part of global antimicrobial stewardship activity.
- SMC – the new pathway for ultra-orphan drugs has been published.
The Chair of SMC commented on the implications of Brexit for the regulation of medicines, which has the potential to impact on the SMC’s role in implementing policies in NHSScotland. The SMC currently has good international links but consideration is being given to whether any of these should be strengthened.

The Chair of SIGN reflected on the need to provide a service designed for the Scottish context. He highlighted the importance of involving the Scottish clinical community and patients but also of collaboration and using expertise from elsewhere, while maintaining the Scottish identity.

The SAPG Chair highlighted work with NHS Education to develop guidelines / tools for antibiotic review in hospitals, and on a nursing stewardship workstream, both of which would be out towards the end of summer. He reported on a useful meeting with key stakeholders regarding use of antibiotics at the end of life, and is giving further consideration to recommendations.

The Chair of the SHTG reported on work to embed new operational and governance arrangements to reflect changed ways of working and improve the Group’s ability to produce different outputs. The non-medicines strategic plan has been developed into an action plan with better alignment of internal resources, now available on the SHTG webpage.

4. **STAKEHOLDER ENGAGEMENT**

4.1 **HIS Strategic Stakeholder Advisory group update**

The Director of Quality Assurance provided an update on the meeting which focused on mental health. The output of the meeting is currently being analysed but included a number of potential areas for HIS development, including:

- strengthened input around leadership
- embedding a mental health perspective across the work programme
- a stronger role in supporting wider system redesign
- greater influence on data collection
- improved coherence and clarity of the HIS offer in relation to mental health
- a better balance of scrutiny work across acute and community sectors

The next step will be for the Executive Team to consider the output of the meeting and agree what will be taken forward.

4.2 **Complaints and feedback annual report**

The Director of NMAHP introduced the report. HIS is required to report annually on the handling of complaints made against the organisation. There have been improvements in the way the organisation is responding to concerns received about the service, however there is a need to develop a more strategic approach to gathering and responding to feedback.

5. **CLOSING BUSINESS**

5.1 **Risk Management for the Quality Committee**

The Director of Finance and Corporate Services presented the report.

The timing of risk on the Committee’s agenda was discussed. The Director of Finance and Corporate Services advised that this had been a conscious decision as many points are addressed during the course of the meeting and the item then allows for an opportunity to identify any new or changed risks arising from the discussion. It was suggested that the use of reputational risk as a category should be reconsidered as...
| that interprets the risk from HIS’ point of view rather than the service or Scottish population. It was noted that board level discussion would be taking place about the definition of risk across the risk register. |
| It was agreed that risks in relation to the Quality Assurance Directorate, discussed earlier on the agenda, would need to be raised. The Employee Director highlighted the current red risks, in relation to mental health access, but noted that mitigations are currently in place. |
| It was noted that each corporate risk is assigned to a Committee, although the Audit and Risk Committee (ARC) received details of all risks, and that this Committee can escalate any concerns either to the ARC or the Board. It was agreed that it would be helpful for Committee members to be provided with a short guide at the next meeting setting out the expectations of them in this area. |
| Alexandra Jones asked about the replacement of Medical Director post which is currently flagged as a risk. At the moment the duties are being covered by other Directors; next steps will be considered at tomorrow’s Executive Remuneration Committee meeting. |

| 5.2 Board report: key points |
| The Chair summed up the three key points for reporting to the Board as follows: |
| 1. The Quality of Care approach progress report and challenges, including risks in a number of areas (capacity, recruitment, training, managing expectations) |
| 2. Support for the developing Growing Older in Scotland Report and the importance of how it is presented externally |
| 3. An overarching theme around workforce and capacity, particularly in the context of increasing new commissions from Scottish Government, and the importance of vigilance in relation to the Operating Framework and of monitoring and reporting on the impact on staff. |

| 6. DATE OF NEXT MEETING |
| 15 August 2019, Gyle Square, Edinburgh |
SUBJECT: Scottish Health Council Committee: key points

1. Purpose of the report
   This report provides the Healthcare Improvement Scotland (HIS) Board with an update on key issues arising from the Scottish Health Council (SHC) Committee Meeting on 27 June 2019.

