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

**Date:** Wednesday 14 May 2014  
**Time:** 12.30pm  
**Venue:** Meeting room 6a/6b, Delta House, Glasgow  
**Contact:** Pauline Donald | pauline.donald2@nhs.net | 0141 225 6872

## AGENDA

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<th>Item</th>
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<tr>
<td>1.1</td>
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<td>Welcome</td>
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<td>Apologies for absence</td>
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<td>Minutes of meeting held on: 26 March 2014</td>
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<td>Chairman</td>
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<td><strong>4. BOARD GOVERNANCE</strong></td>
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<td>4.1</td>
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<td>Register of interests</td>
<td>Director of Finance and Corporate Services</td>
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<td>4.2</td>
<td>12.55</td>
<td>Governance Committee annual reports</td>
<td>Director of Finance and Corporate Services</td>
<td>BM2014/06</td>
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<tr>
<td>4.3</td>
<td>1.05pm</td>
<td>Governance review: next steps</td>
<td>Director of Finance and Corporate Services/Vice Chairman</td>
<td>Verbal</td>
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<tr>
<td>4.4</td>
<td>1.15pm</td>
<td>Annual Accounts and Governance Statement 2013/14: position statement</td>
<td>Director of Finance and Corporate Services</td>
<td>Verbal</td>
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<tr>
<td><strong>5. STRATEGIC BUSINESS</strong></td>
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<tr>
<td>5.1</td>
<td>1.20pm</td>
<td>Driving improvement in healthcare: our strategy 2014-2020</td>
<td>Chief Executive</td>
<td>BM2014/07</td>
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<tr>
<td>5.2</td>
<td>1.30pm</td>
<td>Scottish Patient Safety Programme (SPSP) Strategic Delivery Plan</td>
<td>Director of Safety and Improvement (interim)</td>
<td>BM2014/08</td>
</tr>
<tr>
<td>5.3</td>
<td>1.45pm</td>
<td>Learning from suicides in Scotland</td>
<td>Director of Scrutiny and Assurance and Director of Safety &amp; Improvement (interim)</td>
<td>BM2014/09 Presentation</td>
</tr>
</tbody>
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6. STANDING BUSINESS
   Corporate
   6.1 2pm Financial Performance to 31 March 2014 Director of Finance and Corporate Services BM2014/10

REFRESHMENT BREAK

7. STANDING BUSINESS (GENERAL)

Presentation: Listening and Learning - How Feedback, Comments, Concerns and Complaints can Improve NHS Services in Scotland (2.10pm – 2.40pm) BM2014/11
Director reports: key points

7.1 2.40pm Clinical Executive Clinical Director BM2014/12
7.2 2.50pm Evidence Director of Evidence (interim) BM2014/13
7.3 3pm Safety and Improvement Director of Safety and Improvement (interim) BM2014/14
7.4 3.10pm Scrutiny and Assurance Director of Scrutiny and Assurance BM2014/15
7.5 3.20pm Scottish Health Council Director of Scottish Health Council BM2014/16
7.6 3.30pm Finance and Corporate Services Director of Finance and Corporate Services BM2014/17

8. STANDING BUSINESS (BOARD COMMITTEES): Board will receive minutes of standing committees and a report of key highlights from the Chair of each committee: for information and discussion

8.1 3.40pm Audit Committee: no papers to submit to this Board meeting. Committee Chair BM2014/18
8.2 3.45pm Finance and Performance Committee: no papers to submit to this Board meeting. Committee Chair BM2014/19
8.3 3.50pm Evidence, Improvement and Scrutiny Committee: to receive the key points from the meeting on 17 April 2014 and the approved minute from 27 February 2014. Committee Chair BM2014/18
8.4 3.55pm Staff Governance Committee: no papers to submit to this meeting. Committee Chair BM2014/20
8.5 4pm Scottish Health Council: to receive the key points from the meeting on 8 April 2014 and the approved minute from 4 February 2014. Committee Chair BM2014/21

9. ANY OTHER BUSINESS

10. DATE OF NEXT MEETING

10.1 The next meeting will be held on Wednesday 25 June 2014, at 12.30pm, meeting room 6a/b Delta House, Glasgow.
Meeting of the Board of Healthcare Improvement Scotland
Date: 26 March 2014
Time: 12.30 pm – 4pm
Venue: Meeting room 6a/b, Delta House, Glasgow

Present
Denise Coia Chairman
Paul Edie
Nicola Gallen
John Glennie
Hamish Hamill CB
Peter Johnston
Marian Keogh
Prof Bob Masterton
Duncan Service
Hamish Wilson CBE Vice Chairman
Pam Whittle CBE

In Attendance
Susan Brimelow Chief Inspector, Healthcare Environment Inspectorate
Richard Norris Director, Scottish Health Council (SHC)
Kathlyn McKellar Head of Human Resources
Brian Robson Executive Clinical Director
Sara Twaddle Interim Director, Evidence
Maggie Waterston Director of Finance & Corporate Services

Karen Goudie National Clinical Lead (item 7)
Ian Smith Senior Inspector, Healthcare Environment Services (item 7)
Jan Warner Head of Supporting Safe Clinical Care (item 5.4)
Dr G Fernie Senior Medical Reviewer (item 5.4)

Apologies
Robbie Pearson Director, Scrutiny & Assurance

Committee support
Pauline Donald Corporate Governance Manager
Tracey Savage PA to the Chairman's office (Admin support)

Declaration of interests
Declaration(s) of interest(s) raised as are recorded in the detail of the minute.

Registerable interests
The Board and Executive Team were asked to review and provide any updates to the Register of Interests for recording within the Annual Accounts. All amendments to be submitted to the Corporate Governance Manager. Pauline.donald2@nhs.net

ACTION
1. OPENING BUSINESS

1.1 Chairman’s welcome and introduction
The Chairman welcomed all present to the public meeting of the Board. The Chairman formally recorded her personal thanks and that of the Board to John Glennie who had been the interim Chief Executive over the past year and who will demit post on 31 March 2014. The Chairman acknowledged the significant contribution that he had made to the organisation.

The Chairman announced the appointment of Angiolina Foster as the new Chief Executive effective 14 April 2014. She commented that this was an excellent appointment for Healthcare Improvement Scotland. She advised that Angiolina’s knowledge and wealth of experience across the public sector will be invaluable to the organisation; ensuring that the organisation continues to bring about improvements to the quality of healthcare in Scotland.

The Chairman advised that Angiolina will be arranging to meet with all members of the Board.

During the interim period, Robbie Pearson, Director of Scrutiny and Assurance will take the post of Acting Chief Executive.

1.2 Apologies

Apologies received as noted above.

1.3 Minutes of meeting held on 18 December 2013

The minutes of the meeting held on 18 December 2013 were accepted as an accurate record subject to the following amendments.

- Page 2: Amend to Professor Keith Brown and delete Professor John Kinsella.
- Page 7 – 4th paragraph – feedback from the Royal College of General Practitioners was that they were content with the delay to the implementation.

1.4 Review of action point register: 18 December 2013

The Board received for review the action point register from the meeting held on 18 December 2013.

The Board noted the status report against each action, all forward planning actions and approved the action point register as presented.

The Employee Director advised that the staff survey results had been incorporated into the Staff Governance action plan for 2014/15. The action as detailed will therefore be noted as continuing.

The Executive Clinical Director advised that a further update on the work on the Francis Inquiry will be presented to the EIS committee in June 2014.

2. CHAIRMAN’S REPORT

The Board received a report from the Chairman. The following issues were highlighted:
a) The Chairman highlighted recent meetings with the Director General and Chief Executive of NHSScotland and with the Sponsor Division; both of which were very positive; focusing on our strategy and direction of travel and future sponsorship arrangements.

b) Hamish Wilson reported on the Conference: Collaborative Working between Scrutiny bodies and disability organisations that he attended on behalf of the Chairman. Members noted that the Director of the Scottish Health Council will consider opportunities to not only promote HIS but will also identify opportunities to work with, contribute to and learn from other disability organisations. It was agreed that the Director of the Scottish Health Council will provide an update to the Board as this work progresses.

c) Peter Johnston reported on the Public Partner conference that he attended on behalf of the Chairman and in his role as a committee member of the Scottish Health Council. He commented on the positive engagement with public partners and the range of interesting questions raised. The Board noted that the organisational strategy going forward included increasing opportunities for public engagement and how HIS public partners can contribute to this agenda.

d) The Board noted the publication of the SMC task and finish group report and commented that there was no reference within the report to an evaluation of the recommendations. The Executive Clinical Director advised that the Scottish Government had set out that an evaluation will be conducted within a year but have not yet advised of any further details.

The Board noted that the SMC are in the process of developing an implementation plan to support delivery of the recommendations. It was agreed that the governance reporting route will be through the EIS committee but the Board requested receipt of summary reports.

3. CHIEF EXECUTIVE’S REPORT

The Board received a report from the Chief Executive. The following issue was highlighted:

- Developing a Quality Framework for General Practice in Scotland. The Board noted that a report on this work will be presented to the Board in June 2014.

4. BOARD GOVERNANCE

4.1 Risk management

The Board received a report from the Director of Finance and Corporate Services presenting the current status on the management of risk.

The Board reviewed the risks presented and approved a new corporate risk as recommended by the Audit Committee.

The Chair of the Audit Committee reported that both the corporate and operational risk registers had been reviewed in detail by the committee at their
last meeting. She advised that the committee was content with the new reporting approach and the redeveloped operational risk register.

The Board approved the paper as presented.

4.2 Register of interests

The Board and Senior Staff members were reminded to review the 2013/14 register of interests, advise of any amendments and return their signed declaration forms.

5. STRATEGIC BUSINESS

5.1 Driving improvement in healthcare: our strategy 2014-2020: draft for consultation

The Director of Finance and Corporate Services presented:

- feedback received from the recent consultation exercise associated with Driving Improvement in Healthcare: Our Strategy 2014-2020
- the revised strategy which incorporated the feedback received.

The Board was asked to consider the draft strategy and agree to delay final approval until the Board meeting in May when the new Chief Executive will be in post. However, the Director of Finance and Corporate Services advised that the draft strategy had been shared with the new Chief Executive. The Board noted that she had advised of some suggestions, which had been incorporated into the draft, but, in general, she had been very supportive of the direction of travel.

The Board noted that an Outcomes and Evaluation Framework is being finalised which will form the basis of future planning within the organisation. This will enable more efficient resourcing plans to be prepared to support priority work and formal measurement of progress toward achieving priorities and therefore delivering the strategy. This will be presented to the Board in due course.

The following comments from the Board were noted:

- The summary of the outcomes from the consultation was helpful in understanding the range and type of responses received.
- The Board was content that the consultation process was satisfactorily robust.
- There may be a need to consider the number of people who disagreed that we were the ‘go to’ organisation for improvement and how this impacts on the strategy?
- Is there a need for the strategy to focus more on what HIS will do to improve healthcare for the people of Scotland and less on the reputation of the organisation?
- There is a requirement to distinguish between the number of improvement organisations and their individual roles?
- What steps could be taken to improve the response rate from NHS Boards and, by association, our relationship with NHS Boards/partnerships with other organisations?
- How can HIS improve how it presents its component parts as one organisation?
The Director of Finance and Corporate Services thanked the Board for their comments and advised that these will be considered within further amendments or, as relevant, by the Executive Team. She advised that the final number of responses from NHS Boards was 8 in total. It was considered that this could be an issue to be raised at a NHSScotland Chief Executives/NHSScotland Chairs meeting to support a more encouraging response to such consultations in the future.

The Executive Clinical Director advised that the organisation was very encouraged by the number of responses from the clinical groups.

The Board approved the draft strategy in principle and agreed to receive the final strategy for approval at the Board meeting in May when the new Chief Executive will be present.

It was also agreed to consider how the strategy will be presented in terms of input from the outgoing Chief Executive.

5.2 Local Delivery plan for 2014-2015

The Director of Finance and Corporate Services presented the draft LDP 2014-15 including the financial plan. She advised that HIS is required to have both of these plans approved by the Board and submitted formally to the Scottish Government (SG) by 31 March 2014.

It was noted that the Board discussed the development of both of these plans at the Board seminar held in February 2014 and that the recommendations from this had been incorporated into the draft presented. The financial forecast was also discussed at the board seminar and since then had been finalised into the financial plan. This was presented to the Finance and Performance Committee on 5 March 2014 when it was considered in detail. Particular attention was paid by the Committee to the actions agreed by the Executive Team to ensure financial balance within the context of future reduced baseline funding. The Director of Finance and Corporate Services confirmed that the Executive Team is content that this position is manageable.

The LDP and the Financial Plan were submitted to SG in draft on 14 February 2014. A meeting took place with SG colleagues on 5 March 2014 to receive feedback on the plans which was limited.

The following points were noted/queries/actions raised:

a) LDP 2014-15

- Tissue viability: The Board sought assurance in relation to this area of work given that it was noted as not being progressed. It was confirmed that this programme of work forms part of the safety programme.
- The LDP document is largely a mandatory template which the organisation is required to complete in the format presented.
- The Board sought assurance that workforce requirements are aligned to the LDP. It was clarified that there is a short workforce section which is required to be submitted. The Head of Human Resources advised that the workforce plan was in development and would be submitted to the Board in due course.
The Board advised that they are content to include work that will not be taken forward but considered that this information could be presented at a different point in the document.

- Page 19, final table – requires to be explained further or removed.
- Page 15: include reference to SMC as an output.

The Board advised that they were content to approve the LDP subject to the above amendments.

They commented that they looked forward to receiving the Workforce Plan which they considered was crucial to delivery of the LDP.

b) Financial plan

The Director of Finance and Corporate Services clarified that:

- discussions with the Scottish Government finance colleagues had taken place in relation to financial forecasting for year 2 and 3.
- reassurance was provided to the Board that the Executive Team is content that the financial position as presented is manageable.
- both the Board and the Executive Team noted the continued caution and concerns related to an expanding strategy and reduction in funding and recognised the need to ensure continued dialogue with relevant stakeholders to achieve long term financial stability.

The Board approved the financial plan as presented.

The Board thanked the Director of Finance and Corporate Services and her teams for the work involved in producing the LDP and supporting financial plan.

5.3 Scrutiny and Inspection Plan 2014-2015

The Board received the Scrutiny and Inspection Plan 2014-15.

Minimal amendments were raised and will be addressed: a) include page numbers, b) include reference to Mental Health work.

The Board commended the plan and the commitment of all staff involved in its development.

The Board approved the Scrutiny and Inspection Plan 2014-15 for submission to the Cabinet Secretary.

The Board suggested that discussions take place with the Director General in terms of improving HIS reporting requirements. For example, they considered that the Scrutiny & Inspection Plan could form part of the LDP; as this work is core HIS business.

5.4 Business Intelligence Strategy

The Executive Clinical Director presented the Business Intelligence Strategy for approval and advised that work will now commence to prepare a detailed business case and workplan to enable implementation of the strategy. He asked the Board to note the key aspects of the strategy as detailed under...
section 3 of the supporting paper. He also acknowledged the input from Michael Fuller, Non Executive Director and Dr Peter Christie, Consultant in Public Health Medicine, and Dr Donald Morrison, Head of Business Intelligence and Data Management in designing the strategy.

The Board thanked the Executive Clinical Director and his team for the work undertaken to date. They suggested that the strategy is supported by a reference map which outlines the national and local context related to this area of work, the interrelationships and the implications for HIS.

The Board also acknowledged the importance of this work to the effective delivery of the business of the organisation over the next few years. They therefore requested assurance that this work can be resourced and delivered to timeline. In this respect, it was agreed that a copy of the business case incorporating a high level implementation plan will be submitted to the June meeting of the Board.

The Board approved the Business Intelligence Strategy.

Note: The Chairman reported that Dr Peter Christie recently retired from the NHS and acknowledged his contribution to Healthcare Improvement Scotland.

5.4 Death certification

Note: Paul Edie, Chair of Care Inspectorate and serving local authority council member and John Glennie, Chief Executive as a Non-Executive Board member of NHS24, effective 1 April 2014 both declared an interest in the following agenda item related to their respective roles.

It was not considered a requirement for either party to leave the meeting at discussion of this item.

The Board received a report on the current status of the death certification review programme and noted the following:

- HIS elements of the new Act are on schedule and that milestones are, in general, being achieved.
- The three areas which are under review relate to: context, sample size and communication.
- The Chief Medical Officer has issued a letter with more detailed information for local NHS boards and other healthcare organisations such as hospices. This letter demonstrates the interdependencies of this work and makes very clear the areas for which HIS is responsible and accountable for this programme. A copy will be circulated to the Board.
- Go live date has been confirmed as 1 April 2015.
- The Scottish Government has funded a broader support package which includes electronic certification of death.
- It is anticipated that there will remain an acceptable level of interest from the previous applicants for the vacant reviewer posts. An letter outlining the current position has been circulated to all previous applicants.

In conclusion the team advised the Board that this programme is progressing well although it remains a high risk programme, specifically in relation to the three areas under review. The Board will continue to be updated on progress at regular intervals.
The Board advised that the update as presented provided assurance to the Board that this programme will be delivered. However, they raised the following queries:

a) How will the Board know, following implementation, that the quality and accuracy of death certification reporting has been improved? It was considered that outcome measures should be clarified and included in the report.

b) The Board raised concern with progress of a single coherent communications plan under Scottish Government leadership and direction. It was agreed that the Board will endorse a letter to the Chief Medical Officer advising of the significant concerns and the timelines that are required.

The Board acknowledged the significant amount of work that continues to be managed by the team.

6. STANDING BUSINESS (CORPORATE)

6.1 Financial performance to 28 February 2014

The Board received the financial performance report to 28 February 2014.

The Board acknowledged the excellent financial position and expressed their thanks to the Director of Finance and Corporate Services, the Finance Team and all budget holders for the work involved.

Additionally, the Board noted that all allocations had been received.

6.2 2013/14 Local Delivery Plan (performance report)

The Board received and noted the report on performance to date against the Local Delivery Plan which detailed key issues including highlights, achievements and performance throughout 2012/13.

7. STANDING BUSINESS (GENERAL)

HIS Collaborative working

The Board received a presentation from Karen Goudie, National Clinical Lead and Ian Smith, Senior Inspector with Healthcare Environment Inspectorate on 'Integrated working and Driving Improvement in Healthcare'. They described their approach, the challenges and opportunities to consider the appropriate alignment of scrutiny and improvement within the older peoples work programme and how they are working jointly to support boards with solutions to improve patient care.

The Board noted that this continues to be an area of work in development and acknowledged the challenges outlined in relation to inspection and improvement approaches, whilst ensuring that HIS can react and respond to outcomes from inspections but that they can also support improvement within Boards.
The Director of Safety and Improvement commented that the work undertaken to support older people in acute care had been significant; with the next step to determine the outcome data and start to evidence the achievements in improvements in care. She acknowledged the work of the team involved and their achievements to date.

The Board thanked Karen and Ian for their presentation and were very encouraged by the work undertaken to date.

## 7.1 Executive Clinical Director: key points

The Board received a report from the Clinical Director which provided a high level update on recent activity and key developments within the Directorate. The Board noted the following:

- Clinical Engagement Strategy: will be submitted to the Board in June 2014.
- QI connect webex sessions: these sessions have been very successful to date. The Executive Clinical Director thanked his team for the organisation of these sessions.

The Board encouraged the Executive Clinical Director to consider also using the extensive National/internal expertise and promote the unique work of HIS through the QI connect forum.

## 7.2 Director of Evidence: key points

The Board received a report from the Interim Director of Evidence which provided a high level update on recent activity and key developments within the Directorate. The following additional points were noted:

- SHTG primary submission pilot: presents the HIS contribution to technological innovation agenda across Scotland. This programme will be evaluated. The need to reflect patient/carer views in the process was highlighted.
- SIGN will embed cost effectiveness into the whole guideline development process.

The review of standards will consider an approach that forms the basis for inspections and takes forward improvement work. The Director of Evidence and the Director of Safety and Improvement are working together to build an approach that will evidence how the standards will influence the work of inspection and improvement. It was clarified that HIS is now involved in the work to bring the health and social care perspective into the national care standards.

## 7.3 Director of Safety and Improvement: key points

The Board received a report from the Interim Director of Safety and Improvement which provided a high level update on recent activity and key developments within the Directorate. The following additional points were noted:

- SPSP strategic delivery plan – this will be presented to the Board seminar
in April 2014.

- Extension of funding – this funding evidences the confidence in the organisation to effectively deliver and presents a very positive message to HIS. Associated risks however is the need to balance new work against capacity to respond and the risk of expanding too rapidly. The Chairman advised that she will raise the issue of the process of commissioning work with the Sponsor Division.

- In relation to the funding to test the benefits of increased involvement of pharmacists in primary care, it was noted that the Board will receive a presentation on the ‘Prescription for Excellence’ report at the Board meeting in June and further discussions will take place at this time.

7.4 Director of Scrutiny and Assurance: key points

The Chief Inspector, HEI presented a high level exception report, on behalf of the Director of Scrutiny and Assurance, on the work currently being undertaken within the Directorate of Scrutiny and Assurance.

The Board received and noted the report.

7.5 Scottish Health Council: key points

The Board received a report from the Director of the Scottish Health Council which provided a high level update on recent activity and key developments within the Directorate.

- Progress with Complaints and Feedback review: a presentation on this work will be provided at the Board meeting in May 2014.

- Hamish Wilson referenced the recent conference he attended - ‘Collaborative Working between Scrutiny bodies and disability organisations’ at which they raised the issue of their focus on human rights. He queried whether/how HIS articulated the Human Rights Act. The Director of the SHC advised that we are aware that disability organisations see merit in taking a specific human rights approach but it is something that HIS would need to be clear added value to the approach we take in terms of scrutiny and assurance. It was agreed that this may merit further discussion at a later date.

7.6 Finance and Corporate Services: key points

The Board received a report from the Director of Finance and Corporate Services which provided a high level update on recent activity and key developments within the Directorate.

The Board noted the updates provided and that progress reports will be provided in relation to Shared Services and the short-life working group on Financial Implications of Approaches to Medicines Access which is due to report its findings in April 2014.

8. GOVERNANCE COMMITTEES
The Board received the approved minutes and key points from the meetings of each of the governance committees and the governance committee chairs further reiterated the three key points raised from the meetings recently undertaken.

The following areas were noted in addition to the key points presented from each of the committees:

a) The Audit Committee advised that they very much welcomed the draft SPSP report and that they had been assured by the information presented and the direction of travel. The Board will receive a presentation at the Board seminar on 16 April 2014 and the final draft paper will be presented to the Board meeting in May 2014.

b) EIS committee minute: item 6.6

The Executive Clinical Director clarified that the transfer of taught programmes remained a risk but that HIS will continue to influence its future contribution. He also confirmed that he had written to NES to raise his concerns.

c) Scottish Health Council

Health and social care integration: the SHC will report back to the Board on progress of this work when it is at a later stage.

9. ANY OTHER BUSINESS

The outgoing Chief Executive, John Glennie, expressed his thanks to the Chairman and the Board for the support received during his tenure. He wished the Executive Team and the organisation continued success.

10. DATE OF NEXT MEETING

The next meeting will be held on Wednesday 14 May 2014 at 12:30pm at Gyle Square, Edinburgh.

Post meeting note: the Board meeting on 14 May 2014 will be held in Delta House, Glasgow.
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<th>Timeline</th>
<th>Lead officer</th>
<th>Status</th>
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<tr>
<td>1.1</td>
<td>Welcome</td>
<td>The new Chief Executive will arrange to meet with all Board members.</td>
<td>Ongoing</td>
<td>Corporate Governance Manager</td>
<td>Meetings are currently being arranged.</td>
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<tr>
<td>1.3</td>
<td>Minutes of meeting held on 18 December 2013</td>
<td>Item 1.1 and Item 6.4: to be amended as advised at the meeting (refer to minute 26 March 2014 for details).</td>
<td>27/03/14</td>
<td>Corporate Governance Manager</td>
<td>Actioned.</td>
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<td>1.4</td>
<td>Review of Action point register 18 December 2013</td>
<td>Francis inquiry: an update report will be presented at the EIS Committee in June. Item 4: NHSScotland National Staff survey results. Status report from previous meeting to be noted as continuing.</td>
<td>April 2014</td>
<td>Executive Clinical Director/EIS committee</td>
<td>Notified to EIS committee secretary for inclusion on the agenda.</td>
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<td>April 2014</td>
<td>Staff Governance Committee/Head of HR</td>
<td>Incorporated into the Staff Governance Action Plan for 2014/15.</td>
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<td>April 2014</td>
<td>Corporate Governance Manager</td>
<td>Actioned.</td>
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<td>2.</td>
<td>Chairman’s report</td>
<td>Status update on Collaborative Working between Healthcare Improvement Scotland and disability organisations to come back to the board in due course. Summary reports on SMC implementation plan to be reported to the Board.</td>
<td>In progress</td>
<td>Director of Scottish Health Council</td>
<td>Update will be provided as this work progresses.</td>
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<td>3.</td>
<td>Chief Executive’s report</td>
<td>Developing a Quality Framework for General Practice in Scotland: outputs from this work to be submitted to the Board in June.</td>
<td>June 2014</td>
<td>Director of Evidence (Interim)</td>
<td>Agenda item, June Board meeting</td>
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<td>June 2014</td>
<td>Executive Clinical Director</td>
<td>Agenda item, June Board meeting</td>
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<td>4.2</td>
<td>Register of interests</td>
<td>Board members and Executive Team/ Senior Staff asked to sign and return disclosure forms. Revised Register of Interests to be submitted to the next Board meeting.</td>
<td>31/03/14</td>
<td>All</td>
<td>Actioned.</td>
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<td>5.1</td>
<td>Driving Improvement in Healthcare – Our strategy 2014-2020</td>
<td>• Comments from the Board will be considered within further draft or, as relevant, by the Executive Team. • A final sense check of the full document will be undertaken. • The strategy will be formally approved at the next Board meeting when the new Chief Executive will be present. • Foreward will be signed by the new Chief Executive but consideration will be given to acknowledge the input from the current Chief Executive. Consider approach to improve future consultation responses from NHS Boards.</td>
<td>14/04/14</td>
<td>Corporate Governance Manager</td>
<td>Agenda item, May Board meeting</td>
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<tr>
<td>5.2</td>
<td>Local Delivery Plan for 2014-2015</td>
<td>The following amendments to be considered: • Page 19: Graph on the bottom of the page needs an explanation or should be removed. • Page 15: SMC to be included as an Output. LDP approved by the Board subject to the above amendments. The final version will be submitted to the Scottish Government by 31 March 2014.</td>
<td>31/03/14</td>
<td>Director of Finance and Corporate Services</td>
<td>Actioned.</td>
</tr>
<tr>
<td>Minute ref</td>
<td>Heading</td>
<td>Action point</td>
<td>Timeline</td>
<td>Lead officer</td>
<td>Status</td>
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</tbody>
</table>
| 5.3       | Scrutiny and Inspection plan 2014-2015 | • Page numbers to be included.  
• Include Outputs statement against Mental Health.  
HIS mandatory reporting to Scottish Government to be discussed with the Director General. | ASAP       | Director of Scrutiny and Assurance    | Actioned.                    |
|           |                                        |                                                                              | ASAP       | Chairman/Chief Executive               | Meeting currently being arranged. |
| 5.4       | Business Intelligence Strategy         | Business Intelligence Strategy approved.  
Reference map to be developed.  
Timelines and action plan to be submitted to the Board in June. | June 2014  | Executive Clinical Director           | Agenda item, June Board meeting. |
| 5.5       | Death Certification                    | A letter on the importance of mobilising communications related to the death certification review programme to be sent to the Scottish Government.  
Outcome measures to be clarified and included in the report. | March 2014 | Chief Executive                        | Actioned.                    |
<p>|           |                                        |                                                                              |            | Director of Scrutiny and Assurance    | Actioned.                    |
| 7.1       | Executive Clinical Director: key points | Healthcare Improvement Scotland QI Connect flyer: consideration to be given to National speakers who could be included in the selection process for the Webex sessions. | TBC        | Executive Clinical Director           | The QI connect series for 2014 was established to bring international QI experts to share their experience in a convenient form and the current faculty were selected on that basis. Other mechanisms including Teach back WebExs allow sharing of Scottish work. |
| 7.2       | Director of Evidence: key points       | An evaluation of the Scottish Health Technologies Group Rapid Review process to be carried out. | Early 2015 | Director of Evidence (interim)         | Will be taken forward by Director of Evidence (interim) – early 2015 |</p>
<table>
<thead>
<tr>
<th>Minute ref</th>
<th>Heading</th>
<th>Action point</th>
<th>Timeline</th>
<th>Lead officer</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3</td>
<td>Director of Safety &amp; Improvement : key points</td>
<td>Discuss commission process with Sponsor Division.</td>
<td>15 May 2104</td>
<td>Chief Executive</td>
<td>Meeting arranged for 15 May 2014.</td>
</tr>
<tr>
<td>7.4</td>
<td>Scottish Health Council: key points</td>
<td>The impact of the report on feedback on the complaint process to come back to the Board.</td>
<td>26/06/14</td>
<td>Director of Scottish Health Council</td>
<td>Agenda item: May Board meeting</td>
</tr>
<tr>
<td>7.5</td>
<td>Finance and Corporate Services: key points</td>
<td>SLWG financial implications of approaches to Medicines access: the Board will receive an update following publications of the group’s report.</td>
<td>May 2014</td>
<td>Director of Finance and Corporate Services</td>
<td>Director’s report: May Board meeting.</td>
</tr>
</tbody>
</table>
SUBJECT: Chairman’s report to the Board

1. Purpose of the report
   This report provides Board members 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.

Denise Coia
Chairman
1. Governance

- **Board member appointments**
  
  Board member interviews took place in early April 2014. We are awaiting confirmation of approval of appointment from the Cabinet Secretary.

