Staff Governance Committee

06 March 2020, 10:00 to 12:00
Staff Club

Agenda

1
Apologies for Absence

Margaret Wells

2
Declaration of Members' Interests

Margaret Wells

3
Development Presentation: Resilience

Dr Mairead MacLennan

4
Minutes of Previous Meeting held on 17 January 2020

Margaret Wells

Item 4 Staff Governance Minutes 17 01 20.pdf (8 pages)

5
Action List

Margaret Wells

Item 5 Table of Actions from mtg on 17.01.20.pdf (1 pages)

6
Matters Arising

Margaret Wells

7
GOVERNANCE

7.1
Board Assurance Framework - Staff Governance Risks

Linda Douglas

Item 7.1 NHS Fife Board Assurance Framework (BAF) V18 - Workforce Sustainability.pdf (1 pages)

Item 7.1 BAF Risks - Workforce Sustainability Linked Operational Risks as at Febr.pdf (1 pages)

Item 7.1 BAF Risks - Workforce Sustainability Linked Operational Risks at 2102202.pdf (3 pages)

7.2
Review of Committee's Terms of Reference

Gillian MacIntosh

Item 7 2 Staff Governance Terms of Reference.pdf (6 pages)

7.3
Committee Self-assessment Report

Gillian MacIntosh

Item 7 3 SBAR Committee Self Assesment report Staff Governance.pdf (9 pages)

7.4
Annual Accounts - Progress Update on Audit Recommendations

Gillian MacIntosh

Item 7 4 Staff Governance Annual Accounts Audit Recommendations.pdf (14 pages)

7.5

Annual Workplan 2020/21

Bruce Anderson

Item 7.5 Draft SGC Annual Workplan 2020-21.pdf (2 pages)

7.6

Whistleblowing Standards

Bruce Anderson

Item 7.6 Whistleblowing standards SBAR.pdf (4 pages)

Item 7.6 The National Whistleblowing Standards.pdf (92 pages)

8
PERFORMANCE

8.1

Integrated Performance & Quality Report

Linda Douglas

Item 8.1 IPQR SG Committee SBAR.pdf (2 pages)

Item 8.1 IPQR Feb 2020.pdf (43 pages)

8.2

Attendance Management Update

Item 8.2 Staff Governance Attendance Management Update.pdf (5 pages)

8.2.1

Audit Report update

Bruce Anderson

Item 8.2 a Staff Governance Audit Report B23A - Attendance Management.pdf (3 pages)

Item 8.2a Appendix 1 B23A-20 Attendance Management Audit Report.pdf (18 pages)

8.2.2

BAF Risk update Item 527

Bruce Anderson

Item 8.2b Staff Governance Report - Sickness Absence Risk 527 Update.pdf (3 pages)

8.3

Well at Work

Bruce Anderson

Item 8.3 Staff Governance Well at Work Update.pdf (2 pages)

8.4

iMatter Update and Health & Social Care Staff Experience Report 2019

Bruce Anderson

Item 8.4 SBAR Health & Social Care Staff Experience Report iMatter for SG.pdf (4 pages)

Item 8.4 iMatter Health & Social Care Staff Experience Report 2019.pdf (88 pages)

9
STAFF GOVERNANCE STANDARDS

9.1

Staff Governance Draft Action Plan 2020/21

Bruce Anderson

Item 9.1 Draft Staff Governance Action Plan (2 pages)

SBAR.pdf

Item 9.1 Appendix1 NHS FIFE STAFF GOVERNANCE ACTION PLAN 2019-20 Draft.pdf (10 pages)

9.2

Staff Governance Monitoring Return update 2019/20

Bruce Anderson

10
ITEMS FOR INFORMATION/NOTING

10.1

Minute of the Area Partnership Forum, 22 January 2020

Item 10.1 APF Minutes 220120.pdf (7 pages)

10.2

Minute of the Acute Services Division & Corporate Directorates LPF, 19 December 2019

Item 10.2 ASD Corporate Directorates LPF Minute 191219.pdf (9 pages)

Item 10.2 ASD CD LPF Action List December 2019.pdf (1 pages)

10.3

Minute of the H&SCP LPF, 29 January 2020

Item 10.3 Unconfirmed LPF Minute 290120.pdf (5 pages)

11
ISSUES TO BE ESCALATED

11.1

To the Board in the IPQR & Chair's Comments

12
ANY OTHER COMPETENT BUSINESS

13
DATE OF NEXT MEETING - Friday 1st May 2020, 10 am, Staff Club

Fife NHS Board
UNCONFIRMED

MINUTES OF THE STAFF GOVERNANCE COMMITTEE HELD ON FRIDAY 17TH JANUARY AT 10:00AM IN THE STAFF CLUB, VICTORIA HOSPITAL, KIRKCALDY

Present:
Mrs Margaret Wells, Non Executive Director **(Chairperson)**
Mr Eugene Clarke, Non Executive Director
Mrs Wilma Brown, Employee Director
Mrs Christina Cooper, Non Executive Director
Mr Alistair Morris, Non Executive Director
Mr Paul Hayter, Depute for Co-Chair, Acute Services Division LPF
Mr Simon Fevre, Co-Chair, Health & Social Care LPF
Mrs Helen Buchanan, Director of Nursing

In Attendance:
Mrs Rhona Waugh, Head of HR
Mr Bruce Anderson, Head of Staff Governance
Ms Morag Olsen, Interim Chief Operating Officer (for Acute Services)
Mrs Nicky Connor, Director of Health & Social Care
Mrs Carol Potter, Director of Finance, Deputy Chief Executive (observing)
Mrs Helen Bailey, PA to Director of Workforce (minute taker)

NO.	HEADING	ACTION

01/20 CHAIRPERSON'S WELCOME AND OPENING REMARKS

The Chair welcomed everyone, in particular Alistair Morris, Non Executive Director to his first meeting, Morag Olsen, Interim Chief Operating Officer, Acute Services and Carol Potter, Director of Finance/Deputy Chief Executive, as an observer.

The Chair reminded Members that the notes are being recorded with the Echo Pen to aid production of the minutes. These recordings are also kept on file for any possible reference.

02/20 APOLOGIES FOR ABSENCE

Apologies were received from members Paul Hawkins, Andy Verrecchia (Paul Hayter deputising), Linda Douglas and Gillian MacIntosh.

03/20 DECLARATION OF MEMBERS' INTERESTS

None.

04/20 MINUTES OF PREVIOUS MEETING HELD ON 1ST NOVEMBER 2019

Mr Fevre requested that the words "regular attendee" be removed from the apology list at Ellen Ryabov's name.

Mrs Wells requested the rewording of the 2nd paragraph reflecting the meeting not being quorate to "It was noted that the meeting was not quorate". Given the above, Mrs Brown requested for homologation that the minutes of the meeting held on 30th August 2019 be circulated for approval. **HB**

05/20 ACTION LIST

Mrs Wells reported that all actions are completed or on the agenda.

Regarding Item 105/19 on the Action List Mrs Buchanan gave a verbal update, reporting that the first eHealth BAF has been developed and was presented at Clinical Governance yesterday taking the action forward.

Regarding Item 106/19a on the Action List, Mrs Waugh gave an update on the Acute absence performance and audit report findings, the acute trend information is attached to the absence report and a verbal audit update will be provided under this item.

06/20 MATTERS ARISING

None.

6.1 Staff Governance Role & Remit

Mrs Wells had asked Ms MacIntosh to revise the Role & Remit following the confusion of the quorum at the meeting on 01.11.19. Mr Anderson talked the Committee through the tracked changes.

Mr Clarke referred to Item 4.3 on the Role & Remit and stated it should read that papers are sent out five clear "**working**" days. Mrs Potter stated that the terminology would be consistent with other Board Committees and that there is ongoing national work to issue a set of Standing Orders with templates for Boards to adopt. Ms MacIntosh will be progressing this for the Board. **GM**

Mr Fevre raised concerns that the membership of this Committee are being treated differently in that staff side have to have a nominated deputy but Non Executive Directors do not, highlighting the capacity issues faced by staff side colleagues. Mrs Wells stated this was a fair point, but this was not being proposed as an amendment at this time and referred to the national work around this, which led to a lengthy discussion around this. Mr Fevre stated he wanted a firm commitment that this be looked at in March or May 2020.

Mrs Wells stated that she noted the point and this would be reviewed. **GM**
Mrs Connor and Mr Fevre will review, through the LPF, the availability of staff side to attend committee meetings / support partnership activities. **NC/SF**

The Committee **agreed** the tracked changes to the Role & Remit for quorum purposes, however, Mr Fevre requested it be noted that he did not approve the Role & Remit.

07/20 GOVERNANCE

7.1 Board Assurance Framework (BAF) – Staff Governance Risks

Mrs Waugh spoke to the updates, which reflected the change to the implementation of the workforce strategy and to now add the disbandment of the Brexit Assurance Group. The main focus was the linked risk, which is the high risk relating to our inability to recruit to Consultant Radiologist posts. Mrs Waugh and Ms Olsen gave an update reflecting on the continuing actions on this recruitment.

The Committee **noted** the content and **approved** the risk ratings of the BAF.

7.2 HR Policy Update

Mr Anderson gave an update on NHS Fife activity and development of HR Policies including the update of policies, soft launch of Phase 1 of the Once for Scotland Workforce Policies Programme, the communication strategy and workshops.

Mrs Waugh referred to the new digital platform and suggested the link is sent to Committee members as it is a vast improvement in terms of accessibility to staff, HR colleagues and management. Mr Anderson pointed out that it is still currently in test mode. **BA**

Mr Clarke asked about eHealth currently pursuing other software that could perhaps link to this, Mr Clarke will find out more about this. **EC**

Mrs Cooper welcomed this piece of work but stated that staff need to be aware of changes and given time to look at it.

Mrs Brown stated this was a vast training programme in addition to day to day work and sought assurance from the Committee that this was a priority and resources be brought in, if necessary, to deliver the required training in partnership.

The Staff Governance Committee **noted** the work undertaken by the HR Policy Group in developing and maintaining HR Policies and will escalate the training requirements. **MW**

7.3 Brexit

Mrs Waugh referred to the letter from Scottish Government advising Boards that Brexit contingency arrangements were to be stood down and reiterated that staff support is still being provided by NHS Fife where necessary.

7.4 Annual Accounts – Progress update on Audit Recommendations

Mrs Potter gave an update on the overview of the recommendations emerging from the Internal Audit Annual Report and the Audit Scotland Annual Report of 2018/19 which has been presented to all governance committees.

The Committee **noted** the actions taken to date, particularly in respect of to the recommendations related to areas under its remit.

7.5 Staff Governance Standard Monitoring Return 2018/19

Mr Anderson reported that every year we are required to submit a monitoring return in relation to our Staff Governance performance, Scottish Government then provide a response, usually after the Annual Review, we are then required to provide feedback on that report.

The Committee **noted** the monitoring return feedback response.

7.6 Health and Care Staffing Act (2019)

Mrs Buchanan gave an overview on this Act including the development session on 9th December 2020, the work being progressed throughout NHS Fife and the work being carried out to ensure that the Board meets its duties in relation to safe staffing legislation. A Safe Staffing Steering Group has been set up by Mrs Buchanan to oversee work on workload tools, escalation and risk assessment, nursing and midwifery recruitment and supplementary staffing. Mrs Buchanan referred to ongoing work with the universities, new Mental Health student nurse training at Fife Campus, Modern Apprenticeships, student nurses doing their Masters and Return to Practice, Flying Start Programme and the use of mentors.

Mrs Wells gave credit to all involved with this work.

Mrs Brown acknowledged the work being done and asked if overseas recruitment of experienced nurses was being considered, as this had been a successful approach taken by other Boards. Mrs Buchanan and Mrs Waugh stated that work was ongoing looking at recruitment packs and highlighting the attractions of living and working in Fife.

Mrs Fevre stated that we need to engage other professionals to get involved with this. Mrs Buchanan will discuss this with Ms Douglas. **HB**

The Committee **noted** the update on ongoing work and work to

address the requirements of implementing the Health and Care Scotland Staffing Act (2019).

08/20 PERFORMANCE

8.1 Attendance Management Update

Mrs Waugh referred to the update and the to the data provided by Tableau, reflecting not much change in the Board rate from 5.8% in October to 5.57% in November 2019, which is a slight reduction. Data was provided by divisional area, by job family, by duration and age demographics and reasons for absence.

Tableau is being rolled out to managers to be able to drill down to hot spot and priority areas and also be used at Review and Improvement Panels.

Acute Services Division trends were plotted, showing a few months of hotspots where the rate was over 6%, with reduction in November 2019. Long term sickness absence forces the trend within Acute Services.

The Committee was advised that a taskforce group promoting attendance is being established which will be chaired by Mr Hawkins, Chief Executive. This initiative is welcomed by the Committee.

Mr Clarke thanked Mrs Waugh for the data and asked how NHS Fife compares with other Boards. Mrs Waugh clarified this information is published monthly to Boards for comparison. NHS Fife colleagues are in discussion with other Boards for any learning opportunities around this agenda.

Mrs Cooper welcomed the clear format of this and queried the use of "unknown causes" being used on Page 7, Mrs Waugh clarified that part of that was in relation to the system for recording staff absence, Mrs Wells asked for this to be addressed. **RJW**

Mrs Brown referred to musculoskeletal issues and suggested a deeper drill down with drop down box identifying part of body affected, e.g. neck, shoulder, etc. Mrs Waugh agreed to review hot spot areas. **RJW**

The Committee discussed the challenges of staff feeling undervalued, staff shortages, recruitment difficulties, etc. Committee members also reflected on the value of resilience, leadership, iMatter, staff having breaks and prioritising initiatives.

Mrs Wells requested Mrs Potter to take to EDG for discussion quantifying the impact of Scottish Government initiatives on NHS Fife **CP**
and Ms Douglas to review the discussion and ideas put forward at this meeting. **LD**

The Committee **noted** the position in relation to sickness absence.

8.2 Well at Work

Mrs Waugh referred to the detailed report and drew attention to the Culture of Kindness Conference taking place on 19th May 2020 and encouraged members to attend. Mrs Waugh reported that NHS Fife colleagues, including Dr Wendy Simpson presented on behalf of NHS Fife at the NHS Scotland Staff Wellbeing Conference in November 2019, this was well received, with good feedback.

Mrs Wells requested thanks and congratulations be passed to those involved. The Committee **noted** the ongoing activities in terms of Well at Work.

8.3 Core Training Update

Mr Anderson pointed out a typo on Page 1 of the SBAR under Core Training Activity Summary, 2nd paragraph, 1st line – should read "ending 31st October 2019 is **78%**", not ending 31st May 2019.

Mr Anderson reported 78% compliance, which is an increase of 6%. Mr Anderson spoke to the report and the national progress.

Mrs Brown welcomed the compliance increase but raised concern at areas of life support, health and safety and violence & aggression in Acute Services. Mrs Connor reported ongoing work around life support. Members discussed the digital transformation and core skills provision. It was suggested Lesly Donovan attend this meeting to give us an update. **BA**

The Committee **noted** the performance in Core Skills training activity and the improved compliance position.

8.4 Integrated Performance & Quality Report

Members identified the areas already discussed in the meeting's agenda that require highlighting to the Board, namely sickness absence performance.

The Committee **noted** the Integrated Performance & Quality Report.

09/20 STAFF GOVERNANCE STANDARDS

9.1 Improved and Safe Working Environment

Mr Anderson updated the Committee on Violence & Aggression management report, showing a broad improvement in Acute Services, reduction in physical assaults. Within the H&SC Partnership, the position has increased and this is mainly attributed to the nature of learning disability conditions, which is being managed. The frequency of reporting is now compliant.

Mrs Connor assured the Committee there was detailed work ongoing to support this.

It was agreed that written updates would be brought to futures meetings of the Committee.

Mrs Wells thanked Mr Anderson and Mrs Connor for the verbal update

10/20 **10.1 Workforce Strategy Update**

Mrs Waugh referred to the report and the requirement to change our planning cycle in relation to publication of the NHS Fife Workforce Strategy in line with this new workforce planning guidance. An update on the Action Plan for NHS Fife will need to be provided in terms of the workforce strategy content, taking account of the Annual Accounts Audit Recommendations and the Workforce Strategy Group Terms of Reference will also require to be updated.

The Committee **noted** the content of this paper and the revised three year publication cycle for NHS Fife's Workforce Plan.

10.2 Consultant Recruitment Update

Mrs Waugh referred to the report detailing the statistics and highlighted the difficulties of recruiting consultants in specific areas and work ongoing to address this. Mrs Waugh reported on successful recruitment with 44 new consultant appointments during 2019.

The Committee **noted** the content of the report and the position during 2019.

11/20 ITEMS FOR INFORMATION / NOTING

- Minutes & Action List of the APF (20.11.19)
- Minutes of Acute Services Division & Corporate Division LPF (31.10.19)
- B14-20 Fire Safety Follow Up

These items were **noted**.

12/20 ISSUES TO BE ESCALATED

12.1 To the Board in the IPQR and Chair's Comments

The following items would be highlighted to the Board's next meeting:

- Sickness Absence
- Staff Training/Digital Platform training/enabling staff to attend training **MW /**

- Pressures staff feeling and demand on all staff **LD**
- Recruitment - 44 substantive Consultant appointments made during 2019.

13/20 ANY OTHER BUSINESS

Nothing to report.

14/20 DATE OF NEXT MEETING

Friday 6th March 2020 at 10:00 am in Staff Club, VHK.

TABLE OF ACTIONS from STAFF GOVERNANCE COMMITTEE MEETING held on 17th January 2020

MINUTE REFERENCE	ACTION	LEAD	TIMESCALE	PROGRESS
06/20	Staff Governance Role & Remit	GM	06.03.20	On Agenda
07/20	Once for Scotland Workforce Policies Digital Platform circulated to members	BA	06.03.20	Completed
08/20	Reasons for absence to be changed from “Unknown Causes” and musculoskeletal reasons for absence to drill down by body area	RJW	17.01.20	On agenda
12/20	Items to be highlighted to the Board.	MW	06.03.20	Completed
08/20	Update Committee on Digital Transformation invite Lesly Donovan	BA	01.05.20	Future Meeting

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Workforce Sustainability																													
1415	Exemplar Employer	17.01.2020	21.02.2020	There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	20	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Failure in this area has a direct impact on patients' health. NHS Fife has an ageing workforce with recruitment challenges in key specialities. Failure to ensure the right composition of workforce with the right skills and competencies gives rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; and staff engagement and morale. Failure would also adversely impact on the implementation of the Clinical strategy. The current score reflects the existing controls and mitigating actions in place.	Director of Workforce/ Partnership	Staff Governance Chair: Margaret Wells	*Ongoing actions designed to mitigate the risk including:* 1. • Implementation of the Workforce Strategy 2019 - 2022, to support the Clinical Strategy and Strategic Framework. 2. • Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 - 2022. 3. • Implementation of the NHS Fife Strategic Framework particularly the "exemplar employer"	Nil	Implementation of the Workforce Strategy and associated action planning to support the Clinical Strategy and Strategic Framework	Director of Workforce/Partnership		1. Regular performance monitoring and reports to EDG, APF, Staff Governance Committee 2. Delivery of Staff Governance Action Plan is reported to EDG, APF and Staff Governance Committee	1. Use of national data 2. Internal Audit reports 3. Audit Scotland reports	Full implementation of eESS will provide an integrated workforce system which will capture and facilitate reporting including all learning and development activity	Overall NHS Fife Board has robust workforce planning and learning and development governance and risk systems and processes in place. Continuation of the current controls and full implementation of mitigating actions, especially the Workforce strategy supporting the Clinical Strategy and the implementation of eESS should provide an appropriate level of control.	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	4	Low	Continuing improvement in current controls and full implementation of mitigating actions will reduce both the likelihood and consequence of the risk from moderate to low.
																4. • The Brexit Assurance Group which was established to consider the impact on the workforce with regard to these arrangements once they are known has been disbanded, however, organisational support is still being provided and publicised. 5. An Assurance Group has also been established which will link to existing resilience planning arrangements - now disbanded but as above. 6. • Implementation of eESS as a workforce management system within NHS Fife	Nil	Implementation of proactive support for the workforce affected by Brexit. Full implementation of eESS manager and staff self service across the organisation to ensure enhanced											
																7. • A stepped approach to nurse recruitment is in place which enables student nurses about to qualify to apply for certain posts at point of registration. This model could also be applied to AHP, eHealth, Pharmacist, Scientific and Trades recruitment and other disciplines considered. 8 • Strengthening of the control and monitoring associated with supplementary staffing with identification and implementation of solutions to reduce the requirement and/or costs associated with supplemental staffing. 9. • NHS Fife participation in regional and national groups to address national and	Nil	Strengthen workforce planning infrastructure ensuring co-ordinated and cohesive approach taken to advance key workforce strategies											
																11. • NHS Fife Promoting Attendance Group and local divisional groups established to drive a range of initiatives and improvements aligned to staff health and wellbeing activity, 12. • Well@Work initiatives continue to support the health and wellbeing of the	Nil	Continue to support the implementation of the Health & Wellbeing Strategy and Action Plan, aimed at reducing sickness absence, promoting attendance and staff health and wellbeing											
																13. • The continued roll out and implementation of iMatter across the organisation, to support staff engagement and organisational values.	Nil	Optimise use of iMatter process and data to improve staff engagement and retention											
																14. • Staff Governance and Partnership working underpins all aspects of workforce activity within NHS Fife and is key to development of the workforce.	Nil	Continue to implement and promote Staff Governance Action plans and staff engagement											
																16. • Development of the Learning and Development Framework strand of the Workforce Strategy 17. • Leadership and management development provision is constantly under	Nil	Implementation of the Learning and Development Framework strand of the Workforce Strategy.	Director of Workforce/Partnership											
																18. • Improvement to be made in Core Skills compliance to ensure NHS Fife	Nil	Review of L&D processes , planning and resources											
																19. • The implementation of the Learning Management System module of eESS	Nil	Full roll out of learning management self service											
																20. • Continue to address the risk of non compliance with Staff Governance	Nil	Continuing implementation of the KSF Improvement											
																21. • Utilisation of the Staff Governance Standard and Staff Governance Action	Nil												
																22. • The development of close working relationships with L&D colleagues in neighbouring Boards, with NES and Fife Council to optimise synergistic benefits from collaborative working	Nil		Director of Workforce										

Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner
90	National shortage of radiologists	High 16	J Burdock

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
503	Lack of capacity in Podiatry Service unable to meet SIGN/ NICE Guidelines	Risk Closed		
1042	Staffing levels Community Services East unable to meet staffing establishment	No longer high risk	Moderate 12	K Nolan
1324	Medical Staff Recruitment	No longer high risk	Moderate 9	J Kennedy
1349	Service provision- GP locums may no longer wish to work for NHS Fife salaried practices	Risk Closed		
1353	Medical Cover- Community Services West- expected shortfalls on nurse staffing and GP cover	Risk Closed		
1375	Breast Radiology Service	No longer high risk	Moderate 12	M Cross
1420	Loss of consultants	No longer high risk	Moderate 12	H Bett

ID	
Position of Risk (Risk Register)	Acute Services - WOMEN CHILDREN AND CLINICAL SERVICES DIRECTORATE RISK REGISTER, Acute Services - Women Children and Clinical Services - Radiology Directorate Risk Register
Opened	23.08.2002
Title	National Shortage of Radiologists
Description	There is a risk that we will be unable to recruit to Consultant Radiologist posts due to a national shortage with the consequence that we will be unable to provide a full range of diagnostic services to support unscheduled and scheduled activity within NHS Fife within the required timescales.
Likelihood (initial)	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (initial)	4 - Major
Risk level (initial)	High Risk
Rating (initial)	20
Current Management Actions	17/01/2020 & 24/02/2020 All other previous actions continue. An NHS locum for a fixed term has started in September 2019 and an SpR who is on track to achieve Certification of Completion of Training in February 2020 applied to NHS Fife, but opted to take a post within NHS Forth Valley instead. NHS Lothian has given notice of cessation of PA and sessional input to NHS Fife, this is being followed up by the Clinical Lead. Agency Locum usage has been reduced to 1.0 wte. No candidates secured from participation in NHS Scotland International Recruitment Campaign.
Likelihood (current)	4 - Likely - Strong possibility this could occur
Consequence (current)	4 - Major
Risk level (current)	High Risk
Rating (current)	16
Likelihood (Target)	2 - Unlikely - Not expected to happen - potential exists
Consequence (Target)	4 - Major
Risk level (Target)	Moderate Risk
Rating (Target)	8
Risk Owner	Burdock, Jeanette
Handler	Burdock, Jeanette
Previous Review Date	24.02.2020
Next Review	23.04.2020

ID	1324	90
Position of Risk (Risk Register)	COMMUNITY SERVICES EAST - RISK REGISTER	Acute Services - WOMEN CHILDREN AND CLINICAL SERVICES DIRECTORATE RISK REGISTER, Acute Services - Women Children and Clinical Services - Radiology Directorate Risk Register
Opened	02.12.2016	23.08.2002
Title	Medical staff recruitment and retention	National Shortage of Radiologists
Description	There is an established and continuing risk of significant medical workforce depletion in both Cameron & Glenrothes community hospitals which will result in significant challenges to maintaining service delivery. For Cameron, there is a whole time equivalent specialist doctor vacancy of 10 sessions per week (50%). For Glenrothes there is a 4 session speciality doctor vacancy (40%) and this will escalate to a 10 session vacancy from 1st July 2017. Glenrothes has 59 beds whilst Cameron has 80 beds.	There is a risk that we will be unable to recruit to consultant radiology posts due to a national shortage with the consequence that we will be unable to provide a full range of diagnostic services to support unscheduled and scheduled activity within NHS Fife within the required timescales.
Likelihood (initial)	4 - Likely - Strong possibility this could occur	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (initial)	4 - Major	4 - Major
Risk level (initial)	High Risk	High Risk
Rating (initial)	16	20
Current Management Actions	20/12/19- Risk now high. CDF only until the end of January, then just 1 CDF for Cameron. Locum extension requested. ANP commences in January 2020. Further review of medical staff and cover for the coming months to be discussed and actioned by HSM and Clincial director. Meeting early January. 08/07/19- clinical fellows X2 will commence in August 2019 until February 2020. in Cameron AND Glenrothes, locum cover is still required and in place Unable to recruit fully qualifies ANP, so 2 trainee NP in post as of Oct 2019 01/08/18; Monthly meetings taking place to monitor the current medical provision within the Cameron and Glenrothes Hospital sites. The Hybrid GP advertisement which has been on-going since November 2017 is to be revamped in an attempt to attract interest. Locum medical cover is in place in Cameron Hospital, and the aim is that this will be made permanent. There is a 3 month Service Level Agreement in place for Ward 1 with medics secured for Wards 2 and 3 for the next year. Ward 1, Glenrothes is still subject to re-design with the ward potentially evolving into a step-down facility.	28/10/2019 All other previous actions continue. An NHS locum for a fixed term has started, an SpR who CCT's in February is currently applying to Fife. Lothian Posts with PA's in fife pursued. Agency Locum usage has been reduced to 1WTE.
Likelihood (current)	4 - Likely - Strong possibility this could occur	4 - Likely - Strong possibility this could occur
Consequence (current)	4 - Major	4 - Major
Risk level (current)	High Risk	High Risk
Rating (current)	16	16
Likelihood (Target)	2 - Unlikely - Not expected to happen - potential exists	2 - Unlikely - Not expected to happen - potential exists
Consequence (Target)	1 - Negligible	4 - Major
Risk level (Target)	Very Low Risk	Moderate Risk
Rating (Target)	2	8
Risk Owner	Kennedy, John	Burdock, Jeanette
Handler	Nolan, Karen	Burdock, Jeanette
Previous Review Date	08.07.2019	23.10.2019
Next Review	28.02.2020	23.04.2020

ID	Position of Risk (Risk Register)	Opened	Title	Description	Likelihood (initial)	Consequence (initial)	Risk level (initial)	Rating (initial)	Current Management Actions	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Consequence (Target)	Risk level (Target)	Rating (Target)	Risk Owner	Handler	Previous Review Date	Next Review
1324	COMMUNITY SERVICES EAST - RISK REGISTER	02.12.2016	Medical staff recruitment and retention	There is an established and continuing risk of significant medical workforce depletion in both Cameron & Glenrothes community hospitals which will result in significant challenges to maintaining service delivery. For Cameron, there is a whole time equivalent specialist doctor vacancy of 10 sessions per week (50%). For Glenrothes there is a 4 session speciality doctor vacancy (40%) and this will escalate to a 10 session vacancy from 1st July 2017. Glenrothes has 59 beds whilst Cameron has 80 beds.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	21/02/2020 - Associate Specialist plans to resume work after an extended period of sickness absence on 24/02/2020 Locum cover will still be required as no Clinical Fellow in place from end of April 2020. Acute Services Division recruit CFs and requested to recruit two for cover from August 2020. NP and ANP are in place. 20/12/19 - Risk now high. CDF only until the end of January, then just 1 CDF for Cameron. Locum extension requested. ANP commences in January 2020. Further review of medical staff and cover for the coming months to be discussed and actioned by HSM and Clincial director. Meeting early January. 08/07/19- clinical fellows X2 will commence in August 2019 until February 2020. in Cameron AND Glenrothes, locum cover is still required and in place Unable to recruit fully qualifies ANP, so 2 trainee NP in post as of Oct 2019 01/08/18; Monthly meetings taking place to monitor the current medical provision within the Cameron and Glenrothes Hospital sites. The Hybrid GP advertisement which has been on-going since November 2017 is to be revamped in an attempt to attract interest. Locum medical cover is in place in Cameron Hospital, and the aim is that this will be made permanent. There is a 3 month Service Level Agreement in place for Ward 1 with medics secured for Wards 2 and 3 for the next year. Ward 1, Glenrothes is still subject to re-design with the ward potentially evolving into a step-down facility.	4 - Likely - Strong possibility this could occur	4 - Major	High Risk	16	2 - Unlikely - Not expected to happen - potential exists	1 - Negligible	Very Low Risk	2	Kennedy, John	Nolan, Karen	20.12.2019	28.02.2020

90	ID
Acute Services - WOMEN CHILDREN AND CLINICAL SERVICES DIRECTORATE RISK REGISTER, Acute Services - Women Children and Clinical Services - Radiology Directorate Risk Register	Position of Risk (Risk Register)
23.08.2002	Opened
National Shortage of Radiologists	Title
There is a risk that we will be unable to recruit to consultant radiology posts due to a national shortage with the consequence that we will be unable to provide a full range of diagnostic services to support unscheduled and scheduled activity within NHS Fife within the required timescales.	Description
5 - Almost Certain - Expected to occur frequently - more likely than not	Likelihood (initial)
4 - Major	Consequence (initial)
High Risk	Risk level (initial)
20	Rating (initial)
28/10/2019 All other previous actions continue. An NHS locum for a fixed term has started, an SpR who CCT's in February is currently applying to Fife. Lothian Posts with PA's in fife pursued. Agency Locum usage has been reduced to 1WTE.	Current Management Actions
4 - Likely - Strong possibility this could occur	Likelihood (current)
4 - Major	Consequence (current)
High Risk	Risk level (current)
16	Rating (current)
2 - Unlikely - Not expected to happen - potential exists	Likelihood (Target)
4 - Major	Consequence (Target)
Moderate Risk	Risk level (Target)
8	Rating (Target)
Burdock, Jeanette	Risk Owner
Burdock, Jeanette	Handler
23.10.2019	Previous Review Date
23.04.2020	Next Review

Staff Governance Committee

DATE OF MEETING:	6 March 2020
TITLE OF REPORT:	SG Committee Terms of Reference
EXECUTIVE LEAD:	Linda Douglas, Director of Workforce
REPORTING OFFICER:	Gillian MacIntosh, Board Secretary

Purpose of the Report
For Decision

SBAR REPORT

Situation

All Committees are required to regularly review their Terms of Reference, and this is normally done in March of each year. Any changes are then reflected in the annual update to the NHS Fife Code of Corporate Governance, which is reviewed in full by the Audit & Risk Committee and then formally approved by the Board in May of each year.

Background

The current Terms of Reference for the Committee were last reviewed in January 2020, to reflect recent changes to the reporting lines of the Remuneration Committee and to clarify the wording around the quorum.

Assessment

An updated draft of the Committee's Terms of Reference is attached for members' consideration, with all changes 'tracked' for ease. Proposed amendments largely relate to clarifying the current wording relating to risk, at clauses 7.2 and 7.3, to reflect present practice.

Following review and approval by the Committee, an amended draft will be considered by the Committee as part of a wider review of all Terms of Reference by each standing Committee and other aspects of the Code. Thereafter, the final version of the Code of Corporate Governance will be presented to the NHS Board for approval.

Recommendation

Members of the Committee are asked to:

- **consider and approve** the updated Terms of Reference.

Objectives: (must be completed)	
Healthcare Standard(s):	Governance and assurance is relevant to all Healthcare Standards.
HB Strategic Objectives:	All
Further Information:	
Evidence Base:	N/A
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	N/A

Impact: (must be completed)	
Financial / Value For Money	The update of Committee Terms of Reference will ensure appropriate governance across all areas and that effective assurances are provided.
Risk / Legal:	
Quality / Patient Care:	
Workforce:	
Equality:	

STAFF GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

1.1 The purpose of the Staff Governance Committee is to support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration, and within the direction provided by the Staff Governance Standard.

1.2 To assure the Board that the staff governance arrangements in the Integration Joint Board are working effectively.

1.3 To escalate any issues to the NHS Fife Board if serious concerns are identified regarding staff governance issues within the services devolved to the Integration Joint Board.

2. COMPOSITION

2.1 The membership of the Staff Governance Committee will be:

- Four Non-Executive members, one of whom will be the Chair of the Committee.
- Employee Director (as a Stakeholder member of the Board by virtue of holding the Chair of the Area Partnership Forum)
- Chief Executive
- Director of Nursing
- Staff Side Chairs of the Local Partnership Forums

2.2 Each of the Staff Side Chairs of the Local Partnership Forums shall, annually, notify the Lead Officer to the Committee of a specific nominated deputy who will attend meetings in their absence. This will be reported to the Chair.

2.3 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Workforce
- Chief Operating Officer (Acute Services)
- Director of Health & Social Care
- Board Secretary

2.4 The Director of Workforce will act as Lead Officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three members are present, at least two of whom should be Non Executive members of the Board. In addition, in order to be quorate, each meeting will require one of the staff side Chairs of the Local Partnership Forums or their nominated deputy to be present. There may be occasions when due to unavailability of the above Non Executive members the Chair will ask other Non Executive members to act as members of the Committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Staff Governance Committee shall meet as necessary to fulfil its purpose but not less than four times a year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The remit of the Staff Governance Committee is to:

- Consider NHS Fife's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard;

- Review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters;

- Give assurance to the Board on the operation of Staff Governance systems within NHS Fife, identifying progress, issues and actions being taken, where appropriate;

- Support the operation of the Area Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this;

- Encourage the further development of mechanisms for engaging effectively with all members of staff within the NHS in Fife;

- Contribute to the development of the Annual Operational Plan, in particular but not exclusively, around issues affecting staff;

- Support the continued development of personal appraisal professional learning and performance;

- Review regularly the sections of the NHS Fife Integrated Performance Report relevant to the Committee's responsibility;

- Undertake an annual self assessment of the Committee's work and effectiveness.

5.2 The Committee is also required to carry out a review of its function and activities and to provide an Annual Report incorporating a Statement of Assurance. This will be submitted to the Board via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.4 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

6.3 Delegated authority is detailed in the Board's Standing Orders, as set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Staff Governance Committee reports directly to Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 ~~The Corporate Risk Register will be scrutinised by the relevant Committees of the Board with a bi-annual update on all changes to the Corporate Risk Register being submitted to the Audit & Risk Committee.~~ Each Committee of

the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 ~~The Board Assurance Framework will be scrutinised by the relevant Committees of the Board with an update on all changes being submitted to the Audit & Risk Committee.~~ Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

Staff Governance Committee

DATE OF MEETING:	6 March 2020
TITLE OF REPORT:	Committee Self-Assessment Report 2019-20
LEAD:	Margaret Wells, Chair of the Staff Governance Committee
REPORTING OFFICER:	Gillian MacIntosh, Board Secretary

Purpose of the Report
For Discussion

SBAR REPORT

Situation

The purpose of this paper is to provide the outcome of this year's self-assessment exercise recently undertaken for the Staff Governance Committee, which is a component part of the Committee's production of its annual year-end statement of assurance.

Background

As part of each Board Committee's assurance statement, each Committee must demonstrate that it is fulfilling its remit, implementing its agreed workplan and ensuring the timely presentation of its minutes to the Board. Each Committee must also identify any significant control weaknesses or issues at the year-end that it considers should be disclosed in the Governance Statement, and should specifically record and provide confirmation that the Committee has carried out an annual self-assessment of its own effectiveness. Combined, these processes seek to provide assurance that a robust governance framework is in place across NHS Fife and that any potential improvements are identified and appropriate action taken.

Following the comprehensive review undertaken last year, in early 2019, of the format and range of self-assessment questions previously used, a more light-touch review of the question set was undertaken this year, taking account of members' feedback on the length and clarity of the previous iteration of the questionnaire. Board Committee Chairs each approved a revised set of questions for their respective committee in October 2019.

To conform with the requirement for an annual review of their effectiveness, all Board Committees were invited to complete a self-assessment questionnaire in late December 2019 / early January 2020. The survey was undertaken online, following overwhelmingly positive feedback on the move to a non-paper system of completion, and took the form of a Chair's Checklist (which sought to verify that the Committee is operating correctly as per its Terms of Reference) and a second questionnaire (to be completed by members and regular attendees) comprising a series of effectiveness-related questions, where a scaled 'Agree/Disagree' response to each question were sought. Textual comments were also encouraged, for respondents to provide direct feedback on their views of the Committee's effectiveness.

Assessment

As previously agreed, Committee chairs have received a full, anonymised extract of the survey responses for their respective committee. A summary report assessing the composite

responses for the Staff Governance Committee is given in this paper. The main findings from that exercise are as follows:

Chairs' Checklist (completed by Chair only)
It was agreed that the Committee was operating as per its Terms of Reference (ToR). It was noted that the ToR had recently been amended to clarify the quorum requirements and that future dates of the meetings had been set taking account of any regular clashes with other standing meetings, to aid full attendance.

Self-Assessment questionnaire (completed by members and attendees)
In total, all seven members (excluding the Chair) and four regular attendees completed the questionnaire. The Committee's current mode of operation received a generally positive assessment from the members and attendees who participated, though some areas of improvement were identified.

It was pleasing to read the overall ratings of the self assessment. There are a total of 25 factors in the self assessment and a summary of findings is:

- 13 of the 25 factors were rated 'Agree' or 'Strongly Agree'.
- No factor was rated 'Strongly Disgree'.
- There were six factors where the lowest assessment was rated 'Neutral' (A7, B2, B4, C1, C2, C3), B2 had two respondents providing a Neutral assessment, all other factors it was the assessment of one respondent).
- There were three factors where the lowest assessment was 'Disagree', and in these instances one factor (A6) had three respondents providing that rating, a second factor (B6) had two respondents and in the remaining factor (D3) it was a single respondent's view.
- There were three factors that received a 'Disagree' assessment (A6, B6,D3). In each instance this was the assessment of a single respondent.

The assessment and individual(s) comments provide suggested areas for further discussion and include:

- the current training offered to Committee members on an ongoing basis, particularly around developing national initiatives;
- further work on the level of narrative and data included in papers;
- ensuring that the Committee's monitoring of performance focuses on the key workforce matters and the actions underway to improve performance; and
- improving time management during meetings, with members ensuring that all agenda items are covered adequately.

Recommendation

The Staff Governance Committee is asked to:

- **note** the outcome of the Committee's recent self-assessment exercise, as detailed in the attached; and
- **discuss** what actions members would wish to see implemented to address those areas identified for improvement.

Objectives: (must be completed)	
Healthcare Standard(s):	Governance and assurance is relevant to all Healthcare Standards.
HB Strategic Objectives:	All

Further Information:	
Evidence Base:	N/A
Glossary of Terms:	N/A
Parties / Committees consulted:	Committee Chairs

Impact: (must be completed)	
Financial / Value For Money	The use of a comprehensive self-assessment checklist for all Board committees ensures appropriate governance standards across all areas and that effective assurances are provided.
Risk / Legal:	
Quality / Patient Care:	
Workforce:	
Equality:	

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Comments
A. Committee membership and dynamics							
A1.	The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	4 (36%)	7 (64%)	-	-	-	The Committee has a strong representation of the Executive Team and non-Executive Directors which thereby empowers not only scrutiny and discussion but the ability to make decisions about actions and in some cases the investment in necessary resources. In addition the formal discussion at each Board meeting with the ability to escalate any areas of concern also supports performance of its role. At times, although quorate attendance could be better.
A2.	The Committee's membership includes appropriate representatives from the organisation's key stakeholders.	5 (45%)	6 (55%)	-	-	-	The ability to have discussion not only in relation to the Board but also within the integrated space involving the Health and Social Care Partnership is a clear benefit given the interdependencies in terms of workforce in particular. Lack of attendance from management representatives is noticeable particularly the Chief Executive. The ratio of attendees to members might be worth consideration.
A3.	Committee members are clear about their role and how their participation can best contribute to the Committee's overall effectiveness.	6 (55%)	5 (45%)	-	-	-	I think the recent workshop on appetite for risk helped to enhance this understanding by the Committee in terms of role, scrutiny and also the requirement for members to honestly assess the risk and effectiveness of the SGC in order to ensure that the Board is fully sighted on this, especially if there are particular areas of concern. I am clear about my role and can only assume others are too. Discussions are well focussed with all participants contributing fully.

A4.	Committee members are able to express their opinions openly and constructively.	9 (82%)	2 (18%)	-	-	-	I have not seen any instances where any member has not been able or made welcome to raise any issues or participate in any discussion on the issues raised. This is also demonstrated in terms of the challenges made on particular issues. I bear witness to members expressing their opinions without hesitation. The committee is well chaired and open debate is encouraged. I think the opportunity for constructive dialogue has improved since the last survey that presentations on related topics have improved understanding.
A5.	There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive.	5 (45%)	6 (55%)	-	-	-	I do agree on this point. However, this could be further enhanced by possibly doing specific contextual presentations to members on workforce related topics to provide more background on just what is happening in terms of NHS Fife and NHSiS around staff governance and our workforce agenda. Executive members are regularly challenged in a positive way to ensure objectives are being met. This needs to remain balanced, particularly when there are special interests .
A6.	The Committee has received appropriate training / awareness-raising in relation to the areas applicable to the Committee's areas of business.	3 (27.5%)	4 (36%)	3 (27.5%)	1 (9%)	-	I do believe that we have provided awareness raising on significant issues e.g. Sturrock but as with anything this can always be enhanced further. Or even broader HR, Workforce related information would be helpful. I'm not sure what training members / attendees have undertaken. Board development sessions; individual meetings with Executives when required; Chair and members meet regularly.
A7.	Members have a sufficient understanding and knowledge of the issues within its particular remit to identify any areas of concern.	3 (27%)	7 (64%)	1 (9%)	-	-	I do think members have enough awareness to raise any particular areas of concern As far as I can ascertain without questioning members, they appear to understand and have a degree of knowledge around matters discussed. Though it can a challenge to keep abreast of developments, particularly national ones. There can be repeat discussion on similar themes from meeting to meeting. A range of presentation topics may assist with this longer term.

B. Committee meetings, support and information							
B1.	The Committee receives timely information on performance concerns as appropriate.	5 (45%)	6 (55%)	-	-	-	Regular reports are provided on the significant areas of performance such as absence, TURAS, iMatter which are all key in terms of the employee experience. Yes though still to fine tune the balance of the amount of details versus key issues with some reports. My preferred way is to report by exception.
B2.	The Committee receives timely exception reports about the work of external regulatory and inspection bodies, where appropriate.	4 (36%)	5 (45%)	2 (18%)	-	-	Workforce related reports for SGC sometimes are also discussed in other scrutiny committees such as Clinical Governance e.g. Junior Doctors etc We do always have to be conscious where this overlap occurs as it can be perfectly legitimate for CGC to discuss the issue but also it can also be perfectly legitimate for SGC to be aware from the overarching workforce perspective. When this does occur there has been a helpful discussion between both Chairs and Executive Leads to clarify the main scrutiny committee and also where another committee should be made aware for information purposes.
B3.	The Committee receives adequate information and provides appropriate oversight of the implementation of relevant NHS Scotland strategies, policy directions or instructions.	6 (55%)	5 (45%)	-	-	-	These are highlighted to the SGC examples are Regional collaboration on Recruitment, Nurse Bank, Medical Bank etc and also Once for Scotland policies etc Yes but see previous comments re keeping up to date.
B4.	Information and data included within the papers is sufficient and not too excessive, so as to allow members to reach an appropriate conclusion.	3 (27%)	7 (64%)	1 (9%)	-	-	I think there is more work to be done on refining the absence data to help the members challenge improvement in this area. Also the ongoing development of future HR metrics will also help better inform the SGC in terms of the ongoing monitoring of performance. Recent initiatives/policy have been brought to the committee mainly for information or to inform committee of Fife`s position. Excellent balance of information On balance yes but sometimes too much detail e.g. re incident reports. This is always worth reviewing.
B5.	Papers are provided in sufficient time prior to the meeting to allow members to effectively scrutinise and challenge the assurances given.	5 (45%)	6 (55%)	-	-	-	Rarely is the normal production timetable not met. Some duplication of reports at times means excessive material.

B6.	Committee meetings allow sufficient time for the discussion of substantive matters.	5 (45%)	4 (36%)	1 (9%)	1 (9%)	-	On occasions discussion may have to be stopped dependent upon the length of the agenda. However, if it is the case that it is felt that further discussion is needed this is taken up via agreeing in the Action Plan that it will be carried forward for more time for discussion. Agendas are sometimes too weighty for important matters to be discussed We do sometimes focus on an agenda item for too long which prevents sufficient time on other items. Meetings can often overrun and latter stages of agenda feel rushed. Often inappropriate presentations take up significant periods of time. At times the meetings go past the agreed time. We should recognise this by either editing the agenda or extending the time. Time can be a factor during some meetings, so avoiding repeat discussion would help with this
B7.	Minutes are clear and accurate and are circulated promptly to the appropriate people, including all members of the Board.	6 (55%)	5 (45%)	-	-	-	The turnaround time for minutes is met and they are comprehensive. I would prefer a uniform approach to the style and layout of all board.
B8.	Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete.	6 (55%)	5 (45%)	-	-	-	Demonstrated by the construct of the action plan. All actions are recorded and followed through action plan with clear timescales and named lead officer.
B9.	The Committee is able to provide appropriate assurance to the Board that NHS Fife's policies and procedures (relevant to the Committee's own Terms of Reference) are robust.	5 (45%)	6 (55%)	-	-	-	Updates are provided via the workplan on policy review and provision within the Board and also how the Once for Scotland work is supporting this.
B10.	Committee members have confidence that the delegation of powers from the Board (and, where applicable, the Committee to any of its sub-groups) is operating effectively as part of the overall governance framework.	7 (64%)	4 (36%)	-	-	-	Please see comments previously regarding how the SGC fits in terms of an understanding of its own role and the well established escalation and regular update session inbuilt by consideration of the IPQR at every Board meeting. Excellent alignment of governance and accountability.

C. The Role and Work of the Committee							
C1.	The Committee reports regularly to the Board verbally and through minutes and makes clear recommendations on areas under its remit when necessary.	7 (64%)	3 (27%)	1 (9%)	-	-	Reports at each board and through IPQ&R. Staff governance is an agenda item on Board minutes.
C2.	In discharging its governance role, the focus of the Committee is at the correct level.	4 (36%)	6 (55%)	1 (9%)	-	-	On occasions the SGC may stray into what are operational matters but this is clarified in terms of the role of the Committee to look above this level. Recent example of this was the implementation of change within Acute Services which in essence were operational but did have an overarching consideration via the staff governance standard for staff being involved in the decisions that affect them.
C3.	The Committee's agenda is well managed and ensures all topics within the Committee's Terms of Reference are appropriately covered.	6 (55%)	4 (36%)	1 (9%)	-	-	Evidence via workplan and also ad hoc additions such as Sturrock. Improvements made previously and the workplan support this.
C4.	Key decisions are made in a structured manner and can be publicly evidenced.	8 (73%)	3 (27%)	-	-	-	Please see comment above regarding governance and minutes etc.
C5.	What actions could be taken, and in what areas, to further improve the effectiveness of the Committee in respect of discharging its remit?	Some suggestions above regarding a different presentation method of data if for example attendance management and raising awareness of SGC members around workforce issues and their context. Not changing meeting dates frequently. I believe that the committee should have more focus on pieces of work that have bearing on Attendance Management, i.e. improvement program on attendance. I think the committee discharges its remit appropriately and reports to the Board. No further actions at present. Continuing to ensure that sufficient time is allowed for meetings and that reports focus on key issues and do not just contain lots of data.					

D. Staff Governance Committee specific questions							
D1.	The Committee is provided with appropriate assurance that the corporate risks related to the specific governance areas under its remit (i.e. those related to either Clinical, Finance and Performance, or Staff) are being managed to a tolerable level.	4 (36%)	6 (55%)	1 (9%)	-	-	In the main I agree with this in terms of the regular reporting - obviously some areas as in all Boards can be improved upon. What is clear is that these are discussed in terms of tolerable risk and if it was ever felt that this was not the case as stated above the IPQR discussion at every Board meeting ensures that this could be escalated appropriately. The absence figures prevent quite a challenge / risk to the day to day services delivered and I don't believe this is managed well enough. Strategic risks discussed at committee. It is not always clear the influence the committee has on risk levels. Suggested improvements in this regard are being addressed.
D2.	The performance information and data presented to the Committee allows for easy identification of deviations from acceptable performance (both negative and positive).	6 (55%)	4 (36%)	1 (9%)	-	-	Via IPQR and ad hoc reports where these are necessary. Could be more focussed in this respect.
D3.	Where there is a negative deviation from acceptable performance, the Committee receives adequate information to provide assurance that appropriate action is being taken to address the issues.	4 (36%)	5 (46%)	1 (9%)	1 (9%)	-	Again, around attendance management, I don't believe there is enough action being taken.

Staff Governance Committee

DATE OF MEETING:	6 March 2020
TITLE OF REPORT:	Annual Accounts – Progress Update on Audit Recommendations
EXECUTIVE LEAD:	Margo McGurk, Director of Finance
REPORTING OFFICER:	Gillian MacIntosh, Head of Corporate Governance

Purpose of the Report
For Information

SBAR REPORT
Situation The purpose of this report is to provide an overview of the recommendations emerging from both the Internal Audit Annual Report and the Audit Scotland Annual Report for 2018/19, and the resultant actions progressed to date.
Background As part of the overall governance and assurance processes of the Board, both the Chief Internal Auditor and the Board's External Auditor (currently Audit Scotland) are required to provide an annual report within the dimensions of their respective remits.
Assessment **Audit Recommendations:** Both internal and external audit provided a series of recommendations for the Board, with these set out in the form of Action Plans. These are attached as Appendices 1 and 2 to this paper, with updates of specific actions taken to end of February 2020.
Recommendation The Staff Governance Committee is asked to: • **note** the actions taken to date, particularly in relation to the recommendations related to areas under its remit.

Objectives: (must be completed)	
Healthcare Standard(s):	Governance and assurance is relevant to all Healthcare Standards.
HB Strategic Objectives:	All

Further Information:	
Evidence Base:	N/A
Glossary of Terms:	SGHSCD – Scottish Government Health and Social Care Directorates
Parties / Committees consulted prior to Health Board Meeting:	Executive Directors Group; Board Committees

Impact: (must be completed)	
Financial / Value For Money	Financial Governance is a key component of the assurance process.
Risk / Legal:	Actions taken in response to audit recommendations seek to

	address / mitigate any risks identified
Quality / Patient Care:	Quality & patient care are a core consideration in all aspects of governance including financial governance.
Workforce:	Workforce issues are a core consideration in all aspects of governance including financial governance.
Equality:	Equalities issues are a core consideration in all aspects of governance including financial governance.

Annual Internal Audit Report 2018/19 Action Plan

Finding	Recommendation	Management Response	Responsible Director Action by Date	Relevant Governance Committee	Update on Progress as at 29 February 2020
1. The annual statements of assurance from the Standing Committees provide an opportunity for reflection on the work of the Committee in the year, key issues for the coming year and the BAF risk4s delegated to the Committee as well as the quality and timing of assurances received. Our work indicates that this opportunity is not always being taken and that the quality of assurances provided by Standing Committees could be improved. Standing Committee Annual Reports do not routinely contain assurances over the BAFs assigned to that Committee.	The Board should consider the process by which the Annual Reports are approved and whether there would be merit in setting aside more time for considered reflection, rather than the Annual Report being potentially considered as just another item on a crowded agenda. The template for Standing Committee Annual Assurance Statements could assist in this process by including: • confirmation that they have considered all items on their workplan • explanations for any exceptions and overt consideration of whether they impact on the Committee's ability to provide meaningful assurance • Consideration of relevant internal and external audit reports (see recommendation 3) and external reviews received and their impact on the assurance provided • Commentary on any BAFs for which the Committee is responsible including: • assurance on the accuracy of the score, • the reasons for any movements in-year • the adequacy and effectiveness of the controls described in the BAF • the sufficiency of actions intended to bring the score to its target level the relevance and reliability of assurances over those controls and actions Some Committees may benefit from additional support/training in understanding the assurance requirements of the Board and we would note that the assurance mapping due for 2019/20 should assist in this process.	At present, Board Committee annual statements of assurance are largely prepared by the lead Director for each Committee, leading to some variability in both format and content. For future years, it is proposed that the Board Secretary co-ordinates their production and work to enhance the current template will be part of that exercise. Consideration will be given to including the additional content above to improve the quality of the assurances given.	**Board Secretary** **31 May 2020**	Audit & Risk	In progress. Consideration being given as to how to progress this, taking the advice of the internal auditors on the assurance letter guidance contained within the Scottish Public Finance Manual.

2. Formal assurances were provided by the Executive Directors and Senior Managers of NHS Fife that adequate and effective internal controls have been in place in their areas of responsibility, we note that only seven out of twelve assurance statements included a statement on the risk management arrangements within their area.	As with Standing Committees there is an opportunity to enhance the template but also to consider the process through which these assurance statements are produced and quality assured. Consideration should be given to the SPFM assurance letter guidance which is the subject of ongoing discussions between Internal Audit and the SGHSCD.	A review of the current process for capturing the assurances of senior staff, including the revision of the current template and consideration of which posts should be included in the exercise in future years, has already been agreed in discussions with the External Auditors. The input of Internal Audit would be welcome, to ensure that the new process is fully compliant with SPFM guidance and how this is expected to be implemented locally.	**Director of Finance & Performance and Board Secretary** **31 March 2020**	Audit & Risk	Complete. Amended letter used for recent departures of Director of Health & Social Care, Director of Workforce and Chief Operating Officer. For future years, work ongoing at creating new questionnaire to support the production of year-end assurance statements.
3. The findings from our annual and interim reviews and other internal audit reports are not routinely reported to the relevant Standing Committee(s). We also noted that Audit Scotland's reports are not routinely presented to the relevant standing committee (eg the Audit Scotland Management Report 2017/18 included a finding relevant to Information Governance but was not presented to the Clinical Governance Committee). We also found areas where findings were reported but were not followed to their conclusion by the Committee. As a consequence, significant governance findings for which the agreed action had not been implemented were not identified by Standing Committees in their annual assurance statements.	Internal Audit reports, including annual and interim reports should be presented to the relevant standing committee(s) and relevant sub-committees/groups as they are published. External Audit findings should be similarly communicated. For significant findings, the Committee should establish a suitable monitoring process and ensure it is followed through to completion.	In conjunction with Internal Audit we will seek to align individual audit reports to a specific Committee of the NHS Board. As and when reports are issued, the distribution of the report will include the lead Director for the relevant Committee, for inclusion at the next meeting. The covering email should include an explicit statement reminding the Director of this responsibility (1). Any actions required and taken will be reported accordingly through the minute (2), with a parallel monitoring process (already in place) via the Audit & Risk Committee for both internal and external audit recommendations (3)	**Internal Audit(1)/Board Secretary(2)/Director of Finance(3)** **30 September 2019**	All	Complete. Template developed for use with audit reports tabled to other governance committees.
4. There have been significant and persistent delays in taking forward agreed improvements to the Risk Management Framework, going back many years.	An SBAR should be presented to the Audit & Risk Committee highlighting the challenges and reasons for the delay to the revision of the Risk Management Framework and how they will be addressed so that a realistic and achievable implementation schedule can be agreed and monitored and, most importantly, delivered.	We accept the recommendation and a report will be provided as described above	**Director of Nursing** **30 September 2019**	Audit & Risk	Complete. Final Risk Management Framework will be taken to Audit & Risk Committee and NHS Fife Board in March 2020.

5. Although high level updates on the preparation and approval of the NHS Fife Workforce Strategy have been provided to the SGC in 2018-19 it has not been formally updated on progress towards implementing the NHS Fife Workforce Strategy Action Plan, though we have been informed that the intention is to provide updates to the SGC using the action plan to the new strategy. The Terms of Reference of the NHS Fife Strategic Workforce Planning Group state that '*Work Generated by the group shall be formally reported to EDG and the Staff Governance Committee as appropriate*' but does not include a specific responsibility to provide an annual update on progress against the Workforce Strategy Action Plan to the SGC.	The Terms of Reference of the NHS Fife Strategic Workforce Planning Group should be amended to include a specific responsibility to provide an annual update on progress against the NHS Fife Workforce Strategy Action Plan to the SGC. This is particularly important given that the Workforce Strategy is the key control listed in the Workforce Sustainability BAF. Assurance on progress against the NHS Fife Workforce Strategy from the NHS Fife Strategic Workforce Planning Group to the Staff Governance Committee should be scheduled in the Committee's Annual Workplan for 2019-20 before the SGC Annual Assurance Statement is approved.	The workforce strategy forms part of the current workplan for the Staff Governance Committee. The above recommendation will be incorporated into future workplans and reports will be made as appropriate to the Staff Governance Committee. The ToRs described above will be amended accordingly.	**Director of Workforce** **30 September 2019**	Staff Governance	In progress. An update was provided to Staff Governance Committee in January 2020 detailing the intention to review and publish the Workforce Strategy in line with the revised National Workforce strategy timetable. Updates on Workforce Strategy performance will be provided to the Committee on an annual basis and are built into the Staff Governance Committee annual work plan. The Terms of reference for the Strategic Workforce Planning Group will be amended to reflect the recommendations.
6. The NHS Fife Remuneration Sub-Committee has not undertaken a self assessment using the self assessment pack issued by Audit Scotland for 2017/18 or 2018/19.	The self assessment checklist for the Remuneration Sub-Committee should be completed for the years of 2017/18 and 2018/19. The self assessment should be completed annually before the Remuneration Sub-Committee's Annual Assurance Statement	Discussion on a retrospective self assessment will be discussed at the Sub Committee in June 2019. The self assessment checklist will be incorporated into the overarching Board and Committee self assessment process for 2019/20. Any relevant aspects of the recommendations emerging from national work through the Blueprint for Good Governance will be taken into consideration.	**Director of Workforce** **30 June 2019** **Board Secretary** **31 March 2020**	Remuneration	Complete. Agreed that no retrospective self-assessment for Remuneration Committee for years 2017/18 and 2018/19 would be undertaken, due to limited use of this exercise. Self-assessment report for present year completed, to be considered at March 2020 meeting, using the same template as in use with other governance committees. As part of this process, the Audit Scotland case studies will be reviewed with Committee members.
7. Our recommendation from B08/19 (action point 10) regarding providing the Clinical Governance Committee with adequate assurance regarding compliance with the General Data Protection Regulations (GDPR), the Data Protection Act 2018, the Networks and Information Systems (NIS) Directive, the Public Sector Cyber Resilience Action Plan and the NHS Scotland Information Security Policy Framework has not yet been fully addressed as aside from high level reports on GDPR compliance presented to CGC in January and March 2019 overt assurance on these areas has not been provided. The original timescale for implementation of actions to address this recommendation was by 31 December 2018.	A report should be provided to the NHS Fife Clinical Governance Committee clearly stating the Board's current status of compliance with the General Data Protection Regulations (GDPR), the Data Protection Act 2018, the Networks and Information Systems (NIS) Directive, the Public Sector Cyber Resilience Action Plan and the NHS Scotland Information Security Policy Framework. The report should include overt statements on • How compliance with the NIS Directive will be managed and monitored • How NHS Fife will prepare for external review by the Competent Authority • How existing processes for GDPR, cyber-essentials and any other IG requirements will be assimilated/made congruent with the actions required for the NIS Directive • Overall assessment of likely gaps • Risk assessment.	We accept improvements are required in respect of overt assurance reporting to the Clinical Governance Committee. A detailed report, as described, will be considered by the Information Governance and Security Group in August 2019 for submission to the CGC in September.	**DPO/SIRO** **30 September 2019**	Clinical Governance	In progress. Since Audit B08/19 was compiled, there have been a further two audits - B06/20 and B08/20 - which now supersede. B06-20 Annual Internal Report has been completed and covers all the recommendations from B08/19. Any outstanding actions that remain will be followed up through the usual Internal Audit Follow-Up process.