2. Recommendation
   The Healthcare Improvement Scotland Board is asked to receive and note the key points outlined.

   a) Service Change Guidance
   The Scottish Government and COSLA are currently developing statutory guidance on local community engagement and participation to apply across health and social care bodies. Within that context, the Committee agreed that the Scottish Health Council should review its interim operating position for supporting public involvement in service change in Health & Social Care Partnerships. This will ensure our role is clear until such time as the revised national guidance is produced. Once complete this position paper will be submitted to the HIS Board for consideration.

   b) Corporate Parenting
   The Committee was provided with an overview of the Children and Young People Working Group (CYPWG) and their role in ensuring HIS meets its legal duties in relation to children and young people. The Committee was updated on the group’s progress with the Corporate Parenting Action Plan which now has a RAG rating for each action and is on track to deliver. The Committee was provided with specific examples of Corporate Parenting activity throughout the past year. Evidence would suggest that projects have been enthusiastically supported across HIS and have helped to promote cross-organisational working.

   c) Strengthening Patient and Public Involvement in Primary Care
   Following on from the April meeting the Committee was updated on results of a GP practice survey which was run to further develop Primary Care as a thematic programme within the directorate and support cross-organisational work in HIS. The Committee was provided with a summary of the initial analysis and will receive a final report at the next Committee meeting in September. The Committee found this insight useful and would like to explore how the learning from the survey could be used to inform the work of SHC and HIS. Consideration will be given on how best to promote the key messages and involve agencies such as the Royal College of General Practitioners (and in future the new public health body) in sharing the learnings.

Suzanne Dawson
Chair
Scottish Health Council
MINUTES – V1.0

Meeting of the Scottish Health Council Committee
23/04/2019
Delta House West Nile Street, Glasgow G2 1NP

Present
Suzanne Dawson (SD) Chair
Alison Cox (AC) Member
John Glennie (JG) Member
Christine Lester (CL) Member

In attendance
Anthony McGowan (TMG) Review and Implementation Lead
Christine Johnstone (CJ) Community Engagement & Improvement Support Manager
Daniel Connelly (DC) Service Change Manager
Leslie Marr (LM) Service Change Manager
Sandra McDougall (SMD) Acting Director

Apologies
Irene Oldfather (IO) Member
Elizabeth Cuthbertson (EC) Member

Committee support
Susan Ferguson (SF) Committee Secretary

ITEM | NOTES | ACTION
--- | --- | ---
1 | WELCOME & APOLOGIES FOR ABSENCE | 
1.1 | Welcome | 
Suzanne Dawson (SD) welcomed those attending to the meeting and confirmed her appointment as Chair of the Scottish Health Council. A particular welcome was extended to Christine Lester (CL) who is replacing George Black on the committee as a HIS Board member.

Apologies for Absence

Apologies were received from Elizabeth Cuthbertson (EC) and Irene Oldfather (IO).

1.2 | Minutes of Previous Meeting (28/02/2019) & Matters Arising | 
Minutes of the previous meeting were confirmed as an accurate record and approved. Matters arising were noted as follows:
- Item 1.3 - SF to check committee meeting dates with Pauline Symaniak. SF confirmed that the dates are correct.

- Item 2.1 - TMG to amend wording re Our Voice in the response document and share document with staff. Amended document has been shared with staff.

- Item 2.1 - RN to action agreed changes to revised paper. Agreed changes were made. Revised paper to be discussed at agenda item 2.1.

- Item 2.4 - Lynda Nicholson (LN) to share further views on the renaming and rebranding options with Robbie Pearson (RP) and SMD. LN has emailed RP and SMD, and this will be considered further by SD.

- Item 3.1 - TMG and Mario Medina to provide an update on carers in the workplace. TMG advised that the People and Workplace team has recorded staff members that identify as carers on the electronic Employee Support System (eEES). Awareness raising activity in respect of carers’ rights is planned by staff in the ihub directorate.

- Item 3.4 - CJ to follow up with IO re local engagement in Quality of Care reviews. CJ has forwarded this information to IO by email.

### 1.3 Business planning schedule

The Business planning schedule was noted. SD confirmed that this is a live document that will be updated as required throughout the year, and will be considered at each committee meeting.

### 2 STRATEGIC BUSINESS

#### 2.1 Scottish Health Council Review and Implementation update

SMD referred to the Scottish Health Council review progress and implementation paper, which had two appendices attached.