- **Completion of appointment**
  
  The Board is asked to note that Mr Hamish Hamill will complete his appointment as a Non-Executive Board member effective 31 May 2014. Mr Hamill has been dedicated to the both the establishment of Healthcare Improvement Scotland, the establishment of the Audit Committee; previously holding the role as Chairman of this committee. He has brought significant senior expertise from Government and the wider public sector to the organisation and has been a valued member of the Board.

  The best wishes of the Board and the organisation is extended to Mr Hamill.

- **Annual Leave**
  
  I will be on Annual leave from 21 May 2014 – 30 May 2014. In my absence Dr Hamish Wilson will be Acting Chairman.

2. Emerging issues and updates (the Chairman will provide an update on key issues arising from the following meetings)

- **Joint meeting with Care Inspectorate: Chairman/Chief Executive**
- **Meeting with Derek Bell, President of the Royal College of Physicians, Edinburgh**

3. NHSScotland Chairs meetings

  NHS Chairs continue to meet monthly with the Cabinet Secretary and his officials. Key issues raised at the meeting on 14 April 2014 included Health and Social Care Integration, delayed discharges, Primary Care and an update was given on Joint Improvement Team and Partnership Board arrangements.

4. External meetings, conferences and events attended since the previous Board meeting

- Sponsor Unit – will take place on 15 May 2014
- Director General NHSScotland (currently being arranged)
- Rhona Grant, MSP
- Accounts Commission meeting with strategic scrutiny bodies

5. Conference/meeting dates for information

  Board members are asked to note the following conference/meeting dates:
  
  - Building a Quality Improvement Infrastructure event - the NHSScotland Quality Improvement Hub will be hosting this event which will be held in Edinburgh on 12 May 2014.
  - NHSScotland Event, 3 and 4 June 2014
  - Board meeting, 25 June 2014, Delta House, Glasgow
• Institute of Healthcare Management, Scotland, Annual Conference 2014, 9 and 10 October 2014

6. Social media and communications

• Board communications update
  The Board communications update is circulated on a regular basis to all Board members and includes key issues of relevance to the Board. Please forward any feedback on this approach to Pauline.donald2@nhs.net.

• Parliamentary Activity Briefing
  The Board receives a briefing on parliamentary activity on a monthly basis. The briefing focuses on items:
  o of immediate relevance to Healthcare Improvement Scotland (eg where the organisation has been referred to; where we may be providing evidence or other input)
  o items which are related to our work programme and NHSScotland priorities and which may in future become more directly relevant as they develop.
  Please refer any enquiries to jane.illingworth@nhs.net.

• Social media
  If you are active on Twitter, please follow the Chairman - @denisecoia. Our use of Twitter, facebook www.facebook.com/healthcareimprovementscot and you tube www.youtube.com/user/healthimprovescot is part of our growing media presence as a way of communicating directly with stakeholders and the public.
SUBJECT: Chief Executive's Report to the Board

1. Purpose of the report
   This report provides Board members with an update on recent policy and strategic events.

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

Angiolina Foster
Chief Executive
1. Staff

Senior Staff Appointments / Resignations
This is my first Board meeting since my appointment to the post of Chief Executive on 14 April 2014.

Other issues of note
Professor Jonathan Fox has been appointed as Chair of the Scottish Medicines Consortium.

Directorate of Evidence and Directorate of Improvement
In January 2014 interim arrangements were put in place to ensure the continued effective running of the Evidence and Improvement Directorate teams. It is now clear that separating these responsibilities has strengthened the voice of the teams and has enabled better joint working across all our functions.

For this reason, we have decided to formalise this arrangement and create a Directorate of Evidence and a Directorate of Improvement. The teams sitting within these two directorates will remain as they are, as will the reporting structures. The organisation will now progress with recruitment to the two Director posts.

2. Emerging issues and updates

Driving Improvement Strategy
Our Strategy, Driving Improvement in Healthcare, has now been finalised and is being presented at today’s meeting for ratification. The intention is to have a number of key plans directly aligned to the Strategy including an outcomes and evaluation framework and a three year corporate plan. Both of these are currently being developed by the Driving Improvement team and will be presented to the Board in the near future.

Chronic Pain Services
Healthcare Improvement Scotland published a new report on 28 April 2014 reporting that Chronic Pain services for patients in Scotland are steadily improving, but that there is wide variation in service provision, clinical practice and resources for the 800,000 people who are affected by Chronic Pain.

An additional key finding in the report is that all NHS boards now have Service Improvement Groups made up of healthcare professionals, patients and voluntary organisations, who are driving improvements locally.

The information in the report is designed to help local NHS boards target their improvement work where it is most needed.

Freedom of Information Update
Recent themes
Over the last two months (from the end of February to 30 April 2014) the organisation received 19 FOI requests. There were two subject areas in particular where our responses gave rise to further profile in the Scottish Parliament and in media coverage. The first was an interest in our inspections on the care of older people. There were four FOI requests related to this area of our work - one from a member of the public and three from an MSP's office. The requests asked about the number of improvements made as a result of the inspections, the results of patient questionnaires and what we had done to follow up inspections. The second area of interest was in the work of the Scottish Medicines Consortium (SMC) where we received two FOI requests from the media, and in particular the interest here
was in declarations of interest in pharmaceutical companies by SMC members.

Fulfilling responses on time
Of the 19 FOI requests, 4 are still live, 13 were fulfilled on time, 2 were delivered one day late (after the 20 day period) with the requesters’ agreement. Also, one of the current live requests is overdue by two days, again with the requester’s agreement.

Exemptions and Reviews
There were exemptions claimed on 5 FOI requests for reasons of: personal information, information to be contained in a forthcoming publication and to transfer one request to be answered under the Environmental Information Regulations legislation. One of the 19 requests was a request for an (internal) review of a previous FOI response on a request for information the Scottish Patient Safety Programme – Patient Safety Climate Survey. The information requested related to a specific clinical practice. The response we gave was information not held. (In this instance information held securely on our servers is not accessed, extracted or copied by us in any way. Any analysis is run only by the participating general practices and we suggested the requester approach the specific practice in question.) The result of the internal review was that our initial response was upheld. However we have been notified that the requester has asked for a further review by the Scottish information Commissioner.

Risk Management
Please note there have been no updates to the Risk Register since the last Board meeting in March. Due to the public holidays this month, the meetings at which the Register would have been presented for approval have been rescheduled until June. The Chairman agreed that the Risk Register could be removed from this agenda and presented at the next Board meeting in June.

3. Scottish Government and Scottish Parliament

Health and Sport Committee Evidence Session - Tuesday 22 April 2014
The Committee discussed mortality rates at NHS Lanarkshire and the rapid Review, with several references to the timeline from the first report of a raised HSMR (July - September 2011) to the Review. The actions arising from the rapid Review will run until 2017 and a question was raised over the pace of progress.

A discussion also took place over the level of Healthcare Improvement Scotland’s powers to instigate a process such as the rapid Review. The Cabinet Secretary responded that Healthcare Improvement Scotland has the power to take such a decision, using its professional judgment, without the need to request his permission beforehand. Notwithstanding this, the Cabinet Secretary should be informed of the intention to undertake such work.

Annual Review 2014
Our Annual Review will take place on 27 November 2014 and will be attended by the Minister for Public Health. The follow-up letter for the Annual Review 2013 is currently with the Cabinet Secretary for sign-off and will be forwarded to us in due course.

4. Readout from Recent External Engagements

Health and Social Care Integration
I attended a meeting of the Bill Advisory Group (shortly to be renamed The Integration Implementation Group, given that the Bill is now an Act) chaired by the
Cabinet Secretary. A good meeting, which helpfully reinforced three key areas of continued relevance to Healthcare Improvement Scotland – work to further refine the national outcomes for health and social care, together with the indicators which will underpin these outcomes; public and user engagement in integration; and scrutiny implications of health and social care integration.

Care Inspectorate Liaison
The Chairman and I had a productive meeting with the Chair and Chief Executive of the Care Inspectorate. As well as reviewing existing joint work, we agreed to continue with occasional joint meetings of our respective Boards – as distinct from the setting up of a formally conjoined committee or Board.

Royal College of Physicians of Edinburgh
The Chairman and I had a very positive introductory meeting with the new President of RCPE, Professor Derek Bell. A number of shared areas of interest were identified and we have committed to further work in early course.

Scottish Medicines Consortium
I attended a quarterly meeting with Scottish Government on the work of SMC. Constructive dialogue was held, with agreement reached on imminent changes to SMC arrangements.

5. Internal Engagement

Introductory Meetings
I have held several introductory meetings with cross-sections of Healthcare Improvement Scotland staff. These sessions have been relatively informal, with the simple but important aim of allowing colleagues to begin to engage with me. I am grateful for the good conversations we have begun and for the warm welcome I have received.
SUBJECT: Register of Interests 2014/15

1. Purpose of the report
   To present the current register of interests to the Board.

2. Recommendation
   The Healthcare Improvement Scotland Board is asked to:
   • receive and approve the register of interests.

3. Background and key issues
   Board members and senior staff members of Healthcare Improvement Scotland are required to register their interests as stated in the Code of Corporate Governance (Section A, Standing Orders).

   The register will be presented to the Board on an annual basis. However, Board members and senior staff are also required to declare and register any additional interests at each meeting of the Board or a governance committee, or within one month of them changing.

   The register as attached is up to date as at 1 May 2014.

   The Register of Interests is made available to the public, on request, at the offices of the Board and on the organisation’s website.

Angiolina Foster
Chief Executive
Lead Director

Maggie Waterston
Director of Finance and Corporate Services
Lead Officer

Appendix:
Register of Interests 2014/15
## REGISTER OF INTERESTS – BOARD MEMBERS, EXECUTIVE TEAM AND SENIOR STAFF: Financial year 2014/15

<table>
<thead>
<tr>
<th>NAME</th>
<th>CATEGORY</th>
<th>INTEREST</th>
<th>Date interest commenced (if in FY 2014/15)</th>
<th>Formal notification at Board meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Denise Coia</td>
<td>1</td>
<td>Board member, Care Inspectorate</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Fellow of the Royal College of Psychiatrists</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Honorary Fellow of College of Physicians and Surgeons, Glasgow</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Chair, GMC Quality Scrutiny Group</td>
<td></td>
<td>20/02/2013</td>
</tr>
<tr>
<td>NON-EXECUTIVE BOARD MEMBERS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paul Edie</td>
<td>1</td>
<td>Chair of the Care Inspectorate</td>
<td></td>
<td>26/06/2013</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Member of the Board of Scottish Social Services Council</td>
<td></td>
<td>26/06/2013</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>City of Edinburgh Councillor</td>
<td></td>
<td>26/06/2013</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Member of the Scottish Liberal Democrats</td>
<td></td>
<td>15/05/2014</td>
</tr>
<tr>
<td>Nicola Gallen</td>
<td>1</td>
<td>Management Consultant, British Telecom</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td>Hamish Hamill, CB</td>
<td>1</td>
<td>No interests to declare</td>
<td></td>
<td>29/6/2011</td>
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<td>6</td>
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<tr>
<td>Note: Mr Hamish Hamill will complete his tenure as a Non Executive Board member on 31 May 2014.</td>
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<tr>
<td>Cllr Peter Johnston</td>
<td>1</td>
<td>Elected Member, West Lothian Council</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Non-Executive Director, NHS Lothian</td>
<td></td>
<td>29/6/2011</td>
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<tr>
<td></td>
<td>6</td>
<td>Member of Scottish National Party</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>COSLA Health and Wellbeing Spokesperson</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td>Marian Keogh</td>
<td>6</td>
<td>Member of the Board of Greater East Arts Company, Glasgow</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td>NAME</td>
<td>CATEGORY</td>
<td>INTEREST</td>
<td>Date interest commenced (if in FY 2014/15)</td>
<td>Formal notification at Board meeting</td>
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</tbody>
</table>
| Professor Robert G Masterton | 1        | Professor & Director, Institute of Healthcare Associated Infection, University of the West of Scotland  
2 Director, RGM Consulting Ltd  
2 Fellow of the Royal College of Pathologists  
2 Fellow of the Royal College of Physicians of Edinburgh  
2 Fellow of the Royal College of Physicians of Glasgow | 29/6/2011                                  | 02/05/2012  
24/04/2013  
24/04/2013  
24/02/2013 |
| Duncan Service            | 1        | Evidence Manager, SIGN  
6 Director and Company Secretary, SHU East District Ltd  
6 UNISON Steward  
6 Board member, Guidelines International Network (GIN)  
29/6/2011  
11/7/2011  
25/09/2013 |
| Pam Whittle, CBE          | 1        | Chair, Scottish Health Council  
6 Advisory Council Member: Glasgow Centre Population Health  
6 President, Royal Caledonian Horticultural Society  
6 Director, Gardening Scotland  
29/6/2011  
29/6/2011  
25/09/2013 |
| Dr Hamish Wilson, CBE     | 1        | Council Member, General Medical Council  
1 Lay Member, Scottish Dental Practice Board  
6 Member of Scottish Advisory Board for Marie Curie Cancer Care  
6 Honorary Fellow of the Royal College of General Practitioners  
1 Lay Member of the Assembly (the Governing body) of the Royal Pharmaceutical Society of Great Britain | 29/6/2011                                  | 29/6/2011  
29/6/2011  
29/6/2011  
26/6/2013  
26/6/2013 |
<table>
<thead>
<tr>
<th>NAME</th>
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<th>Formal notification at Board meeting</th>
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<tbody>
<tr>
<td></td>
<td>6</td>
<td>Member of National Trust for Scotland</td>
<td></td>
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<td></td>
<td>6</td>
<td>Member of Chartered Management Institute</td>
<td></td>
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<tr>
<td></td>
<td>6</td>
<td>Friend of Glasgow Theatres</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXECUTIVE BOARD MEMBER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Susan Brimelow</td>
<td>1</td>
<td>Chief Inspector, HEI, Healthcare Improvement Scotland</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Director on Board of Directors for Glasgow Volunteer Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Trustee of Abbeyfield, Bearsden</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Member of the Royal College of Nursing</td>
<td></td>
<td></td>
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<td></td>
<td>6</td>
<td>Member of the Institute of Healthcare Managers</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>6</td>
<td>Non-Executive Director Community Integrated Care UK</td>
<td></td>
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</tr>
<tr>
<td>Ruth Glassborow</td>
<td>1</td>
<td>Interim Director of Safety and Improvement</td>
<td>1 January 2014</td>
<td>26/3/2014 15/5/2014 15/5/2014</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Generation Q Fellow with Health Foundation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>NHS Borders employee seconded to Scottish Government and then seconded to Healthcare Improvement Scotland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kathlyn McKellar</td>
<td>1</td>
<td>Head of Human Resources, Healthcare Improvement Scotland</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Richard Norris</td>
<td>1</td>
<td>Director, Scottish Health Council</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Member, Board of Management of the Centre for Scottish Public Policy</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Non-member Director, VOX (Voices of eXperience)</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td>SENIOR STAFF MEMBERS</td>
<td></td>
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<tr>
<td>Note: Board Member, Scottish Improvement Science Collaborating Centre (appointment pending)</td>
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<td></td>
</tr>
<tr>
<td>NAME</td>
<td>CATEGORY</td>
<td>INTEREST</td>
<td>Date interest commenced (if in FY 2014/15)</td>
<td>Formal notification at Board meeting</td>
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</tr>
<tr>
<td>Robbie Pearson</td>
<td>1</td>
<td>Director of Scrutiny and Assurance, Healthcare Improvement Scotland</td>
<td></td>
<td>2/05/2012</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No other interests to declare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Brian Robson</td>
<td>1</td>
<td>Executive Clinical Director, Healthcare Improvement Scotland</td>
<td></td>
<td>14/12/2011</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Advisor, Health Foundation</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>GP – attached to Glasgow Practice</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Institute for Healthcare Improvement (IHI) Fellow and Faculty</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Member of Scottish Council Royal College of General Practitioners (RCGP)</td>
<td></td>
<td>29/6/2011</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member, British Medical Association (not previously recorded in Register: member since 1988)</td>
<td></td>
<td>14/5/2014</td>
</tr>
<tr>
<td>Dr Sara Twaddle</td>
<td>1</td>
<td>Interim Director of Evidence, Healthcare Improvement Scotland</td>
<td>November 2013</td>
<td>18/12/2013</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Member, UNISON</td>
<td></td>
<td>15/5/2014</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Husband is a General Practitioner</td>
<td></td>
<td>15/5/2014</td>
</tr>
<tr>
<td>Maggie Waterston</td>
<td>1</td>
<td>Director of Finance and Corporate Services</td>
<td>1 May 2013</td>
<td>26/6/2013</td>
</tr>
</tbody>
</table>

**Note:** *Clinical practice at Mearns Medical Centre, 30 Maple Avenue, Newton Mearns, Glasgow, G77 5BQ since 2005 in accordance with the Healthcare Improvement Scotland contract of Dr Robson. Commitment is at least 1 session a week although this is variable across the year. Dr Robson has no financial interest in the practice and does not receive any remuneration in relation to this work.*
SUBJECT: Governance Committee Annual Reports

1. Purpose of the report
   To provide Board members with the Governance Committee Annual Reports for the period 1 April 2013 - 31 March 2014.

2. Recommendation
   The Healthcare Improvement Scotland Board is asked to:
   • Receive and approve the Governance Committee Annual Reports.

3. Background and key messages
   • It is a requirement of Good Governance that all Governance Committees submit an Annual Report to the Board.
   • The purpose of the Annual Report is to assist the Board in conducting the review of the effectiveness of the organisation’s systems of internal control.
   • The Annual Reports describe the outcomes from Committee business and provides assurance to the Board that the Committees have met their remit during the year.
   • The following Governance Committee Annual Reports are attached for review:
     o Audit Committee
     o Finance & Performance Committee
     o Evidence, Improvement & Scrutiny Committee
     o Staff Governance Committee
     o Scottish Health Council
     o Executive Remuneration Committee
   • The Board is asked to note that the supporting appendices to the Annual Reports are as follows:
     1. Committee membership and attendance
     2. Committee business planning schedule 2011/12
     3. Governance map
     4. Committee key points presented reported to each Board meeting

     For the purposes of providing a summarised report to the Board, the appendices are not included with this report but are available on request.

   • The Governance Committees will consider the recommendations from each of their reports. They will also be considered by the sub-group of the Board taking forward the recommendations from the review of governance committees and the Board evaluation.

Maggie Waterston
Director of Finance and Corporate Services
Lead Director

Pauline Donald
Corporate Governance Manager
Lead Officer
Audit Committee

Chair: Nicola Gallen
Lead Director: Chief Executive
Lead Officer: Director of Finance and Corporate Services

Introduction

In order to assist the Board in conducting a regular review of the effectiveness of the organisation’s systems of internal control, it is good practice for Governance Committees to submit an annual report to the Board. The Annual Report describes the outcomes from the Committee during the year and provides assurance to the Board that the Committee has met its remit during the year.

This report is therefore submitted on behalf of the Audit Committee for the year 1 April 2013 to 31 March 2014.

Background

Briefly describe purpose and remit of this Committee

Purpose

The purpose of the Audit committee is to assist the Board to deliver its responsibilities for the issues of risk, control and governance and associated assurance through a process of constructive challenge. In particular, the Committee will seek to provide assurance to the Board that an appropriate system of internal control is in place.

Remit

The remit of the Committee shall be in line with the NHSScotland Audit Committee Handbook 2008 NHSScotland Audit Committee handbook.pdf. The Audit Committee will advise the Board and Accountable Officer on:

- the strategic processes for risk, control and governance and the Governance Statement
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management’s letter of representation to the external auditors
- the planned activity and results of both internal and external audit
- the adequacy of management response to issues identified by audit activity, including external audit’s management letter/report
- the effectiveness of the internal control environment
- assurances relating to the corporate governance requirements for the organisation
- proposals for tendering for either internal or external audit services or for purchase of non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit Committee met its remit for the year 1 April 2013 to 31 March 2014. The detailed Terms of Reference for the Audit Committee are available within the Code of Corporate Governance.
The Governance map (Appendix 3) provides an overview of the committee business. The map is aligned to the business planning scheduled provided as Appendix 2.

**Reporting to the Board**
- The Committee reports to Healthcare Improvement Scotland Board
- The Committee provides a summary report to each meeting of the board (3 key points)
  Following a meeting of the Committee, the approved minute of that meeting is presented at the next Healthcare Improvement Scotland Board meeting.

**Summary of key business conducted 2013/14:**
- A report of all the business conducted is attached as Appendix 2 (Business Planning Schedule).
- Appendix 4 provides the key areas of business arising from each meeting (3 key points) and reported to the Board. These business areas are listed below:

**3 April 2013**
- Code of Corporate Governance
- Risk Register
- Planning for Annual Accounts and Governance Statement
- Re-appointment of Internal Auditors

**24 June 2013**
- Annual Accounts
- Risk Management
- Scottish Patient Safety Programme

**4 September 2013**
- New Risk Register
- Internal Audit Actions
- Counter Fraud

**27 November 2013**
- Framework Agreement
- Risk Management
- Scottish Patient Safety Programme

**12 March 2014**
- Scottish Patient Safety Programme
- Internal Audit Reports / Progress against Internal Audit actions
- Corporate Governance Framework Agreement

**Summary of key outcomes in relation to purpose:**

Outcomes in relation to each item of business are recorded in the full minutes of each meeting of the Committee. Among the principal outcomes this year were:

- The achievement of an unqualified audit opinion for the Board’s accounts and financial statements for the year 2012/13.
- The audit committee has led a review of risk management across the organisation which has achieved:
  - improved engagement with the risk agenda at corporate level
Approval of a Risk Management Strategy which has provided a more robust platform to embed risk within the organisation and which includes the corporate risk appetite as defined by the Board

- Approval of revised corporate and operational risk registers
- Approval to develop an internal database which will support the integration of performance reporting and risk management reporting

- The provision of reasonable assurance by the Internal Auditors on the framework of controls operating within the organisation
- The delivery of a full programme of Audit reports
- An updated Code of Corporate Governance
- Continued focus on Counter Fraud best practice and activities

Risks
(highlight any risks that need to be considered by the Committee)

All corporate risks related to committee remit are discussed at each meeting as a standing agenda item. The Committee also has the remit to consider all corporate and operational risks at each meeting.

Recommendations: (consider purpose of committee in relation to key business and terms of reference) (include what worked well and what could be improved and future aspirations)

During 2013/14 much effort was put into developing the Risk Management Strategy and refreshing the corporate and operational risk registers. The Committee would like to thank all those involved for their efforts, and recognises that to reap the benefits we need to continue to have robust discussions about risk descriptions, risk appetite and mitigating actions at Board and Committee level.

The Committee places reliance on the work of internal audit and its reviews of Healthcare Improvement Scotland. In 2014/15 we would like to build on the role of internal audit as a critical friend and encourage all Directorates to work closely with internal audit to ensure speedier implementation of audit actions. We would also like to see improved attendance at Committee meetings by members of the Executive Team.

Conclusion:

The Committee saw a significant improvement in 2013/14 in the preparation and submission of the annual accounts and governance statement, partly due to the accounts workshop which took place in early June. We are pleased to note that this process is in place for the 2013/14 accounts.

2014/15 will bring change for the organisation, with a new Chief Executive and changes to the Executive Team. The challenge will be to build on the solid foundations put in place this year as regards steady financial performance, visibility and management of allocations from Scottish Government, and longer-term strategic planning.

There will also be changes in the membership of the Committee, and we would like to thank Hamish Hamill for the outstanding contribution he has made.

Sign-off details:

<table>
<thead>
<tr>
<th>Person responsible</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee Chair</td>
<td>Nicola Gallen, Non Executive Director</td>
<td>31 March 2014</td>
</tr>
<tr>
<td>Lead Director</td>
<td>Chief Executive</td>
<td>31 March 2014</td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Director of Finance and Corporate Services</td>
<td>31 March 2014</td>
</tr>
</tbody>
</table>
Introduction

It is a requirement of Good Governance that all Governance Committees submit an annual report to the Board. The purpose of the annual report is to assist the Board in conducting the review of the effectiveness of the organisation’s systems of internal control (Healthcare Improvement Scotland Code of Corporate Governance applies). The Annual Report describes the outcomes from Committee business and provides assurance to the Board that the Committee has met its remit during the year.

This report is therefore submitted on behalf of the Finance & Performance Committee for the year 1 April 2013 to 31 March 2014.

Background

Briefly describe purpose and remit of this Committee

Remit

The purpose of the Finance and Performance Committee is to ensure that the resource plans for the organisation are integrated with and driven by the Strategic Plan. This involves scrutiny of all resource plans to ensure that resources are allocated to support the organisation’s strategy.

The Committee will review progress against the financial and non financial targets of the Board, ensuring that appropriate arrangements are in place to deliver against organisational objectives and imperatives. The Committee also has a responsibility to review progress against the duty of best value.

Key duties

The Finance and Performance Management Committee is responsible for providing scrutiny of financial reports and other reports and proposals delegated to it by the Board and for reporting the results of its deliberations, together with recommendations on decisions, back to the Board. This shall include specifically the following areas of work:

- providing detailed scrutiny and oversight of the annual budgets and 5 year Financial Plans for Healthcare Improvement Scotland (HIS) and making recommendations on these to the Board
- providing detailed scrutiny of the estimates of income and expenditure associated with significant new developments
- providing detailed consideration of quarterly reports concerning expenditure against budgets and the reasons for variances and making recommendations concerning these reports to the Board
- providing detailed consideration of quarterly reports covering key performance indicators for the Board
- considering the financial and non financial performance detailed within the annual financial statements and making recommendations to the Board
- considering and making recommendations to the Board on matters relating to the financial management of HIS, including purchasing and procurement, efficiency programmes and resource allocation and the financial arrangements governing relationships with other organisations
- considering and making recommendations to the Board on policy regarding organisational and administrative matters
- considering and making recommendations to the Board in relation to the ICT, its implementation plan and progress throughout the year
- considering matters relating to accommodation, maintenance of premises and provision of services; and
- dealing with any such other matters as may be assigned to the Committee by the Board and
making recommendations to the Board thereon.

The Governance map (Appendix 3) provides an overview of the committee business as well as the identification of gaps against its terms of reference. The map is aligned to the business planning scheduled provided as Appendix 2.