8. The Executive Director's Annual Assurance Letter from the Chief Operating Officer for Acute Services Division who was identified as the Board's SIRO from 28 January 2019 provided their assurance as SIRO but only for the period from 28 January 2019 to 31 March 2019. No Executive Director's Assurance Letter was requested from the previous SIRO before they left.	The disengagement process for Executive Directors who leave NHS Fife should include obtaining from them an Executive Director's Assurance Letter covering the period they were in post.	We accept the recommendation and a process will be implemented to ensure appropriate assurances are received in the event of a Director leaving post	**Board Secretary** **30 September 2019**	Audit & Risk	Complete (see 2 above). Process now in place to capture these assurances at times other than year end.

Issue / Risk	Recommendation	Management Response	Responsible Director Action by Date	Relevant Governance Committee	Update on Progress as at 29 February 2020
1. PECOS access controls In 2017/18 we found three users with approval permissions on the PECOS purchasing system that were not appropriate to their job role. Audit testing this year found one of the users identified last year still had inappropriate access, a further three users had approval rights despite having left the health board and one user had changed roles and access to PECOS was no longer appropriate. **There is a risk that users have inappropriate access to PECOS and erroneous or fraudulent entries could be made.**	User access permissions for PECOS should be reviewed on a regular basis to ensure that the permissions granted are appropriate to job roles and relate only to current employees.	On occasion, individuals may remain on the system with authorisations delegated to their deputy, pending the replacement starting. We will work with eHealth colleagues to ensure the IT access termination documentation also covers PECOS; and with HR colleagues to remind line managers of the requirement to advise on movers/leavers.	***Head of Procurement*** ***30 September 2019***	Audit & Risk	In progress. A short life working group is being established with colleagues from eHealth, HR and also Financial Management, to ensure that support is available to Procurement staff with regards to appropriate permissions being granted / available within the system. An operational procedure will produced to confirm the process before the next update is due.
2. Changes to supplier details We reported last year that in the majority of cases no independent verification of changes to suppliers bank details were sought. From discussions with Finance staff this year there is still no agreed or consistent procedure for verifying changes. The Assistant Director of Finance – Financial Services confirmed the current procedure is to telephone suppliers when a letter from the supplier notifying a change in bank details is received. If an invoice is received that has new bank details on it there is no further verification. **There is a risk of exposure to fraud as not all requests to change bank details are verified from an independent source.**	A formal procedure should be prepared and shared with Finance staff which clarifies that all changes to supplier bank details should be verified as agreed by management in 2017/18.	An email has been sent to all ledger staff confirming the procedure for requested changes to supplier bank details. The desktop procedure is under review.	***Assistant Director of Finance*** ***31 July 2019***	Audit & Risk	Complete
3. Delivery of savings There is no information on the specific savings plans within the high level workstreams reported in the IPR or the proposals to address outstanding savings. **There is a risk financial targets will not be met as there is no detail on how savings will be achieved.**	Specific and achievable savings plans should be developed to ensure that the Board can deliver the required savings. Sufficient information on these plans should be provided to enable the FP&RC and Board to carry out effective scrutiny.	Detailed savings plans for 2019/20 have been considered via the IJB for Health & Social Care services but these are not sufficient to close the gap overall. The impact on the NHS Fife position has been requested from the Director of Health & Social Care. Detailed savings plans are in development for Acute Services, with a report to the FP&R Committee in May	***Director of Health & Social Care / Chief Operating Officer*** ***31 May 2019***	Finance, Performance & Resources	In progress. Discussions ongoing within the IJB in relation to delivery of savings. Reviewed the Deloitte recommendations and operationalised the improvements identified. These will be monitored through the ASD Performance Reviews within each Directorate.
4. Reliance on non recurrent savings NHS Fife continues to rely on non recurrent savings to deliver against the statutory financial target of break even and is relying on financial flexibility to offset the significant overspend within Acute Services. **There is a significant risk that the Board will not deliver the savings required to achieve a balanced budget on a recurring basis which increases the pressure on budgets in future years.**	The Board should take steps to reduce its reliance on non recurrent savings to achieve financial targets.	This issue is recognised and will be addressed in line with the previous action above.		Finance, Performance & Resources	Delivery of savings, within the context of the overall financial position, is a high risk on the BAF. A financial recovery plan is an essential component of the Annual Operational Plan for 2020/21.

5. Openness and transparency The NHS Fife website is not user friendly and some information, including committee papers, is either not available or is difficult to find. **There is a risk that the lack of information on the website impacts on the public's perception of the health board's openness and transparency.**	The NHS Fife website requires further improvement to make it more user friendly. Committee papers should be uploaded on a timely basis.	This issue is recognised. NHS Fife intends to invest in the creation of a new website design, hosting and development platform in 2019. This will be equipped witih enhanced search, clear navigation and accessible service modules, viewable on a range of devices. A new content management system will ensure that the new NHS Fife website will be future proof, while still being capable of accommodating and indexing existing historical content. Meantime, a more robust checking procedure has recently been introduced to ensure that Board and Board Committee papers are uploaded timeously after the issue of papers to members and that the resultant file posted on the website is subsequently accessible to all users.	***Head of Communications*** ***31 December 2019***	Finance, Performance & Resources	In progress. Procurement and tender process completed. External agency appointed in December 2019 to host and develop the new NHS Fife website. Redesign of the website structure and navigation has begun and the first phase of the new website development due to go live on 1st April 2020. This first phase will include a dedicated "Governance" area to host information about NHS Fife Committees and Groups, NHS Fife Board membership, meetings and associated papers.
6. Escalation of issues to the NHS Fife Board There is a lack of follow up in relation to some items escalated to the NHS Fife Board by the Board committees. **There is a risk that issues escalated for consideration by the NHS Fife Board are not subject to effective scrutiny at this level.**	Further enhancement of the Board escalation process is required. There should be sufficient time and resources set aside at Board meetings to ensure there is proper consideration of the items escalated from committees. This should include appropriate follow up of ongoing issues.	There is no limitation placed by the Board on the time presently allowed for the escalation of items from Board Committees. Some key issues initially identified by Committees as matters for escalation to the Board can on occasion be covered elsewhere in the agenda, but Committee Chairs are all aware of the need to discuss potential topics for escalation at Committee meetings and explicitly identify these in the cover sheet accompanying Committee minutes. Items for subsequent follow-up by the Board will be flagged as such in the Board's rolling Action List.	***No further action required***	All	Complete

7. Committee self- assessment process Members have identified several areas to improve the effectiveness of committees but no action on these has been taken to date. **There is a risk that action is not taken on the results of the self-assessment process to improve the effectiveness of governance committees.**	A Board meeting or development session to consider common and/or ongoing issues identified as well as any further improvements to the process should be arranged and appropriate actions agreed.	After initial consideration by each Committee in March, the Board has considered the results of the Committee self-assessment exercise at its scheduled Development Session in April 2019. An action plan has been created, aligning this improvement work with the local implementation of the new NHS Scotland Blueprint for Good Governance, to ensure that governance-related improvements are co-ordinated and standardised across all Board Committees. A revised Committee questionnaire format, taking account of members' feedback on this year's process, will be put in place for the next iteration of the survey, to be undertaken across all Committees in late 2019.	***Board Secretary*** ***31 October 2019***	Audit & Risk	Update given to the Board in November 2019 on completion of the current Blueprint Action Plan, and this reported externally to the Scottish Government. Revised committee self-assessment questionnaire agreed with Committee chairs and completed by members in Dec 19/Jan 20.

8. Health and social care partnership arrangements Some of the local challenges around operational and governance arrangements for the health and social care partnership have not been fully resolved. Staff and members are sometimes predisposed towards the interests of their employing organisation rather than the partnership. **There is a risk that the health and social care arrangements in Fife are not operating effectively.**	The operational and governance arrangements between the Board and IJB should be clarified to ensure that staff, senior management and members of the partner bodies work as a partnership.	Fife – like all HSCP's – have been asked by SG & COSLA to complete a self-assessment against the recommendations of the Ministerial Steering Group Review of Integration. That self-assessment is to be completed and returned by 15 May. Senior leaders in the HSCP, NHS Fife and Fife Council met recently to discuss the self-assessment. That is now being worked up and will be agreed amongst all partners before submission on 15 May. The governance structure of the IJB remains under development, though further work has been undertaken in recent months by Partnership colleagues to create H&SCP versions of key governance documents (such as induction manuals and revised Committee Terms of Reference) to address the outstanding deliverables of the IJB's Governance Framework Action Plan (dated July 2018). A proposed review of the Integration Scheme by the parent bodies in 2019 will provide an opportunity to reflect on the current governance structures in place and make further changes to clarify roles and responsibilities, supporting effective partnership working.	***Chief Executive*** ***30 September 2019***	All	In progress. This matter is being addressed through the H&SCP / NHSF / FC joint response to the Ministerial Steering Group report on Integration, which includes a detailed action plan. This is being led by the Director of Health & Social Care. Meetings are also currently underway with Integration Partners to review the present Integration Scheme, which will take into account existing governance structures and reporting lines, with the intention to bring a revised version of the Scheme for Partners' approval in Spring 2020.
9. IT data recovery There is no technical recovery procedure for either Trakcare or Patientrack at the present time. Scheduled data recovery testing has not been done for several years. **There is a risk that data recovery procedures are not effective resulting in the loss of data essential to patient care and/or business continuity.**	Technical recovery procedures for critical IT systems should be prepared. IT data recovery should be tested on a rotational basis that ensures all aspects are included, procedures are effective and that staff are familiar with the procedures and can implement them in a variety of scenarios.	Ongoing Network improvements between primary and secondary platforms for these systems will drive new recovery point and time objectives. These will be documented within a Business Impact Analysis (BIA) and new Technical Recovery Procedure Documentation. The BIA will also drive future recovery testing scope and frequency.	***General Manager, eHealth*** ***31 December 2019***	Clinical Governance	Attrition and flux within the technical teams and delays lining up the supplier (Service Catalogue and BIA assessment) has pushed this work back. The expected date of completion is now **30 June 2020**. February 2020 - no update to add.

10. Organisational resilience self-assessment There is no formal action plan to monitor progress in respect of those standards included in the NHRU framework which were identified as not fully implemented following the Board's self-assessment in August 2018. **There is a risk that improvements to the Board's organisational resilience identified from completing the self-assessment are not achieved.**	A formal action plan should be prepared to monitor progress in implementing the NHRU resilience standards.	Whilst the Board has been addressing the issues outlined in the report, a formal action plan has not yet been approved. This will be submitted to the NHS Fife Resilience Forum in July 2019.	***Director of Public Health*** ***31 July 2019***	Clinical Governance	Complete. An action plan has been approved and delivery thereof is well underway. Scottish Government have responded to our initial self-assessment and a further progress update to SG will be prepared for submission in April 2020. An update in the meantime will be given to Clinical Governance and the Board in January 2020.
11. Cyber security There is no evidence of regular updates on issues such as progress towards achieving cyber essentials accreditation being provided to the Board during 2018/19. **There is a risk that cyber resilience efforts do not receive support and commitment at Board level.**	Updates on progress towards achieving cyber essentials accreditation and other digital issues should be reported to the NHS Fife Board periodically to ensure these receive the necessary support.	A Cyber Resilience Governance plan was agreed under Key Action 2 of the Scottish Government Cyber Resilience Framework 2018. This includes a reporting and assurance path to the NHS Fife Board. The scope and context of these reports are now being devised and will drive the level of detail presented to the Board.	***General Manager, eHealth*** ***31 December 2019***	Clinical Governance	A change of Cyber Security Manager (who was assigned this work) has caused a delay. However, a Cyber Resilience Plan has now been drafted and this will drive the reporting based on the key deliverables. Full report path expected to be in place by **30 March 2020**. February 2020 - no update to add.
12. GDPR compliance We have been informed that the health board is not expected to be fully compliant with GDPR until December 2019. **There is a risk that non compliance could result in data breaches, fines and adverse publicity**	NHS Fife should take action to address compliance with GDPR as a matter of urgency.	NHS Fife currently have the correct policies and procedures in place to satisfy the Information Commissioners Office from a legislative perspective. NHS Fife are conducting a robust audit of the 12 areas in relation to GDPR as part of a business improvement plan, to ensure full compliance which is anticipated to be completed by no later than 31/12/19. Audits in this area will be continuous as compliance is at a 'point in time' and is subject to constant change.	***General Manager, eHealth*** ***31 December 2019***	Clinical Governance	Complete. The 12 areas in the GDPR Business Plan have now been addressed and implemented. The quarterly Information Governance & Security (IG&S) Group (which is the ISMS under its Terms of Reference) is kept appraised of the status of GDPR compliance via the reports submitted. The NHS Fife SIRO chairs the IG&S Group and is a Director who sits on the Board and therefore is able to raise any appropriate GDPR risks or issues as they deem necessary. The Information Governance department has implemented principle of Plan, Do, Check, Act (PDCA) to ensure that appropriate responses to changes to the organisation or its operations that raises the risk of GDRP non-compliance.

13. Sickness absence Sickness absence remains at a high level despite continuing efforts to improve performance. There is no clear action plan to enable more effective scrutiny and no monitoring of what actions are achieving a successful outcome. **There is a risk that sickness absence will remain at a high level and impact on staff morale, quality of care and the achievement of statutory performance targets.**	NHS Fife should develop a better understanding of the underlying reasons behind sickness absence levels and identify those actions which are resulting in improvements. An action plan, with clear objectives and milestones, would help to monitor progress and enable the SGC to scrutinise the process. The Board could also ask other health boards what actions they have taken to improve attendance rates.	Attendance Management is a standing item on the Staff Governance Committee Agenda. This enables monitoring of performance in this area and surveys have been conducted in "hot spot" areas to identify further underlying reasons for absence. The report also includes data on reasons for absence and the work and actions being taken to improve attendance levels. Dialogue has taken place with other Boards in terms of improvement actions. Improvement targets are also being set for all areas. This narrative will be converted into an Action Plan as per the recommendation.	***Director of Workforce*** ***30 September 2019***	Staff Governance	Complete. Monthly improvement trajectory is discussed at EDG in advance of consideration at APF and Staff Governance Committee. An action plan has been agreed and is being taken forward for the Well @ Work initiative. The recently revised IPQR highlights key improvement actions. This will continue through the year.
14. Transformation programme governance framework Revised transformation programme governance arrangements have not been formally agreed by any NHS Fife or IJB governance committees or the NHS Fife Board. There is a lack of consistency in the understanding of the assurance lines to the Board and its governance committees on the programmes reported separately through the IJB. The JSTG is not operating effectively and the Community Transformation Board does not appear to be operating as expected. **There is a risk that transformational change and implementation of the Clinical Strategy does not progress as planned.**	The transformation programme governance arrangements and any subsequent revisions should be formally agreed by the Board and the IJB The revised framework should clarify the assurance lines to NHS Fife for the transformation programmes led by the IJB, including the remit of the Community Transformation Programme Board	A joint programme of strategic and operational transformation is essential to the sustainability of services. As such we are implementing a refreshed approach under the leadership of the Chief Executive and Director of Finance & Performance; as well as an enhanced framework of performance and accountability between operational services and the Board's governance Committees	***Director of Finance & Performance*** ***30 September 2019***	All	In progress. The need for focus on joint transformation has been recognised and the outcomes from the summer Joint Transformation Workshop has informed the savings plans of the Health Board and IJB, with further work underway.
15. Reporting on progress with the transformation programme There is no consistent reporting framework for the transformation programme. There is a lack of focus on targets, milestones and timescales and papers are not always available on a timely basis. **There is a risk that progress with the transformation programme is not subject to effective scrutiny.**	The agreed governance framework should include a basis for reporting to each of the groups identified in the framework, including the CGC and JSTG or its replacement. Reporting on progress should focus on outcomes and timescales and papers should be issued on a timely basis.	This issue is recognised and will be addressed in line with the previous action above		All	The refresh of the governance arrangements for transformation across Fife has resulted in the establishment of the Integrated Transformation Board (ITB). Further support is available via the Interim Director of the Project Management Office for a six-month period.

16. Update on the Clinical Strategy The report on the Clinical Strategy - Two Years On is overdue. Previous updates on the Clinical Strategy recommendations summarised progress to date but didn't highlight the outstanding actions or identify the timescales needed to ensure all the recommendations are fully implemented by the end of the five year period. **There is a risk that gaps in transformational change required to implement the Clinical Strategy are not identified.**	An annual update on the Clinical Strategy recommendations should be prepared on a timely basis. The update should highlight outstanding areas and how these will be addressed as well as the progress that has been made.	The first annual update of the Clinical Strategy was a very high level document outlining some of the progress against the Clinical Strategy recommendations. Plans were in place to repeat this update but was delayed due a vacancy since February 2018 in the Planning team until March 2019. An update on the progress of the transformation programmes associated with the Clinical Strategy is provided to the Clinical Governance Committee every 2 months. These programmes are reviewed and agreed at the start of each financial year in the Annual Operational Plan which includes the identification of the strategic priorities for NHS Fife. This is the process that would identify risks to the organisation in the delivery of the Clinical Strategy. A paper providing an update on the recommendations from each of the Clinical Strategy workstream reports was provided for the Clinical Governance Committee in March 2019 and described progress of the transformation programmes as well as other improvement work in individual clinical services not captured elsewhere	***Associate Director of Planning & Performance*** ***30 September 2019***	Clinical Governance	In progress. As the Clinical Strategy is in its fourth year, the proposal is to undertake a full review of the recommendations of the Clinical Strategy by May 2020, with a revised Clinical Strategy 2021-26 being approved by the Board by the end of the year.
17. Timetable for unaudited accounts We received the unaudited accounts on 10 May 2019 therefore the deadline of 3 May 2019 agreed in our annual audit plan was not met. We identified several areas where improvements to working papers or dependency on key personnel could improve the efficiency of the audit. **There is a risk his could delay completion of the final accounts audit beyond 30 June.**	NHS Fife should ensure that the agreed timetable for presenting the unaudited annual report and accounts for audit is met and a more complete set of working papers should be readily accessible. Consideration should also be given to addressing key person dependencies.	Agreed. We will review our internal timetable and key responsibilities to ensure the complete draft accounts are available on a timely basis. We accept the level of knowledge and expertise in some technical areas is held by one individual but in a small team it is difficult to have more than one person fully up to speed but where feasible, we will look to put cross over arrangements in place.	***Director of Finance*** ***31 March 2020***	Audit & Risk	Timetable for 2019/20 annual accounts has been agreed as part of External Audit Annual Plan, and internal support will be aligned appropriately.

18. Holiday pay accrual The holiday pay accrual includes medical and dental staff who have individual leave years beginning on the anniversary of their start dates. There is no centralised record of annual leave and data from individual staff are not collected. Management estimates the leave accrual for this group of staff based on the percentage applied to all other staff. This amounted to one day per medical and dental individual. In the previous year this was set as a maximum of five days. The estimate is subject to management bias **There is a risk expenditure is subject to manipulation through management estimates and expenditure for the year is misstated.**	A method of collecting and collating a significant sample of individual balances should be introduced for medical and dental staff.	We will review the sampling method in place to determine if it is feasible to replicate the process for medical & dental staff or identify an alternative means of ensuring a robust approach for this calculation.	***Deputy Director of Finance*** ***31 March 2020***	Audit & Risk	In progress. The routine annual template to capture untaken annual leave for AFC and Executive Manager staff groups has been distributed to budget holders for their completion (early February 2020). This year a representative sample of untaken medical and dental staff will be collected in conjunction with Service Managers to inform the overall holiday pay accrual.
19. Efficiency savings NHS Fife is required to achieve efficiency savings of £17 million on a recurring basis from 2019/20. The majority of savings have been allocated to workstreams but the detailed plans on how these will be delivered have yet to be fully developed. **There is a risk financial targets will not be met as there is a lack of clarity in how the required savings will be achieved.**	Detailed savings plans should be developed to ensure that NHS Fife can deliver the required savings.	There are detailed plans in place for the health budgets delegated to the Health & Social Care Partnership (c£7 million). The remaining £10 million target (for the Acute Services Division) is under review and a detailed plan requested for the Finance, Performance & Resources Committee in July 2019. Significant efforts have been made to reduce from a recurring gap of £30 million in 2016/17 to a £17 million gap for 2019/20.	***Chief Operating Officer*** ***31 July 2019***	Finance, Performance & Resources	See update provided for items 3 & 4 above.

STAFF GOVERNANCE COMMITTEE – ANNUAL WORKPLAN 2020/21

	Lead	May	July	Sep	Oct	Jan	Mar
Governance							
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓	✓
Minutes of other Committees & Groups	**Chair**	✓	✓	✓	✓	✓	✓
Board Assurance Framework (BAF)	**Director of Workforce**	✓	✓	✓	✓	✓	✓
Review of Committee's Terms of Reference	**Board Secretary**						✓
Committee Self Assessment Report	**Board Secretary**						✓
Annual Assurance Statement	**Board Secretary**	✓					
Annual Workplan	**Board Secretary**						✓
Corporate Calendar – Committee Dates	**Board Secretary**			✓			
HR Policies Monitoring Update	**Head of Staff Governance**			✓		✓	
Dignity at Work Action Plan	**Head of Staff Governance**			✓			
Whistleblowing	**Director of Workforce**		✓				
Brexit	**Director of Workforce**				✓	✓	✓
Risk Management	**Director of Workforce**			✓			
Planning							
Nurse Recruitment Update	**Director of Nursing**	✓					✓
Consultant Recruitment Update	**Head of HR / Medical Director**	✓				✓	
Workforce Strategy Update	**Director of Workforce**		✓				
Workforce Projections	**Director of Workforce**		✓				
Young People's Workforce Strategy	**Director of Workforce**			✓			
Digital Readiness	**Head of eHealth**		✓				
Medical Revalidation Update	**Medical Director**				✓		
Performance							
Integrated Performance & Quality Report	**Director of Workforce**	✓	✓	✓	✓	✓	✓
Attendance Management Update	**Head of HR**	✓	✓	✓	✓	✓	✓
Well at Work	**Head of HR**	✓	✓	✓	✓	✓	✓
Core Training Update	**Head of Staff Governance**		✓			✓	
KSF / TURAS Update	**Head of Staff Governance**		✓		✓		
iMatter Update	**Head of Staff Governance**		✓		✓		✓
Health & Social Care Staff Experience Report – iMatter	**Head of Staff Governance**	✓					

	Lead	May	July	Sep	Oct	Jan	Mar
Staff Governance & SG Standards							
Draft Staff Governance Action Plan	**Head of Staff Governance**						✓
Staff Governance Action Plan Mid-Year Review	**Head of Staff Governance**			✓			
Final Staff Governance Action Plan & Year-End Review	**Head of Staff Governance**	✓					
Staff Governance Annual Monitoring Return	**Head of Staff Governance**			✓			✓
Well Informed – Communication & Feedback	**Head of Staff Governance**	✓					
Appropriately Trained	**Head of Staff Governance**		✓				
Involved in Decisions	**Head of Staff Governance**				✓		
Treated Fairly and Consistently	**Head of Staff Governance**			✓			
Improved and Safe Working Environment	**Head of Staff Governance**					✓	

Item 7.6

STAFF GOVERNANCE COMMITTEE

DATE OF MEETING:	6 March 2020
TITLE OF REPORT:	The National Whistle blowing Standards
EXECUTIVE LEAD:	Linda Douglas, Director of Workforce
REPORTING OFFICER:	Bruce Anderson, Head of Staff Governance

Purpose of the Report (delete as appropriate)		
For Information		

SBAR REPORT

Situation

The National Whistleblowing Standards have been issued in final draft form in advance of Parliamentary approval expected in the Summer 2020. The standards have been in development for a number of years and together with the appointment of the Independent National Whistleblowing Officer (INWO) and the appointment of Board Whistleblowing Champions set out the expectation on all NHS service providers to handle concerns that are raised with them and which meet the definition of a 'whistleblowing concern'.

Boards have been provided with the draft to assist in preparing for implementation in advance of Parliamentary approval.

The final draft standards are attached for Committee member information.

Background

The Public Services Reform (Scotland) Act 2010 empowered SPSO to develop simplified, standardised public sector Complaints Handling Principles. SPSO also established a Statement of Complaints Handling Principles that was approved by the Scottish Parliament.[1] The CHPs reflected and built upon that Statement of Complaints Handling Principles.

As well as emphasising quicker, simpler complaint handling by empowered and well trained staff, the Model CHP emphasises valuing complaints through recording all complaints, reporting key performance information and using lessons learned to improve service delivery. The seven models reflect the needs and circumstance of each service. However, there are some key elements common to all:

- A shared definition of what is and what is not a complaint;
- A two stage process where complaints are resolved as close to the point of service delivery as possible;
- Frontline resolution of complaints
- An investigation stage, which provides the organisation's final decision;

- Active learning from complaints through recording, reporting and publicising complaints information;
- A requirement to ensure that governance structures are actively involved in monitoring and learning from complaints.

Assessment

These Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to handle concerns that are raised with them and which meet the definition of a 'whistleblowing concern'.

These Standards are underpinned by a suite of supporting documents, which provide instructions on how the INWO expects concerns to be handled. Together these documents form a framework for the delivery of the National Whistleblowing Standards.

The Standards consist of:

Whistleblowing Principles

these underpin the approach that must be taken to handling any concerns raised by staff or those working in NHS services; and they include definitions of whistleblowing and whistleblower. **Whistleblowing** is defined in the Public Services Reform (the Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020 as:

when a person who delivers services or used to deliver services on behalf of a health service body, family health service provider or independent provider (as defined in section 23 of the Scottish Public Services Ombudsman Act 2002) raises a concern that relates to speaking up, in the public interest, about an NHS service, where an act or omission has created, or may create, a risk of harm or wrong doing.

Procedure Overview this provides definitions and an explanation of what is a whistleblowing concern, who can raise a concern, and a brief description of the procedure for handling these concerns (see Part 2).

Supporting information this sets out how the INWO expects the procedure to be applied, together with the governance arrangements that must be in place (see Parts 3-10). These sections are of specific relevance to the committee and inform the work to be undertaken to ensure effective implementation.

The aim is to provide a suite of documents and guidance which enable readers to refer readily to the parts used most often. The table of contents gives an overview of what each document contains.

These Standards are applicable across **all NHS services**. This means they must be accessible to **anyone** working to deliver an NHS service, whether directly or indirectly. This includes current (and former) employees, bank and agency workers, contractors (including third sector providers), trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

Specific instructions are provided for: NHS service providers (both Primary Care Services and contracted services):

Part 7 sets out what the INWO expects of these providers and how this should be achieved including Health and Social Care Partnerships (HSCPs)

Part 8 sets out expectations in relation to joint working arrangements between local authority and

NHS staff.

Organisations involved in providing student and trainee placements.

Part 9 sets out expectations relating to students and trainees raising concerns.

Part 10 sets out how volunteers should be given access to these Standards.

To ensure effective leadership and oversight, the INWO has developed governance requirements for Boards, both in relation to their own internal processes (Parts 4 and 5) and in relation to management of their primary care and other contractual services (Part 6).

Further information about the INWO and additional resources for implementation of the Standards will be available on the [INWO website].

It is anticipated that the Standards will be reviewed three years after implementation, to identify any potential improvements or amendments.

An implementation plan will be developed to ensure full compliance with the standards. Learning modules are being developed nationally in partnership with the INWO and SPSO staff with NHS leaders and will be rolled out shortly. Support with training has been offered by the INWO and their staff and arrangements are underway to co-ordinate the most effective use of this offer.

The national review and relaunch of the Whistleblowing Workforce policy as part of the Once for Scotland Policy work is developing in tandem with the Standards.

Recommendation

For Information:
The Staff Governance Committee is asked to **note** the contents of this report and the National Whistleblowing Standards.

Objectives: (must be completed)	
Healthcare Standard(s):	2020 Workforce Vision Staff Governance Standards: Well Informed Appropriately Trained Involved in decisions which affect them Treated fairly and consistently Provided with an improved and safe working environment
HB Strategic Objectives:	Complete iMatter roll out by 2017 in line with Scottish Government expectations. Meet Exemplar Employer Objectives

Further Information:	
Evidence Base:	An extensive Literature Review (published August 2012) focused primarily on exemplar organisations within the public and private sectors out-with NHS Scotland. University of the West of Scotland validated the NHSScotland Employee Engagement Index "The NHSSEEI is a robust, reliable, valid and popular measure of staff engagement. It is also an excellent tool to measure

	improvement in staff engagement".
Glossary of Terms:	EEI – Employee Engagement Index
Parties / Committees consulted prior to Health Board Meeting:	Report will go to Area Partnership Forum after Staff Governance Committee due to timing of meetings.

Impact: (must be completed)	
Financial / Value For Money	None
Risk / Legal:	None
Quality / Patient Care:	Engaged staff deliver a higher standard of quality patient care.
Workforce:	iMatter allows staff to express their views on their experience of working for NHS Fife and work within their teams to change or improve that experience.
Equality:	iMatter helps ensure staff are treated fairly and consistently in line with Staff Governance Standards.

INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Introduction to the Standards

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

1. These Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to handle concerns that are raised with them and which meet the definition of a 'whistleblowing concern'.

2. The Standards are underpinned by a suite of supporting documents, which provide instructions on how the INWO expects concerns to be handled. Together these documents form a framework for the delivery of the National Whistleblowing Standards. A comprehensive list of the documents is provided on pages 5 and 6.

3. The Standards consist of:

3.1. Whistleblowing principles

3.1.1. These underpin the approach that must be taken to handling any concerns raised by staff or those working in NHS services; and

3.1.2. They include definitions of whistleblowing and whistleblower (see Part 1).

3.2. Procedure overview

3.2.1. This provides definitions and an explanation of what is a whistleblowing concern, who can raise a concern, and a brief description of the procedure for handling these concerns (see Part 2).

3.3. Supporting information

3.3.1. This sets out how the INWO expects the procedure to be applied, together with the governance arrangements that must be in place (see Parts 3-10).

4. The aim is to provide a suite of documents and guidance which enable you to refer readily to the parts you most often use. The table of contents on pages 5 and 6 of this document gives an overview of what each document contains.

5. These Standards are applicable across **all NHS services**. This means they must be accessible to **anyone** working to deliver an NHS service, whether directly or indirectly. This includes current (and former) employees, bank and agency workers, contractors (including third sector providers), trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships. Specific instructions are provided for:

5.1. NHS service providers (both primary care services and contracted services):

5.1.1. Part 7 sets out what the INWO expects of these providers and how this should be achieved.

5.2. Health and social care partnerships (HSCPs):

5.2.1. Part 8 sets out expectations in relation to joint working arrangements between local authority and NHS staff.

5.3. Organisations involved in providing student and trainee placements:

5.3.1. Part 9 sets out expectations relating to students and trainees raising concerns.

5.4. Arrangements for volunteers:

5.4.1. Part 10 sets out how volunteers should be given access to these Standards.

6. To ensure effective leadership and oversight, the INWO has developed governance requirements for boards, both in relation to their own internal processes (Parts 4 and 5) and in relation to management of their primary care and other contractual services (Part 6).

7. Further information about the INWO and additional resources for implementation of the Standards will be available on www.inwo.org.uk.

8. It is anticipated that the Standards will be reviewed three years after implementation, to identify any potential improvements or amendments.

9. Text marked in [square brackets] indicates a link or development that will be available in the final version of the Standards, but which is still currently under development.

The National Whistleblowing Standards – Contents

Part 6: Board requirements and external services

- Requirement to meet the Standards
- Board oversight
- Ensuring compliance through contracts
- NHS boards and integration joint boards
- Working with higher education institutions
- Working with voluntary sector providers
- Providing a confidential contact

Part 7: Information for primary care providers

- Promoting raising concerns
- Requirement to meet the Standards
- How to raise concerns; options for small organisations
- Informing staff
- Recording of concerns
- Monitoring, reporting and learning from concerns

Part 8: Information for Integration Joint Boards

- Promoting raising concerns
- Requirement to meet the Standards
- Ensuring equity for staff
- How to raise concerns
- Recording of concerns
- Monitoring, reporting and learning from concerns

Part 9: Arrangements for students

- Student and trainee access to the Standards and the INWO
- Students raising concerns within NHS services
- Students raising concerns through course advocates
- Recording student concerns
- Support for the student
- Signposting to the INWO

Part 10: Arrangements for volunteers

- Volunteers' access to the Standards and the INWO
- Volunteers raising concerns within NHS services
- Volunteers raising concerns through the charity's representative
- Recording volunteer concerns
- Support for the volunteer
- Signposting to the INWO

INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 1

Whistleblowing principles

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

Whistleblowing principles for the NHS

These principles underpin how NHS services **must** approach concerns that are raised by staff, students and volunteers about health services.

An effective procedure for raising concerns (whistleblowing) is:

1. **open**
2. **focused on improvement**
3. **objective, impartial and fair**
4. **accessible**
5. **supportive to people who raise a concern and all people involved in the procedure**
6. **simple and timely, and**
7. **thorough, proportionate and consistent.**

1. Open

1.1. Handle concerns **openly and transparently** throughout the process. At the same time, recognise and respect that everyone involved has the right to confidentiality.

1.2. Have clear governance arrangements that make sure someone is accountable for putting in place the procedure for raising concerns, and for monitoring and reviewing that procedure.

1.3. Following an investigation, make sure that any **lessons learned are shared** locally and more widely across the organisation. This should include telling people what improvements have been made as a result of the investigation.

2. Focused on improvement

2.1. Actively encourage staff, students and volunteers to report any concerns about patient safety or malpractice. Encourage them to do this as part of their day-to-day work, even before the start of any formal procedure.

2.2. The procedure for raising concerns should reflect and promote excellence in providing services.

2.3. Use the outcomes of concerns to identify and demonstrate **learning and improvement** and share best practice, both in providing services and in the procedure itself.

2.4. Have systems in place to make sure all reported whistleblowing concerns are investigated quickly and appropriately, and to monitor how they are handled.

2.5. Use information from cases where concerns have been raised to:

- guide the organisation's performance, targets and standards; and
- identify trends and highlight problems, with the overall purpose of **continuously improving** the way services are provided and concerns are handled.

3. Objective, impartial and fair

3.1. Procedures for raising concerns should be objective, based on evidence and driven by the facts and circumstances. They should not be based on assumptions. This should be clearly demonstrated.

3.2. Gather relevant facts and confirm these in an **objective, confidential and sensitive** way.

3.3. Staff investigating concerns should be **impartial, independent and accountable**. They must not be involved in investigations where they have a conflict of interest, or may be seen to have a conflict of interest.

3.4. Procedures for raising concerns should be **fair** to the person raising the concern, people investigating concerns, and anyone else involved in the investigation.

4. Accessible

4.1. Communicate the procedures for raising concerns **clearly**. The procedures should be **easy to understand and accessible to everyone**.

4.2. Senior staff must welcome concerns and make sure they are handled by people who have the appropriate skills and knowledge to investigate the concern and are authorised to take action.

4.3. Make sure the National Whistleblowing Standards and the organisation's procedures for raising concerns are well-publicised.

4.4. Procedures for raising concerns should be written in plain, clear language. Avoid jargon and technical terminology as far as possible. If you need to use technical terms, make sure they are explained. Procedures should be **clear to all staff** and **there should be no doubt about how whistleblowing and whistleblowers are supported**.

5. Supportive to people who raise a concern and all staff involved in the procedure

5.1. **Offer support and protection** to all staff, students and volunteers who raise a concern or who are directly involved in a concern, at all stages of the process.

5.2. When someone raises a concern, listen to them, support them, treat them with dignity and respect, and be sensitive and professional.

5.3. Offer alternative methods to people who may not want to raise concerns with their line manager. This should include access to a confidential and impartial contact.

5.4. As far as the law allows, respect the **confidentiality** of any person who raises a concern, unless they agree that you do not have to.

5.5. Make staff, students and volunteers aware of all forms of support and guidance that are available to people involved in whistleblowing.

5.6. People who raise a concern must not be victimised or suffer detrimental treatment as a result of raising a concern. This includes bullying and harassment, inappropriate use of policies, breaking the terms of their contract, financial loss and reputational or professional damage.

6. Simple and timely

6.1. Procedures for raising concerns should keep to the National Whistleblowing Standards.

6.2. Timescales should be clearly published and met wherever possible.

6.3. Investigations into a reported concern should be thorough. In particularly complex cases this may mean it is not possible to keep to published timescales. If timescales are not met for a good reason, tell the person who raised the concern (and any other relevant person) the reason, and give them a revised timescale for completing the investigation.

7. Thorough, proportionate and consistent

7.1. Procedures for raising concerns should provide **good-quality outcomes** through a thorough but proportionate investigation.

7.2. There should be detailed, well-publicised quality standards for handling concerns, and these should be supported by a clear explanation of what action will be taken if the standards are not met.

7.3. Investigation methods and approaches to handling concerns should be **thorough and consistent, but proportionate and appropriate** to the circumstances of the case.

7.4. All concerns should be treated seriously.

7.5. Findings and conclusions should be based on analysing evidence and weighing up the facts and circumstances. Decisions should explain your reasons and show clearly how findings and conclusions were used.

7.6. The outcomes of investigations should be appropriate to the findings, and should set out what actions will be taken, or have been taken, to put things right or improve practice.

INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 2

The procedure and when to use it

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

Definitions

What is whistleblowing?

1. **Whistleblowing** is defined in the Public Services Reform (the Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020 as:

   when a person who delivers services or used to deliver services on behalf of a health service body, family health service provider or independent provider (as defined in section 23 of the Scottish Public Services Ombudsman Act 2002) raises a concern that relates to speaking up, in the public interest, about an NHS service, where an act or omission has created, or may create, a risk of harm or wrong doing.

2. This includes an issue that:

   2.1. has happened, is happening or is likely to happen; and
   2.2. affects the public, other staff or the NHS provider (the organisation) itself.

3. People also often talk about 'raising concerns' or 'speaking up'. These terms can also refer to whistleblowing. The issue just needs to meet the definition above, whatever language is being used to describe it.

4. Risks can relate to a wrongdoing, patient safety or malpractice which the organisation oversees or is responsible or accountable for. In a health setting, these concerns could include, for example:

   4.1. patient-safety issues;
   4.2. patient-care issues;
   4.3. poor practice;
   4.4. unsafe working conditions;
   4.5. fraud (theft, corruption, bribery or embezzlement);
   4.6. changing or falsifying information about performance;
   4.7. breaking any legal obligation;
   4.8. abusing authority; or
   4.9. deliberately trying to cover up any of the above.

5. A whistleblowing concern is different to a grievance. A grievance is typically a personal complaint about an individual's own employment situation. There is more information about raising concerns and bullying and harassment in Annex B.

6. Healthcare professionals may have a professional duty to report concerns. Managers and all staff (including students and volunteers) must be aware of this, as it can affect how and when concerns are raised. However, the processes for handling concerns should be the same for any concern raised.

Who can raise a concern?

7. **Anyone** who provides services for the NHS can raise a concern, including current (and former) employees, agency workers (and others on short or insecure contracts such as locums and bank staff), contractors (including third-sector service providers), trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social-care partnerships. A person raising a concern has usually witnessed an event, but they may have no direct personal involvement in the issue they are raising.

8. If the person does not want to use this procedure, see the section on confidentiality at paragraph 58 for more information.

9. More than one person can raise the same concern, either individually or together. Anyone receiving a concern must make sure they understand who wants to achieve what, and whether everyone wants to be kept informed and updated on the progress of any investigation.

10. It is important for everyone involved in this procedure to be aware that some people may feel at greater risk than others as a result of raising a concern. For example:

    10.1. employees whose employment may be less secure, such as agency staff or those who need a visa to work in the UK;
    10.2. students and others who are due to be assessed on their work; or
    10.3. people from any of the recognised equalities groups.

11. Some people may consider themselves to be more likely to be treated unfairly as a result of raising a concern, particularly if they are in more than one of the above groups. It is particularly important to make sure people are aware of the support available through this procedure, and that any concerns they raise are treated seriously.

12. If the person is raising a concern about a service that is not their employer, for example, a district nurse working in a GP service, a locum pharmacist working for an agency, or a care assistant working within an HSCP service, they must be able to raise concerns either direct with their employer or within the service itself, and they must have full access to the National Whistleblowing Standards (these Standards).

How to raise a concern

13. These Standards are designed to work with, not repeat or replicate, NHS processes and procedures that staff use every day to report what is happening in local areas. These processes and procedures are called 'business as usual' in the Standards.

14. People may report or mention issues through business as usual processes which could meet the whistleblowing definition. To avoid duplication and confusion, the procedure set out in these Standards should normally only be used if:

    14.1. no other procedure or processes are being used;
    14.2. an existing procedure or process has been used but has not resulted in the outcome the person raising the concern expected; or
    14.3. the person asks for the whistleblowing procedure to be used.

15. See below for more information about moving from business as usual to this procedure for raising concerns.

16. People should raise concerns within six months of first becoming aware of the issue the concern relates to. For more information on this, see Part 3 of the Standards.

Support and protection through the procedure

17. Nobody should be treated unfairly as a result of raising a concern, having a whistleblowing allegation made against them, or co-operating with any investigation. If staff are victimised as a result of being involved in a whistleblowing case, this must be treated as a disciplinary matter.

Support for the person raising a concern

18. It can be stressful and isolating to raise a concern, but when someone does raise a concern, they are trusting the organisation and giving it an opportunity to put right a wrongdoing or reduce risk. The organisation must repay this trust by protecting the person throughout the process and making sure they do not suffer any harm as a result of speaking up.

    19. Anyone receiving a concern must:
    19.1. thank the person for raising the concern;
    19.2. listen to them carefully;
    19.3. take the concern seriously; and
    19.4. reassure them that:
    - the concern will be handled sensitively;
    - they have done the right thing by raising the concern; and
    - they will not be treated badly, even if no risks are identified.

20. In some cases, it will be enough to thank the person raising the concern, and provide regular feedback on any resulting investigation. In other cases, the person may need more specialist support. Anyone receiving concerns must ask what support the person raising the matter may need and how this can be provided, when they first raise the concern. If support needs are identified, the appropriate resources must be provided wherever possible, and the person must be given contact details for support providers.

21. The support that is available may include:

    21.1. access to a confidential contact who can provide information and advice on the procedure for raising concerns, as well as support during the process;
    21.2. counselling or psychological support services for people suffering from stress because they are involved in this procedure;
    21.3. occupational health services which take account of the stress involved in raising a concern; and
    21.4. considering, with the person who has raised a concern, a range of actions to reduce any consequences they are facing (or think they may face) as a result of raising the concern. These actions may include making changes at work or putting in place temporary arrangements to reduce risk.

22. Anyone raising a concern may want to have someone to support them at meetings, or throughout the process. This could be a union representative, friend or colleague. If it is a friend, relative or colleague, their role is to support the person raising the concern rather than to represent them or respond on their behalf. Union representatives can be more involved in discussions, although it is best if the person raising the concern openly shares the information they have. It is worth noting that the person providing support may also face some risks through being involved in the process. The person the concern was raised with should discuss this with them, and provide appropriate support.

Employer's duty of care

23. Employers have a duty of care to their employees and must take all reasonable steps to protect their health, safety and well-being. They must do everything that is reasonable in the circumstances to keep their employees safe from harm. They also have a moral and ethical duty not to cause, or fail to prevent, physical or psychological injury.

24. Under their duty of care, employers may have to:

    24.1. ensure, so far as is reasonably practicable, a safe work environment; and
    24.2. provide adequate training so that employees can safely carry out their designated role.

25. Employees also have a responsibility to take reasonable care for their own health and safety at work. For example, they should be able to refuse to do work that would be unsafe for them, without fearing disciplinary action. An employee also has a duty to take reasonable care for the health and safety of other employees who may be affected by their acts or omissions at work.

26. In the context of raising concerns, this means that the organisation should have systems in place to protect anyone who raises a concern from detriment.

27. If it becomes clear that a person who has raised a concern is being (or may be) treated unfairly or victimised, managers must take action. This may include informal action or formal disciplinary procedures. In most cases, removing the person who has raised a concern from their workplace, either by relocating or suspending them, is not an appropriate response, as this reinforces the attitude that it is risky to raise concerns and shows that the organisation does not support people to speak up.

Legal protection for those raising concerns

28. The Public Interest Disclosure Act 1998 (PIDA) is often called the 'whistleblowing law'. It is there to protect all 'workers' (as defined in the Employment Rights Act 1996 – this classification is broader than, but includes all employees), who have made a 'protected disclosure' from being treated unfairly as a result of raising a concern. Protection against discrimination on the grounds of being a whistleblower, or appearing to be a whistleblower, is also given to applicants for work with some NHS employers (including NHS boards).

29. A concern is considered a 'protected disclosure' when it meets this legal test: the person raising it must **reasonably believe** that it is in the public interest to raise a concern, and that the information available shows that the following has happened, is happening or is likely to happen. For example:

    29.1. a criminal offence
    29.2. an act that creates a risk to health and safety
    29.3. an act that damages the environment
    29.4. a miscarriage of justice
    29.5. a breach of any other legal obligation not being met
    29.6. concealment of any of the above being covered up

30. A full list is available in the legislation here: http://www.legislation.gov.uk/ukpga/1998/23/section/1

31. It is important to note that making a 'protected disclosure' does not mean that the concern must be raised or investigated in a certain way. It provides legal protection for workers who suffer detriment **after** raising concerns. If a worker is unfairly dismissed or treated unfairly as a result of raising a concern, they can claim compensation under PIDA at an employment tribunal.

32. PIDA encourages workers to make the 'protected disclosure' to their employer first, if possible. However, this is not essential as it recognises that workers may have good reason for raising a protected disclosure outside their workplace (either before or after reporting the concern to their employer). PIDA lists the 'prescribed persons' with whom workers can raise a concern with, beyond their own employer, and still have their employment protected.

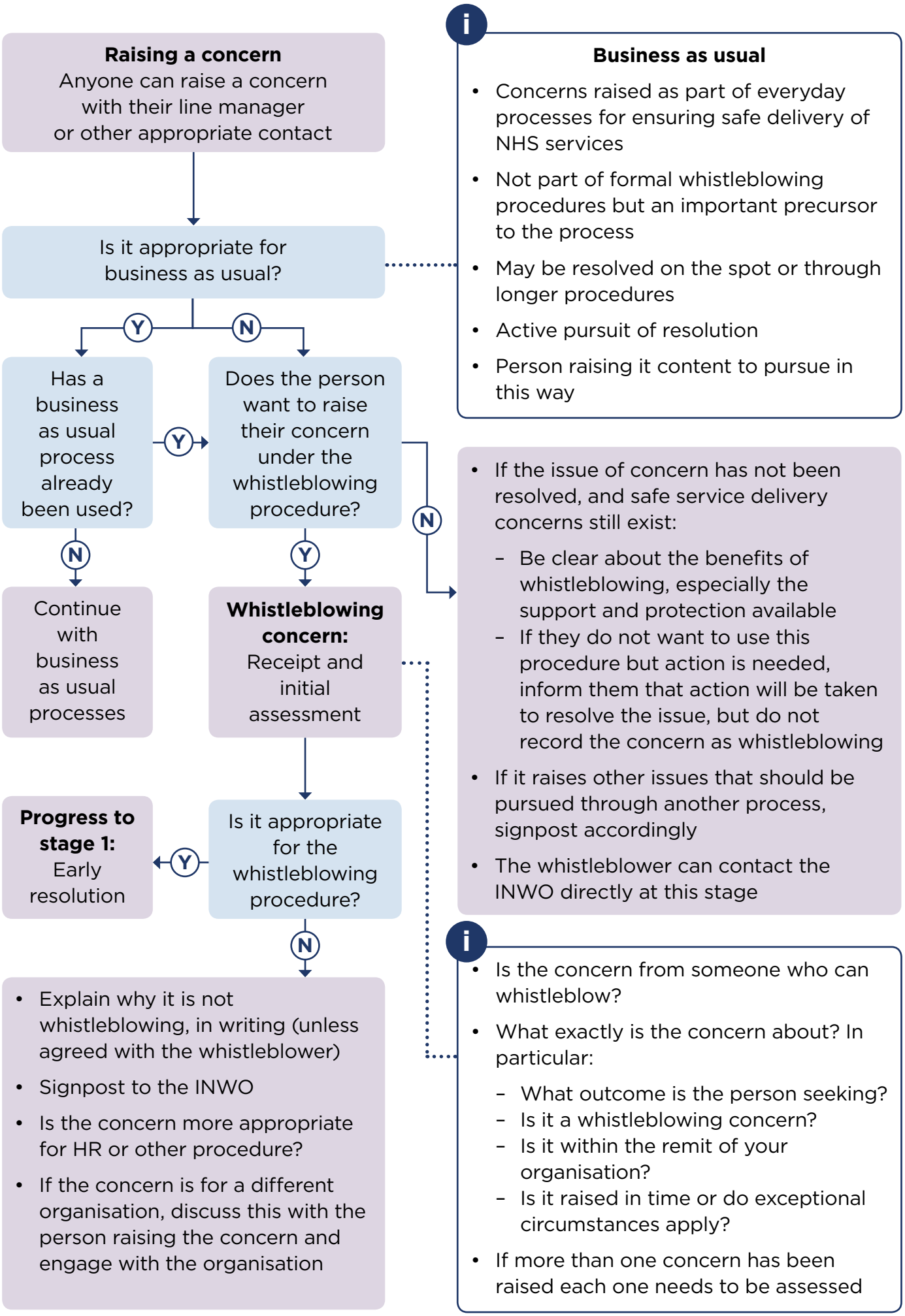
33. The Independent National Whistleblowing Officer (INWO) [is being added] to the list of organisations, so NHS employees [will be] able to raise their concerns direct. The INWO will approach each case on the basis that it is better for the organisation involved to identify the learning and improvements that are needed. However, they can agree to accept concerns direct if they do not feel it is reasonable to expect the person to use their employer's whistleblowing procedure. They will decide whether to do this case by case, but could take into account, for example, whether the organisation is very small or the issue involves very senior staff. In limited circumstances the INWO may be able to help make sure concerns are dealt with appropriately. This may include monitoring the progress of an investigation.

Overview of the procedure for raising concerns

34. The procedure for raising concerns aims to provide a quick, simple and streamlined process for making sure concerns are dealt with early and locally by capable, well-trained staff. It also includes actions to make sure people who raise a concern receive any support they may need, so that the process allows people to share information safely.

35. This overview summarises the main points, and provides further information to explain each stage.

Accessing the Standards



Stage 1 and 2 overview

Stage 1: Early resolution
Five working days

What to expect at stage 1

- On-the-spot explanation and/or action to resolve the matter quickly, in five working days or less
- Extend timescales with agreement if there are exceptional circumstances
- Handled by member of staff receiving the concern OR referred to appropriate person for early resolution (within five working days) OR progressed to stage 2 (within five working days)

If the whistleblower is not satisfied with the response at stage 1, or agreed action has not been taken, they can take their concern to **stage 2: Investigation**

Stage 2: Investigation
20 working days for definitive response

What to expect at stage 2

- Respond in 20 working days following thorough investigation of concern(s)
- Extend timescales to achieve quality investigation and outcomes
- Responses signed-off by senior management and must signpost to the INWO, including timescales

Action taken as agreed to resolve issue of concern and avoid any repeat

If the whistleblower is not satisfied with the response they have received to stage 2, they can bring their concern to the INWO for independent external review

INWO consideration

Anyone raising a concern can come to the INWO at any point in this process, and the INWO can provide information and advice to support the process

Closing the case at stage 1: information for case handlers

- Record details of the concern, outcomes and actions taken (or planned)
- Reflect on how the concern was handled: what went well and what could be improved

Closing the case at stage 2: information for case handlers

- Record details of the concern, outcomes and actions taken (or planned)
- Use the concern and outcome to improve services and patient safety

Information about the INWO

- Concerns that have completed the process will either have been thoroughly investigated or will have been refused by the organisation at initial assessment; these must be signposted to the INWO
- INWO may assess
  - how the concern was handled by the organisation
  - whether the organisation's decisions about the concern were reasonable
  - how the whistleblower was treated through the process
  - how the organisation supports a culture of speaking up

36. NHS boards and other NHS service providers must have arrangements in place to make sure the organisation supports people who raise a concern, takes all appropriate actions, and records and regularly reports on these concerns. They must also show they have learnt from any concerns that have been raised by putting in place service improvements, and share this learning with their staff and stakeholders.

Initial actions

37. All concerns are important to the organisation, and must be acted on to provide safe and effective care and treatment.

38. The *Accessing the Standards* flow diagram above works through whether a concern is appropriate for this procedure. The section below gives more information about how to make that decision.

Raising concerns through existing processes (business as usual)

39. People regularly identify risks or harm, and speak up to get them dealt with. This is usually very successful, with no repercussions for the person raising the concern. This is 'business as usual' and describes everyday processes or actions that deal with an issue or concern, including formal processes for identifying and improving patient safety. Some examples would be:

    39.1. reporting short staffing on DATIX (a system used for recording a range of incidents and reports by NHS boards), and action being taken to deal with this;
    39.2. raising an issue during a team meeting or handover, leading to an investigation or action (or both); or
    39.3. an issue being investigated through an existing safe-practice review or audit.

40. It's not possible for these Standards to apply to every action that is taken through business as usual processes. These Standards will only apply if the person raising the concern asks for it to be handled under this procedure.

41. However, people who raise a concern should not necessarily need to know these Standards. Managers should identify issues which would be appropriate to handle under these Standards, and tell the person about the procedure. This might apply, for example, if the person is worried about their concern not being acted on or if they are worried they might be victimised by colleagues or management as a result of raising the concern.

42. Organisations should have service standards in place for their various business as usual processes. Whatever the issue and however it is raised, the organisation is expected to respond appropriately to concerns, and must not tolerate victimisation of anyone who raises a concern. How the person is treated through business as usual processes, and the organisation's response to the concern, can form part of any subsequent investigation by the INWO.

Who to raise a concern with

43. There should always be several options for raising concerns.

    43.1. people can raise a concern with their line manager or team leader;
    43.2. they can raise their concern with a more senior manager if circumstances mean this is more appropriate;
    43.3. organisations should have a confidential contact that people can raise concerns with (in some places there may also be speak-up ambassadors or advocates);
    43.4. large organisations should also provide a single phone number and email address for raising concerns.

44. Whoever receives it, each concern must be taken seriously and handled in line with the Standards.

45. Any organisation that provides NHS services in Scotland must provide access to a confidential contact. This could be a contact within the board, with another service provider, or through an independent service with which the organisation has a contract.

46. Each board must have clear arrangements in place so people know who to approach if they have any concerns about senior management or board members (see Part 4 of the Standards). These arrangements must be agreed with the whistleblowing champion, and must be available to staff, including through their confidential contact.

47. Anyone who wants to raise a concern about senior management must be able to discuss the most appropriate course of action with the board's confidential contact or other speak-up representative. They will be able to suggest the appropriate action to take, or pass on the concern, based on their assessment of the situation and the approach the person would prefer to take.

48. The arrangements within primary care (see Part 7 of the Standards), and for students (see Part 9) and volunteers (see Part 10), may be slightly different.

49. Concerns about fraud within the NHS can be raised directly with NHS Counter Fraud Services (CFS). There is more information about this service at https://cfs.scot.nhs.uk/. However, if someone with a concern about fraud wants to ensure access to these Standards they should first raise it with their confidential contact, or other appropriate manager. Details of any potential fraud must be passed onto the board's fraud liaison officer within two working days (in line with existing arrangements between the CFS and NHS boards). The fraud liaison officer will pass on these concerns to NHS CFS.

Getting information or advice

50. Information and advice about what options are available, whether it is appropriate to deal with a concern under this procedure, or what to expect, are available from:

    50.1. National Alert Line (phone 0800 008 6112 or email alertline@protect-advice.org.uk);
    50.2. the board's confidential contact for raising concerns or other speak-up representative;
    50.3. the INWO (they can provide information and advice about how a concern should be handled, and can provide support through the process);
    50.4. union representatives;
    50.5. professional bodies;
    50.6. university representatives (for students);
    50.7. NHS Education Scotland (for trainee doctors and dentists); and
    50.8. volunteer coordinators (for volunteers)

51. Anyone raising a concern may also be able to get support from other organisations, such as:

    - their employer's occupational health service;
    - employee assistance programme;
    - chaplaincy services; and
    - Whistleblowers UK.

52. See Annex A for contact details for several relevant agencies.

Initial discussion

53. Once a concern has been raised (in writing, in person or by phone), there needs to be some discussion about whether the concern can be handled under this procedure. This should include:

    53.1. considering whether the issue fits the definition of a concern suitable for this procedure;
    53.2. considering whether the issue is being handled through business as usual;
    53.3. considering whether the person **wants** the issue to be handled through this procedure, and receive the support and protection that is available through it;
    53.4. directing the person to any other appropriate procedures (for example, HR procedures);
    53.5. considering issues relating to confidentiality; and
    53.6. considering what support would be helpful for the person.

54. If the person does not want to use this procedure, they can raise their concern without giving their name (see the section on anonymous and unnamed concerns below). The organisation can choose how to investigate the concern, but good practice would be to follow the whistleblowing principles, and investigate the concern in line with the Standards, particularly if existing business as usual procedures have not been able to deal with the issue successfully.

55. If the organisation decides a concern cannot be handled under this procedure (for some or all of the issues raised), even if the person raising the concern has asked for this procedure to be used, it must record this decision and tell the person how to refer the matter to the INWO. Both sides must agree whether a written response is needed, and this agreement must also be recorded. If possible, the organisation should tell the person face-to-face or over the phone that it won't be following this procedure. It is important to record full and accurate details of the decision not to consider the concern through this procedure, and to make sure that the person understands this decision. If there is information that the organisation cannot share with the person, it should explain why.

56. If the organisation is not responsible for the issue of concern, the person receiving the concern should signpost to the appropriate organisation, or contact the INWO directly to make sure the concern is passed on and acted on appropriately. Remember to keep the person's details confidential.