With regard to Appendix 2 - the Report of the Short-life Governance Group on the Scottish Health Council – SMD highlighted that the proposed revisions to the Committee Terms of Reference would be submitted for approval to the HIS Board in June 2019 as part of the wider review of the Code of Corporate Governance. The remaining recommendations would be considered by SD, Lyndsey Cleland the new Director of Community Engagement who will be joining the organisation in early June 2019, the HIS Chair and Chief Executive, with input from the committee as appropriate.

SD noted that it would be important to give careful consideration to both the Terms of Reference and the recommendations and suggested that it may be useful to arrange a Committee development session out-with normal Committee business to enable sufficient time to be dedicated to this. Committee members agreed with this suggestion.

TMG gave an overview of the draft Change Implementation Plan. Workstream 5, relating to the production of a Directorate Development Plan, will be
considered particularly important from the perspective of staff, as it will reflect some of the feedback obtained during the recent staff consultation. TMG also highlighted that the development plan will promote openness, innovation and agile working within an operating context that ensures collaboration within the directorate and other directorates across HIS.

Following points of clarification raised by Committee members, the draft Change Implementation Plan was approved for sharing with staff, subject to any necessary minor revision.

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<td>SMD explained the purpose of the paper, highlighting that Appendix 1 set out the background to the Participation Standard and experience of operating it to date. Appendix 2 set out a potential way forward, taking account of that experience and based on the Quality of Care approach.</td>
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<td>Feedback from NHS Boards referred to in Appendix 1 was discussed. It was agreed following a request from CL that this feedback would be shared with the Committee.</td>
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<td>With regard to Appendix 2, the Committee agreed that there is merit in testing further whether there would be stakeholder support for the proposed approach.</td>
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<td>The Committee agreed with the recommendations in Appendix 1 subject to revision to make it clear that the Participation Standard would continue until such point as it may be superseded by the proposed new approach.</td>
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<td>CJ set out the background to the identification of Primary Care as a thematic programme within the Directorate, and part of cross-organisational work in HIS, and explained that the local activity to date had largely focused on the establishment and support of Patient Participation Groups (PPGs) linked to GP practices. There is an ambition to develop this work further, with input from other teams in the Directorate, and for our support offering to be informed by the findings from a survey that is currently being conducted across GP practices. An enabling factor is the revised GP contract which encourages an open and innovative approach to engaging and involving communities.</td>
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<td>Committee members sought clarification on the survey, in terms of how many responses had been received to date and when the survey would close. CJ advised that of the 930 GP practices contacted, 193 (1.9%) have already responded. The survey had been running for one week with a further three weeks to respond.</td>
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<td>CJ agreed to update the Committee on the results of the survey at the next Scottish Health Council committee meeting.</td>
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<td>CL asked about engagement of Integration Authorities in relation to the survey. SMD undertook to share details of the survey through contact with the Chief Officers Group Health and Social Care Scotland.</td>
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|     | TMG to amend Change Implementation Plan and issue to Scottish Health Council staff |
|     | TMG to share feedback from NHS Boards on the Participation Standard with the committee |
|     | SMD to amend Appendix 1 |
|     | CJ to update the committee on GP practice survey results at June meeting – SF to add to business planning schedule |
### 3. Committee Governance

#### 3.1 Draft Annual Report 2018-19

SD explained the purpose of the draft Annual Report, which had been prepared by Pam Whittle, former Chair of the Scottish Health Council, prior to her leaving the organisation at the end of February. Committee members agreed the content of the report.

#### 3.2 Draft Progress Report 2018-19

SMD introduced the draft Progress Report for 2018-19, noting that it provided an overview of the work of different teams within the directorate, and that it was hoped that this would be particularly useful for new Committee members, in demonstrating the range of activity that takes place.

SD agreed that this was a useful document. For any similar future reports, SD suggested it would be helpful to include personal stories to illustrate specific pieces of work, along with more local examples.

The draft report was approved subject to the following amendments:

- Include figures to add context in respect of local work to support the development of Patient Participation Groups
- Set out our local involvement in terms of supporting the Quality Assurance Directorate within Healthcare Improvement Scotland to implement the Quality of Care approach, as an illustration of greater cross-organisational working
- Amend wording on publication of major service change reports to make this clearer
- Include work on the future of the Participation Standard.

SMD thanked the committee for its feedback on the draft report and confirmed that it would be shared with staff once finalised and used to inform content on the Scottish Health Council website.