**Reporting to the Board**
- The Committee reports to Healthcare Improvement Scotland Board
- Following a meeting of the Committee, the approved minute of that meeting is presented at the next Healthcare Improvement Scotland Board meeting.
- A report of all the business conducted is attached as Appendix 2 (Business Planning Schedule).
- Appendix 4 provides the key areas of business arising from each meeting (3 key points) and reported to the Board. These business areas are listed below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Key Areas of Business</th>
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</table>
| 24 April 2013 | • Efficiency and Productivity Programme  
                 • Financial performance  
                 • Local Delivery Plan |
| 5 June 2013   | • eHealth Plan  
                 • Sustainable development  
                 • Local Delivery Plan performance reporting |
| 4 September 2013 | • eHealth Plan  
                         • Sustainable development  
                         • Performance Management Framework (PMF) and Report |
| 20 November 2013 | • eHealth Plan  
                               • Shared Services  
                               • Financial planning and performance |
| 3 March 2014  | • 2013-14 Operational Plan Performance Report  
                     • Business Continuity  
                     • Financial Plan 2014-2017 |

**Summary of key outcomes in relation to purpose:**
- Ongoing scrutiny of financial performance in-year, including management and monitoring of funds, and the delivery of efficiency savings targets
- Financial planning for future years allied to the corporate strategy, including cost pressures and savings targets
- Ensuring an effective LDP development process, taking account of lessons learned from previous year
- New performance management framework and reporting on LDP and Operational Plan
- Scrutiny of progress with implementation of eHealth Strategy
- Review of progress on shared services at the various levels and the implications for efficiencies and ways of working
**Risks**  
(highlight any risks that need to be considered by the Committee)

All corporate and operational risks related to Committee's remit are discussed at each meeting as a standing agenda item.

**Recommendations: (include what worked well and what could be improved and future aspirations)**

**What worked well:**
- Excellent management support to the work of the Committee
- A focus on the future challenges for financial planning as well as assurance on current performance and controls
- A clearer linkage between financial and human resource planning within the LDP
- Improvements to the process for developing the LDP for 2014-15

**For the future:**
- Ongoing oversight of the assumptions and risks for the Financial Plan 2014-2017, including allocations, savings targets and workforce implications
- Ongoing development of performance reporting to provide assurance to the Board about delivery of the LDP and strategy
- Opportunity to consider how the HIS eHealth strategy can add further value to the planning and delivery of its functions

**Conclusion:**

The Committee is satisfied that it is fulfilling its remit and considers that it provides, under the current arrangements, effective scrutiny of those areas of activity on behalf of the Board.

**Sign-off details:**

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<thead>
<tr>
<th>Person responsible</th>
<th>Signature</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Committee Chair:</td>
<td>Hamish Wilson</td>
<td>May 2014</td>
</tr>
<tr>
<td>Lead Director:</td>
<td>Maggie Waterston, Director of Finance and Corporate Services</td>
<td>May 2014</td>
</tr>
</tbody>
</table>
Introduction

In order to assist the Board in conducting a regular review of the effectiveness of the organisation’s systems of internal control, it is good practice for governance committees to submit an annual report to the Board. The annual report describes the outcomes from the committee during the year and provides assurance to the Board that the committee has met its remit during the year.

This report is therefore submitted on behalf of the Evidence, Improvement and Scrutiny Committee for the year 1 April 2013 to 31 March 2014.

Background

Remit

The Committee shall be responsible for oversight of the governance and assurance mechanisms of the work of Healthcare Improvement Scotland, to ensure that it maximises our contribution to improvement of healthcare services within Scotland, as described within our Local Delivery Plan in line with our strategic objectives.

Key duties

The Committee is responsible for considering and advising on the development and review of progress in all areas of the integrated cycle of improvement (Evidence, Improvement and Scrutiny). This will include the overall management of our work programme, including the following specific areas of work:

- the selection and prioritisation, including benefits realisation/impact assessment of existing and future work
- the facilitation and related implementation to drive improvement in patient safety including the implications of reports, guidance and legislation
- the development and support to implement guidance in clinical governance
- the development and support to implement evidence and knowledge into practice
- the development and support to implement the Healthcare Scrutiny Model within NHS boards and the independent healthcare sector. Including the inspection process and
- provide support to ensure co-operation and collaboration with independent healthcare providers to achieve a common understanding of what is required to improve healthcare.

The Governance map (Appendix 3) provides an overview of the committee business as well as the identification of gaps against its terms of reference. The map is aligned to the business planning scheduled provided as Appendix 2. The business planning schedule is regularly updated as a standing item on the committee agenda.

The workload required of the Committee to meet the above responsibilities is significant and is regularly reviewed by the Chair and the Executive Lead. A further review of the frequency, format and content of the Committee has been undertaken as part of the 2013/14 business planning.

Reporting to the Board

- The Committee reports to the Healthcare Improvement Scotland Board.
- Following a meeting of the Committee a short paper listing three key issues arising from the meeting is submitted by the Chair of the Committee to the next Healthcare Improvement Scotland Board.
Board meeting. This gives opportunity for a supporting verbal update by the Chair of the Committee and allows members of Healthcare Improvement Scotland Board to raise any questions they may have which can then be addressed promptly or other matters highlighted.

• Following a meeting of the Committee, the approved minute of that meeting is presented at the next but one Healthcare Improvement Scotland Board meeting.

Summary of key business conducted 2013/2014:

• A report of all the business conducted is attached as Appendix 2 (Business Planning Schedule).
• Appendix 4 provides the key areas of business arising from each meeting (3 key points) and reported to the Board. These business areas are listed below:

8 May 2013

• a) Increase in strategic pace - Rapid and significant progress was noted in delivery of a number of strategies and action plans such as Clinical Engagement, Making Measurement Count and Medicines, and the Committee noted that this was achieved within current resources.

• b) Variation - how to measure and reduce it - was a recurring theme across several strands of work for example HSMR, clinical profiles, adverse events, screening, audits. The need to reduce waste, harm and variation in practice is core work, and we need to address the balance between clinical freedom and consistency of patient management.

• c) Cultural change – involves leadership at all levels. The organisation should take a quality improvement approach to cultural change and delivery eg issues arising from the Tayside report, the professionalism agenda, and 2020 Vision. This is distinct from the Francis Report approach, which focuses on standards, compliance audit and sanctions in NHS England.

28 August 2013

• a) Resources and Priorities - In relation to a number of items on the agenda, the generic and recurring issue of adequacy of resources when constantly under pressure to do more across our portfolio of responsibilities – for example NHS Lanarkshire Quality and Safety Review, Hospital Standardised Mortality Ratios and wider Business Intelligence, Scrutiny, Scottish Medicines Consortium Review and expanding safety portfolio.

• b) Business Intelligence - The increasing importance of ‘softer’ intelligence and qualitative information which the organisation is starting to use to inform our work, for example NHS Lanarkshire Quality and Safety Review, inter-agency work etc. It will be important to develop methods that record, interpret and codify qualitative intelligence and deal with the technical challenges and Freedom of Information issues. The next iteration of the draft Business Intelligence Strategy will come to the November Evidence, Improvement and Scrutiny Committee and December Board.

• c) Implications for Healthcare Improvement Scotland in relation to national reports - There are significant implications for our work following on from the Francis, Keogh, Berwick and imminent Vale of Leven reports. Bringing the combined resources of Healthcare Improvement Scotland together to address these implications will be essential, in addition to ensuring that appropriate assurance mechanisms for the Healthcare Improvement Scotland Board are incorporated into resultant action plans and developments.

In addition to the above key themes, the Committee considered: the issues in relation to Information Governance in Healthcare Improvement Scotland with an urgent requirement to address outstanding areas of guidance, training and resources; and, asked that the Board be further informed about the
progress of the **Scottish Patient Safety Programme** and the governance thereof at the September 2013 Board.

### 13 November 2013

- **a) Risk register.** The Committee considered the key risks and mitigating actions with a focus on quality assurance of the national screening programmes. The Committee also considered the risk relating to the Person Centred Care Collaborative required to be regarded and progress reviewed at the February 2014 committee. The current review and assimilation of the corporate risk register was welcomed.

- **b) Scottish Medicines Consortium** – The Committee noted progress by the SMC Programme Board, highlighted the Board’s interest in the governance of the responses to the New Medicines’ Review and supported an update in the reserved business of the December Board.

- **c) Information Governance** – The Committee commended the progress made to address information governance concerns raised at the August meeting and noted progress including: a specialist diagnostic review; development of an information asset register, and enhanced staff training and review of policies and procedures.

In addition to the above key themes, the Committee considered the draft 2014-15 Scrutiny and Inspection Plan and approved submission to the Healthcare Improvement Scotland Board in December 2013.

### 27 February 2014

- **a) Medicines and Clinical Engagement Strategies -** The Committee noted the successful progress of the Medicines and Clinical Engagement Strategies and highlighted the need to ensure appropriate resources are prioritised to deliver these key pieces of work.

- **b) Business Intelligence strategy –** The Committee welcomed the revised version of this document which underpins our new corporate strategy and recommends it to the Board.

- **c) Completion of work –** The Committee welcomed the successful conclusion of the Releasing Time to Care work and the completion of the Out of Hours Indicators project.

### Summary of key outcomes in relation to purpose:

Outcomes in relation to each item of business are recorded in the full minute from each meeting of the Committee.

The Committee welcomed the broadening of its engagement with public partners since May 2013, the more recent representation from SMC, SIGN and SHTG and a more focused approach allowing the Committee to give due attention to items and to perform its primary function.

Based upon the above description of its work the EIS committee considers that it has fulfilled its core governance functions for the year in terms of both operational oversight and constructive review as well as in providing assurance to the full Board through timely and appropriately detailed reporting.
Risks
(highlight any risks that need to be considered by the Committee)

All corporate risks related to committee remit are discussed at each meeting as a standing agenda item.

Recommendations: (consider purpose of committee in relation to key business and terms of reference) (include what worked well and what could be improved and future aspirations)

What has worked well:
The focus of the Committee is on achieving continuous improvement and it is a consistent welcomed feature of the reports now placed before the committee that they are presented in a comprehensive and well-argued manner, so enabling the committee members to make informed decisions in line with the principles of best value.

The Committee has pioneered the further development of public partner working within Healthcare Improvement Scotland at the level of Board Sub-committees. It is a valued comment received that the involved public partners have found that they have received excellent support for their preparation and participation in these important Board functions.

The previous composition of the Committee, a mixture of professional, medical, executive and union experience, has proven to provide a productive environment of challenge and development in seeking to find a consensus around change and its impact on the service. It is vital that this mixture of expertise is maintained in any future composition of the Committee.

Opportunities for development:
Further work is needed to better develop, enhance and refine the links between scrutiny, evidence and improvement. A key evolving feature in this respect will be closer working relationships with NHS Boards at local level and the recent NHS Lanarkshire experience will offer key insights in that regard. The culture must remain continuous improvement and the maintenance of best practice without the attribution of blame.

The Committee has effectively championed the concept of setting national standards within the NHS. As the integration of health and social care progresses it will be important to be alive to, and enthusiastic about, progressing productively these same principles across this exciting new agenda.

As the work of the Committee has become greater so the need to be sure that the Board is receiving appropriate assurance means that the Committee must retest its delivery of this prime remit in order that it can satisfy both the Board and itself on this point.

Looking to the future the following developments have been suggested:
1. Understanding how best to use the Business Intelligence Strategy to drive the Committee’s agenda.
2. Identifying how NHS Board Clinical Governance Committees can be better empowered.
3. Finding ways to move forward the Committee’s role and function in the integration agenda.
4. Considering how The Patient’s Rights (Scotland) Act 2011 has impacted upon the Committee’s agenda to date to see whether further opportunities exist to promote its tenets productively in the furtherance of Healthcare Improvement Scotland functions.
5. Considering how the changes in assessment of introduction of new medicines affect technologies.
Conclusion:

This has been another productive and busy year for the EIS Committee. As part of its healthy evolution the opportunities grasped to broaden participation and input amongst public and professionals have been particularly rewarding and pleasing. It is clear to the Committee that its development is incomplete and EIS committee members look forward in the forthcoming year to addressing remaining key issues including workload focus and broader Board member awareness.

Sign-off details:

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<tr>
<th>Person responsible</th>
<th>Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>Committee Chair:</td>
<td>Professor Sir Lewis Ritchie (to August 2013)/Professor Bob Masterton (from November 2013)</td>
<td></td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Dr Brian Robson, Executive Clinical Director</td>
<td></td>
</tr>
</tbody>
</table>
Staff Governance Committee

Committee: Staff Governance
Chair: Michael Fuller
Lead Officer: Kathlyn McKellar

Introduction
In order to assist the Board in conducting a regular review of the effectiveness of the organisation’s systems of internal control, it is good practice for Governance Committees to submit an annual report to the Board. The Annual Report describes the outcomes from the Committee during the year and provides assurance to the Board that the Committee has met its remit during the year.

This report is therefore submitted on behalf of the Staff Governance Committee for the year 1 April 2013 to 31 March 2014.

Background
Briefly describe purpose and remit of this Committee
The Committee shall hold the organisation to account in terms of meeting the requirements of the NHS Scotland Staff Governance Standard (the Standard).

Duties
The duties of the Committee are as follows:
• commission the introduction of structures and processes which ensure that delivery against the standard is being achieved
• monitor and evaluate strategies and implementation plans relating to people management
• propose and support any policy amendment, funding or resource submission to achieve the Staff Governance Standard
• take responsibility for the timely submission of all staff governance information required for national monitoring arrangements
• monitor benefits realisation processes, where applicable
• provide staff governance information for the statement of internal control.

The Governance map (Appendix 3) provides an overview of the committee business as well as the identification of gaps against its terms of reference. The map is aligned to the business planning schedule provided as Appendix 2.

Reporting to the Board
• The Committee reports to Healthcare Improvement Scotland Board
• Following a meeting of the Committee, the approved minute of that meeting is presented at the next Healthcare Improvement Scotland Board meeting.

Summary of key business conducted 2013/14:
• A report of all the business conducted is attached as Appendix 2 (Business Planning Schedule).
• Appendix 4 provides the key areas of business arising from each meeting (3 key points) and reported to the Board. These business areas are listed below:

30 May 2013
Staff Governance Action Plan

21 August 2013
Personal Development Review Update
Workforce Plan and Projections
Driving Improvement
Summary of key outcomes in relation to purpose:

(a) Workforce Strategy. The prime purpose of the Strategy is to maintain the right number of employees, the appropriate level of skills and the necessary number of jobs to ensure the delivery of the Local Delivery Plan and we continue to regard those objectives as the main priority of the Committee. That has been done by regularly updating the Committee on workforce issues relating to the Workforce Plan and organisational development activities. The Committee is grateful to the Senior HR and OD teams for their efforts in ensuring the continuing and effective implementation of those plans.

(b) The completion of KSF/Personal Development Reviews has been an issue over the course of the year. The Committee has challenged management to improve performance on this issue and through focussed attention achieved a completion rate of 99.6% at end of February 2014. The Committee wishes to acknowledge the efforts of managers in achieving this outcome and will continue to monitor this in 2014-15.

Risks
(highlight any risks that need to be considered by the Committee)

All corporate risks related to committee remit are discussed at each meeting as a standing agenda item.

Recommendations: (consider purpose of committee in relation to key business and terms of reference) (include what worked well and what could be improved and future aspirations)

(a) Staff survey. The Committee acknowledges the high participation rate by HIS staff in the NHS Scotland annual staff survey. The Committee wishes to ensure that the issues highlighted are addressed timeously. This will be achieved through monitoring the delivery of the Staff Governance Action Plan for 2014-15 as approved in principle by the Committee.

(b) Meeting dates have been set for end of May, August and November 2014 and at the end of March 2015 to deal with the substantial business of the Committee. The Committee is keen to encourage Executive Directors to continue to attend meetings of the Committee on a regular basis, to ensure wide and informed participation in the important debates on the agenda.

Conclusion:

The Committee acknowledges the importance of good staff governance in terms of maximising workforce performance and contribution to achieving the aims of the Driving Improvement Strategy and improving healthcare for the people of Scotland.

Sign-off details:

<table>
<thead>
<tr>
<th>Person responsible</th>
<th>Signature</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Committee Chair</td>
<td>Michael Fuller</td>
<td>February 2014</td>
</tr>
<tr>
<td>Committee Chair</td>
<td>Duncan Service (with effect from 1 March 2014)</td>
<td>March 2014</td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Kathlyn McKellar</td>
<td>February 2014</td>
</tr>
</tbody>
</table>
Scottish Health Council

<table>
<thead>
<tr>
<th>Committee:</th>
<th>Scottish Health Council</th>
<th>Chair:</th>
<th>Pam Whittle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lead Officer:</td>
<td>Richard Norris, Director</td>
</tr>
</tbody>
</table>

**Introduction**

In order to assist the Board in conducting a regular review of the effectiveness of the organisation’s systems of internal control, it is good practice for Governance Committees to submit an annual report to the Board. The Annual Report describes the outcomes from the Committee during the year and provides assurance to the Board that the Committee has met its remit during the year.

This report is therefore submitted on behalf of the Scottish Health Council Committee for the year 1 April 2013 to 31 March 2014.

**Background**

Briefly describe purpose and remit of this Committee

**Remit**

The Scottish Health Council’s remit is to:

- Support, ensure and monitor NHS Boards’ activities regarding patient focus and public involvement.
- Support and ensure that Healthcare Improvement Scotland meets its duties in respect of:
  - (i) patient focus, public involvement
  - (ii) equalities (excluding staff governance),
  - (iii) User Focus.
- Contribute to the development of person centred services in NHS Scotland.

**Key Duties**

The key duties of the Council as set out in the Code of Corporate Governance and taking account of its statutory responsibilities are:

- approval of the Council’s strategic objectives, priorities and workplan
- review of performance against workplan and delivery of outcomes.
- arrangements for the appointment/removal of key staff
- establishment of terms of reference, membership, and reporting arrangements for any sub committees acting on behalf of the Council
- approval of systems and processes by which the organisation makes assessments of NHS Boards’ performance in patient focus and public involvement
- approval of any reports or self assessments to the Board of Healthcare Improvement Scotland on the Duty of User Focus, Equalities Duties or Person Centredness

**Reporting to the Healthcare Improvement Scotland Board**
The Scottish Health Council Committee reports to Healthcare Improvement Scotland Board. Following a meeting of the Committee, the key areas of business arising from each meeting are reported to the Board. Once approved the minute of that meeting is presented at the next available Healthcare Improvement Scotland Board meeting and provided to the Audit Committee.

Summary of key business conducted 2013/14:

Key business items considered in 2013/14 are listed below:

9 April 2013
Operational Plan for 2013/14
Options for Public Engagement
Strategy for e-participation
Health and Social Care Integration – staff event and working group
Equality Mainstreaming report
Equality Outcomes report

11 June 2013
Evaluation of 2012/13 activity
Strengthening public partner activity: review of approach, re-accreditation of Investing in Volunteers, refresh of Volunteer Handbook
Health and Social Care Integration: research findings on participation
HIS Participation Standard assessment report

14 October 2013
Future strategic direction of the Scottish Health Council
Formal statement on health and social care integration
Public Partners recruitment criteria
EQIA Audit of board papers
Patient Rights (Scotland) Act

10 December 2013 (Strategy meeting)
Strengthening the patient and public voice
Complaints and Feedback project
The Participation Standard

4 February 2014
Operational Plan progress
Engaging People Strategy
Future Strategic Direction
Health and Social Care Integration – pilots and work from around Scotland

(See Appendix 1 for summary reports)

Summary of key outcomes in relation to purpose:

Key outputs have included:

- Leading the national debate on participation in the integrated Health and Social Care structures, through
  - Initiating, commissioning, and publishing independent new research based on a broad variety of stakeholder views, bringing together users and professionals in health and social care, with
a think piece providing conclusions and next steps

b. Events across Scotland disseminating the research and developing themes
c. Developing an agreed position, and influencing the Scottish Government and Health and Sport Committee to agree to explore a new Participation Standard for integrated health and social care
d. A pilot project in Midlothian, including a consultation event facilitated by the Scottish Health Council

The work overseen by the Council has included:

- Providing ongoing support for the NHS across Scotland for approximately 90 service change engagement exercises
- Providing a formal view on whether an NHS proposal constituted ‘major’ service change on 6 occasions, with 2 of those identified as major.
- Carrying out a Scotland wide assessment exercise for the Participation Standard and publishing a national overview report
- Agreeing Equality Outcomes for Healthcare Improvement Scotland
- Carrying out an EQIA Audit of Healthcare Improvement Scotland Board papers
- Monitoring progress against Local Delivery Plan and operational work plan, and regular oversight and scrutiny of Risk Register
- Supporting the public to have an input into national policy making and national health projects by responding to nine requests for support from stakeholders to gather views across Scotland
- Supporting Managed Clinical Networks (local, regional and national) with public engagement activities
- Refreshing and republishing the Participation Toolkit
- Publishing an e-Participation Toolkit
- Providing support to NHS Boards for volunteering activities by hosting the National Programme for Volunteering in Scotland
- Providing tailored support to 22 NHS Boards to improve their public engagement activities
- Chairing and supporting the National Monitoring and Advisory Group for the Patient Advice and Support Service (PASS) and leading on the development for a system of gathering user feedback for the service.

Publishing *Scottish Grief and Bereavement Hub: Summary of Stakeholder Feedback*

- Publishing *Evaluating Participation: A guide and toolkit for health and social care practitioners*
- Publishing a *Review of NHS Boards’ Annual Reporting on Feedback, Comments, Concerns and Complaints 2012-13*
- Publishing *Volunteering in NHSScotland: a handbook for volunteering*
- Publishing *Volunteering in NHSScotland: a starting point for engaging young volunteers in the NHS*
- Publishing *Involving Rural Communities in Health and Care Services Co-production: promoters and barriers as reported in the academic literature*
- Holding a Research Symposium for practitioners, academics and policy makers, jointly organised with Healthcare Improvement Scotland.

**Risks**

(highlight any risks that need to be considered by the Committee)

Particular risks that the Scottish Health Council need to be mindful of are: (2013-2014)

Whilst the Scottish Health Council has embedded Healthcare Improvement Scotland’s refreshed risk management strategy throughout the Directorate, a new Directorate Risk register is continuously
reviewed through Directorate team meetings to monitor whether or not the Scottish Heath Council’s risk profile is changing, gain assurance that risk management is effective and to identify when further action is necessary to deliver assurance on the effectiveness of control. The Council continues to monitor this closely. One particular additional risk that the Council is mindful of is that we fail to deliver core functions consistently across all NHS Boards because of the requirement for savings across a geographically dispersed staff complement resulting in potential for loss of impact, profile and credibility.

**Recommendations:** (consider purpose of committee in relation to key business and terms of reference) *(include what worked well and what could be improved and future aspirations)*

What worked well:

- The leadership and expertise provided by Council members in leading the Health & Social Care Project in 2013 and Social Media work was of particular value.
- Public Partner Review work. This was initiated at a difficult time but resulted in a much improved relationship and integration of Public Partners. As a result Public Partners designed and developed own event, engagement with Public Partners is more effective and feedback has been positive. However, it is important to ensure this is an ongoing process.
- Healthcare Improvement Scotland’s own Participation Standard assessment was carried out by NHS Education and concluded that Healthcare Improvement Scotland had demonstrated an improvement.
- Working in partnership with other directorates and the Scottish Government to deliver specific aspects, such as the Complaints and Feedback Work.

**Conclusion:**

During the past year the Council and its officers have worked hard to ensure the work of the Council is inline with the Healthcare Improvement Scotland overall strategic direction. The revised Healthcare Improvement strategy makes this much easier to demonstrate but there is still work to do in ensuring a wider understanding of the extent and integral nature of the work of the Scottish Health Council as a part of Healthcare Improvement Scotland.

**Sign-off details:**

<table>
<thead>
<tr>
<th>Person responsible</th>
<th>Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>Committee Chair:</td>
<td>Pam Whittle</td>
<td>April 2014</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Richard Norris</td>
<td>April 2014</td>
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Remuneration Committee

<table>
<thead>
<tr>
<th>Committee:</th>
<th>Executive Remuneration Committee</th>
<th>Chair:</th>
<th>Peter Johnston</th>
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<td>Lead Officer:</td>
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<td>Chief Executive</td>
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**Introduction**

It is a requirement of Good Governance that all Governance Committees submit an annual report to the Board. The purpose of the annual report is to assist the Board in conducting the review of the effectiveness of the organisation’s systems of internal control (Healthcare Improvement Scotland Code of Corporate Governance applies). The Annual Report describes the outcomes from Committee business and provides assurance to the Board that the Committee has met its remit during the year.

This report is therefore submitted on behalf of the Executive Remuneration Committee for the year 1 April 2013 to 31 March 2014.

**Background**

Briefly describe purpose and remit of this Committee

**Remit**

The Committee is appointed by the Board to assist it in discharging its responsibilities for executive and senior management remuneration and to maintain the highest possible standards of corporate governance in this area.

**Key duties**

- Agree all terms and conditions of employment for all staff on the executive and senior management pay scales, including job description, job evaluation, terms of employment, basic pay, performance pay and benefits (including pension or superannuation arrangements and motor cars)

- Agree the performance plan for all staff on the executive and senior manager pay scales before the start of the year in which performance is assessed, and consider and agree, in exceptional circumstances, the revision of the performance plan in the course of an assessment year

- Review the performance of all staff on the executive and senior manager pay scales against their performance plans

- Agree the Board’s arrangements for job evaluation of staff on the executive and senior manager pay scales and to oversee these arrangements with the assistance of the Board’s Head of Human Resources

- To act as the appeals body for those on the executive and senior manager pay scales who have a grievance concerning their Terms and Conditions of Service and in relation to disciplinary matters

**Reporting to the Board**

- The Committee reports to Healthcare Improvement Scotland Board (private session)
  Following a meeting of the Committee, the approved minute of that meeting should be presented at the next Healthcare Improvement Scotland Board meeting (private meeting).
Summary of key business conducted 2013/14:

The Committee has met twice and the subject matter has been as follows:

- Executive appraisals
- Oncall Arrangements

The Committee have also undertaken three remote notifications as follows:

- Appointment of Senior Medical Reviewer
- Settlement agreement
- Appointment of Chief Executive

The detail of the above is confidential and therefore will not be reported in this document. The Board is assured that a full audit trail of administrative process and minutes are held in accordance with our policies.

Risks
(highlight any risks that need to be considered by the Committee)

All corporate risks related to committee remit are discussed at each meeting.

Recommendations: (consider purpose of committee in relation to key business and terms of reference) (include what worked well and what could be improved and future aspirations)

Conclusion:

The Executive Remuneration Committee is satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee during 2013/14 has allowed us to fulfil our remit as detailed in the committee terms of reference within the Code of Corporate Governance.

Sign-off details:

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<tr>
<th>Person responsible</th>
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<tbody>
<tr>
<td>Committee Chair:</td>
<td>Peter Johnston, Committee Chair</td>
<td>March 2014</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>John Glennie, Interim Chief Executive</td>
<td>March 2014</td>
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SUBJECT: Driving Improvement in Healthcare – Our Strategy 2014-2020

1. Purpose of the report
   The purpose of this report is to present to the Board the final version of Driving Improvement in Healthcare: Our Strategy 2014-2020.

2. Recommendation
   The Healthcare Improvement Scotland Board is asked to:
   • Approve and adopt Driving Improvement in Healthcare: Our Strategy 2014-2020

3. Background and key issues
   During 2013, Healthcare Improvement Scotland embarked upon a change programme with the objective of becoming a high performing organisation by 2015. As part of this programme, the organisational strategy was reviewed and updated to align as far as possible to the 2020 strategic vision set out by Scottish Government. The strategy has been developed, consulted on and revised to accommodate the feedback received.

   Two previous Board development sessions have been held (July 2013 and February 2014) to allow full Board participation in this process and specific meetings have been held with key stakeholders out with the formal consultation phase. The strategy was presented at the Board meeting on 26th March 2014 for further review by Board members and it was approved subject to some minor wording changes and subject to the approval of the incoming Chief Executive.

4. Strategic objectives/Local Delivery Plan
   The strategy sets out our strategic objectives until 2020.

5. Measures for improvement
   An Outcomes and Evaluation Framework is being prepared which will form the basis of future planning within the organisation. This will enable more efficient resourcing plans to be prepared to support priority work and formal measurement to be made of progress toward achieving our priorities and therefore delivering our strategy.

6. Risk and legal implications
   There is a significant risk for the organisation of not having clearly articulated purpose and aims.

7. Resource implications
   The Corporate Management team are the formal steering group and therefore ‘owners’ of this work. Meetings are held monthly where progress is discussed and any alterations to focus or resourcing are agreed. Integrated plans, including finance and workforce plans will support delivery of the strategy.

8. Workforce Implications/Consultation
   An internal engagement process was conducted with staff during December and January as part of the formal consultation process. These sessions were well attended and contributions from staff led to good debate. An internal communication plan is being prepared to share the final strategy with staff. This plan will include drop in sessions and presentations for all staff that will be led by CMT and a process for cascading the meaning of the strategy via team meetings.
9. **User involvement and person centredness/public consultation**
   The strategy places a major emphasis on putting people at the centre of all we do.