Immediate threat to safety

57. If someone raises a concern that needs immediate action to avoid any further risk to patient safety, **action must be taken**. This is likely to involve referring the matter to an appropriate senior manager, but it will depend on the situation. The person raising the concern must also be told that this will happen, and why. Any confidentiality concerns must be taken into account and discussions should cover all the same issues as the initial discussion (above).

Confidentiality and anonymity

58. **Confidentiality** refers to the requirement not to disclose information about the person raising a concern, unless the law says that it can or must be disclosed. This includes anyone else involved in the process, such as other witnesses.

59. **Anonymity** refers to a situation when nobody knows the identity of the member of staff who raised the concern.

Confidentiality and data protection

60. Confidentiality **must** be maintained as far as possible in all aspects of the procedure for raising concerns. Staff need to know that their identity will not be shared with anyone other than the people they have agreed can know it, unless the law says that it can or must be. **The name of the person raising the concern must not be routinely or automatically shared at any point, either during the investigation or afterwards.** There are, however, times when information about the person raising a concern will become clear to others, or when it will be necessary to share this information in order to put things right or continue with an investigation.

61. It is important that all aspects of confidentiality are discussed when the person first raises the concern, as not doing so may lead to the organisation breaking data-protection law. The person should be given clear information by the person

that is applying the Standards and processing their personal data (or personal information) about what might or will happen to this data and about the lawful basis for processing it.

62. The discussion should include:

    62.1. recording the concern, and who will have access to this information;
    62.2. who the concern will be shared with and why;
    62.3. who the person raising the concern is happy for their identity to be shared with, and in what circumstances;
    62.4. who else might need to know their identity and why;
    62.5. if there is a high risk that their identity could become clear to others, are there ways of reducing that risk; and
    62.6. what action could be taken to limit the number of people who are made aware of the concern, while still taking appropriate action.

63. It is important that all of the issues raised in the investigation are treated confidentially unless there is a lawful basis or requirement for sharing information with others.

64. To protect the identity of the person raising the concern, managers and clinical leads should look for ways to investigate the concern without making others suspicious. For example, making the investigation appear like carrying out business as usual or a random spot check.

65. There is more information in Part 5 of the Standards – *Governance: from recording to learning lessons*, on the organisation's responsibilities in relation to data protection and information sharing.

Anonymous and unnamed concerns

66. An anonymous concern is one that has been shared with the organisation in such a way that **nobody** knows who provided the information.

67. Alternatively, someone may raise a concern with the organisation but not be willing to have their name or personal details recorded. This is known as an 'unnamed concern' (someone is aware of their identity, so it is not completely anonymous).

68. While the organisation must respect the person's request for their concern to be unnamed, it must also make it clear to the person that if their name is not recorded, their concern **cannot** be handled under the Standards and they cannot refer the matter to the INWO.

69. The organisation should make it clear to all staff that they will not have the same level of protection if they raise an anonymous or unnamed concern as they would if their details were shared and recorded confidentially. Raising an anonymous or unnamed concern limits:

    69.1. the legal protections available to the person raising it;
    69.2. the organisation's ability to provide feedback and offer support; and
    69.3. the person's ability to ask the INWO to consider the matter.

70. If other staff guess the identity of the person who has raised concerns, that person may be at risk of unfair treatment if they don't have the protection or support these Standards provide.

71. Raising an anonymous or unnamed concern may also mean the concern cannot be investigated and handled effectively, as there may be significant gaps in the information needed for the investigation.

72. If an anonymous or unnamed concern is raised, managers should record as much information as possible and carry out an appropriate investigation. The organisation can choose how to investigate the concern, and sometimes will need to take immediate action to reduce risks. Good practice would be to follow the whistleblowing principles and investigate the concern in line with the Standards, particularly if existing business as usual procedures have already been attempted.

73. Although it is good practice, the organisation is not **required** to follow these Standards.

The difference between a grievance and a concern

74. A person raising a concern is usually a witness and may have no direct personal involvement in the concern they are raising. They are simply trying to tell management about the risks they have identified. These concerns usually affect other people; they are not **only** about matters that have a personal effect on the person raising the concern.

75. When a person raises a grievance or makes an allegation about being subject to bullying or harassment, this relates to their own employment situation, employment rights or how **they** have been treated.

76. Examples of a grievance include if the person:

    76.1. is not satisfied with their pay and working conditions;
    76.2. disagrees with their terms of employment or workplace rules;
    76.3. claims they are being treated unfairly at work;
    76.4. claims they are being bullied or harassed; or
    76.5. has a disagreement with a colleague.

77. See Annex B for examples of whistleblowing, grievances or bullying and harassment.

78. Sometimes a person may raise issues which contain both whistleblowing and grievance concerns. These issues need to be dealt with separately through the appropriate policies or procedures.

79. **If someone raises a combination of grievance and whistleblowing issues, the organisation must discuss all their concerns with them, and must tell them about all the options available to them, including services that may be able to support them.**

80. If a concern of public interest or patient safety is raised through a grievance procedure, the organisation must ask the person if they want the concern to be raised through these Standards, with the protection they provide.

81. Issues relating to employment rights may also have a wider public interest (for example, if poor working conditions are having a damaging effect on the service provided). If it is not clear whether an issue is a grievance or a whistleblowing concern, the manager (or confidential contact) should find out what the person raising the concern wants to achieve (for example, a solution for them personally or a solution for patients, the organisation or the public). It may be that, whatever outcome the person is hoping for, in the interests of providing a safe service, the public interest issue needs to be considered and investigated. The concern **must not** be recorded as whistleblowing if the person raising it does not want it to be.

Claims of unfair treatment

82 If someone raises a concern and, at the same time, claims they have been treated unfairly as a result of raising this concern through business as usual, the initial discussion must identify what outcomes the person would like to achieve. The organisation must also direct them to any appropriate HR procedures to make sure this can be handled appropriately. It is also particularly important to make sure appropriate support is in place to prevent any further unfair treatment. If the organisation does not do this, it would be failing to meet its duty of care to its employee.

Concerns raised maliciously

83. Every concern should be considered fully and properly, whatever others may say about why it has been raised. However, if a full investigation reveals that a concern was knowingly based on inaccurate information in order to create difficulties for a colleague, the organisation should take appropriate disciplinary action against the person who raised the concern.

Annex A: Contact details for support agencies, regulators and professional bodies

Allied Health Professions Federation
Phone: 0131 226 5250
Email: admin.ahpfs@ahpf.org.uk
Website: www.ahpf.org.uk/Contact.htm

British Dental Association
Phone: 01786 476040
Email: enquiries@bda.org
Website: www.bda.org/contact-us

British Medical Association
Phone: 0300 123 1233
Website: www.bma.org.uk/contact-bma

Care Inspectorate
Phone: 0345 600 9527
Email: enquiries@careinspectorate.com
Website: www.careinspectorate.com/index.php/contact-us

Dental Defence Union
Phone: 0800 374 626
Website: www.theddu.com/

General Dental Council (currently unable to provide support to their registrants)
Phone: 020 7167 6000
Website: www.gdc-uk.org/contact-us

General Medical Council (currently unable to provide support to their registrants)
Phone: 0161 923 6602
Email: gmc@gmc-uk.org
Website: www.gmc-uk.org/contact-us

General Pharmaceutical Council
Phone: 020 3713 8000
Website: www.pharmacyregulation.org/

General Optical Council
Phone: 020 7580 3898
Website: www.optical.org/

Health and Care Professions Council
Phone: 0300 500 6184
Website: www.hcpc-uk.org/contact-us/

Healthcare Improvement Scotland
Phone: 0131 623 4602
Email:hcis.respondingtoconcerns@nhs.net
Website: www.healthcareimprovementscotland.org/our_work/governance_and_assurance/responding_to_concerns.aspx

Medical and Dental Defence Union of Scotland
Phone: 0333 043 444
Website: www.mddus.com/

Medical Defence Union
Phone: 0800 716 646
Website: www.themdu.com/

Medical Protection Society
Phone; 0800 136 759
Website: www.medicalprotection.org/uk/home

Mental Welfare Commission for Scotland
Phone: 0131 313 8777
Email: enquiries@mwcscot.org.uk
Website: www.mwcscot.org.uk/contact-us

NHS Education Scotland
Phone: 0131 656 3200
Website: www.nes.scot.nhs.uk/contact-us.aspx

NHS Scotland Confidential Alert Line
Phone: 0800 0086112
Email: alertline@protect-advice.org.uk

NHS Scotland Counter Fraud Services
Phone: 01506 705200
Website: www.cfs.scot.nhs.uk/contact-us.aspx

Nursing and Midwifery Council
Phone: 020 7637 7181
Website: www.nmc.org.uk/contact-us/

Optometry Scotland
Phone: 0141 202 0610
Email: info@optometryscotland.org.uk
Website: www.optometryscotland.org.uk/contact-us/contact-us

Office Of The Uk Information Commissioner – Scotland
Phone: 0303 123 1115
Email: Scotland@ico.org.uk
Website: www.ico.org

Protect
Phone: 020 7404 6609
Website: www.protect-advice.org.uk/contact-us/
Email: whistle@protect-advice.org.uk

Royal College of Nursing Scotland
Phone: 0345 772 6100
Website: www.rcn.org.uk/scotland/about/contact

Royal College of Anaesthetists
Phone: 020 7092 1500
Website: www.rcoa.ac.uk/

Royal College of Emergency Medicine
Phone: 020 7404 1999
Website: www.rcem.ac.uk/

Royal College of General Practitioners
Phone: 020 3188 7400
Website: www.rcgp.org.uk/

Royal College of Obstetricians and Gynaecology
Phone; 020 7772 6200
Website: www.rcog.org.uk/

Royal College of Ophthalmologists
Website: www.rcophth.ac.uk/

Royal College of Paediatrics and Child Health
Phone: 020 7092 6000
Website: www.rcpch.ac.uk/

Royal College of Pathologists
Phone: 020 7451 6700
Website: www.rcpath.org/

Royal College of Physicians of Edinburgh
Website: www.rcpe.ac.uk/

Royal College of Physicians and surgeons of Glasgow
Phone: 0141 221 6072
Website: www.rcpsg.ac.uk/

Royal College of Psychiatrists
Phone: 020 7235 2351
Website: www.rcpsych.ac.uk/

Royal College of Radiologists
Phone: 020 7405 1282
Website: www.rcr.ac.uk/

Royal College of Surgeons of Edinburgh
Phone: 0131 527 1600
Website: www.rcsed.ac.uk/

Royal Pharmaceutical Society
Phone: 0131 556 4386
Website: www.rpharms.com/about-us/contact-us

Scotland Deanery
Phone: 0131 65 3200
Website: www.scotlanddeanery.nhs.scot/contact/

Scottish Social Services Council
Phone: 0345 60 30 891
Website: www.sssc.uk.com/contact-us/

Annex B: Examples to help to distinguish between whistleblowing and a grievance or bullying and harassment issues

The following examples will help with deciding if the issue raised should be handled under this procedure or under the grievance or bullying and harassment procedure.

Whistleblowing	Grievance or bullying and harassment
Key test: The issue is in the public interest.	**Key test:** The issue relates solely to an individual and so is a matter of personal interest.
Examples	**Examples**
Management persistently pressurises the team into dangerous overtime conditions.	I haven't been granted my flexible-working request.
A person's dangerous working practices are leading to the risk of a serious incident.	I have been inappropriately shouted at by a senior manager in relation to an action that I took at work.
Working practices or actions may be a risk to others. [Note: Or it is suspected that there is something inappropriate happening in an area which could be a risk to the public, but there is not substantial evidence.]	I am not happy with the way my manager spoke to me when they discovered I was not following the correct health and safety procedures.

INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 3

The two-stage procedure

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

Overview of the procedure

Stage 1: Early resolution
Five working days

What to expect at stage 1

- On-the-spot explanation and/or action to resolve the matter quickly, in five working days or less
- Extend timescales with agreement if there are exceptional circumstances
- Handled by member of staff receiving the concern OR referred to appropriate person for early resolution (within five working days) OR progressed to stage 2 (within five working days)

If the whistleblower is not satisfied with the response at stage 1, or agreed action has not been taken, they can take their concern to **stage 2: Investigation**

Stage 2: Investigation
20 working days for definitive response

What to expect at stage 2

- Respond in 20 working days following thorough investigation of concern(s)
- Extend timescales to achieve quality investigation and outcomes
- Responses signed-off by senior management and must signpost to the INWO, including timescales

Action taken as agreed to resolve issue of concern and avoid any repeat

If the whistleblower is not satisfied with the response they have received to stage 2, they can bring their concern to the INWO for independent external review

INWO consideration

Anyone raising a concern can come to the INWO at any point in this process, and the INWO can provide information and advice to support the process

Closing the case at stage 1: information for case handlers

- Record details of the concern, outcomes and actions taken (or planned)
- Reflect on how the concern was handled: what went well and what could be improved

Closing the case at stage 2: information for case handlers

- Record details of the concern, outcomes and actions taken (or planned)
- Use the concern and outcome to improve services and patient safety

Information about the INWO

- Concerns that have completed the process will either have been thoroughly investigated or will have been refused by the organisation at initial assessment; these must be signposted to the INWO
- INWO may assess
  - how the concern was handled by the organisation
  - whether the organisation's decisions about the concern were reasonable
  - how the whistleblower was treated through the process
  - how the organisation supports a culture of speaking up

Stage 1: Early resolution

1. Stage 1 is for simple and straightforward concerns that can be responded to within five working days or less. These concerns will involve little or no investigation, and can be handled by providing an explanation or taking limited action. The line manager should be involved in resolving the situation, where appropriate. Issues that are more complex, and will clearly take more than five working days to address, should move straight to stage 2.

2. Organisations must make sure staff have access to an impartial, confidential contact who they can contact by email or phone, or talk to in person. People can raise their concerns with their line manager, the confidential contact or another representative such as a senior manager.

3. Ideally, the person raising the concern will have a face-to-face discussion about the situation. However, if the concern is straightforward and has been raised with someone who is able to take appropriate action, this may be enough to resolve the issue. The person raising the concern must be updated with what has been done.

4. Anyone raising a concern can contact the INWO at any point in the process. The INWO can provide information and advice to support them, and can also give investigators and managers advice on how to handle concerns.

Initial discussions

5. **Anyone** who provides services for the NHS can raise a concern. This includes current (and former) employees, bank and agency workers, contractors (including third-sector service providers), trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

6. The person raising the concern must want it to be handled using this procedure. The organisation must offer to support them with raising their concern. The person can be accompanied by a union representative, friend or colleague. See Part 2 of these Standards for more details of the support that is available.

7. If the person does not want to use this procedure, they can raise their concern without giving their name. (See the section on anonymous and unnamed concerns in Part 2 of these Standards for more information about this.) The organisation can choose how to investigate the concern, but good practice would be to follow the whistleblowing principles and investigate the concern in line with these Standards, particularly if existing 'business as usual' procedures have not been able to address the issue successfully.

Time limit for raising concerns

8. The timescale for accepting a whistleblowing concern is within six months from when the person raising the concern became aware of the issue. The organisation can extend this time limit if there is good reason to do so, for example if the issue is still ongoing or if business as usual procedures have led to a delay. The most important thing to consider is whether there is any chance that the situation could create an ongoing risk of harm or wrongdoing.

9. If a case is not being handled under this procedure due to the timescales involved, this should be clearly explained to the person raising the concern. The organisation must also tell the person that they can ask the INWO to consider the decision.

Timescales – five working days

10. The organisation has five working days to respond to any concerns that are raised. The manager or the person who received the concern will normally provide the response. If there are clear and justifiable reasons why they cannot meet this timescale, someone more senior in the organisation may agree to allow them a further five working days to respond. Reasons for allowing more time for stage 1 include staff absence or difficulty arranging a meeting. The organisation must tell the person why it is not able to respond within five days, and when they can expect a response.

11. If it is clear from the start that a concern is too complex for the organisation to respond to within five working days, it should move straight to stage 2. If the organisation needs more time to provide a response at stage 1, it must not use this as a reason to delay moving the concern to stage 2.

Stage 1 discussion

12. Once the organisation has agreed that the concern should be handled under this procedure, the next stage is to discuss and agree:

    12.1. what outcomes the person who raised the concern is hoping to achieve, and whether these are possible;
    12.2. what action the organisation needs to take to put things right, and appropriate timescales for this;
    12.3. whether all the issues are appropriate for this procedure or whether it would be appropriate to handle some of them under other procedures, and if so, which procedures to direct the person to (see Part 2 of these Standards);
    12.4. whether any immediate action is needed to put things right or reduce risk to patient safety or the organisation; and
    12.5. whether the person who raised the concern needs support (see Part 2) and, if so, how they will get this.

13. If the discussion at stage 1 raises issues which a manager considers would be more appropriate to handle under other HR procedures (such as grievance procedures), they should carefully consider whether any parts of the concern should be handled under this whistleblowing procedure.

14. If someone raises a concern, but a manager decides it is a grievance not a whistleblowing concern, they should tell the person this in writing. They **must** tell the person they can ask the INWO to review this decision if they are not satisfied with it.

15. When a manager or other person receives a concern, they must make sure that the person who raised it receives the support and information they need to consider all appropriate options for handling the concern, including HR procedures. They must tell the person what support is available, and when and how they can get it.

16. Discussions about the concern must cover:

    16.1. what exactly the person is concerned about;
    16.2. who else is involved;
    16.3. what support the person raising the concern or other staff need (or are likely to need);
    16.4. the best way to maintain the person's confidentiality;
    16.5. the best person to respond to the concern; and
    16.6. whether the concern can be responded to in five working days or fewer, or whether it should be handled at stage 2.

17. There is more guidance on considering concerns in Annex A.

Recording the concern

18. The organisation must record details of all concerns raised by staff and other workers. The manager (or other person) should record a concern when they receive it, and should consider any requests the person raising it makes to keep their details confidential (so they are only shared with people who need to know them in order to investigate and address the concern) or for the concern to be raised anonymously (so nobody in the organisation knows the identity of the person who raised it) (see Part 2). Full details on how to record concerns are provided in Part 5 of these Standards.

Closing the concern

19. The organisation must provide a written response to a concern that has been handled at stage 1, unless it has agreed with the person who raised the concern that this is not needed (in which case this decision should be recorded). The response (however it is provided) must:

    19.1. respond to all the issues raised;
    19.2. give the organisation's reasons for any decisions;
    19.3. explain what action the organisation is taking in response to the concern; and
    19.4. explain how the person can take their concern to stage 2 if they do not feel it has been handled properly.

20. If the organisation does not provide its response in writing, it must still keep a record of its decision and tell the person who raised the concern. It must then close the case and update the records system as appropriate. The date the case is closed is the date when the person receives the response to their concern.

Learning, improvements and recommendations

21. Concerns raised at stages 1 and 2 of this procedure will often identify changes that are needed to provide services more safely and efficiently, or improve governance arrangements (how the organisation is managed and held accountable for its actions). Any improvements must be appropriately planned, making sure that everyone concerned is kept informed of changes. There is more information on learning from concerns in Part 5 of these Standards. The organisation must include details of any changes that are identified as a result of a concern in the reports it produces on concerns (every three months and every year).

22. The organisation must also consider whether:

    22.1. wider learning is needed across other departments following the investigation; and
    22.2. the improvements would be beneficial to other NHS organisations across Scotland. If so, it should share them with national organisations or clinical groups to take forward as appropriate.

When to move a concern to stage 2

23. Some concerns will not be appropriate for stage 1, and should move straight to stage 2. This includes concerns which:

    23.1. contain issues that are complex and need detailed investigation;
    23.2. relate to serious, high-risk or high-profile issues; or
    23.3. the person does not want to be considered at stage 1 because they believe a full investigation is needed.

24. Concerns that relate to serious, high-risk or high-profile issues may need someone more senior in the organisation to investigate them.

25. Or, after a concern has been considered at stage 1, the person who raised it can ask for it to be investigated at stage 2 if they do not feel that stage 1 has addressed the issue appropriately, and they still have concerns. They can do this immediately after receiving the decision at stage 1 or some time later.

26. The organisation should record that the concern has moved from stage 1 to stage 2, and the records system must be clear that this is the same concern, not a new one.

Stage 2: Investigation

27. Concerns handled at stage 2 of the whistleblowing procedure tend to be serious or complex, and need a detailed examination before the organisation can provide a response. Concerns can move straight to stage 2 if they include issues which are too complex to handle at stage 1, which means a full investigation is needed from the start.

28. An investigation aims to establish all the facts relating to the points raised in the whistleblowing concern. It should be thorough, in proportion to the seriousness of the concern and impartial, so that the organisation can identify any problems and consider what improvements can be made. This may include action to put things right in the short term, or an action plan for future changes. It is also very important to give the person raising the concern a full response that is based on evidence and sets out the organisation's final position.

29. If a concern which is appropriate for stage 2 is raised with someone who was involved in the situation, or was involved in a decision at stage 1, the organisation should do all it can to make sure the person can discuss the situation and their concern with an appropriate person who has not been involved in the situation. This may be a confidential contact or an impartial manager.

Timescales – 20 working days

30. The following timescales apply to stage 2.

    30.1. The organisation should acknowledge the concern in writing within three working days.
    30.2. It should provide a full response to all concerns as soon as possible, and within 20 working days, unless it needs to extend this time limit.
    30.3. If the organisation needs to extend the time limit, it must tell the person raising the concern when they can expect a full response within the first 20 working days (and then at least every 20 working days after that).
    30.4. The organisation should provide updates every 20 working days to everyone directly affected by the investigation. The updates should provide information about what progress has been made and what will happen before the organisation provides the next update or a full response.
    30.5. If it will take longer than expected to provide a full response to a concern, the organisation should offer support to those involved during this period.

Acknowledgement

31. The acknowledgement should include:

    31.1. contact details for the person overseeing the investigation;
    31.2. an explanation of the timescales at stage 2, when these timescales might need to be extended and what this would mean; and
    31.3. details of the support that is available for the person, including information about other agencies and their professional body if appropriate.

32. It may also be appropriate to provide other information in the acknowledgement, including:

    32.1. appropriate contact details in case there are any urgent safety issues during the investigation;
    32.2. a summary of the concern and the outcomes the person who raised it are hoping to achieve;
    32.3. an outline of the proposed investigation and who will be involved;
    32.4. an offer for the person who raised the concern to discuss the issues either with the investigating officer or a senior member of staff; and
    32.5. a consent form that gives a clear mandate, if a representative has raised the concern on the person's behalf.

Extending the timescale

33. The organisation should do all it can to meet the timescale above, as not doing so may delay changes that are needed to improve unsafe working practices, and could put patient safety or the organisation at risk, or have a harmful effect on the person raising the concern or the people involved in the investigation.

34. The organisation should aim to provide a full response within 20 working days, but this is not a target or performance measure. It **should carry out a thorough investigation that leads to good outcomes, even if that takes longer than 20 days**. The timescale is there to make sure that organisations take prompt action, and that there is an **ongoing focus on investigating and addressing the concern**, while keeping everyone involved updated on the progress of the investigation.

35. If the organisation cannot provide a final decision within 20 working days, it should still be able to show it has made **significant progress.** The investigation must not be delayed if this could be avoided.

36. There is no flexibility to pause or delay the whistleblowing procedure. The timescale can only be extended if there are clear and justifiable reasons for this. If there are, the investigator should ask a senior manager for authorisation to do so. The organisation must explain the revised timescales to the person who raised the concern and others involved in the investigation, as appropriate.

37. Reasons for extending the timescale might include:

37.1. the organisation needs essential accounts or statements from staff who are unavailable due to long-term sickness or leave;
37.2. staff have asked a representative from their professional body to be with them at a meeting, and this has caused unavoidable delays;
37.3. the organisation cannot get information that is essential to the investigation within normal timescales; or
37.4. the investigation is disrupted by circumstances that the organisation could not have expected or avoided, for example industrial action or severe weather conditions.

38. If a complex concern, involving several issues, is likely to take longer than 20 working days to address fully, the organisation should consider whether it could respond to some of the issues in an interim report.

First considerations

39. When a concern is raised at stage 2 the organisation should consider the following issues:

39.1. whether any immediate action is needed to put things right or reduce risk to patient safety or the organisation;

39.2. who should investigate the concern. If possible, this should be a senior member of staff from another department or service. (Part 4 of these Standards on board and staff responsibilities reviews how to handle concerns about an organisation's senior leaders or board members.);
39.3. what the investigation should cover, using the list in paragraphs 12 and 16 and Annex A to look into the concerns in more detail;
39.4. how involved the person who raised the concern wants to be in the investigation, and whether this is appropriate;
39.5. whether it is appropriate to direct the person who made the concern to any other procedures (for example, HR procedures);
39.6. what risks are involved, how they could be reduced, what support the organisation can provide to the person who raised the concern and how to make sure they have access to this;
39.7. what to expect in terms of timescales and updates.

40. Whenever possible, the organisation should discuss the above issues with the person raising the concern.

41. Managers should make sure they are aware of how the person would prefer to be contacted, and use this communication method whenever possible and appropriate. They must also take account of any data protection concerns when communicating, especially by email. If they are using an employee's work email address, the person raising the concern must have consented to this, as they may not always have access to it, or may have concerns about who else has access to it.

42. It is also important to take account of any accessibility issues the person has told the organisation about.

The investigation

43. The investigation must focus on the practices or procedures that are unsafe or inappropriate. It must focus on patient safety, safe working practices and good governance; it must be fair, robust and proportionate to the risks identified. It must aim to handle and provide a full response to all the issues involved in the whistleblowing concern that has been raised.

44. The organisation must tell the person raising the concern how the investigation will be carried out and what their role in it will be.

45. If a concern has already been through stage 1 of this procedure, the investigator should make sure they have all the case notes and associated information that was considered at stage 1. They must also work out, as early as possible, what extra information they will need and how they will get this.

46. It is good practice for the organisation to keep a record of meetings throughout the investigation (either notes or recordings), including any discussions with the person who raised the concern, and to share this record with those involved within an agreed timescale.

47. The investigation should be kept independent of any other procedures, including HR procedures. However, where possible, any linked procedures should be carried out in parallel with the whistleblowing procedure.

48. Similarly, if NHS Counter Fraud Services are carrying out an investigation into allegations of fraud, the organisation may still be able to investigate other issues. The board's Fraud Liaison Officer will be able to confirm if there is an ongoing fraud investigation and whether it would be appropriate to carry out any concurrent investigations.

49. Investigators and decision-makers must take account of the whistleblowing principles (see Part 1 of the Standards), and must:

49.1. be trained in what their role involves and how to carry it out;
49.2. give everyone involved the right to be heard;
49.3. not have a personal interest in the situation or the outcome;
49.4. act only on the evidence;
49.5. make decisions in good faith and without bias;
49.6. consider any person whose interests will be affected by the decision; and
49.7. have time set aside to carry out the investigation.

Other staff involved

50. Raising concerns can be stressful for anyone involved in the case, including the person who is being investigated, the investigator and witnesses. Everyone involved must be treated professionally and with respect.

51. If someone is accused of poor practice through this procedure, the organisation should tell them:

51.1. that an investigation is taking place;
51.2. of what they have been accused;
51.3. what the investigation process is;
51.4. what their rights and responsibilities are; and
51.5. what support is available to them.

52. They do not need to know how the organisation found out about the concern, and the organisation must take care to protect the identity of the person who raised the concern.

Responding to the concern

53. At the end of the investigation, the organisation must give the person who raised the concern a full and considered response, setting out its findings and conclusions, and how it reached these. It must also provide evidence that it has taken the concern seriously and investigated it thoroughly. It must include the conclusions of the investigation and information about any action it has taken or plans to take as a result of the concern, both to deal with the current situation and to avoid it from happening again in the future.

54. It is best practice for a single, senior member of staff (or someone authorised to act on their behalf) to be responsible for reviewing each decision made under this procedure before the organisation issues its response. This person must make sure that all necessary investigations have been finished and action is planned to prevent future risks.

55. The organisation's response must be in writing and should also be provided in the way the person who raised the concern has told the organisation they prefer to be contacted. The organisation must keep a record of the decision and how it gave this to the person who raised the concern.

56. It must be clear from the response that this is the organisation's final decision, and that if the person is still not satisfied with it, or the way their concern has been investigated, they can take their concern to the INWO.

57. The organisation must also keep other people who were directly involved in the investigation updated on the final outcome, and must tell them about any recommendations or action they have taken as a result of the whistleblowing concern. Any updates must be in line with data protection law.

58. The quality of the investigation and the final (and any interim) report is very important. The report should:

    58.1. be clear and easy to understand, and written in a way that is non-confrontational and focuses on the people involved;
    58.2. use language appropriate to the person who raised the concern and their understanding of the issues;
    58.3. address all the issues raised and show that each element has been fully and fairly investigated;
    58.4. include an apology where things have gone wrong;
    58.5. highlight any areas where the organisation does not agree with the person's concern and explain why no further action can be taken;
    58.6. give the name of a member of staff the person can speak to if they don't understand something in the letter; and
    58.7. explain how the person can refer their concerns to the INWO if they are not satisfied with the outcome of the organisation's investigation.

59. If anyone involved in the investigation has had ongoing support from their union or another third party, the organisation should also tell the person or organisation providing the support that it has issued a decision, to make sure they can provide appropriate support when the person needs it. (What further details the organisation can give will depend on the situation.)

Recording the concern

60. Details of all concerns investigated at stage 2 must be recorded. As with stage 1 concerns, the person who receives the concern should record it when they receive it, and consider any requests the person makes to keep their details confidential. (See Part 2 for information about anonymous and 'unnamed' concerns when no personal details are recoded).

61. The record at stage 2 must be a continuation of the record created at stage 1, if this applies. The organisation must update the details when the investigation ends.

62. Full details on how to record concerns are provided in Part 5 of these Standards.

Learning, improvements and recommendations

63. The process for learning, improvements and recommendations is the same as for stage 1. See paragraphs 21 and 22.

64. At the end of stage 2, organisations may also be able to learn from reflecting on how they have handled the concern. One way to do this, and to make sure the organisation provides consistent responses to concerns, is to involve two different parts of the organisation in reviewing how concerns have been handled and the outcomes of concerns. Not all organisations will be able to do this, but, it is good practice if it is possible.

Meetings and correspondence with the person who raised the concern after the organisation's decision

65. Once the person who raised the whistleblowing concern has received the organisation's decision, they can ask for more information or a meeting, but this should only be to explain the decision.

66. The organisation should make it clear before any meeting that it is for explanation only and not to reinvestigate or reopen the concerns raised. This meeting should be separate from any meeting relating to HR issues. If the person is not satisfied with the way they have been treated, the organisation should tell them they can ask the INWO to look into this. It should also direct them to any appropriate HR procedures.

67. The organisation should not consider any communication relating to how the investigation was carried out or the decisions or outcomes that were reached. Instead, it must refer the person who raised the concern to the INWO for stage 3 of this procedure.

Independent external review

68. Anyone who has raised a concern through this procedure can ask the INWO to consider the way the concern was handled, the outcome of the investigation, or how the person was treated through the process. If someone has not been allowed to raise a concern using this procedure, they can also ask the INWO to investigate this refusal, or the concern.

69. An INWO investigation may include:

    69.1. how the organisation has responded to the concern raised, applied these Standards and investigated the issues raised;
    69.2. whether the organisation's decisions and actions relating to the concern were reasonable in the circumstances;
    69.3. how the organisation treated the whistleblower and other people involved, including telling them about any relevant HR procedures;
    69.4. the organisation's wider approach to learning from concerns; including how it supports and encourages a culture of speaking up to improve patient safety and service delivery.

70. The INWO recommends that organisations use the wording below to tell people they can ask the INWO to consider the whistleblowing concern.

Information about the Independent National Whistleblowing Officer (INWO)

The INWO is the final stage for whistleblowing concerns about the NHS in Scotland. If you remain dissatisfied with an NHS organisation after its process has concluded, you can ask the INWO to look into your concern.

The INWO cannot normally look at concerns:

- where you have not gone all the way through the whistleblowing procedure, or
- more than 12 months after you became aware of the matter you want to bring to the INWO.

The INWO's contact details are:
INWO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

[Freepost TBC] (You don't need to use a stamp)

Freephone: 0800 377 7330

Online: www.inwo.org.uk/contact-us
Website: www.inwo.org.uk

71. If a person raises a whistleblowing concern with the INWO, the INWO may ask the organisation to send all relevant papers and other information to their office, or to speak directly with staff. For more information about what to expect from an INWO investigation, visit www.inwo.org.uk.

Time limits for raising concerns with the INWO

72. Anyone who has raised a concern and had a final response from the organisation can refer their concern to the INWO within 12 months from the date they became aware of the issue. (The INWO can decide to extend these timescales in a similar way as the organisation can, as described in paragraph 8 above.)

73. These Standards and the INWO's powers come into force in July 2020. The INWO only has powers to investigate if a concern has been raised, within the correct time limits, and under the procedure set out in these Standards.

74. Concerns which have been considered under previous whistleblowing procedures or arrangements (those that were in place before July 2020) must be handled under those procedures, and cannot be reviewed by the INWO. Issues raised under this procedure can relate to concerns that were first raised before July 2020, but the time limits above still apply.

75. If someone raises a concern directly with the INWO before the appropriate organisation has carried out a full investigation, the INWO can provide information and advice. They can also agree to investigate a concern that has not been raised with the organisation involved if they consider it is not reasonable to expect the person to use their employer's whistleblowing procedure. The INWO will approach each case on the principle that it is better for the organisation involved to investigate and identify the learning and improvements that are needed. The INWO will look at each case individually when deciding whether to accept a concern direct but could take into account, for example, whether the organisation is very small or the issue involves very senior staff. In limited circumstances the INWO may be able to help make sure concerns are handled appropriately. This may include, for example, monitoring the progress of an investigation.

Annex A: Further guidance for people receiving concerns

What does the person want to achieve by raising this concern, and can this be achieved?

When you receive a concern you need to be clear from the start about the outcome the person wants to achieve. The person may not be clear about this, or they may know that they want things to change but not be sure how. It may be appropriate to direct them to other HR procedures if there are connected issues.

Your discussions with the person should include whether the organisation can achieve the outcome they are hoping for. If it is not going to be possible to achieve the outcome, tell the person why. They may expect more than the organisation can provide, or you may feel that any action which would be needed to achieve the outcome is not in proportion to the risks that have been identified.

What exactly is the person's concern?

It is important to understand exactly what concern the person is raising. It may be necessary to ask for more information to get a full picture. When you receive a concern, remember that the person who raised it may be nervous about doing so. Make sure they have enough time and privacy to explain their concern fully. It can also be stressful to speak about a concern, so if you have a meeting you may need to take breaks or have more than one meeting.

Who are the other people involved?

Consider whether other staff are aware of the issue, or whether they should be. If so, who are the other staff, and has the person already discussed the concern with them? In particular, consider whether senior staff responsible for this area of work are aware of the issue, or whether they have been told about the concern. You should also take account of any previous investigations into this issue.

What support does the person raising the concern and other staff involved need?

Always check if the person raising the concern needs support. Discuss with them what support would be helpful and how this can be provided. This may include getting support from their trade union or professional representative body. Also consider whether others involved in the situation also need support and, if so, how this can be provided. (See Part 2 for a list of contact details for support agencies and professional bodies.)

Does the person raising the concern want their involvement to remain confidential?

It is important to discuss the level of confidentiality the person wants to maintain. Sometimes the investigator will need to know who raised the concern, but in other cases this isn't necessary or appropriate.

The person may want to remain completely anonymous (so their details are not recorded anywhere). Explain to them the limits of raising an anonymous concern. This would mean they wouldn't have access to the Standards, and the organisation would choose the best way to handle the concern. (See Part 2 of these Standards for more information about anonymous concerns.)

In all cases, the person's name must not be shared with anyone who does not need to know it in order to investigate the concern, unless it has to be shared by law. It is important to ensure that records containing the persons names have access restricted.

Who is the best person to respond to the concern at stage 1?

If you cannot resolve the concern because, for example, you are not familiar with the issue or do not have the authority to make the changes that are needed, explain this to the person raising the concern, and pass details of the issue to someone who can. Keep the person who raised the concern informed about what is happening and who is responsible for investigating the matter.

INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 4

Governance: NHS board and staff responsibilities

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

Role of NHS board members

Leadership

1. Board members have a critical role in setting a tone and culture in their organisation that values the contributions of all staff, including those who identify the need for changes through speaking up. This leadership role should not be underestimated, and is a critical function of the board when it comes to concerns raised about safe and effective service delivery.

2. Board members need to show interest and enthusiasm for issues that arise through concerns raised by staff, and in particular, to support the learning and improvements that stem from them. They also need to ensure that the arrangements in place act to promote trust between staff and the board in raising concerns.

3. Every NHS board must ensure that there is a clear description of the roles and responsibilities of staff in relation to raising and receiving concerns at each level of the organisation.

Monitoring

4. The number of concerns raised by staff will be reported to a public meeting of the board on a quarterly basis. It is the board's responsibility to ensure this reporting is on time and accurate. The analysis should highlight issues that may cut across services and those that can inform wider decision-making. Board members should show interest in what this information is saying about issues in service delivery as well as organisational culture. This may mean on occasions that board members challenge the information being presented or seek additional supporting evidence of outcomes and improvements. They should also explore the reasons behind lower than expected numbers of concerns being raised, based on trend analysis and benchmarking data.

Services provided by other organisations

5. All NHS boards are responsible for ensuring that the services that are contracted out by their organisation (including primary care and on site contracted services) have arrangements in place that encourage staff to raise concerns, including procedures that meet the requirements of the Standards.

6. The board also has responsibility for ensuring there are arrangements in place that ensure students and volunteers are made aware of their right to access this procedure. In addition, systems must be in place to allow for communication and the raising of concerns via the universities and colleges which they work with to deliver student placements and training opportunities.

7. NHS boards that work in partnership with local authorities, to provide health and social care with the oversight of an integration joint board (IJB), will also be expected to work with the IJB to ensure that all staff in the partnership can raise concerns about NHS services through this procedure.

8. More detailed information is available about requirements on board members in relation to monitoring contracted services, primary care providers contracted services, health and social care partnerships (HSCPs), higher education institutions and voluntary sector providers in other parts of the Standards.

Support for the whistleblowing champion

9. As non-executive directors, whistleblowing champions are part of the board. The board must show support for the whistleblowing champion, and must listen to and take action as a result of the issues they raise.

Support for the person raising concerns

10. The board members' leadership in relation to raising concerns extends to ensuring that there are support systems in place for members of their staff who raise concerns. The support available may include:

    10.1. access to a 'confidential contact' who is able to provide information and advice in relation to the procedure for raising concerns, as well as support during the process;

    10.2. counselling or psychological support services for those suffering from stress due to their involvement in this procedure;

    10.3. occupational health provision which would take account of the stresses involved in raising a concern;

    10.4. consideration of a range of actions to reduce the impact on the individual, in consultation with them, such as variations in their work or putting in place temporary arrangements to reduce risk.

11. It is not appropriate to redeploy staff who have raised a concern, even if their concern involves issues relating to other staff or line management. Alternative options should always be considered.

The whistleblowing champion

12. Each NHS board has a whistleblowing champion who monitors and supports the effective delivery of the organisation's whistleblowing policy. This role has been developed by the Scottish Government and complements the work of the Independent National Whistleblowing Officer (INWO).

13. The whistleblowing champion is predominantly an assurance role which helps NHS boards comply with their responsibilities in relation to whistleblowing. The whistleblowing champion provides critical oversight ensuring managers are responding to whistleblowing concerns appropriately, in accordance with these Standards. The whistleblowing champion is also expected to raise any issues of concern with the board as appropriate, either in relation to the implementation of the Standards, patterns in reporting of concerns or in relation to specific cases.

14. Beyond the services delivered directly by the NHS board, the whistleblowing champion will have responsibility for ensuring that the organisation has appropriate systems in place to ensure that services delivered indirectly, including primary care services, contracted services and those delivered by HSCPs, are meeting the requirements of the Standards. In particular, they may need to work with colleagues in IJBs to clarify expectations and requirements in relation to raising concerns.

15. The role of the whistleblowing champion is explained in more detail through guidance provided by the Scottish Government.

The role of NHS staff

Chief executive

16. Overall responsibility and accountability for the management of whistleblowing concerns lies with the organisation's chief executive, executive directors and appropriate senior management.

17. The chief executive provides leadership and direction in ways that guide and enable staff to perform effectively across all services. This includes ensuring that there is an effective whistleblowing procedure, with a robust investigation process which demonstrates how the organisation learns from the concerns they receive. The chief executive may take a personal interest in all or some of the concerns, or may delegate responsibility for the whistleblowing procedure to senior staff. Delegation must be clearly stated and accepted. Regular management reports assure the chief executive of the quality of performance.

18. The chief executive must work with board members to decide how oversight of the implementation of these Standards will be achieved, and who will have responsibility for this.

Executive directors

19. On the chief executive's behalf, executive directors may be responsible for:

    19.1. managing whistleblowing concerns and the way the organisation learns from them;

    19.2. overseeing the implementation of actions required as a result of a concern being raised;

    19.3. investigating concerns; and/or

    19.4. deputising for the chief executive on occasion.

20. In particular, directors have responsibility and accountability for signing off stage 2 decision letters. They may also be responsible for preparing decision letters, though this may be delegated to other senior staff. Either way, they must be satisfied that the investigation is complete and their response addresses all aspects of the concern raised. This will reassure the person raising the issue that their concern has been taken seriously.

21. Wherever possible, it is important for the decision on a concern to be taken by an independent senior member of staff (i.e. a senior member of staff from another directorate, with no overlap with the concern that has been raised). Directors should retain ownership and accountability for the management and reporting of concerns.

22. If the director delegates responsibility for the process, then they must ensure that the person given this responsibility has the skills and resources to document the process, be able to evaluate the quality of the investigation, and ensure that recommendations are implemented.

23. The director responsible for primary care services has specific responsibilities for concerns raised within and about primary care service provision. They must ensure that all primary care services contracted by the NHS board are reporting appropriately on concerns raised and resolved by the provider. In addition, the director may be contacted in relation to concerns about primary care. These concerns may come to the NHS board in a range of ways:

    23.1. From staff within primary care services, who are reluctant to raise concerns to their employer;

    23.2. From staff who have already raised concerns with their employer, but have not had a satisfactory response (stage 2 concerns); or

    23.3. From representatives of students in primary care settings (or the students themselves), who have raised concerns in relation to their placement in a primary care service.

24. There is more detailed information available about requirements for NHS boards in relation to primary care services as well as requirements for primary care providers (see Part 7 of the Standards) and higher education institutions (see Part 9).

HR or workforce director and their team

25. HR or workforce directors are responsible for ensuring all staff have access to this procedure, as well as the support they need if they raise a concern. They are also responsible for ensuring that anything raised within HR procedures which could amount to a whistleblowing concern is appropriately signposted to this procedure for full consideration.

26. HR teams will also be involved in assisting managers and confidential contacts to identify HR issues that are raised within concerns, and to provide appropriate signposting in relation to these HR issues.

27. The HR/workforce director is responsible for ensuring that all staff are made aware of the Standards and how to access them, including the channels available to them for raising concerns. They must also ensure that managers have the training they need to identify concerns that might be appropriate for the Standards, and have the skills to handle stage 1 concerns.

28. However, the HR/workforce director does not necessarily have any specific responsibilities in relation to implementing these procedures or investigating any concerns raised by staff, unless this is considered appropriate in a specific case. For example, they would be responsible for providing expert HR input when there is interaction between HR procedures and an investigation into a concern.

29. HR functions should not be involved in investigating whistleblowing concerns, unless the concern directly relates to staff conduct issues.

Investigators

30. Investigations must be carried out by an appropriately skilled, senior member of staff from another directorate (where possible), and in particular, with no conflict of interest or perceived conflict of interest with the issue of concern. The investigator needs to take full account of the sensitivities of the case, and have strong inter-personal skills, including skills in supportive conversations. They need to be able to separate out the HR from the whistleblowing concerns, and to focus on the issues which are appropriate for this procedure.

31. Investigators have an important role in drafting recommendations. They should listen to those who have raised the concern or are involved in the service, to judge what is appropriate and reasonable, and how the service improvements can be taken forward.

The 'confidential contact' or whistleblowing ambassador

32. All organisations that deliver services for NHS Scotland must ensure that they provide staff with at least one point of contact who is independent of normal management structures (for the purposes of this role) and who has the capacity and capability to be an initial point of contact for staff from across the organisation (or their part of the organisation) who want to raise concerns. Small organisations such as those in primary care should work with their NHS board to ensure

access to a confidential contact for their staff. The confidential contact must support staff by providing a safe space to discuss the concern, and assist the staff member in raising their concern with an appropriate manager. This will not always be the person's line manager, and in some instances it should be someone with a level of independence from the situation.

33. However, this role goes beyond simply providing advice and support to those raising concerns. In particular, the confidential contact needs to:

    33.1. work with the whistleblowing champion to ensure that all staff are aware of the arrangements for raising concerns within their organisation;

    33.2. promote a culture of trust, which values the raising of concerns as a route to learning and improvement;

    33.3. through direct contact with frontline staff, ensure they are aware of and have access to the support services available to them when they raise concerns;

    33.4. assist managers in using concerns as opportunities for learning and improvement;

    33.5. work with the chief executive and those they have identified to oversee application of the Standards, to ensure the Standards are functioning at all levels of the organisation.

34. Confidential contacts must have the appropriate skills to carry out a role that requires significant interpersonal skills and the capacity to work with all staff, from senior managers to support staff. This role is best suited to someone with experience of direct service provision rather than an HR representative.

35. NHS boards may choose to broaden the reach of their confidential contacts, by recruiting whistleblowing mentors, or similar roles. These staff members would work with the confidential contact to broaden access to raising concerns, and assist with raising awareness across the organisation. It is up to each NHS board to develop such roles that meet the needs of their own structure and organisational requirements.

INWO liaison officer

36. The NHS board's INWO liaison officer is the main point of contact between the INWO and the organisation, particularly in relation to any concerns that are raised with the INWO. They have overall responsibility for providing the INWO with whistleblowing concern information in an orderly, structured way within requested timescales. They may also provide comments on factual accuracy on behalf of the organisation in response to INWO investigation reports. They are also expected to confirm and provide evidence that INWO recommendations have been implemented.

Fraud liaison officer

37. If a concern includes issues of fraud, the board's fraud liaison officer should be contacted for advice. If appropriate, they will be able to pass information onto NHS Counter Fraud Services, for consideration and potential investigation. They will also be able to provide updates on the status of any investigation – whether it is ongoing, closed, or has been passed to the procurator fiscal. The fraud liaison officer will be responsible for sharing any updates with the appropriate case contact.

38. Fraud liaison officers must also be aware of these Standards, and if someone raises a concern about fraud directly with them, they must enquire whether they want to use the Standards. If so, they must make sure that appropriate steps are taken so that the concern is progressed appropriately. This may be by the fraud liaison officer, or by an appropriate manager, or the confidential contact.

Managers

39. Any manager in the organisation may receive a whistleblowing concern. Therefore all managers must be aware of the whistleblowing procedure (see Part 3 of the Standards) and how to handle and record concerns that are raised with them. Managers must be trained and empowered to make decisions on concerns at stage 1 of this procedure. While all managers are encouraged to try to resolve concerns early and as close to the point of service delivery as possible, they should also be aware of who to refer a concern to if they are not able to personally handle it. They should also be aware of any barriers their staff may encounter in raising concerns, and work to reduce these barriers.

All staff

40. Anyone who delivers an NHS service should feel able and empowered to raise concerns about harm or wrong-doing. They should be trained so they are aware of the channels available to them for raising concerns, and what access to the Standards means.

Union representatives

41. Union representatives can provide helpful insights into the functioning of systems for raising concerns. They should be involved in implementation and monitoring of these systems where possible.

Training

42. NHS boards need to ensure that their staff have the knowledge and skills to implement the Standards. In particular, those with specific responsibilities detailed in the Standards must have appropriate training to ensure they can fulfil their roles and are fully informed of the requirements of their role. This includes:

    42.1. whistleblowing champions;

    42.2. confidential contacts/ whistleblowing ambassadors, and any other representatives for raising concerns;

    42.3. executive directors involved in signing off investigations; and

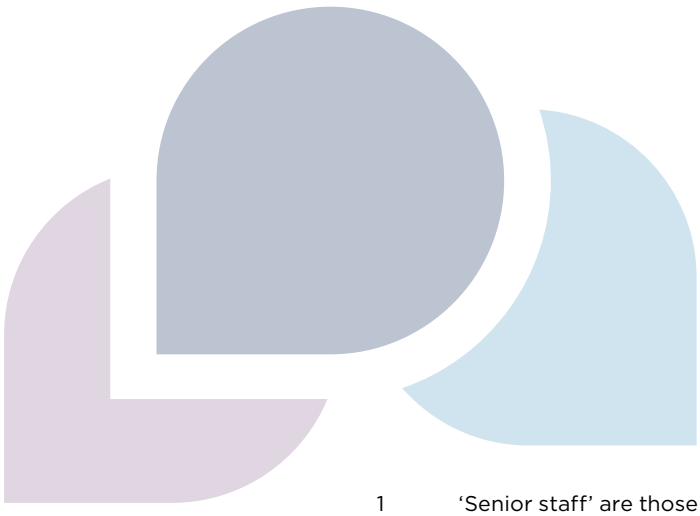
    42.4. investigators.

43. All staff will need to be informed of how to raise concerns, the channels they can use, the support available if they do raise concerns, and the benefits for the organisation in them doing so. Those who may receive concerns will also need training in supportive conversations/interview skills.

Handling concerns about senior staff

44. Whistleblowing concerns raised about senior staff[1] can be difficult to handle, as there may be a conflict of interest for the staff managing or investigating the concern. When concerns are raised against senior staff, it is particularly important that the investigation is conducted by an individual who is not only independent of the situation, but empowered to make decisions on any findings of the investigation.

45. The organisation must ensure there are strong governance arrangements in place that set out clear procedures for handling such concerns. This should include consideration of who oversees the case; how other staff are treated through the process; who should investigate; and what support is in place to assist with the investigative process. For example, each NHS board must clearly set out how it intends to consider a concern raised about the chief executive or a board member.



1 'Senior staff' are those whose position in the organisation means that there are limited or no staff members with clear seniority over them.

Working with other organisations

Services provided on behalf of the NHS

46. NHS boards must ensure that all the services they use to deliver their services, including primary care providers or contractors, have procedures in place which are in line with these Standards. It is for each NHS board to ensure that external service providers are meeting the requirements of the Standards, and they must have mechanisms in place to provide this assurance.

47. These requirements include recording and reporting (see Part 6 of the Standards) on all concerns. This means that service providers must record concerns raised with them (or their confidential contact), monitor these concerns, and report them to the NHS board. The board is required to ensure that systems are in place to facilitate this reporting, and that they receive quarterly reports about concerns raised and performance against the Standards.

48. In addition to quarterly reporting of concerns raised within the board (and in relation to services delivered via an HSCP), there must also be systems in place to gather reports of concerns from primary care and contractors on a quarterly basis.

Higher education providers

49. Higher education institutions (HEIs) work closely with the NHS in a wide range of settings. This includes staff (who can be contracted to work for an HEI, but nevertheless carry out work for the NHS) and students. Anyone working or learning in NHS services must be able to access a procedure for raising concerns which is in line with these Standards. NHS boards must ensure that staff under contract with an HEI have equal access to any systems and arrangements for raising concerns as those under contract with the NHS.

50. NHS boards must ensure that systems are in place to enable this access, particularly for students. This means that arrangements for placements must include information for the student and their course representative on how to raise a concern, including access to the confidential contact.

51. NHS boards also need to ensure that concerns raised by staff or students of HEIs about the board's services and considered through the Standards are included in any reporting of concerns to the board and externally.

52. Further information on arrangements for students (see Part 9) covers these requirements in more detail.

Integration joint boards (IJBs)

53. Most NHS boards have arrangements with their local authority colleagues to provide health and social care services in an integrated way. The levels of integration vary between areas and services. However, NHS boards are expected to work with their local authority colleagues to ensure that arrangements are made by the IJB to enable all those working in NHS services to raise concerns about these services, whether they are employed by the local authority or directly by the NHS.

54. The requirement is for each IJB to develop an agreement that would allow for staff working across the partnership to raise concerns (in line with the Standards) across all the services they deliver, to ensure fair access to this procedure. The only procedural difference would relate to the final stage of the process: concerns relating to social work and care services should be signposted to the Care Inspectorate, whereas those relating to health services should be signposted to the INWO for review.

55. NHS boards also need to ensure that concerns raised by staff in integrated services are included in any reporting of concerns to the board and externally.

Voluntary sector providers

56. Voluntary organisations work alongside and within the NHS in a range of settings, from providing transport to direct care and support for patients. Both staff and volunteers of these organisations may identify issues of concern about the board's services. It is for NHS boards to ensure that there is clear information for these organisations on how they can raise concerns, in line with these Standards. Their staff and volunteers must have access to the NHS board's confidential contact, or other representative for raising concerns.

57. Managers in areas that regularly work alongside voluntary organisations must be aware of the need to facilitate access to this procedure, and any other local arrangements that are in place to ensure access.

58. NHS boards also need to ensure that concerns raised by volunteers or volunteer coordinators about the board's services and considered through the Standards are included in any reporting to the board and externally.

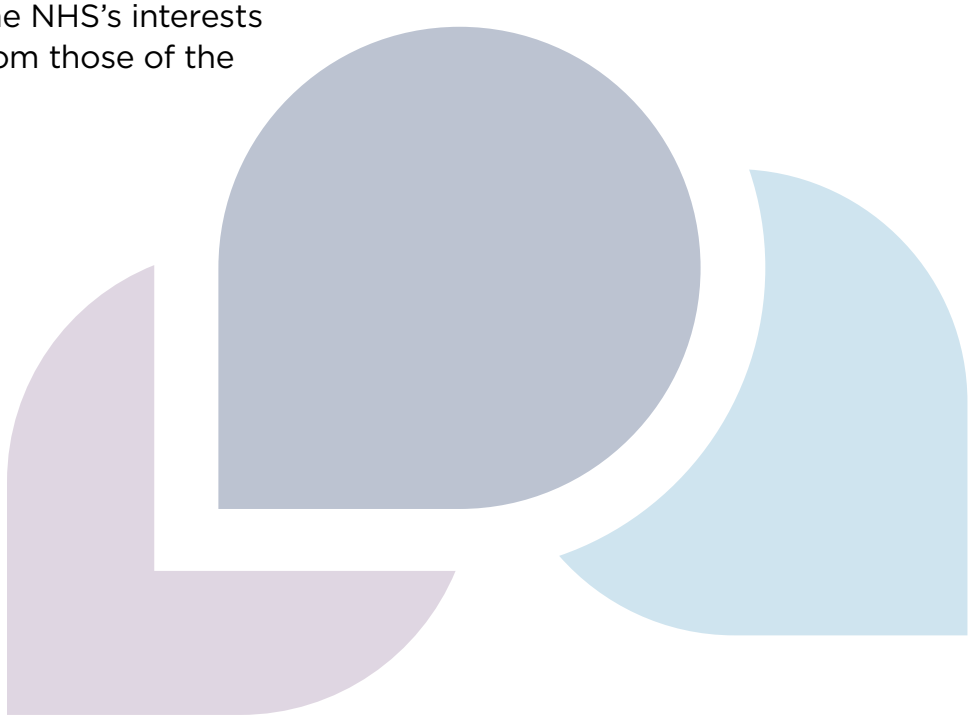
59. Further information on arrangements for volunteers (see Part 10) covers these requirements in more detail.

Regulatory investigations

60. NHS boards are expected to work with organisations that regulate their services or staff, to ensure that investigations are as effective and efficient as possible, even when a concern has been raised with both the NHS and the regulator.

61. If a concern is raised with more than one organisation, it is always important to make sure that it is clear which elements of the concern are being pursued by which organisation, and what outcomes are being sought by the person raising the concern. In some instances, it may be appropriate to have parallel investigations, as the NHS's interests may be different from those of the other regulator.

62. Regulators must be informed if an investigation identifies issues around a professional's fitness to practise. However, both regulators and NHS providers must be aware of the potential for staff to raise concerns as an act of retribution. The Standards should be used for specific consideration of issues relating to risks to safe practice and patient safety, and must be kept separate from disciplinary issues.



INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 5

Governance: from recording to learning lessons

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

The importance of recording and reporting

1. One of the main aims of the whistleblowing procedure is to ensure learning from the outcome of whistleblowing concerns and to identify opportunities to improve NHS services.

2. Managers must record all whistleblowing concerns, in a systematic way so that the concerns data can be analysed to identify themes, trends and patterns and to prepare management reports. By recording and using concerns information in this way, the root causes of concerns can be identified and addressed, such as through service improvements or training opportunities.

IT systems

3. The organisation must have structured systems for recording whistleblowing concerns, their outcomes and any resulting action taken to resolve the concern. It is important that these systems are able to hold records in a way that takes full account of the need for staff confidentiality, the requirements of the General Data Protection Regulation (GDPR), and the current Scottish Government Records Management Code of Practice.

Confidentiality and data protection

4. It is essential that recording systems are able to maintain confidentiality, and that access to personal data (such as the person's identity and other personal information) is restricted. In some cases, this will mean that only one person or a very select (and specific) group can access this personal data. The person raising the concern should be informed as to who their personal data will or may be shared with and the body sharing the personal data must ensure that they have a lawful basis for sharing that data.

5. Every data controller and data processor (i.e. anyone that is receing a concerna and applying the Standards) must satisfy themselves that they are meeting the requirements of the General Data Protection Regulation and the Data Protection Act 2018[1], as well as their own duties of confidentiality. This relates both to the personal data of the person raising the concern and to all personal data and confidential information used in applying the Standards.

6. For example, the organisation should consider matters including, but not limited to, compliance with data protection law and confidentiality requirements when:

1 The General Data Protection Regulation and the Data Protection Act 2018 can be found at: http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

6.1. recording a concern and setting limits on who will have access to the information being processed in relation to the concern raised, based on an assessment of what is needed for the process; and

6.2. taking appropriate technical and organisational measures to preserve the integrity and security of the information;

7. Likewise, anyone that is receiving a concern and applying the Standards should give consideration to:

7.1. deciding who the concern will be shared with and why;

7.2. finding out whether anyone sharing their own personal data understand who their personal data may or will need to be shared with, and under what circumstances; and

7.3. assessing who else might need to be informed of the identify of the person raising the concern and why.

8. Information relating to the concern can be shared more widely than the person's personal details, though care must still be taken to do this lawfully and to consider who will have access to this information and what assumptions may be made about who raised the concern. This information should be shared only where it is necessary to resolve or investigate the concern. There should be a presumption against sharing information unless there is good reason to do so, to reduce risks for patients and/or the organisation.

9. All managers and the organisation's confidential contact or whistleblowing ambassador must be able to record concerns. However, they must not be able to access other records, unless they have good reason to do so, and have been given specific permission.

10. It may be appropriate to hold personal data about the person who has raised the concern in a different part of the system from that which contains details of the concern raised and handling of the case. Each organisation's IT arrangements will vary, to reflect their structures and the size of the organisation.

Enabling reporting

11. The organisation must ensure that systems allow for full reporting of all concerns raised under this procedure, regardless of who they have been raised with. There will be some members of staff who need access to data specifically for reporting purposes. As a minimum this would include the organisation's confidential contact or whistleblowing ambassador and the whistleblowing champion (for boards). Most organisations will need to ensure that others can also access some or all of this information, and it is for each organisation to establish how best to ensure effective reporting arrangements.