#### 3.3 Draft Operational Plan template 2019-20

SMD advised the committee that the management team has been developing objectives at team level and, in terms of thematic working, at cross-directorate level. However, these objectives have not been formally recorded in the usual format as the Operational Plan template is currently being reviewed. This is because work is being carried out at a corporate level to revise and streamline reporting to the Healthcare Improvement Scotland Board. As a result, SMD proposed that the Operational Plan template for reporting to the committee should be aligned to this, in order to make the reporting process more efficient. The committee were in agreement with this.

JG advised the committee that he is one of the two Board members who are working with officers to improve performance reporting to the Board.

#### 3.4 Risk Register

SMD to amend progress report and issue to Scottish Health Council staff

SMD to revise directorate operational plan format to align to revised performance reporting to the HIS Board
The committee reviewed the Risk Register. It was agreed in response to a request from CL, that the Risk Register would be printed in colour and sent in advance to committee members as this would make the document easier to read.

SMD advised that the management team had reviewed the Risk Register at its most recent meeting and were content with the levels of risk recorded for existing risks.

With regard to risk 778 – Service Change – following discussion, it was agreed that this risk would remain unchanged for the time-being with the expectation that the risk level may be reduced further in coming months.

With regard to risk 880 - Review – JG questioned if this should still be regarded as a current risk, given that the change implementation plan was in place and had been approved by the committee. SMD outlined the rationale for including this, in particular that the Change Implementation Plan contained multiple work-streams which were inter-related in nature and many of which involved dependencies out-with the direct control of Scottish Health Council staff. A number of risks relating to particular work-streams were set out in the plan, and SMD proposed that these should be reflected in an overarching risk which took all of the elements into account. TMG agreed with this and undertook to monitor this risk closely. This was supported by the Committee.

SMD advised that the management team considered that an additional risk should be recorded relating to one particular aspect of the change implementation plan i.e. renaming and rebranding the Scottish Health Council, due to concerns about the specific communication and logistical issues that this raised. SMD tabled a proposed new risk and sought agreement from the Committee to add this to the risk register.

Following discussion to clarify the nature and components of the proposed risk, the committee agreed its inclusion on the Risk Register.

SD noted that there were elements in the way that the Risk Register is presented that she felt could be improved, and CL agreed with this. SD confirmed that this was a corporate issue and would be better raised through other Board mechanisms. JG advised that he is now Chair of the Audit and Risk Committee and would be happy to discuss this matter separately.

### 3.5 Service Change Briefing

DC introduced the service change update paper and referred to earlier discussions at the Service Change Group. This update was noted by the committee.

### 4.0 Additional items of Governance

#### 4.1 Service Change Working Group

Service Change Working Group action points from meeting on 27 November 2018 were noted.

CL indicated her interest in joining this group, and it was agreed that she would join the group at its next meeting.
5. **AOB and Close**

No other business was discussed.

**Date of next meeting**

27 Jun 2019, 6th Floor, Delta House, 50 West Nile Street, Glasgow, G1 2NP.
SUBJECT: Staff Governance Committee: key points

1. Purpose of the report
This report provides the Healthcare Improvement Scotland Board with an update on key issues arising from the Staff Governance Committee held on 29 August 2019.

2. Recommendation
The Healthcare Improvement Scotland Board is asked to receive and note the key points outlined.

a) Sturrock Conversation – Psychological Safety
Discussions during the review of the Sturrock submission from Healthcare Improvement Scotland confirmed that building relationships and trust is important through regular and meaningful contact and maintaining an appropriate relationship between staff side and management. It was also recognised that iMatter is most valuable at team and Directorate level and there was a need to recognise pressure from external stakeholders and how that will then impact on the organisation and staff. In the discussion it was also debated that iMatter measures engagement, but evidence indicates that psychological safety in teams is important. The Committee Chair will take this forward to consider if it’s an area that can be measured as an organisation.

b) Evidence Directorate – Presentation by Director
Safia Qureshi provided a detailed presentation for the Committee on the work underway within the Evidence Directorate to meet the requirements of the staff governance standard. Information was provided on staff stories from The Source, including working mums and the barriers being broken through the post hosted with Glasgow Centre for inclusive living scheme. Safia also described the recent iMatter results for the directorate and planned work to ensure better transparency on decision making and teams getting to know each other better.

c) Tableau Demonstration – Workforce Information System
Angela Paton from the Workforce Information Team in NSS and Dougie Craig, Resource Specialist from Healthcare Improvement Scotland, gave an overview of the Tableau system.