10. **Equality and diversity**
    The impact assessment is currently being finalised.

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**Appendix:**
Driving Improvement in Healthcare – Our strategy 2014–2020

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Angiolina Foster  
Chief Executive

Maggie Waterston  
Director of Finance and Corporate Services
Driving
Improvement
in Healthcare
Our Strategy 2014-2020
# Contents

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</table>
Foreword

The 2020 vision for health and social care services in Scotland clearly sets out Scotland’s aims for the next six years, and the Quality Strategy emphasises our collective continued commitment to pursuing the three Quality Ambitions of safe, effective and person-centred care. This strategy sets out our role, direction and priorities for the next six years, and the actions we will take that will contribute to delivering the 2020 vision.

We are the national healthcare improvement organisation for Scotland, established to advance improvement in healthcare. We have a vital role in supporting healthcare providers to deliver safer, more effective and more person-centred care.

We are committed to collaborating with healthcare providers to make improvements for patients by providing:

- **sound evidence**
- **open, informed scrutiny and assurance** and,
- **effective quality improvement implementation support**.

We believe that by integrating our evidence, scrutiny and assurance, and quality improvement implementation support functions we can effectively drive the delivery of world-class care for the people of Scotland.

Leading both quality improvement and quality assurance from one organisation offers a unique opportunity to establish and embed complex, and often cultural, change. The Berwick report¹ highlights the vital role that ‘intelligent inspection’ plays. However, this cannot stand alone and must be combined within a system of improvement.

One thing is very clear to us: simply criticising the standards of care is not enough to make sure that change happens.

First and foremost, it is NHS boards across the country that are responsible for, and make, improvements to the care we all receive. However, we provide encouragement and challenge as well as advice and practical support when needed.

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We believe there are significant opportunities for us to proactively develop and strengthen key areas of our work over the next six years to further improve patient care and experience. For example:

- empowering people to have an informed voice that maximises their impact in managing their own care and shaping how services are designed and delivered
- reliably spreading and supporting implementation of best practice to improve healthcare, and
- undertaking comprehensive assessments of the quality and safety of healthcare.

We will respond to the demands of the people of Scotland and to the changing policy context, for example health and social care integration. Our strategy will evolve over the next six years so that we can meet these needs. Our three-year corporate plans and annual local delivery plans will incorporate the flexibility and ambition required to deliver this strategy by 2020.

We are fully committed to improving care for every person, every time.

To be the recognised healthcare improvement organisation which drives the delivery of world-class, person-centred healthcare in Scotland.

Dr Denise Coia
Chair

Angiolina Foster
Chief Executive
Who we are

The people of Scotland have a right to expect safe and effective care, to be informed and involved in decisions about their care and treatment, and to be involved in decisions about healthcare services. They must be treated with dignity and respect. We have a key role in supporting healthcare providers to make sure that their services meet these expectations.

We are a statutory body, part of NHSScotland, that works with healthcare providers to drive and support improvements in the quality of healthcare, and empower patients and the public.

Our mission

To be the recognised healthcare improvement organisation which drives the delivery of world-class, person-centred healthcare in Scotland.

Why we exist (our strategic objective)

To drive improvement in the quality of healthcare

What we do (our priorities)

Empower people | Reliably spread and support implementation of best practice | Assess the quality and safety of healthcare

How we do it

Evidence | Scrutiny and assurance | Quality improvement implementation support
One organisation | Best use of our resources | Valuing people

Our strategy map below sets out what we will do to drive improvement and how we will do it.

Appendix 2 contains a more detailed version of our strategy map which can be used as a ‘standalone’ to this strategy.
What we do - our priorities

Over the next six years, our key organisational priorities are to work together with healthcare providers and the people of Scotland to:

- **empower people** to have an informed voice that maximises their impact in managing their own care and shaping how services are designed and delivered
- **reliably spread and support implementation of best practice** to improve healthcare, and
- **comprehensively assess the quality and safety of healthcare.**

Through these priorities, we will deliver our statutory responsibilities as set out in the Public Services Reform (Scotland) Act 2010.

These priorities will be achieved by working with others to support the delivery of safe, effective and person-centred care, and contribute to achieving Scotland’s 2020 vision for health and social care. Appendix 3 contains more information about the strategic context.

Empower people

- We are committed to involving people in everything we do: as partners in our governance, in the development and delivery of our work, and in the messages we produce. This is underpinned by our legal Duty of User focus.
- We provide support to NHS boards in patient focus and public involvement at local and national level.
- We provide information to the public about the quality of healthcare services through publication of our reports.
- We support staff across NHSScotland to lead and deliver improvements in the quality of care.
- We support people to proactively manage their health and care.
- We listen to what patients and communities say about healthcare services, and their views and experiences inform everything we do.
- We strengthen the patient and public voice.
- We support communities to be involved in the design, planning and delivery of healthcare services.
- We work with a wide range of volunteers to design, implement and monitor our work.
Reliably spread and support implementation of best practice

- We identify, develop and promote standards and good practice, and support their implementation.
- We evaluate and provide advice on the clinical and cost effectiveness of health technologies, including medicines, devices and procedures, and service redesign.
- We deliver, in collaboration with NHS boards, a range of national improvement programmes including the world-leading Scottish Patient Safety Programme.
- We provide robust and reliable advice and guidance.
- We provide guidance, support, and share best practice in patient focus and public involvement.

Assess the quality and safety of healthcare

- We regulate and register independent healthcare services.
- We scrutinise NHS services to safeguard the public, provide public assurance and improve safety and standards of care.
- We proactively support NHS boards to improve services through learning from data such as adverse events, complaints, claims and Hospital Standardised Mortality Ratios.
- We support and measure implementation of the Scottish Patient Safety Programme in NHS boards.
- We use a range of data to assess the quality and safety of healthcare.
How we will deliver our priorities

One organisation

We are one organisation, with all of our activities focused on driving improvement in healthcare. We deliver our priorities through evidence, scrutiny and assurance, and quality improvement implementation support. Throughout everything we do, we value people, make best use of our resources and work effectively as one organisation.

We can only achieve our aim of driving the delivery of world-class, person-centred healthcare by integrating our evidence, scrutiny and assurance, and quality improvement implementation support functions.

The Healthcare Improvement Scotland model of quality improvement includes a range of quality improvement tools and techniques including scrutiny and assurance methodologies. These are underpinned by sound evidence, and together provide robust assessments to identify and support improvements.

Additionally, delivering these functions from one organisation offers a unique opportunity to establish and embed complex, and often cultural, change.

Our quality improvement model
Our values

Our strategy map sets out our strategic objective and what we will do to drive improvement in the quality of healthcare.

The map is based firmly on the values that are shared across NHSScotland:

- **Care and compassion** – we care about the impact that our work, our actions and our behaviours have on people. We are considerate in our dealings with people and in the pursuit of the best treatment for everyone, putting them at the centre of everything we do.

- **Dignity and respect** – we value staff and partners’ views and we ensure equality and fairness in everything we do. We promote a positive working environment based on constructive relationships. We listen to and respect different points of view and will give fair and honest feedback internally and externally.

- **Openness, honesty and responsibility** – we are objective and impartial in all our work and proactively share knowledge. We are individually and collectively committed to, and responsible for the quality and delivery of our work. We are open and honest in all our dealings with people and maintain the highest integrity at all times.

- **Quality and teamwork** – we are one organisation and we work collaboratively with all our partners, harnessing the expertise from all to deliver reliably to the highest standard. We are committed, flexible and responsive and continually seek out new ways to improve

We will embed these values in everything we do by:

- describing the behaviours that underpin our values
- demonstrating our values in the way we work and treat each other
- using these values to guide the decisions we take
- recognising when people are exceeding behavioural expectations
- identifying and dealing with behaviours that do not line up to our expectations, and
- being responsible for the way we work and not just for the work that we do.
Evidence

We develop the evidence base through primary (our research strategy and European Union collaborations) and secondary research (Scottish Intercollegiate Guidelines Network, Scottish Health Technologies Group and Scottish Medicines Consortium outputs).

We use information and intelligence to produce evidence-based recommendations for NHSScotland.

We produce information in a variety of formats to support patients, carers and healthcare professionals.

We work in partnership to identify and share existing good practice and knowledge, and support the translation of knowledge into action across NHSScotland.

To continually improve how we deliver our priorities, we will:

- make better use of information and data
- strengthen intelligence gathering and sharing mechanisms within, and between us and other bodies, and
- improve the responsiveness of our evidence processes to reflect the need for advice in the face of rapidly developing medicines, technologies and treatments and the increase of multimorbidity.

Scrutiny and assurance

We provide effective and impartial quality assurance.

We assess services to support providers make improvements.

We provide local and public assurance on the standards of care being provided.

To continually improve how we deliver our priorities, we will:

- undertake comprehensive assessments of the quality of healthcare, bringing together separate inspection regimes and considering other areas such as leadership, the workforce, listening to public feedback and assessing the safety and effectiveness of care
- proactively take a proportionate, timely and risk-based approach to scrutiny to support improvement in healthcare, considering how data and information can inform prioritisation of the areas that require review and support
- work more closely with other scrutiny agencies, especially in multi-agency reviews and the sharing of intelligence, with clear thresholds for triggering intervention, and
- build multidisciplinary teams to support reviews and inspections with the right mix of skills, expertise and experience.
Quality improvement implementation support

We design and deliver national improvement programmes that support sustainable improvements in the quality of care.

We develop resources and tools that support the work of continuous quality improvement.

We develop and sustain networks that facilitate the sharing of improvement expertise and enable effective collaboration between local, national and international leaders in quality improvement.

We work with partners to test innovative models of practice and support the spread of successful innovation across NHSScotland.

To continually improve how we deliver our priorities, we will:

- continue to build our capacity and capability to drive quality improvement across NHSScotland
- develop our knowledge, skills and expertise so we are the ‘go-to’ organisation for improvement expertise and advice within the Scottish healthcare sector
- convene professionals from across Scotland and internationally to enhance the thriving improvement community
- accelerate the pace and scale of local improvements in safe, effective and person-centred care across Scotland
- focus on spreading improvements reliably on a larger scale so they are consistently part of everyday practice, and
- work with our key partners across health and social care to align and integrate the existing national improvement programmes.
Best use of our resources

We effectively manage our resources through good governance processes and prioritisation of our work.

We have efficient and effective finance, HR, communications and IT functions that support our improvement work.

We are working with limited financial resources while maintaining a high quality work programme. It is essential that we provide value for money, comply with legal requirements placed upon public bodies and can demonstrate the impact of our work. In responding to this challenge, we are acting on the opportunities to improve our organisation and maximise the impact we have on healthcare services in Scotland.

To continually improve how we deliver our priorities, we will:

- develop effective evaluation processes to better evidence the outcomes, benefits and impact of our work
- make transparent, robust decisions about which pieces of work we carry out
- design work processes which enable integrated planning and closer working between our directorates
- have a flexible, skilled and expert workforce supplemented when necessary by drawing on the expertise of others
- ensure our staff have generic improvement skills to support delivery of our priorities
- continue to develop effective and lean business services
- work with colleagues across NHSScotland to increase the use of shared services
- strengthen the marketing and communications about our work to improve our impact, reputation and visibility
- strengthen our accountability as an organisation to the people of Scotland, and
- learn from other high performing organisations within the UK and internationally.
Valuing people

We empower and support our staff and volunteers to be engaged, highly skilled and perform well.

We work in partnership with healthcare providers across NHSScotland and the independent healthcare sector to improve the quality of healthcare.

We are open and honest in our communications and keep people regularly informed.

We actively listen to people and act on their feedback.

We use public partners across all our programmes of work.

We actively engage clinicians through our clinical engagement strategy to ensure they are involved across our whole portfolio of work.

To continually improve how we deliver our priorities, we will:

- build better relationships with healthcare providers, local authorities, patient organisations and third sector organisations
- strengthen the patient and public voice by proactively developing and facilitating public input into everything we do
- consider the integration of health and social care when determining the future direction of the Participation Standard and aspects of the Patient Rights (Scotland) Act 2011
- in line with our Duty of User focus, ensure that people’s views and experiences are used to improve the quality of healthcare services
- develop the Scottish Health Council to lead and shape the debate for health and social care partnerships, and
- work relentlessly to put people at the centre of everything we do.
Next steps

We will put this strategy into practice by defining clear and measurable outcomes within our three-year corporate plans and annual local delivery plans.

We need to be responsive to the demands of the people of Scotland and the changing policy context. Therefore, how we deliver our priorities will evolve over the next six years. This will be described in greater detail in our three-year corporate plans and our annual local delivery plans.

The planning framework below illustrates how we will achieve our strategy through our corporate and operational plans, including the local delivery, workforce and finance plans, and each individual’s annual objectives.

Planning framework

<table>
<thead>
<tr>
<th>Strategy (2014-2020)</th>
<th>Sets out our role, direction and strategic priorities.</th>
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<tr>
<td></td>
<td>Approved by the Board</td>
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<td>Annual Report</td>
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<thead>
<tr>
<th>Corporate plan (2014-2017)</th>
<th>Defines how we will deliver and resource our priorities over a three-year period. Includes three-year workforce and finance plans.</th>
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<tr>
<td></td>
<td>Corporate risk register</td>
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<td></td>
<td>Identifies and analyses business risks and how we will deal with them.</td>
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<td>Quarterly performance reporting. Updates at each audit committee meeting.</td>
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<tr>
<th>Local Delivery Plan (2014-2015)</th>
<th>Defines our one year delivery plan as required by Scottish Government.</th>
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<td>Quarterly performance reporting. Updates at each audit committee meeting.</td>
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<th>Finance plan (2014-2015)</th>
<th>Sets out our finance plan to deliver our one year delivery plan.</th>
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<td>Quarterly performance reporting. Updates at each audit committee meeting.</td>
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<th>Workforce plan (2014-2015)</th>
<th>Sets out our workforce needs to deliver our one year delivery plan.</th>
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<td>Quarterly performance reporting. Updates at each staff governance committee meetings.</td>
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<tr>
<th>Detailed operational plans</th>
<th>Set out each directorate’s contribution to delivering the corporate plan.</th>
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<tr>
<td></td>
<td>Describe specific outputs and performance measures.</td>
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<td></td>
<td>Updates at Corporate Management and Finance and Planning committees.</td>
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<tr>
<th>Individual personal development reviews</th>
<th>Set out each individual’s annual objectives, learning and development plans. Linked to directorate and organisation objectives.</th>
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<tr>
<td></td>
<td>Annual appraisals and regular informal reviews.</td>
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We will regularly monitor and report on our performance against our plans to update our Board, our staff and the public on progress. We will take action to address any risks to the delivery of our priorities.
Appendix 1: About Healthcare Improvement Scotland

Why we exist

Healthcare Improvement Scotland is constituted by the National Health Service (Scotland) Act 1978 to further improve the quality of healthcare, as amended by the Public Services Reform (Scotland) Act 2010.

The Public Services Reform (Scotland) Act 2010 sets out our duties and functions, including:

- furthering improvement in the quality of healthcare
- supporting, ensuring and monitoring the quality of healthcare
- evaluation and provision of advice to the health service on the clinical and cost effectiveness of new and existing health technologies including drugs
- supporting, ensuring, monitoring and encouraging public involvement and equal opportunities within each NHS board
- involving users in the design and delivery of our functions
- co-operation and co-ordination with other organisations
- spreading good practice through advice and guidance, and
- provision of advice to Scottish Ministers.

Other statutory duties include:

- scrutiny of medical certificates of cause of death as stipulated by the Certification of Death (Scotland) Act 2011, and
- support to the Controlled Drugs Accountable Officers Network in Scotland to improve and strengthen governance systems for the safe and effective use of controlled drugs for patients as stated in The Controlled Drugs (Supervision of Management and Use) Regulations 2013.

Our governance

Healthcare Improvement Scotland is governed by a Board of 14 members, comprising an independent chair, and non-executive and executive members. Our code of corporate governance sets out the purpose and role of the Board, and the committees that are established for the economical, efficient and effective governance of our business.

Our code of corporate governance is available at: [www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/corporate_governance.aspx](http://www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/corporate_governance.aspx)

We are accountable to the Cabinet Secretary for Health and Wellbeing, who appoints our Board members. Within this context, it is essential that we act independently from Government to demonstrate our work is fair, objective and impartial.
Our history

Healthcare Improvement Scotland was created by the Public Services Reform (Scotland) Act 2010 and formed in April 2011. We bring together the functions of NHS Quality Improvement Scotland and the regulation of independent healthcare that the Care Commission had previously been responsible for.

We have a strong record of delivering evidence, scrutiny and assurance, and quality improvement activities in healthcare.

- We continue to deliver evidence-based advice and guidance through the Scottish Intercollegiate Guidelines Network (SIGN), the Scottish Health Technologies Group and Scottish Medicines Consortium.

- We continue to deliver a programme of Healthcare Environment Inspections and a programme of inspections of the care of older people in acute hospitals. We also regulate and inspect all independent healthcare services in Scotland as well as collaborate with Her Majesty’s Chief Inspector of Prisons, providing healthcare advice to prison inspections.

- Our scrutiny activities include an ongoing programme to quality assure clinical governance processes and the quality of healthcare services provided across NHS boards in an impartial and objective way, for example the rolling programme of NHS board adverse event reviews.

- We lead independent reviews, such as the investigation into an individual patient treatment request and the review of the national paediatric cardiac service.

- Patient Focus and Public Involvement in the NHS in Scotland has been monitored by the Scottish Health Council since 2005, leading to demonstrable improvements in the quality of participation at local level.

- We have delivered, in collaboration with NHS boards, the world-leading Scottish Patient Safety Programme since 2008 and are spreading the improvement programme across four key work streams of Acute Adult, Maternity and Children, Mental Health and Primary Care.

- We continue to deliver quality improvement support, education, training and technical expertise through the Quality Improvement Hub.

- We have delivered collaborative programmes of improvement support in priority areas such as nutritional care, pressure ulcer care, infection control and mental health.

- We have an established clinical engagement strategy to ensure clinicians are involved across our whole portfolio of work.
Appendix 2: Healthcare Improvement Scotland Strategy Map 2014-2020

**Our mission**
To be the recognised healthcare improvement organisation which drives the delivery of world-class, person-centred healthcare in Scotland.

**Why we exist (our strategic objective)**
To drive improvement in the quality of healthcare

**What we do (our priorities)**

<table>
<thead>
<tr>
<th>Empower people</th>
<th>Reliably spread and support implementation of best practice</th>
<th>Assess the quality and safety of healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are committed to involving people in everything we do: as partners in our governance, in the development and delivery of our work, and in the messages we produce. This is underpinned by our legal Duty of User focus. We provide support to NHS boards in patient focus and public involvement at local and national level. We provide information to the public about the quality of healthcare services through publication of our reports. We support staff across NHSScotland to lead and deliver improvements in the quality of care. We support people to proactively manage their health and care. We listen to what patients and communities say about healthcare services, and their views and experiences inform everything we do. We strengthen the patient and public voice. We support communities to be involved in the design, planning and delivery of healthcare services. We work with a wide range of volunteers to design, implement and monitor our work.</td>
<td>We identify, develop and promote standards and good practice, and support their implementation. We evaluate and provide advice on the clinical and cost effectiveness of health technologies, including medicines, devices and procedures, and service redesign. We deliver, in collaboration with NHS boards, the world-leading Scottish Patient Safety Programme. We provide robust and reliable advice and guidance. We provide guidance, support, and share best practice in patient focus and public involvement.</td>
<td>We regulate and register independent healthcare services. We scrutinise NHS services to safeguard the public, provide public assurance and improve safety and standards of care. We proactively support NHS boards to improve services through learning from data such as adverse events, complaints, claims and Hospital Standardised Mortality Ratios. We support and measure implementation of the Scottish Patient Safety Programme in NHS boards. We use a range of data to assess the quality and safety of healthcare.</td>
</tr>
</tbody>
</table>
Driving Improvement in Healthcare
Our Strategy 2014-2020

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**How we do it**

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Scrutiny and assurance</th>
<th>Quality improvement implementation support</th>
</tr>
</thead>
<tbody>
<tr>
<td>We develop the evidence base through primary (our research strategy and</td>
<td>We provide effective and impartial quality assurance.</td>
<td>We design and deliver national improvement programmes that support sustainable</td>
</tr>
<tr>
<td>European Union collaborations) and secondary research (Scottish</td>
<td>We assess services to support providers make improvements.</td>
<td>improvements in the quality of care.</td>
</tr>
<tr>
<td>Intercollegiate Guidelines Network, Scottish Health Technologies Group</td>
<td>We provide local and public assurance on the standards of care being provided.</td>
<td>We develop resources and tools that support the work of continuous quality</td>
</tr>
<tr>
<td>and Scottish Medicines Consortium outputs).</td>
<td></td>
<td>improvement.</td>
</tr>
<tr>
<td>We use information and intelligence to produce evidence-based recommendations for NHSScotland.</td>
<td></td>
<td>We develop and sustain networks that facilitate the sharing of improvement</td>
</tr>
<tr>
<td>We produce information in a variety of formats to support patients, carers</td>
<td></td>
<td>expertise and enable effective collaboration between local, national and</td>
</tr>
<tr>
<td>and healthcare professionals.</td>
<td></td>
<td>international leaders in quality improvement.</td>
</tr>
<tr>
<td>We work in partnership to identify and share existing good practice and</td>
<td></td>
<td>We work with partners to test innovative models of practice and support the spread</td>
</tr>
<tr>
<td>knowledge, and support the translation of knowledge into action across</td>
<td></td>
<td>of successful innovation across NHSScotland.</td>
</tr>
<tr>
<td>NHSScotland.</td>
<td></td>
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</tbody>
</table>

**One organisation**

We are one organisation, with all of our activities focused on driving improvement in healthcare. We deliver our priorities through evidence, scrutiny and assurance, and quality improvement implementation support. Throughout everything we do, we value people, make best use of our resources and work effectively as one organisation.

**Best use of our resources**

We effectively manage our resources through good governance processes and prioritisation of our work.

We have efficient and effective finance, HR, communications and IT functions that support our improvement work.

We are working with limited financial resources while maintaining a high quality work programme. It is essential that we provide value for money, comply with legal requirements placed upon public bodies and can demonstrate the impact of our work. In responding to this challenge, we are acting on the opportunities to improve our organisation and maximise the impact we have on healthcare services in Scotland.

**Valuing people**

We empower and support our staff and volunteers to be engaged, highly skilled and perform well.

We work in partnership with healthcare providers across NHSScotland and the independent healthcare sector to improve the quality of healthcare.

We are open and honest in our communications and keep people regularly informed.

We actively listen to people and act on their feedback.

We use public partners across all our programmes of work.

We actively engage clinicians through our clinical engagement strategy to ensure they are involved across our whole portfolio of work.
Appendix 3: The strategic context

The Scottish Government has set out the strategic vision (the 2020 vision) for achieving sustainable, world-leading and high quality health and care services across Scotland. We support this vision and have embedded it within our strategy.

The 2020 vision for health and care in Scotland

“Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management.

When hospital treatment is required, and cannot be provided in a community day setting, day case treatment will be the norm.

Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.

There will be a focus on ensuring that people get back into their home or community environment as soon as possible, with minimal risk of re-admission.”

The Quality Strategy, developed by the Scottish Government, is the approach and shared focus for all work across NHSScotland to realise the 2020 vision. It emphasises our collective, continued commitment to pursuing the Quality Ambitions of safe, effective and person-centred care.

The Route Map to the 2020 Vision describes 12 priority areas for action to achieve the vision for high quality sustainable health and social care services in Scotland in three domains:

- Quality of care
- Health of the population
- Value and financial sustainability.

There are many health and social care bodies working in Scotland to deliver the 2020 vision for health and social care in Scotland.

As a public body, we contribute to securing the value and financial sustainability of Scotland’s health and care services. We do this by increasing our efficiency and productivity in order to make best use of resources. We also positively impact on the value and financial sustainability of the health service through our evidence-based advice and guidance on the clinical and cost effectiveness of health technologies, medicines and service redesign.

Our main focus as a healthcare improvement organisation is to drive improvement in the quality of healthcare, working with healthcare providers. Our strategy map (see pages 6, 20 and 21) sets out what we will do to drive improvement. We have a less obvious role in relation to improving the general health of the population. We continue to recognise the importance of improving our public health record, but there are other national organisations that are responsible for delivering improvements in this area. However, we will work with others as required to ensure robust impact assessments are integral to all our work to help to reduce health inequalities and to support people to live longer, healthier lives.

The integration of health and social care has begun and we have a clear role in collaborating with health and care organisations. We need to work seamlessly with our colleagues in social care to drive improvement across all components of a patient’s pathway of care. Our skills and expertise in the healthcare setting will complement their skills and expertise in the social care setting.

We will ensure we carry out our work with an awareness of the whole pathway of care, crossing both health and social care. We will increasingly work with our partners across health and social care to share skills, expertise and intelligence and work together towards the integrated management of care.
SUBJECT: Scottish Patient Safety Programme (SPSP) Strategic Delivery Plan

1. Purpose of the report
The purpose of this report is to:
   i) share with the Board the feedback received from the recent consultation on the Scottish Patient Safety Programme (SPSP) Strategic Delivery Plan.
   ii) present the final SPSP Strategic Delivery Plan 2014 - 2016 for approval.

2. Recommendation
   The Healthcare Improvement Scotland Board, is asked to:
   i) note the feedback received from the consultation and that the draft plan has been changed in response to this.
   ii) approve the SPSP Strategic Delivery Plan 2014 – 2016.

3. Background and key issues
   In August 2012 a review of the Scottish Patient Safety Programme by Scott Moncrieff made a number of recommendations including the creation of a SPSP Strategy. This is now being positioned as the SPSP Strategic Delivery Plan.

   In early March the draft document was circulated to a range of key stakeholders for comment including NHS boards and Scottish Government officials. Feedback was received from 43 individuals and/or groups (Appendix B). A summary of the key issues raised in the consultation responses is included in Appendix C and this also highlights what changes have been made to the SPSP Strategic Delivery Plan in response to these comments.

   Healthcare Improvement Scotland’s Audit Committee also considered the draft plan at its meeting on the 12 March 2014. Having considered the document it made the decision to sign off the outstanding internal audit recommendations as complete.

   An overview of the Strategic Delivery Plan was presented to the Board Seminar on 16 May 2014. The Board considered that the presentation not only provided assurance of progress but gave the opportunity for clarification and discussion of areas of concern/opportunity.

4. Strategic objectives/Local Delivery Plan
   SPSP is a key component and priority of Healthcare Improvement Scotland and is directly linked to the safe ambition of the NHS Quality Strategy and 2020 vision.

5. Measures for improvement
   A detailed action plan is being put together to sit alongside the SPSP Strategic Delivery Plan. This will identify the specific actions that are to be taken by whom and by when. Progress against this will be monitored through the SPSP Programme Board which reports into the EIS Committee.

   In addition, measures for improvement are developed for all SPSP work programmes; these may include both national and local measures dependent upon the scope and scale of the individual programmes.
6. Risk and legal implications
The operational risk register highlights that there is a risk of reputational damage to HIS because of a lack of alignment between the Scottish Government, Healthcare Improvement Scotland and NHS Boards on the priority deliverables for SPSP and different understandings of the respective roles and responsibilities for actioning these deliverables. This may result in confused communications, potential duplication of efforts and differing perceptions on whether what has been delivered is in line with what was expected. (OP7)

The SPSP strategy will help to manage and reduce this risk.

7. Resource implications
There are no resource implications attached to the strategy as there is a commitment that the proposed actions will be deliverable within the existing allocations, though there may need to be some re-profiling of budgets to achieve this.

8. Workforce implications/consultation
There are no expected workforce implications.

9. User involvement and person centredness/public consultation
The strategy has been produced in liaison with key SPSP leads at NHS board level and key safety leads within the Scottish Government. Consultation has also taken place with public partners through the programme delivery groups.

The summary of key themes from the consultation and Healthcare Improvement Scotland’s response demonstrates that the organisation has listened and made changes in response to the views expressed through the consultation process.

10. Equality and diversity
Equality and diversity impact assessments are undertaken as relevant to individual programmes of work.