What to record

12. It is essential to record all information on whistleblowing concerns (including concerns raised anonymously) as follows:

    12.1. person's name, work location (where appropriate), and contact details (mindful of their preferred method of contact) – access to this information must be restricted;

    12.2. the nature of the concern raised;

    12.3. if the concern was raised on behalf of another person, whether that other person has given consent to do so;

    12.4. what role the person raising the concern has (e.g. nurse, technician, doctor, administrator, etc);

    12.5. date the concern was received;

    12.6. date the event occurred;

    12.7. how the whistleblowing concern was received;

    12.8. service area to which the whistleblowing concern refers;

    12.9. whether the concern includes an element of bullying and harassment and/or other HR issue;

    12.10. whether the concern raises issues of patient safety;

    12.11. whether the person has already experienced detriment as a result of raising this concern;

    12.12. date the concern was closed at the early resolution stage (where appropriate);

    12.13. date the concern was escalated to the investigation stage (where appropriate);

    12.14. date the concern was closed at the investigation stage (where appropriate);

    12.15. outcome of the investigation at each stage;

    12.16. findings in relation to safety concerns and potential harm;

    12.17. findings in relation to concerns of fraud or administrative failures; and

    12.18. action taken to remedy any findings.

Key performance indicators

Reporting whistleblowing concerns

13. All NHS service providers **must** record and review information in relation to concerns raised about their services on a **quarterly basis**.

14. Data required for these quarterly reports is based on these key performance indicators (KPIs):

    14.1. a statement outlining learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns;

    14.2. a statement to report the experiences of all those involved in the whistleblowing procedure (where this can be provided without compromising confidentiality);

    14.3. a statement to report on levels of staff perceptions, awareness and training;

    14.4. the total number of concerns received;

    14.5. concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed;

    14.6. concerns upheld, partially upheld and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage;

    14.7. the average time in working days for a full response to concerns at each stage of the whistleblowing procedure;

    14.8. the number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working days;

    14.9. the number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1; and

    14.10. the number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2.

15. Further information and guidance will be available in relation to these KPIs, and in particular in relation to the INWO's expectations of the statements on the INWO website.

Performance at stage 2 and extensions

16. The timescale of 20 working days for a concern to be closed at the investigation stage aims to ensure cases are progressed as efficiently as possible; while overall timescales will be measured, there is no performance measure or KPI that sets down how many cases must be closed within this timescale.

17. Extensions to timescales should be signed off by senior leadership, and only when it is clear that additional time is needed to ensure a thorough and robust investigation of the issues of concern. If an extension is granted,

those involved must all be informed of indicative revised timescales and regular updates on progress must be sent every 20 working days.

18. Any related HR processes should progress in parallel with an investigation into the concerns raised through this procedure. Every effort should be made to avoid delay in this procedure as a result of associated HR procedures, as this could raise the risk of unsafe or ineffective service delivery.

Senior management review

19. Concerns must be analysed for trend information to ensure service failures are identified and appropriate action is taken. Quarterly reporting to senior management helps to identify how services could be improved or internal policies and procedures updated. Where appropriate, this review must also consider any recommendations made by the INWO in relation to the investigation of NHS whistleblowing concerns.

20. The outcomes of these reviews should be reported via the organisation's governance structure to the NHS board for review by its members, or equivalent governing body.

Reporting from primary care and other contracted services

21. NHS boards are responsible for ensuring all primary care and other contracted service providers supply the appropriate KPI information to their board as soon as possible after the end of the quarter.

22. For contracted services, the contract or service level agreement must set out the requirements in relation to reporting concerns.

23. In instances where no concerns have been raised within either primary care or other contracted services, there is no need to provide a quarterly return to the board, but annual reports must still be submitted, setting out the concerns that have been raised over the year, or an explanation that there have been no concerns raised. The board should use this longer-term monitoring of the raising of concerns to gain assurances that staff have confidence in the systems in place.

Learning from concerns

24. The two key ways of learning from concerns are:

    24.1. identifying improvements based on the findings of an investigation; and

    24.2. using statistical analysis of concerns raised at a departmental or organisational level to identify recurrent themes, trends or patterns of concerns.

Improvements following investigations

25. When an investigation identifies that there is a need for change, the organisation must proactively explore the root causes of the concern, how widespread the issue is and the likelihood of recurrence.

26. Investigations may identify improvements which are applicable across other services or clinical departments, and it is important for senior leaders to ensure that every opportunity is taken to explore when service improvements can lead to wider organisational learning.

Statistical analysis

27. Statistical analysis can be used to identify trends, themes and patterns from the concerns raised across a department or service. Given the potential for different routes to be used to raise concerns, and for confidentiality concerns to limit the number of people informed of them, it is particularly important that the outcomes of concerns are reported and analysed.

28. Where a pattern is identified, this must be fully explored to identify if there are any shared root causes which should be addressed. For example, several concerns raised about cleaning services may reflect a more significant issue in relation to the delivery of cleaning services within a department.

Annual reporting and monitoring performance

29. Boards must publish an annual report setting out performance in handling whistleblowing concerns. This should summarise and build on the quarterly reports produced by the board, including performance against the requirements of the Standards, KPIs, the issues that have been raised and the actions that have been or will be taken to improve services as a result of concerns.

30. Boards must work with their services providers (including primary care (see Part 7 of the Standards)) to ensure they get the required information so that this annual report covers all the NHS services provided through the board. Integration joint board (IJB) (see Part 8) reporting must also be covered in this report, unless a separate annual report covering all IJB services is published by the IJB itself. The annual report must also include concerns raised by students (see Part 9) and volunteers (see Part 10) about NHS services.

31. This provides the opportunity for boards to show that they have listened to their staff, addressed the concerns raised and made improvements to services. A focus on the lessons learned will demonstrate that concerns are taken seriously and that staff are treated well through the process.

32. An increase in the number of whistleblowing concerns is not necessarily a cause for concern; it may reflect a shift towards a culture that values the raising of concerns as opportunities to learn and improve.

However, an increase in anonymous whistleblowing concerns may be driven by different considerations, and potentially a culture that does not value the raising of concerns. Likewise, very low numbers of concerns being reported may indicate a lack of confidence in the processes and support in place. The data should be considered in the context of existing trends and benchmarking data. The reason for any major variations must be fully explored, and appropriate action taken in response.

33. Every effort must be made during the preparation of these reports to ensure that the identities of those involved in whistleblowing concerns cannot be discerned from the information or context provided in the report. This is particularly relevant where small numbers of cases are involved. In such instances it may be necessary to provide more limited information.

34. These reports must be easily accessible to members of the public and available in alternative formats as requested.

Sharing the learning

35. As well as publicising performance in relation to concerns handling, all providers should show that they encourage staff to speak up, and that doing so leads to improvements in services. This can be achieved through sharing the learning from concerns as widely as possible, and by publicising good news stories on a regular basis. This could be through staff newsletters, leaflets, posters or on staff intranet pages, to ensure that staff across the organisation have easy access to it. This helps to show staff that raising concerns can influence service delivery and improve the profile and transparency of the whistleblowing procedure.

36. Openly and regularly discussing improvements that have been made as a result of concerns raised by staff at a team or departmental level will also encourage staff to raise their concerns. This must be done carefully and with sensitivity, to ensure appropriate confidentiality is maintained. However, the benefits of gaining staff trust through discussing and sharing improvements should be explored when possible.

INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 6

Governance: NHS board requirements for external services

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

Requirement to meet the Standards

1. This part of the Standards sets out the responsibilities of all NHS boards for the services they provide indirectly – through primary care, contracted services (including any maintenance and domiciliary services), health and social care partnerships (HSCPs), and in conjunction with higher education institutions and voluntary sector providers.

2. Further information on the requirements for these various service providers are available in Parts 7-10 of the Standards.

Board oversight

3. NHS boards must have effective mechanisms for oversight of the concerns raised about their own services. They must also have systems in place to ensure that they are aware of concerns that are raised about the services they fund or support through alternative delivery routes.

4. This means that boards must ensure that all services delivered by them or on their behalf have appropriate procedures in place for their staff, students, contractors, volunteers and others to access a whistleblowing procedure that is in line with these Standards.

5. They must also ensure that they receive quarterly reports from all those organisations that deliver services on their behalf. In particular, boards will be expected to compile reports on concerns raised with primary care providers and contracted services.

6. Boards must review these quarterly reports and follow up on any issues that they raise. They must also take a considered approach to what these reports say about the culture of speaking up within the organisation and beyond. This is particularly important in relation to primary care services, where a lack of reporting of any concerns may indicate difficulties for staff in raising concerns.

Ensuring compliance through contracts

7. As set out above, it is the **NHS board's responsibility to ensure that primary care and other contracted service providers have procedures in place that are in line with these Standards**. This must form a part of all contracts or service level agreements with contracted service providers.

8. Boards must have mechanisms for ensuring compliance with these requirements, including the requirement to report concerns handling information to the board on a quarterly basis when necessary.

9. Boards must have a confidential contact, who staff from primary care and contracted providers can contact if they do not feel able to raise their concerns within their own organisation.

10. This confidential contact must be able to provide information and support to the person raising a concern. They must also be familiar with routes for progressing such concerns and the requirements of the Standards, so they can discuss options with the person raising the concern.

11. Where an investigation within the contracted service is not possible, due to potential conflicts of interest, the provider must discuss the concern with the NHS board contracting the service, and work with the board to investigate the issue.

12. NHS boards must be willing to assist with the investigation of concerns raised in relation to primary care or contracted services. This assistance may involve providing an investigator with an appropriate level of experience and expertise, or advice on how to conduct an investigation. The board must gain assurances that appropriate action has been taken to address concerns raised with them about a service they are providing under contract.

NHS boards and integration joint boards

13. Each integration joint board (IJB) must develop an agreement which sets out how staff employed by both the NHS board and the local authority can raise concerns about services that are the responsibility of either the NHS board or the local authority.

14. This agreement must ensure that concerns about NHS services can be considered through the Standards. While good practice would suggest that a similar approach is taken to local authority services, these cannot be reviewed by the INWO, but are more likely to be appropriate for consideration by the Care Inspectorate.

15. The board must satisfy itself that:

    15.1. concerns raised within the health and social care partnership (HSCP) are recorded and reported in line with the Standards;

    15.2. arrangements are in place for quarterly reporting of concerns raised by staff to the IJB itself; and

    15.3. quarterly reports reflect the concerns that have been raised within the HSCP, performance in handling these concerns and lessons learned.

16. Further information is provided in the Part 8 of the Standards, for IJBs.

Working with higher education institutions

Enabling students to raise concerns

17. Students and trainees work in a range of settings, and cover many disciplines. Students must be able to raise concerns and have access to support services, in line with the Standards.

18. Students must also be encouraged to raise concerns with an appropriate manager within the service they are working in. Feeling confident and able to do this is an important part of their training. They must also have access to the board's confidential contact or whistleblowing ambassador. However, it is acknowledged that students are, mostly, inexperienced and particularly at risk of detriment in relation to their course marks. For this reason, it is important that they also have access to an alternative route for raising concerns.

19. In order to achieve this, higher education institutions (HEIs) courses must identify an appropriate contact for any student group that will be working in an NHS service. This could be a course coordinator or similar. Their role will be to provide information and support to any students raising concerns with them. Further information is available in Part 9 of the Standards on arrangements for students.

Higher education institution staff in the NHS

20. Many NHS boards have departments where staff from HEIs work alongside NHS staff, and their educational and health care roles normally overlap. These workers are as likely as anyone else to identify an issue within an NHS service which needs to be addressed for the benefit of patient safety, efficient service delivery or good governance. It is therefore important that, in relation to whistleblowing, they should have equal access to this procedure and to the support they need in raising their concern.

21. On occasion, these staff may wish to raise a concern with a supervisor or line manager who is outside the NHS. However, while they may be well placed to provide support for the individual, they may not be well placed to take forward appropriate service changes. On this basis, HEI staff should be encouraged to raise concerns with an appropriate manager within the department they are working in. They must also have access to the board's confidential contact.

22. Boards must also ensure that access to the Standards is included within their Allied Health Professionals' NES Practice Placement Agreements, so that boards, HEIs and students are aware of the process.

Working with voluntary sector providers

23. Voluntary organisations work within the NHS in a number of ways, most common of which are:

    23.1. provision of additional services, paid for by the voluntary sector, e.g. Macmillan nurses;

    23.2. provision of services contracted by the NHS, e.g. delivery of nursing care at home; and

    23.3. volunteers working within an NHS setting, e.g. ward visitors.

24. All these groups may find there are issues which concern them about how work is being carried out in an NHS service, so all must be able to access this procedure, and have access to the support and protection provided by these Standards.

25. People working for voluntary organisations contracted to provide a service for the NHS are included through contractual arrangements, in line with all other contracted services.

26. People working (either paid or voluntarily) for voluntary services that are additional to NHS services, but work alongside them, must be able to raise any concern they have with the most appropriate local manager. They must also be able to have access to the board's confidential contact and to any support they need in relation to raising the concern.

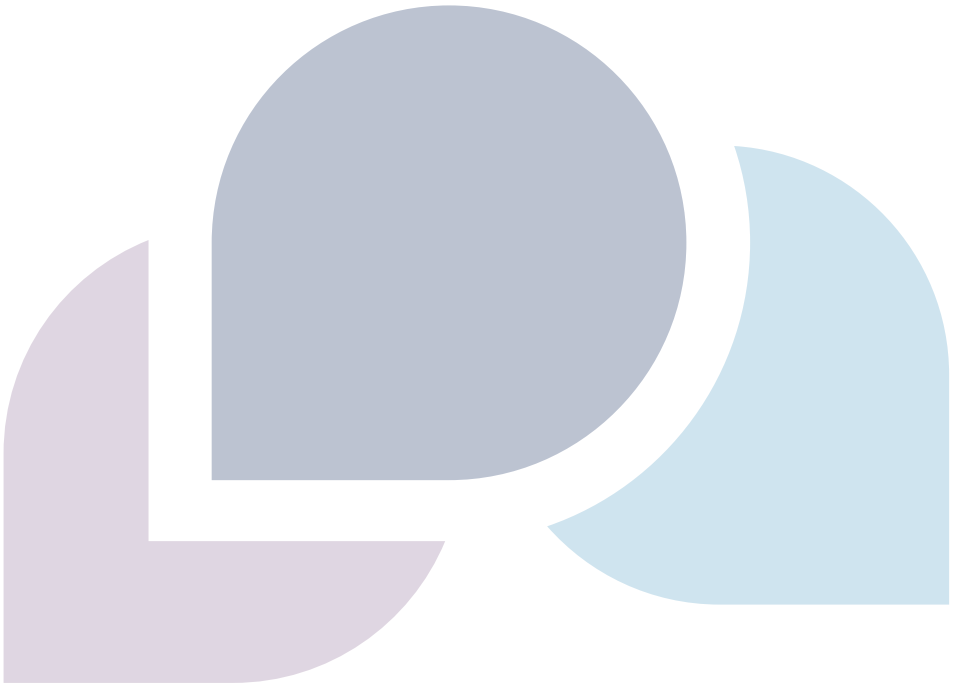
27. These workers may prefer to raise their concern with a representative from the voluntary organisation (particularly volunteers, who may not feel able to raise concerns directly). It is expected that each voluntary organisation that works within an NHS setting will have at least one member of staff who is informed and able to support their volunteer or colleague through this procedure. They can act as an advocate if the individual does not feel able to raise the concern themselves. NHS managers must facilitate such raising of concerns and be open to the learning opportunities they provide.

Providing a confidential contact

28. Details of the role of the confidential contact or whistleblowing ambassador are provided in Part 4 of these Standards. In relation to their role with external service providers, the confidential contacts must be aware of the board's obligation to receive concerns and provide support to anyone working within or alongside a service provided by the board. They must welcome such concerns and actively encourage them when promoting the raising of concerns.

29. Confidential contacts are encouraged to develop relations with representatives from HEIs and voluntary sector providers, to develop a mutual understanding of their roles, and so if issues do arise, communication is easier.

30. Boards may choose to have several confidential contacts; it may be appropriate to have one specifically for these groups, and another to work with primary care and contracted services, to encourage the raising of concerns in these areas.



INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 7

Information for primary care providers and other contracted services

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

Promoting raising concerns

1. The Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to respond when staff raise concerns. This document reviews the expectations for all primary care and contracted services in implementing the Standards.

2. Listening and responding to concerns raised by staff about the way services are provided is a vital way in which organisations of all sizes can improve their services. In primary care and other small organisations it is particularly important to make this process easy and straightforward, and to show the benefits of raising concerns.

3. Staff in small teams or organisations can find it particularly difficult to raise concerns about the work they or their colleagues are doing, and it is important that they receive the support and encouragement they need to raise concerns in a way which can improve safe, effective service delivery and good governance.

4. Senior managers play a critical role in promoting a culture that encourages staff to raise issues or concerns. Their leadership and behaviour will set the tone for the way other staff behave, particularly in a small organisation. All NHS services must strive for a culture that welcomes concerns from people working within their services, whoever they are, and whatever their concern, with the focus on good governance and delivering safe and effective services.

5. The Standards set out how the INWO expects primary care providers and contracted services to respond when staff raise concerns, and this includes providing support within a culture that welcomes concerns from people working within their services.

Requirement to meet the Standards

6. All primary care providers and contracted services are required to have a procedure that meets with the requirements of these Standards. This means that any organisation delivering NHS services, whether it is a private company, a third sector organisation or a primary care provider, has the same requirement to ensure access to a procedure in line with these Standards. This includes third sector organisations providing services on behalf of NHS Scotland and private companies under contract with NHS Scotland, including maintenance and domiciliary services.

7. All those delivering NHS services **must** be able to raise concerns about NHS services, and **must** have access to the support they need to do so. Access to the Standards **must** be available to:

    7.1. anyone who works directly for these services; and

    7.2. anyone working for another organisation, but within these services, such as district nurses, agency staff, students/trainees and volunteers.

8. If the individual is raising a concern about a service that is not their employer (such as a district nurse working in a GP service or a locum pharmacist working for an agency) then they must be able to raise concerns either directly with their employer or within the service itself, including full access to the Standards.

9. This includes:

    9.1. providing clear information about who staff and other workers can raise concerns with, both within the organisation and externally;

    9.2. access to a two stage procedure (see Part 3), where the worker has agreed to use this procedure;

    9.3. the availability of support (see Part 2) for those involved in raising a concern;

    9.4. arrangements for raising concerns about senior staff (see Part 4);

    9.5. the requirement to record (see Part 5) all concerns;

    9.6. the requirement to report (see Part 5) all concerns internally and to the board on a quarterly basis; and

    9.7. the requirement to share information about how services have improved following raising of concerns, taking care not to reveal who has raised the concern.

10. Anyone raising a concern about a service provided by NHS Scotland must be signposted to the INWO at the end of this process. More information about this is available in Part 3 of the Standards.

11. When a primary care or contracted service is being delivered by a much larger organisation, such as a local pharmacy that is run by a national company, this company must ensure that any services delivered on behalf of NHS Scotland are compliant with these requirements.

How to raise concerns: options for small organisations

12. Small organisations face varying challenges around the raising of concerns, and it is important for managers to be aware of these. The most obvious difficulty is for staff to raise concerns in a confidential way, when the size of the team means it will be obvious who has raised the concern. This is likely to be exacerbated by worries that a concern may be investigated by another member of the team.

13. Small organisations can reduce the difficulties their workers may face in raising concerns by:

    13.1. providing an alternative point of contact for raising a concern, for example, sharing 'confidential contacts' with other local services or practices. They would not share the details of who had raised the concern, but would act as the person's advocate, passing on information and updates as appropriate; and

    13.2. using an external investigator to investigate concerns raised at stage 2.

14. To ensure all staff working for NHS providers can safely raise concerns about the services they provide, NHS boards are required to provide a confidential contact for primary care and contracted providers, and this person can provide information and advice to anyone considering raising a concern. If necessary the confidential contact will ensure that appropriate action is taken to reduce immediate patient risk.

15. Where an investigation within the organisation is not possible, due to potential conflicts of interest, the provider must discuss the concern with the NHS board contracting the service, and work with the board to investigate the issue.

16. For their part, NHS boards must be willing to assist with the investigation of concerns raised in relation to primary care or contracted services. This assistance may involve providing an investigator with an appropriate level of experience and expertise, or advice in how to conduct an investigation. The board must gain assurances that appropriate action has been taken to address concerns raised with them about a service they are providing under contract.

17. Sharing information about how services have been improved may be more difficult if there is a concern about confidentiality. Care must be taken in reporting both statistical and case specific information. However, where this information can be appropriately anonymised, it provides the potential to reassure staff that their concerns will be listened to and acted on, so every effort must be made to share information in some way.

18. At the end of this process, the worker must be signposted to the INWO. The INWO's assessment of a case will consider whether the procedures were in line with the Standards, and that sufficient attempts have been made to ensure staff can raise concerns confidentially.

Informing staff

19. Encouraging staff to raise concerns early is the best way to resolve them easily. It is important, alongside encouraging staff to raise concerns, that they are also given the information they need to raise concerns through the Standards. This must include information on who they can raise concerns with, and how, including the board's confidential contact, as well as any local routes for raising concerns.

20. They must also be informed of the two stage process and contact details for the INWO, along with information about where they can access information and support on raising concerns. Ensuring this information is readily available will show staff that the organisation values the concerns that they raise.

Recording of concerns

21. The detailed information about recording concerns (Part 5 of the Standards) is also applicable to primary care and contracted services.

22. There is not necessarily a need to have complex recording and reporting systems in place. However, it is important to ensure that there is the capacity to maintain confidentiality for the person raising the concern. This may be achieved by holding information on the person separate from information on the investigation of the concern. Ensuring that access to records is limited to those people for whom access is necessary in relation to the process is critical for compliance with confidentiality and data protection law. Ensuring that those raising concerns are informed of the extent of proposed information sharing before providing their personal information is equally important.

Monitoring, reporting and learning from concerns

23. The detailed information about monitoring, reporting and learning from concerns (Part 5 of the Standards) is also applicable to primary care and contracted services.

24. It is important for all services to listen to staff concerns, and for this to lead to learning and service improvements. Learning can be identified from individual cases (including the potential for improvements across other areas of the service) and through statistical analysis of more minor concerns raised at stage 1 of the procedure. Any learning that is identified from concerns must be recorded within the case record, including any action planning.

26. The number of concerns raised within a single primary care service may be limited, making the outcomes of statistical analysis less valid. For this reason, it is particularly important that primary care services report their concerns data, including lessons learned, to their board. Each board will then be able to collate this information and identify areas for specific attention, based on the themes and trends within the services in their area. On this basis, primary care services must:

    26.1. **annually report** concerns data to the board, even if to report that there were no concerns raised; and

    26.2. **quarterly** only report to the board if concerns were raised in that quarter; if no concerns have been raised, there is no need to report, though it is good practice to let the board know.

27. Individual services are also expected to show their staff that they value the concerns that are raised by staff and other workers. There are a range of ways they show this, and one of the best ways is to use case studies when concerns have led to improvements. All primary care and contracted services must publish information about the concerns that have been raised with them, unless this is likely to identify any individuals. High level information (with very limited information about what was investigated) may still be appropriate, and will provide the opportunity to show staff that managers will listen and respond to concerns.

INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 8

Information for health and social care partnerships

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

Promoting raising concerns

1. The Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to respond when staff raise concerns, including supporting the person raising a concern. This document reviews the expectations and options for health and social care partnerships (HSCPs) in implementing the Standards.

2. Listening and responding to concerns raised by staff about the way services are provided is a vital way in which organisations can improve their services. HSCPs are in an unusual position in having employees from two organisations delivering services together. The challenges this creates in governance arrangements must not get in the way of staff raising concerns when they see working practices which are unsafe or risky, or where they believe there has been improper conduct, mismanagement or fraud.

3. People working in joint teams may feel reluctant or uneasy in raising concerns relating to staff with different lines of management, or where employers have different arrangements in place for whistleblowing. It is, therefore, more important than ever that senior managers in HSCPs and the integration joint board (IJB) itself promote a culture that encourages staff to raise issues or concerns at the earliest opportunity.

4. Senior managers play a critical role in promoting a culture that encourages staff to raise issues or concerns. Their leadership and behaviour sets the tone for the way other staff behave. All NHS services must strive for a culture that welcomes concerns from people working within their services, whoever they are, and whatever their concern, with the focus on good governance and delivering safe and effective services.

Requirement to meet the Standards

5. All those working in HSCPs **must** be able to raise concerns about NHS services, and **must** have access to the support they need to do so, whoever their employer is. Any concerns about the delivery of NHS services must be handled in line with the requirements of these Standards, and anyone raising a concern through these Standards will have access to the INWO, whoever their employer is.

6. IJBs must ensure that all HSCP staff, across both the local authority and the NHS, as well as any students, trainees, agency staff or volunteers, must be able to raise a concern through this procedure.

7. This includes:

   7.1. providing clear information about who staff and other workers can raise concerns with, either within their service or at a more senior level;

   7.2. ensuring access to the 2 stage procedure (see Part 3 of the National Whistleblowing Standards), where the worker has agreed to use this procedure;

   7.3. the availability of support (see Part 2) for those involved in raising a concern;

   7.4. the ability to raise concerns about senior staff (see Part 4);

   7.5. a requirement to record all concerns (see Part 5);

   7.6. a requirement to report all concerns to the IJB and the NHS board on a quarterly basis (see Part 5); and

   7.7. a requirement to share information about how services have improved as a result of concerns, taking care not to identify who raised the concern.

8. Anyone raising a concern about a service provided by NHS Scotland must be signposted to the INWO at the end of this process. More information about this is available in Part 3 of the Standards.

9. It may be that in considering concerns about NHS services, issues are identified which relate to local authority services. If that is the case, the whistleblower should be signposted to the INWO in respect of issues that relate to NHS services and the Care Inspectorate or other appropriate regulatory or oversight body for issues that relate to local authority services.

10. An agreement by the IJB may be required to ensure support and protection for all those working within the HSCP, in raising concerns about its NHS services.

Ensuring equity for staff

11. The requirement to have the Standards in place for all NHS services and not for local authority services could lead to disparity between those working for HSCPs. It could also lead to some confusion around which procedure to use, these Standards or the local authority's procedure for raising concerns. This could be particularly difficult where these services are closely integrated.

12. While this procedure must be available to all those working within NHS services, it is also important for those working in any of the HSCP's other services to also feel able to raise concerns. This is critical to:

    12.1. ensure effective governance arrangements;

    12.2. enable safe and efficient delivery of services;

    12.3. ensure equity for staff whoever they work for;

    12.4. assist senior managers in sharing a consistent message in encouraging staff to raise concerns through a simple and straightforward procedure; and

    12.5. enable a joined up approach to raising concerns, where lessons can be learnt across the organisation.

13. With this in mind, and particularly where services have been effectively integrated, the INWO recommends that HSCPs adopt the same approach to handling concerns raised about local authority services as they do in relation to NHS services. This would extend any agreement in place in relation to the raising of concerns for NHS services, and would ensure that all those working within the HSCP have equal access to a procedure in line with these Standards. The only variation would need to be at the review stage, when concerns about different services would need to be signposted as appropriate, to the INWO, the Care Inspectorate or in some cases, Audit Scotland.

14. The details of any extended agreement are for each IJB and their HSCP to consider; each HSCP have different arrangements in place for the delivery of their services, and it will be for them to consider whether such an agreement should cover all of their services or only the NHS services. This may depend to some extent on how differentiated the HSCP's services are from other local authority services; it would not be appropriate to create confusion for local authority staff in how to raise concerns about their services.

15. Chief officers are responsible for ensuring that systems and procedures are in place for raising concerns within these Standards, in relation to NHS services. They must also take a leading role in reviewing arrangements in relation to local authority services, and taking forward any changes to ensure the Standards can be met, as well as any other changes to ensure equity of access across the HSCP.

How to raise concerns

16. Those working in HSCPs must be able to raise concerns in several ways, including:

    16.1. with their line manager or team leader (whether they are employed by the NHS or the local authority);

    16.2. a more senior manager from either employer if circumstances mean this is more appropriate; or

    16.3. a confidential contact for raising concerns (in some places there may also be speak up ambassadors or advocates); this may be someone within the board.

17. A key element of the Standards is for those people who raise concerns to be advised of their right, and agree to access this procedure. This can be done in the initial conversation about the concern, or following receipt of an email.

18. Within HSCPs, the confidential contact will need to be familiar with the way concerns are handled across its services, as well as the board's expectations around handling concerns.

19. The board's whistleblowing champion will have a role in ensuring that appropriate arrangements are in place to ensure delivery of the Standards. (Further information about this role is available in Part 2 of the Standards.) They will be able to provide guidance for HSCP managers on how concerns raised in relation to NHS services must be handled, as well as sharing information about appropriate governance arrangements.

Recording of concerns

20. The detailed information about recording concerns (Part 5 of the Standards) is also applicable to concerns raised within HSCPs in relation to their NHS services.

21. Each HSCP needs to consider how they hold information about concerns that have been raised through this procedure. In particular, there need to be systems in place to ensure that personal information is only shared with individuals as agreed or explained to the person raising the concern. The details of the concern itself, and how it has been handled, need to be stored in a way that will enable reporting and monitoring of concerns and concerns handling.

22. This may mean that concerns about local authority services are recorded separately from those relating to NHS services. Any joint systems that are developed will need to be able to separate out concerns about NHS services from those about the local authority services, so the NHS board can carry out appropriate monitoring of these concerns.

Monitoring, reporting and learning from concerns

23. The detailed information about monitoring, reporting and learning from concerns (Part 5 of the Standards) is also applicable to concerns raised within HSCPs in relation to their NHS services.

24. It is important for all services to listen to staff concerns, and, where appropriate, for this to lead to organisational learning and service improvements. Learning can be identified from individual cases closed at stage 2 and through statistical analysis of concerns resolved at stage 1 of the procedure. This may include the potential for improvements across other areas of the service. Any learning that is identified from concerns must be recorded within the case record, including any action planning.

25. NHS boards are responsible for collating reports of concerns raised in relation to the services they deliver, including those raised within the HSCPs in its area. In this way, boards will be able to identify areas for specific attention, based on the themes and trends across these HSCPs. Feedback from this process provides the opportunity to demonstrate the benefits of raising concerns.

26. Each HSCP is also expected to show their staff that they value the concerns that are raised by staff and other workers. All IJBs must ensure that information is published and promoted about the concerns that have been raised about their services, unless this is likely to identify individuals. High-level information (with very limited information about what was investigated) may still be appropriate, and will provide the opportunity to show staff that managers will listen and respond to concerns.

INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 9

Arrangements for students and trainees

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

Student and trainee access to the Standards and the Independent National Whistleblowing Officer (INWO)

1. Students, trainees, and anyone on apprenticeships and internships working and/or studying within NHS services must have access to these Standards for raising concerns about NHS service delivery. They must be able to speak out by raising concerns over patient safety or malpractice, and they must have access to the support they need to do so.

2. Students and trainees are often at specific risk of detriment during placements, as they will be relying on managers and mentors for assessment and grading. They may be deterred from raising concerns if they feel this would impact on their marks, and this concern must be taken into consideration when responding to concerns raised by students.

3. During their training, most students will be informed of what whistleblowing means and how raising concerns provides an important mechanism for service improvements. Some will also be informed of the duty they will have to raise concerns, once they are registered professionals. Their confidence in putting this into practice will vary, depending on a range of factors, including their previous placements and the culture they experience around them where they are working.

Students raising concerns within NHS services

4. Students and trainees working in an NHS setting should be encouraged to participate fully in the organisation's learning culture and should be encouraged to use the systems available to all regular members of staff to raise concerns.

5. They must have access to information and advice from all the same sources as other staff within the service, including:

    5.1. National Alert Line – 0800 008 6112 or email – alertline@protect-advice.org.uk;
    5.2. the board's confidential contact for raising concerns, or other confidential speak up contact;
    5.3. the INWO;
    5.4. union representatives;
    5.5. professional bodies;
    5.6. university representatives (for students); and
    5.7. NHS Education Scotland (for trainee doctors and dentists).

6. They must also be able to raise concerns with:

    6.1. a service manager or team leader;
    6.2. a more senior manager if circumstances mean this is more appropriate;
    6.3. a university representative (see below for details); or
    6.4. a confidential contact for raising concerns (in some places there may also be speak up ambassadors or advocates).

7. All NHS boards and service providers must be open to receiving concerns either directly from a student, or through a representative from their course, and must ensure that these concerns are responded to in line with the Standards.

8. Students may have concerns that relate to the way their course has been managed or how their placement fits into their wider studies. Concerns such as these, that relate to their course rather than the delivery of NHS services, should be directed to the complaints procedure in their higher education institution (HEI). Concerns about NHS services should always be referred to the NHS for consideration, either by the student or via their course advocate, as detailed below.

9. (Staff that have NHS as well as teaching responsibilities should raise their concerns through the NHS procedure, as this will provide protection through the Standards. See Part 6 of the Standards for further information.)

Students raising concerns through course advocates

10. In addition to the routes normally available to staff, students can also raise their concerns with a representative on their course. It may be that information and advice is enough for the student to then raise the concern within the service. However, if this is not felt appropriate in the circumstances, or if the student does not feel confident that this would achieve the right outcomes for them, they must be able to raise their concern through their course representative or 'course advocate'.

11. Each course that provides placements, traineeships or work experience in NHS services must have a named person (such as the course coordinator), who can act as an advocate, and take the concern to the board or primary care service on their behalf. This person must be fully aware of these Standards, what students can expect when they raise a concern, and who to contact in each of the boards where their students work, in case any concerns are raised.

12. The course advocate must provide information and advice to students, and discuss the implications of raising the concern either directly or through the advocate. This discussion must include:

    12.1. consideration of confidentiality issues;
    12.2. support available to the student and how to access it; and
    12.3. details of the procedure and what to expect.

13. If a student chooses to, they can use the course advocate to raise the concern on their behalf, and can choose whether they then remain anonymous to the board or service provider. If they choose to be anonymous, all communication must go through the course advocate. This includes enquiries for further information, updates and a final response at the end of the process.

14. Trainees that are under a direct contract with NHS Education Scotland (NES) can choose to raise their concern directly with the NHS board they are working for, or through NES, with NES acting in the same way as an HEI. Trainees must be informed of who they can contact within NES if they want to raise a concern or would like advice or support in raising a concern.

Recording student concerns

15. Student concerns should be recorded in the same way as any other concerns. Detailed information about what to record is available in Part 5 of these Standards.

16. For concerns that are raised by a course advocate rather than by the student, the record should indicate the role of the person bringing the concern, as well as their full contact details, and information about the concern being raised. The name, contact details or any other personal details (including course details) of the student must not be recorded, as this could put them at risk of detriment.

Support for the student

17. Students raising concerns must have access to the same support as staff do in relation to raising concerns. Their course advocate will be able to provide some support in person. The advocate will also be expected to be able to advise on support options provided by the board or service provider. This may, on occasion, mean making special arrangements to ensure access, for example, to counselling which would normally be provided through an employee assistance scheme.

Signposting to the INWO

18. The final decision provided by the NHS service on any concern raised with them must include signposting to the INWO. This applies equally to student concerns, and, where appropriate, course advocates must take responsibility for passing on this information to the students concerned.

INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The National Whistleblowing Standards

Part 10

Arrangements for volunteers

JANUARY 2020

Final draft – shared for information by the SPSO, ahead of publication in Summer 2020 – exact date to be confirmed

Volunteers' access to the Standards and the Independent National Whistleblowing Officer (INWO)

1. All volunteers working within NHS services must have access to these Standards; they must be able to speak out where they have concerns over patient safety or malpractice, and they must have access to the support they need to do so.

2. Volunteers often have a unique perspective on the work of a ward or service. Their regular presence may mean they become aware of issues which are of concern, and they may well be uncertain of how to deal with them. They may also be uncertain about how serious a problem is, or whether it is something they should have any involvement in.

3. Volunteers are unlikely to share their concerns unless they are encouraged and offered the opportunity to share their insights with others. They may not feel that a whistleblowing procedure applies to them, so it is particularly important to ensure that all volunteers are informed of the procedure and how they can access it.

Volunteers raising concerns within NHS services

4. Volunteers do not have access to most NHS policies and procedures, but this procedure is an exception. They must have access to information and advice from all the same sources as board staff, including:

    4.1. National Alert Line – 0800 008 6112 or email – alertline@protect-advice.org.uk;
    4.2. the board's confidential contact for raising concerns, or other confidential speak up contact;
    4.3. the INWO; and
    4.4. coordinator for the organisation they are volunteering for.

5. They must also be able to raise concerns with:

    5.1. a service manager or team leader;
    5.2. a more senior manager if circumstances mean this is more appropriate;
    5.3. a volunteer representative (see below for details); or
    5.4. a confidential contact for raising concerns (in some places there may also be whistleblowing ambassadors or advocates).

6. NHS boards must be open to receiving concerns either directly from a volunteer, or through a volunteer coordinator or representative.

Volunteers raising concerns through the charity's representative

7. In addition to the routes normally available to staff, volunteers can also raise their concerns with a volunteer representative. This is the person nominated by the organisation arranging the volunteering opportunity (which could be directly through the NHS, a charity or other third sector provider). It may be that information and advice is enough for the volunteer to then raise the concern within the service. However, if this is not felt appropriate in the circumstances, or if the volunteer does not feel confident that this would achieve the right outcome, they must be able to raise their concern through the organisation's representative or volunteer coordinator.

8. Any organisation that engages volunteers to work in NHS services must be provided with information about these Standards and asked to ensure that they have someone (such as the volunteer coordinator), who can act as an advocate, and take the concerns to the board or primary care service on the volunteer's behalf, if needed. This person must be fully aware of these Standards, what volunteers can expect when they raise a concern, and who to contact in each of the boards where their volunteers work, in case any concerns are raised.

9. The volunteer representative must provide information and advice to volunteers, and discuss the implications of raising the concern either directly or using the representative as an advocate. This discussion must include:

    9.1. consideration of confidentiality issues;
    9.2. support available to the volunteer and how to access it; and
    9.3. details of the procedure and what to expect.

10. If a volunteer chooses to, they can use the volunteer representative to raise a concern on their behalf, and can choose whether they then remain anonymous to the board or service provider. If they choose this anonymity, all communication must go through the volunteer representative. This includes enquiries for further information, updates and a final response at the end of the process.

Recording volunteer concerns

11. Volunteer concerns should be recorded in the same way as any other concerns. Detailed information about what to record is available in Part 5 of the Standards.

12. For concerns that are raised by a volunteer representative rather than by the volunteer, the record should indicate the role of the person bringing the concern, as well as their full contact details, and information about the concern being raised. The name, contact details or any other personal details (including volunteering role) of the volunteer must not be recorded, as this could put them at risk of detriment.

Support for the volunteer

13. Volunteers raising concerns must have access to all appropriate forms of support. Their representative will be able to provide some support in person. They will also be expected to be aware of, or seek out information about, support options provided by the board or service provider.

14. Boards must ensure that, wherever possible, volunteers have access to the same support as staff do in relation to raising concerns. This may, on occasion, mean making special arrangements to ensure access, for example, to counselling which would normally be provided through an employee assistance scheme.

Signposting to the INWO

15. The final response or feedback provided by the NHS service on any concern raised with them must include signposting to the INWO. This also applies to concerns raised by volunteers, and the volunteer representative must take responsibility for passing on this information to the volunteer concerned.

INWO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Web **www.inwo.org.uk**

INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER

People Centred | Improvement Focused

NHS FIFE
STAFF GOVERNANCE COMMITTEE

DATE OF MEETING:	6th March 2020
TITLE OF REPORT:	Integrated Performance & Quality Report (IPQR)
EXECUTIVE LEAD:	Carol Potter
REPORTING OFFICER:	Susan Fraser

Purpose of the Report (delete as appropriate)		
~~**For Decision**~~	**For Discussion**	~~**For Information**~~

SBAR REPORT

Situation

This SBAR accompanies the Integrated Performance & Quality Report (IPQR), the main Corporate Performance reporting mechanism for the NHS Fife Board.

Background

The IPQR is produced monthly, and the most recent version is presented at each meeting of the Standing Committees – Clinical Governance, Staff Governance and Finance, Performance & Resources. It comprises an Executive Summary (covering key Clinical Governance, Operational Performance, Finance and Staff Governance measures) and 'drill-downs' for performance areas of particular interest – these are generally but not exclusively where performance is not consistently achieving the expected level.

Assessment

The Staff Governance aspect of the report covers Sickness Absence, and its current status is shown in the table below.

Measure	Update	Local/National Target	Current Status
Sickness Absence	Monthly	4.89% for 2019/20 (4.00% is the LDP Standard)	Not achieving

Recommendation

- **Discussion** – the Committee is asked to consider the contents of the report, with specific focus on the measure and performance relevant to Staff Governance, and identify any performance-related issues which require to be escalated to the next meeting of the NHS Fife Board (on 25th March 2020)

Objectives: (must be completed)	
Healthcare Standard(s):	
HB Strategic Objectives:	

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Health Board Meeting:	

Impact: (must be completed)	
Financial / Value For Money	e.g. - Financial impact or capital requirements
Risk / Legal:	e.g. - Completion of a risk assessment with plans in place to mitigate any risks identified - Likelihood of legal challenge
Quality / Patient Care:	e.g. - Inequity of provision (postcode lottery/commissioning) - Consequences of delaying/denying treatment - Consideration of exceptional circumstances
Workforce:	e.g. - Impact on existing staff - Potential for clinical/staff opposition - Consideration of Organisational Change Policy (HR15) - Identification of training requirements
Equality:	The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty (for information on EQIAs, click here EQIA Template click here • Has EQIA Screening been undertaken? Yes/No (If yes, please supply copy, if no please state reason) • Has a full EQIA been undertaken? Yes/No (If yes please supply copy, if no please state reason) • Please state how this paper supports the Public Sector Equality Duty – further information can be found here • Please state how this paper supports the Health Board's Strategic Equality Plan and Objectives – further information can be found here • Any potential negative impacts identified in the EQIA documentation - Yes/No (if yes please state)

Fife Integrated Performance & Quality Report

Produced in February 2020

NHS Fife

Introduction

The purpose of the Integrated Performance and Quality Report (IPQR) is to provide assurance on NHS Fife's performance relating to National LDP Standards and local Key Performance Indicators (KPI).

The IPQR comprises of the following sections:

I. Executive Summary

a. LDP Standards & Local Key Performance Indicators (KPI)

b. National Benchmarking

c. Indicatory Summary

d. Assessment

II. Performance Assessment Reports

a. Clinical Governance

b. Finance, Performance & Resources
   Operational Performance
   Finance

c. Staff Governance

Section II provides further detail for indicators of continual focus or those that are currently underperforming. Each report contains data, displaying trends and highlighting key problem areas, as well as information on current issues with corresponding improvement actions. The latter, along with trajectories, are taken as far as possible from the 2019/20 Annual Operational Plan (AOP). For indicators outwith the scope of the AOP, improvement actions and trajectories were agreed locally following discussion with related services.

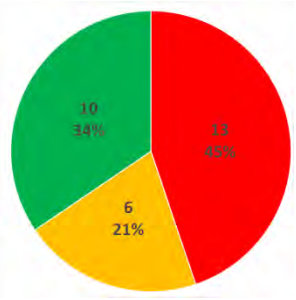
A summary report of the IPQR, the Executive Summary IPQR (ESIPQR), is presented at each NHS Fife Board Meeting.

I. Executive Summary

At each meeting, the Standing Committees of the NHS Fife Board consider targets and Standards specific to their area of remit. This section of the IPQR provides a summary of performance against LDP Standards and local Key Performance Indicators (KPI). These indicators are listed within the Indicator Summary, which shows current, previous and (where appropriate) 'Year Previous' performance as well as benchmarking against other mainland NHS Boards.

a. LDP Standards & Key Performance Indicators

The current performance status of the 29 indicators within this report is 10 (35%) classified as **GREEN**, 6 (21%) **AMBER** and 13 (44%) **RED**. This is based on whether current performance is exceeding standard/trajectory, within specified limits or considerably below standard/trajectory.

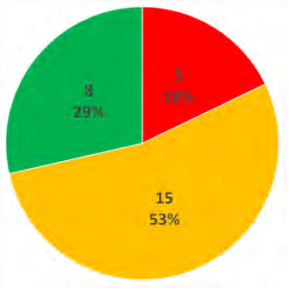


There are three indicators that consistently exceed the Standard performance; IVF Treatment Waiting Times (regional service), Antenatal Access and Drugs & Alcohol Waiting Times. Other areas of success should also be noted…

- SAB Infection Rate (HAI/HCAI) falling and well-below the target for 2019-20
- Diagnostics (% of Patients Waiting no more than 6 Weeks at Month End) continuing to be very close to the 100% target
- Cancer 31-Day DTT achieving the Standard for the seventh successive month
- Improved performance against both Mental Health targets (although both still some way short of the 90% Standard)

b. National Benchmarking

National Benchmarking is based on whether NHS Fife performance is in the upper quartile of the 11 mainland Health Boards (●), lower quartile (●) or mid-range (●). The current benchmarking status of the 28 indicators within this report has 8 (29%) within upper quartile, 15 (53%) in mid-range and 5 (18%) in lower quartile. There are indicators where national comparison is not available or not directly comparable.



Indicator Summary

Performance
meets / exceeds the required Standard / on schedule to meet its annual Target
behind (but within 5% of) the Standard / Delivery Trajectory
more than 5% behind the Standard / Delivery Trajectory

Benchmarking	
●	Upper Quartile
●	Mid Range
●	Lower Quartile

Section	LDP Standard	Standard	Target 2019/20	Reporting Period	Year Previous		Previous		Current			Reporting Period	Fife		Scotland
Clinical Governance	N/A	Major & Extreme Adverse Events	N/A	Month	Dec-18	58	Nov-19	50	Dec-19	47	↑	N/A			
	N/A	HSMR	N/A	Year Ending	Jun-18	N/A	Mar-19	1.01	Jun-19	1.04	↓	YE Jun-19	1.04	●	1.00
	N/A	Inpatient Falls	5.97	Month	Dec-18	6.31	Nov-19	6.07	Dec-19	6.88	↓	N/A			
	N/A	Inpatient Falls with Harm	2.16	Month	Dec-18	1.66	Nov-19	1.31	Dec-19	1.81	↓	N/A			
	N/A	Pressure Ulcers	0.42	Month	Dec-18	0.85	Nov-19	0.86	Dec-19	0.91	↓	N/A			
	N/A	Caesarean Section SSI	2.5%	Quarter Ending	Sep-18	2.3%	Jun-19	2.0%	Sep-19	2.5%	↓	QE Sep-19	2.5%	●	1.1%
	N/A	SAB - HAI/HCAI	20.2	Quarter Ending	Dec-18	N/A	Nov-19	12.1	Dec-19	10.9	↑	YE Sep-19	15.2	●	16.9
	N/A	SAB - Community	N/A	Quarter Ending	Dec-18	N/A	Nov-19	8.6	Dec-19	6.4	↑	YE Sep-19	11.6	●	9.0
	N/A	C Diff - HAI/HCAI	6.9	Quarter Ending	Dec-18	N/A	Nov-19	14.3	Dec-19	14.2	↑	YE Sep-19	8.6	●	13.1
	N/A	C Diff - Community	N/A	Quarter Ending	Dec-18	N/A	Nov-19	3.2	Dec-19	3.2	↔	YE Sep-19	5.1	●	5.1
	N/A	ECB - HAI/HCAI	40.3	Quarter Ending	Dec-18	N/A	Nov-19	55.0	Dec-19	60.0	↓	YE Sep-19	40.4	●	38.7
	N/A	ECB - Community	N/A	Quarter Ending	Dec-18	N/A	Nov-19	24.8	Dec-19	28.8	↓	YE Sep-19	42.7	●	44.2
	N/A	Complaints (Stage 1 Closure Rate)	80%	Quarter Ending	Dec-18	82.5%	Nov-19	76.0%	Dec-19	75.1%	↓	2018/19	70.7%	●	81.5%
	N/A	Complaints (Stage 2 Closure Rate)	65%	Quarter Ending	Dec-18	59.8%	Nov-19	56.3%	Dec-19	50.0%	↓	2018/19	49.1%	●	53.7%
Operational Performance	90%	IVF Treatment Waiting Times	90%	Month	Dec-18	100.0%	Nov-19	100.0%	Dec-19	100.0%	↔	N/A			
	95%	4-Hour Emergency Access	96%	Month	Dec-18	92.8%	Nov-19	92.7%	Dec-19	88.0%	↓	Dec-19	88.0%	●	83.8%
	95%	New Outpatients Waiting Times	95%	Month	Dec-18	92.2%	Nov-19	92.7%	Dec-19	91.8%	↓	Sep-19	94.3%	●	72.9%
	100%	Diagnostics Waiting Times	100%	Month	Dec-18	98.4%	Nov-19	99.1%	Dec-19	98.6%	↓	Sep-19	99.0%	●	82.3%
	100%	Patient TTG (Ongoing Waits)	90.6%	Month	Dec-18	83.3%	Nov-19	90.1%	Dec-19	89.7%	↓	Sep-19	91.2%	●	67.5%
	90%	18 Weeks RTT	84%	Month	Dec-18	80.4%	Nov-19	80.9%	Dec-19	82.0%	↑	Sep-19	79.8%	●	76.9%
	95%	Cancer 31-Day DTT	95%	Month	Dec-18	98.2%	Nov-19	96.3%	Dec-19	99.2%	↑	QE Sep-19	96.4%	●	95.8%
	95%	Cancer 62-Day RTT	94%	Month	Dec-18	90.2%	Nov-19	87.3%	Dec-19	90.7%	↑	QE Sep-19	82.9%	●	83.3%
	29%	Detect Cancer Early	27%	Year Ending	Sep-18	26.9%	Jun-19	25.2%	Sep-19	24.8%	↓	2017, 2018	25.1%	●	25.5%
	N/A	Delayed Discharge (% Bed Days Lost)	5%	Month	Dec-18	8.2%	Nov-19	7.4%	Dec-19	7.6%	↓	QE Jun-19	7.6%	●	6.7%
	80%	Antenatal Access	80%	Month	Oct-18	87.0%	Sep-19	81.8%	Oct-19	86.2%	↑	2018/19	91.3%	●	87.6%
	473	Smoking Cessation	473	YTD	Sep-18	80.0%	Aug-19	93.9%	Sep-19	90.7%	↓	YT Jun-19	92.4%	●	92.4%
	90%	CAMHS Waiting Times	88%	Month	Dec-18	85.5%	Nov-19	66.0%	Dec-19	71.3%	↑	QE Sep-19	75.2%	●	64.5%
	90%	Psychological Therapies Waiting Times	82%	Month	Dec-18	73.9%	Nov-19	66.0%	Dec-19	75.8%	↑	QE Sep-19	66.5%	●	79.4%
	80%	Alcohol Brief Interventions (Priority Settings)	80%	YTD	Sep-18	69.6%	Jun-19	73.8%	Sep-19	77.3%	↑	YT Sep-19	77.3%	●	89.3%
	90%	Drugs & Alcohol Treatment Waiting Times	90%	Month	Oct-18	97.0%	Sep-19	96.6%	Oct-19	94.6%	↓	QE Sep-19	96.7%	●	95.0%
	N/A	Dementia Post-Diagnostic Support	TBD	Annual	2016/17	87.5%	2017/18	87.5%	2018/19	90.2%	↑	2018/19	90.2%	●	58.6%
	N/A	Dementia Referrals	TBD	Annual	2016/17	60.1%	2017/18	55.4%	2018/19	60.5%	↑	2018/19	60.5%	●	40.8%
	N/A	Freedom of Information Requests	85%	Quarter Ending	Dec-18	N/A	Nov-19	49.7%	Dec-19	53.0%	↑	N/A			
Finance	N/A	Revenue Expenditure	£0	Month	Jan-19	N/A	Dec-19	£5.405m	Jan-20	£5.220m	↑	N/A			
	N/A	Capital Expenditure	£9.217m	Month	Jan-19	N/A	Dec-19	£4.558m	Jan-20	£5.305m	↑	N/A			
Staff Governance	4.00%	Sickness Absence	4.89%	Month	Dec-18	5.54%	Nov-19	5.58%	Dec-19	5.82%	↓	YE Dec-19	5.71%	●	5.45%

d. Assessment

Clinical Governance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
HSMR	1.00	N/A	N/A	YE Jun-19	1.04	YE Jun-19	●
The annual HSMR for NHS Fife increased during the second quarter of 2019. The number of deaths is small, but the predicted deaths per year rose by 15, and this led to a Fife rate which is higher than the Scottish average. This could easily fall back during quarter 3. HSMR changed to be an annual measure at the start of 2019, the way in which the data is created as changed and it is possible this doesn't properly reflect a hospital such as QMH, which is largely populated by elderly patients.							
Inpatient Falls Reduce falls with harm by 20% by December 2020	2.16	Dec-19	2.16	Dec-19	1.81	N/A	N/A
While an increase in falls is noted in the December figures there is acknowledgement that, as in previous years, this is reflective of the significant increased winter activity across the system. Ongoing monitoring of this will continue with consideration of any related factors associated with this high level of activity and an expectation that the overall trend will return to the usual month to month variation. The repeat falls audit will now take place February/March.							
Pressure Ulcers 50% reduction by December 2020	0.42	Never Met	0.42	Dec-19	0.91	N/A	N/A
The number of pressure ulcers (PU) reported continues to vary with no sustained improvement. A Quality Improvement (QI) programme is commencing across Fife (HSCP and ASD) to work with teams to drive QI and reduce patient harm. Scrutiny and monitoring for assurance is via the Fife Tissue Viability Steering Group. The target end date for a 50% reduction has been extended to December 2020.							
Caesarean Section SSI We will reduce the % of post-operation surgical site infections to 2.5%	N/A	QE Sep-19	2.5%	Sep-19	2.5%	QE Sep-19	●
Following a review of the surveillance methodology, a new process for ascertaining SSI status was adopted from the start of October. There was a significant reduction in SSI rate during Q2 of 2019, and this rate increased slightly in Q3. It is hoped that a sustained lower rate will be achieved throughout the remainder of the year.							
SAB (MRSA/MSSA) We will reduce the rate of SAB HAI/HCAI by 10% between March 2019 and March 2022	18.8	QE Dec-19	20.2	QE Dec-19	10.9	YE Sep-19	●
There were 4 SAB in December, 2 HCAI (1 HAI, 1 HCAI) and 2 CAI. In the whole of 2019, there were 85 SAB, the second lowest annual figure on record and 25% less than in 2018. VAD continued to be the major source of infections (27% in 2019), while PWID (People Who Inject Drugs) accounted for around 16% of the total. The quarterly –measured HAI/HCAI rate remains significantly less than the target for March, while the annually–measured rate is in line with the Scottish average.							
C Diff We will reduce the rate of C Diff HAI/HCAI by 10% between March 2019 and March 2022	6.5	QE Jun-19	6.9	QE Dec-19	14.2	YE Sep-19	●
There were 4 CDIs in December, 2 HAI and 2 CAI. In the whole of 2019, there were 47 CDI, equalling the record low of 2018. Around 15% of infections were due to a recurrence of infection. The quarterly-measured HAI/HCAI rate remains significantly greater than the target for March, but this is expected to reduce in January and the annually measured rate is much better than the Scottish average (Fife 8.6, Scotland 13.0)							
ECB We will reduce the rate of E. coli bacteraemia HAI/HCAI by 25% between March 2019 and March 2022	33.0	Never Met	40.3	QE Dec-19	60.0	YE Sep-19	●
There were 20 ECs in December, 12 HAI/HCAI and 8 CAI. In the whole of 2019, there were 264 ECB, a decrease from the 2018 figure of 291 (although the % of HAI/HCAI increased from 54% to 59%). UTI and CAUTI remain the most prevalent source of ECB. The quarterly measured HAI/HCAI rate remains significantly higher than the target for March, while the annually-measured rate is in line with the Scottish average.							
Complaints - Stage 2 At least 75% of Stage 2 complaints are completed within 20 working days	N/A	Never Met	65%	QE Dec-19	50.0%	FY 2018/19	●
Although the weekly complaint meeting to review current performance across NHS Fife continues, stage 2 performance continues to fall. Delays at approval within ASD, the hospital site capacity and staffing issues within the Patient Relations Department are the main areas of concern.							

Finance, Performance & Resources Operational Performance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
4-Hour Emergency Access 95% of patients to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment	95%	Jul-19	95%	Dec-19	88.0%	Dec-19	●
Performance against the 4-hour emergency access target deteriorated in December with capacity challenges on a daily basis and consistent use of additional bed base. The main pressure within December was prior to Christmas with increased attendance at both ED and medical assessment. There was a robust clinical support plan in place over the festive period which maintained performance above the Scottish average.							
New Outpatients 95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment	95%	Aug-19	95%	Dec-19	91.8%	Sep-19	●
Performance deteriorated in December and remains below the standard and trajectory with 91.8% of patients waiting less than 12 weeks at month end. Additional independent sector activity is now being delivered and locums are in place. Performance is recovering and it is anticipated that it will be above the standard by end of March.							
Patient TTG (Ongoing Waits) All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat	100%	Never Met	90.6%	Dec-19	89.7%	QE Sep-19	●
Performance has deteriorated over the last 2 months due to challenges in recruitment to vacant posts, difficulties in securing planned additional activity and greater than expected demand particularly in orthopaedics and ophthalmology. Efforts continue to secure more activity, however it is anticipated recovering this position and meeting the trajectory at the end of March will be very challenging.							
Cancer 62-Day RTT 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral	95%	Oct-17	94%	Dec-19	90.7%	QE Sep-19	●
Performance improved in December, with 8 patient treatment breaches across 5 specialties, ranging from 4 to 54 days. Breaches are attributed to routine staging and investigations, review of results, issues in the gynaecology service, delay to plastic surgery and surgical outpatient appointments outwith Fife. Improvement was supported by an increase in the number of patients who started treatment in the month.							
Delayed Discharge The % of Bed Days 'lost' due to Patients in Delay is to reduce	N/A	Aug-18	5%	Dec-19	7.6%	QE Jun-19	●
Although the number of patients in delay at the December census point was less than at the November Census (65, against 73), the elapsed days to discharge for patients from the point of being fit for discharge was slightly higher than the previous month. This meant a slight increase in the % bed days lost (7.4% to 7.6%). This was, however, an improvement on the position at December 2018.							
Smoking Cessation Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas	100%	YT May-19	100%	YT Sep-19	90.7%	YT Jun-19	●
Delivery of Stop Smoking support in Carnegie Leisure Centre has had a very low uptake so we have stopped the clinic, freeing up staff to increase engagement in communities via the mobile unit. Temporary Abstinence pathway work in the VHK is progressing well with on-ward training sessions, and we have seen some patients engage in the service where we haven't been successful before. No Smoking Day planning is well underway with promotion on the internal panels of all buses, and FM Radio will be promoting the service pre and post No Smoking Day.							
CAMHS Waiting Times 90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral	90%	Sep-16	88%	Dec-19	71.3%	QE Sep-19	●
Clinical Activity continues to be directed at those accessing treatment and those who have waited the longest. Increased activity against the waiting list through evening clinics has a direct, negative impact on the 18 week RTT. Initial work has been completed with the Scottish Government Mental Health Performance & Improvement Unit, with recommendations made on the specific additional staffing resource required to meet the ongoing demand and achieve sustainable improvements towards the 18 week RTT.							

Finance, Performance & Resources Operational Performance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
Psychological Therapies 90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral	90%	Never Met	82%	Dec-19	75.8%	QE Sep-19	●
We continue to meet the RTT for patients with less complex needs, and service redesign in this area has freed capacity for high intensity work. Addressing the longest waiting patients impacts negatively on our RTT performance. Further service re-design to meet needs of more complex patients is on-going. Work with an ISD/MHAIST data analyst and SG advisor is highlighting that additional resource will be required to meet RTT. Demand-capacity modelling in relation to the improvement trajectory is in progress.							
FoI Requests At least 85% of Freedom of Information Requests are completed within 20 working days	N/A	N/A	85%	QE Dec-19	53.0%	N/A	N/A
For the Health Board, December performance has recovered to its highest level since February 2019, despite ongoing issues about the availability of administrative resource. Challenges still remain in triaging and allocating requests that fall to the services managed by the IJB within the statutory timeframe for response.							