Tableau is a data visualisation tool, which is changing the way HR data is presented within the NHS. It has interactive views, high-level summaries and trend data, allowing managers to view the cost of absence, workforce demographics and conduct forecasting. It was confirmed in the discussion that the system is ready to be rolled out within Healthcare Improvement Scotland, pending confirmation of user names to provide access.

Duncan Service, Employee Director
Chair of Staff Governance Committee
MINUTES - Approved

Meeting of the Healthcare Improvement Scotland Staff Governance Committee at 10.30
14 May 2019
Room 2.13, Gyle Square, Edinburgh

Present

Duncan Service          Board Member, Committee Chair
Bryan Anderson          Board Member
Kathleen Preston        Board Member
Christine Lester       Board Member
Robbie Pearson         Chief Executive (from noon, item 7.1)
Maggie Waterston       Director of Finance and Corporate Services
Sybil Canavan          Associate Director of Workforce
Andrew Moore           Head of Excellence in Care
Belinda Henshaw        Partnership Representative
Ruth Glassborow        Director of Improvement
Kenny Crosbie          Partnership Representative

In Attendance

Anne Lumsden          Head of OD & Learning
Ann Laing             Head of People & Workplace

Committee Support

Steven Smyth          Administrative Officer

Apologies

Ann Gow              NMAHP Director
1. **WELCOME AND APOLOGIES FOR ABSENCE**

1.1 The Chair welcomed all present to the meeting, introductions were made. Apologies were noted as above.

1.2 **Declaration of interest**

No declarations were noted.

2. **MINUTES OF PREVIOUS MEETING/ACTION REGISTER**

2.1 **Minute of Staff Governance Committee meeting on 21 February 2019**

The minutes of the meeting held on 21 February 2019 were approved as an accurate record of the meeting.

2.2 **Review of action point register of Staff Governance Committee on 21 February 2019**

The Committee reviewed the action point register from the meeting on 21 February 2019 and noted the status report against each action. The following action point was discussed:

5.4 – There is positive support for an annual Margaret McAlees (Equality and Diversity) award for both the individuals and groups categories.

The Committee were content with the progress made on the action point register.

3. **COMMITTEE GOVERNANCE**

3.1 **Business planning schedule**

The Committee received the latest business planning schedule and an additional paper setting out proposals for a Staff Governance Delivery Group.

**Future Vision for Staff Governance Delivery Group**

The Head of Organisational Development and Learning presented this paper setting out a proposal for this new group. The proposal was not endorsed as a single focus group and there was significant discussion regarding the role of the Staff Governance Committee in holding organisation to account.

An item related to a Culture Survey will be added to the business planning schedule for an agenda item by October.

3.2 **Draft Annual Report 2018/2019**

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<tr>
<th>Annual Report 2017/18</th>
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<tr>
<td>The Director of Finance and Corporate Services presented the first draft of the Committee’s 2018-19 annual report.</td>
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<td>The Committee noted that good progress had been made against the action plan from the 2017-18 annual report but there were still some outstanding actions. The Committee provided some additional wording to include in the report.</td>
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<td>The 2018-19 Annual Report will be finalised and circulated to the Committee for approval.</td>
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**Committee Secretary**

**Director F&CS**
### 4. CORPORATE

#### 4.1 Workforce Plan 2019/20

The Associate Director of Workforce presented the draft Workforce Plan and provided an update on progress.

The Committee welcomed the plan, particularly the integrated nature of the planning, the emphasis on flexibility and the inclusion of time limits.

The Committee approved the draft Workforce Plan for 2019-22 for submission to the Board meeting in June for final approval prior to submission to Scottish Government in accordance with their timeline.

#### 4.2 Staff Governance Action Plan

The Head of Organisational Development and Learning was invited to present this paper and highlighted the following points:

- a) The Staff Governance Action Plan for 2019-20 is being developed in Partnership.
- b) Key requirements are to identify areas for improvement and make progress with actions from the previous year.
- c) iMatter results are not available until the end of July and there is concern related to issuing the iMatter survey and a culture survey at the same time.

In the discussion that followed, the Committee provided comments on the papers presented and highlighted the following points:

- d) There could be improvements in the format of the report and assigning actions.
- e) Gant charts may be useful to demonstrate progress with actions.
- f) It provided a good foundation for areas that had gone well and those that needed improvement.
- g) There would be merit in combining the four reports presented into a single report.

The Committee discussed and agreed that a group be established to rationalise the monitoring arrangements and to feedback progress to the Committee at future meetings.