11. Governance and future reporting schedule
SPSP has implemented a programme wide governance structure for the overseeing the delivery of this improvement programme. The ongoing delivery of the agreed priorities for SPSP will be overseen by the SPSP Programme Board who will report through to the EIS Committee and HIS Board.

<table>
<thead>
<tr>
<th>Key milestone to be reported against in forthcoming year:</th>
<th>To be reported to:</th>
<th>Date presented/to be presented:</th>
<th>Version number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update reports to EIS Committee</td>
<td>EIS</td>
<td>12 June 9 October 19 February</td>
<td></td>
</tr>
</tbody>
</table>

Ruth Glassborow  
Interim Director of Safety and Improvement  
Lead Director

Jo Matthews  
Head of Safety  
Lead Officer

Appendices:
1. SPSP Strategic Delivery Plan
2. Scottish Patient Safety Programme Strategic Delivery Plan Consultation Summary
3. List of who responded to the consultation
Scottish Patient Safety Programme (SPSP)
Strategic Delivery Plan (2014 – 2016)

Purpose of this document

The purpose of this document is to ensure there is a shared understanding and agreement on the:

- scope of the SPSP.
- aims of the SPSP.
- roles of the NHS boards, Healthcare Improvement Scotland and the Scottish Government in relation to the SPSP.
- priority issues that need to be addressed over the next two years by the national SPSP team to support NHS boards to deliver the aims of SPSP.
- key actions that will be taken over 2014/15.

This document is not:

- a safety strategy for Healthcare Improvement Scotland. Neither does it seek to explore the wider range of work in place across NHS Scotland focused on supporting the delivery of safer care.
- a 2014/15 detailed delivery plan that identifies who will do what by when. A detailed delivery plan is in development and will be available on the SPSP website at [www.scottishpatientsafetyprogramme.scot.nhs.uk](http://www.scottishpatientsafetyprogramme.scot.nhs.uk)
**Scope of the Scottish Patient Safety Programme**

The SPSP was initiated in 2008 with a focus on acute adult services. Since 2008, the ambition of the SPSP has increased considerably and it is now a wide ranging programme on a scale and scope not seen anywhere else in the world. It includes four national safety programmes covering:

- **Primary Care** with a focus on improving the following aspects of care in General Practice: the safety culture, the safer use of high risk medicines and the communication of key information with other parts of the healthcare system.

- **Mental Health** with a focus on reducing key harms across psychiatric inpatient units.

- **Maternity and Children Quality Improvement Collaborative (MCQIC)** with a focus on reducing key harms across maternity, neonatal and paediatric care and increasing women’s satisfaction with their experience of maternity care.

- **Acute Adult.** As the longest standing programme this now has a broad scope which covers work focused on Sepsis, Venous thromboembolism (VTE), Deteriorating Patient, Heart Failure, Surgical Site Infection, reducing the four key harms covered by the Scottish Patient Safety Indicator (falls, catheter associated urinary tract infections, pressure ulcers and cardiac arrests) and supporting implementation of the 10 key essentials of patient safety (outlined in appendix A).

In addition to the four national safety programmes, Healthcare Improvement Scotland has secured funding from the Health Foundation to test work focused on the contribution that pharmacists can make to delivering safer care in community pharmacy and general practice settings.

For more detailed information on the scope and focus of these programmes please visit our website at [www.scottishpatientsafetyprogramme.scot.nhs.uk](http://www.scottishpatientsafetyprogramme.scot.nhs.uk).
Aims of the Scottish Patient Safety Programme

The SPSP is working to improve the safety of healthcare and reduce the level of harm experienced by individuals using healthcare services. Ideally, each programme would have a set of measurable aims directly associated to improvements in safety and reductions in harm. This is the case for the acute adult programme and the maternity work.

Table 1: Summary of the current aims for Acute Adult and Maternity

<table>
<thead>
<tr>
<th>Measurable aims focused on harm reduction in place</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Adult</strong></td>
</tr>
<tr>
<td>• Reduce HSMR by 20% by Dec 2015.</td>
</tr>
<tr>
<td>• Reduce mortality in pilot population from Sepsis by 10% by December 2014.</td>
</tr>
<tr>
<td>• Reduce healthcare associated harm so that 95% of people in acute adult health care are free from harms identified in the Scottish Patient Safety Indicator by Dec 2015:</td>
</tr>
<tr>
<td>o Catheter Associated Urinary Tract Infections (CAUTI) - reduce by 30%</td>
</tr>
<tr>
<td>o Falls with harm – reduce by 25% .</td>
</tr>
<tr>
<td>o Hospital acquired pressure ulcers (grade 2-4) reduce to 300 days or more between incidences</td>
</tr>
<tr>
<td>o Cardiac Arrest – reduce CPR attempts in general ward by 50% by improved escalation and care planning for deteriorating patients</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
</tr>
<tr>
<td>• Reduce avoidable harm in women and babies by 30% by 2015 through:</td>
</tr>
<tr>
<td>o reducing stillbirths and neonatal mortality by 15%</td>
</tr>
<tr>
<td>o Reducing severe post-partum haemorrhage by 30%</td>
</tr>
<tr>
<td>o Reducing the incidence of non-medically indicated elective deliveries prior to 39 weeks gestation by 30%</td>
</tr>
<tr>
<td>o Offer all women Carbon Monoxide (CO) monitoring when booking their antenatal care appointment</td>
</tr>
<tr>
<td>o Refer 90% of women who have raised CO levels or who are smokers to smoking cessation services</td>
</tr>
<tr>
<td>o Provide a tailored package of care to all women who continue to smoke</td>
</tr>
</tbody>
</table>

In addition the maternity care strand has an additional outcome aim to:

• Increase the percentage of women satisfied with their experience of maternity care to > 95% by 2015

The pioneering nature of the mental health, primary care, neonatal and paediatrics work, however, means that they have had to conduct work to agree: what constitutes harm in these settings, how to then measure that harm, and what is a realistic aim for a reduction in that harm. These programmes are all in different stages of developing their measurable aims as highlighted in the following table.

Table 2: Summary of current state of aim development work for MCQIC, Mental Health and Primary Care

<table>
<thead>
<tr>
<th>Current situation</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health – agreed measures of harm</strong></td>
<td>Now that outcome measures are agreed the focus is on collecting baseline measurements prior to then setting a measurable aim for a reduction in harm.</td>
</tr>
<tr>
<td>• Rate of violence and aggression</td>
<td></td>
</tr>
<tr>
<td>• Percentage of patients engaged in violent and aggressive behaviour</td>
<td></td>
</tr>
<tr>
<td>• Rate of patients being restrained</td>
<td></td>
</tr>
<tr>
<td>• Percentage of patients being restrained</td>
<td></td>
</tr>
<tr>
<td>• Percentage of patients who experience one or more episodes of seclusion</td>
<td></td>
</tr>
<tr>
<td>• Percentage of patients who experience self harm</td>
<td></td>
</tr>
<tr>
<td>• Days between inpatient suicide</td>
<td></td>
</tr>
<tr>
<td>• Percentage of patients who have emergency detention or use of nurse holding power</td>
<td></td>
</tr>
</tbody>
</table>
Current situation

**Primary Care** – in absence of agreed measures of harm, the aim focuses on improving the processes of care and the culture.
Reduce the number of events which cause avoidable harm to people from healthcare delivered in any primary care setting with the aim that 95% of primary care clinical teams will be developing their safety culture and achieving reliability in 3 high-risk areas by 2016

**MCQIC**
Its overall aim is to improve outcomes and reduce inequalities in outcomes by providing a safe, high-quality care experience for all women, children, babies and families in Scotland.

**Neonatal Care Aim**
Reduce avoidable harm in Neonatal Care by 30% by 2015 by seeking to reduce:
- Harm from mechanical ventilation
- Harm from invasive lines
- High risk medicines
- Transitions of care
- Undetected deterioration and also to
- Increase natural feeding
- Improve Service User Engagement

**Paediatric Care Aim**
Reduce avoidable harm in Paediatric Care by 30% by 2015 by addressing
- Serious safety events
- Ventilator assisted pneumonia
- Central venous catheter blood stream infection
- Unplanned admission to intensive care
- Medicines harm
- Child protection harm

Next Steps

Work has been initiated to agree measures of harm for primary care prior to then setting a measurable aim for a reduction in those harm.

Maternity has measurable aims as identified above. Neonatal and Children have agreed which harms they want to measure and are now finalising the details of how they measure them.

In 2008, when the programme was initiated, the overriding aim was to reduce the Hospital Standardised Mortality Ratio (HSMR) by 15% by December 2012. In June 2012 this was amended to 20% by December 2015. The HSMR is a measure of whether the number of people who die within 30 days of an admission to an acute hospital is higher or lower than predicted. It is not relevant to the mental health programme and will only be marginally impacted by the primary care programme. Indeed, the scope and breadth of SPSP means it is not now possible to set a single measurable aim that sits over all four programmes.

During 2014/15, we will:

- develop and test an approach to measuring harm in the primary care programme;
- finalise testing of the harm measures in mental health prior to setting measurable aims for reduction and;
- finalise work to define the measures for paediatric care and neonatal care.

These will then sit alongside the current acute adult and maternity aims to form a suite of measures that form the overall aims for the SPSP.
Key roles in relation to the Scottish Patient Safety Programme

Scottish Government
The role of Scottish Government is to set the strategic direction for NHSScotland and to develop the policies to support delivery of these objectives. Progress in implementing these policies is assessed and ensured through the NHSScotland performance framework. In respect of the SPSP this means that the Scottish Government role is to:

- co-ordinate the portfolio of work to deliver the safe ambition (of which SPSP is a key element), and identify the priority areas for improvement to deliver the 2020 vision.
- agree the national priorities for the SPSP programme. It is expected that this will be undertaken in consultation with key delivery partners including NHS boards and Healthcare Improvement Scotland.
- commission and, where appropriate, fund work at a national level to support implementation of the SPSP programme.
- work to remove any policy or structural barriers to improvement in safety and ensure system levers and incentives are aligned with the safe ambition.
- assess and ensure progress in implementation of the SPSP through the NHSScotland Performance Framework.

Healthcare Improvement Scotland
The role of Healthcare Improvement Scotland is to design and deliver the SPSP. It has a national SPSP team which sits within its Improvement Directorate and which works collaboratively with individuals in NHS boards to:

- design and implement national programmes that support the delivery of the healthcare safety priorities identified by the Scottish Government.
- develop new and innovative programmes of work focused on delivering safer care.
- advise the Scottish Government on the key successes and barriers with regards to the delivery of SPSP across NHSScotland to inform the ongoing development of policy that enables the delivery of safer care for all.

To deliver this role, Healthcare Improvement Scotland will:

- work with subject matter and improvement experts to develop practical tools and guidance which support the delivery of safer care in line with the programme aims.
- support NHS boards to develop their local capacity and capability to deliver safer care.
- provide leadership and advice on the effective use of data to drive improvements in the safe delivery of care.
- implement systems for harnessing, sharing and spreading learning/good practice.
- ensure a programme of evaluation is in place across all aspects of the SPSP.
- ensure maximum integration with other relevant national programmes of work.

For more detailed information on the approach taken please see SPSP roles and responsibilities document at www.scottishpatientsafetyprogramme.scot.nhs.uk.
NHS boards

The role of NHS boards in relation to the delivery of the SPSP is to:

- provide clear strategic direction for the local SPSP work based on an understanding of the key safety issues faced locally.
- ensure there is a prioritised and realistic local SPSP delivery plan which includes plans for spread.
- create a culture where patient safety is recognised as everyone’s business, whatever their role in the organisation.
- build organisational capacity and capability for quality improvement and ensure a critical mass of experts are available to provide improvement advice and support for services and teams involved in SPSP
- understand the wider contextual factors impacting on the delivery of safer care and devise strategies to proactively manage them.
- hold the organisation to account for the delivery of the SPSP programme.
- seek assurance that the systems in place for delivering the SPSP aims are robust and reliable.
- create a learning culture that is built on openness, transparency and candour.

In addition, the successfully delivery of the SPSP programme is dependent on

- key individuals from NHS boards working collaboratively with the national team to design and test relevant measures, tools and guidance.
- NHS boards providing key information on the focus, spread and outcomes of their SPSP work. This then enables work to take place nationally to identify practices and learning for spread across NHS boards and to identify common challenges that may require action at a national level to facilitate solutions.
Scottish Patient Safety Programme - National Priority Issues

Working with complexity includes recognising that it is not always possible to chart in detail the actions that need to be taken to get from the current state to the agreed destination. Further, there may be many different routes to organisations achieving the reliable delivery of high quality safe health services. At a national level this means that the focus should be on creating the conditions that enable local teams to deliver improvements in safety and an ongoing reduction in harm and mortality.

Due to its success, level of maturity and scope of work, local SPSP teams are encountering a range of challenges including:

- Competing priorities and, in some cases, a lack of quality improvement knowledge and skills needed to provide board level leadership for large scale improvement initiatives.
- Insufficient numbers of individuals within NHS boards who have the skills and dedicated time to provide expert level improvement support to local teams and services and insufficient number of places available to territorial NHS boards on the national improvement advisor course.
- Insufficient programme manager capacity for the scope of the current SPSP.
- The fact that many NHS boards resource their safety and improvement infrastructures through fixed term funding leading to difficulties recruiting to posts and high turnover of staff.
- The challenges associated with moving from testing improvements at a small scale to universal implementation.
- Disparities between the perceived spread of interventions such as the 10 essentials and the reality in practice.
- Working with an unclear and contested evidence base about what works in reducing harm in a given clinical area. This is a particular, but not unique, challenge for the mental health and primary care programmes.
- Setting measurable and deliverable aims in a context where little is known about what actually works to reduce harm.
- Reliable implementation of medicines reconciliation.
- Potential impact of the health and social care integration.
- Knowledge on when and how to move from quality improvement approaches to quality assurance approaches.
- Challenges around the collection, analysis, reporting and interpretation of data including issues around the amount of data that frontline staff are being asked to collect and the lack of an effective IT solution for local data capture and reporting of the SPSP measures.
- The number of national improvement programmes which may be impacting on a particular clinical team at any one moment in time.

In response to these challenges this plan identifies 7 priority areas for work at a national level over the next two years.

1. Supporting NHS boards to ensure sufficient capacity and capability to deliver the safety aims within the context of a broader organisational approach to quality improvement.
2. Developing the capacity of the system to use data to drive improvements in safety.
3. Ensuring effective systems are in place to evaluate the Scottish Patient Safety Programme.
4. Developing the capacity of NHS boards to spread and sustain improvement.
5. Review the SPSP delivery model to ensure it is delivering effective support to NHS boards as efficiently as possible.
6. Review the national SPSP infrastructure.
7. Improve the alignment and integration of the safety work with other national improvement programmes to maximise the benefits and cross programme learning and reduce duplication and confusion.
Scottish Patient Safety Programme - Key Actions for 2014/15

National SPSP Priority Area 1
Supporting NHS boards to ensure sufficient capacity and capability to deliver the safety aims within the context of a broader organisational approach to quality improvement.

Historically, SPSP delivered a series of quality improvement capacity building programmes. These included the SPSP Fellowship, the Improvement Advisors Programme, Scottish Improvement Skills and Boards on Boards. The Institute for Healthcare Improvement (IHI) supported the development of these programmes and have delivered the Improvement Advisor programme.

In April 2014, the funding and delivery of these programmes was transferred to NES and they now sit as part of wider programme of training aimed at supporting NHS boards to develop their quality improvement capacity and capability. HIS will work with NES to support the delivery of these programmes and ensure that they remain relevant to the practical challenges faced in implementing the safety programme.

Key actions for 2014/15

- Work through the QI Hub and the Scottish Government to develop an NHS board QI development programme for both executive and non-executive directors.
- Work through the QI Hub to support the development a Scottish expert improvement facilitators programme to replace the current IHI Improvement Advisors course. The aim is to double the number of places available for NHS boards in 2014/15 compared with Improvement Advisor places in 2013/14.
- Work through the QI Hub to support access to QI skills development for General Managers and Service Managers.
- Continue to work with NES to support the delivery of the SPSP Fellowship and will explore with NHS boards options for facilitating release of dedicated SPSP fellows time for leading improvement work within NHS boards.
- Ensure that all SPSP national clinical leads, improvement advisors and associate improvement advisors have the skills to provide effective coaching on the use of data to drive improvement and the appropriate application of The Model for Improvement.
- Explore the option of a QI Associate model that enables the national programme to employ individuals on a time limited basis to provide particular focused QI expertise into NHS boards on key issues.
- Lead work to develop guidance and a programme of training that supports the effective implementation of mortality reviews.
- Work through the QI Hub and in partnership with the JIT to explore opportunities for working with Health and Social Care Partnerships to further develop their knowledge and skills for safety work within a multiagency context.
National SPSP Priority Area 2
Developing the capacity of the system to use data to drive improvements in safety.

The use of data to identify opportunities for improvement, assess reliable implementation of changes and understand whether those changes have led to a reduction in harm and mortality, are fundamental to the approach of the Scottish Patient Safety Programme. There are four key areas of work:

1. Supporting the development and refinement of meaningful measures that help drive improvements in safety across all four programmes of work, whilst being practical and proportionate in the burden of data collection.

2. Supporting the development of the local capacity to interpret and use data to drive improvement

3. Supporting the implementation of systems for capturing and reporting key data at local and national level. At an NHS board level, systems need to be in place for collecting, analysing and reporting measurement for each programme. At a Scotland wide level mechanisms need to be in place to collate and report data nationally.

4. Developing the national level data reporting. Data is needed at a national level to monitor and track the progress of the SPSP work in terms of improved processes and outcomes in the test areas and the scale of spread. The knowledge this provides about what is working will inform the will and focus for spread. Further, this information is important to justify the ongoing investment by the Scottish Government in these programmes of work.

Key actions for 2014/15

- Progress work to develop harm reduction outcome measures for the primary care programme and finalise harm reduction outcome aims for neonatal care, paediatric care and mental health.
- Move to reporting nationally against a suite of measures that cover all four programmes or work.
- Develop guidance and examples of how safety data across all four programmes of work could be presented at a speciality and NHS board level.
- Ensure processes are in place across all the four programmes to review NHS boards measurement returns on a regular cycle and provide feedback and coaching support as appropriate.
- Explore and test an NHS board buddy system whereby those with higher levels of expertise and experience on using data are paired with those at an earlier stage of development.
- Develop existing guidance on self-assurance mechanisms for improvements that are already at universal implementation to include advice on how to integrate existing assurance data such as that collected through the HEI route.
- Complete an option appraisal for an integrated data capture and reporting system that meets the needs of both NHS boards and the national reporting requirements, agree with key partners the preferred option and work with them to implement to an agreed timeline.
- Agree what reports will be produced nationally across each of the four programmes and who will have access to them.
- Ensure clear data sharing agreements are developed between the NHS boards, Healthcare Improvement Scotland and the Scottish Government.
- Finalise work to develop an approach to assessing progress and capturing spread locally across each of the four programmes and agree a national reporting framework on this between NHS boards, Healthcare Improvement Scotland and the Scottish Government.
National SPSP Priority Area 3
Ensuring effective systems are in place to evaluate the Scottish Patient Safety Programme.

SPSP historically measured its performance on the basis of delivering the measurable high level aims. This approach doesn’t:

- capture key information on the mechanism by which the improvement was made. In complex social systems, this will be an interaction between the intervention, how it was implemented and the context in which the work took place. Capturing this information would help inform the focus of work going forward.
- differentiate the contribution of the national and local programmes of work to the delivery of the outcomes.
- provide meaningful information on the cost savings attached to improving safety. There is a hypothesis that improving safety also reduces costs. If true, the evidence needs to be captured as it would support the release of additional clinical and improvement facilitation time for safety work.

Another issue is the lack of a systematic process to evaluate whether innovative change actions, where the evidence base is either weak or non-existent, are delivering a reduction in harm. This is a particular issue for mental health and primary care where a number of the interventions are based on expert opinion that making the change will lead to a reduction in harm.

At present, three of the four current programmes have funding for evaluation. Further, the Sepsis programme has already commissioned an external evaluation and the Mental Health and Primary Care Programmes are already providing a test-bed for the development of in-house evaluation skills. Progressing with separate programmes of evaluation however, is likely to be a more expensive and less informative approach then developing an integrated programme.

The University of Dundee in collaboration with NHS Tayside and a range of other academic, health and other partners recently secured funding for a Scottish Improvement Science Collaborating Centre (SISCC) from the Scottish Funding Council, Chief Scientist Office and NES. The primary focus of SISCC is on research associated with the effectiveness of improvement work and includes a number of areas that interface with the work of the SPSP. This presents an exciting opportunity for collaboration with leading academics across Scotland.

Key actions for 2014/15

- Develop an Improvement Programmes Evaluation Framework that identifies the different aspects of the work that need to be evaluated, the preferred method for each of those, which aspects of the evaluation can be delivered in house and which, for reasons of expertise and independence, need to be commissioned externally.
- Ensure that clear evaluation plans in place for each of the four main safety programmes that outline how the evaluation framework will be applied in practice.
- Work with the new Scottish Improvement Science Collaborating Centre to maximise the opportunities for collaboration on evaluating the impact of the SPSP.
National SPSP Priority Area 4
Developing the capacity of NHS boards to spread and sustain improvement.

Critical to the success of the Scottish Patient Safety Programme is the ability to spread and sustain improvements at scale. Whilst 3 of the 4 National Safety programmes are still within the early testing stage, the Acute Adult programme is now facing the challenge of universal implementation of the 10 patient safety essentials (see Appendix A). Within this context, NHS boards have identified the need for support to move from an approach of testing at a ward or service level to one of universal implementation across the whole acute system.

The NHS Scotland Quality Improvement (QI Hub) is doing work to support NHS boards to spread and sustain improvement. The focus of this work is on building the knowledge and skills to embed, spread and sustain improvements including the development of practical guidance and tools. The SPSP is linking closely with this work which includes a detailed analysis of the experience of spreading the safety programme within an NHS board. Further information about this can be found at [www.qihub.scot.nhs.uk](http://www.qihub.scot.nhs.uk).

In addition to this generic work around spread and sustainability, there is also a need to develop our understanding about which SPSP changes are spreading and which are experiencing difficulties in moving beyond the initial test phase. Identifying whether there are any systems which have managed to overcome common challenges also provides opportunities to identify any key learning that could be applied to other areas. This then enables an informed hypothesis on how to address the challenges in other NHS boards which can follow through to a co-ordinated programme of further testing.

**Key actions for 2014/15**

- The QI Hub will complete a detailed analysis of the experience of spreading the safety programme within an NHS board which will then inform the development of practical guidance and tools to support NHS boards in meeting the challenge of moving from testing at a ward or service level to universal implementation.
- The SPSP will complete an assessment of the current spread of the 10 patient safety essentials and agree what, if any, additional action needs to be taken to support NHS boards to reliably implement them across all relevant clinical areas.
National SPSP Priority Area 5
Review the SPSP delivery model to ensure it is delivering effective support to NHS boards as efficiently as possible.

SPSP is currently using a modified version of the Breakthrough Series Collaborative (BTS) which was developed by the Institute for Healthcare Improvement (IHI). This model was designed to support rapid improvement and spread in areas where there was a clear gap between current practice and the evidence base, where improvements would produce visible positive results, and where the possibility of rapid improvement had been demonstrated by at least some organisations.

In practice, the mental health and primary care programmes do not meet the conditions for the BTS model and the acute adult programme has now being going far longer than the initial collaborative model envisaged. All four programmes remain based on the BTS model though, in reality, the approach has evolved over time to accommodate the different contexts faced by these programmes.

The evolving Scottish context, combined with the scale and scope of the SPSP, means there is a need to review the national approach to ensure it remains an effective and efficient way of supporting local services to deliver sustained improvements in safety. For 2014/15 the focus will be on identifying opportunities to integrate and streamline work across the four national programmes. Future years will focus on applying learning from both the SPSP evaluation work and any relevant evaluations from other improvement programmes in both Scotland and internationally.

Key actions for 2014/15

• Finalise work on a generic SPSP leadership and QI infrastructure driver diagram that sits across all four programmes and work through the QI Hub to align this with the wider QI infrastructure work.

• Finalise work on a generic medicines management and reconciliation driver diagram and review the support in place to drive improvement in this key area of work.

• Redesign the NHS board visit approach into:
  a) An annual safety infrastructure visit that will take place once a year and will focus on the organisational leadership and infrastructures across all four programmes. The SPSP national team will allocate a named Improvement Advisor for each NHS Board who also acts as point of contact for any follow-up/ongoing issues. SPSP will also ensure links are made with the work being led by the QI hub on quality improvement infrastructures and will look for opportunities to align and streamline as appropriate.
  b) Programme specific visits – the frequency will be determined by programmes and local need.

• Move to one day national learning sessions and review the mix of national, regional and local delivery with an increasing focus on supporting NHS board learning sessions using a collaborative within a collaborative model.

• Deliver a national safety event that covers all four programmes of work.

• Review the range of different networking opportunities in the place with the aim of rationalising them so as to ensure we are making best use of both local and national QI capacity for safety work.

• Continue to work with IHI as the technical strategic partner with a focus on using their time for strategic planning support and expert advice on measurement.
National SPSP Priority Area 6
Review the national SPSP infrastructure.

In addition to the key infrastructure issues already called out through the specific priority action areas the following also needs to be reviewed:

**National SPSP Team Infrastructure**
At present there are key gaps in capacity in the following areas:

- data analyst time to support the range of work around information for improvement
- pharmacist time to support the safer medicines work across all four programmes
- a pool of individuals with both the relevant subject matter and improvement expertise that can be deployed in a flexible manner to work with NHS boards on particular topic areas where they are facing key challenges.
- specialised skills to both develop and deliver a programme of evaluation
- communications support to ensure guidance and tools are accessible and to help explain the benefits and progress of the programme to an expanding group of stakeholders.

**UK and international collaboration**
Scotland has much to share and learn from other systems in the UK and beyond. Therefore, SPSP is building relationships with others in NHS England, Wales and Ireland coupled with the existing international networks within the US and Europe. These networks provide key opportunities for sharing and learning with others involved in a similar pursuit of improving safety in healthcare.

**Funding and sponsorship**
At present a significant percentage of the safety programme budget is through time limited project funding with 5 different funding streams. This results in considerable time being spent on funding and contractual issues each year due to the number of sponsors that SPSP relates to and the fixed term staffing arrangements within the national team due to the time limited nature of the funding. It also presents challenges for integrating delivery approaches when funding is ring-fenced to particular programmes.

**Key actions for 2014/15**

- Work with the Scottish Government to agree a re-profiling of the national budgets that enables the capacity gaps in the national team to be addressed within the current overall resource envelop.
- Continue to develop links with other organisations leading safety work to ensure we are maximising the opportunities to both learn from others and share our learning with others.
- Refresh the SPSP website to enhance its functionality and accessibility
- Develop and implement an SPSP Communications Strategy
- Explore with the Scottish Government the options for moving the safety funding into HIS’ core allocation and options for moving Board QI allocations on to a longer term funding cycle.
National SPSP Priority Area 7

Improve the alignment and integration of the safety work with other national improvement programmes to maximise the benefits and cross programme learning and reduce duplication and confusion.

The SPSP has key links with a range of other national programmes of work including:

- **The Person Centred Health and Care Programme.** There is a big opportunity to develop the ways that we engage patients, carers and families in all of the four safety programmes. The Mental Health Safety Programme is leading the way with person centred care approaches firmly embedded into all of its driver diagrams and change packages.

- **Acute Patient Flow.** The NHS Lanarkshire Review Report highlighted the significant interfaces between the work in place to improve patient flow across the acute sector and the work to improve safety. There is an urgent need to look at improving the connections between these two programmes of work at both a national and local level.

- **Older People in Acute Care Improvement Programme.** This programmes focus on the effective management of frailty and delirium will impact on the extent to which these individuals experience harm within the acute care setting.

- **National Dementia Care Improvement Programme.** This programme includes within its remit work to improve the care of people with dementia in acute hospitals. There is a clear evidence base that individuals with dementia in acute care can and do experience avoidable harm and therefore key interface issues with the safety programme.

- **Leading Better Care/Healthcare Associated Infections (HAI).** There has been an explicit requirement to integrate the work of HAI taskforce, Leading better Care and the Safety Programme around common purposes for safety. Collaboration and integration is on going to reduce harm from falls, pressure ulcers and CAUTI (catheter associated blood stream infection).