Finance, Performance & Resources Finance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
Revenue Expenditure Work within the revenue resource limits set by the SG Health & Social Care Directorates	Breakeven	N/A	Breakeven	Jan-20	+ £5.220m	N/A	N/A
The revenue position for the 10 months to 31 January reflects an overspend of £5.220m. Based on this in-year position, and a number of high level planning assumptions as agreed by delegated budget holders, the year end forecast ranges from a potential optimistic forecast of £3.4m overspend to a potential worst case of £8.7m overspend. Notwithstanding the forecast position outlined above, the current forecast overspend of the IJB is significantly higher than the original approved budget gap (and capped risk share pressure) with a potential further £2.9m - £3.4m impact on the NHS Fife position at year end. Taking account of the potential offsetting benefits described above and the further overspend of the IJB, the forecast outturn position moves to an overspend of £4.8m (best case) to £10.5m (worst case). This highlights the ongoing challenge in achieving financial balance and our ability to meet our statutory obligations, without further financial support from Scottish Government.							
Capital Expenditure Work within the capital resource limits set by the SG Health & Social Care Directorates	£9.217m	N/A	£9.217m	Jan-20	£5.305m	N/A	N/A
The total Capital Resource Limit for 2019/20 is £9.217m. The capital position for the 10 months to January shows investment of £5.305m, equivalent to 57.56% of the total allocation. Plans are in place to ensure the Capital Resource Limit is utilised in full.							

Staff Governance	Standard / Local Target	Last Achieved	Target 2019/20	Current Performance		Benchmarking	
Sickness Absence To achieve a sickness absence rate of 4% or less	4.00%	Never Met	4.89%	Dec-19	5.82%	YE Dec-19	●
The sickness absence rate for December was 5.82%, 0.25% higher than November. This means that the gap between the actual performance and the improvement trajectory specified at the start of the FY has increased to 0.81%. This increase corresponds with the seasonal variation seen in previous years and the onset of winter ailments. Improvement actions continue to be implemented within each operational unit to work towards achieving the trajectories set for the Board.							

II. Performance Exception Reports

Clinical Governance

Finance, Performance & Resources – Operational Performance

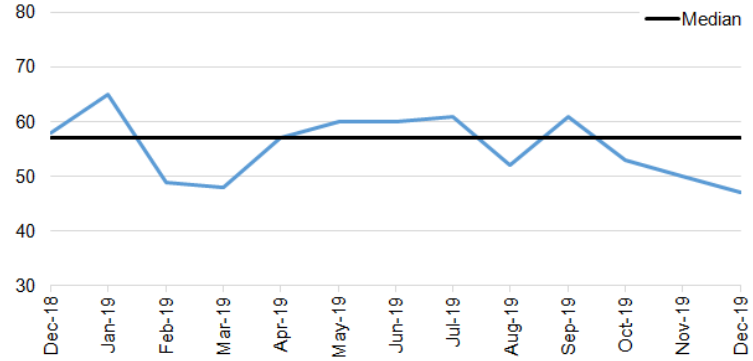
Finance, Performance & Resources – Finance

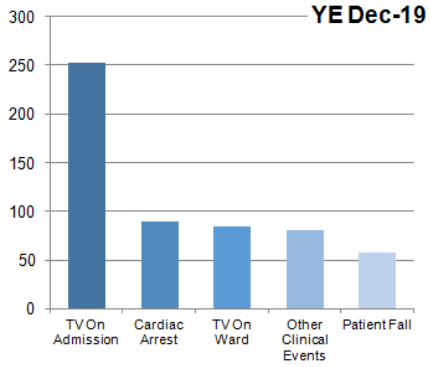
Staff Governance

Clinical Governance

Adverse Events

Major and Extreme Adverse Events





All Adverse Events

Month	2018/19				2019/20								
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NHS Fife	1240	1348	1263	1280	1233	1291	1242	1401	1296	1247	1352	1346	1361
Acute Services	578	630	586	574	537	594	566	560	573	531	660	572	574
HSCP	619	667	625	662	644	625	628	798	668	670	645	729	750
Corporate	43	51	52	44	52	72	48	43	55	46	47	45	37
NHS Fife	870	973	874	895	852	934	834	910	834	813	937	881	907
Acute Services	519	568	524	524	485	551	516	517	519	485	595	531	519
HSCP	340	389	337	355	355	346	297	378	284	310	319	335	377
Corporate	11	16	13	16	12	37	21	15	31	18	23	15	11

Commentary

The numbers of adverse events reported across NHS Fife remains consistent, which demonstrates a good reporting culture. There are working processes in place across the organisation to provide good oversight and monitoring of all adverse events, and these are constantly reviewed.

The national Healthcare Improvement Scotland (HIS) Report which followed from the self assessment exercise in November 2018, has led to the introduction a national notification system from January 1st 2020. It has been introduced to inform HIS of all commissioned significant adverse event reviews.

Clinical Governance

HSMR

Value is less than one, the number of deaths within 30 days of admission for this hospital is fewer than predicted. If value is greater than one, number of deaths is more than predicted.

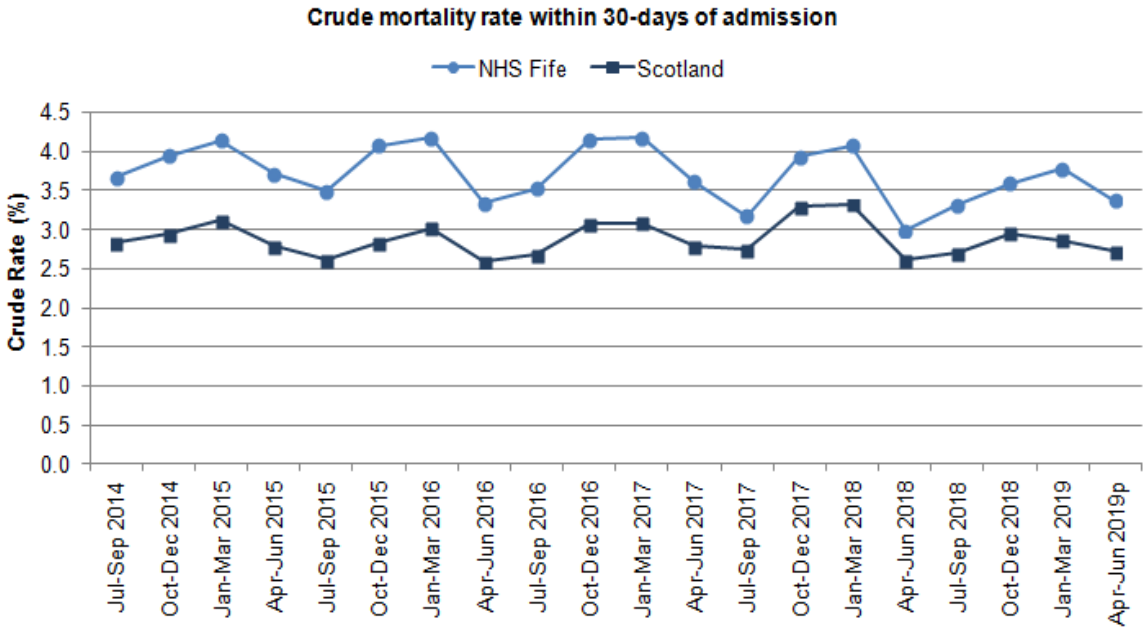
Reporting Period; July 2018 to June 2019p

Please note that as of August 2019, HSMR is presented using a 12 month reporting period when making comparisons against the national average. This will be advanced by three months with each quarterly update.

Crude mortality values presented here are reflective of the latest 12 month HSMR reporting period. For crude mortality trends by individual quarter please refer to **Crude Trends (Overall)**.

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR
Scotland	25,525	25,525	697,417	3.7%	1.00
NHS Fife	1,748	1,689	38,104	4.6%	1.04
Queen Margaret Hospital	65	46	7,524	0.9%	1.41
Victoria Hospital	1,624	1,579	30,335	5.4%	1.03

Crude Mortality Rate



Commentary

The annual HSMR for NHS Fife increased during the second quarter of 2019. The number of deaths is small, but the predicted deaths per year rose by 15, and this led to a Fife rate which is higher than the Scottish average. This could easily fall back during quarter 3.

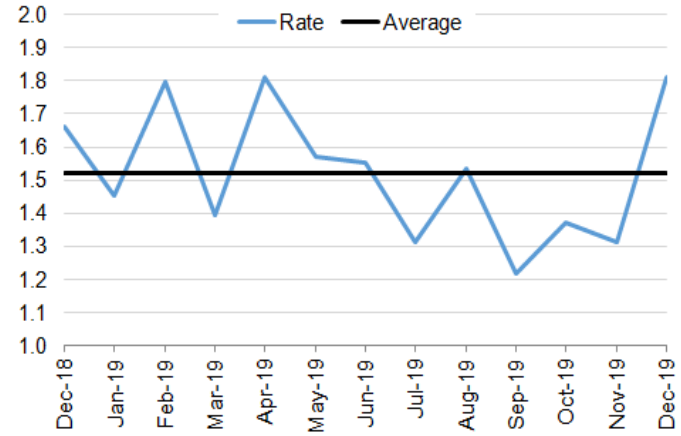
HSMR changed to be an annual measure at the start of 2019, the way in which the data is created has changed and it is possible this doesn't properly reflect a hospital such as QMH, which is largely populated by elderly patients.

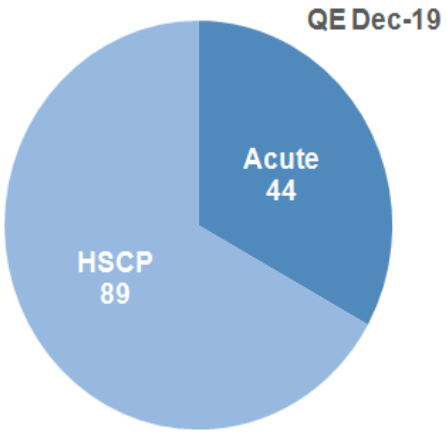
Clinical Governance

Inpatient Falls with Harm

Reduce Inpatient Falls With Harm rate per 1,000 Occupied Bed Days (OBD)
*Improvement Target rate (by end December 2020) = **2.16 per 1,000 OBD***

Local Performance





Service Performance

Month	2018/19				2019/20								
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NHS Fife	1.66	1.45	1.80	1.40	1.81	1.57	1.55	1.31	1.53	1.22	1.37	1.31	1.81
Acute Services	1.49	1.19	1.62	0.84	1.17	0.89	1.73	0.54	1.34	1.13	0.88	1.00	1.40
HSCP	1.80	1.69	1.95	1.85	2.34	2.15	1.40	1.95	1.70	1.29	1.79	1.56	2.16

Commentary

While an increase in falls is noted in the December figures there is acknowledgement that, as in previous years, this is reflective of the significant increased winter activity across the system. Ongoing monitoring of this will continue with consideration of any related factors associated with this high level of activity and an expectation that the overall trend will return to the usual month to month variation. The repeat falls audit will now take place February/March.

Current Challenges	Need to continue to review the performance with increased demands in in-patient settings and bed modelling within the acute setting. Bed Modelling is continuing. – ***All Actions***

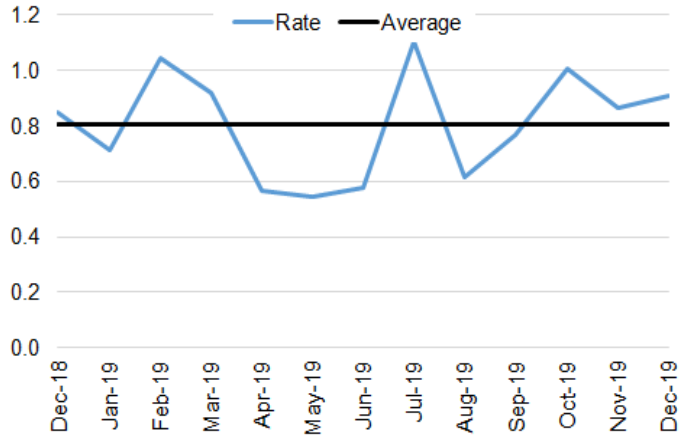
Improvement Actions	Progress	Timescale/ Status
1. Review the Falls Toolkit and Falls Flowchart		Complete
2. Develop Older People's Knowledge and Skills Framework		Complete
3. Falls Audit	The audit was completed over a 5 week period, focused on 5 acute wards and showed that falls intervention reviews are poorly completed. Improvement is anticipated following the launch of the revised toolkit, and a further compliance audit was planned for January 2020. **The audit tool and process is currently being refined and the plan is to re-audit February/March.**	~~Jan 2020~~ Revised to Mar 2020
4. Care and Comfort Rounding		Complete
5. Improve effectiveness of Falls Champion Network	The Falls Champions Network was anticipated as a regular face to face session to support champions. Ongoing evaluation notes the challenges in staff from in-patient areas being able to attend frequent sessions. This is currently being reviewed to explore a range of methods of providing update and support.	Apr 2020 On Track

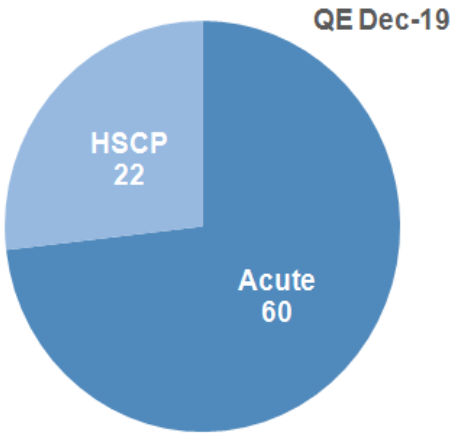
Clinical Governance

Pressure Ulcers

Achieve 50% reduction in pressure ulcers (grades 2 to 4) developed in a healthcare setting
*Improvement Target rate (by end December 2020) = **0.42 per 1,000 Occupied Bed Days***

Local Performance





Service Performance

Month	2018/19				2019/20								
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NHS Fife	0.85	0.71	1.04	0.92	0.57	0.55	0.58	1.10	0.61	0.76	1.00	0.86	0.91
Acute Services	1.57	1.12	1.54	0.91	0.70	0.89	1.25	2.15	1.19	0.98	1.47	1.62	1.40
HSCP	0.25	0.36	0.61	0.92	0.45	0.25	0.27	0.25	0.13	0.58	0.62	0.25	0.49

Commentary

The number of pressure ulcers (PU) reported continues to vary with no sustained improvement. A Quality Improvement (QI) programme is commencing across Fife (HSCP and ASD) to work with teams to drive QI and reduce patient harm. Scrutiny and monitoring for assurance is via the Fife Tissue Viability Steering Group.

The target end date for a 50% reduction has been extended to December 2020.

Current Challenges	Reducing number of pressure ulcers across all NHS Fife Wards – ***Actions 1, 3, 4 and 5***
	Reducing the random monthly variation in HSCP wards – ***Actions 3 and 6***

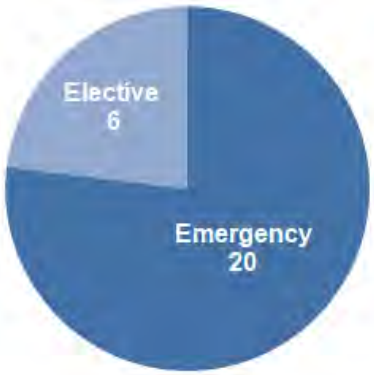
Improvement Actions	Progress	Timescale/ Status
1. All identified wards will undertake a weekly audit of compliance with SSKIN		Complete
2. Fife-wide task group commissioned to review SBAR/LAER reporting		Complete
3. Improvement collaborative project extended to December across identified wards		Complete
4. Improve consistency of reporting	Implementation of the revised process, parameters of reporting and reviewing pressure ulcer development and incidents across Fife in heath care settings	Mar 2020 *** **NEW** ***
5. Review TV Champion Network Effectiveness	Regular face-to-face sessions to support the already existing TV Champions Network is challenging due to clinical commitment. We need to consider how best to support the champions to deliver their role effectively.	Jun 2020 *** **NEW** ***
6. Reduce PU development	Redesign of the Quality Improvement Model to support the clinical teams to reduce harm, led by a HoN from the HSCP and ASD. To provide senior leadership support in practice.	Mar 2020 *** **NEW** ***

Clinical Governance

Caesarean Section SSI

To reduce C Section SSI incidence (per 100 procedures) for inpatients and post discharge surveillance to day 10 by 4% by March 2020.

Local Performance



Service Performance

Quarter	2017/18				2018/19				2019/20			
Ending	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20
NHS Fife	3.0%	4.5%	4.0%	3.3%	3.1%	2.3%	1.7%	6.5%	2.0%	2.5%		
Scotland	1.2%	1.3%	1.6%	1.6%	1.5%	1.5%	1.4%	1.6%	1.0%	1.1%		

Current Challenges	NHS Fife SSI Caesarean Section incidence rate still remains higher than the Scottish incidence rate – ***Action 1***
	NHS Fife BMI rates are higher than the national rate – ***Action 2***

Improvement Actions	Progress	Timescale/ Status
1. Address ongoing and outstanding actions as set out in the SSI Implementation Group Improvement Plan	Improvement Plan updated following receipt of Exception Report for Q1 2019. New case ascertainment methodology adopted from October.	Mar 2020 On Track
2. Support an Obesity Prevention and Management Strategy for pregnant women in Fife, which will support lifestyle interventions during pregnancy and beyond	Current strategies remain in place: • Family Health Team • Winning By Losing • Smoking Cessation Data analysis of these improvement strategies continues to assess effectiveness	Mar 2020 On Track

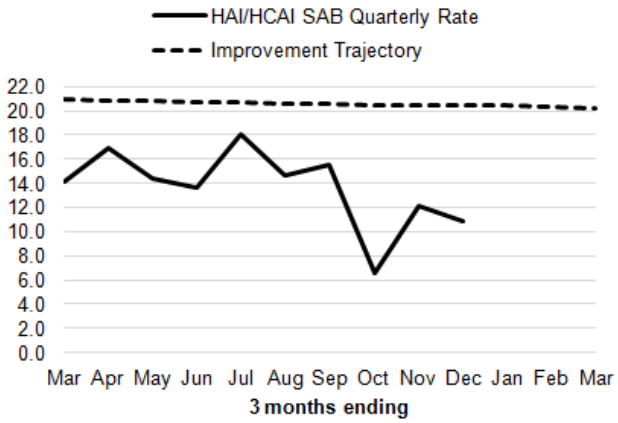
Clinical Governance

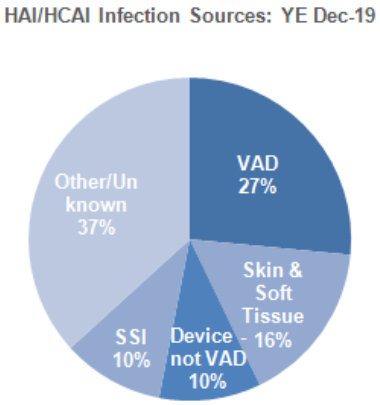
SAB (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Note: This equates to reducing the NHS Fife rate from 20.9 to 18.8 (per 100,000 TOBD) over 3 years, or to 20.2 by March 2020, 19.5 by March 2021 and 18.8 by March 2022

Local Performance | Quarter Ending





National Benchmarking | Year Ending

Year Ending		FY 2018/19	FY 2019/20			
		Mar	Jun	Sep	Dec	Mar
NHS Fife	HAI & HCAI Infection Rate (per 100,000 TOBD)	20.9	17.6	17.7		
Scotland		16.8	16.7	16.9		

Current Challenges	Increase in number of SAB in People Who Inject Drugs (PWID) – ***Action 1***
	Increase in number of VAD-related infections – ***Action 2***
	Reducing number of CAUTI infections – ***Action 3***
	Achieving HPS reduction of HCAI SAB by 10% by 2021/22 – ***Action 4***

Improvement Actions	Progress	Timescale/ Status
1. Reduce the number of SAB in PWIDs	The Infection Prevention Control Team continue to support the Addiction Services with the SAB improvement project. However, this has been postponed by the Addictions management team and for now the SAB improvement project is on hold until they have prioritised their ongoing working projects. A SOP for accessing antibiotics for patients identified with SSTI by Addiction Services is out for consultation with GPs.	Mar 2021 On Track (but work currently On Hold)
2. Ongoing surveillance of all VAD-related infections	Monthly charts distributed to clinical teams to inform of incidence of VAD SABs - these demonstrate progress and promote quality improvement	Mar 2021 On Track
3. Ongoing surveillance of all CAUTI infections	Bi-monthly meetings of the Urinary Catheter Improvement Group (UCIG) are taking place, to identify key issues and take appropriate corrective actions – Group next due to meet on 21st February.	Mar 2021 On Track
4. Optimise comms with all clinical teams in ASD & the HSCP	Monthly anonymised reporting with Microbiology comments to gain better understanding of disease process and those most at risk. This allows local resources to be focused on high risk groups/areas and improve patient outcomes.	Mar 2022 On track

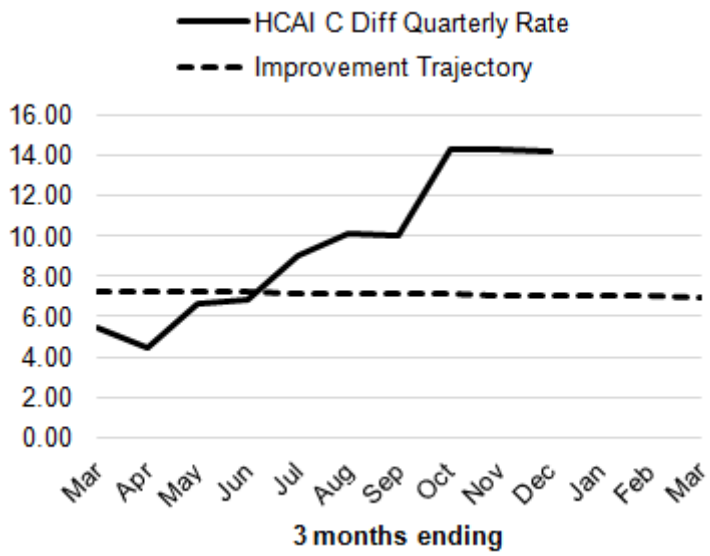
Clinical Governance

C Diff (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Note: This equates to reducing the NHS Fife rate from 7.2 to 6.5 (per 100,000 TOBD) over 3 years, or to 6.9 by March 2020, 6.7 by March 2021 and 6.5 by March 2022

Local Performance | Quarter Ending



National Benchmarking | Year Ending

Year Ending		FY 2018/19	FY 2019/20			
		Mar	Jun	Sep	Dec	Mar
NHS Fife	HCAI Infection Rate (per 100,000 TOBD)	7.2	7.7	8.6		
Scotland		14.8	13.8	13.1		

Current Challenges	High % of all HCAI CDIs classed as 'Recurrence of CDI' **– *Action 1***
	Addressing antimicrobials as a risk factor for CDI – ***Action 2***
	Achieving HPS reduction of HCAI CDIs by 10% by 2021/22 – ***Action 3***

Improvement Actions	Progress	Timescale/ Status
1. Reducing recurrence of CDI	NHS Fife has been approved for the pioneering use of commercial FMT (Faecal microbiota transplantation) for use in the prevention of recurrence of infection	Oct 2020 On Track
2. Reduce overall prescribing of antibiotics	National antimicrobial prescribing targets are being utilised by NHS Fife's microbiologists, working continuously alongside Pharmacists and GPs to improve antibiotic usage. New empirical antibiotic guidance has been circulated to all GP practices and the Microguide app has been revised.	Oct 2020 On Track
3. Optimise communications with all clinical teams in ASD & the HSCP	Monthly anonymised CDI reports with Microbiology comments and graphs are being distributed, to enable staff to gain a clearer understanding of the disease process. ICN ward visits reinforce SICPs and contact precautions, provide education to promote optimum CDI management and daily Medical management form completion. Ward Dashboard continuously updated, for clinical staff to access and also to be displayed for public assurance.	Oct 2020 On Track

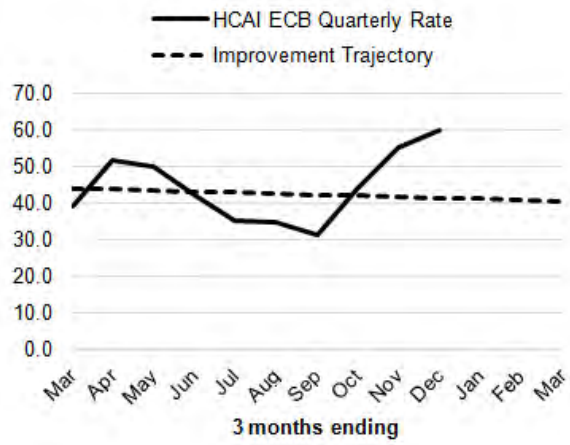
Clinical Governance

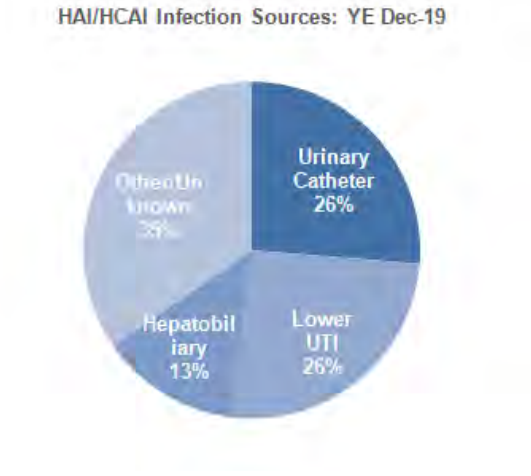
ECB (HAI/HCAI)

Reduce Hospital Infection Rate by 25% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Note: This equates to reducing the NHS Fife rate from 44.0 to 33.0 (per 100,000 TOBD) over 3 years, or to 40.3 by March 2020, 36.6 by March 2021 and 33.0 by March 2022

Local Performance | Quarter Ending





National Benchmarking | Year Ending

Year Ending		FY 2018/19	FY 2019/20			
		Mar	Jun	Sep	Dec	Mar
NHS Fife	HCAI Infection Rate (per 100,000 TOBD)	44.0	42.3	40.4		
Scotland		38.4	38.6	38.7		

Current Challenges	Achieving HPS reduction of HCAI ECBs 25% by 2021/22 and by 50% by 2023/24 – ***Action 1***
	Reducing infections caused by lower urinary tract infection (UTI) as source ***– Action 2***
	Reducing infections caused by catheter associated UTIs (CAUTIs) as source ***– Action 3***

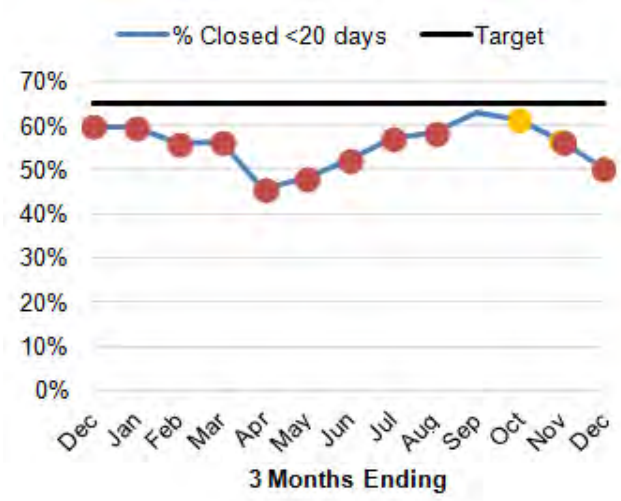
Improvement Actions	Progress	Timescale/ Status
1. Optimise communications with all clinical teams in ASD & the HSCP	As well as the mandatory national surveillance (introduced in 2015), NHS Fife has commenced additional voluntary enhanced surveillance from January. Monthly reporting and graphs of ECB data to key clinical staff across NHS Fife (HSCP & Acute services) has been introduced (and also supports Action 3).	Mar 2022 On Track
2. Formation of ECB Strategy Group	The first meeting of the ECB Strategy Group took place on 13th January, and was attended by a Public Health Consultant. The remit of the Group is to discuss, analyse and address key issues around understanding and preventing UTI. The next meeting will be in March, with a wider involvement from public health.	Mar 2021 On Track
3. Ongoing work of Urinary Catheter Improvement Group (UCIG)	The next meeting of this Group will be on 21st February. All trauma-related ECB CAUTI are recorded in DATIX – there was a single occurrence in 2019, down from 8 in 2018 and 6 in 2017.	Mar 2021 On Track

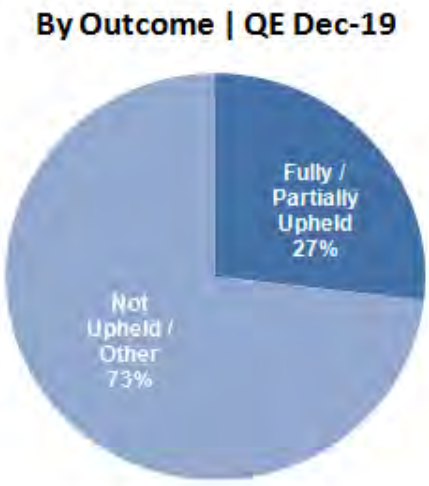
Clinical Governance

Complaints | Stage 2

At least 75% of Stage 2 complaints are completed within 20 working days
*Improvement Target for 2019/20 = **65%***

Local Performance





Local Performance by Directorate/Division

3-Month Ending	2018/19				2019/20								
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NHS Fife	59.8%	59.6%	55.8%	56.5%	45.5%	48.0%	52.3%	57.3%	58.3%	62.8%	61.2%	56.3%	50.0%
Acknowledged <= 3 Days	93.2%	89.9%	92.3%	92.4%	92.2%	93.3%	91.9%	95.1%	94.8%	95.9%	95.9%	94.1%	94.4%
ASD	70.7%	69.0%	62.7%	60.3%	52.6%	59.6%	67.7%	71.4%	66.7%	64.2%	61.0%	61.1%	57.7%
HSCP	26.5%	35.3%	38.2%	44.4%	21.1%	11.1%	8.7%	22.6%	33.3%	54.3%	57.6%	45.2%	33.3%

Current Challenges	To improve quality of draft responses – ***Action 1***
	To improve quality of investigation statements – ***Action 2***
	Inconsistent management of medical statements and inconsistent style of responses within ASD – ***Action 3***

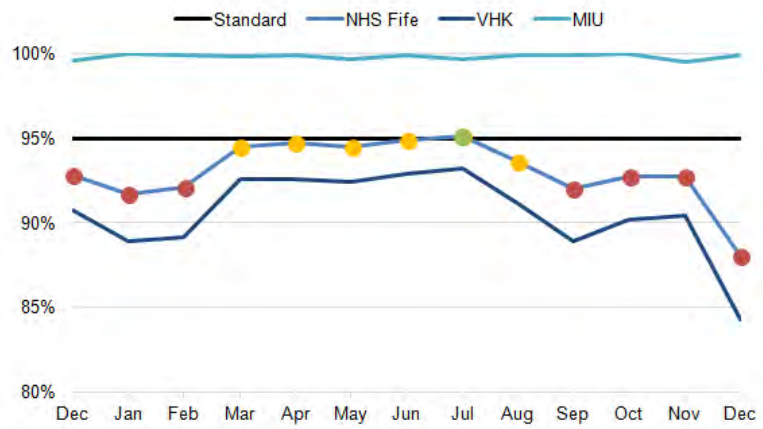
Improvement Actions	Progress	Timescale/ Status
1. Patient Relations Officers to undertake peer review	This continues and learning is being shared directly with individual Officers. Monthly meetings with ASD to discuss complaint issues and style of drafts are in place. Joint education session to be arranged to agree draft styles.	Mar 2020 On Track
2. Deliver education to service to improve quality of investigation statements	Yearly education delivered to FY2 doctors and student nurses. *Ad Hoc* training sessions are also delivered when required.	Mar 2020 On Track
3. Agree a process for managing medical statements, and a consistent style for responses	ASD to discuss with Clinical Leads PRD raise issues at monthly meeting SPSO training for clinical staff around the complaints process and providing statements took place in December, and a further session was also held in January	Mar 2020 On Track

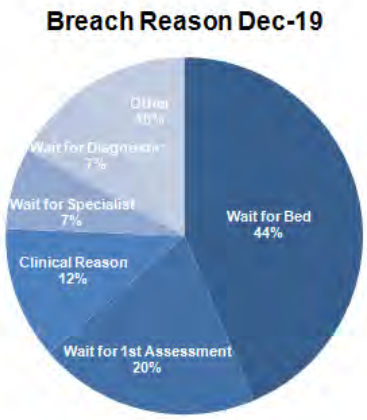
Finance, Performance & Resources – Operational Performance

4-Hour Emergency Access

At least 95% of patients (stretch target of 98%) will wait less than 4 hours from arrival to admission, discharge or transfer for Accident and Emergency treatment
*Improvement Target for 2019/20 = **96%***

Local Performance





National Benchmarking

Month	2018/19				2019/20								
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NHS Fife	92.8%	91.7%	92.1%	94.5%	94.7%	94.5%	94.9%	95.1%	93.6%	92.0%	92.7%	92.7%	88.0%
Scotland	89.6%	88.8%	89.3%	91.3%	89.9%	90.7%	90.3%	91.2%	90.6%	88.7%	88.0%	85.5%	83.8%

Current Challenges	Variation in 4-Hour Emergency Access Performance - ***Action 1***
	Patient Flow – ***Action 2***
	ECAS and OPAT Services and Capacity – ***Actions 3 and 4***

Improvement Actions	Progress	Timescale/ Status
1. Formation of PerformED group to analyse performance trends	Group has focused on review of breaches and pathways. Change of management for some chest pain presentations now in place and assessment of what other conditions could benefit from changes to existing processes is taking place. **Completion date changed to reflect additional scope of work.**	~~Jan 2020~~ Revised to Mar 2020
2. Review of AU1 Assessment Pathway		Complete
3. Implementation of OPAT		Complete
4. Development of services for ECAS	Review of ECAS utilisation and medical/staffing model with increased OPAT offering within existing staffing model is taking place. An assessment of relocation opportunities to support expansion is also underway.	Mar 2020 On Track

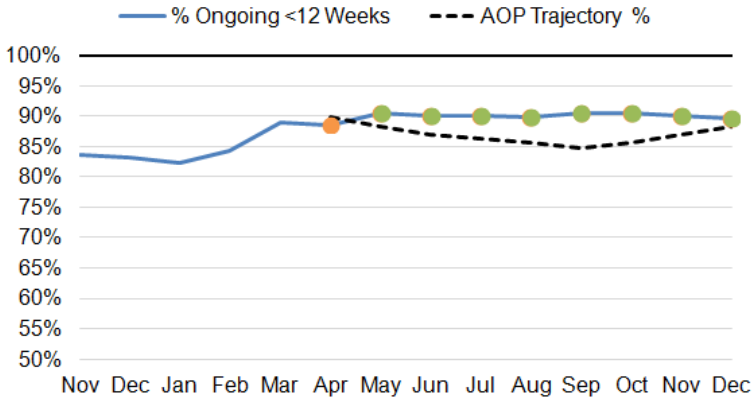
Finance, Performance & Resources – Operational Performance

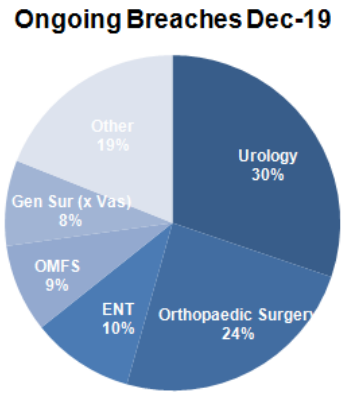
Patient TTG

We will ensure that all eligible patients receive Inpatient or Daycase treatment within 12 weeks of such treatment being agreed

*Improvement Target for 2019/20 = **90.6%** (Patients Waiting <= 12 Weeks at month end, as per Scottish Government Waiting Times Plan)*

Local Performance





National Benchmarking

	2018/19					2019/20									Mar-20
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Target
NHS Fife	83.5%	83.3%	82.4%	84.4%	89.0%	88.5%	90.4%	90.1%	90.1%	89.9%	90.6%	90.5%	90.1%	89.7%	**90.6%**
Scotland		67.5%	66.6%	66.8%	70.1%	68.9%	68.4%	67.8%	67.8%	66.8%	67.5%				

Current Challenges	Recurring gap in IP/DC capacity – ***Actions 2, 3 and 4***
	Difficulty in recruiting to Specialist Consultant posts – ***Actions 2 and 4***
	Difficulty in staffing additional in-house activity - ***Actions 2, 3 and 4***
	Cancellation of IP/DC activity due to unscheduled care pressures - ***Action 2***

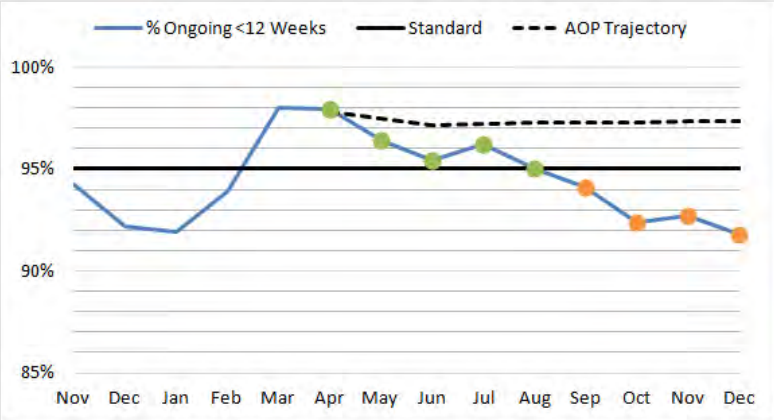
Improvement Actions	Progress	Timescale/ Status
1. Secure resources in order to deliver waiting times improvement plan for 19/20		Complete
2. Develop and deliver Clinical Space redesign Improvement programme	Report from front Door analysis received and being considered. Relocation of the Discharge Lounge on a permanent basis to be reviewed. Paper to SLT.	Mar 2020 On Track
3. Theatre Action Group develop and deliver plan	Monthly meetings continue, action plan in place. Day Surgery event planned for February to explore options for delivery of the new BADS targets and to maximise the use of day surgery capacity at QMH.	Mar 2020 On Track
4. Review DCAQ and develop waiting times improvement plan for 20/21, and secure resources	Plan for 2020/21 submitted and currently being revised for final agreement. On-going work to secure in-sourced capacity and use all available staff in weekend theatre sessions to meet current gap and reduce the backlog.	Mar 2020 On Track

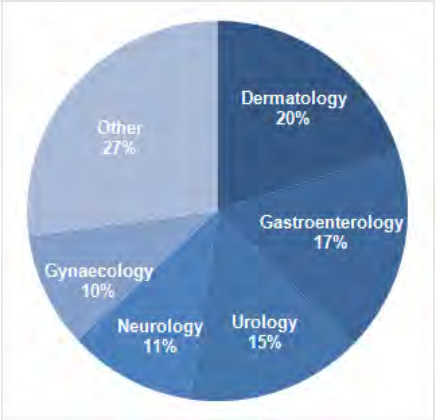
Finance, Performance & Resources – Operational Performance

New Outpatients

95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment

Local Performance





National Benchmarking

	2018/19				2019/20									Mar-20 Target
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
NHS Fife	92.2%	91.9%	93.9%	98.0%	98.0%	96.4%	95.4%	96.2%	95.0%	94.1%	92.4%	92.7%	91.8%	**98.7%**
Scotland	70.1%			75.0%	74.5%	74.4%	73.5%	73.5%	72.2%	72.9%				

Current Challenges	Recurring gap in Outpatient capacity – ***Actions 1, 2 and 3***
	Difficulty in recruiting to Specialist Consultant posts – ***Actions 2 and 3***
	Difficulty in staffing additional in-house activity - ***Actions 1 and 2***

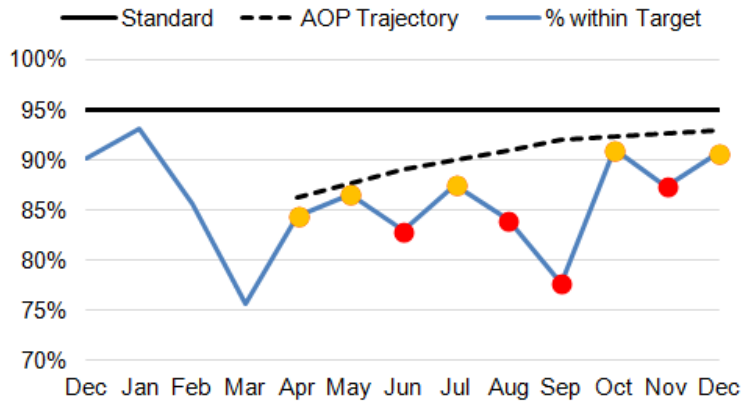
Improvement Actions	Progress	Timescale/ Status
1. Review DCAQ and secure activity to deliver funded activity in waiting times improvement plan for 19/20 and 20/21	Plan for 2020/21 submitted and currently being revised for final agreement. Contracts awarded for in-source activity and alternative solutions in place to increase capacity in Q4.	Mar 2020 On Track
2. Develop and deliver Outpatient Transformation programme to reduce demand	Transformation Group set up and meeting regularly, with focused programme and workstreams in place to deliver projects	Mar 2020 On Track
3. Improve recruitment to vacant posts and/or consider service redesign to increase capacity	New Consultant posts in Urology, General Surgery, Cardiology, Gynaecology, Anaesthetics, Oncology and Orthopaedics have been recruited to. Speciality Doctor post recruited for Ophthalmology and General Surgery. Discussions ongoing regarding new Oral Maxilofacial post and Speciality doctor post in ENT. Recruitment to replacements for existing posts continues to be a challenge in a number of specialities.	Mar 2020 On Track

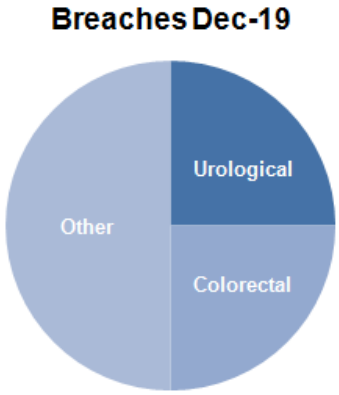
Finance, Performance & Resources – Operational Performance

Cancer 62-Day Referral to Treatment

At least 95% of patients urgently referred with a suspicion of cancer will start treatment within 62 days
*Improvement Target for 2019/20 = **94%***

Local Performance





National Benchmarking

	2018/19				2019/20									Mar-20
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Target
NHS Fife	90.2%	93.1%	85.6%	75.6%	84.4%	86.6%	82.9%	87.5%	84.0%	77.7%	91.0%	87.3%	90.7%	**94.0%**
Scotland	83.4%	79.9%	79.9%	81.6%	80.4%	81.1%	82.6%	81.8%	82.1%	83.7%	82.7%	81.9%	84.6%	

Current Challenges	Urology 62 day performance (Prostate) – ***Actions 1 and 2***
	Cancer Waiting Times 'education' – ***Action 2***
	Delays to steps in pathways for 1st OPA, diagnostic investigations and reporting – ***Action 2***
	Number of breaches in various specialties – ***Action 3***

Improvement Actions	Progress	Timescale/ Status
1. Urology Improvement Group review prostate pathway to minimise wait between each step	Improvements implemented have delivered a reduction in waits to 1st OPA, MRI, TRUS biopsy. Further work is being undertaken with the clinical team, pathology and oncology to minimise further waits between steps, and this will be picked up in 2020/21.	Complete
2. Improvement in cancer governance structure and redesign of weekly PTL meeting together with organisation-wide education sessions to ensure clear focus on escalation processes	• Governance structure agreed • CWT education package development continuing • SOP reviewed • Cancer Scorecard in development Further metrics introduced into the PTL meeting to allow services to manage cancer referral demand and capacity.	Complete
3. Robust review of timed cancer pathways to ensure up to date and with clear escalation points	Progress affected by staffing pressures in cancer audit team. Detailed work is also being carried out by the Lead Cancer Nurse. **Completion date moved to reflect situation.**	~~Jan 2020~~ Revised to Jun 2020

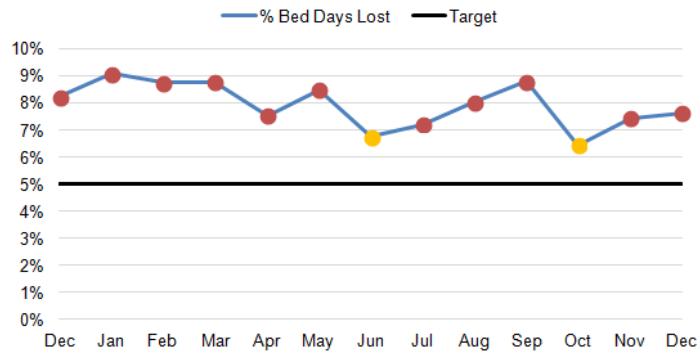
Finance, Performance & Resources – Operational Performance

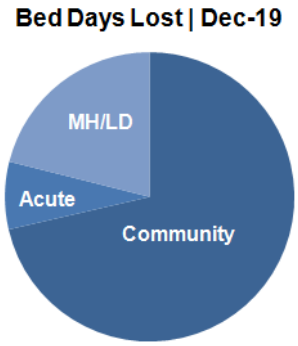
Delayed Discharges (Bed Days Lost)

We will reduce the hospital bed days lost due to patients in delay, excluding Code 9, to 5% of the overall beds occupied

*Improvement Target for 2019/20 = **5%***

Local Performance





National Benchmarking

Quarter Ending		2018/19				2019/20			
		Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	TOBD	87,527	92,599	91,463	91,885	87,857			
	Bed Days Lost	3,638	4,200	6,744	8,141	6,685			
	% Bed Days Lost	4.2%	4.5%	7.4%	8.9%	7.6%			
Scotland	TOBD	1,552,301	1,541,821	1,551,451	1,567,162	1,540,155			
	Bed Days Lost	101,712	107,120	109,366	101,959	103,422			
	% Bed Days Lost	6.6%	6.9%	7.0%	6.5%	6.7%			

Current Challenges	To reduce the number of hospital bed days lost due to patients in delay – ***Actions 1 and 3***
	To improve the time taken to complete social work assessments – ***Actions 2 and 4***

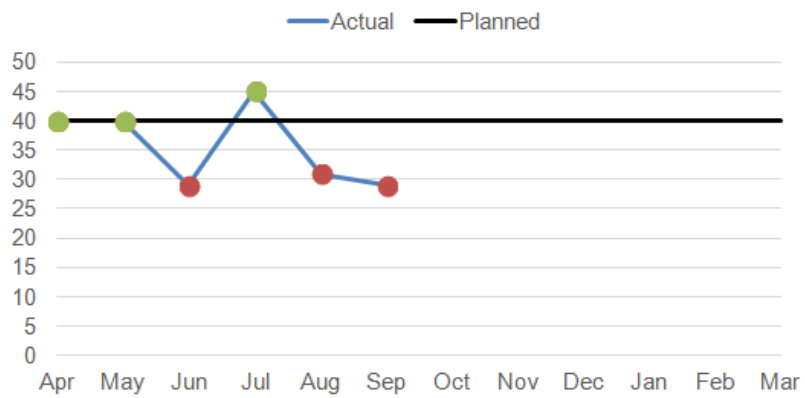
Improvement Actions	**Progress**	**Timescale/ Status**
1. Test a trusted assessors model within VHK for patients transferring to STAR/assessment beds	Framework developed. Training and shadowing sessions for staff to be progressed	Mar 2020 On Track
2. Review timescales of SW assessments		Complete
3. Moving On Policy to be implemented to support staff where families are refusing choices and/ or where there is no availability of the assessed resource	Policy to be signed off and implemented by winter **Still to be signed off.**	~~Jan 2020~~ Revised to Feb 2020
4. Improve flow of communication between wards and Discharge HUB	Progressing two tests of change to improve efficiency of assessments and reduce waits – direct transfer of information on to iPads at ward level, and a 'sticker' system	Mar 2020 On Track

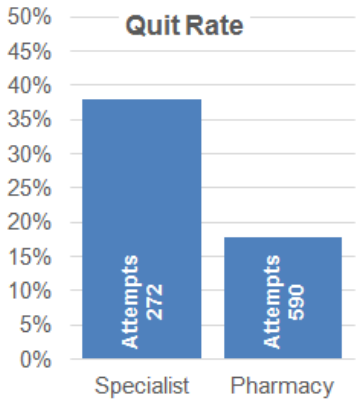
Finance, Performance & Resources – Operational Performance

Smoking Cessation

In 2019/20, we will deliver a minimum of 473 post 12 weeks smoking quits in the 40% most deprived areas of Fife

Local Performance





National Benchmarking

% Achieved Against Target		2019/20											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS Fife	Actual	40	40	29	45	31	29						
	Actual Cumul	40	80	109	154	185	214	214	214	214	214	214	214
	Planned Cumul	40	79	118	158	197	236	276	315	354	394	434	473
	Achieved	100.0%	101.3%	92.4%	97.5%	93.9%	90.7%						
Scotland	Achieved			92.4%									

Current Challenges	To improve uptake in deprived communities – ***Action 1***
	To increase uptake of Champix – ***Action 2***
	To increase smoking cessation in Antenatal Setting – ***Action 3***
	Increase at-work support to NHS Staff – ***Action 4***

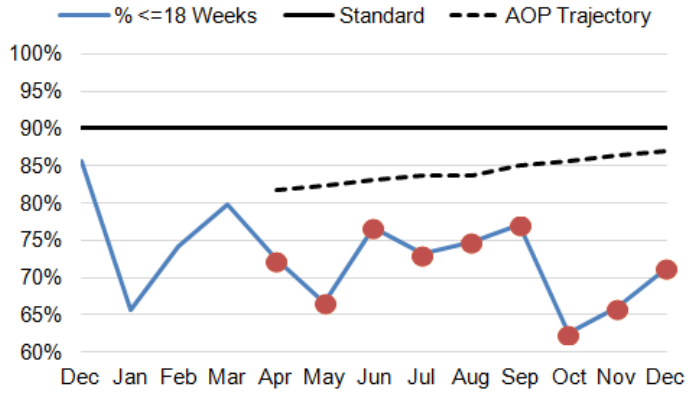
Improvement Actions	Progress	Timescale/ Status
1. Outreach development with Gypsy Travellers in Thornton		Complete
2. Test effectiveness and efficiency of Champix prescribing at point of contact within hospital respiratory clinic	Plans in progress, monthly meetings with Respiratory Consultant to organise paperwork and process/pathways. Committee approval has been received, the first trial run (to check process and procedures) started in December and the real-time test started on 9th January. A promotional stand within QMH will be set up in February.	Mar 2020 On Track
3. 'Better Beginnings' class for pregnant women on Saturday mornings	Plans have progressed and Saturday provision has started - ongoing monitoring in place	Mar 2020 On Track
4. Enable staff access to medication whilst at work	Initial discussion on potential for staff to access their nicotine addiction management medication whilst at work has taken place. Small scale test of change to be considered.	Aug 2020 On Track

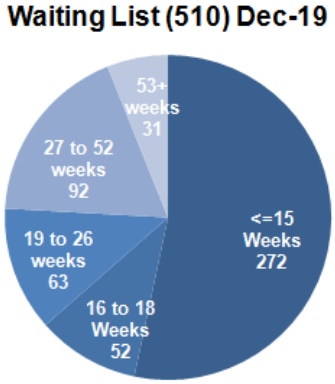
Finance, Performance & Resources – Operational Performance

CAMHS 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment
*Improvement Target for 2019/20 = **88%***

Local Performance





National Benchmarking

Month	2018/19				2019/20									Mar-20 Target
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
NHS Fife	85.5%	65.7%	74.3%	79.8%	72.3%	66.7%	76.7%	73.2%	74.8%	77.1%	62.5%	66.0%	71.3%	**88.0%**
Scotland	78.6%	72.1%	73.4%	75.6%	69.2%	69.1%	70.9%	62.7%	63.8%	66.9%				

Current Challenges	Increased referrals to service – ***Action 1***
	Pressure on existing staff – ***Action 2***
	Improving efficiency of workload allocation – ***Action 3***

Improvement Actions	Progress	Timescale/ Status
1. Introduction of Primary Mental Health Worker (PMHW) First Contact Appointments System and Group Therapy Programme	Following the departure of existing staff in September 2019, recruitment has been successful for 4 wte temporary posts, with starting dates in January and February. The service is currently operating with 3 staff instead of 7 due to the resignations, which has significant negative consequences on appointment times which now sit between 8 and 9 weeks compared to the planned response time of 2 to 3 weeks. The impact of this service however has been significant with 48% of referrals to CAMHS being redirected following assessment to more appropriate support providers.	Mar 2020 On Track
2. Waiting List Additional Staffing Resource	Additional Tuesday and Wednesday evening clinics are now running. It is anticipated that 80 to 100 additional C&YP will be allocated individual therapy, depending on uptake and attendance. Activity data from December indicates that from the original list of 107 waiting more than 1 year, only 7 were awaiting appointments. The Group Programme is underway, resulting in 158 C&YP being allocated group places up until January.	Sep 2019 to Feb 2020 On Track
3. Introduction of Substantive Team Leader Role	East & West Team Leader Posts filled. Active allocation of appointments underway. Team Leaders identifying patients for prioritisation and for evening clinics.	Mar 2020 On Track

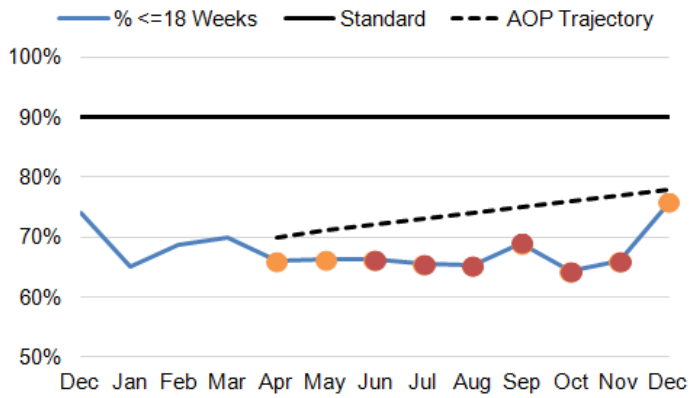
Finance, Performance & Resources – Operational Performance

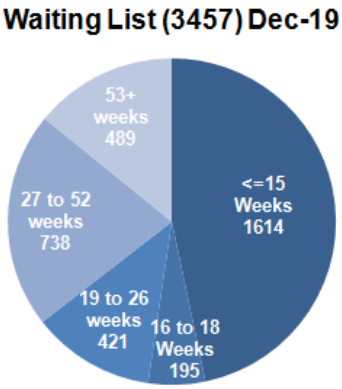
Psychological Therapies 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment for Psychological Therapies

*Improvement Target for 2019/20 = **82%***

Local Performance





National Benchmarking

Month	2018/19				2019/20									Mar-20 Target
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
NHS Fife	73.9%	65.0%	68.7%	69.8%	66.1%	66.2%	66.3%	65.5%	65.2%	69.0%	64.2%	66.0%	75.8%	**82.0%**
Scotland	77.5%	75.3%	77.7%	79.6%	76.7%	79.3%	80.0%	78.8%	79.2%	80.1%				

Current Challenges	To reduce delays for patients with complex needs requiring PTs within care programme approach – ***Action 1***
	To provide sufficient low-intensity PTs for mild-moderate mental health problems – ***Action 2***
	To increase capacity in services offering PTs for secondary care patients – ***Actions 3 and 5***
	To improve triage in Primary Care to improve access to appropriate PTs – ***Action 4***

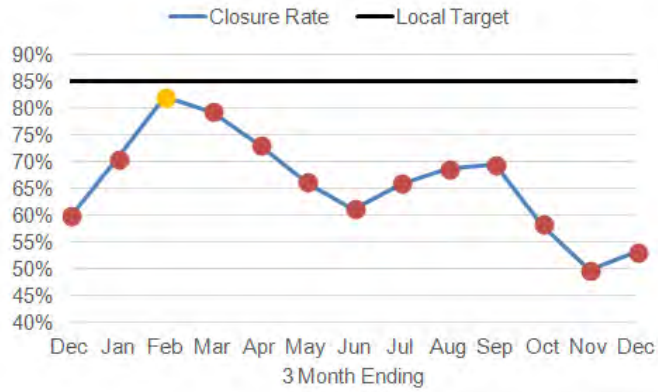
Improvement Actions	Progress	Timescale/ Status
1. Introduction of single point of access for secondary care patients via CMHT		Complete
2. Introduction of Extended Group Programme in primary care, accessible by self-referral	Data indicates that this change has had a sustained positive impact on capacity for more highly specialist work within this tier of service. Plans underway to expand self referral via website for low intensity PTs within Child and Family Psychology service.	Mar 2020 On Track
3. Redesign of Day Hospital provision to support CMHTs	Implementation of full re-design delayed due to revised timetable for staff engagement work. Further progress required to impact on capacity for delivery of PTs.	Mar 2020 On Track
4. Implement triage nurse pilot programme in Primary Care	Staff in post in selected GP Cluster areas; service being well-utilised; positive findings from interim evaluation in September 2019; final evaluation due this September	Sep 2020 On Track
5. Trial of new group-based PT options for people with complex needs	Develop and pilot two new group programmes for people with complex needs who require highly specialist PT provision from Psychology service. Specific requirements identified from audit of Psychology AMH WL.	Sep 2020 On Track

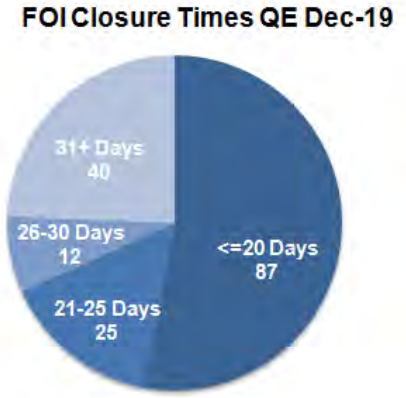
Finance, Performance & Resources – Operational Performance

Freedom of Information Requests

In 2019/20, we will respond to a minimum of 85% of FOI Requests within 20 working days

Local Performance





Service Performance

Monthly	2018/19				2019/20								
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Health Board	76.0%	83.7%	80.4%	73.8%	52.2%	56.8%	55.6%	68.9%	73.7%	48.3%	36.1%	48.5%	75.0%
IJB		100.0%	100.0%	55.6%	100.0%	86.7%	71.4%	86.7%	100.0%	85.7%	77.8%	66.7%	14.3%

Current Challenges	Performance variable due to delays in the return of responses from services and pressure on corporate support for finalising responses – ***All actions***

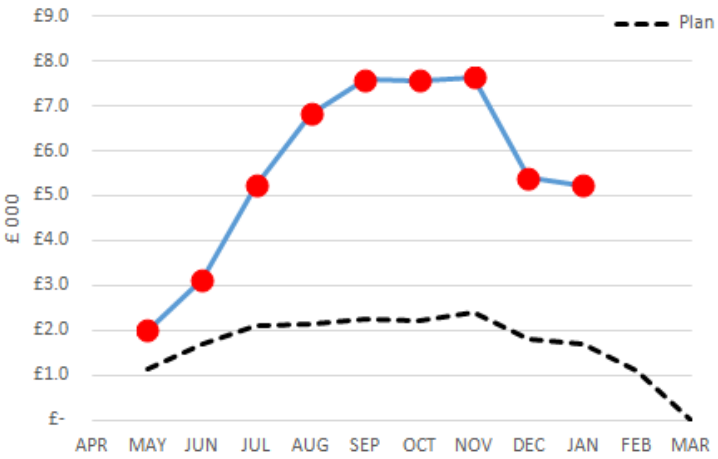
Improvement Actions	Progress	Timescale/ Status
1. Map pathway out, identify areas that have recurring issues with delayed responses		Complete
2. Improve FOI case recording and monitoring of timeliness of responses		Complete
3. Review cover arrangements for administration of requests, to improve resilience		Complete
4. Update of processes to reflect involvement of IG&S Team		Complete
5. Refresh process with H&SC partnership for requests received that relate to their services	IG&S Team working with IJB officer to agree protocol of dealing with partnership-related requests. Further meeting held in January to discuss performance. Recent change at level of Chief Executive, in addition to that of Director of Health & Social Care, provides an opportunity to review existing protocol and ensure this is still fit for purpose. **Completion date extended to account for this.**	~~Jan 2020~~ Delayed to Mar 2020
6. Align internal reporting on FOI to avoid unnecessary duplication of effort	Agree and implement one format of reporting on FOI performance, aligned to that developed for IPQR, for quarterly meetings of Information Governance & Security Group. Further discussion to be held on data capture to ensure information gathered can also be utilised for external reporting to Scottish Information Commissioner.	Complete
7. Formalise long-term resource requirements for FOI administration	There is present uncertainty around the long-term resource available to manage FOI administration, as Information Governance has only temporary resource available within the existing team. This issue has been escalated to the SIRO and the Data Protection Officer, and a temporary solution found at present.	Feb 2020 On Track

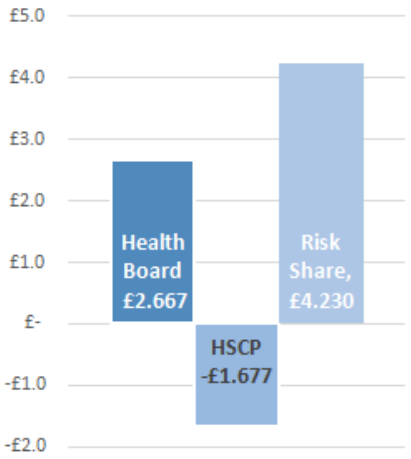
Finance, Performance & Resources – Finance

Revenue Expenditure

NHS Boards are required to work within the revenue resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

Local Performance





Expenditure Analysis

Memorandum	Budget			Expenditure			Variance Split By	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Savings £'000
Health Board	406,634	420,368	344,716	347,383	2,667	0.77%	-3,407	6,074
Integration Joint Board	349,372	351,844	292,868	291,191	-1,677	-0.57%	-1,823	146
Risk Share	0	0	0	4,230	4,230	0.00%	4,230	0
Total	**756,006**	**772,212**	**637,584**	**642,804**	**5,220**	**0.82%**	**-1,000**	**6,220**

Current Challenges	Acute Services Division: overspend of £11.898m, the key drivers being run rate overspend and shortfall on savings delivery – ***Actions 1 and 3***
	IJB: extent of social care overspend and significant risk to delivery of break even position if we are required to fund the full forecast IJB overspend (as opposed to the capped budget gap) – ***Actions 2 and 3***
	Non recurring financial flexibility: under continuous review but currently insufficient to offset full extent of overspend, including IJB risk share – ***Action 3***

Improvement Actions	Progress	Timescale/ Status
1. Savings	(Deloittes) external review complete ASD to prepare detailed action plan **This will be an ongoing activity throughout 2019/20 and 2020/21**	Mar 2020
2. Discussions with Scottish Government to support financial position	Meetings held in October to date – remains a live conversation and is likely to continue over final quarter of the financial year	Mar 2020 On Track
3. Ongoing grip and control measures across all services	Detailed assessment of potential financial flexibility ongoing, with early decision, action and release of identified benefit to the financial position	Mar 2020 On Track

Finance, Performance & Resources – Finance

1. Annual Operational Plan

1.1 The Financial Plan for 2019/20 was approved by the Board on 27 March 2019, with the related Annual Operational Plan approved on 29 May 2019.