#### 4.3 Staff Governance Monitoring Return

The Head of Organisational Development and Learning presented this paper setting out the Scottish Government Staff Governance Standard Monitoring Framework Return 2018–19.

The following points were highlighted:

- a) The previous Staff Governance Monitoring Return paper was included for comparison.
- b) The reasons for sickness absence would need to be addressed to ensure the information recorded is complete and accurate.
- c) Feedback on any issues or areas for improvement would be provided to the Scottish Government.

The Committee approved the Staff Governance Standard Monitoring Framework Return 2018-19 for submission to Scottish Government.
### 4.4 National Boards Collaboration

The Director of Finance & Corporate Services provided a verbal update on collaboration across national Boards and highlighted the following points:

- **a)** HIS has committed to using the new recruitment system and agreed to use the shared services model for accounts payable, although this work is currently paused.
- **b)** The main strands of collaboration are Finance, HR, Procurement and Estates.
- **c)** The Delta House lease expires in March 2021 and work is underway to establish alternative accommodation including potential options as part of the National Board Collaborative. The landlord at Delta House has been approached and is willing to extend the lease if required and revised terms would have to be agreed. It was agreed that information will be shared with staff and at Partnership Forum once more information is known.

The Committee noted the update.

### 5. WORKFORCE METRICS

#### 5.1 Workforce Data

The Head of People & Workforce presented this paper and highlighted the following points:

- **a)** The information relates to the full operational year 2018-2019 and has been drawn from the Workforce Plan.
- **b)** The paper provides statistics relating to staffing, absence, turnover and the age profile of the organisation.
- **c)** The staffing level is 472 staff with a mix of payroll and non-payroll.
- **d)** There is much improved information relating to health and safety.

The Committee noted the latest data.

#### 5.2 Nursing & Midwifery Revalidation

The Head of Excellence in Care presented this paper and provided an update on:

- **a)** Progress in developing and implementing assurance processes for Nursing and Midwifery registration and revalidation.
- **b)** The next steps required for Nursing and Midwifery Registration
- **c)** The induction process that is being developed within HIS
- **d)** The management of Nursing and Midwifery Revalidation by providing sufficient clinical experience to HIS staff to enable them to revalidate.

The next steps were set out:

- **e)** Routine reports on compliance will be submitted to the Staff Governance and Performance and Clinical and Care Governance Committee via the Clinical and Care Governance group.
- **f)** The report will be strengthened by including the numbers of professionals in each staff group and also stratified by registration required for role and registration not required for role.
- **g)** Other professional non clinical groups that require registration for their role, e.g. CIPD, will be explored.
The Committee noted the update.

6. VALUES BEHAVIOURS, ENGAGEMENT & COMMUNICATION (VBEC)

It was noted that this section was covered within the Staff Governance Monitoring Return.

7.1 RISK MANAGEMENT

[Robbie Pearson joined the meeting]

The Director of Finance and Corporate Services presented the latest risk register showing the corporate and high operational risks within the remit of the Committee. The Director asked the Committee to note the high organisational risk related to the SIGN team.

The risk category descriptions would be updated following the Board Seminar risk workshop.

The Committee noted the risk update and were assured that risk is being effectively treated, tolerated or eliminated.

8. PAPERS FOR INFORMATION


The Committee noted the minutes.

8.2 Partnership Forum 3 Key Points – 13 February & 11 April 2019

The Committee noted the key points.

8.3 Whistleblowing – Speaking Up and Raising Concerns

The Head of Organisational Development and Learning presented a paper setting out resources to assist staff with speaking up about their concerns and highlighted the following points:

a) There has been a lack of clarity for staff on the difference between raising a grievance and whistleblowing which the new resource would address.

b) Work was in progress by Scottish Government to appoint Whistleblowing Champions to NHS Boards.

The Committee noted the update and endorsed the approach set out.

9. ANY OTHER BUSINESS

There were no items of any other business.

10. STANDING BUSINESS

10.1 Board report 3 key points

The three key points for submission to the June Board meeting were agreed as:

2. Robust data now available on Health and Safety.
3. The information to signpost staff to raising concerns
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<td>The Committee welcomed the improved focus of the meeting.</td>
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<th>11.</th>
<th>DATE OF NEXT MEETING</th>
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<td>The next meeting of the Staff Governance Committee will be held in the Room Boardroom in Gyle Square on 29 August 2019</td>
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