Working out how to integrate these programmes of work is complex. The solution will need to be co-produced between NHS boards, the organisations running national improvement programmes and the policy leads at the Scottish Government. The initial next step is to understand the challenges presented to front line staff and from this, start to develop alternative delivery models for testing.

**Key actions for 2014/15**

- Work through the QI Hub to facilitate an initial one day meeting with the national improvement programme leads to explore opportunities for better alignment and integration.

- Work with one NHS Board to understand the challenges faced in practice and test practical ideas for better alignment and integration of the work focused on acute adult wards (where the majority of the interface issues are).
The patient safety essentials come out of the work of the acute adult programme and are 10 items which had been reported as widely implemented. This meant that the focus of the work needed to move from testing implementation on individual wards and units to ensuring universal spread across all relevant clinical areas. These 10 interventions have now been positioned as **Patient Safety Essentials**, endorsed by Scottish Government and mandated by means of a Chief Executive Letter [CEL 19 (2013)], issued to the service on 2 September 2013\(^1\).

<table>
<thead>
<tr>
<th>The 10 Patient Safety Essentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Hygiene</td>
</tr>
<tr>
<td>Leadership walk rounds</td>
</tr>
<tr>
<td>Communications; Surgical Pause and Brief</td>
</tr>
<tr>
<td>Communications; General Ward Safety Brief</td>
</tr>
<tr>
<td>Intensive Care Unit Daily goals</td>
</tr>
<tr>
<td>Ventilator Associated Pneumonia Bundle</td>
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<td>Early Warning Score</td>
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<tr>
<td>Central Venous Catheter Insertion</td>
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<tr>
<td>Central Venous Catheter Maintenance</td>
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<tr>
<td>Peripheral Venous Cannula Bundle</td>
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</table>

The CEL identifies all NHS Boards should develop local methods to assure themselves that the 10 Patient Safety Essentials are comprehensively spread and reliably implemented in all relevant clinical areas. A priority for SPSP this year is to complete an assessment of the current spread of the 10 patient safety essentials and agree what, if any, additional action needs to be taken to support NHS boards to reliably implement these in all relevant clinical areas.

Appendix B – SPSP Governance

Supporting this Strategic Plan is an overarching work plan which details the actions, timelines and key leads for each area. This will be monitored through the existing Scottish Patient Safety Programme Board and supporting governance as outlined below.

Scottish Patient Safety Programme Governance
This document summarises the key themes that came out of the consultation and the response to them.

<table>
<thead>
<tr>
<th>Comment</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current document is too long.</td>
<td>Final version has been streamlined</td>
</tr>
<tr>
<td>Evaluation needs to include effectiveness of the national programme and this needs to be undertaken independently.</td>
<td>Actions amended in response to this and will now develop an Improvement Programmes Evaluation Framework that will include clarity on which parts of the evaluation need to be undertaken by an external agent.</td>
</tr>
<tr>
<td>There is a need to be clearer on ‘how much by when’.</td>
<td>The final document will have an action plan alongside it that includes who is responsible for doing what, by when.</td>
</tr>
<tr>
<td>A number of the cross SPSP issues are actually cross improvement programme issues.</td>
<td>Agreed, however there is an issue of phasing and timing. Trying to progress work in an integrated way across all improvement programmes could slow down the pace of change for the integration across the safety programmes. Therefore we are proposing that HIS continues with plans to integrate issues as identified across SPSP whilst also progressing work around the wider integration across improvement programmes.</td>
</tr>
<tr>
<td>Release of individuals trained in QI (including SPSP fellows) to lead improvement work is a key challenge for NHS boards.</td>
<td>Agreed that not enough to simply train individuals, they then need to be given time to lead and participate in improvement work. Options for supporting increased capacity and capability for QI work are being taken forward through the Quality Improvement Infrastructure work led by QI Hub. Over 2014/15 HIS will also explore with NHS boards options for facilitating the release of SPSP fellows time.</td>
</tr>
<tr>
<td>Need to develop QI skills at executive and non-executive director level across NHS boards as well as expanding access to Improvement Advisor (IA) skills training.</td>
<td>HIS linking into work through the QI Hub focused on developing Board level leadership for quality improvement. HIS also supporting the work NES are doing to look at Scottish Leadership Skills training to replace the current IA training and expand provision of places to NHS boards.</td>
</tr>
<tr>
<td>Safer medicines management should be called out as a cross programme issue which needs appropriate resourcing.</td>
<td>Document revised to include reference to the challenges this work is facing, highlight work on generic medicines management driver diagrams as a priority and identify the need for additional pharmacy input to provide overall leadership to safer medicines work across all four programmes.</td>
</tr>
<tr>
<td>Need to build the business case for safety centrally to support investment in work locally.</td>
<td>This will be included as part of the proposed HIS Improvement Programmes Evaluation Framework.</td>
</tr>
<tr>
<td>Need to look at interfaces with work around critical incident reviews and adverse</td>
<td>Action under this will be progressed under Priority Area 7.</td>
</tr>
<tr>
<td>Incidents</td>
<td>Added in an additional action to work with QI Hub and JIT during 2014/15 to explore opportunities for working with Health and Social Care Partnerships to further develop their knowledge and skills for safety work within a multiagency context.</td>
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<tr>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Need to consider impact of health and social care integration going forward.</td>
<td>These issues are already identified under Priority Area 2.</td>
</tr>
<tr>
<td>Need to develop capacity and capability at local level to use data to drive improvement, underpinned by effective systems to collect and report at local and national levels. Also need to use data sharing agreements to bring clarity to what information will be reported at national level and how it will be used.</td>
<td>These issues are already identified under Priority Area 2.</td>
</tr>
<tr>
<td>Need to describe more effectively the links or separation of scrutiny and improvement work.</td>
<td>SPSP sits as part of Healthcare Improvement Scotland’s Improvement Directorate and will not be undertaking scrutiny work. As part of the proposed data sharing agreements we will be spelling out what information we may share with our scrutiny colleagues and under what conditions so that all stakeholders are clear.</td>
</tr>
<tr>
<td>The role and infrastructure supporting programme managers within NHS Boards requires review to reflect the significant expansion of the programme. Resources at a board level have not necessarily matched the national increase in programmes.</td>
<td>This is a key issue for NHS boards to take forward. This document focuses on the work that can be progressed nationally which includes streamlining the approach to reduce the burden on programme managers.</td>
</tr>
<tr>
<td>Programme has been spread too thinly without sustaining improvements already achieved. Increased volume of national improvement programmes in addition to the expansion of safety dilutes focus at local level. Also results in duplication of effort and reporting.</td>
<td>Restructuring the overall programme to identify the elements core across boards and those that are programme specific will enable more efficient use of existing board resources. Priority Area 7 recognises the need to work on integration across all national improvement programmes.</td>
</tr>
<tr>
<td>Other stakeholders not necessarily outlined as could have been such as NSS, Health protection Scotland and Information Services and the role they play within the overall improvement programmes.</td>
<td>Current document focuses on roles of Scottish Government, Healthcare Improvement Scotland and NHS boards in relation to SPSP as this was the initial priority. Agreed that further work is needed to build on this foundation and identify roles of organisations such as NES and PHI.</td>
</tr>
<tr>
<td>Method of delivering programmes does require reviewing to reflect NHS Board level developments, local collaborative and capacity to release staff to multiple national events across all improvement programmes.</td>
<td>Agreed, Priority Area 5 describes a range of models for testing over 2014/15 to inform most effective and useful method of delivery across the safety programme. Priority Area 7 picks up the issues around wider integration across national improvement programmes.</td>
</tr>
</tbody>
</table>
### Scottish Patient Safety Programme Strategic Delivery Plan

#### List of who responded to the consultation

**NHS boards, SPSP Programme Managers, Clinicians**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Adams</td>
<td>Head of Primary Care &amp; Community Services NW Sector, Glasgow CHP</td>
</tr>
<tr>
<td>Jackie Agnew</td>
<td>SPSP-MH, NHS Highland</td>
</tr>
<tr>
<td>Jennifer Armstrong</td>
<td>Medical Director, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Paul Bowie</td>
<td>Programme Director (Safety &amp; Improvement), NHS Education for Scotland</td>
</tr>
<tr>
<td>Hazel Borland</td>
<td>NHS Dumfries &amp; Galloway</td>
</tr>
<tr>
<td>Ian Clarke</td>
<td>SPSP-MH Delivery Group &amp; SPSP-MH Programme Manager/Lead</td>
</tr>
<tr>
<td>Angela Cunningham</td>
<td>SPSP-MCQIC</td>
</tr>
<tr>
<td>Annette Henderson</td>
<td>NHS Lothian Education and Development Team</td>
</tr>
<tr>
<td>Neil Houston</td>
<td>National Clinical Lead, SPSP-PC, SPSP Fellow</td>
</tr>
<tr>
<td>Morag MacRae</td>
<td>NHS Tayside</td>
</tr>
<tr>
<td>Linda McKechnie</td>
<td>SPSP-MH, NHS Dumfries &amp; Galloway</td>
</tr>
<tr>
<td>Fiona Mitchelhill</td>
<td>SPSP Programme Board, NHS Grampian</td>
</tr>
<tr>
<td>Jane Murkin</td>
<td>NHS Lanarkshire</td>
</tr>
<tr>
<td>Diane Murray</td>
<td>Board Executive Leads, NHS Ayrshire and Arran</td>
</tr>
<tr>
<td>Kerry Russell</td>
<td>NHS Shetland</td>
</tr>
<tr>
<td>Julia Scott</td>
<td>SPSP Programme Board, NHS Borders</td>
</tr>
<tr>
<td>Mark Swatton</td>
<td>Head of Clinical Governance, National Waiting Times Centre Board</td>
</tr>
<tr>
<td>Audrey Trotter</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Marion Walker</td>
<td>NHS National Services Scotland</td>
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</tbody>
</table>

**Networks and Committees**

| Rosemary Hector | The safer use of medicines network                                           |

Healthcare Improvement Scotland Audit Committee, 12 March 2014
### SPSP Fellows

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Rachel</td>
<td>Bruce</td>
</tr>
<tr>
<td>Malcolm</td>
<td>Daniel</td>
</tr>
<tr>
<td>Julie</td>
<td>Hannah</td>
</tr>
<tr>
<td>Marion</td>
<td>Slater</td>
</tr>
<tr>
<td>Peter</td>
<td>Thomson</td>
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### Scottish Government

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
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</thead>
<tbody>
<tr>
<td>Anne</td>
<td>Aitken, Quality Team</td>
</tr>
<tr>
<td>Angiolina</td>
<td>Foster, Director of Health and Social Care Integration</td>
</tr>
<tr>
<td>Geoff</td>
<td>Huggins, Deputy Director of Health and Social Care Integration</td>
</tr>
<tr>
<td>Jason</td>
<td>Leitch, Clinical Director, Quality Unit</td>
</tr>
<tr>
<td>Andy</td>
<td>Longmate, National Clinical Lead for Patient Safety</td>
</tr>
<tr>
<td>Craig</td>
<td>White, Divisional Clinical Lead, Quality Unit</td>
</tr>
<tr>
<td>Lesley</td>
<td>White, Interim National Lead, Mental Health</td>
</tr>
<tr>
<td>Allison</td>
<td>Wood, Directorate of Chief Nursing Officer</td>
</tr>
</tbody>
</table>

### Healthcare Improvement Scotland Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gareth</td>
<td>Adkins, Implementation &amp; Improvement Team Lead</td>
</tr>
<tr>
<td>Kirsty</td>
<td>Ellis, Associate Improvement Advisor, SPSP MCQIC</td>
</tr>
<tr>
<td>Jill</td>
<td>Gilles, Improvement Advisory, SPSP – Primary Care</td>
</tr>
<tr>
<td>Rosemary</td>
<td>Hector, Programme Manager, HIS Medicines Team</td>
</tr>
<tr>
<td>Alison</td>
<td>Hunter, Improvement Advisor, SPSP-Acute Adult</td>
</tr>
<tr>
<td>Johnathan</td>
<td>MacLennan, Improvement Advisor, SPSP-MH</td>
</tr>
<tr>
<td>Bernie</td>
<td>McCulloch, Improvement Advisor, SPSP MCQIC</td>
</tr>
</tbody>
</table>
SUBJECT: Learning from Suicides in Scotland

1. Purpose of the report
Jamie Malcolm (Clinical Advisor) and Anna Wimberley (Programme Manager) will present on progress in learning from Mental Health services’ suicide reviews and how this informs both the wider suicide prevention agenda in Scotland and national Mental Health Service improvement.

2. Recommendation
The Healthcare Improvement Scotland Board is asked to:
- Note the key issues highlighted
- Note Healthcare Improvement Scotland’s commitment in Scottish Government’s Suicide Prevention strategy and associated work plan to be implemented jointly by the Scottish Patient Safety Programme for Mental Health and the Suicide Reporting and Learning System

3. Background and key issues
Since Healthcare Improvement Scotland established the Suicide Reporting and Learning System in 2008, its focus has been on supporting NHS boards to improve processes to review the care given to people in touch with their Mental Health services who take their own lives. Substantial progress has been made and there is now a systematic approach to learning from these tragic events across NHSScotland:
- We are now in the unique position of having national aggregated learning from suicide review reports, from which we can make recommendations for national service improvement and work with partner organisations to take these recommendations forward. We will present on current activity.
- A priority for improvement is organisational culture within which suicide reviews are managed – supporting NHS board’s to develop a just, learning culture has been a key aim of the Suicide Reporting and Learning System and continues to be central to the programme’s approach. We will present on progress, including the engagement and appropriate involvement of families and carers both in care planning and the review process.
- The Suicide Reporting and Learning System and Scottish Patient Safety Programme for Mental Health have influenced the development of Scottish Government’s Suicide Prevention Strategy 2013-16 and will be instrumental in its implementation. We will present on our commitment within the strategy and our planned programme of work.

4. Strategic objectives/Local Delivery Plan
Our organisations strategic priorities provide a framework through which we are delivering our national contribution to learning from suicides and improving mental health services:
- We are empowering people through engagement and consultation with service users, families, carers to have an informed voice in both care planning and review processes, shaping how we identify and implement learning to design and deliver services
- Through the Scottish Patient Safety Programme for Mental Health and the Suicide Reporting and Learning System we are reliably spreading and supporting implementation of best practice to improve healthcare.
• We are assessing the safety and quality of healthcare both through continuous improvement, and through the scrutiny and assurance structure provided by the integrated arrangements of the Suicide Reporting and Learning System and the Mental Welfare Commission for Scotland.

5. Measures for improvement
The Scottish Patient Safety Programme for Mental Health has a suite of agreed measures which together with the Suicide Reporting and Learning System's key quality indicators will provide a measurement framework for our integrated improvement work. This will form part of our presentation.

6. Risk and legal implications
No specific additional legal implications arise as a result of these activities. All projects and programme risks are reported elsewhere.

7. Resource implications
In addition to integrated working across the Scottish Patient Safety Programme for Mental Health and the Suicide Reporting and Learning System, we are exploring mechanisms for joint working with partner organisations and key stakeholders (NHS boards / NHS Health Scotland / Health and Safety Executive / National Confidential Inquiry/ Scottish Government / NHS Education for Scotland / support and voluntary organisations).

8. Workforce implications/consultation
Both the Scottish Patient Safety Programme for Mental Health and the Suicide Reporting and Learning System regularly consult and work with NHS boards to deliver the programmes of work. The key areas highlighted within the presentation have formed the basis of discussions with NHS boards during a programme of progress visits led by the Suicide Reporting and Learning System team.

9. User involvement and person centredness/public consultation
Both the Scottish Patient Safety Programme for Mental Health and the Suicide Reporting and Learning System engage and consult with service users, families and carers to develop and deliver the programmes of work. We will present on specific areas which have benefited from this approach.

10. Equality and diversity
Equality and Diversity Impact Assessments are undertaken for both programmes of work.

11. Governance and future reporting schedule

<table>
<thead>
<tr>
<th>Key milestone to be reported against in forthcoming year:</th>
<th>To be reported to:</th>
<th>Date presented/to be presented:</th>
<th>Version number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1 of delivery of commitment 6 of Suicide Prevention Strategy</td>
<td>Executive Team</td>
<td>December 2014</td>
<td></td>
</tr>
</tbody>
</table>

Robbie Pearson  
Director of Scrutiny and Assurance  
Lead Director

Anna Wimberley  
Programme Manager  
Lead Officer
SUBJECT: Financial Performance report as at 31 March 2014

1. Purpose of the report
   The paper provides an update on the provisional financial position for 2013/14 as at 31 March 2014.

2. Recommendation
   The Healthcare Improvement Scotland Board is asked to:
   • note the provisional financial position at 31 March 2014
   • note the progress with regard to cash releasing efficiency savings (CRES).

3. Background and key issues
   The organisation’s most recent financial position is reported at each meeting of the Finance and Performance Committee.

4. Strategic objectives/Local delivery plan
   The financial plan underpins the Local Delivery Plan of the organisation. Any changes to this plan are approved by Executive Team to ensure that they meet the strategic objectives of the organisation.

5. Measures for improvement
   The Executive Team consider finance updates on a weekly basis. These include progress being made towards meeting financial targets, the introduction of new, national finance systems and the implementation of revised management procedures.

6. Risk and legal implications
   The risk associated with managing the financial outturn of the organisation is mitigated by regular reporting of the financial position to the Executive Team and the Corporate Management Team. Any areas of concern will be addressed as soon as they become evident. In addition, the management accountants work closely with designated budget holders and meet regularly to assess the impact of any changes to the financial position.

7. Resource implications
   There are no specific resource implications associated with this report

8. Workforce implications/consultation
   There are no specific workforce implications associated with this report

9. User involvement and person centredness/public consultation
   Not applicable.

10. Equality and diversity
    There are no equality and diversity issues as a result of this paper.
11. Governance and reporting

The Board receives a financial performance update report as a standing item. The Finance and Performance committee and the Audit committee both have specific remits in relation to the financial governance of the organisation and appropriate reports are submitted at each meeting as required.

Maggie Waterston
Director of Finance and Corporate Services
Lead Director

Brian W Ward
Finance General Manager
Lead Officer

Appendix:

Financial performance 2013/14 as at 31 March 2014 (Provisional)
Appendix

Financial performance for the period to 31 March 2014 (Provisional)

The provisional outturn positions for both revenue and capital resource allocations have now been established and will be the subject of audit which commences on 12 May 2014. Thereafter the draft Annual Accounts will be considered in detail at the Audit Committee Workshop on 4 June before being formally presented to the Audit Committee on 23 June and the Board on 26 June 2014.

Revenue resource allocation

Table A below shows the summary position by directorate at 31 March 2014. This demonstrates a year to date under spend of £0.150million or 0.75% of phased budget. This is in line with the Scottish Government ceiling on the carry forward of revenue resource allocation to the financial year 2014-15 of £0.200million.

Table A
Financial position at 31 March 2014

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Full Year Budget</th>
<th>Budget Remaining</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>2,808,167</td>
<td>(44,161)</td>
<td>2,808,167</td>
<td>2,852,328</td>
<td>(44,161)</td>
</tr>
<tr>
<td>Clinical Directorate</td>
<td>1,271,344</td>
<td>(8,389)</td>
<td>1,271,344</td>
<td>1,279,733</td>
<td>(8,389)</td>
</tr>
<tr>
<td>Corporate Provision</td>
<td>486,010</td>
<td>160,035</td>
<td>486,010</td>
<td>325,975</td>
<td>160,035</td>
</tr>
<tr>
<td>Evidence &amp; Improvement</td>
<td>6,863,151</td>
<td>78,268</td>
<td>6,863,151</td>
<td>6,784,883</td>
<td>78,268</td>
</tr>
<tr>
<td>Property</td>
<td>1,231,320</td>
<td>2,470</td>
<td>1,231,320</td>
<td>1,228,850</td>
<td>2,470</td>
</tr>
<tr>
<td>Scrutiny &amp; Assurance</td>
<td>3,298,409</td>
<td>(60,632)</td>
<td>3,298,409</td>
<td>3,359,041</td>
<td>(60,632)</td>
</tr>
<tr>
<td>Scottish Health Council</td>
<td>2,444,525</td>
<td>(6,181)</td>
<td>2,444,525</td>
<td>2,450,705</td>
<td>(6,181)</td>
</tr>
<tr>
<td>Scottish Medicines Consorti</td>
<td>1,618,469</td>
<td>28,418</td>
<td>1,618,469</td>
<td>1,590,051</td>
<td>28,418</td>
</tr>
<tr>
<td>Total</td>
<td>20,021,395</td>
<td>149,828</td>
<td>20,021,395</td>
<td>19,871,567</td>
<td>149,828</td>
</tr>
</tbody>
</table>

Revenue Resource Allocations

All anticipated revenue resource allocations have now been received from SGHSCD as demonstrated in Table B below. This shows that just over 20% of resources worth more than £4 million came in the form of 47 additional allocation adjustments in year.
Table B
Revenue resource allocations

<table>
<thead>
<tr>
<th>Allocations</th>
<th>Recurring</th>
<th>Non-Recurring</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Baseline 1 April 2013</td>
<td>15,918</td>
<td>0</td>
<td>15,918</td>
</tr>
<tr>
<td>Received to date</td>
<td>240</td>
<td>3,863</td>
<td>4,103</td>
</tr>
<tr>
<td><strong>Total 2013/14</strong></td>
<td><strong>16,158</strong></td>
<td><strong>3,863</strong></td>
<td><strong>20,021</strong></td>
</tr>
</tbody>
</table>

Releasing Efficiency Savings (CRES)

The target for cash releasing efficiency savings for the financial year 2013/14 is £0.866million of which £0.568million has come from pay costs with the balance being found from within accommodation and other cost savings. Progress to date is shown in table C below which demonstrates that the annual target has been achieved and by the end of the financial year is expected to exceed requirement by £0.110million.

Table C
Cash releasing efficiency savings 2013/14

<table>
<thead>
<tr>
<th>Category</th>
<th>Target</th>
<th>Achieved</th>
<th>Excess</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Pay</td>
<td>568</td>
<td>568</td>
<td>-</td>
</tr>
<tr>
<td>Other (Incl. Accommodation)</td>
<td>298</td>
<td>408</td>
<td>(110)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>866</strong></td>
<td><strong>976</strong></td>
<td><strong>(110)</strong></td>
</tr>
</tbody>
</table>

The introduction of the Driving Improvement Programme is expected to have a growing impact in the area of efficiency and productivity. The extent to which individual working groups will add to the cash releasing savings target in future will vary but particular contributions can be expected from the workforce, non-pay and processes working groups. The effect in the financial year was understandably limited and the real impact will be felt in 2014-15 and beyond.

Capital Expenditure 2013-14

It is anticipated that capital expenditure will total £0.091million during 2013-14. This comprises £0.038million in respect of modifications to the accommodation at Gyle Square and £0.053million for improvement to the provision of off-site ICT back-up solution.

The capital resource limit is £0.095million resulting in a provisional under spend of £0.004million or 4.2%.
SUBJECT: Listening and Learning - How Feedback, Comments, Concerns and Complaints can improve NHS services in Scotland

1. Purpose of the report
   The above report and its findings will be presented to the board on the 14 May 2014 and the following key areas will focus discussion on:
   • the report findings and recommendations
   • the next steps for the Scottish Health Council and alignment with broader Healthcare Improvement Scotland activity
   • Healthcare Improvement Scotland as a listening organisation and the use of complaints and feedback as part of our dashboard for safety and quality

2. Recommendation
   The Healthcare Improvement Scotland Board is asked to:
   • review the Executive Summary as attached and consider the areas identified above, for discussion at the Board meeting.

3. Background and key issues
   On the 30 April 2014, the Scottish Health Council published the report entitled ‘Listening and Learning - How Feedback, Comments, Concerns and Complaints can improve NHS services in Scotland’

   The attached Executive Summary sets out the approach and findings from a review undertaken by the Scottish Health Council into how NHS Scotland is listening to and learning from complaints and feedback.

   The review gathered views from patients and the public, included visits to all 21 of Scotland’s NHS Boards and involved conversations with a number of key national bodies.

   Since publication on the 30 April 2014, the report was highlighted in National press on two occasions and has received a very positive response among boards and subject experts.

   The Scottish Health Council will continue to work with NHS Boards and national bodies with an interest in the recommendations in this report

Richard Norris
Director, Scottish Health Council

Jacki Smart
Person-Centred Care Advisor

Lead Director
Lead Officer

Appendix:
Executive Summary: Listening and Learning - How Feedback, Comments, Concerns and Complaints can improve NHS services in Scotland
Appendix

Listening and Learning - How Feedback, Comments, Concerns and Complaints can improve NHS services in Scotland

Executive summary

This report sets out the findings and recommendations that are designed to help NHSScotland improve how it listens to what people say about their experiences of using healthcare services. These findings have been informed by a review that sought to understand how well NHSScotland listens to feedback, comments, concerns and complaints and how it is learning from these to improve the services they provide and how well prepared and supported the people of Scotland are to provide this in a meaningful way.

As part of the review, the Scottish Health Council gathered views from local people. The local office network of the Scottish Health Council, with offices in every NHS Board area, puts it in a unique position to gather local public comment and feedback.

The key points from the public engagement were:

- the majority of people did not know how to give feedback or make a complaint about their local health service, and
- most people said they were not aware of the support available to help them do so.

The main barriers to giving feedback or making a complaint were identified by respondents as:

- a fear of repercussions for their own or relatives’ treatment
- not knowing how to make contact or who to make contact with, and
- a lack of confidence that anything will be done.

The Scottish Health Council also visited and met with colleagues in all 21 Boards in Scotland and spoke with colleagues in the Scottish Public Services Ombudsman’s office, the NHS Complaints Personnel Association Scotland (NCPAS), NHS Education for Scotland and the Scottish Government.

One important aspect of the visits to NHS Boards was the opportunity to identify achievements and areas of good practice that could be shared across NHSScotland. There were a great number of areas of good practice which will be shared fully in a variety of ways following publication of this report. A number of key examples however are highlighted throughout the detail of the report.

The insight gained and recommendations made to focus improvement activity are detailed later in the report. These focused on the following areas:

- NHS Boards’ response to the 'Can I Help You?’ guidance
- how NHS Boards are encouraging and handling feedback, comments, concerns and complaints
- how learning from complaints and feedback is driving improvement in the quality and experience of care in NHSScotland
- training and development for NHS staff
- accountability and governance mechanisms for complaints and feedback
- future annual reporting, and

8 http://www.scotland.gov.uk/Publications/2012/03/6414
• using complaints and feedback information as part of the ‘dashboard’ for safety and quality.

The findings show that all NHS Boards have made some progress in responding to the aspirations of the Patient Rights (Scotland) Act 2011 and many were able to demonstrate innovative thinking and techniques in their handling of complaints and feedback. The findings also show that there is still a considerable amount of effort needed. The three most significant learning points that emerged to focus improvement activity moving forward are:

1. **Remove the fear factor**
   There is a clear message from the public that one of the main barriers to giving feedback or making a complaint is fear of repercussions for their own or relatives’ treatment. This is compounded by the level of fear and defensiveness that some staff reported when dealing with feedback, and it is clear that considerable effort should be made on transforming the culture to support staff and the public to be open and confident. This will be essential to allow NHSScotland to truly understand what needs to improve and to ensure care and services are reliably of high quality.

2. **Welcome feedback**
   The shared importance that everyone places on understanding the experiences that people have of NHSScotland is clear. Given that a significant number of the public still report a lack of knowledge of the opportunities to share all types of feedback, or make a complaint, NHS Boards must widely publicise the information required to encourage and support people to openly share.

3. **Show the Improvement**
   There is a necessity to learn and improve as a result of complaints and feedback. Given the challenges NHS Boards reported in closing the ‘learning loop’, and the reflections from some members of the public who believe nothing happens with the information they share, there must be a focus on learning from feedback, implementing the changes and informing people what improvements were made.

There are implications in these recommendations for NHS Boards, the Scottish Government and other national organisations.

The Scottish Health Council will continue to work with NHS Boards and national bodies with an interest in the recommendations in this report to help improve how NHSScotland responds to feedback, comments, concerns and complaints. This will include sharing examples of good practice across NHS Boards.
SUBJECT: Executive Clinical Director: key points

1. Purpose of the report
This report provides the Healthcare Improvement Scotland Board with information on key developments relevant to the overall programme of work associated with the Clinical Directorate and complements the update provided in the Performance Report to the Board.