2. Financial Allocations

Revenue Resource Limit (RRL)

2.1 NHS Fife received confirmation of the December core revenue and core capital allocation amounts on 3 February. The updated core revenue resource limit (RRL) per the formal funding letter was confirmed at £746.780m; and anticipated allocations total £1.065m.

Non Core Revenue Resource Limit

2.2 In addition NHS Fife receives 'non core' revenue resource limit funding for technical accounting entries which do not trigger a cash payment. This includes, for example, depreciation or impairment of assets. The confirmed non core RRL funding totals £24.367m.

Total RRL

2.3 The total current year budget at 31 January is therefore £772.212m as detailed in Appendix 1.

3. Summary Position – Commentary

3.1 The revenue position for the 10 **months to 31 January reflects an overspend of £5.220m**. Based on this in-year position, and a number of high level planning assumptions as agreed by delegated budget holders, the **year end forecast ranges from a potential optimistic forecast of £3.4m overspend to a potential worst case of £8.7m overspend.** This assumes a capped risk share cost to NHS Fife of £7.05m (the original agreed budget gap of the IJB of £6.5m plus £0.55m additional social care packages agreed by the respective Chief Officers) and does not take into consideration some further non recurring offsetting benefits currently being explored.

3.2 Discussions have been held with the Director of Health Finance, Scottish Government over the last few months, to work collaboratively to find a solution to the financial challenges facing NHS Fife. As reported previously a range of areas were considered. Last month the transfer of full capital receipts of £1m into our revenue position was actioned which supports the in year position on a non recurring basis. Work continues on: the identification of qualifying expenditure for potential ADEL funding; the review of allocations for any slippage or flexibility; and a final review of balance sheets accruals both in terms of value and accounting treatment. The potential additional non recurring offsetting benefit of these actions may be in the region of £1.5m, but this requires further ongoing scrutiny in the remaining 2 months of the year.

3.3 Notwithstanding the forecast position outlined in 3.1 above, the current forecast overspend of the IJB is significantly higher than the original approved budget gap (and capped risk share pressure) with a potential further £2.9m - £3.4m impact on the NHS Fife position at year end.

3.4 Taking account of the potential offsetting benefits described above and the further overspend of the IJB, the **forecast outturn position moves to an overspend of £4.8m (best case) to £10.5m (worst case)**. This highlights the ongoing challenge in achieving financial balance and our ability to meet our statutory obligations, without further financial support from Scottish Government.

3.5 Other key challenges continue as previously reported and comprise: the overspend on Acute Services (run rate overspend related to a number of cost pressures; and non delivery of savings), and includes £5.127m overspend relating to a number of Acute services budgets that are 'set aside' for inclusion in the strategic planning of the IJB, but which remain managed by the NHS Board; and the growing cost pressure in relation to activity outside Fife and in particular, the continuing number of specialist high cost, low volume procedures undertaken in Edinburgh reported in recent months.

3.6 For the purposes of reporting to Scottish Government in the Monthly Financial Performance Return (FPR) we have included a funding assumption of £4.8m (optimistic scenario) to meet the value of the full risk share impact net of potential offsetting benefits.

3.7 Table 1 below provides a summary of the position across the constituent parts of the system for the year to date: an overspend of £2.667m is attributable to Health Board retained budgets; whilst an underspend of £1.677m is attributable to the health budgets delegated to the Integration Joint Board; and an overspend shown of £4.230m relating to the IJB risk share (capped at the opening budget deficit of £6.5m plus agreed additional social care packages).

Table 1: Summary Financial Position for the period ended January 2020

Memorandum	Budget			Expenditure			Variance Split By	
	FY	CY	YTD	Actual	Variance	Variance	Run Rate	Savings
	£'000	£'000	£'000	£'000	£'000	%	£'000	£'000
Health Board	406,634	420,368	344,716	347,383	2,667	0.77%	-3,407	6,074
Integration Joint Board (Health)	349,372	351,844	292,868	291,191	-1,677	-0.57%	-1,823	146
Risk Share (Capped)	0	0	0	4,230	4,230	0.00%	4,230	0
Total	**756,006**	**772,212**	**637,584**	**642,804**	**5,220**	**0.82%**	**-1,000**	**6,220**
	Budget			**Expenditure**			**Variance Split By**	
	FY	CY	YTD	Actual	Variance	Variance	Run Rate	Savings
	£'000	£'000	£'000	£'000	£'000	%	£'000	£'000
Acute Services Division	199,040	209,077	174,891	187,785	12,894	7.37%	6,865	6,029
IJB Non-Delegated	8,392	8,539	7,113	7,118	5	0.07%	-40	45
Estates & Facilities	72,837	73,208	60,540	59,743	-797	-1.32%	-797	0
Board Admin & Other Services	53,273	82,822	71,613	70,531	-1,082	-1.51%	-1,082	0
Non-Fife & Other Healthcare Providers	85,566	85,566	71,316	72,889	1,573	2.21%	1,573	0
Financial Flexibility & Allocations	12,707	15,472	8,921	-682	-9,603	-107.64%	-9,603	0
Health Board	**431,815**	**474,684**	**394,394**	**397,384**	**2,990**	**0.76%**	**-3,084**	**6,074**
Integration Joint Board - Core	373,936	401,919	335,241	333,788	-1,453	-0.43%	-1,599	146
Integration Fund & Other Allocations	13,877	639	250	0	-250	0.00%	-250	0
Sub-total Integration Joint Board Core	**387,813**	**402,558**	**335,491**	**333,788**	**-1,703**	**-0.51%**	**-1,849**	**146**
IJB Risk Share Arrangement	0	0	0	4,230	4,230		4,230	0
Total Integration Joint Board - Health	**387,813**	**402,558**	**335,491**	**338,018**	**2,527**	**0.75%**	**2,381**	**146**
Total Expenditure	**819,628**	**877,242**	**729,885**	**735,402**	**5,517**	**0.76%**	**-703**	**6,220**
IJB - Health	-38,441	-50,714	-42,623	-42,597	26	**-0.06%**	26	0
Health Board	-25,181	-54,316	-49,678	-50,001	-323	**0.65%**	-323	0
Miscellaneous Income	**-63,622**	**-105,030**	**-92,301**	**-92,598**	**-297**	**0.32%**	**-297**	**0**
Net Position Including Income	**756,006**	**772,212**	**637,584**	**642,804**	**5,220**	**0.82%**	**-1,000**	**6,220**

4. Operational Financial Performance for the year

Acute Services

4.1 The Acute Services Division reports a **net overspend of £12.894m for the year to date**. This reflects an overspend in operational run rate performance of £6.865m, and unmet savings of £6.029m per Table 2 below. Within the run rate performance, pay is overspent by £5.486m. The overall position has been driven by a combination of unidentified savings and continued pressure from the use of agency locums, junior doctor banding supplements, incremental progression and nursing recruitment in line with the workforce planning tool, as well as supplementary staffing to support surge capacity. As the operational performance section of the IPQR highlights, there is

increasing pressure across unscheduled care in terms of demand; the financial position demonstrates the cost impact of the additional capacity required. Included within the ASD position is £5.127m overspend relating to the budgets 'set aside' for inclusion in the IJB's strategic plans but which remain managed by the NHS Board.

Table 2: Acute Division Financial Position for the period ended January 2020

	Budget			Expenditure			Variance Split By	
	FY £'000	CY £'000	YTD £'000	Actual £'000	Variance £'000	Variance %	Run Rate £'000	Savings £'000
Acute Services Division								
Planned Care & Surgery	69,165	73,147	60,696	64,110	3,414	**5.62%**	1,582	1,832
Emergency Care & Medicine	73,254	77,849	65,635	72,086	6,451	**9.83%**	4,739	1,712
Women, Children & Cinical Services	54,093	55,507	46,259	49,930	3,671	**7.94%**	1,186	2,485
Acute Nursing	596	616	492	434	-58	**-11.79%**	-58	0
Other	1,932	1,958	1,809	1,225	-584	**-32.28%**	-584	0
Total	**199,040**	**209,077**	**174,891**	**187,785**	**12,894**	**7.37%**	**6,865**	**6,029**

4.2 As previously reported, the Acute Services team continue the design phase for implementation of an effective savings programme following the external expertise provided through Deloitte LLP. The Acute Services management team's transformation programme will translate findings from the external Deloitte report in to the 'art of the possible' for 2020/21 and beyond. In parallel the interim PMO Director is reviewing and advising on the overarching governance arrangements and infrastructure across Health and into Social Care.

Estates & Facilities

4.3 The Estates and Facilities budgets report an **underspend of £0.797m** which is generally attributable to vacancies, energy and water and property rates, and partially offset by an overspend on property maintenance. The favourable movement in-month reflects a rates revaluation rebate.

Corporate Services

4.4 Within the Board's corporate services there is **an underspend of £1.082m**. Further analysis of Corporate Directorates is detailed per Appendix 2.

Non Fife and Other Healthcare Providers

4.5 The budget for healthcare services provided out with NHS Fife is **overspent by £1.573m** per Appendix 3. This remains an area of increasing challenge particularly given the relative higher costs of some other Boards, coupled with the unpredictability of activity levels.

Financial Plan Reserves & Allocations

4.6 As part of the financial planning process, expenditure uplifts including supplies, medical supplies and drugs uplifts were allocated to budget holders from the outset of the financial year as part of the respective devolved budgets. A number of residual uplifts and new in-year allocations are held in a central budget. Whilst no specific decisions are made to hold back new allocations, there are often unplanned underspends which emerge as the year progresses. As we approach the final 2 months of the financial year the routine robust monthly review of financial flexibility is detailed per Appendix 4.

4.7 As in every financial year, this 'financial flexibility' allows mitigation of slippage in savings delivery, and is a crucial element of the Board's ability to deliver against the statutory financial target of a break even position against the revenue resource limit.

Integration Services

4.8 The health budgets delegated to the Integration Joint Board report an **underspend of £1.703m for the year to date**. This position comprises an underspend in the run rate performance of £1.849m; together with unmet savings of £0.146m. The underlying

drivers for the run rate under spend are vacancies in community nursing, health visiting, school nursing, community and general dental services across Fife Wide Division. The aforementioned underspend is partly offset by locum costs within mental health services and inpatient service costs within East and West Fife.

4.9 In addition the capped IJB risk share for the first 10 months of 2019/20 is a **cost of £4.230m**, representing a risk share percentage (72%) of the overall initial budget gap of £6.5m plus £0.550m relating to additional approved social care packages. In previous years, and in agreement with Fife Council colleagues, the overspend on the IJB has been managed through the risk share arrangement described at 8.2.4 of the Integration Scheme.

4.10 The initial health IJB position at month 10 is therefore a **net £2.527m overspend**. However if NHS Fife are required to fund the full HSCP overspend this will add an additional £2.9m - £3.4m pressure to the outturn position.

Income

4.11 A small over recovery in income of £0.297m is shown for the year to date.

5. Pan Fife Analysis

5.1 Analysis of the pan NHS Fife financial position by subjective heading is summarised in Table 3 below.

Table 3: Subjective Analysis for the Period ended January 2020

	Annual Budget	Budget	Actual	Net Over/(Under) Spend
Pan-Fife Analysis	**£'000**	**£'000**	**£'000**	**£'000**
Pay	375,805	312,232	314,813	2,581
GP Prescribing	72,665	60,930	60,949	19
Drugs	31,220	26,734	26,349	-385
Other Non-Pay	388,864	327,038	329,743	2,705
IJB Risk Share	0	0	4,230	4,230
Efficiency Savings	-7,423	-6,220	0	6,220
Commitments	16,111	9,171	-682	-9,853
Income	-105,030	-92,301	-92,598	-297
Net Underspend	**772,212**	**637,584**	**642,804**	**5,220**

Pay

5.2 The overall pay budget reflects an overspend of £2.581m. There are underspends across a number of staff groups which partly offset the overspend position within nursing & midwifery and medical & dental staff; both are being largely driven by the additional cost of supplementary staffing to cover vacancies; sickness absence and supervision policies.

5.3 Against a total funded establishment of 7,917 wte across all staff groups, there was an average 7,845 wte staff in post in December.

Drugs & Prescribing

5.4 Across the system, there is a net under spend of £0.366m on medicines largely due to an under spend of £0.659m on sexual health and rheumatology drugs. Prescribing controls in line with formulary, biosimilar switches and price reductions have been the main contributory factors. The GP prescribing position is based on 2018/19 trend analysis and October and November 2019 actual information (2 months in arrears). Medicine shortages are resulting in price increases however the financial impact is currently being contained.

Other Non Pay

5.5 Other non pay budgets across NHS Fife are collectively overspent by £2.705m. The overspends are in purchase of healthcare from other Health Boards and independent providers, other supplies, property & hotel expenses and surgical sundries. These are offset by underspends across a number of areas including energy and diagnostic supplies.

6 Financial Sustainability

6.1 The Financial Plan presented to the Board in March highlighted the requirement for £17.333m cash efficiency savings to support financial balance in 2019/20. The Plan was approved with a degree of cautious optimism and confidence that the gap would be managed in order to deliver a break even position in year 1 of the 3 year planning cycle. This view was entirely predicated on a robust and ambitious savings programme across Acute Services and the Health & Social Care Partnership; supported by ongoing effective grip and control on day to day expenditure and existing cost pressures; and early identification and control of non recurring financial flexibility.

6.2 The extent of the recurring / non recurring savings delivery for the year is illustrated in Table 4 below and reflects a c50/50 split. In addition Table 4 reflects a significant under delivery of savings within Health Board (principally Acute Services Division).

Table 4: Savings 2019/20

	Target £'000	Identified & Achieved Recurring £'000	Identified & Achieved Non-Recurring £'000	Total Identified & Achieved To Date £'000	Outstanding £'000
Health Board	10,873	1,228	2,017	3,245	7,628
Integration Joint Board	6,460	3,485	2,799	6,284	176
Total Savings	**17,333**	**4,713**	**4,816**	**9,529**	**7,804**

7 Key Messages / Risks

7.1 The key challenges include the overspend on Acute Services (driven by non delivery of savings and a number of specific cost pressures; and includes £5.127m overspend relating to a number of ASD budgets that are set aside for inclusion in the IJB's strategic plans, but which remain managed by the NHS Board); the risk share impact of the IJB position (entirely driven by social care costs); and the increasing cost pressure associated with non-Fife activity.

7.2 Based on the year to date position and high level planning assumptions, estimates and information available at this time, agreed by delegated budget holders, the year end forecast based on a capped risk share ranges from a potential optimistic forecast of £3.4m overspend to a potential worst case of £8.7m overspend.

7.3 Discussions have been held with the Director of Health Finance, Scottish Government over the last few months, to find a solution to the financial challenges facing NHS Fife. Work continues on: the identification of qualifying expenditure for potential ADEL funding; the review of allocations for any slippage or flexibility; review of balance sheets accruals both in terms of value and accounting treatment; reporting of acute set aside budgets; and discussions with partners on the HSCP risk share methodology. The potential offsetting benefits may allow the optimistic overspend per 3.1 above to be reduced.

7.4 However the current forecast overspend of the IJB is significantly higher than the original approved budget gap. Correspondence and discussions to date between the respective partners continue. Notwithstanding, if we are required to fund the full IJB overspend, the forecast outturn position increases to a forecast overspend (after potential offsetting benefits) to an overspend of £4.8m (best case) to £10.5m (worst case). This then compromises our ability to achieve financial balance and our ability to meet our statutory obligations.

7.5 The impact of the points raised in 7.2 to 7.4 are illustrated in Table 5 below.

Table 5: Financial Outturn (modelling based on actual position at 31 Jan 2020)

Forecast Outturn	Pessimistic £'000	Mid-Range £'000	Optimistic £'000
Acute Services Division	10,361	9,564	8,886
Acute Services Division (Acute Set Aside)	6,096	5,795	5,495
IJB Non-Delegated	40	16	-9
Estates & Facilities	-598	-909	-1,809
Board Admin & Other Services	-1,170	-1,380	-1,527
Non-Fife & Other Healthcare Providers	2,038	2,038	2,038
Financial Flexibility	-11,387	-11,387	-11,387
Miscellaneous Income	-350	-350	-350
Health Board Retained Budgets	**5,030**	**3,387**	**1,337**
IJB Delegated Health Budgets	-1,141	-1,879	-2,692
Integration Fund & Other Allocations	-300	-300	-300
Sub Total IJB Delegated Health Budgets	**-1,441**	**-2,179**	**-2,992**
Risk Share	5,076	5,076	5,076
Net IJB Health Position	**3,635**	**2,897**	**2,084**
Total Forecast Outturn (based on capped risk share)	**8,665**	**6,284**	**3,421**
Potential Offsetting Benefits			
Additional ADEL	-1,500	-1,500	-1,500
Revised Forecast Outturn after Potential Benefits	**7,165**	**4,784**	**1,921**
Full Risk Share Adjustment	3,358	3,131	2,924
Revised Forecats Outturn (based on full risk share)	**10,523**	**7,915**	**4,845**

7.6 The optimistic forecast has been used for reporting purposes and is scrutinised each month as part of a balanced risk approach. Key areas for highlighting this month include the Emergency Care Directorate within Acute Services whose use of agency staff continues for which there does not appear to be an exit plan. This is exacerbated by the surge ward capacity which was open for 5 months of the last financial year, but is expected to be in place for this full year. This unanticipated additional exceptional cost is in spite of additional grip and control measures being put in place and contributes to the forecast overspend. This position remains under close review. In parallel the Planned Care Directorate optimistic forecast has worsened on the basis

that the savings targets will fall short of that planned in the year to date. In all areas of Acute the savings delivered are anticipated to fall short of the target, with a significant shortfall against recurring delivery.

7.7 The range of Estates & Facilities forecasts varies greatly between each scenario and is underpinned by detailed assumptions, plans and risk assessment ratings. The optimistic forecast used in the overall reporting at £1.8m underspend (compared to £0.9m 'realistic scenario' underspend) includes £0.3m high risk assumptions; and £0.6m medium risk assumptions.

7.8 The level of financial flexibility released in to the position at month 9 includes £2m share of new medicines funding; and £0.85m capital to revenue transfer; along with a updated and reduced potential slippage of waiting times funding to £0.2m which reflects the activity and plans in place across the Acute Division.

7.9 Even with the additional financial flexibility per 7.8, there is limited assurance that NHS Fife can remain within the overall revenue resource limit should there be a requirement to cover the full impact of the IJB position.

7.10 For the purposes of reporting to Scottish Government in the Monthly Financial Performance Return (FPR), a funding assumption to the value of £4.8m has been included. This does, however, hold a degree of risk; and reflects the most optimistic outturn and assumes mitigating benefits will crystallise in full.

7.11 Discussions with SGHSCD colleagues in relation to the financial position continue.

8 Recommendation

8.1 Members are invited to approach the Director of Finance or Chief Executive for any points of clarity on the position reported and are asked to:

- **Note** the reported overspend of £5.220m for the year to 31 January 2020; and

- **Note** the previously reported *potential* outturn position of break even is at risk, even with an assumption of additional funding from SGHSCD to support any impact of the full IJB risk share.

Appendix 1: Revenue Resource Limit

		Baseline Recurring	Earmarked Recurring	Non-Recurring	Total	Narrative
		£'000	£'000	£'000	£'000	
Confirmed	Opening	662,752			662,752	
Confirmed	May Adjustments	-696		-229	-925	
Confirmed	June Adjustments	16,293	3,774	6,265	26,332	
Confirmed	July Adjustments		2,863	1,678	4,541	
Confirmed	August Adjustments	280	3,268	2,341	5,889	
Confirmed	September Adjustments	-29	52,759	2,236	54,966	
Confirmed	October Adjustments		-157	1,842	1,685	
Confirmed	November Adjustments	-531	1,363	-16,058	-15,226	
Confirmed	December Adjustments		5,459	94	5,553	
Confirmed	Infrastructure Support			1,027	1,027	Receipts
Confirmed	Infrastructure Support			234	234	Capital to Revenue
Confirmed	ScotStar			-330	-330	Annual Contribution
Confirmed	AHP Muskoskeletal MATS			-20	-20	Contribution to Service
Confirmed	Cancer and Diagnostic Activity			69	69	Additional Funding
Confirmed	Additional Funding for Elective Activity			40	40	Additional Funding
Confirmed	Distinction Awards		193		193	Annual Award
	Total Core Revenue Allocation	**678,069**	**69,522**	**-811**	**746,780**	
Anticipated	NSD Adjustments	-27			-27	
Anticipated	Primary Care Fund GP Sub Committee			34	34	
Anticipated	Primary Care Improvement Fund			1,123	1,123	
Anticipated	Capital to Revenue			-65	-65	
	Total Anticipated Core RRL Allocations	**-27**	**0**	**1,092**	**1,065**	
Confirmed	PFI Adjustment			3,374	3,374	
Confirmed	Donated Asset Depreciation			117	117	
Confirmed	Impairment			1,000	1,000	
Confirmed	AME Provision			-843	-843	
Confirmed	IFRS Adjustment			4,833	4,833	
Confirmed	Depreciation from Core Allocation			12,386	12,386	
Confirmed	ADEL			3,500	3,500	
	Total Non-Core RRL Allocations	**0**	**0**	**24,367**	**24,367**	
	Grand Total	**678,042**	**69,522**	**24,648**	**772,212**	

Appendix 2: Corporate Directories

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
E-Health Directorate	12,827	9,923	9,965	42
NHS Fife Chief Executive	209	173	170	-3
NHS Fife Finance Director	6,296	5,191	4,666	-524
NHS Fife HR Director	3,210	2,689	2,567	-121
NHS Fife Medical Director	6,813	5,077	4,908	-169
NHS Fife Nurse Director	4,222	3,439	3,319	-120
Legal Liabilities	29,215	28,543	28,588	45
Public Health	2,347	1,908	1,746	-162
Early retirement & Injury Benefits	269	134	82	-52
Regional Funding	284	241	225	-17
Depreciation	17,131	14,294	14,294	0
Total	**82,822**	**71,613**	**70,531**	**-1,082**

Appendix 3: Service Agreements

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	95	79	48	-31
Borders	43	36	39	3
Dumfries & Galloway	24	20	50	30
Forth Valley	3,089	2,572	2,781	209
Grampian	349	290	261	-29
Greater Glasgow & Clyde	1,607	1,340	1,315	-25
Highland	131	109	185	76
Lanarkshire	111	93	169	76
Lothian	30,600	25,499	23,843	-1,656
Scottish Ambulance Service	98	81	88	7
Tayside	39,392	32,830	33,189	359
	75,539	**62,949**	**61,968**	**-981**
UNPACS				
Health Boards	8,063	6,719	8,860	2,141
Private Sector	1,209	1,008	1,600	592
	9,272	**7,727**	**10,460**	**2,733**
OATS	690	575	398	-177
Grants	65	65	63	-2
Total	**85,566**	**71,316**	**72,889**	**1,573**

Appendix 4 - Financial Flexibility & Allocations

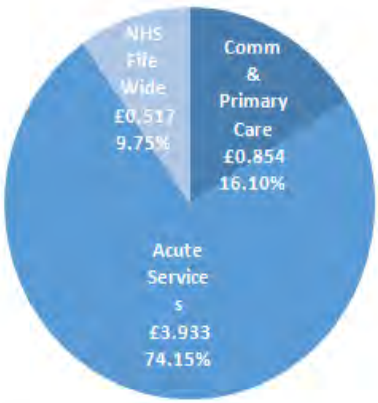
	CY Budget £'000	Flexibility Released to Jan-20 £'000
Financial Plan		
Drugs	2,365	833
Complex Weight Management	50	42
Adult Healthy Weight	104	86
National Specialist Services	38	31
Band 1s	307	256
Unitary Charge	213	178
Junior Doctor Travel	97	72
Consultant Increments	50	41
Cost Pressures	3,429	2,992
Financial Flexibility	523	436
Sub Total Financial Plan	**7,176**	**4,967**
Allocations		
Health Improvement	93	78
AME Impairments	1,195	0
AME Provisions	-51	0
Waiting Lists	1,550	133
Best Start	306	217
Advanced Breast Practitioner Radiology	36	
Insulin Pumps & CGM	44	
Carry Forward 18-19	260	217
Urolift	26	
Neonatal Expenses	16	8
Capital to Revenue	169	
ADEL	708	417
Winter Planning	0	
Cancer Waiting Times	198	44
Hand Surgery	0	0
New Medicine Fund	2,381	1,984
Additional Elective Activity	310	
Health Records	28	
Capital Receipts	1,027	856
Sub Total Allocations	**8,296**	**3,954**
Total	**15,472**	**8,921**

Finance, Performance & Resources – Finance

Capital Expenditure

NHS Boards are required to work within the capital resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

Local Performance



Commentary

The total Capital Resource Limit for 2019/20 is £9.217m. The capital position for the 10 months to January shows investment of £5.305m, equivalent to 57.56% of the total allocation. Plans are in place to ensure the Capital Resource Limit is utilised in full.

Current Challenges	Overall programme of work to address all aspects of backlog maintenance, statutory compliance, equipment replacement, and investment in technology considerably outstrips capital resource limit available

Improvement Actions	Progress	Timescale/ Status
1. Managing expenditure programme within resources available	Risk management approach adopted across all categories of spend	Mar 2020 On Track

1. Annual Operational Plan

1.1 The Capital Plan 2019/20 was approved by the NHS Board on 27 March 2019. For information, changes to the plan since its initial approval in March are reflected in Appendix 1. On 3 June 2019 NHS Fife received confirmation of initial core capital gross allocation amounts of £7.394m. NHS Fife has received a capital allocation of £0.120m for Hospital Eye Scotland for the procurement of ophthalmic equipment. NHS Fife has received an allocation of £1.703m for the new Elective Orthopaedic Centre and an expected adjustment for the transfer to revenue schemes that will be actioned during the year (£0.234m).

2. Capital Receipts

2.1 Work continues on asset sales with several disposals planned or completed:

- Lynebank Hospital Land (Plot 1) (North) – Under offer
- Forth Park Maternity Hospital – Sold
- Fair Isle Clinic – Sold
- Skeith Land – now on market
- ADC – Sold

Discussions with the SGHSCD have confirmed use of the capital receipts to support the challenges in the Board's revenue position.

3. Expenditure To Date / Major Scheme Progress

3.1 Details of the expenditure position across all projects are set out in the dashboard summary above. Project Leads have provided an estimated spend profile against which actual expenditure is being monitored. This is based on current commitments and historic spending patterns. The expenditure to date amounts to £5.305m or 57.56% of the total allocation, in line with the plan, and as illustrated in the spend profile graph above.

3.2 The main areas of investment to date include:

Statutory Compliance	£1.391m
Minor Works	£0.279m
Equipment	£2.155m
E-health	£0.481m
Elective Orthopaedic Centre	£0.968m

4. Capital Expenditure Outturn

4.1 At this stage of the financial year it is currently estimated that the Board will spend the Capital Resource Limit in full.

5. Recommendation

5.1 Members are invited to approach the Director of Finance or Chief Executive for any points of clarity on the position reported and are asked to:

- **Note** the capital expenditure position to 31 January 2020 of £5.305m and the forecast year end spend of the capital resource allocation of £9.217m

Appendix 1: Capital Expenditure Breakdown

Project	CRL New Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2019/20 £'000
COMMUNITY & PRIMARY CARE			
Statutory Compliance	984	594	984
Capital Minor Works	345	176	345
Capital Expenditure	91	85	91
Condemned Equipment			
Total Community & Primary Care	1,420	854	1,420
ACUTE SERVICES DIVISION			
Capital Equipment	1,992	1,975	1,992
Statutory Compliance	2,423	792	2,423
Minor Works	164	103	164
Condemned Equipment	95	95	95
Elective Orthopaedic Centre	1,703	968	1,703
Hospital Eye Services	120		120
Total Acute Services Division	6,496	3,933	6,496
NHS FIFE WIDE SCHEMES			
Condemned Equipment			
Information Technology	1,041	481	1,041
Equipment Balance	0	0	0
Scheme Development	60	2	60
Contingency	100	30	100
Statutory Compliance - Fire Compartmentation	100	5	100
Minor Works	0	0	0
Total NHS Fife Wide Schemes	1,301	518	1,301
TOTAL ALLOCATION FOR 2019/20	**9,217**	**5,305**	**9,217**

Appendix 2: Capital Plan - Changes to Planned Expenditure

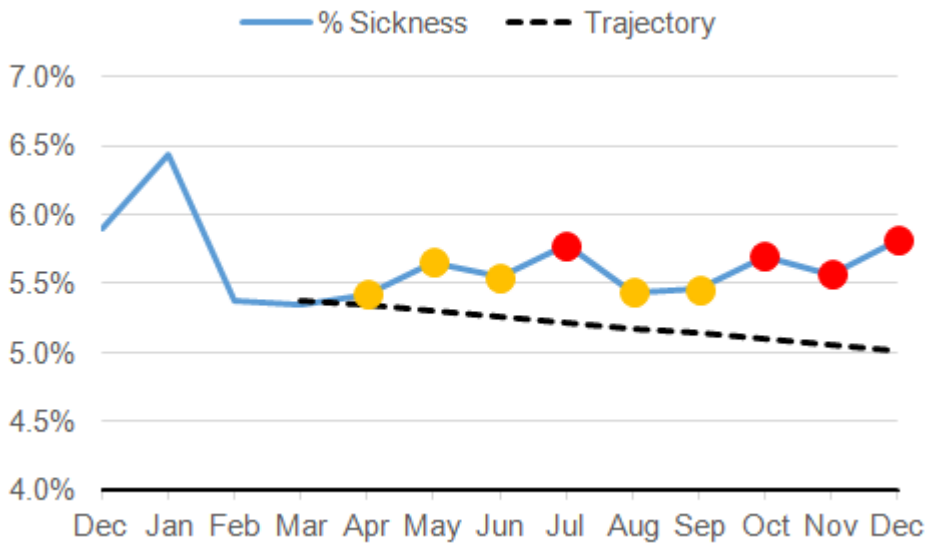
Capital Expenditure Proposals 2019/20 Routine Expenditure	Board Approved 27/03/2019 £'000	Cumulative Adjustment to December £'000	January Adjustment £'000	Total January £'000
Community & Primary Care				
Minor Capital		342	2	345
Capital Equipment		90	1	91
Statutory Compliance		766	218	984
Condemned Equipment				
Total Community & Primary Care	**0**	**1,199**	**221**	**1,420**
Acute Services Division				
Minor Capital		168	-4	164
Capital Equipment		2,018	-26	1,992
Statutory Compliance		2,613	-190	2,423
Condemned Equipment		95	0	95
Hospital Eye Service		120		120
Elective Orthopaedic Centre			1,703	1,703
	0	**5,014**	**1,482**	**6,496**
Fife Wide				
Minor Work	498	-498		0
Information Technology	1,041			1,041
Backlog Maintenance / Statutory Compliance	3,569	-3,469		100
Condemned Equipment	90	-90		0
Scheme Development	60			60
Fife Wide Equipment	2,036	-2,036		0
Fife Wide Contingency Balance	100			100
Total Fife Wide	**7,394**	**-6,093**	**0**	**1,301**
Total	**7,394**	**120**	**1,703**	**9,217**

Staff Governance

Sickness Absence

To achieve a sickness absence rate of 4% or less
*Improvement Target for 2019/20 = **4.89%***

Local Performance



National Benchmarking

Month	2018/19				2019/20									Mar-20 Target
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
NHS Fife	5.89%	6.43%	5.38%	5.34%	5.42%	5.66%	5.55%	5.78%	5.44%	5.46%	5.70%	5.57%	5.82%	**4.89%**
Scotland	5.54%	6.17%	5.23%	5.10%	5.04%	5.23%	4.98%	5.22%	5.18%	5.24%	5.69%	5.58%	5.83%	

Current Challenges	Sickness Absence Rate Significantly Above Standard – ***Action 1***
	High Level of Sickness Absence Related to Mental Health – ***Action 2***

Improvement Actions	Progress	Timescale/ Status
1. Targeted Managerial, HR, OH and Well@Work input to support management of sickness absence	This is being progressed through Attendance Management Leads within their respective areas, HR Officers / Advisors, and through the trajectory reporting for each business unit and use of the RAG status reports. A plan for additional OH support, including OH Drop-in Sessions, has been developed. Sessions took place throughout September and October, and further sessions will be held in Spring 2020.	Mar 2020 On Track
2. Early OH intervention for staff absent from work due to a Mental Health related reason	This has been in place since March 2019 and is now in the process of being reviewed by OH, HR, service and staff side colleagues to check on the appropriateness and impact of this approach. Further consideration to include how we promote general awareness of mentally healthy workplaces, support for managers to create mentally healthy and resilient workplaces and further awareness raising of support for staff.	Feb 2020 On Track

CAROL POTTER
Chief Executive
19th February 2020

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

Item 8.2

REPORT TO STAFF GOVERNANCE COMMITTEE

DATE OF MEETING:	Friday 6 March 2020
TITLE OF REPORT:	Attendance Management Update
EXECUTIVE LEAD:	Linda Douglas, Director of Workforce
REPORTING OFFICER:	Rhona Waugh, Head of Human Resources

Purpose of the Report (delete as appropriate)		
~~For Decision~~	For Discussion	~~For Information~~

SBAR REPORT

Situation

The purpose of this report is to update the Staff Governance Committee on the latest NHS Fife Sickness Absence statistics.

Background

1. CURRENT NHS FIFE SICKNESS ABSENCE DATA

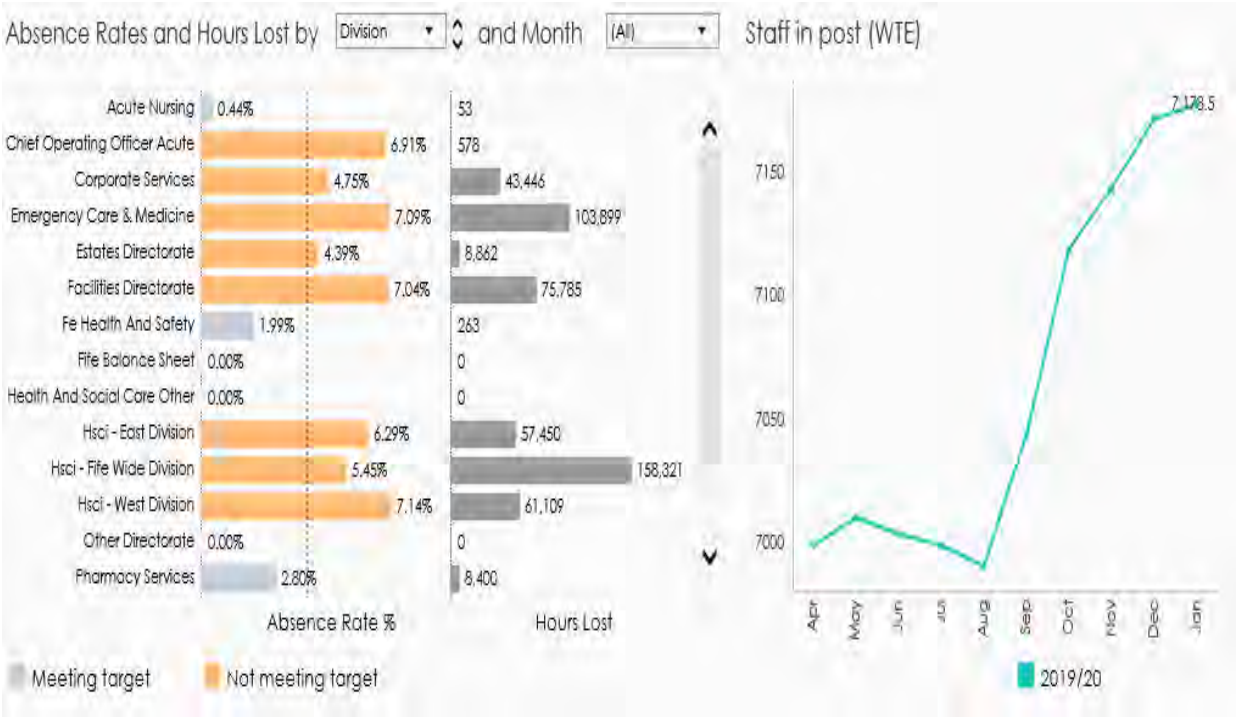
1.1 The NHS Fife sickness absence rate for January 2020 was 6.59% (Graph 1), with data for this report produced via Tableau.

Graph 1 – Sickness Absence Trend, NHS Fife

1.2 It should be noted that the NHS Fife sickness absence rates from SWISS will report a lower sickness absence rate from the Tableau sickness absence rate as the Tableau information is obtained in a more timely manner and incorporates projected sickness absence data, which is corrected prior to the population of the SWISS figures.

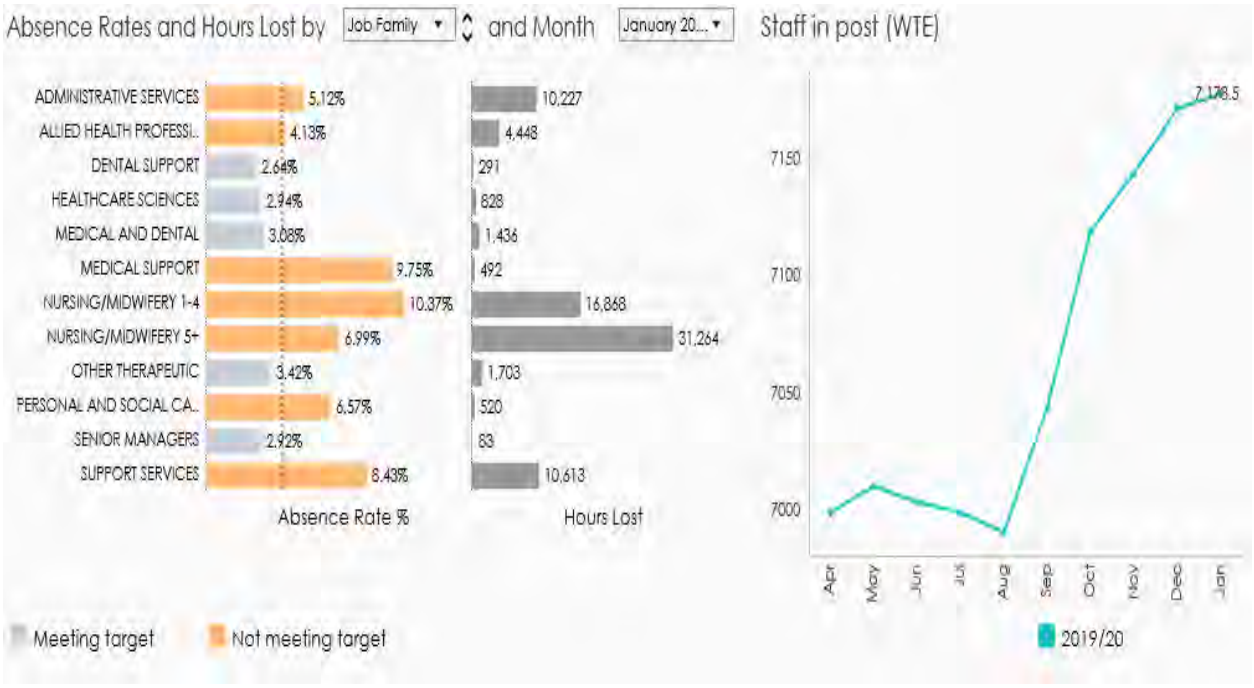
1.3 Comparative information by Division, based on average attendance rates for a ten month period ending January 2020, is provided in Graph 2 below. Eight areas reported average attendance rates below the trajectory set of 4.89% by the end of March 2020.

Graph 2 – Average Sickness Absence by Divisional Area



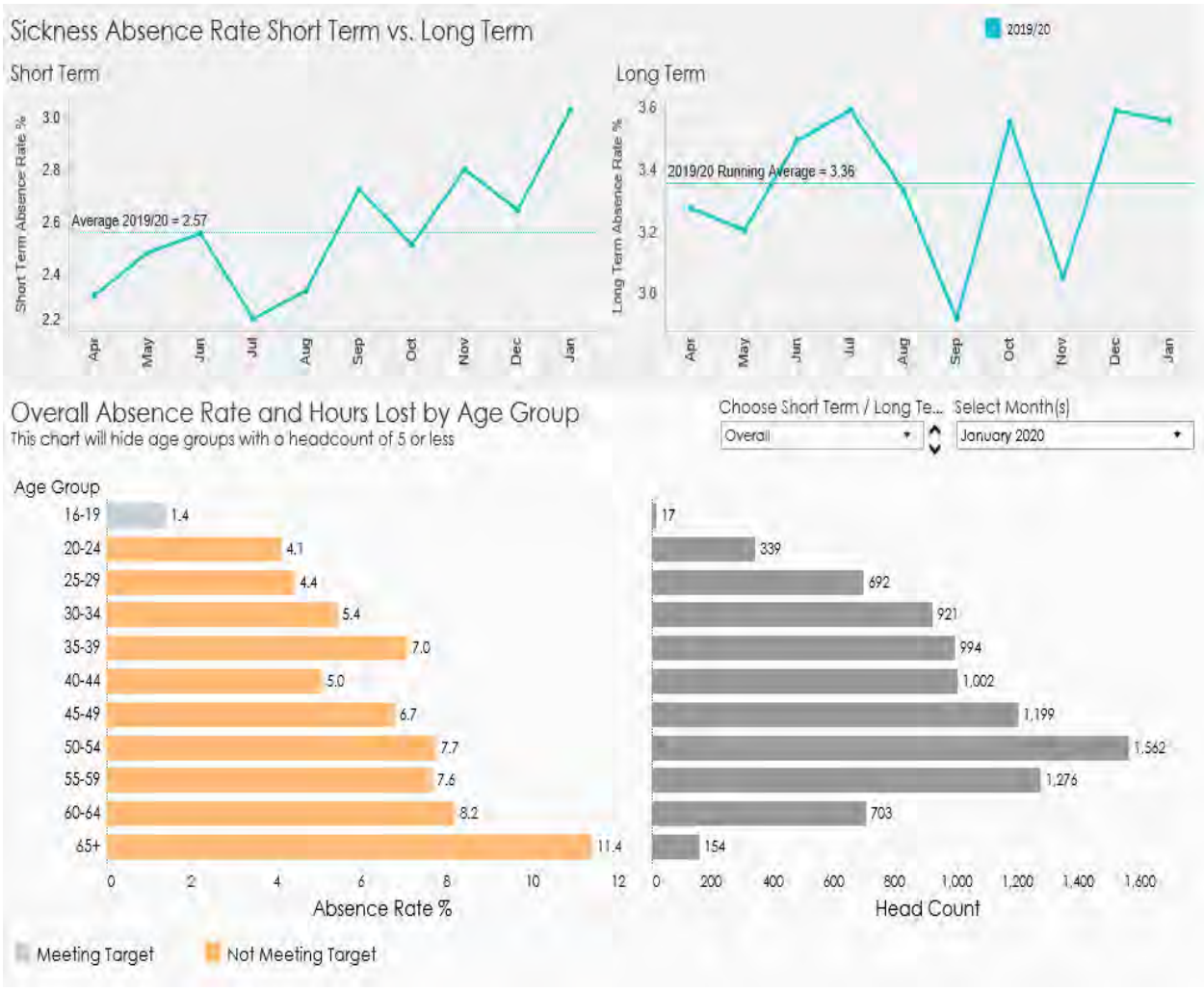
1.4 The trajectory for sickness absence is to achieve a rate of 4.89% by the end of March 2020. In January 2020, six job families had an average attendance rate below the trajectory set of 4.89%.

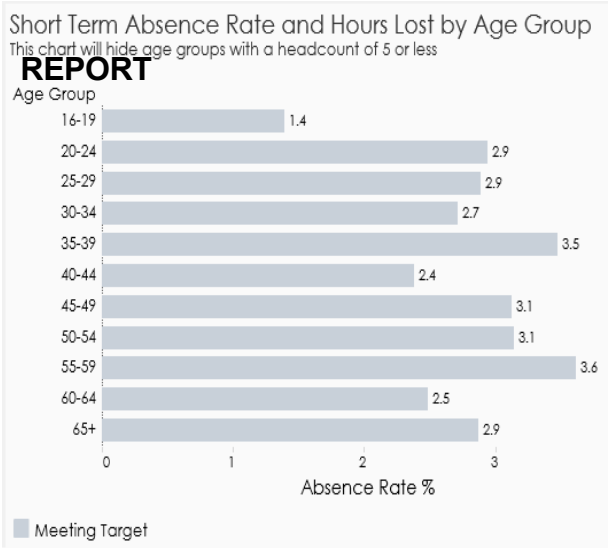
Graph 3 – Sickness Absence by Job Family

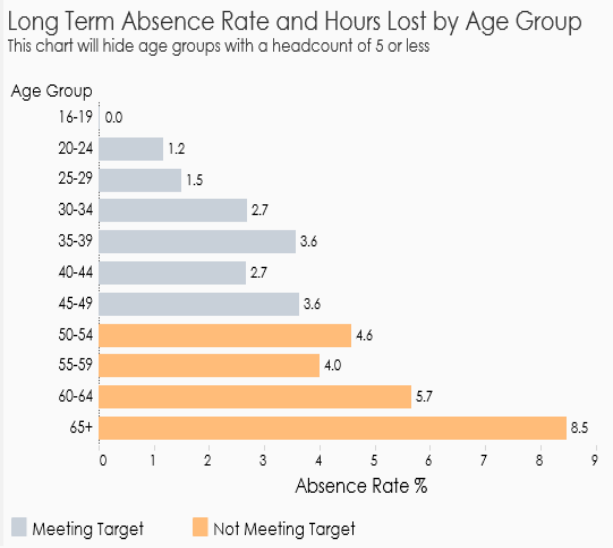


1.5 Sickness absence is broken down by duration and age demographics in Graph 4 below. Based on this information staff aged between 16 and 29 on average achieved the March 2020 attendance target of 4.89% in January 2020, with those aged 30 and above exceeding this target. The graph identifies that the proportion of staff who report short term absence appears consistent between the various age ranges, although there seems to be a closer correlation between long term absence and an ageing workforce.

Graph 4 – Sickness Absence by Duration and Age Demographics

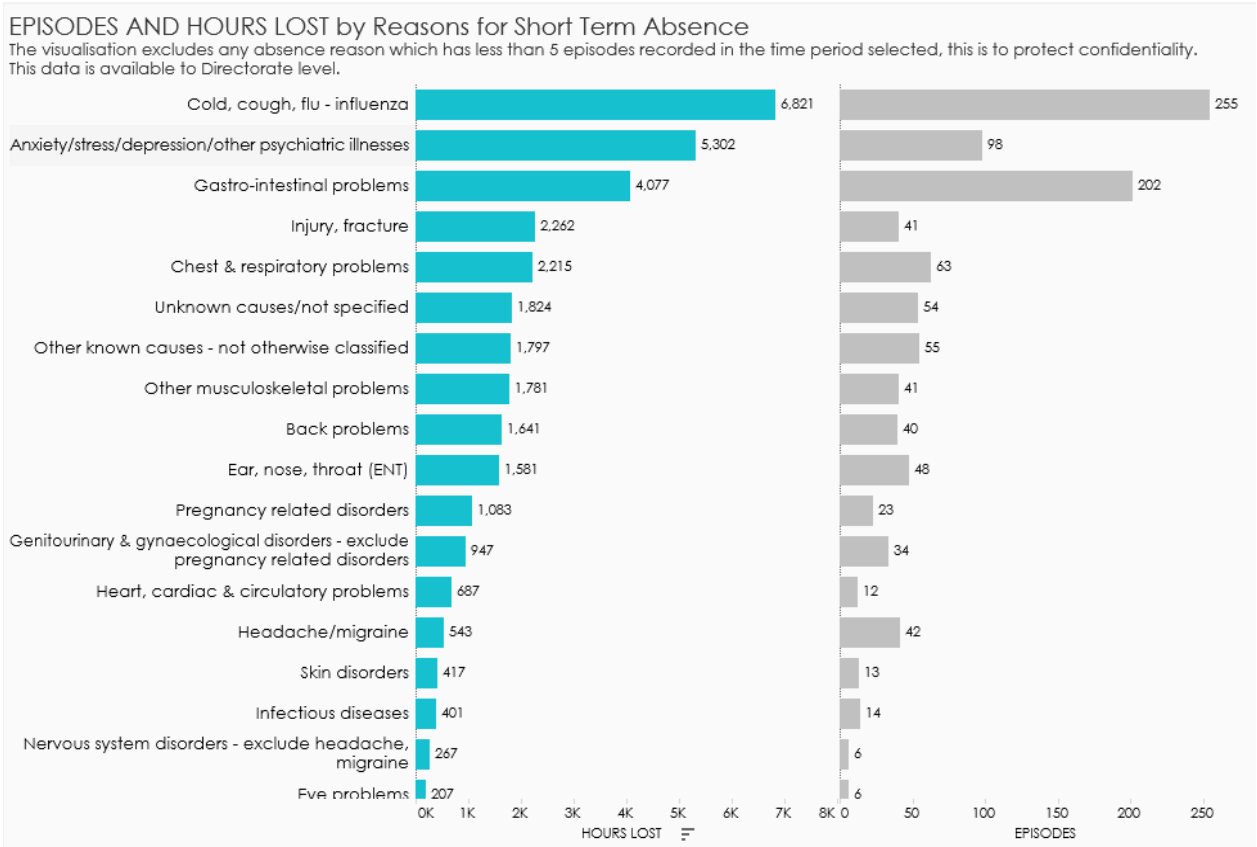




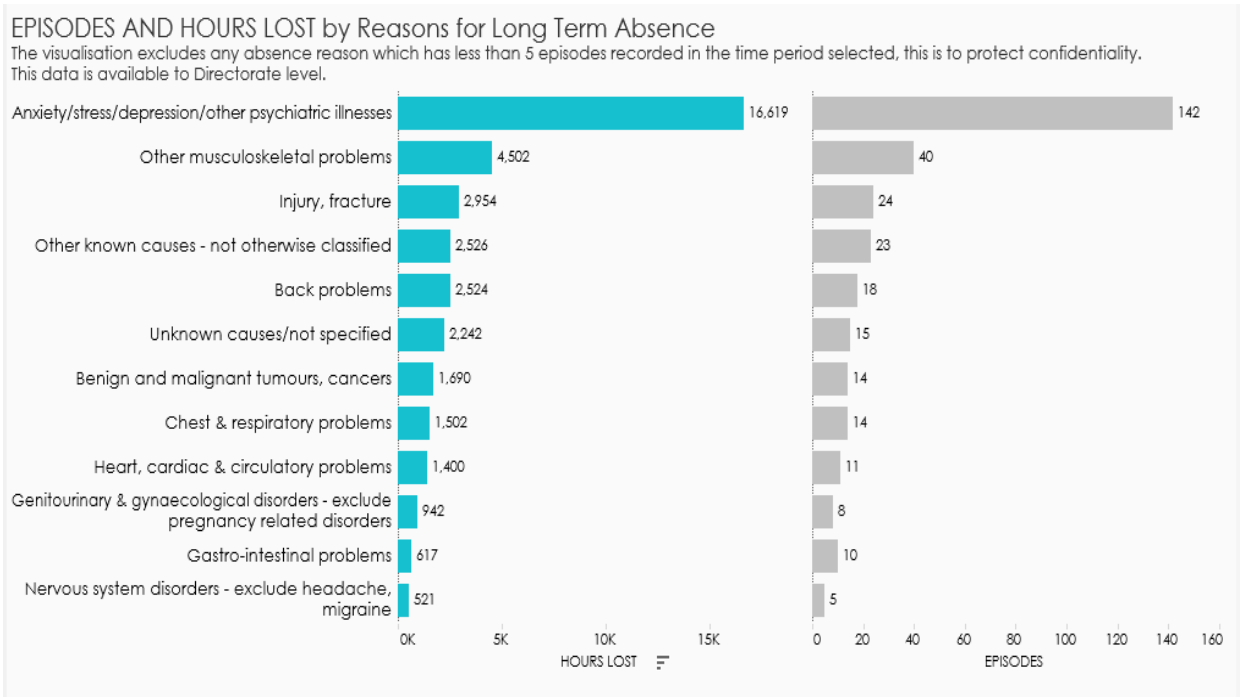


1.9 The reasons for both short and long term sickness absence are detailed in Graphs 5 and 6 below. In relation to short term absence, Cold, Cough, Flu – Inflenzua accounts for the most hours lost within NHS Fife in January 2020. Anxiety / Stress / Depression / Other Psychiatric illnesses accounts for the most hours lost in relation to long term absence within NHS Fife in January 2020. This is due to the number of episodes that these conditions account for.

Graph 5 – Short term Absence Episodes and Hours Lost by Reason



Graph 6 – Long term Absence Episodes and Hours Lost by Reason



1.6 The Regional Workforce Dashboard continues to be rolled out to local managers, providing them the ability to interrogate sickness absence data based on the eFinance structure (i.e. cost centres) and to identify their priority areas based on in-built algorithms within the Dashboard. This work will be complemented by the current Review and Improvement Panel process.

Assessment

The sickness absence rates in the year to date continue to be disappointing given on-going managerial, Occupational Health and HR efforts. It is anticipated that the launch of the new Once for Scotland Promoting Attendance policy on 1 March 2020 will secure a fresh impetus, alongside the plan for the Chief Executive and Director of Workforce to chair a new Promoting Attendance Task Force, specifically focussing on the long term absence. This Task Force is in the process of being set up.

Recommendation

Staff Governance Committee members are asked to **note** the position in relation to sickness absence.

Objectives: (must be completed)	
Healthcare Standard(s):	Staff Governance
HB Strategic Objectives:	Employer of Choice. Delivery of Patient Care

Further Information:	
Evidence Base:	SWISS Statistics, local NHS Fife stats
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	Management Teams, Attendance Management Groups, Area and Local Partnership Forum, Acute Services Staff Governance Board.

Impact: (must be completed)	
Financial / Value For Money	Costs of sickness absence and associated costs of cover.
Risk / Legal:	HEAT Standard and agreed Board trajectory not met.
Quality / Patient Care:	Impact on delivery of patient care.
Workforce:	Impact on existing staff and morale.
Equality:	N/A

Item 8.2a

REPORT TO STAFF GOVERNANCE COMMITTEE

DATE OF MEETING:	Friday 6 March 2020
TITLE OF REPORT:	Workforce Planning – Attendance Management Internal Audit Report
EXECUTIVE LEAD:	Linda Douglas, Director of Workforce
REPORTING OFFICER:	Rhona Waugh, Head of Human Resources

Purpose of the Report (delete as appropriate)		
~~**For Decision**~~	**For Discussion**	~~**For Information**~~

SBAR REPORT

Situation

The purpose of this report is to update the Staff Governance Committee on the outcome of the Workforce Planning – Attendance Management Internal Audit which was recently undertaken within NHS Fife, attached at **Appendix 1**.

Background

The NHS Fife Board Strategic Framework includes the aspiration for NHS Fife to be an Exemplar Employer and lists related objectives associated with enabling its employees to have fulfilling employment.

The NHS Fife Workforce Sustainability Board Assurance Framework (BAF) describes the following risk which could threaten the achievement of this strategic objective:

"There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy".

The current controls recorded in the BAF to mitigate this risk include:

- Absence Management Steering Group and local divisional groups established to drive a range of initiatives and improvements aligned to staff health and wellbeing activity.
- Well@Work initiatives continue to support the health and wellbeing of the workforce, facilitate earlier interventions to assist staff experience and retain staff in the workplace along with Health Promotion and Staff Wellbeing and Safety.