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

3. Key points
a) To support NHS Boards in Scotland, Healthcare Improvement Scotland has produced a resource Implementing an electronic prescribing and medicines administration system: a good practice guide. This guidance is available on our website, and provides information and tools for a wide multi-disciplinary audience. The guide contains recommendations, self-assessment checklists, action planning tools, case studies and an exploration of our strategic approach to benefits realisation of electronic prescribing and medicines administration systems within NHSScotland. A short summary has also been prepared which contains the key information from the complete good practice guide. We fully expect this to be endorsed by the Scottish Government eHealth Strategy Board at the June 2014.

b) Following approval of the Business Intelligence Strategy by the Board in March, the Business Intelligence Implementation Group has been established – and, in the first instance, this group is overseeing the development of an implementation plan for the strategy which will be presented to the Board in June 2014. A key component of our external intelligence is under development in association with agencies including Audit Scotland, NHS Education Scotland, Public Health and Intelligence and the Care Inspectorate as a priority for 2014/15.

c) Development of our Clinical Engagement Strategy
Our Clinical Engagement Strategy (2011-14) was originally developed using a ‘90 day innovation process’ modelled by Proctor and Gamble and later adapted by the Institute of Healthcare Improvement. We have recently re-applied this approach to review and refresh our Strategy for 2014-17, within the wider engagement focus of Driving Improvement. This work was informed by a literature search, a semi-structured interviews (30+), focus group sessions and results from an on-line survey (235 respondents).

The draft Strategy was positively received by the Evidence, Improvement & Scrutiny Committee on 17 April and it was noted that there had been significant progress to date in strengthening HIS’ relationships with national strategic clinical groups, including the Royal Colleges. There has been a natural shift towards engaging front line clinicians through specialist societies and Managed Clinical Networks.

The draft Strategy will be provided to the Board for discussion at the June 2014 meeting – and will include a refreshed Driver Diagram, change package and action plan.

Dr Brian Robson
Executive Clinical Director
SUBJECT: Evidence Directorate: key points report

1. Purpose of the report
This report provides the Healthcare Improvement Scotland Board with information on any other significant issues relevant to the overall programme of work associated with the Evidence Directorate, but which is additional to the update provided in the Performance Report to the Board.

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

3. Key points

a) Scottish Medicines Consortium – progress on implementation of the new medicines review recommendations

The recommendations for SMC are in addition to business as usual and will significantly increase the volume and scope of the SMC work programme. In March 2014 the Scottish Government agreed additional funding of around £800K per annum to enable SMC to deliver the additional work associated with these recommendations. A recruitment process is now underway.

Two significant actions, meetings in public and the Patient and Clinician Engagement Process (PACE), will commence imminently. The first meeting in public will take place on 6 May and the PACE process will be applied, if necessary, to any submissions for medicines relating to end of life or very rare conditions received from 1 May 2014.

b) Consensus guidelines
SIGN will publish its first guideline based on formal consensus methods on 6 May. This guideline, on care of the deteriorating patient, has been developed with input from the Scottish Patient Safety Programme.

Consensus based guidance, based around the Delphi process, will not replace the need for evidence based guidelines. Instead it will enhance the ability of the Evidence Directorate to produce guidance where no good quality evidence exists or where there is conflicting evidence. As the process is carried out electronically, it can be undertaken at low cost and as our experience grows in this area, the development time should be relatively short.

Two further uses of consensus methodology are planned, addressing inpatient mortality review processes, in collaboration with the Clinical Directorate, and the appropriate use of anti-microbial dressings, in collaboration with SHTG.
Healthcare professionals, policy makers, service users and the public often find it challenging to understand guidelines and the quality of the evidence on which they are based. Guidelines are generally in the form of ‘one size fits all’, although some guideline developers, including SIGN, produce versions specifically for lay audiences.

The Developing and Evaluating Communication Strategies to Support Informed Decisions and Practice Based on Evidence (DECIDE) project seeks to address these challenges through the development of strategies for communicating evidence based recommendations to different groups of potential users. The project is funded by the European Union 7th Framework Programme. Healthcare Improvement Scotland is leading Workpackage 3 to develop public and patient focussed strategies for dissemination of guideline recommendations. Further information can be found at http://www.decide-collaboration.eu

Healthcare Improvement Scotland is organising the DECIDE international conference which will take place on 2-4 June in the Royal College of Physicians, Edinburgh. In addition to contributions from SIGN staff, speakers include Professor Bruce Guthrie (University of Dundee) and representatives from a number of guideline producers including the Norwegian Knowledge Centre, the Swedish National Institute for Public Health and McMaster University. Currently around 220 delegates are registered to attend this event which will include presentations, workshops and panel sessions exploring the findings from the DECIDE project and wider issues relating to the development and use of guidelines.

Sara Twaddle
Director of Evidence (Interim)
SUBJECT: Director of Safety and Improvement: key points report

1. Purpose of the report
This report provides the Healthcare Improvement Scotland Board with information on any other significant issues relevant to the overall programme of work associated with the Safety and Improvement Directorate, but which is additional to the update provided in the Performance Report to the Board.

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

3. Key points

a) Scottish Improvement Science Collaborating Centre (SISCC)
The Scottish Improvement Science Collaborating Centre has just been launched and is based at the University of Dundee. It is a large-scale collaboration involving universities, health boards, local authorities, patients, carers, communities and advocacy groups. It is led by Professor Mary Renfrew from the University of Dundee and Professor Dilip Nathwani from NHS Tayside. Healthcare Improvement Scotland is a partner.

Its aim is to improve the quality of patient care and ensure that world-leading research leads to an impact across society. It has a particular focus on researching the effectiveness of quality improvement interventions. Funding of £3.25 million has been allocated from a partnership involving the Scottish Funding Council, the Chief Scientist Office, The Health Foundation, and NHS Education for Scotland (NES).

In the funding application, SISCC outlined an ambitious range of research, some of which has a direct interface with the HIS work programme. Appendix A provides more information on this. This is an exciting development with the potential to create stronger links between the academic research community and the quality improvement work across NHSScotland. A meeting with Professor Mary Renfrew has been arranged for early May to discuss how SISCC and Healthcare Improvement Scotland can work in partnership to maximise the benefits from this initiative.

b) Building a Quality Improvement Infrastructure
The focus of this work, led by the Quality Improvement (QI) Hub, is to support NHS boards to undertake a current state assessment of their local QI infrastructure and from this, identify priority areas for development. The overall aim is to develop QI infrastructures that help to accelerate the pace and scale of improvement. The current state assessment will be facilitated through the use of a QI diagnostic exercise which is an IHI tool that has been amended for the Scottish context.

As part of this work, a one-day event aimed at NHS board members, Scottish Government leads and QI Hub strategic partners will be held on 12th May 2014. On the 13th May the QI Hub is facilitating an expert team to undertake QII visits to NHS Tayside and NHS Fife. The visits are designed in partnership with NHs boards with the aim supporting them to progress the findings from their QII diagnostic exercise by producing a local QII prioritised action plan.
Following a process of review and refinement, the remaining visits to participating boards will be completed by December 2014.

c) **Spread and Sustainability-NHS Event 2014**  
This year the QI Hub, hosted by Healthcare Improvement Scotland, is overseeing the Poster Exhibition at the NHS Scotland Event. The theme of the event is ‘spreading and sustaining quality’, and will include an exhibition of over 200 posters from organisations/teams highlighting work which contributes to the quality agenda.

Following the NHS Event the newly upgraded QI Hub’s web site will promote the top posters, as well as new products developed by QI Hub partners including the Spread and Sustainability narrative review, People Connect and e-mentoring for Leading Quality.

Ruth Glassborow  
Director of Safety and Improvement (Interim)
## Summary of the SISCC proposed research programme which potentially overlaps with Healthcare Improvement Scotland

<table>
<thead>
<tr>
<th>Theme</th>
<th>Research questions</th>
<th>Lead researchers</th>
<th>Methods and approach</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement science methods</td>
<td>1. What are the strengths, weaknesses of process, outcome and balancing measures currently used in quality and safety improvement in Scotland and internationally? &lt;br&gt; 2. To what extent are existing process measures tightly-linked to outcome and what work would be required to demonstrate such linkage where it is absent? &lt;br&gt; 3. How should balancing measures be created and used?</td>
<td>Prof Bruce Guthrie, Dundee</td>
<td>Review of measures used in SPSP acute and primary care workstreams &lt;br&gt; Literature review of link between existing process measures and outcomes measures &lt;br&gt; Review of use of balancing measures and definition of characteristics of good balancing measures</td>
<td>Potential to provide methods for reliable development of valid measures for future improvement programmes &lt;br&gt; Potential for questioning of the validity of measures currently employed in SPSP</td>
</tr>
<tr>
<td>Context</td>
<td>1. What effective strategies to influence patient, organisation and social/legal barriers to improvement exist and to what degree are their effectiveness, sustainability and affordability likely to be context dependent? &lt;br&gt; 2. What are key stakeholder and experts' views as to how barriers to local contextualisation of evidenced based interventions can be tackled?</td>
<td>Dr Steve MacGillivray, Dundee (Q1)</td>
<td>Realist review to identify strategies and define framework to overcome barriers to improvement &lt;br&gt; Testing of framework in maternity and child health and older peoples care &lt;br&gt; Definition of approaches to aid scaling up in real world contexts</td>
<td>Models defined may conflict or may be complementary &lt;br&gt; Potential overlap with QI Hub spread and sustainability work</td>
</tr>
<tr>
<td>Theme</td>
<td>Research questions</td>
<td>Lead researchers</td>
<td>Methods and approach</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Behavioural determinants and change strategies | 1. What are the most effective means of achieving behaviour change among group/teams of professionals regarding knowledge translation?  
2. What are the barriers and facilitators (including the role of users/carers) to health professionals effectively implementing evidence based behaviour change techniques to change patient/carer behaviour? | Prof Ronan O’Carroll, Stirling     | Rapid review and case study analysis of approaches to achieving behaviour change  
Development of novel interventions and strategies  
Implementation and evaluation of strategies to support behaviour change | Potential to interface with emerging human factors work which is lead by NES in partnership with HIS and others |
| Knowledge management, eHealth and health informatics | Was included in initial proposal but looks like may not have been funded.                                                                                                                                                   | Dundee & Farr Institute           | Development of Quality Improvement System Intelligence Platform.                                                                 |                                                                                                                                                                                                       |
| Workforce capacity and capability          | 1. What are the barriers and facilitators to successful completion of improvement projects by students and early career professionals?  
2. What types of costs are incurred by clinical teams and organisations from hosting QI projects?  
3. In what ways might supervision of QI projects change clinical team culture?  
4. In what ways might hosting QI projects facilitate organisational change? | Joint leads: Diane Campbell, NHS Tayside and Prof Kevin Rooney, UWS | Focused work on evaluation of maternal and older peoples workstreams  
Methods described as ‘realist’ and ‘perspective will be Return on Investment’  
Outputs: report on barriers and facilitators to forming successful improvement teams; sustainable improvement Faculty; grant applications for future research | Potential to interface with NES capacity and capability strategy and Quality Improvement Infrastructure work lead by QI Hub |
<table>
<thead>
<tr>
<th>Theme</th>
<th>Research questions</th>
<th>Lead researchers</th>
<th>Methods and approach</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Sustainability and spread  | 1. What cost-effective processes support innovation and improvement and can be developed and sustained at scale across the health systems?  2. What are the enabling conditions for people and organisations to transform their working practices and achieve improved health outcomes? | Prof Mary Renfrew, Dundee | Review of determinants of behaviour maintenance in individuals and systems/organisations  
Analysis of factors in behaviour maintenance in SPSP, CLAHRCs etc  
Year 1-2 implementation of large scale change programme in maternity units. Followed by year 1-3 roll out of programme in older people care | Opportunity to identify complementary programme of research in maternity care QI to support spread of SPSP programme in maternity care. Potential for two QI programmes creating a burden of activity and confusion in the service  
Potential overlap with QI Hub spread and sustainability work. Models defined may be complementary or may conflict |
SUBJECT: Director of Scrutiny and Assurance: key points

1. Purpose of the report
   This report provides the Healthcare Improvement Scotland Board with information on any other significant issues relevant to the overall programme of work associated with the Directorate of Scrutiny and Assurance.

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

3. Key points
   a) Joint Inspections of the Care of Adults with the Care Inspectorate
      Healthcare Improvement Scotland and the Care Inspectorate are making good progress in the development of the joint scrutiny and inspection plan and in the sharing of intelligence on health and social care. Healthcare Improvement Scotland and the Care Inspectorate are collaborating in developing an integrated intelligence/risk assessment summary for the health and social care partnerships in Scotland. This assessment will be used to inform the prioritisation of areas for inspection. It will draw on a range of pieces of qualitative information and quantitative indicators, including information provided by the national Joint Improvement Team (JIT). A joint risk assessment meeting will be held at the end of August 2014, to explore and recommend areas for joint adult inspections in 2015-16.

   b) The Learning and Improvement from Adverse Events in Scotland
      Healthcare Improvement Scotland held a national event on 7 May 2014 to review progress in building a more consistent approach to the learning and improvement from adverse events in Scotland. The event marks nearly two years of work with NHS Boards in building a more a open and systematic approach to identifying significant adverse events, sharing experiences and ultimately delivering the necessary improvements to prevent such events happening in the future. The event provides the basis for the further development of the national framework for the management of adverse events (published by Healthcare Improvement Scotland in September 2013) and to put in place further measures to support the sharing of good practice across NHS boards.

   c) Leading a more Systematic approach to the Sharing of Intelligence
      Healthcare Improvement Scotland held a meeting on 1 May 2014 with a range of stakeholders (Audit Scotland, NES, NSS and the Care Inspectorate) to agree the next steps in formalising the forum for intelligence sharing between agencies. This builds on work already undertaken by the Directorate of Scrutiny and Assurance to test the sharing of intelligence and information between bodies and provides a platform for taking forward the organisation’s Business Intelligence Strategy, led by the Executive Clinical Director.

      It has been agreed to further develop the proposed formal terms of reference for a national intelligence group. The draft proposals will be presented to the chief executives of the bodies involved in this exercise in the next couple of months. Any proposals will need to demonstrate coherence with other national pieces of work and reinforce the opportunities to share both health and social care intelligence.

Robbie Pearson
Director of Scrutiny and Assurance
1. Purpose of the report
This report provides the Healthcare Improvement Scotland Board with information on any other significant issues relevant to the overall programme of work associated with the Scottish Health Council, but which is additional to the update provided in the Performance Report to the Board.

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

3. Key points

   a) In May we published a new report on our website: Evaluation of Chest Heart & Stroke Scotland's Voices Scotland Programme.

   The report follows an review of Voices Scotland, which was jointly commissioned by the Scottish Health Council and Chest Heart & Stroke Scotland. Voices Scotland is a programme of workshops and support for patients and carers, together with advice and facilitation for NHS managers and clinicians, aimed at helping patients to become effectively involved in improving healthcare services. The programme has been running since 2005 and has evolved over the past 3 years to incorporate training for service users to become “Champions of Self Management in Care” (COSMIC), with a view to developing networks of local individuals within each NHS Board area who will champion self management. Since 2012, COSMIC training resources have been made available to other organisations who might wish to adapt and use them with their own service users.

   The evaluation found that the Voices Scotland programme has achieved notable impact. There is still much to do in terms of extending the training to people with conditions other than those relating to chest, heart and stroke, reaching every NHS Board area and replenishing the supply of trained service users – but the Voices Scotland team has made a significant and distinctive contribution over a sustained period of time. The Scottish Health Council has been working closely with the Voices Scotland Programme to increase access to the workshops, and currently our own staff are being trained to deliver the Programme in partnership with local NHS board staff.

   The report, and an accompanying briefing paper, are available to download from our website at www.scottishhealthcouncil.org/publications/evaluation_reports/voices_scotland_programme.aspx
b) e-Participation Toolkit

March saw the publication of our e-Participation Toolkit – a companion to our refreshed Participation Toolkit. The e-Participation Toolkit provides information and ideas on how social media, e-petitions, online focus groups, digital apps and similar methods can be used to involve patients, carers and members of the public in making decisions about their own health and care and about local services.


c) Listening and Learning

In April the Scottish Health Council published the report entitled ‘Listening and Learning - How Feedback, Comments, Concerns and Complaints can improve NHS services in Scotland’

The report sets out the findings and recommendations that are designed to help NHSScotland improve how it listens to what people say about their experiences of using healthcare services. These findings have been informed by a review that sought to understand how well NHSScotland listens to people, how it is learning from their experiences to improve services, and how well supported people are to provide feedback in a meaningful way.

The review gathered views from patients and the public, included visits to all 21 of Scotland’s NHS Boards and involved conversations with a number of key national bodies.

The Scottish Health Council will continue to work with NHS Boards and national bodies with an interest in the recommendations in this report

The report was highlighted in National press on two occasions and has received a very positive response among boards and subject experts.

The report can be downloaded at http://www.scottishhealthcouncil.org/publications/research/listening_and_learning.aspx#.U2etM2xOXcs

Richard Norris
Director
Scottish Health Council
SUBJECT: Director of Finance and Corporate Services

1. Purpose of the report
This report provides the Healthcare Improvement Scotland Board with information on any other significant issues relevant to the overall programme of work associated with the Directorate of Finance and Corporate Services, but which is additional to the update provided in the Performance Report to the Board.

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

3. Key points

a) Healthcare Improvement Scotland – Future Funding Model
On 1 May 2014, a productive meeting was held with Scottish Government (SG) finance colleagues to discuss and agree the future funding requirements of the organisation. The risks encountered by the organisation as a result of the current funding model are well understood by SG colleagues who committed to speak with all relevant policy leads before the end of May to identify funds that can be incorporated within our baseline (core) funding. It was agreed that any changes will take effect from the 2015-16 financial year. An update of progress will be made at the next Board meeting in June.

b) Driving Improvement Working Groups – Progress Update
At our most recent meeting of the Chairs of the working groups it became clear that many of the original tasks had been completed. It was agreed that all working groups should revisit their original driver diagrams and refresh them as necessary to bring them up to date. Significant progress has been made in all groups and this is to be shared across the organisation when the strategy is launched.

A brief update from each of the groups is as follows:

a. **Strategy** – an internal engagement plan is being prepared to launch the strategy with staff. The objective being to raise awareness of our priorities and to create a consistent message about our purpose. (Chair is Maggie Waterston, Sponsor is CEO)

b. **Workforce** - this group has three sub groups that are responsible for creating the workforce plan, promoting the values and behaviours required by the organisation and addressing the learning and development requirements to be a high performing organisation. As part of their work they are also actively engaged in addressing the actions required by the Staff Governance Action plan and the actions identified by the staff survey. (Chair is Karen Ritchie, Sponsors are Duncan Service and Kathlyn McKellar)

c. **Non Pay Group** – scrutiny of all non-pay budgets continues with the current focus being on costs of conferences and events. This group has identified areas of saving to support the budget reduction in 2014-15 and are actively promoting the need for cost effectiveness across the organisation eg using computer
screensavers to promote cheaper travel options. (Chair is Anne Hanley, Sponsor is Robbie Pearson)

d. **Efficient Processes** – changes to some processes have already improved efficient working within the organisation eg introducing the electronic room booking system and making all diaries available to staff. Current focus is on standardising systems and templates. LEAN methodology is being introduced to ensure that more efficient ways of working are introduced. (Chair is Lesley Holdsworth who has just taken over from Sara Twaddle, Sponsor is Ruth Glassborow)

e. **External Engagement and Customer Focus** – an overarching communications strategy has been prepared which incorporates plans to address the following audiences: NHS Boards; independent providers; political; media and broader public; involving people; and clinical engagement. (Chair is Fiona Dagge Bell, Sponsor is Dr Brian Robson)

f. **Integration** – this group was looking at a very broad remit which included the methodology of how new work would be assessed in line with our revised priorities and also how indicators could be developed to assist with evaluation. It was recently agreed to review the remit of this group and this will take place before the end of May. (Chair is Donald Morrison, Sponsor is Richard Norris).

c) **Short Life Working Group on the Financial Implications of Approaches of Access to Medicines**

The finance team and SMC have contributed to this Scottish Government led short life working group. The draft report from the group is currently being finalised and will be discussed with the Directors of Finance at their meeting on 8th May 2014. Scottish Government colleagues have been grateful for the support provided by Healthcare Improvement Scotland and have been complementary about the detailed financial modelling that has been submitted to support this work.

Maggie Waterston
Director of Finance and Corporate Services
SUBJECT: Evidence, Improvement and Scrutiny 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 Evidence, Improvement and Scrutiny Committee meeting held on 17 April 2014.

2. Recommendation
   The Healthcare Improvement Scotland Board is asked to receive and note the key points outlined:

   a) The Scottish Medicines Consortium (SMC) is due to hold its first revised meeting with public representatives in May. It was noted that at present no evaluation programme is in place and the SMC were encouraged to implement same as soon as possible.

   b) The Committee was pleased to note good progress with the introduction of the new death certification scheme. It supported the concern expressed by officers that the multi-agency communication program has yet to be agreed and encouraged that this should be addressed as a matter of priority.

   c) The Committee looked forward to receiving a report on the QI May event and results of the QI diagnostic tool at its June meeting.

Professor Bob Masterton
Chair
Evidence Improvement and Scrutiny Committee
MINUTES – Approved

Meeting of the Evidence, Improvement and Scrutiny Committee, Public Session

Date: Thursday 27 February 2014 1pm – 4.35pm
Venue: Meeting Room 6a, Delta House, 50 West Nile Street, Glasgow

Present

Non-Executive Members
Michael Fuller  Non-Executive Director, deputising as Chair for Professor Masterton
Duncan Service  Non-Executive, Employee Director

Healthcare Improvement Scotland Officers
Brian Robson  Lead/Executive Clinical Director
Ruth Glassborow  Interim Director of Safety and Improvement
John Glennie  Interim Chief Executive (up to and including item 5.5)
Robbie Pearson  Director of Scrutiny and Assurance (up to and including item 5.5)

John Kinsella  Chair of SIGN
Philip Rutledge  Chair of SHTG (up to and including item 7.2)
Angela Timoney  Chair of SMC (up to and including item 6.4)

Public Partner
Eric Sinclair  (up to and including item 6.5)

In attendance
Gareth Adkins  Implementation and Improvement Team Lead (item 6.5 and up to and including item 6.7)
Colin Bell  Data and Measurement Advisor (item 6.2)
Susan Brimelow  Chief Inspector (item 6.2)
Fiona Dagge-Bell  Chief Nurse, Midwife and Allied Health Professional
Pauline Donald  Corporate Governance Manager, Glasgow (up to and including item 5.3)
Jennifer Graham  Programme Coordinator
Laura McIver  Chief Pharmacist (up to and including item 6.2)
Simon Mackenzie  Clinical Advisor, Data Measurement and Business Intelligence Team (item 5.5 and up to and including item 6.2)
Donald Morrison  Head of Data Measurement and Business Intelligence (up to and including item 6.2)
John Porter  Prisoner Healthcare Lead Nurse (item 6.2)
Karen Ritchie  Head of Knowledge and Information
June Wylie  Head of Implementation and Improvement (up to and including item 7.2)

Committee Support
Lesley Forsyth  Committee Secretary

Apologies
Bob Masterton  Non-Executive Director, Chair
Denise Coia  Chairman, Healthcare Improvement Scotland
Norman Gibb  Public Partner
Sara Twaddle  Interim Director of Evidence
1. OPENING BUSINESS

1.1 Welcome

The Chair welcomed all present to the public session of the Evidence, Improvement and Scrutiny Committee (EIS). Attendees introduced themselves.

1.2 Apologies for absence

Apologies were noted as above.

1.3 Minutes of meeting held on 13 November 2013

The minutes of the meeting held on 13 November were approved. The approved minutes would be submitted to the March Board meeting.

1.4 Review of action note register: 13 November 2013

The Committee reviewed the action point register from the meeting held on 13 November 2013 and received updates on the following actions:

Item 2.1 OP9 Patient safety - The Interim Director of Safety and Improvement reported that the risk had been reclassified to highlight the work in place and was still live on the new risk register. Discussions were ongoing with Scottish Government. Progress had been made in clarifying the safety work and on delivery for next year.

6.6 Taught programmes - The Director of Safety and Improvement reported that NES have established a Programme Board and that the transfer for 1 April 2014 was going to plan. Both she and the Executive Clinical Director were involved in the governance arrangements and would have ongoing input to delivery. The Executive Clinical Director confirmed that the planned governance arrangements he anticipated would meet the requirements of the clinical engagement strategy.

The Committee noted that all action points were complete or included in the agenda.

2. COMMITTEE GOVERNANCE

2.1 Risk Management for Evidence, Improvement and Scrutiny Committee

The Chief Executive reported that the risk register had been to the Board and the Corporate Management Team (CMT). He highlighted the yellow risk scrutiny findings. The Director of Scrutiny and Assurance confirmed there was robust quality assurance of reports ahead of publication. He also confirmed that there would be continued vigilance by this Committee and the Board around death certification.
2.2 Evidence, Improvement and Scrutiny Committee Annual Report 2013/2014

The Executive Clinical Director presented the draft annual report. Pauline Donald confirmed that, the governance map at Appendix 3 and terms of reference will be updated to reflect the recommendations from the Internal Audit review of governance committees.

The Chair of SMC confirmed that a final draft of the SMC governance review would be submitted to the April EIS Committee.

The Committee agreed that health technology chairs should be more directly involved with the Committee and work more closely together to develop governance arrangements in Board papers. It was agreed that the EIS Committee would provide governance of SMC, SIGN and SHTG.

The Committee agreed to add a fifth point in the Recommendations section looking to the future regarding how the changes in assessment of introduction of new medicines affect technologies.

The Chief Executive requested an amendment be made to the second point in Looking to the future regarding 'local' NHS Board Clinical Governance committees to be widened to cover others not just territorial boards.

The final version of the annual report would be submitted to the May Board meeting.

2.3 Declarations of interest

The Chair reminded members to declare any potential conflicts of interest. None were raised.

3. STRATEGIC BUSINESS

3.1 Business intelligence Strategy - update on progress

The Head of Data Measurement and Business Intelligence confirmed that the draft had been revised to include recent feedback from the Executive Team and the Corporate Management Team. A detailed business case and work plan to enable implementation of the strategy would be developed and brought back to the June EIS Committee meeting.

He reported that a Business Intelligence Programme Board had been established, which he chaired, and he thanked Michael Fuller and Campbell McLundie of Scott Moncrieff for their input. He emphasised that IT was critical but subservient to the strategy and business intelligence requirements.

There was discussion on how to make the best use of intelligence, enhance what is currently available, and how to
make clearer the difference between internal and external facing intelligence work. The Strategy document stated explicitly that different data was collected for different purposes. A key message was that external work could not be jeopardised.

There were no new resources regarding the Business Intelligence framework. Resources would be addressed in more detail in the business case. How national organisations work together in relation to intelligence agenda, how roles complement each other and how to capitalise on efficiency savings would also be addressed.

The Committee noted the importance of the patient experience and the inclusion of qualitative data.

The Chair of SIGN suggested that, to prepare for centralised information collection with the organisation, different parts of the organisation should be sorting out their data and linking data together.

The Head of Data Measurement and Business Intelligence confirmed that the Driving Improvement programme was addressing internal processes, streamlining and standardising work already in place.

The Committee welcomed the document and noted progress. The Strategy would be submitted to the 26 March Board meeting for approval.

The Executive Clinical Director recorded thanks to Donald Morrison and Peter Christie for their work.

4. STANDING BUSINESS

4.1 Healthcare Improvement Scotland 2013/14 Local Delivery Plan

The Chief Executive reported that the Local Delivery Plan had been submitted to Scottish Government on 14 February. He confirmed that he had a meeting with Finance and Policy colleagues at Scottish Government in early March to discuss resources and that he had met with the new Policy Director Michael Kellet. Discussion was required on matching resources with expectations.

The Chief Executive informed the Committee that HIS had the highest percentage cut of any Board in Scotland which may reflect the previous programme based approach by NHS Quality Improvement Scotland /HIS ie that such programmes could simply be stopped in line with budget cuts.

The Executive Clinical Director confirmed that non-Executives had been able to input to the content of the LDP following full discussion at the last Board meeting The Director of Scrutiny and Assurance asked that there be closer alignment between the LDP and Scrutiny and Inspection Plan.
The Committee noted the latest position.

4.2 Business planning schedule for the Evidence, Improvement and Scrutiny Committee

The Executive Clinical Director presented the updated schedule showing the current and forthcoming year and advised the Committee that, following a review of governance, changes may be made to the Committee structure and that items may be allocated appropriately across the new structure. He invited new members to contribute to the schedule.

5 EVIDENCE

5.1 Knowledge Management Strategy Annual report and 2014-2015 Action Plan

The Head of Knowledge and Information presented the Annual report for the period 2013-2014 and the new Action Plan of 2014-2015. She confirmed that her team supports the whole of the organisation in particular SIGN but needed to become more proactive in supporting other parts of the organisation. Embedding knowledge brokers in to teams eg Improvement and Implementation and Safety and Improvement had proved to be very successful and had helped build the expertise of the staff.

The Head of Knowledge and Information reported that the national subscriptions procedure was changing and that access to records through databases and journals would become more expensive due to a funding cap of £2.5 million within NES. This would impact upon the organisation’s assessment methodologies. There would be more emphasis on synthesised evidence in the form of summaries and guidance.

The Chair of SMC congratulated the Head of Knowledge and Information and her team on the complex and challenging work they did for SMC.

The Committee noted the report and approved the new Action Plan.

5.2 Information Governance Strategy Annual report and 2014-2015 Action Plan including Diagnostic Review report re risks and further steps

The Executive Clinical Director congratulated Alison Winning and Karen Ritchie on their work and in refocussing effort and resource in line with the EIS Committee’s direction in 2013. The Head of Knowledge and Information confirmed that more resources and energy had been put in to the diagnostic review of information governance controls. The recommendation from the review, although not mandatory, was that staff training, risk assessment and policy could be strengthened by implementing an accountability framework. The Information Risk Owner for the organisation was the Head of Finance and Corporate Support,
Maggie Waterston.

Training of information asset owners, responsible for maintaining information assets, would take place over the next few weeks. The Committee noted that a short term resource had been secured for nine months to support a formal plan for records management and Freedom of Information and that a separate business case needed to be made for moving towards electronic record management.

The Committee noted progress and approved the proposed one year extension to the current 2011-14 strategy and the Action Plan for 2014/15.

5.3 Research Governance Update and Research Strategy Annual Report

The Executive Clinical Director reported that Professor Masterton had been asked to establish a small working group including Graham Teasdale, David Steel, Lewis Ritchie, John Gillies and Denise Coia. The organisation needs a more systematic approach to producing research, develop relationships with the research community and encourage staff to publish areas in which they are involved.

The Head of Knowledge and Information highlighted a number of collaborations with research organisations including the Health Services Research Unit in Aberdeen, Universities of Dundee, Edinburgh and the West of Scotland and the Scottish Improvement Science Research Collaborating Centre (SISCC).

She confirmed that four areas identified in the research gaps will be further scoped and proposals for addressing these gaps considered and presented to ET to request the appropriate support.

The Committee noted for assurance the two new research projects and HIS’s strategic approach to engaging with the Scottish Improvement Science Research Collaborating Centre (SISCC). It also noted the Annual Report highlighting research strategy progress, the prioritised research gaps identified and the recommendation that HIS will not provide financial support for unsolicited primary research projects.

Head of K&I
5.4 Medicines Strategy

This item was taken prior to 5.1.

The Chief Pharmacist highlighted key points from the Annual report for 2013-2014, and the Action Plan for 2014-2015. The focus of the medicines team has been developing key strategic alliances and partnerships with those who have an interest in safe and effective use of medicines in Scotland, identify and deliver the aspects of the national agenda in relation to medicines and provide ongoing advice and assurance to support the medicines elements of the organisation’s work programme. Examples of collaboration with key stakeholders were included in the report and a range of outputs described including the production of a guide for implementing electronic prescribing.

(The Business Manager, Glasgow left the meeting.)

The Chief Pharmacist explained that one of the challenges was that work was unpredictable eg the need to respond to legislative or regulatory changes such as the decriminalisation of dispensing errors. She reported that significant unplanned pieces of work, one for NHS Ayrshire and Arran and another the development of a national framework for the use of chemopreventative treatment for women with familial breast cancer, had impacted on the regular business.

An Internal Audit re delivery of strategy had been considered in detail at the Audit Committee and discussed by the Executive Team and had proved to be positive overall. It was acknowledged that programme management and project management needed to be better documented and that resources to deliver this important work should be reviewed.

A policy document ‘Prescription for Excellence’ published in September 2013 describing a 10 year vision for pharmaceutical care in the community would have a significant influence on the future medicines strategy from 2015.

The Committee noted that the Executive Team would discuss the issue of resources as to whether they were appropriate or whether, in order to sustain the work, this needed to be taken up with Scottish Government.

The Committee welcomed the suggestion of a health technologies strategy to supplement the Medicines Strategy. This would be a substantive item for the EIS Committee. The Chief Pharmacist agreed to discuss this at OMTG and bring a future delivery plan to the EIS during 2014-15.

The Executive Clinical Director commended the work done and suggested that the Medicines Strategy be included as a key point to the Board as a mechanism to highlight the importance of the work and the need for additional resources.

The Committee noted the report and action plan.
5.5 Overarching Medicines and Technologies Group including annual reports from SIGN, SMC and SHTG and 2014-15 OMTG Action Plan

The Executive Clinical Director thanked the Chairs of SIGN, SMC and SHTG for their input.

(Simon Mackenzie joined the meeting.)

The Chief Pharmacist reported that work had been refocused to concentrate on strategic leadership and areas for collaborative working. The next meeting of OMTG would focus on innovation.

The Chair of SIGN commented that the SIGN website receives over 1.5 million hits a month. In addition to dealing with guidelines for specific diseases, SIGN was moving towards including broad topics eg chronic pain which led to more clinical engagement and had more usability across the whole of the service.

The Chair of SHTG highlighted a number of successes of the group including ongoing support to NHSScotland boards regarding the clinical and cost effectiveness of existing and new technologies likely to have significant implications for patient care in Scotland; and ongoing support for the National Planning Forum including providing timely evidence review and advice on a number of topics eg transcatheter aortic valve implantation (TAVI).

Plans for 2014-2015 included piloting the development of a primary submission process to enable manufacturers and other stakeholders to make a direct case for the adoption and diffusion of a non-medicine technology within NHSScotland. This is a new area requiring processes to be developed which will impact on the resources of the organisation.

The Chair of SMC reported on the challenges presented by the implementation of the reviews of the managed introduction of new medicines in response to the Health and Sport Committee Inquiry on access to new medicines. She also reported that SAPG continues to lead Health Boards Antimicrobial Management Teams and is making a significant contribution in several high priority clinical areas.

The focus for 2014-2015 is a complete review of processes to implement and embed the recommendations coming from the government response to Health and Sport Committee including developing processes for end of life and those with rare conditions.

The Chief Executive commented on the challenge in securing funding from the Government to do this work and to complete the work within the given deadlines bearing in mind that much of the work needs recruitment of staff. The Chair of SMC commented that confirmation of resources to deliver to timelines that the Cabinet Secretary has requested was required by the end of the
month or deadlines may slip.

The Committee welcomed the report including annual reports from SIGN, SMC and SHTG and the 2014-2015 Action Plan.

The Chair welcomed Simon Mackenzie.
The Chief Executive and Director of Scrutiny and Assurance left the meeting.

6. IMPROVEMENT AND IMPLEMENTATION

6.1 Clinical Engagement Strategy Annual report

The Chief NMAHP presented the annual report reviewing activity against the Action Plan for 2013-2014. She reported that, a 90 day process, due to finish on 6 March 2014, was being used to refresh the clinical engagement strategy for 2014-2016 and establish a framework to strengthen the organisation’s approach to clinical engagement making sure the strategy is fit for purpose and the right clinicians to work with are engaged. She highlighted the driver diagram in Appendix 2 indicating the activity to be undertaken over the next year.

Jennifer Graham presented the results of the survey of 219 respondents including nurses, hospital doctors, general practitioners, pharmacists, midwives and AHPs and the key messages which emerged through interviews with key stakeholders and data collected via an online survey. JW explained the low response from AHPs was possibly due to a shift in the work programme away from areas where they focus their work. In the light of this Eric Sinclair queried whether there was a message to be taken away about the work plan to ensure relevance to AHPs.

The Committee noted the issues around capacity and resources and that this was being progressed in the workforce plans.

It was acknowledged that further work needed to be done to continue to improve engagement with clinicians, particularly those directly involved in delivering patient care, in future LDP planning. Simon Mackenzie suggested using the deanery structure.

The Chief NMAHP reported that clinical engagement was one of the strands of work included in the Driving Improvement work and a refreshed strategy would be submitted to the March Board meeting.

The Committee noted the report, survey results and key themes and driver diagram.

The Executive Clinical Director and Chair recorded their thanks to the Chief NMAHP and Jennifer Graham.
6.2 Hospital Standardised Mortality Ratio (HSMR) update on progress

The Head of Data Measurement and Business Intelligence provided an update about progress in developing recommendations about the future of the Hospital Standardised Mortality Ratio (HSMR) in Scotland.

The Committee noted that an HSMR SLWG had met on 12 February 2014 to consider its draft recommendations including a suite of metrics on quality and safety; use and presentation of HSMR as a flag and not to make judgements; operational improvement support to improve the understanding and use of HSMR and be more active in promoting the updated HSMR Guide for Boards; and better understanding of the statistical model used to produce HSMR. The SLWG is aiming to produce its final recommendations in March 2014 and EIS Committee will be updated at the June meeting.

Simon Mackenzie emphasised that HSMR was a controversial issue. He clarified that comparisons are not done between hospitals and that HSMR on its own is not a direct measure of quality/safety but that the HSMR are published in order to be transparent. A challenge was how to make HSMR understandable for the public given that ratios are ranked by the press from high to low. Data needed to be put in context and handled in an appropriate way. Simon Mackenzie offered to deliver a seminar for SPSP Programme Managers.

(The Chief Pharmacist left the meeting. The Chief Inspector and John Porter joined the meeting.)

The point was made that whilst internal investigations, which staff have bought in to, are drivers for improvement, external investigations which are imposed are different.

The Committee noted the update and the summary of feedback on the recommendations.

Simon Mackenzie and Colin Porter left the meeting.

The Chair invited the Chief Inspector and John Porter to introduce themselves.

6.3 Quality Improvement Hub Strategy update against Action Plan

The Director of Safety and Improvement provided an update on the NHSScotland Quality Improvement Hub (QI Hub) and HIS key deliverables.

The report highlighted a lack of clarity on how performance against the QI Hub plan is managed across the key partners. The Boards require national and special health boards to work together on areas where we interface and the onus is on this organisation to ensure the Hub focuses on things that can only
be done in partnership. Work has been initiated to review the model of delivery and the changes needed to enhance partnership working and at the same time to review the aims and work programme. A clear framework for performance management will be established.

The Head of Implementation and Improvement confirmed that Boards would set up their own hubs and be supported by HIS. She reported that the QI Hub is leading a four phase programme which aims to understand how to create the best available conditions to encourage reliable and effective spread and sustainability of improvements. Boards decide on which clinical areas to take forward based on local and national pressures.

The Committee noted the work currently in place to review the delivery model and work plan for the QI Hub and noted the update on progress against the operational Action Plan.

6.4 Person-Centred care

The Director of Safety and Improvement invited Gareth Adkins to provide an update on the progress to date of the Person-Centred Health and Care (PCHC) Collaborative.

Gareth Adkins thanked the Committee for the opportunity to present at the development session of the last Committee. Following that session a new governance structure had been put in place. A Person-Centred Health and Care Collaborative Operational Delivery group will provide operational governance for the duration of the collaborative and will report to the EIS Committee via the Executive Team and to the Board as directed by this Committee. Funding for an additional improvement adviser and of the collaborative will be extended to December 2015.

The aim of the collaborative was by December 2015 for each test team and the people using their services, 90% of people will have a positive experience of care and get the outcomes they expect. It was also agreed that HIS will work with Scottish Government and senior leaders in each health board to agree a rate of spread of test teams, and a distribution of test teams that encompasses a range of healthcare settings and contexts to ensure future spread of person-centred approaches across all of Health and Care. A project team will be established to develop an agreed reporting mechanism to measure and monitor progress against milestones and final outcomes for the Collaborative. A report would be brought back to the June EIS meeting.

(The Chair of SMC left the meeting.)

The Committee noted the changes to the scope, aims and outcomes for the Person-Centred Health and Care Collaborative agreed with Scottish Government; the successful delivery of the key elements of infrastructure to support the Collaborative and the measures to ensure stronger governance of the Collaborative and improved reporting of progress against milestones and final
outcomes.

6.5 Releasing time to care

The Director of Safety and Improvement provided a final update on the Releasing Time to Care (RTC) Programme run by HIS between October 2011 and October 2013. The final report was published in December 2013. Two positive press articles have since been published.

The national programme was effective in spreading RTC through increasing the number of teams across NHSScotland able to use the tools and methods to improve the way they deliver health care. Examples of the impact are included in the final report.

Boards would take responsibility for the programme via a network of leads and facilitators and would be self governing. Eric Sinclair asked to revisit this in a year’s time to see if systems are embedded.

The Committee noted the report.

(Eric Sinclair left the meeting.)

6.6 Healthcare Improvement Scotland Clinical Forum – key points

The Chief NMAHP provided an update on the three key issues arising from the Clinical Forum meeting held on 24 January 2014.

The Committee received and noted the key points outlined.

6.7 Primary Care Out of Hours National Quality Indicators Programme update

The Executive Clinical Director reported that this programme had been well received in the service and would give some confidence to the public given that there had been significant concerns raised about the quality of out of hours services in the past.

Gareth Adkins reported that Phase 3 is due to conclude at the end of March 2014. From April 2014 NSS will provide the data for all services.

Two indicators will require Boards to have appropriate resources to support services in local data collection, analysis and use in driving improvement. Given the difficulties in filling rotas over weekends and at peak demand periods some Boards have provided extra funding to attract clinicians to PCOOH services. However difficulties remain in filling rotas and feedback from Boards indicates that further resources are required.

Discussion is ongoing with Scottish Government to support targeted work around asthma indicators and accuracy of triage for home visits.
The Executive Clinical Director recorded thanks to Douglas Dean, Clinical Lead for the Programme, who finishes at the end of March.

The Committee noted the progress in achieving phase 3 outcomes Appendix 1 and noted the issues raised in data capture and workforce sustainability that are impacting on the ability of NHS Boards to implement the indicators and measure improvements in service delivery.

7 SCRUTINY

7.1 Draft Scrutiny and Inspection Plan 2014-2015

This item was taken after 2.3.
The Director of Scrutiny and Assurance provided an update on the consultation between December 2013 and 21 February 2014 on Help us shape the scrutiny of your healthcare informed development of the draft Scrutiny and Inspection Plan: Contributing to the 2020 Vision for Healthcare highlighting the key themes.

There was recognition, post Francis and Keogh, that scrutiny needs to be proportionate and intelligence led. To ensure improvement better alignment was required between findings and recommendations eg older people’s nutrition and cognitive screening and the marshalling of separate streams of work in the Boards.

The Executive Clinical Director reported on an older people’s improvement event demonstrating inspection and improvement working closely together which received positive feedback from Boards. A number of Royal Colleges and the British Geriatric Society (Scotland) had signed up to work with HIS in the future on the older people’s work.

The Director of Safety and Improvement confirmed that the experience of individual patients and staff is captured in the local data.

A final draft would be submitted to the Cabinet Secretary for approval early March 2014, the final version presented to the March Board meeting and the report published on the HIS website 1 April 2014.

The Committee noted the update.

7.2 Healthcare Improvement Scotland's role in prison inspections including evaluation of findings from prison inspections

The Chief Inspector presented the key messages regarding the inspection of prison health care. Her Majesty’s Chief Inspector of Prisons (HMCIP) is accountable for all aspects of the inspection of prisons. Healthcare Improvement Scotland assists by providing health inspectors and where necessary clinical advice. The Chief
Inspector of Prisons owns and publishes the reports. The Chief Inspector reported that she has delegated responsibility for inspection of prison health care and that two new inspectors have been employed, one experienced in mental health and one with considerable prison experience.

The Chief Inspector acknowledged the support in providing clinical assurance from the Clinical Directorate in particular the Chief NMAPH and Executive Clinical Director.

The paper identified the emerging themes and priorities for improvement that have been identified in HMCIP inspection of Scottish Prison reports in the year 2012 - 2013. The information that has been extrapolated relates to the recommendations made in respect of healthcare against the standards specified by HMCIP for Scotland.

John Porter reported that Scotland is a world leader in prison health care and that huge improvements have been made in the last 10 to 15 years. The NHS would be involved in developing standards used in prison inspections and a clear message given that standards are the same as for the NHS. There was discussion around whether prisons do get equitable health care.

Healthcare Improvement Scotland will cease to host the National Prisoner Healthcare Network (NPHN) after March 2014. Discussion is ongoing regarding whether a new post created by Scottish Government of NHS Director, Justice and Health, will take on the role of chair of the NPHN. A need for ‘back office’ support has been identified to support this new role and explores the provision of professional input to the NPHN, the Forensic Network and the Policy Custody network.

The Chief Inspector confirmed that HIS has no improvement plan in place as the reports are the responsibility of Prison Governors and Chief Executives of Health Boards. She also confirmed that the Healthcare Environment Inspection reports are made public. Any major health issues need to be flagged up to the Health Minister.

The Committee noted the report.

The Executive Clinical Director thanked the Chair of SHTG for attending the meeting and recorded thanks also to the Chair of SMC both of whom demit office at the end of March 2014.

(The Head of Implementation and Improvement and the Chair of SHTG left the meeting.)

8

CLOSING BUSINESS

8.1 Board report: three key points

The Committee agreed to submit the following key points to the March Board meeting:
a) Medicines and Clinical Engagement Strategies - The Committee noted the successful progress of the Medicines and Clinical Engagement Strategies and highlighted the need to ensure appropriate resources are prioritised to deliver these key pieces of work.

b) Business Intelligence strategy – The Committee welcomed the revised version of this document which underpins our new corporate strategy and recommends it to the Board.

c) Completion of work – The Committee welcomed the successful conclusion of the Releasing Time to Care work and the completion of the Out of Hours Indicators project.

8.2 Any other business

The Executive Clinical Director recorded his thanks to Michael Fuller for his commitment and dedication to the Committee over the last three years.

Peter Christie joined the meeting at the break to receive a presentation from the Executive Clinical Director on behalf of the Committee as he was retiring.

9 DATES OF NEXT MEETINGS

Dates in brackets are corresponding Wednesday Board meeting dates at Delta House, Glasgow

(26 March*)

Thursday 17 April – Meeting Room A Gyle Square Development Session 10am -12pm plus Gyle Square Boardroom 1, Ground floor (20 max) from 12pm (14 May 2014)

Thursday 12 June Delta House 6a and 6b, (25 June 2014 and 30 July 2014)

Thursday 21 August Delta House 6a and 6b, (24 September 2014)

Thursday 9 October Gyle Square Boardroom level 2 (17 December 2014)

Thursday 18 December Gyle Square Boardroom 2, Ground floor (25 February 2015)

Thursday 19 February 2015 Delta House 6a and 6b.
SUBJECT: Scottish Health Council – 8 April 2014: key points

The following key points come from the meeting of the Scottish Health Council on 8 April 2014. Council committee members were pleased that the Chair of Healthcare Improvement Scotland joined them for the meeting.

1. **Scottish Health Council Operational Plans.** The Council committee members considered the outcome and output from 2013-2014 and the draft of the 2014-15 plan. The draft 2014-15 report has been aligned to the Healthcare Improvement Scotland Driving Improvement Strategy, the Healthcare Improvement Scotland Local Delivery Plan and the Engaging People Strategy.

2. **Health and Social Care Integration.** This remains a key area of interest and concern for the Council. Whilst the benefit of integration is widely acknowledged, there are concerns about maintaining and ensuring adequate patient and public engagement and that any such engagement should be effective and meaningful. The Committee is keen for Scottish Health Council officers to continue to work with the pilot areas and ensure that the momentum is not lost with the formal introduction of guidance in respect of the new structures.

3. **Complaints and Feedback report:** Following the introduction of the Patients Rights Act NHS Boards were required to produce an annual report which was to include information on how feedback and complaints were used to improve services. The Scottish Health Council was asked by Scottish Government to provide an analysis of these reports which was duly published in January 2014. As a result of the considerable variability in the level of detail in the NHS reports, Ministers asked the Scottish Health Council to undertake a further piece of work in order to obtain a more thorough picture and make recommendations. This follow on report will be published at the end of April.

Pam Whittle, Chair
Scottish Health Council
8 April 2014
MINUTES - approved

Meeting of the Scottish Health Council
4 February 2014
Meeting Room 4, Delta House, 50 West Nile Street, Glasgow G1 2NP

Present
Pam Whittle Chair
Laura Borland Member
Helen Cadden Member
Carol Vanzetta Member
Peter Johnston Member
Michael Fuller Member

In attendance
Richard Norris Director
Sandra McDougall Head of Policy
Pauline Boyce Head of Operations

Committee support:
Linda Bickerton Committee Secretary

1  WELCOME AND APOLOGIES FOR ABSENCE

1.1 The Chair thanked everyone for attending and confirmed that there were no apologies so we had a full team present. The Chair then announced that this was the last Committee Meeting to be attended by Michael Fuller as his term of office with the Healthcare Improvement Scotland Board ceases on 31st March 2014. This is due to a Government recommendation that any Healthcare Improvement Scotland Board Members should not also serve as Members on another NHS Board.

1.3 Minutes of meeting held on 14 October 2013

The minutes of the meeting held on 14 October 2013 had been approved as read by email process due to the December Committee meeting date being utilised for a Strategy Day rather than a formal meeting.

1.4 Matters Arising

The Chair asked for any matters arising which were not covered later in the meeting.

The Chair and the management team had recently met with Paul Gray, the new Director General Health and Chief Executive of NHS Scotland. Rhona Dubery, our sponsor and Maureen Bruce also attended the meeting which was fairly informal. Paul Gray previously worked in Information Technology and is keen to promote social media usage. He also spent time working in the Government Health Department on Primary Care so has a previous
understanding of Scottish Health Council work. The Director added that Paul Gray is committed to improving patient experience and promoting social media, he believes that patient experience will frame what happens next in the NHS. The Scottish Health Council work on strengthening and supporting the patient and public voice was discussed and Paul Gray was very supportive of the approach and direction being taken by the Scottish Health Council.

There were no further matters arising.

2 COMMITTEE GOVERNANCE

2.1 SHC - Operational Plan – 2013/2014

The Director commenced this discussion by confirming that we would look at the plan on the usual exceptions basis and that a full evaluation covering the 2013/2014 period would be brought to a future Committee Meeting.

Page 1 – Participation Toolkit – deliver awareness sessions for SHC staff. Helen Cadden asked why this action was marked as amber. The Head of Operations explained that this was due to capacity issues as our social researcher had needed to concentrate on other work but we plan to bring in an external facilitator to get the sessions delivered.

Page 13 – Complaints and Feedback approaches – Jacki Smart and Liz Taylor have now commenced their planned visits to Boards to gather the information required and the local offices are holding focus groups in tandem to collect public opinion on the subject. A final analysis report is expected to be published in April 2014.

2.2 Operational Plan – 2014/2015

The Director reported that work was underway on preparing the full Local Development Plan for Healthcare Improvement Scotland which will be submitted to Scottish Government for approval at the end of March. The Scottish Health Council individual Operational Plan for 2014/2015 will be brought to the next Committee meeting in April.

2.3 Risk Register

The Head of Operations reported that she had recently received training on the compilation of the new risk register currently being developed and a new template has been created. At the moment the risk description and risk scoring is being worked on and managers are encouraged to take ownership of their own specific directorate risks.

The Chair commented that the Risk Management issue has been debated at length by the Audit Committee and developing the new approach has been a lengthy process but she feels we are now making good progress.
3 STRATEGIC BUSINESS

3.1 Engaging People Strategy

The Head of Policy reported that the Engaging People Strategy forms part of a broader Communication and Engagement Strategy to support delivery of Healthcare Improvement Scotland’s Driving Improvement Strategy. This is a strategic document which examines priorities for involvement in the design and delivery of healthcare policy services. Our aim is to ensure we have a sustainable, effective and progressive approach to engaging with external stakeholders. Staff have been fully consulted during the process and their input has been incorporated into the draft strategy document.

The Chair queried whether the document was written for outside stakeholders or for internal staff.

The Head of Policy explained that it had been written for a broad range of people and there have been various methods undertaken to obtain input and feedback. The Strategy document is very much a work in progress which is likely to change but the substance will remain intact. The Committee will be kept updated on progress of the Driving Improvement Strategy as it develops.

3.2 Update on Public Partner Review

The Head of Policy outlined the progress to date on the Public Partner Review process, explained that the paper summarised the conclusions from the review and confirmed that these conclusions would now be incorporated into the Operational Plan for 2014-2015.

The Head of Policy announced that we have recently achieved re-accreditation of the Investing in Volunteers Standard for a further 3 years and the award certificate will be presented at the Public Partners Conference on 6th February.

3.3 Complaints and Feedback Overview

The Head of Policy introduced a paper which provided an update on the work being carried out to increase understanding of the use of feedback, comments, concerns and complaints in NHS Scotland and to identify potential areas for improvement.

Our initial desktop analysis of Board Reports on Complaints showed a large variation in how the NHS Boards produce their annual reports on complaints received. We published this analysis as a report in January and have commenced the second strand of this project which involves meeting with Boards in person and holding local events to also consider public opinion. We are hoping to identify pockets of good practice which will help Boards to produce better reports in future.

A further update will be provided to the Committee at the next meeting in April.
The Chair confirmed that this is a really important piece of work.

3.4 Scottish Health Council Role – Strategic Direction

The Director reported that this paper was an update on an earlier report to Committee where the initial thoughts have now been developed to outline our direction of travel and opportunities for change.

Our role is to strengthen the patient and public voice but we want to focus on how we do that effectively and support patients to be engaged. We want to question whether our role fits with statute requirements and whether we need to change the strategic description of our role.

The main points which emerged following consultation with staff were:-

- Current role versus future role
- Capacity to adopt requirements for new work
- Consideration of new technologies
- Any new role in the emerging integration agenda

The Director proposed as a next step that we hold a dedicated staff meeting in March 2014 to discuss the strategic and practical implications in order to produce a role descriptor and action plan. After this event it is proposed that we organise a broader stakeholder event in the summer which would involve patients and the public as well as Scottish Government, NHS, Local Authority and Third Sector representatives to achieve the objective of strengthening the patient and public voice in Scotland.

Committee agreed approval for the Director to proceed with the proposals put forward.

3.5 Participation Standard Update

The Head of Policy outlined how the Participation Standard was originally developed to allow Boards to demonstrate in a more cohesive way their approach to patient and public participation. Since then Boards have continued to develop their approaches and demonstrated genuine improvement in their processes and practice of participation in the past two years.

The Scottish Government has indicated that it is content to explore a single standard for participation in the context of integrated health and social care services and we have confirmed that we would be happy to be involved in developing this.

3.6 Health and Social Care Integration – Pilot update

The Head of Operations explained that the Scottish Health Council is currently working with Midlothian Council and NHS Lothian to develop a public involvement structure for their integrated partnerships. We are facilitating a public involvement mapping exercise, developing priorities for public involvement in health and social care in Mid-Lothian and looking at what structures are need to achieve these priorities.
We have also consulted with Public Partnership Forums in the Greater Glasgow & Clyde Health Board area. We are considering what methods of public involvement may need to feature in the new Integrated Health and Social Care Partnerships and what indicators would show that public involvement has been successful.

Peter Johnston asked if we had any links with the Scottish Government Joint Improvement Team. The Head of Operations said we have spoken to the Joint Improvement Team and asked about public involvement. The team responded that it was something they hoped to look at within the next 6 months.

4. ANY OTHER BUSINESS

The Chair reported that John Glennie would be leaving the organisation at the end of March and the recruitment process to identify a new Chief Executive for Healthcare Improvement Scotland was expected to be concluded by end February.

The Chair then formally closed the meeting.

5. DATE OF NEXT MEETING

10.00 – 13.00 Tuesday 8th April 2014

in Meeting Room 4, Delta House, Glasgow