It was recommended that an Internal Audit was required to be undertaken to establish if NHS Fife were fulfilling these aspirations.

Assessment

In March 2019, the Scottish Government issued NHS Circular PCS(AFC)2019/2, Policy on Management of Sickness Absence (Promoting Attendance). The circular includes key recommendations to be implemented by 1 April 2019, including working towards reducing sickness absence by 0.5% per annum over the next three years, the adoption of common NHS Scotland trigger points and the right to appeal decisions made. NHS Fife has Management of Ill Health and Management of Capability policies in place, with the expectation of adopting the '*Once for Scotland'* policies when they are available from the National Group. The implementation date for first six policies, including Promoting Attendance, is 1 March 2020.

The process of Workforce Planning, which includes attendance management, has been identified within the strategic audit planning process as **High** and within the Client Corporate Risk Register as **Moderate** with a rating of 12.

The Attendance Management Audit evaluated the design and operation of the controls and specifically considered whether:

- Extant policies and procedures relating to attendance management are being followed by departments, by visiting areas and carrying out compliance testing against the policy.
- Attendance Management Training is focused to the most relevant areas and people.
- Mitigating actions to improve attendance management outlined in the BAF such as the Well@Work and other initiatives are effectively reducing sickness absence by 0.5% per annum.
- Effective clear reporting on attendance management to the Board, Standing Committees and relevant groups, is in place.

The Internal Audit Team concluded that NHS Fife had a **Moderate** Level of Assurance for Attendance Management and evidenced an adequate framework of key controls, but recommended the following actions:

- The Staff Governance Committee use this sickness absence data to form a view on whether the overall approach is effectively mitigating the risk and utilise the existing escalation route to the Board appropriately.
- A communication is disseminated to all Managers to raise awareness of the importance of the timeliness of the return to work discussion.
- If NHS Fife have input to the Return to Work Form, cognisance of the recently published Once for Scotland Workforce Policies should be considered to include prompts for discussion, trigger levels and tick boxes. This will be fed back to the Once for Scotland Policy Group.
- A governance review is undertaken to identify any gaps or duplication with the Attendance Management groups and ensure that there is a clear framework of all the groups, their purpose (strategic or operational) and how they interrelate to ensure that themes, reporting and escalation are defined and reported.

Recommendation

Staff Governance Committee members are asked to **note** the content of the outcome of the Workforce Planning – Attendance Management Internal Audit report and the recommendations and actions arising from this report, which will be implemented by Line Managers, HR staff and overseen by NHS Fife Promoting Attendance Groups / Executive Directors Group.

Objectives: (must be completed)	
Healthcare Standard(s):	Staff Governance
HB Strategic Objectives:	Employer of Choice. Delivery of Patient Care

Further Information:	
Evidence Base:	B234/20 – FTF Internal Audit Report on Workforce Planning – Attendance Management
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	Management Teams, Attendance Management Groups, Area and Local Partnership Forum, Acute Services Staff Governance Board.

Impact: (must be completed)	
Financial / Value For Money	Costs of sickness absence and associated costs of cover.
Risk / Legal:	HEAT Standard and agreed Board trajectory not met.
Quality / Patient Care:	Impact on delivery of patient care.
Workforce:	Impact on existing staff and morale.
Equality:	N/A

FTF Internal Audit Service

Workforce Planning – Attendance Management

Report No.B23A/20

Issued To: P Hawkins, Chief Executive
C Potter, Director of Finance

B A Nelson, current Director of Workforce
L Douglas, Director of Workforce from 1 January 2020
R Waugh, Head of Human Resources

M Olsen, Interim Chief Operating Officer – Acute Services Division
N Connor, Director of Health and Social Care
Follow-Up Co-ordinator
Audit and Risk Committee & Staff Governance Committee
External Audit

Contents

Draft Report Issued	18 October 2019
Management Responses Received	22 October 2019
Target Audit & Risk Committee Date	09 January 2020
Final Report Issued	**16 January 2020**

CONTEXT AND SCOPE

1. The NHS Fife Board Strategic Framework includes the aspiration for NHS Fife to be an Exemplar Employer and lists related objectives associated with enabling its employees to have fulfilling employment.

2. The NHS Fife 'Workforce Sustainability Board Assurance Framework (BAF)' describes the following risk which could threaten the achievement of this strategic objective – '*There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy*'.

3. The current controls recorded in the BAF to mitigate this risk include:

    - Absence Management Steering Group and local divisional groups established to drive a range of initiatives and improvements aligned to staff health and wellbeing activity.
    - Well@Work initiatives continue to support the health and wellbeing of the workforce, facilitate earlier interventions to assist staff experience and retain staff in the workplace along with Health Promotion and Staff Wellbeing and Safety.

4. In March 2019, the Scottish Government issued the NHS Circular PCS(AFC)2019/2, Policy on Management of Sickness Absence (Promoting Attendance). The circular includes key recommendations to be implemented by 1 April 2019, including working towards reducing sickness absence by 0.5% per annum over the next three years, the adoption of common NHSScotland trigger points and the right to appeal decisions made. NHS Fife has Management of Ill Health and Management of Capability policies in place, with the expectation of adopting the '*Once for Scotland'* human resources policies when they are available from the National Group.

5. The process of Workforce Planning, which includes attendance management, has been identified within the strategic audit planning process as **High** and within the Client Corporate Risk Register as **Moderate** with a rating of 12.

6. Our audit evaluated the design and operation of the controls and specifically considered whether:

    - Extant policies and procedures relating to attendance management are being followed by departments, by visiting areas and carrying out compliance testing against the policy;
    - Attendance Management Training is focused to the most relevant areas and people;
    - Mitigating actions to improve attendance management outlined in the BAF such as the Well@Work and other initiatives are effectively reducing sickness absence by 0.5% per annum;
    - Effective clear reporting on attendance management to the Board, Standing Committees and relevant groups, is in place.

AUDIT OPINION

7. The Audit Opinion of the level of assurance is as follows:

Level of Assurance	System Adequacy	Controls
Moderate Assurance	Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.

A description of all definitions of assurance and assessment of risks are given in Section 4 of this report.

8. NHS Fife aims to improve Attendance Management and uses a holistic multifaceted approach, as no one intervention can lead to an improvement in this area. The approach includes the consistent application of the NHS Fife Management of Ill Health and Management of Capability policies; supporting Well@Work initiatives to promote healthier lifestyles for the workforce; NHS Fife and local Attendance Management Groups which provide support with the implementation of the policies; Review and Improvement Panels to facilitate earlier interventions to support staff and managers when managing attendance and seeking supportive measures to stop staff having to be absent from work or to return them to the workplace earlier following a period of absence; implementation of new management information systems such as Tableau which will provide real time information for Managers; In addition, the staff experience within NHS Fife is measured via the use of iMatter which is a national NHS Scotland tool adopted by all Boards. National evidence also demonstrates that a positively engaged workforce leads to less absence from work and the delivery of quality care to patients.

9. Many of the controls and actions relating to the management of absence within the Workforce sustainability BAF and specifically those with regard to measuring the health and wellbeing of staff are “qualitative” in nature and neither ourselves or management were able to quantify their impact on the risk score, although the Director of Workforce has informed Internal Audit that without these initiatives the absence management rate may increase and that are vital to the overall management of attendance management.

10. It is accepted that demonstrating effective controls within the area is complex given the many component parts that need to be operating at the optimum level to support a sustained improvement in attendance levels. The Attendance Management update to the SGC meeting of 30 August 2019 states that the current sickness absence rate of 5.55% for June 2019 is 0.29% above the trajectory of 5.26%. The trajectory for sickness absence is to achieve a rate of 4.89% by the end of March 2020. Where there is quantifiable data such as absence rates these will continue to be considered in the normal manner as reported to the relevant committees and the Board. We recommend that the SGC use this sickness absence data to form a view on whether the overall approach is effectively mitigating the risk.

11. The key points arising from the audit work were:

- Many groups and initiatives have been introduced to facilitate absence management. The NHS Fife Attendance Management Group is one of the mitigating actions within the Workforce Sustainability Board Assurance Framework. However, it is not clear if this group is strategic or operational. There is further scope to improve the governance arrangements around the purpose of the NHS Fife Attendance Management Group and the other associated groups such as the Review and Improvement panels to show each groups purpose and how they interrelate to provide a Framework on Attendance Management with clear lines of reporting and escalation.
- We concluded that from the 10 departments tested in the sample, the extant policies and procedures are substantially being followed. The Return to Work Forms tested from our sample achieved an 86% compliance rate and we evidenced that discussions relating to the absences were taking place.
- Internal Audit testing reviewed the timeliness of the return to work form and concluded that only 43% of forms were completed within 2 days of an employee's return to work. The return to work discussion is a key part of the management of attendance and can be a highly effective approach to managing short term absence and should take place as close to the return to work as possible to facilitate a smooth safe effective return to work.
- We identified that there is further scope to enhance the Return to Work Forms by providing prompts for users from the Policy document, discussions and possibly tick box options for support initiatives such as Mental Health wellbeing and Well@Work. However, we note that this may not be possible due to a standard form set up within the eEES system which is planned for the future.
- Internal Audit carried out an awareness survey where we asked members of staff from 10 Fife Wide departments about their knowledge and awareness of attendance management policies and procedures. We concluded from the survey that staff have a high level of awareness and demonstrated appropriate knowledge. See page 10 for the detailed survey.
- Training sessions for attendance management are held every 2 months and are accessible to all managers and supervisors with responsibility for managing employee attendance. In addition, Promoting Attendance Management Events have been held in April, August and a further session is planned for October 2019. Data analysis is being used to focus the attendance management training to areas where a need has been identified.
- NHS Fife established a Well@Work Programme and achieved the Gold Healthy Working Lives Award in May 2016 and has successfully retained the award on an annual basis since then. The Well@Work update provided to the August 2019 meeting of the Staff Governance Committee (SGC) advised that '*Work is progressing on the Going Beyond Gold Year 2 plan to consolidate the integration of mindfulness and Good Conversation training*.'
- Our review of the Board papers noted that there is regular reporting to the Board and the SGC on Attendance Management.

Action

12. The action plan at Section 2 of this report has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

13. We would like to thank all members of staff for the help and co-operation received during the course of the audit.

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1		
Finding:		
It is accepted that demonstrating effective controls within the area is complex given the many component parts that need to be operating at the optimum level to support a sustained improvement in attendance levels. The Attendance Management update to the SGC meeting of 30 August 2019 states that the current sickness absence rate of 5.55% for June 2019 is 0.29% above the trajectory of 5.26%. The trajectory for sickness absence is to achieve a rate of 4.89% by the end of March 2020. Where there is quantifiable data such as absence rates these continue to be considered in the normal manner as reported to the relevant committees and the Board. We recommend that the SGC use this sickness absence data to form a view on whether the overall approach is effectively mitigating the risk.		
Audit Recommendation:		
We recommend that the SGC use this sickness absence data to form a view on whether the overall approach is effectively mitigating the risk and utilise the existing escalation route to the Board appropriately.		
Assessment of Risk:		
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:		
Agreed		
Action by:		
Director of Workforce		
Date of expected completion:		
By 31 December 2019		

Action Point Reference 2		
Finding:		
As depicted by the Pie Chart on page 9 of this report, only 43% of forms are completed within 0-2 days of return to work. The return to work discussion is a key part of the management of attendance and can be a highly effective approach to managing short term absence and should take place as close to the return to work as possible to facilitate a smooth safe return to work.		
Audit Recommendation:		
We recommend that a communication is disseminated to all Managers to raise awareness of the importance of the timeliness of the return to work discussion.		
Assessment of Risk:		
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:		
This recommendation is supported and further communication will be disseminated to all Managers to raise awareness of the importance of the timeliness of the return to work discussion. This will also be re-iterated within all of the relevant groups involved in progressing work in respect of promoting Attendance Management within the Board.		
Action by:		
Head of Human Resources		
Date of expected completion:		
31 December 2019		

Action Point Reference 3		
Finding:		
Whilst the Return To Work Form is fit for purpose, with the recent introduction of the Once for Scotland Workforce Policies, there is further scope to enhance the form by providing prompts for users from the Policy document, discussions and possibly tick box options for support initiatives.		
Audit Recommendation:		
If NHS Fife have input to the Return to Work Form, cognisance of the recently published Once for Scotland Workforce Policies should be considered to include prompts for discussion, trigger levels and tick boxes.		
Assessment of Risk:		
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:		
The national work in respect of the paperwork associated with the Management of Attendance has been concluded therefore the ability to influence the design of the Return to Work Form may be limited. Once the national guidance is received this will be implemented within the Board.		
Action by:		
Head of Human Resources/Head of Partnership.		
Date of expected completion:		
Upon receipt of the agreed national policy and associated guidance from SWAG (indicative date of 31 January 2020)		

Action Point Reference 4

Finding:

Many groups and initiatives have been introduced to facilitate Attendance Management. The NHS Fife Attendance Management Group is one of the mitigating actions within the Workforce Sustainability Board Assurance Framework. However, it is not clear if this group is providing a strategic role or if it is an operational group. There is further scope to improve the governance arrangements around the purpose of the NHS Fife Attendance Management Group and the other associated groups such as the Review and Improvement panels to show each groups purpose and how they interrelate to provide an Attendance Management Framework with clear lines of reporting and escalation.

Audit Recommendation:

We recommend that a governance review is undertaken to identify any gaps or duplication with the Attendance Management groups and ensure that there is a clear framework of all the groups, their purpose (strategic or operational) and how they interrelate to ensure that themes, reporting and escalation are defined and reported.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

This recommendation is accepted. Attendance management is such a significant area for improvement in terms of the health and wellbeing of the workforce and also in terms of the impact upon supplementary spend that the ability to review the current arrangements and remits is timely.

Action by:

Director of Workforce

Date of expected completion:

By 31 March 2020

Compliance with extant policies and procedures

1. We selected a sample from the April 2019 report of '*Absence % for Wards/ Departments*' produced by the Human Resources department. The majority of the sample was selected due to the high number of absences in the area with 2 selected as good practice areas due to their low absence rates. We visited ten departments, over the seven areas of the organisation to check compliance with the NHS Fife Management of Ill Health and Management of Capability policies. The areas selected for compliance testing were:

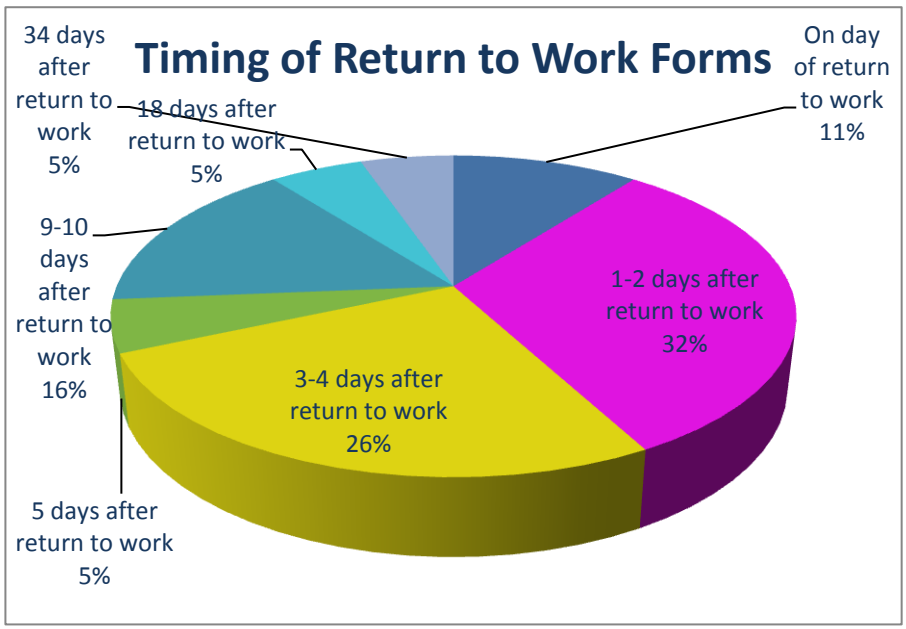
    - Acute Services
    - East Division
    - West Division
    - Finance
    - Corporate Services
    - Fife Wide Division
    - Women and Children

2. A sample of 32 absences were reviewed to ascertain if a Return to Work Form (RTWF) was completed for each absence.

    - We concluded that 19 of the 32 absences had a completed RTWF retained within the department;
    - 10 of the absences were 'non-applicable' for a RTWF. The 'non-applicable' absences included 7 absences where the employees were on long term sick leave and had not yet returned to work. Where this was the case, Internal Audit evidenced records of contact between the manager and the employee and of discussions that had taken place, one absence the employee resigned, one absence the employee had not yet returned to work due to annual leave and one absence the employee returned to work on the day of our testing;
    - Of the remaining 3 absences that did not have a completed RTWF's, we noted that one was for 3 weeks one was for 1 month, and one was 5 weeks; after the date the employee returned to work. We were advised of planned dates for completion of these RTWFs between the manager and the employee on the day of our testing;
    - We reviewed the 19 completed RTWFs, 18 of the 19 evidenced a discussion had taken place regarding the absence. There was no evidence on the other RTWF that any discussion had taken place. However, the lack of information on the RTWF does not necessarily mean that a conversation did not happen.

- We reviewed the timing of the completion of the 19 RTWFs completed forms, the results are illustrated below:

3. As depicted by the Pie Chart below only 43% of forms are completed within 0-2 days of return to work.



4. Our testing included an awareness survey where we asked members of staff from 10 Fife Wide departments about their knowledge and awareness of attendance management policies and procedures. We concluded from the survey that staff have a high level of awareness and are well informed of the NHS Fife Policies and how they should be implemented. See below:

Question	Respondents answer	Additional Notes
Are you aware of the NHS Fife policy or policies that would cover management of sickness absence?	100% of respondents were aware of the two HR Policies relating to Attendance Management.	N/A
When was the last time that you have undertaken Attendance Management Training?	30% respondents attended training a few months ago. 50% respondents attended training two or more years ago. 20% respondents have not attended Attendance Management Training.	Of the two respondents who have not attended training, One was unaware of training and the other was new into post and has new responsibility over staff.
When should you hold a return to work interview? a) When you are next doing your admin. b) As soon as you can for the employee's return to work. c) When the employee asks to sign their absence record form.	100% of respondents selected the correct answer (b).	N/A

Question	Respondents answer	Additional Notes
What is the NHS Scotland HEAT Standard for Sickness Absence?	90% of respondents knew the heat target is 4%. 1/10 provided an answer of 5%	N/A
What are the current triggers for managing sickness absence?	90% of respondents provided the correct current triggers for managing sickness absence. 1/10 or 10% provided an incorrect answer	N/A
At what point should management of short term absence start?	100% of respondents gave the correct answer of immediately.	N/A
Are you aware of what workplace factors can impact on absenteeism?	100% of respondents, gave relevant factors such as stress, workload, capacity etc.	N/A
Can you give two options which may assist achieving improvement with an ill health capability issue (long and short term absences)?	100% of respondents provided two relevant options.	N/A
What is the purpose of a management referral to Occupational Health?	100% of respondents gave the valid reason of ensuring that the employee has a supported safe return to work.	N/A
Would you be familiar with the steps following the *Stage 1 Formal Capability Hearing* and the next steps in the process?	100% of respondents stated that they are familiar with the *Stage 1 Formal Capability Hearing* and the next steps in the process.	N/A
The Review & Improvement Panel? Do you attend this?	40% of respondents attend a Review/Improvement Panel. 30% of respondents do not attend but their line manager attends. 30% of respondents advised that they do not attend the Review and Improvement Panel.	N/A

Attendance Management Training

5. Training workshops for attendance management are held every 2 months and are accessible via the staff intranet to all staff with responsibility for managing employee attendance. The training includes awareness of NHS Fife Management of Ill Health and Management of Capability policies, Flowchart of the absence management procedure as well as helpful examples of how good conversations can take place. In addition, a detailed attendance management report for all wards and departments, with an absence percentage from April 2018-19 was produced showing a RAG status with any absence over 8% as red, over 5% as amber and anything under 5% as green. This data analysis is being used to target attendance management training to the areas it is most needed. This was reported within the Integrated Performance Report (IPR) to the July 2019 Board meeting' '*enhanced data analysis of sickness absence trends, aligned to other related workforce information, combined with bespoke local reporting*' is being used to target Staff Wellbeing and Safety support and other initiatives to the most appropriate areas. Human Resources Management have advised that Attendance Management Training has been undertaken by over 1250 managers to date.

6. Promoting Attendance Management Events have been held in April, August and a further session is planned for October 2019. The SBAR to the Executive Directors Group (EDG) advised that '*the Promoting Attendance event on Monday 29 April 2019 had over 70 managers from all Divisions of the Board participating, alongside staff side colleagues*.' A further thirty five managers from all Divisions participated in the second session held on 9 August 2019.

Mitigating Actions for Improving Attendance Management

7. The NHS Fife Management of Attendance Group (MAG) meets quarterly. The group receives updates on actions from local areas. A representative from each area provides updates on actions i.e. Acute Services Division, East Division, West Division and Fife Wide Division. These areas also have localised Attendance Management Groups where a Human Resources (HR) Officer attends for input and support. The Head of Human Resources is Chair of the NHS Fife Management of Attendance Group. The MAG receives updates and feedback on progress with attendance management local action plans. This group is instrumental on the overview of the implementation of the attendance management policies and is referred to as one of the mitigating controls within the Workforce Sustainability BAF. Many groups and initiatives have been introduced to facilitate Attendance Management.

8. The Well@Work initiative has been established to support NHS Fife employees to achieve a healthy work-life balance. The Head of Human Resources is the Chair of the group and the group meets quarterly. The initiative includes Healthy eating, Physical activity, Stress reduction, Stopping smoking, Sensible Drinking. The group has produced a 'Staff Health & Well being Activities – What's on in 2019?' Events Planner. The planner is regularly updated to incorporate events and activities as they become available. Updates on the Well@Work Group activities have been provided to every meeting of the SGC in 2019/20 to date. Other activities of the group have included: the revision of the Well@Work Handbook and leaflet to provide staff with a list of useful organisations and resources in relation to wellbeing topics. Well@Work blogs have been established and statistics are recorded and retained on the number of views for each blog, the 'Kindness Calendar' blog which comprises of 21 separate blogs, achieved 8,294 hits from 11 December 2017 to January 2019 and the '*Does your 9-5 leave no time for structured exercise*' blog has

achieved 1536 hits from 10 October 2017 to January 2019. The 'Going Beyond Gold: Creating a Kind, Mindful and Healthy Organisation' Final Report and Evaluation was published in June 2019. The overall aim was to create a kinder, more mindful organisation where staff, patients and carers feel looked after and valued, thus improving the health and wellbeing of the organisation. A training programme, along with peer support networks was developed for Mindfulness and Good Conversations.

9. Review and Improvement Panels and Promoting Attendance at Work Panels have been established to facilitate earlier interventions to assist staff experience and retain staff in the workplace, with a schedule of Review and Improvement Panels in place for all areas. The SBAR presented to the June EDG meeting, stated '*these have recently taken place within H&SCP West Division, East Division and Fife Wide Division, Women, Children and Clinical Services, Emergency Care, Planned Care and Estates and Facilities.*' The Review and Improvement Panel, Chaired by the General Manager, reviews an anonymised report of the top ten long term absences and the top twenty short term absences. The HR Officer and Staffside attend the meeting. The Panel go through the list providing a status update and discuss subsequent actions. Any further support is identified and issues addressed in line with the relevant Human Resources Policies. The Manager receives immediate feedback. Management have advised that a brief note is taken at these meetings and it is brought to the next meeting to track progress. Management have advised that a report on numbers of stage 2 and 3 hearings is presented to the HR Accountability Review.

10. A new Staff Wellbeing & Safety Service with self referrals has been introduced to NHS Fife designed for earlier intervention to enhance staff wellbeing, with specific focus on early management referrals of staff off work due to mental health related reasons for absence implemented in March 2019.

11. The Human Resources Management have advised that there is a planned roll out of Tableau in 2019, which will provide Managers with improved up to date information on absence management. Tableau will provide a Board overview and include vacancies and the use of supplementary staff.

12. We evidenced further work has progressed on raising awareness of Resilience. Presentations on '*Personal & Team Resilience- Leading with Mindfulness*' by Dr. Mairiead McLennan has been provided to two out of the three attendance management groups and at the Promoting Attendance event held at the Queen Margaret Hospital in August 2019.. In addition, Management have advised that work is being progressed on how NHS Fife can facilitate support for managers and employees during the Menopause.

13. We commend the approach of seeking good practice from other Boards and organisations. Senior Human Resources Management advised that good practice is being sought from NHS Grampian and Fife Council. The Head of HR is investigating the possibility of using the Derek Mowbray model and workbooks for facilitating Resilience in the workforce.

Reporting on Attendance Management

14. Our review of the Board papers concluded that there is regular clear reporting to the Board on Attendance Management via the Integrated Performance Report (IPR). The IPR to the July 2019 Board meeting, highlighted the main reasons for sickness absence in FY 2018/19 were anxiety, stress and depression, other muscoskeletal problems and unknown causes/ not specified, remedial actions are addressed by noting '*Key Actions for Improvement, Planned Benefits, Due by date and Status*.' These key actions included:

- Building on the success of Well@Work Group, with planned benefits of adopting a holistic and multidisciplinary approach to identify solutions to manage absence and promote staff wellbeing;
- Utilisation of enhanced data analysis of sickness absence trends, aligned to other, related workforce information combined with bespoke local reporting to enable NHS Fife to target Staff Wellbeing and Safety support and other initiatives to the most appropriate areas;
- Establishment of working group to explore challenges and opportunities relating to an ageing workforce, with planned benefits of identifying appropriate mechanisms to allow staff aged 50 and over to remain healthy at work supporting the resilience of the workforce;
- Refreshed Management Attendance training with focus on the use of the Attendance Management Resource pack. Return to work interviews and mental health and wellbeing at work. An additional programme of Mental Health in the Workplace training supported by Healthy Working Lives Fife will be explored. The planned benefits is the reduction of sickness level with particular decreases in absence linked to Mental Health and the implementation of agreed trajectories within each business unit in line with the Once for Scotland Promoting Attendance Circular;
- A quarterly staff newsletter has been launched to help improve the wellbeing of healthcare staff working in Fife (1st edition March 2019) and 2nd edition June 2019). The planned benefits of 'All About You' will highlight wide range of support available to assist staff in being fit and healthy and will share the high level absence statistics and is designed to support a reduction in sickness absence;
- The development and production of return to work and health review meeting video clips for Line Managers and Supervisors to access via intranet. The benefit of the accessibility example of best practice available to Line Managers and Supervisor is to support conducting return to work interviews.

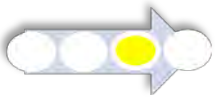
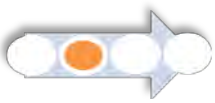
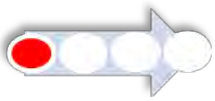
15. There is regular reporting to the SGC on Attendance Management through the Attendance Management Update paper which reports the sickness absence rate in comparison to the previous month. In addition, a separate paper is provided on the Well@Work initiative which outlines recent activities of the group.

16. We noted in line with NHS Circular PCS (AFC) 2019/2, Policy on Management of Sickness Absence (Promoting Attendance) a revised trajectory has been set and is reported against in the Attendance Management Update to the SGC. The Attendance Management update to the SGC meeting of 30 August 2019 states that the current sickness absence rate of 5.55% for June 2019 is 0.29% above the trajectory of 5.26%. The trajectory for sickness absence is to achieve a rate of 4.89% by the end of March 2020. We note that seasonal adjustments are not included in these figures and consideration should be given to using these in the future to account for seasonal fluctuations'.

Section 4 Definition of Assurance and Recommendation Priorities

Definition of Assurance

To assist management in assessing the overall opinion of the area under review, we have assessed the system adequacy and control application, and categorised the opinion based on the following criteria:

Level of Assurance		System Adequacy	Controls
Comprehensive Assurance		Robust framework of key controls ensure objectives are likely to be achieved.	Controls are applied continuously or with only minor lapses.
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses.
No Assurance		High risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

Section 4 Definition of Assurance and Recommendation Priorities

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	None
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Four

Item 8.2b

STAFF GOVERNANCE COMMITTEE

DATE OF MEETING:	Friday 6 March 2020
TITLE OF REPORT:	Risk 527 (Sickness Absence)
EXECUTIVE LEAD:	Linda Douglas, Director of Workforce
REPORTING OFFICER:	Rhona Waugh, Head of Human Resources

Purpose of the Report (delete as appropriate)		
~~**For Decision**~~	~~**For Discussion**~~	**For Information**

SBAR REPORT

Situation

The Staff Governance Committee supports the development of a culture within NHS Fife where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within NHS Fife. This approach is built upon partnership and collaboration and within the direction provided by the Staff Governance Standard.

As the Lead Officer for the Staff Governance Committee, the Director of Workforce, has the key responsibility for monitoring the application of the Staff Governance framework, including the monitoring of performance and reporting to the Staff Governance Committee.

Background

The Staff Governance Committee, as a governance committee of the Board, will consider and review all risks identified against the Committee in the Corporate Risk Register, at two meetings throughout the year.

These reviews will be included in and inform:

1) A 6 monthly report to the Audit Committee on the Corporate Risk Register; and

2) The Annual Assurance Statement which will be submitted to the Audit Committee and ultimately Fife NHS Board.

Risks In The Corporate Risk Register

The risk register identifies the risks the Staff Governance Committee is required to report on and how they are managed throughout the year.

Risk ID 527 Staff Governance: Sickness Absence: Sickness absence rates are a HEAT standard and there is a risk that NHS Fife will not meet the HEAT standard of 4%.

Assessment

Risk ID 527: A range of actions continue to be undertaken to mitigate this risk, which is aligned to the staff health and well being agenda. The NHS Fife sickness absence rate for the 2019/20 financial year to date has deteriorated by 0.33% when compared with the 2018/19 position. The NHS Fife rate for December 2019 of 5.82% (Scottish Workforce Information Standards System reported rate) was 0.01% below the NHS Scotland average rate. The NHS Fife absence rate has been above 5% for the first nine months of the 2019/20 financial year.

Attendance Management training sessions continue to take place, with over 1,300 managers and supervisors trained to date. The revised NHS Fife "Sickness Absence – What You Need to Know" Booklet continues to be distributed routinely to all new NHS Fife staff and an Attendance Management Resource Pack is available to managers and accessible on the intranet, as is the Staff Well at Work Handbook.

As Anxiety, Stress and Depression remains the top reason for sickness absence, the implementation of early referrals to Occupational Health for staff absent due to Mental Health related reasons for absence was implemented. A series of Manager's Occupational Health Drop-In Sessions continue to take place, offering bespoke advice and support to managers on OH issues and to assist in the interpretation of Occupational Health reports to help with Attendance Management. NHS Fife has undertaken three Mental Health in the Workplace training sessions for Managers within the Health & Social Care Partnership and Emergency Care Directorate within Acute Services, as part of the assistance that is being offered to Line Managers, in supporting staff who have Mental Health related reasons for absence. Two Management of Attendance Workshops for managers, OH and staff side colleagues took place in April and July 2019.

It is anticipated that the launch of the new Once for Scotland Promoting Attendance policy on 1 March 2020 will secure a fresh impetus, alongside the plan for the Chief Executive and Director of Workforce to chair a new Task Force, specifically focussing on the long term absence associated with promoting attendance. This Task Force is in the process of being set up.

EDG members are regularly reminded about their responsibilities and the need for managerial focus on attendance issues. In addition, the recommendations from the recent Internal Audit report are being implemented.

Key Actions Over The Next Six Months

Risk ID 527: NHS Fife will continue to implement the initiatives outlined above, in support of the continued determination to improve attendance levels. Focussed activity is being undertaken within all areas of NHS Fife in terms of the Review & Improvement Panel meetings, at Attendance Mangement Group meetings and at local Management Team meetings. These actions, together with the input to the wider health and wellbeing agenda will help to address this multi-factorial problem.

Statement of Assurance

I can confirm, as Lead Officer for the Staff Governance Committee, that we have fulfilled our obligations as specified in the NHS Fife Risk Register & Risk Assessment Policy and are not aware of any weaknesses or failures in the risk management system in our area of control.

Recommendation

The Staff Governance Committee is asked to **note** the risk identified as the Committee's responsibility and the current range of actions.

Objectives: (must be completed)	
Healthcare Standard(s):	Staff Governance.
HB Strategic Objectives:	Employer of Choice. Delivery of Patient Care.

Further Information:	
Evidence Base:	SWISS Statistics, local NHS Fife statistics.
Glossary of Terms:	N/A
Parties / Committees consulted prior	Management Teams, NHS Fife Attendance Management

to Health Board Meeting:	Groups, Area and Local Partnership Forums, Acute Services Staff Governance Boards.

Impact: (must be completed)	
Financial / Value For Money	Cost of sickness absence and associated costs of cover.
Risk / Legal:	HEAT standard and agreed Board trajectory not met.
Quality / Patient Care:	Impact on delivery of patient care.
Workforce:	Impact on existing staff and morale.
Equality:	N/A

Item 8.3

REPORT TO STAFF GOVERNANCE COMMITTEE

DATE OF MEETING:	Friday 6 March 2020
TITLE OF REPORT:	Well at Work Update
EXECUTIVE LEAD:	Linda Douglas, Director of Workforce
REPORTING OFFICER:	Rhona Waugh, Head of Human Resources

Purpose of the Report (delete as appropriate)		
~~For Decision~~	**For Discussion**	~~For Information~~

SBAR REPORT

Situation

The purpose of this report is to update the Staff Governance Committee on the latest Well at Work (Healthy Working Lives) activity.

Background

The purpose of this report is to provide an update on the activities which are currently in place or are being planned to support the Board's on-going commitment to staff health and wellbeing:

- The fourth "All About You" – Supporting Staff Health and Wellbeing newsletter is currently being prepared and will be available to staff via the Intranet, Notice Boards and Ward / Department Briefings.

- Plans are well underway for the Culture of Kindness Conference due to take place on Tuesday 19 May 2020 within the Lochgelly Centre to show case the work on Mindfulness, Good Conversations and Joy in Work. The main speaker will be Dr David Hamilton, a leading scientist and author in the fields of mind-body health being mindfulness and happiness. The conference will involve a mix of speakers and Well at Work related workshops.

- The Meat Free Mondays promotion proved to be unpopular resulting in undesirable food waste. Therefore, it has been agreed that additional vegetarian dishes would be available on a Monday, alongside a meat option.

- The Samaritans "Brew Monday" event held across the UK on Monday 20 January 2020 proved to be successful, with representatives from the Samaritans available within Queen Margaret Hospital and Victoria Hospital to encourage staff who may be going through a difficult time to get together, on what is known as the "most difficult day of the year", for a cuppa and chat with trained volunteers. The Samaritans are keen to return at a future date to provide support to staff.

- Well at Work Suggestion boxes have been situated near the Well at Work Notice Boards and staff are being encouraged to make Well at Wok suggestions.

- A new NHS Fife's Menopause policy is currently being prepared, alont with a new Health Promotion workplace resource pack, available for local use.

- NHS Fife has recommended that vaping or e-cigarettes should be treated in the same way as tobacco smoking. New materials have been prepared for display at entrances and exits to promote 'smoke free' sites, prior to implementation of the new legislation.

- National No Smoking Day will take place on Wednesday 11 March 2020, which aims to help people who want to stop smoking by creating a supportive environment for them, and by highlighting the many sources of help available to people who want to quit. Further information is available via the Intranet.

- The local Well at Work Groups continue to support different workshops, themes and events throughout the year to promote staff health and wellbeing.

Assessment

The NHS Fife Well@Work and local Well@Work Groups continue to promote how managers can support the health and wellbeing of their staff, aligned to achieving a reduction in absence rates. Engagement with staff, especially harder to reach staff is on-going.

Recommendation

Staff Governance Committee members are asked to **note** the on-going activities in terms of Well at Work.

Objectives: (must be completed)	
Healthcare Standard(s):	Staff Governance
HB Strategic Objectives:	Employer of Choice. Delivery of Patient Care

Further Information:	
Evidence Base:	Healthy Working Lives
Glossary of Terms:	Well at Work – NHS Fife branding of Healthy Working Lives
Parties / Committees consulted prior to Health Board Meeting:	NHS Fife Well at Work Groups, Area and Local Partnership Forum, Acute Services Staff Governance Board.

Impact: (must be completed)	
Financial / Value For Money	Costs of sickness absence and associated costs of cover.
Risk / Legal:	HEAT Standard and agreed Board trajectory not met.
Quality / Patient Care:	Impact on delivery of patient care.
Workforce:	Impact on existing staff and morale.
Equality:	N/A

Item 8.4

STAFF GOVERNANCE COMMITTEE

DATE OF MEETING:	6 March 2020
TITLE OF REPORT:	iMatter Health and Social Care Staff Experience Report 2019
EXECUTIVE LEAD:	Linda Douglas, Director of Workforce
REPORTING OFFICER:	Bruce Anderson, Head of Staff Governance

Purpose of the Report (delete as appropriate)		
For Information		

SBAR REPORT

Situation

The National Health and Social Care Staff Experience report was published on 3rd February 2020. The report provides highlighted comparisons between Boards and the NHS Scotland average performance.

This report provides Staff Governance Committee with the review of the iMatter tool after five years of engagement cycles for all Health and Social Care staff in NHS Scotland.

This report is a high level overview.

Background

iMatter is a tool designed in partnership with staff in NHS Scotland to help individuals, teams and Health Boards understand and improve the staff experience. This is a term used to describe the extent to which employees feel motivated, supported and cared for at work. It is reflected in levels of engagement, motivation and productivity.

Understanding the staff experience at work is the first step to putting in place measures that will help to maintain and improve it. This will benefit employees, patients, clients, their families and other service users.

Assessment

The report provides an overview of the iMatter implementation programme nationally over the last three years.

The highlights from an initial assessment of the full report are as follows:

iMatter Response Rates, EEI & Action Plans 2019 per Organisation

This report contains the percentages for Response Rate, Employee Engagement Index score and Action plans recorded within 12 weeks for each Organisation.

Organisation	Response rate			(EEI) Employee Engagement Index			Action plans agreed		
	2017	2018	2019	2017	2018	2019	2017	2018	2019
NHS Fife	62%	53%	62%	75%	No EEI	76%	41%	42%	42%
National Average	63%	59%	62%	75%	No EEI	76%	43%	56%	58%

iMatter Results Comparison per Organisation

The response rates achieved by the organisations within Health and Social Care varied from 53% to 93%.

The share of action plans completed within a 12 week period range from 13% to 100% between the organisations. There are big differences between the organisations in terms of share of action plans completed within a 12 week period. It is noticeable that none of the larger health boards show in either the top or bottom of the list.

NHS Fife was highlighted as a Board with highest equal improvement in response rates up 9%;

NHS Fife was highlighted as a case study for the improvement in response rate following the success of the “Tea Break Campaign”.

NHS Fife improved it’s percentage of teams that received no report by 11% in 2019 with 36% down from 47% in 2018.

OVERALL ASSESSMENT FOR NHS FIFE

Work will need to be done to ensure that more action plans are agreed by teams who have received a report with those who have not received a report also being supported to have an action plan process which deals with and resolves their receiving a report.

iMatter Report of EEI scores for teams per Organisation

The table below shows the report percentage of EEI scores and the distribution of teams per Organisation.

Organisation	Strive & Celebrate (67-100) %	Monitor to Further Improve (51-66) %	Improve to Monitor (34-50) % AMBER	Focus to improve (0-33) %	No report	Total
NHS Fife	58%	6%	0%	0%	36%	100%
NHS Scotland Average	59%	7%	0%	0%	34%	100%

OVERALL ASSESSMENT FOR NHS FIFE

In terms of comparison to NHS Scotland we are sitting in relative terms in the middle of the pack regarding our responses and EEI performance. It is positive that we have no teams within the red category and we are showing a total of 64.5% teams within the Green/Yellow categories with 0% in the Amber category.

Although an 11% improvement was made further work will need to be done to reduce the number of teams that did not receive a report 36%. This has a bearing on action plan completion with a greater likelihood of no action plan being completed by teams without a report.

We have work to do to improve our action plan completion rates with only 42% completed in 2019.

This presentation has been at a high level of the responses received. The Committee can be assured that the feedback will be used to develop appropriate action plans or organisational interventions to seek improvement in the areas identified.

Recommendation

For Information:
The Staff Governance Committee is asked to note the contents of this report.

Objectives: (must be completed)	
Healthcare Standard(s):	2020 Workforce Vision Staff Governance Standards: Well Informed Appropriately Trained Involved in decisions which affect them Treated fairly and consistently Provided with an improved and safe working environment
HB Strategic Objectives:	Complete iMatter roll out by 2017 in line with Scottish Government expectations. Meet Exemplar Employer Objectives

Further Information:	
Evidence Base:	An extensive Literature Review (published August 2012) focused primarily on exemplar organisations within the public and private sectors out-with NHS Scotland. University of the West of Scotland validated the NHSScotland Employee Engagement Index "The NHSSEEI is a robust, reliable, valid and popular measure of staff engagement. It is also an excellent tool to measure improvement in staff engagement".
Glossary of Terms:	EEI – Employee Engagement Index
Parties / Committees consulted prior to Health Board Meeting:	Report will go to Area Partnership Forum after Staff Governance Committee due to timing of meetings.

Impact: (must be completed)	
Financial / Value For Money	None
Risk / Legal:	None

Quality / Patient Care:	Engaged staff deliver a higher standard of quality patient care.
Workforce:	iMatter allows staff to express their views on their experience of working for NHS Fife and work within their teams to change or improve that experience.
Equality:	iMatter helps ensure staff are treated fairly and consistently in line with Staff Governance Standards.

Health & Social Care Staff Experience Report 2019

‘Positive Staff Experience Supports Improved Care’

EVERYONE MATTERS:
2020 WORKFORCE VISION

Healthier Scotland
Scottish Government

Contents

Ministerial Foreword for Staff Experience Report 2019

This report is a detailed analysis of the iMatter Continuous Improvement Model, carried out by Webropol Ltd, an independent company commissioned by the Scottish Government. All 22 Health Boards and 28 Health and Social Care Partnerships in Scotland participated in iMatter in 2019. I would like to personally thank every one of you that took part, and in particular, those of you who helped develop your teams' Action Plans.

Our staff, across Health and Social Care are our biggest asset and good staff experience is key to good patient care and delivering quality services. iMatter means that teams, managers and employers can measure and understand, improve and evidence staff experience. An independent evaluation of iMatter and Dignity at Work, carried out by Strathclyde University in 2018/19 found that staff, managers and trade unions viewed iMatter as an effective tool for promoting staff engagement. This is key to effective team working and empowering staff to take action to improve their experience in the workplace.

I was encouraged by the stories of innovations shared by teams covering a wide range of areas including health and wellbeing, team values, celebrating diversity, improved communication and visible leadership. These are all vital to creating healthy workplace cultures. This is a collective effort and we all have equally important roles to play, whether that is as a team member, line manager, or senior leader. I expect senior leaders and managers across health and social care to reflect on this report, celebrate staff achievements and champion our shared aim of improving staff experience.

iMatter is our shared journey to continuously improve our workplace cultures. Moving forward this will be supported by the roll-out of refreshed workforce policies that put staff at the centre, and which are applied consistently across NHS Scotland. I have also convened a Ministerial Short Life Working Group on Culture and Wellbeing, with representation from across Health and Social Care. This group is considering impactful ways of engaging staff to shape and embed cultures where staff work in open, fair, supportive and responsive environments, whatever their role and wherever they might be based. This group will report back to me with its proposals for delivering workplace improvements before the summer recess. Work is also underway to co-produce a new Dignity at Work measurement tool to make sure health and social care staff feel valued, listened to and treated with respect. Crucially this will be developed by staff for staff, using a similar methodology to that adopted to develop iMatter.

The roll out of 2020 iMatter questionnaires will begin this February. Your views matter, so thank you again for participating in 2019 and please take the opportunity to have your say, as we move forward into 2020.

Jeane Freeman OBE, Cabinet Secretary for Health and Sport

Introduction

Employers in Health and Social Care are committed to improving patient and public services through enhancing staff experience.

Our 2020 Vision for Health and Social Care makes a commitment to valuing and empowering everyone who works in NHSScotland and supporting them to work to the best of their ability. We recognise that improved staff experience is critical for delivery of the Scottish Government's Health and Social Care Delivery Plan, to provide better care, better health and better value.

It is therefore essential that staff at all levels in NHSScotland, including those working within Health & Social Care Partnerships (H & SCPs) are empowered and enabled to have their voices heard, that they are valued within their immediate team and wider organisation, and that their views, opinions and actions contribute to continuous improvement.

The work to measure and report staff experience in Health and Social Care in 2019 was commissioned by the Scottish Government and carried out by Webropol Ltd, an independent company.

The iMatter Continuous Improvement Model

The iMatter Continuous Improvement Model was developed by NHSScotland staff and aims to engage staff in a way that feels right for people at every level. As a team-based tool, iMatter offers individual teams, managers and organisations the facility to measure, understand, improve and evidence staff experience. The iMatter team stories included in this report illustrate the continued dedication of staff to improving not only their staff experience but in turn improving the care and services they deliver.

Arrangements for the delivery of the iMatter model were developed in full partnership and have been endorsed by the Scottish Workforce and Staff Governance Committee (SWAG) and approved by the Cabinet Secretary for Health and Sport. iMatter was initially rolled out over a three year period from 2015 to 2017 to all staff across NHSScotland and 24 Health & Social H & SCPs that chose to participate. The 2018 and 2019 programmes have repeated that process.

The implementation of iMatter has enabled us to obtain a comprehensive picture of staff experience. Indicating areas of success and those which require improvement both nationally and locally, it helps inform progress in delivering the commitments of our Staff Governance Standard. Our commitment to promoting effective staff governance was reinforced with the NHS Scotland (Reform) Act 2004 and the Staff Governance Standard underpins that commitment.

iMatter Process

The iMatter questionnaire enables staff the opportunity to feed back their experience within their team and at organisational level on a real-time basis. iMatter results are directly reported at team, directorate and organisation levels. Once team results are delivered two weeks after questionnaires closing, teams are invited to collectively share responsibility for developing an action plan within a 12 week period and to review actions and progress made throughout the year. As an integral part of the iMatter process teams come together to review the results and share thoughts and ideas in order to develop and implement Action Plans. This process is illustrated through the sharing of Team Stories. This report includes a summary of the main themes emerging and includes hyperlinks to all of the Team Stories submitted (Appendix 2).

iMatter Report 2019

This report provides detailed information and analysis of the iMatter responses for 2019. It also contains comparisons to 2018 and 2017 where appropriate.
The findings from this report will be used by a range of stakeholders, including:

- Individual organisations (Health Boards and local authorities)
- The Scottish Government
- Partnership Groups such as the Scottish Partnership Forum (SPF) and the Scottish Workforce and Staff Governance Committee (SWAG)

Data Collection

The iMatter questionnaire used Webropol to distribute electronic and paper questionnaires to NHSScotland employees, as well as those employed by the local authority who work in a Health & Social Care Partnership (H & SCPs) who chose to participate. In 2019, 22 Health Boards and 28 H & SCPs took part.

For 2019 all fieldwork was carried out between 5 February and 17 September. Paper responses were accepted through until 24 September to allow for post processing. The 2019 questionnaire additionally asked a question on staff groupings but was otherwise unchanged from 2018 and 2017. The report therefore contains data from all three years of the iMatter survey. Further details of the method are included in Appendix 1.

Key Performance Indicators

Throughout the analysis of iMatter there is focus on 4 KPIs, all of which have improved in 2019.

Overall Response Rate
62%
Questionnaires Issued: 179,453
Responses Received: 111,512

Response Rate

The response rate is calculated as the percentage of questionnaires issued that have been completed and returned within the allowable time. In total 179,453 questionnaires were issued. 25,782 (14%) of these were to social care staff within participating H & SCPs and 153,671 (86%) were NHSScotland staff. A total of 111,512 usable responses were received. This equates to an overall response rate of 62%. **This response rate has increased from 59% in 2018.**

No Report
4 Boards
34% Teams

No Report

The level of No Report is tracked at a Team, Directorate and Board level*. This shows the proportion within each group who have not achieved the response rate threshold.
Overall 4 out of 22 Boards and 34% of Teams did not receive an iMatter report. **This is a notable improvement from 2018 when 9 Boards and 38% of Teams did not receive an iMatter report.**

EEI Score
76

Employee Engagement Index Score (EEI)

The Employee Engagement Index (EEI) is calculated based on the number of responses for each point on the scale (Strongly Agree to Strongly Disagree) multiplied by its number value (6 to 1). These scores are added together and divided by the overall number of responses to give the score to show level of engagement.
The 2019 EEI Score for Health and Social Care is 76, an improvement of one point from the 2017 score. No EEI was published in 2018 as the response rate threshold was not achieved.

Action Plans Agreed
58%

Action Plans Agreed

Each team is invited to complete a continuous improvement action plan. 58% of teams had an agreed Action Plan in place within 12 weeks of receiving iMatter results. **This is a small improvement on the 56% achieved in 2018.**

*Note: From 2020 it is anticipated that the reported KPI will be the percentage of teams issued with reports.

Key Performance Indicators (KPIs) by Board

The table below shows the KPIs for each of the Health and Social Care Boards.

Board	Response Rate	EEI	No Report*	Action Plans
Health & Social Care	**62%**	**76**	**34%**	**58%**
Golden Jubilee Foundation	67%	77	29%	52%
Healthcare Improvement Scotland	90%	78	19%	73%
NHS 24	65%	78	43%	54%
NHS Ayrshire & Arran	60%	76	34%	55%
NHS Borders	53%	No Report	47%	70%
NHS Dumfries & Galloway	66%	74	25%	58%
NHS Education for Scotland	87%	82	10%	93%
NHS Fife	62%	76	36%	42%
NHS Forth Valley	68%	75	26%	72%
NHS Grampian	62%	77	35%	52%
NHS Greater Glasgow & Clyde	59%	No Report	37%	57%
NHS Health Scotland	93%	81	0%	100%
NHS Highland	60%	74	37%	49%
NHS Lanarkshire	65%	79	30%	77%
NHS Lothian	63%	77	34%	57%
NHS National Services Scotland	82%	76	13%	88%
NHS Orkney	66%	75	30%	70%
NHS Shetland	63%	78	33%	41%
NHS Tayside	61%	75	38%	47%
NHS Western Isles	56%	No Report	43%	13%
Scottish Ambulance Service	59%	No Report	42%	62%
The State Hospital	79%	77	8%	79%

* Teams with No Report are teams of more than 4 people who did not achieve a 60% response rate and teams of 4 or less people that did not achieve 100% response rate. As the No Report KPI is a ‘negative’ metric the lower the percentage for this metric the better the performance.

Team Stories

Introduction to Team Stories

Team Stories are a vital part of the iMatter programme. They illustrate the way in which individuals and teams have come together to review the results and share thoughts and ideas in order to develop and implement Action Plans. Team Stories give best practice examples of how to address challenges that may be experienced by many teams. They therefore provide inspiration and ideas for other teams and for the organisation as a whole.

Team Stories are analysed in this section of the report with illustrative examples. Team Stories are incorporated elsewhere in this report, where they demonstrate how teams have addressed challenges in specific areas (e.g. response rates, long term trends, individual Staff Governance Standards etc.) A link to all Team Stories can be found on the Picture Boards in Appendix 2.

As was seen last year, Team Stories are demonstrative of the range of focus areas and actions that iMatter influences. In total 37 Team Stories have been submitted, 13 more than were put forward in 2018. They represent 15 NHSScotland Boards and include 11 Health and Social Care Partnership stories.

Health and Social Care	
NHS Education for Scotland	NHS Health Scotland
The State Hospital	NHS Highland
NHS Lothian	NHS Lanarkshire
NHS Greater Glasgow & Clyde	NHS Orkney
NHS 24	NHS Tayside
NHS Borders	Scottish Ambulance Service
NHS Dumfries & Galloway	Golden Jubilee Foundation
NHS Grampian	

HSCPs
Inverclyde (NHS Greater Glasgow & Clyde)
West Dunbartonshire (NHS Greater Glasgow & Clyde)
East Dunbartonshire (NHS Greater Glasgow & Clyde)
Angus (NHS Tayside)
Orkney HSCP
South Lanarkshire (NHS Lanarkshire)
North Lanarkshire (NHS Lanarkshire)
Dumfries & Galloway HSCP

It is notable that a number of the Team Stories are written against a **background of change**. Whether linked to personnel, organisational or working practice, change can cause uncertainty from which other issues emerge, such as lack of confidence, apparent lack of communication, workplace feelings of stress etc. Many stories start from a period of change, recognise the impact on the team and then move forward to turning that change into an opportunity for improvement as the example overleaf illustrates:

The migration to the new hospital has put strain on NHS Orkney, making the need for teams to work well together and for roles and responsibilities to be clear even greater. With new team members the Organisational Development Team need to be proactive in establishing and strengthening their team:

"Team Development day was well spent mapping out roles and responsibilities, it included a lot of fun during the day – which continued on into the evening!"

NHS Orkney, Organisational Development and Learning. Knowing me, Knowing you

Summary of themes

Across the 37 stories there are a wide range of topics addressed and differing approaches to how Action Plans are developed and implemented. The format that stories are presented in also vary considerably demonstrating again how each Team Story is owned by, and is a reflection of, that individual team.

In broad terms the following themes recur through the Team Stories. Each of these are explored in more depth in the following sections of the report:

- Staff wellbeing
- Collaboration and communication
- Teamwork
- Long-term commitment to improvement
- Outcomes beyond iMatter
- Improving the iMatter process

Staff Wellbeing

It is positive to see many stories focusing on staff wellbeing. In addition to the examples here, the topic is further explored in the **Staff Governance Standard – My Organisation** section of the report, through a powerful team story from the **Scottish Ambulance Service**.

An example of a proactive approach to understanding and improving the staff experience is provided by the Drum Ward, who have used an accessible approach to enable staff to be open about how they feel:

As a direct result of 'poor' scores for 'experience as an individual' the senior team has adopted the 'Joy at Work' programme for the Drum Ward. The programme focused on supporting staff health and wellbeing and has led to the Drum Ward team having an emotion board through which staff have an open opportunity to share and discuss their feelings.

NHS Grampian, Mental Health & Learning Disabilities Drum Ward. Team Journey

Sometimes it is simple things that can go a long way to supporting staff as illustrated in the Bee Happy at Work story:

"We are also making a conscious effort to spend lunch together allowing for time for social interaction with colleagues and building relationships….Looking after each other means we are better equipped to look after and support NHS Borders Staff."

NHS Borders Work and Wellbeing – Occupational Health Team – Bee Happy at Work

---

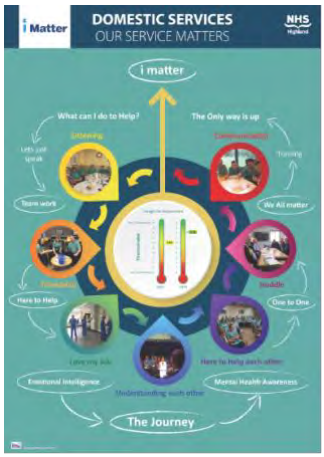
The Domestic Services team at Raigmore Hospital started their iMatter journey in 2015, initially getting staff engaged in the programme. They firstly invested in training to improve communication skills and are now moving on to focus on staff wellbeing:

"Through working together we have now developed a workplace culture that fosters team work allowing us to set clear goals and agree objectives with our individual teams and wider service users."

More recent focus has been on raising the team profile across the organisation and continued skills development of the team. For 2019 the priority is the importance of happy staff:

"We began to think about mental health and wellbeing within the workplace, understanding how to deal with it positively and how to support each other."

NHS Highland Domestic Services Team – Our Services Matter



Collaboration and Communication

Similar to last year, many team stories focus on how to improve communication and collaboration within teams, across teams or with senior management. There is a recognition that proactivity is needed, as illustrated by the example below:

The Community Children's Nursing Team took a very pro-active approach to improving two-way communication between their team and senior management.
The team identified a two-way knowledge gap between the team and senior management *"who were they and what did they know about us as a team."*
Various actions were taken to engage with the senior team, including inviting them to meetings, running Q&A sessions and having regular informal 'back to the floor' sessions

North Lanarkshire HSCP, Integrated Nursing Service. Our iMatter Journey

---

Teamwork

Again, as last year, many stories demonstrate how teamwork has been improved, whether within the individual team or through greater understanding and collaboration across teams. The three examples below come from NHS Education for Scotland and illustrate different aspects of team building:

---

1. Celebrating Diversity

"The diverse mix of our team members is also very helpful – we have a range of experiences, backgrounds and ambitions, and everyone is happy to share and learn from each other."

NHS Education for Scotland, CPD Connect Team. Better communication means better staff experience

2. Raising awareness of the team and what it does, by using new solutions to do so

"Our aim is to increase knowledge and awareness of the team's activities, both within the NES organisation and externally…. maximising opportunities to showcase the team's work… new ways to network with key partners and would like to make more use of digital and social media in the future."

NHS Education for Scotland, Oral Health Improvement Team. Raising the profile of the team

3. Dealing with the additional challenges of a dispersed team, recognising the increased need for two-way communication that this can present. This example demonstrates the importance both of speaking up and of listening:

"We introduced a weekly stand up every Monday to allow the whole team, from all offices, to hear and share the key areas of work for the upcoming week … they have improved awareness and transparency around priorities across the team.. allowed team members to become involved in decisions within the team, give and receive feedback on matters of priority to them or the team."

NHS Education for Scotland – Pharmacy Team – Improving communication across the team

---

Long-term Commitment to Improvement

Several of the stories track iMatter performance over time of response rate, scores or both. These show the importance and value of remaining committed to a specific course of action over extended periods of time in order to achieve sustained improvement. They also illustrate how it can sometimes take time for changes in behaviour to have an impact on performance and scores. Several stories highlight progress over 3 or 4 years of the iMatter programme, demonstrating the value of continued focus in driving sustained change. In addition to the examples below, another further Team Story is included in the **EEI** section of this report.

The story from Stracathro Hospital below demonstrates how continued focus can have huge impact on scores:

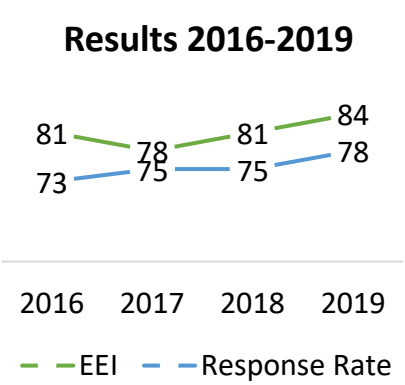
The team have focused on one individual Component: *I have sufficient support to do my job well*. In 2017 it scored 50, alongside an EEI of 57. Through open communication and clarity around roles and responsibilities they have seen the Component rating rise to 92 this year and an EEI that is now 92.

Angus HSCP, Social Therapy and Recovery Service. Our iMatter Journey

---

The story below from an East Dunbartonshire HSCP team shows how the development of their intranet set has contributed to long term improvements both is response rate and EEI score:

'**Keep connected in Oral Health'** developed an intranet site, through which staff are able to get involved and see their contributions listened to and acted on. It has helped achieve continued increases in both response rate and EEI as well as having wider benefits for the team.



"The site is intended to be a resource that supports all staff by providing a variety of information and guidance on the services within oral health as well as a range of useful links and documents and has been found to be a very effective resource for staff induction."

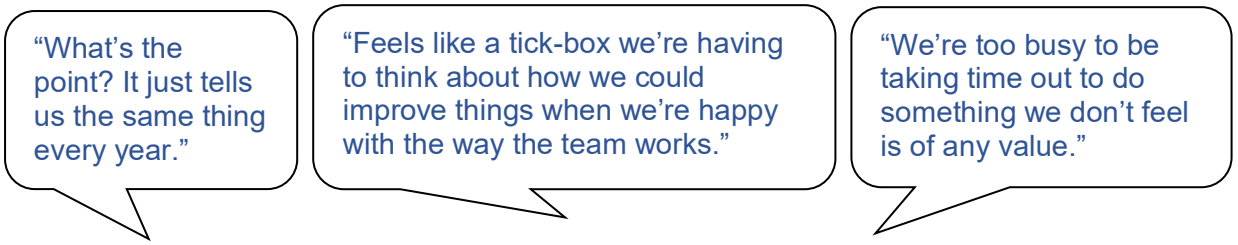
East Dunbartonshire Oral Health Directorate HSCP, NHS Greater Glasgow and Clyde

---

Improving the iMatter Process

Several team stories focus in on actions taken to improve the way in which iMatter is approached within their teams. For some this starts with a very honest reflection on staff scepticism towards the value iMatter. For others it is a recognition that awareness of iMatter is low and engagement with it is limited. Actions put in place to address these concerns show great results in raising the profile and importance of iMatter to those teams. Examples of these stories are also included within the **Response Rates** section of this report.

The Person Centred Improvement Team faced a positive challenge. For the last 3 years they have achieved 100% for My Team/My Direct Line Manager. This has led to some reticence towards iMatter:



In order to maintain the positivity, the team used the patient-focused 'What Matters to You?' initiative, testing the creative feedback model to explore how to overcome perceived barriers and ensure the whole team was able to contribute meaningfully to the Action Plan development process

The State Hospital, Person Centred Improvement Team. Building Thoughts: Connecting Blocks

---

Outcomes Beyond iMatter

A number of stories refer to team Action Plans that were developed to address a specific area of iMatter performance and go further to have a considerable onward benefit to wider team performance (KPIs, patient care etc.). The example below illustrates this point well:

In 2018 the team scored 62 for 'My team works well together' and set about identifying their team values to drive their team culture. These values became a part of everyday life and led to a 2019 score for 'My team works well together' of 97; a huge increase. The additional outcome of this improvement was record highs in performance on all KPIs such as staff absence, products on time, right first time etc. It is notable also that this team remains committed to maintaining *"this positive culture and further improve the team's joy at work."*

NHS Lothian, Radio pharmacy, Royal Infirmary of Edinburgh. Improving Culture, Improves Performance

---

Best Practice in Communicating Messages

Every story is unique and each is an illustration of best practice and a focus on improvement. Each story can provide other teams across Health and Social Care with ideas that they can take back into their own teams. Often those that use visual illustrations such as this example, are powerful and can easily be adapted to be of value to other teams across the organisation:

"Sometimes it feels like we have to climb a mountain. It's much easier to get to the top each day if we use the tools, resources and support of colleagues… There are many routes and after obstacles to overcome on the path."

The mountain was pinned on the noticeboard and each team member put footprints on where they are on their journey. This will give the team a shared view of their current position and will be valuable to track over time as they work towards the 'peak'

NHS Health Scotland, HWL Advice Line. Climbing a mountain

Summary

It is encouraging to see the increase in the number of Team Stories put forward this year. Each story is unique to its authors, both in the topic it addresses and the format it is told in. Many stories demonstrate considerable personal commitment from the team, along with creative and innovative approaches to developing solutions.

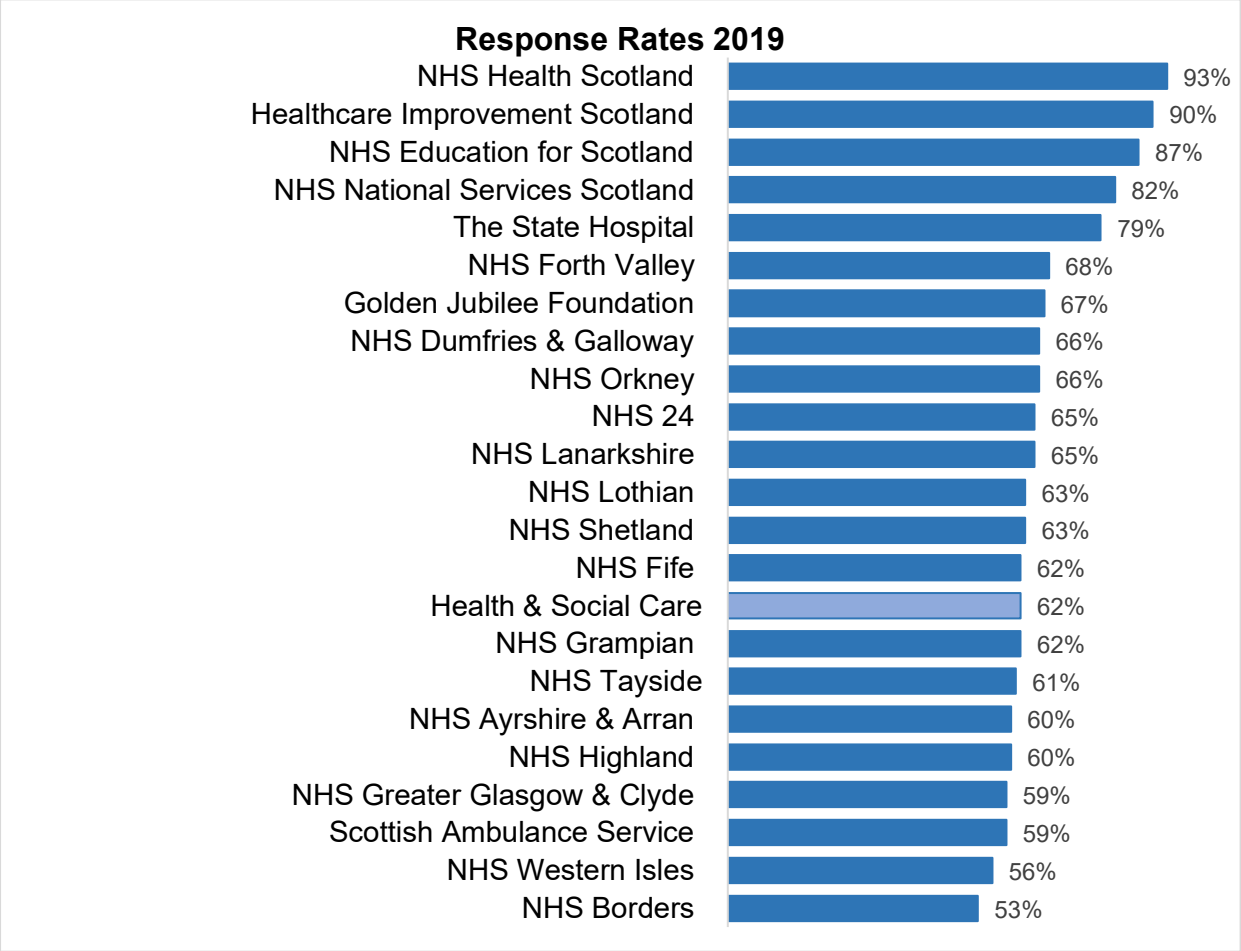
The Team Stories provide other teams with examples of best practice actions along with ideas and inspiration for how to address challenges they may be facing.

Response Rates

All questions on the iMatter questionnaire are mandatory to eliminate partial loss of data. Only those questionnaires that have every question answered can be included within the analysis. The response rate shows the number of staff issued with the questionnaire (Recipients) and the number of staff who responded (Respondents) as an overall percentage. A response rate of 60% is required for teams of 5 or more and 100% for teams of 4 or less to generate a report. This is to ensure anonymity and also the higher the response rate, the more realistic the feedback of how staff feel about working in their team. In total 179,453 questionnaires were issued and 111,512 usable responses were received. This equates to an overall response rate of 62%.

2019 Board Response Rates

While the overall response rate for Health and Social Care for 2019 is 62%, there is considerable variation in response rates across the Boards, ranging from 53% to 93%.



There are 5 Boards, all of which are National Boards, that stand out in terms of high response rates:

- NHS Health Scotland (93%)
- Healthcare Improvement Scotland (90%)
- NHS Education for Scotland (87%)
- NHS National Services Scotland (82%)
- The State Hospital (79%)

The highest response rate in a Geographic Board is NHS Forth Valley (68%). NHS Borders has the lowest response rate at 53%, with a further 3 Boards not reaching the 60% threshold:

- NHS Western Isles (56%)
- Scottish Ambulance Service (59%)
- NHS Greater Glasgow and Clyde (59%)

Comparing 2019 Response Rates to Previous Years

The table below shows the response rates for the three years that iMatter has been in place. The overall response rate for Health and Social Care has risen to 62% this year, an improvement of 3 percentage points over 2018. It is now only 1 percentage point below the 63% achieved in 2017.

Across the 22 Boards, 17 have an improved response rate in 2019 over 2018, two have remained unchanged and three have declined.

Board	2017	2018	2019	Response Rate Movement 2019-2018 (pp)
Health and Social Care	**63%**	**59%**	**62%**	**+3**
Golden Jubilee Foundation	68%	63%	67%	+4
Healthcare Improvement Scotland	80%	86%	90%	+4
NHS 24	67%	70%	65%	-5
NHS Ayrshire & Arran[1]	64%	59%	60%	+1
NHS Borders	61%	53%	53%	0
NHS Dumfries & Galloway	63%	59%	66%	+7
NHS Education for Scotland	81%	84%	87%	+3
NHS Fife	62%	53%	62%	+9
NHS Forth Valley	65%	62%	68%	+6
NHS Grampian	64%	60%	62%	+2
NHS Greater Glasgow & Clyde	58%	54%	59%	+5
NHS Health Scotland	85%	91%	93%	+2
NHS Highland	58%	51%	60%	+9
NHS Lanarkshire	65%	62%	65%	+3
NHS Lothian	65%	63%	63%	0
NHS National Services Scotland	76%	77%	82%	+5
NHS Orkney	73%	83%	66%	-17
NHS Shetland	61%	56%	63%	+7
NHS Tayside	65%	58%	61%	+3
NHS Western Isles	52%	52%	56%	+4
Scottish Ambulance Service	64%	64%	59%	-5
The State Hospital	78%	77%	79%	+2

The largest increases from 2018 to 2019 are

- NHS Highland up 9 percentage points from 51% to 60%
- NHS Fife up 9 percentage points from 53% to 62%
- NHS Dumfries and Galloway up 7 percentage points from 59% to 66%
- NHS Shetland up 7 percentage points from 56% to 63%

All four of these Boards succeeded in increasing their response rates to above the 60% threshold. Case studies overleaf illustrate actions taken to achieve these increases:

[1]The NHS Ayrshire and Arran response rate for 2017 was amended following the 2018 report publication from 63% to 64%.

Case study 1: Improving Response Rate

NHS Fife Tea Break Campaign 2019 recognised that as well as staff knowing about iMatter, they also need to have access to the survey in an environment that was conducive to participation.

"We co-ordinated a series of visits direct to staff workplaces with a tea trolley, tea urn, biscuits, fruit (had to ensure our healthy working lives credentials were sound) and access to the iMatter survey. We had a number of laptops, ipads and access to local follow on printers for staff who were keen on completing paper copies. Our two trolleys were supported by Communications staff, HR staff and partnership representatives who volunteered to assist."

An example of the process can be seen here at https://youtu.be/hadKaVWUqFk

Case Study 2: Improving Response Rate

NHS Highland started by providing greater resource in the Preparation and Confirmation Stages. This led to a considerable reduction in the number of teams. There were a series of iMatter Awareness sessions and weekly reporting of response rates.

Actions were taken to reduce the volume of paper surveys and an increased response rate was achieved among those responding on paper. The most significant change was the level of support from senior management in the Board. The interim Chair and the new CEO. The weekly CEO bulletin was used to publicise key aspects of iMatter and considerable support came from the Director of Communications who ensured important iMatter messages were distributed via the Team Brief.

Case Study 3: Improving Response Rate

NHS Dumfries & Galloway took a number actions, building on previous years activity including a considerable increase in Action Plans in 2018. They delivered Staff Awareness Sessions aimed at highlighting the importance of staff engagement the cycle of improvement, stages of the iMatter cycle and how to effectively action plan.
They increased communications throughout the cycle – all staff emails, articles in Workforce Briefing paper and weekly staff Core Briefing and created an iMatter video.
Specific action was taken to reduce the number of paper surveys by offering Support Services staff the opportunity to participate via providing a personal email address instead of paper questionnaires. This resulted in 25% of Support Services staff opting to complete online.

Looking at progress from 2017 there are three Boards that have increased their response rates each year:

- Healthcare Improvement Scotland (80%, 86%, 90%)
- NHS Education for Scotland (81%, 84%, 87%)
- NHS Health Scotland (85%, 90%, 91%)

In contrast, the response rate in NHS Orkney has dropped from 83% in 2018 to 66% in 2019. NHS Orkney's relocation to a new hospital led to some internal delays and technical issues. The additional workload to implement this move and maintain patient care are likely to have impacted staff's availability to complete the iMatter questionnaire this year.

Method Effect – online and paper response rates

In order to ensure all staff have the opportunity to take part in iMatter, paper questionnaires are distributed to those without access to the online survey.

In 2019 86% of surveys were issued online and 14% were on paper. The proportion of paper surveys issued has continued to drop slightly from 16% in 2018 and 18% in 2017. The share of the responses received is 92% online and 8% paper. This is due to the higher response rate to the online survey, leading to online being a higher proportion of the responses.

Health and Social Care 2019	Volume issued	% of Volume Issued	Usable Response Volume	% of Responses Received	Response Rate by Method
Online	153,989	86%	102,099	92%	66%
Paper	25,464	14%	9,413	8%	37%
Total	179,453		111,512		62%

Both online and paper response rates have increased from 2018. The online response rate has improved by 2 percentage points and the paper response rate by 6 percentage points.

Typically the Geographic Boards make more use of paper surveys than their National counterparts. The highest use of paper surveys is in NHS Grampian and NHS Greater Glasgow and Clyde, with both issuing paper surveys to 19% of their staff.

Further detail of response volume and response rates by method are contained in Appendix 4.

As seen in the overall response rates there is considerable variation across Boards in both the online and paper response rates.

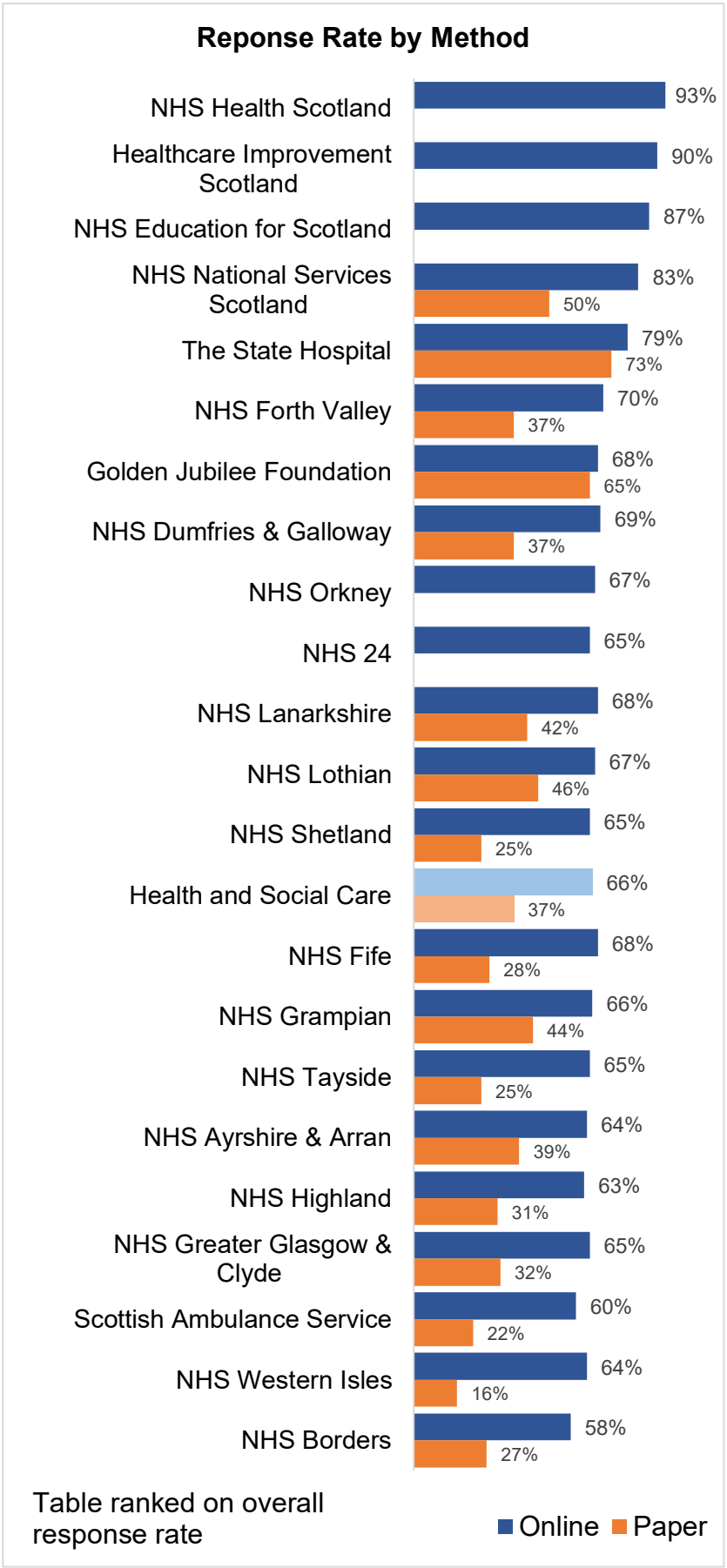
The three Boards with the highest overall response rate only used the online survey, as did NHS Orkney and NHS 24.

The State Hospital achieved a 73% response rate on the paper survey, coming close to their online survey response rate of 79%. Golden Jubilee Foundation also achieve a high paper response rate (65%), similar to the Board's online response rate of 68%.

Case Study 4: Migrating from paper surveys

The State Hospital made a concerted effort in 2019 to reduce the number of paper surveys used particularly in teams where paper was the majority response method.

Discussions between the iMatter Board Administrator and iMatter Team Leaders resulted in additional support being given to staff to set up valid e-mail accounts before the survey went live. Time was then allocated for staff to visit the Learning Centre where they were given the opportunity to use a PC to complete their e-mail survey.



Case Study 5: Migrating from paper surveys

The Golden Jubilee Foundation; "*Based on previous response rates from paper questionnaires, the Op Lead had contacted all those areas who had previously opted for paper questionnaires over the last few years. Recognising that many of the staff in these areas did not frequently access their work e-mail accounts, each of the managers were provided with the option to use personal e-mail addresses. The managers communicated this to their teams and many staff opted to have the questionnaire sent electronically to their personal e-mails. This in turn reduced the number of paper questionnaires sent. The mangers within the departments who utilised the paper questionnaires this year continue to be committed to the continuous improvement model and have continued to encourage and engage with their teams which resulted in the increase in responses.*"

The Future

As noted, there has been a small reduction in the volume of paper questionnaires issued and several Boards have taken proactive steps to reduce their reliance on paper surveys.

The Care at Home Services team from West Dunbartonshire HSCP took an innovative approach to reducing paper questionnaires. Key actions are highlighted below and their Team Story "Text for Success" provides full details.

Case Study 6: SMS Pilot

As a team of home carers, most had previously received paper questionnaires, but lacked engagement in iMatter. The team garnered support from NHS GG&C, the Scottish Government and Webropol to embark on a mobile technology supported pilot, that involved text messages to home carers informing them about iMatter and providing the link to the survey. Not only did this pilot generate an 85% iMatter response rate, but it has also served as a catalyst for using technology to enhance learning and communications across the team

"We are thrilled with the success of the project, and excited about the potential of using SMS technology to engage staff in the improvement process even more widely in the future."

West Dunbartonshire HSCP, Care at Home Services. SMS Pilot

Looking to the future, the combination of encouraging staff towards the online questionnaire and use of technologies such as SMS will continue to reduce the volume of paper surveys and should increase the overall response rate.

Unusable Responses

A prerequisite of iMatter is that every question on the questionnaire is answered. If there are any errors on the questionnaire then it is not processed.

For the online questionnaire this is monitored within the script and so non-completion is not an issue. However, in 2019 there were 6,630 recipients (4% of the total online survey volume) who clicked on the survey invitation but did not then finish the survey. This is an improvement on 2018, when 8,625 did not complete the online survey. In addition, 1,362 people reached the end of the survey but did not hit the "Submit" button and so their surveys are not included in the results. Some of these people may have made a conscious decision not to submit their responses, but others may simply not have realised that they needed to 'submit' their response for it to be processed. Some design enhancements are under consideration for next year to reduce the volume who accidentally miss the 'Submit' button.

On the paper questionnaire it is not possible to monitor responses as they are being completed and so it is only when returned questionnaires are processed that incomplete or incorrectly completed responses are identified.
Of the 25,464 paper surveys issued, 9,413 (37%) were input and a total of 2,278 (9%) were rejected for the reasons shown here.
Of the partial responses 79% were only missing a response to one question.

Health and Social Care 2019	Volume	% of paper surveys sent
Paper Surveys Sent	25,464	
Responses Processed	9,413	37%
Responses Rejected	2,278	9%
Reasons for Rejection		
Partial Response	1,587	6%
Completion Errors	282	1%
Duplicate	167	1%
Past Deadline	242	1%

Summary

Overall the response rate has increased 3 percentage points from last year to 62% meaning the reporting threshold of 60% has been achieved. This increase is reflected across most of the Boards, with only three having a lower response rate in 2019 than 2018. Of those, NHS Orkney saw a considerable drop, but there are mitigating circumstances with a major hospital relocation impacting all staff during the iMatter fieldwork period.

The increase in response rates has occurred in both online and paper surveys, though there has also been a small reduction in the share of paper surveys issued.
Several Boards have shown considerable increases in their response rates and as the Case Studies show those improvements are as a result of concerted effort across the whole iMatter process, raising awareness and engaging with staff at all stages as well as senior management demonstrating their support throughout.

No Report

With the higher overall response rate in 2019 the number of Boards with No Report has reduced from nine in 2018 to four this year. Whilst this is a considerable improvement it is still one Board more than in 2017.

The table below shows the 10 Boards that have had one or more 'No Report' over the three years of iMatter. Of these, two have never had a report (NHS Greater Glasgow and Clyde, NHS Western Isles) because their response rate has remained below 60%, though both have improved year on year. Two Boards have had No Report for two of the three years (NHS Borders and NHS Highland).
This is the first year that the Scottish Ambulance Service has not received an EEI Report as their response rate dropped 5 percentage points to 59%.

No Report	2017	2018	2019
Health and Social Care		**No Report**	
NHS Ayrshire & Arran		No Report	
NHS Borders		No Report	No Report
NHS Dumfries & Galloway		No Report	
NHS Fife		No Report	
NHS Greater Glasgow & Clyde	No Report	No Report	No Report
NHS Highland	No Report	No Report	
NHS Shetland		No Report	
NHS Tayside		No Report	
NHS Western Isles	No Report	No Report	No Report
Scottish Ambulance Service			No Report

Of the 4 Boards that did not receive a report this year, NHS Borders were a considerable volume of responses short, as their response rate has remained at 53%.
To reach the 60% threshold three Boards only needed a small number of additional completed surveys:

NHS Greater Glasgow and Clyde	336 surveys
NHS Western Isles	33 surveys
Scottish Ambulance Service	3 surveys

Teams with No Report

Note: From 2020 it is expected that the reported metric will be the % of Teams Receiving Reports, rather than the current 'No Report' metric. This is designed to bring this metric in line with the format of the other KPIs.

Overall the proportion of teams with No Report in 2019 has decreased to 34% (down 4 percentage points from last year). However, at individual Board level there are some considerable movements in the proportion of teams not receiving reports.

	Teams with No Report		Change 2018 – 2019 (pp)
	2018	2019	
Health and Social Care	**38%**	**34%**	**+4**
Golden Jubilee Foundation	31%	29%	+2
Healthcare Improvement Scotland	15%	19%	-4
NHS 24	34%	43%	-9
NHS Ayrshire & Arran	33%	34%	-1
NHS Borders	44%	47%	-3
NHS Dumfries & Galloway	39%	25%	+14
NHS Education for Scotland	15%	10%	+5
NHS Fife	47%	36%	+11
NHS Forth Valley	35%	26%	+9
NHS Grampian	37%	35%	+2
NHS Greater Glasgow & Clyde	41%	37%	+4
NHS Health Scotland	0%	0%	0
NHS Highland	51%	37%	+14
NHS Lanarkshire	35%	30%	+5
NHS Lothian	34%	34%	0
NHS National Services Scotland	16%	13%	+3
NHS Orkney	11%	30%	-19
NHS Shetland	44%	33%	+11
NHS Tayside	44%	38%	+6
NHS Western Isles	50%	43%	+7
Scottish Ambulance Service	33%	42%	-9
The State Hospital	23%	8%	+15

Geographic Boards

All but three of the Geographic Boards have reduced the percentage of teams not receiving reports considerably, typically reflecting the increase in response rate they have achieved. Those with the largest improvements in teams with no report are:

NHS Highland reduced the percentage of teams with no report by14pp to 37%, reflecting the 9pp increase in their overall response rate (to 60%). They typically have larger teams with an average of 13 people. The number of teams has increased only marginally from 2018 to 818 teams in 2019.

NHS Dumfries and Galloway reduced the number of teams with no report to 25% (down 14pp from 2018), again reflecting the 7pp increase in overall response rate. They have the largest average team size with 16 people per team and the total number of teams has increased 10% this year from 259 to 285.

An example of action taken in one team to increase engagement and response rate is illustrated here:

Case Study 7: Improving Response Rate

The iMatter Operational Lead and Trainee Improvement Advisor worked with a senior charge nurse and her team to improve their engagement with the iMatter questionnaire and action plan. The project had a specific measure of increasing engagement from 43% to over 60% in line with the Workforce 2020 vision of staff engagement. This was achieved – they reached 64% and obtained a team report for the first time. The engagement work included a number of actions to improve staff health and wellbeing including peer and team reporting of positive achievements and developing a stronger team ethos.

NHS Dumfries and Galloway

In **NHS Fife** the proportion of teams with no report reduced by 11pp, to 36%, reflecting the 9pp increase achieved in overall response rate. The average team size is 13 people and the number of teams has remained almost constant from 2018.

NHS Shetland also reduced the percentage of teams with no report by 11 percentage points to 33%, reflecting the 7pp increase in response rate in 2019. The number of teams in NHS Shetland reduced from 150 in 2018 to 135 in 2019 and the average team size is now 11 people.

In contrast, 30% of **NHS Orkney** teams did not receive a report in 2019, up 19pp from only 11% in 2019. As noted earlier, NHS Orkney has faced challenges this year that have impacted their overall response rate (down from 83% in 2018 to 66% in 2019) that is then reflected in the reduced share of teams receiving reports.

National Boards

Across the 8 National Boards, four have reduced the proportion of teams not receiving a report and three have a higher proportion of teams with no report in 2019. **NHS Health Scotland** has maintained its 100% record with all teams again receiving a report in 2019. It has an average team size of 10 and it has just one more team from 2018 (now 31 teams).

The State Hospital has improved the most, reducing 15pp from 23% of teams not receiving a report in 2018 to only 8% in 2019. It is noted that their overall response rate increased by 2%, but that the number of teams reduced in 2019 to 63 from 92 in 2018 (down 32%) and the average team is now 10 people.

The two National Boards with the largest increase in the proportion of teams not receiving a report are:

NHS 24 is up 9pp to 43% of teams not receiving a report. Their overall response rate dropped 5pp to 65% which will have impacted teams' potential to receive a report. NHS 24 increased the number of teams from 196 in 2018 to 214 in 2019 (an increase of 9%). The average team size is 7 people.

Scottish Ambulance Service is also up 9% in 2019 with 42% of teams not receiving a report this year, reflecting the drop of 5% in their overall response rate. The average team size is 12 people and the number of teams has increased only marginally from 2018.

The absence of a report, be that at Board or Team level, should not be a barrier to focusing on iMatter topics and striving to provide the best possible working environment for staff. One Team Story stands out as illustration of this point. Although Golden Jubilee as a Board has reached the response rate threshold each year, 29% of the teams within it did not receive a report in 2019. Golden Jubilee Conference Hotel team is one of those and the following Team Story demonstrates how Action Plans can still be effectively developed and implemented:

The **NHS Golden Jubilee Conference Hotel Team** is a large team, working shifts, that have been through many changes of personnel and management structure. The team have not received an iMatter report for the last two years. However, the team have fully engaged with the Action Planning process. They have identified 4 focus areas:

- Role clarity
- Visible and consistent leadership
- Valued as an individual
- Effective team work.

The team have been actively engaged in focus groups and have senior management commitment to valuing staff. This year they held a motivational staff appreciation day. For the future, staff will be given dedicated time to complete the iMatter survey in a safe environment

"The hard work will not stop there as we now look forward to ways we can continue to improve as a team and also how we continue deliver and improve the hotel experience to our guests and customers."

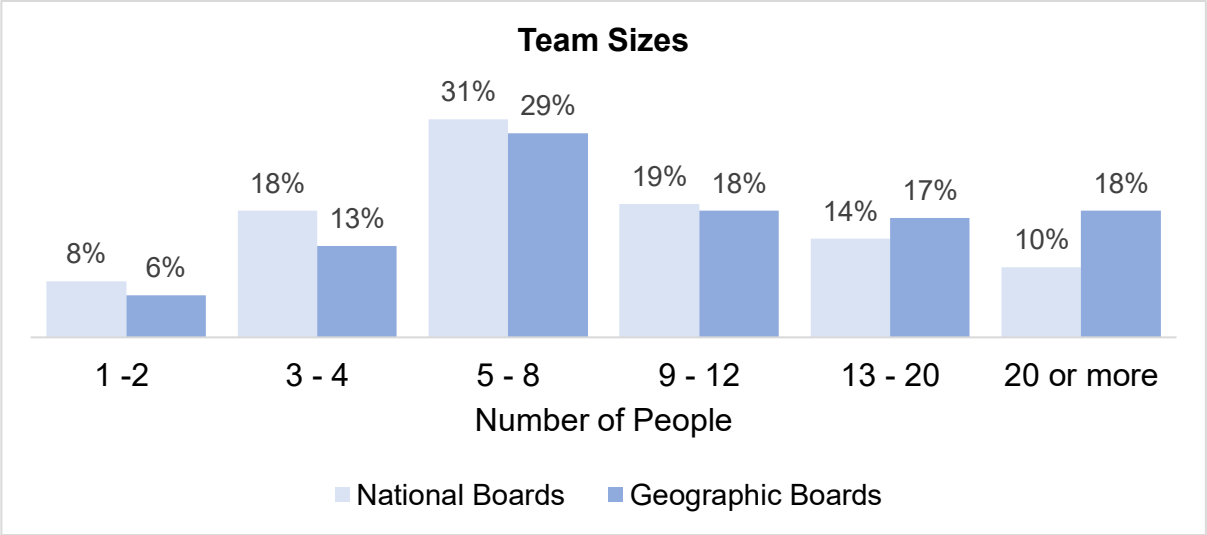
NHS Golden Jubilee, Conference Hotel Team

Impact of Team Size on No Report

Across Health and Social Care team sizes vary considerably from teams of just 1 person through to teams with more than 20 people. The distribution of team sizes below shows that of the 14,388 teams in 2019, 29% consist of 5-8 people.

	1 – 2 people	3-4 people	5-8 people	9-12 people	13-20 people	More than 20 people	Total
Number of Teams	869	1,998	4,174	2,567	2,350	2,430	14,388
Percentage of Teams	6%	14%	29%	18%	16%	17%	100%

The chart below illustrates that National Boards are more likely to have smaller teams with 26% of their teams having 4 or less people in them, compared to only 19% of Geographic Boards. In contrast, at the other end of the spectrum 18% of Geographic Board teams have 20 or more people in them, compared to only 10% of National Board teams.



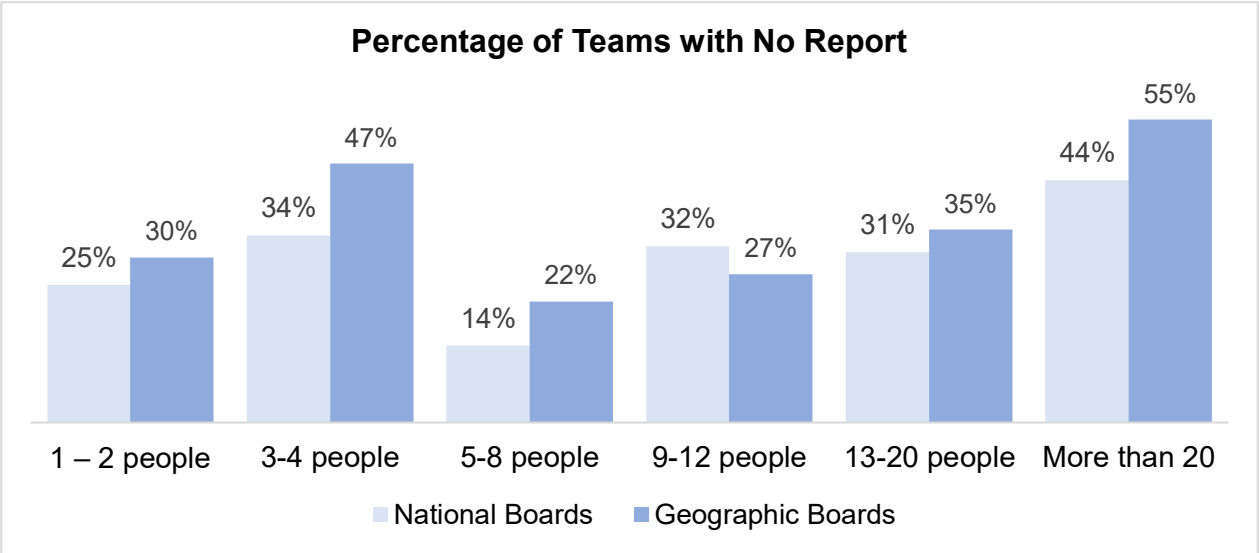
For teams with 4 or less people in, a 100% response rate is required for them to receive a report and for teams of 5 or more people a 60% response rate is required. Therefore, whilst the analysis that follows compares response rate across team sizes, it is important to bear this difference in threshold in mind when considering the results.

	1 – 2 people	3-4 people	5-8 people	9-12 people	13-20 people	20 or More	Total
Total Number of Teams	869	1,998	4,174	2,567	2,350	2,430	14,388
Number of Teams with No Report	256	899	898	713	816	1,320	4,902
% of Teams with No Report	29%	45%	22%	28%	35%	54%	34%

Among teams with 5 or more people (i.e. 60% response rate requirement) the percentage of teams not receiving a report increases as the team size grows, from 22% of teams with 5-8 people to 54% of teams with more than 20 people.

Among teams requiring 100% response rate, 29% of teams with 1 or 2 people have No Report compared to 45% of teams with 3-4 people.

These patterns are reflected in both the National and Geographic Boards, though typically at higher levels for Geographic Boards, reflecting the lower overall response rates.



Summary

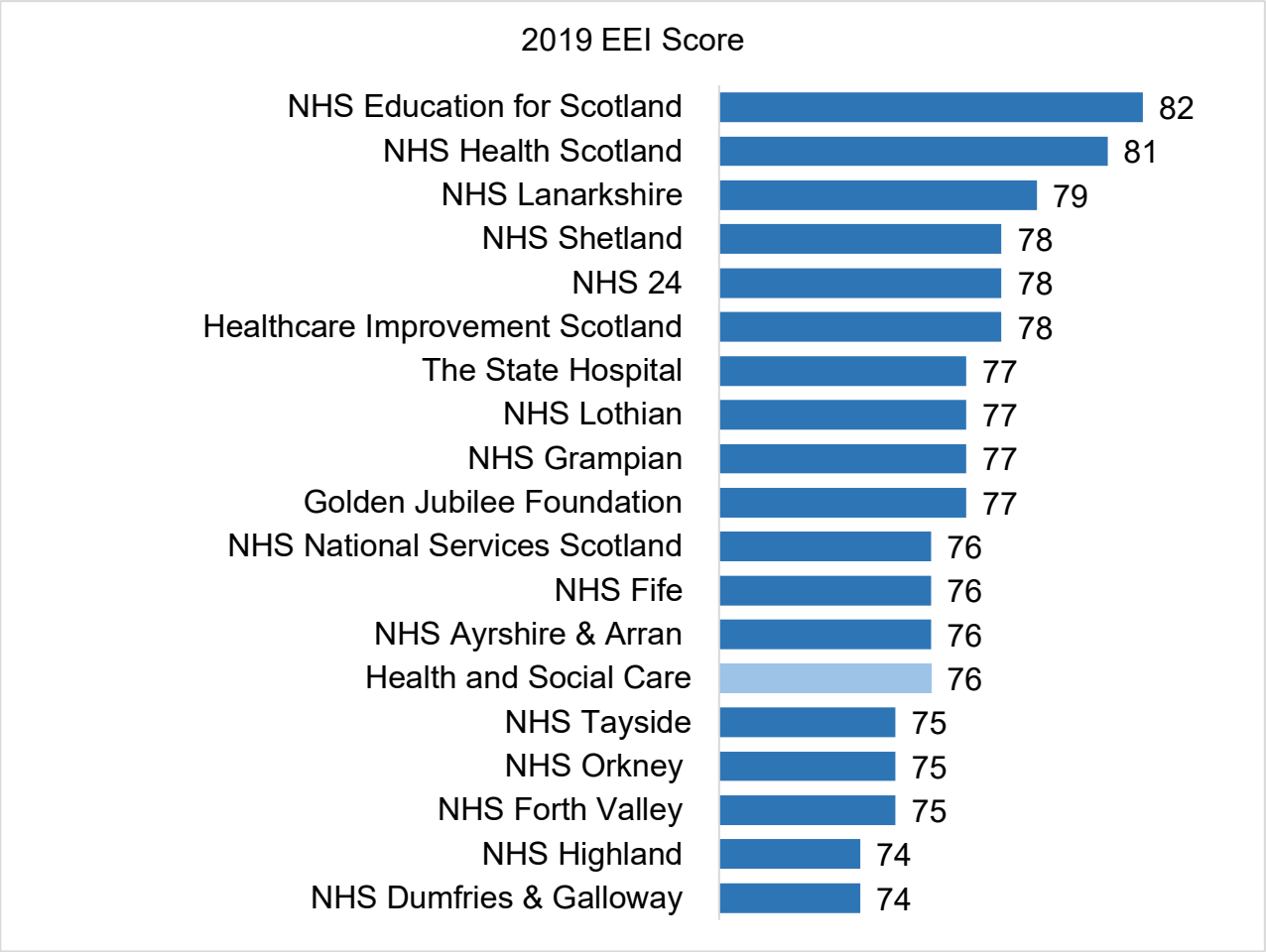
The volume of No Report at Board level has reduced with only 4 Boards not receiving and EEI report in 2019. Overall there is also a reduction in the proportion of teams not receiving a report from 38% in 2018 to 34% in 2019. These improvements reflect the overall increase in response rate. However, there are 6 Boards (3 National and 3 Geographic) that have an increase in the percentage of their team with No Report.

It is positive to see Team Story and Case Study examples of teams that have still developed an Action Plan despite not having a report, demonstrating their commitment to iMatter and to improvement.

iMatter EEI per organisation

The Employee Engagement Index (EEI) is calculated based on the number of responses for each point on the scale (Strongly Agree to Strongly Disagree) multiplied by its number value (6 to 1). These scores are added together and divided by the overall number of responses to give the score to show level of engagement.

The overall EEI score of 76 for Health and Social Care is one point higher than in 2017. There was no reported score for 2018 as the threshold response rate of 60% was not achieved.

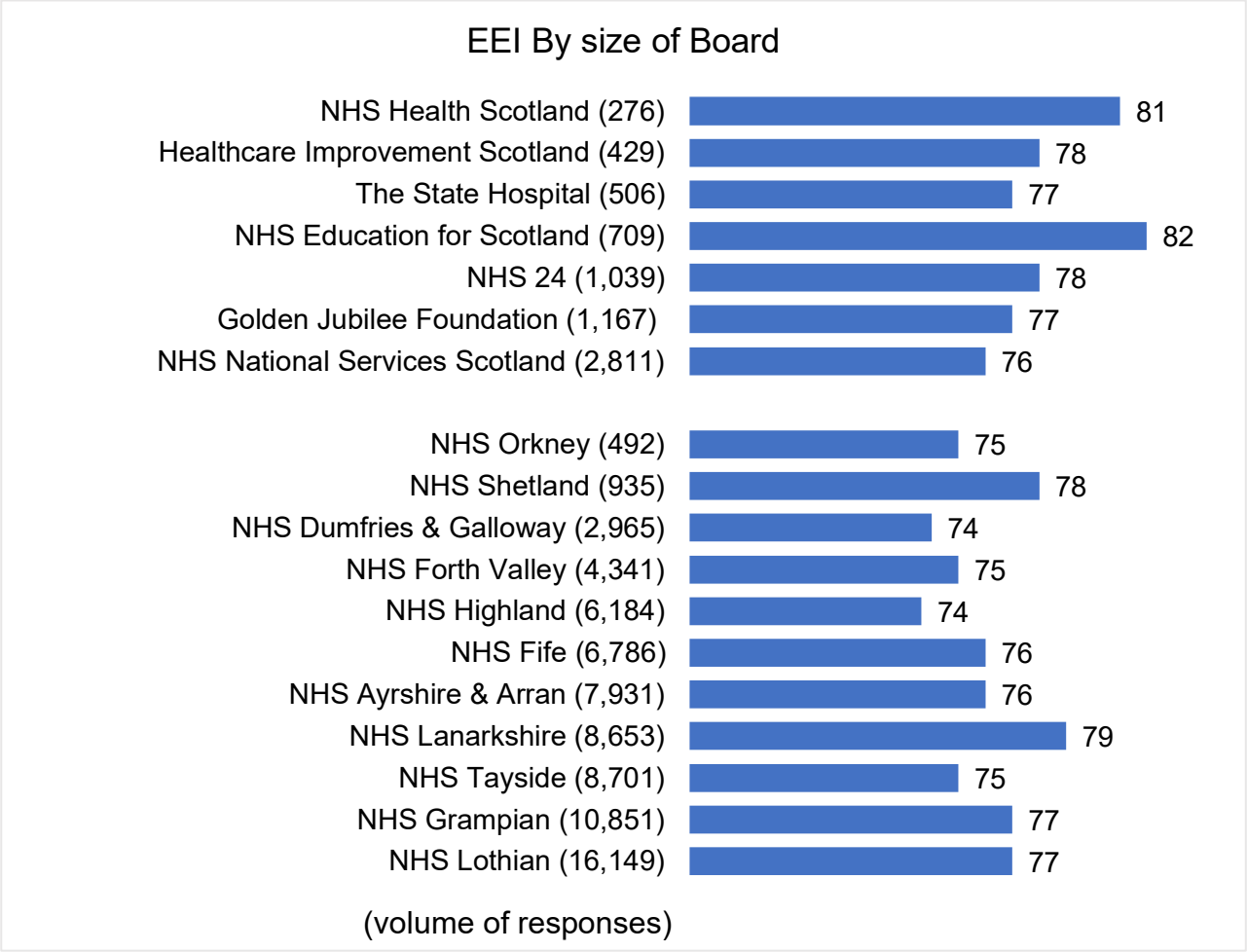


NHS Education for Scotland now has the highest ever reported Board EEI score of 82. NHS Health Scotland has the second highest score this year, remaining at 81.

Among the Geographic Boards NHS Lanarkshire has achieved the highest EEI score (79).

NHS Dumfries & Galloway and NHS Highland have the lowest reported EEI scores at 74. It is noted that the lowest EEI score in 2018 was the Scottish Ambulance Service (67) which did not reach the response rate threshold to receive a report this year.

Whilst there is a tendency overall for National Boards to have higher EEI scores than Geographic Boards, there is not a clear and obvious link between the EEI score and the size of a Board.



Comparing 2019 EEI to Previous Years

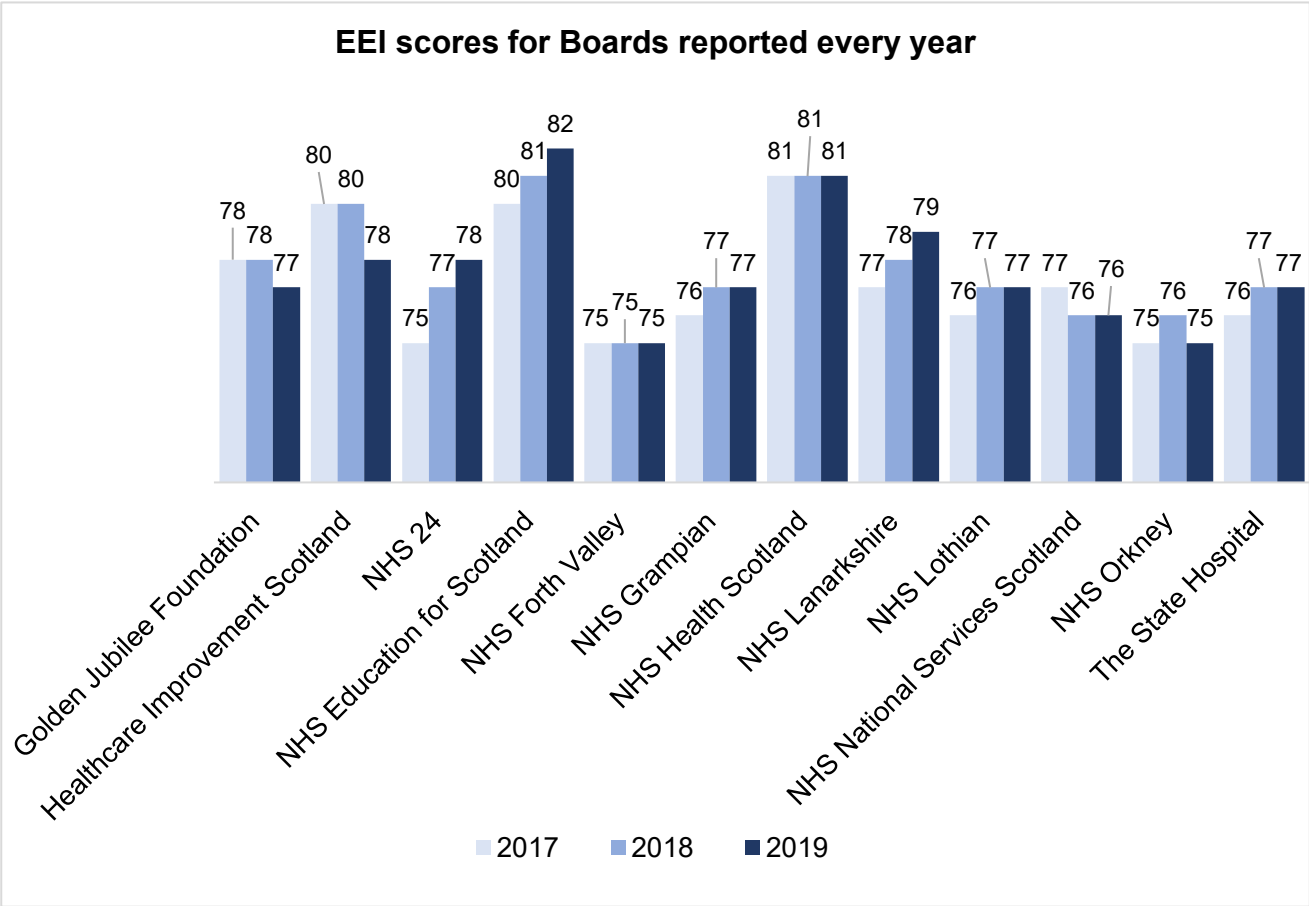
Of those Boards that received an EEI score this year 5 have increased by 1 point over their previous score (achieved in either 2018 or 2017). 8 Boards remain unchanged from their previous score. Four Boards have a lower EEI score than previously, three having gone down by 1 point and one Board (Healthcare Improvement Scotland) by 2 points.

EEI Score	2017	2018	2019	Movement from previous reported EEI*
Health and Social Care	**75**	**No Report**	**76**	**+1**
Golden Jubilee Foundation	78	78	77	-1
Healthcare Improvement Scotland	80	80	78	-2
NHS 24	75	77	78	+1
NHS Ayrshire & Arran	76	No Report	76	0
NHS Borders	74	No Report	No Report	
NHS Dumfries & Galloway	75	No Report	74	-1
NHS Education for Scotland	80	81	82	+1
NHS Fife	75	No Report	76	+1
NHS Forth Valley	75	75	75	0
NHS Grampian	76	77	77	0
NHS Greater Glasgow & Clyde	No Report	No Report	No Report	
NHS Health Scotland	81	81	81	0
NHS Highland	No Report	No Report	74	
NHS Lanarkshire	77	78	79	+1
NHS Lothian	76	77	77	0
NHS National Services Scotland	77	76	76	0
NHS Orkney	75	76	75	-1
NHS Shetland	78	No Report	78	0
NHS Tayside	74	No Report	75	+1
NHS Western Isles	No Report	No Report	No Report	
Scottish Ambulance Service	67	67	No Report	
The State Hospital	76	77	77	0

*Movement is shown from the most recent year each Board previously received a report.

Looking at the Boards who have received reports in all 3 years, it is notable that NHS 24, NHS Education for Scotland and NHS Lanarkshire have shown continuous improvement in their EEI score across all 3 years. NHS 24 have the largest reported improvement overall from 75 in 2017 to 78 in 2019

Two Boards; NHS Health Scotland and NHS Forth Valley have no reported change in their EEI score across all 3 years.



Several team stories highlight progress over 3 or 4 years of the iMatter programme, demonstrating the value in continued focus in driving sustained change as illustrated below (further examples are included within the Team Story section on this report).

The team has successfully focused on continuous improvement, by having regular reviews and open discussion. Through this process they have *"identified alternative, more effective & efficient ways of working to reduce staff pressures, alongside achieving better outcomes for service users and releasing time to care."*
This has been reflected in considerable progress in iMatter metrics:

	2017		2018		2019
Response Rate	71%		71%		80%
EEI score	61		67		74
Component results	7 Amber 11 Yellow		10 Yellow		1 Yellow
	10 Green		18 Green		27 Green

East Dunbartonshire Alcohol & Drugs Service HSCP, 'The Road to Success'

Whilst NHS Dumfries and Galloway have seen a drop of 1 point from 2017 when an EEI report was last received to 2019, the Board are utilising the QI Hub process to support staff:

Case Study 8: NHS Dumfries and Galloway QI Hub

"The Board has a local QI Hub which provides networking sessions and drop-in opportunities for staff to receive QI advice and support for their projects. There are also formal courses; around 150 staff to date have taken the Scottish Improvement Skills course. The Board is encouraging 2-3 members of a team to attend the course to build up whole team QI skills. The Board has also introduced the Scottish Coaching and Leading for Improvement course which provides more advanced training. The aim is to help local teams integrate QI skills within their projects from the outset."

NHS Dumfries and Galloway

Relationship between Response Rate and EEI

Across the Boards who have received reports in all three years, there is no consistent relationship between response rate movement and EEI movement.

	Response Rate			EEI		
Organisation	2017	2018	2019	2017	2018	2019
Golden Jubilee Foundation	68%	63%	67%	78	78	77
Healthcare Improvement Scotland	80%	86%	90%	80	80	78
NHS 24	67%	70%	65%	75	77	78
NHS Education for Scotland	81%	84%	87%	80	81	82
NHS Forth Valley	65%	62%	68%	75	75	75
NHS Grampian	64%	60%	62%	76	77	77
NHS Health Scotland	85%	91%	93%	81	81	81
NHS Lanarkshire	65%	62%	65%	77	78	79
NHS Lothian	65%	63%	63%	76	77	77
NHS National Services Scotland	76%	77%	82%	77	76	76
NHS Orkney	73%	83%	66%	75	76	75
The State Hospital	78%	77%	79%	76	77	77

Of the 4 Boards that have seen improvement in response rate year-on-year across the three years:

- NHS Education for Scotland has also seen an increase in EEI year-on-year
- Healthcare Improvement Scotland's EEI has declined each year
- The EEI for NHS Health Scotland has remained unchanged across the three years
- NHS National Services Scotland saw a drop of 1 in EEI from 2017 to 2018 and in 2019 it remained unchanged

Therefore it is reasonable to assume that continuing to increase response rates in future years will NOT have a direct detrimental effect on EEI score.

iMatter Report of EEI scores for Teams per Organisation

Across the whole of Health and Social Care (including both Boards that did receive a report and those that did not) the distribution of teams across each of the score bands is as shown below. The vast majority of teams that received a report score in Strive to Celebrate (67-100). Across the whole of Health and Social Care there are only 59 teams that have an EEI score between 34 and 50 (less than 1% of all teams) and just one team with a score of 33 or less.

Organisation	Number of Teams	Percentage of Teams
Strive & Celebrate (67-100)	8,438	59%
Monitor to Further Improve (51-66)	988	7%
Improve to Monitor (34-50)	59	0%
Focus to Improve (0-33)	1	0%
No Report	4,902	34%
Total Health and Social Care	14,388	100%

Of the 60 teams that scored 50 or less, 16 of them (27%) are in Boards that did not receive a report in 2019. This compares with 25% of the teams scoring Strive and Celebrate and 33% of the teams scoring Monitor to Further Improve being in Boards that did not receive a report.

The table overleaf shows the distribution of team scores for each Board that received a report in 2019.

NHS Health Scotland is the only board with all teams in the Strive and Celebrate band. Additionally, there is one Geographic Board and three National Boards that have all teams with reports scoring either Strive and Celebrate or Monitor to Further Improve:

- NHS Orkney
- NHS 24
- NHS Education for Scotland
- The State Hospital

90% of the volume of teams in reported Boards are in Geographic Boards and only 10% in National Boards. Of teams scoring Strive and Celebrate, 89% are in Geographic Boards reflecting the slightly lower overall EEI among Geographic Boards.

The above threshold categories were developed and recommended in the Staff Experience Project Report and Recommendations 2013 and approved in June 2013 by the Scottish Workforce and Staff Governance Committee.

Boards that received a report in 2019	Strive & Celebrate 67-100	Monitor to Further Improve 51-66	Improve to Monitor 34-50	Focus to Improve 0-33	No Report	Total
Golden Jubilee Foundation	95	7	2	0	42	146
	65%	5%	1%	0%	29%	100%
Healthcare Improvement Scotland	63	8	1	0	17	89
	71%	9%	1%	0%	19%	100%
NHS 24	110	11	0	0	93	214
	51%	5%	0%	0%	43%	100%
NHS Ayrshire & Arran	566	58	3	0	321	948
	60%	6%	0%	0%	34%	100%
NHS Dumfries & Galloway	187	25	1	0	72	285
	66%	9%	0%	0%	25%	100%
NHS Education for Scotland	91	1	0	0	10	102
	89%	1%	0%	0%	10%	100%
NHS Fife	475	45	4	0	294	818
	58%	6%	0%	0%	36%	100%
NHS Forth Valley	343	49	3	0	141	536
	64%	9%	1%	0%	26%	100%
NHS Grampian	799	76	2	0	462	1,339
	60%	6%	0%	0%	35%	100%
NHS Health Scotland	31	0	0	0	0	31
	100%	0%	0%	0%	0%	100%
NHS Highland	415	69	2	0	285	771
	54%	9%	0%	0%	37%	100%
NHS Lanarkshire	704	37	6	0	326	1,073
	66%	3%	1%	0%	30%	100%
NHS Lothian	1,313	129	10	0	736	2,188
	60%	6%	0%	0%	34%	100%
NHS National Services Scotland	285	23	2	0	45	355
	80%	6%	1%	0%	13%	100%
NHS Orkney	49	5	0	0	23	77
	64%	6%	0%	0%	30%	100%
NHS Shetland	84	6	1	0	44	135
	62%	4%	1%	0%	33%	100%
NHS Tayside	693	105	7	0	501	1,306
	53%	8%	1%	0%	38%	100%
The State Hospital	54	4	0	0	5	63
	86%	6%	0%	0%	8%	100%

EEI scores for Teams per Organisation comparison over time

The table below shows the EEI scores for the Boards that achieved reports in all three years. Percentages are based on the teams receiving a report. Overall there is consistency in the distribution of team scores over time. However, 3 Boards have increased the proportion of teams with reports scoring Strive and Celebrate across all three years

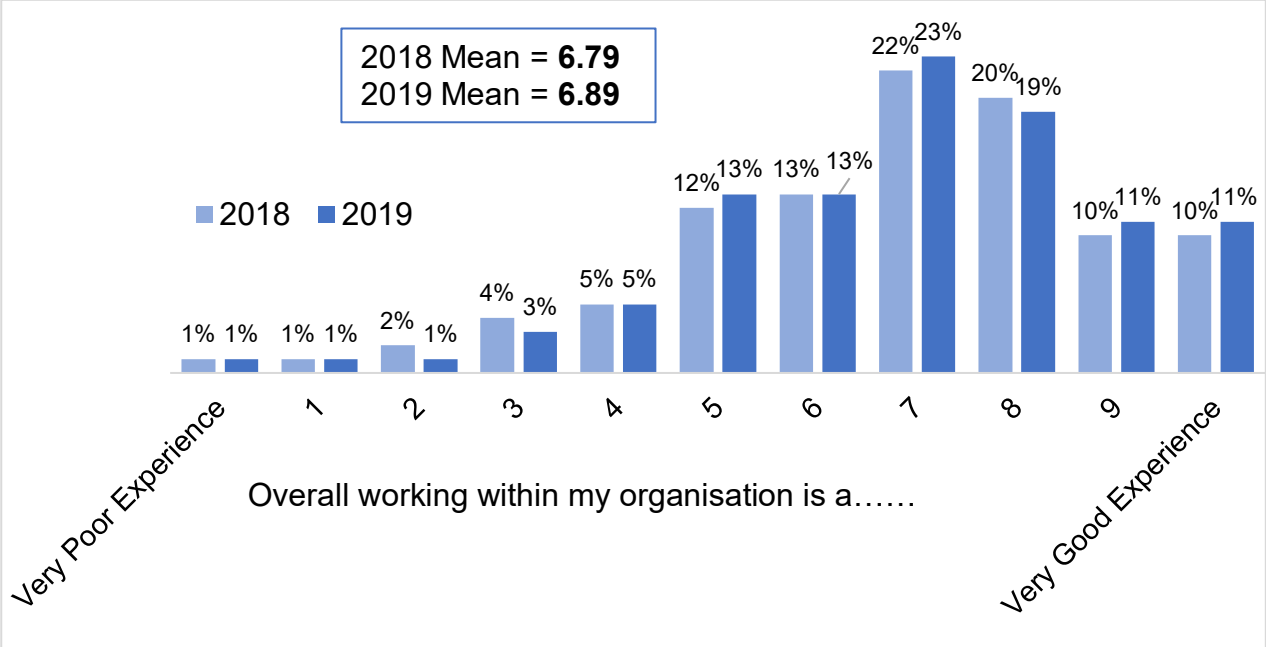
- NHS 24 (87% in 2017, 89% in 2018, 91% in 2019)
- NHS Education for Scotland (93%, 94%, 99%)
- The State Hospital (87%, 90%, 93%)

The proportion of teams with reports who have scored in the Strive and Celebrate band has decreased each year for The Golden Jubilee Foundation (95% in 2017, 93% in 2018 and 91% in 2019), leading to increases in the percentage of teams in the Monitor to Further Improve and Improve to Monitor bands.

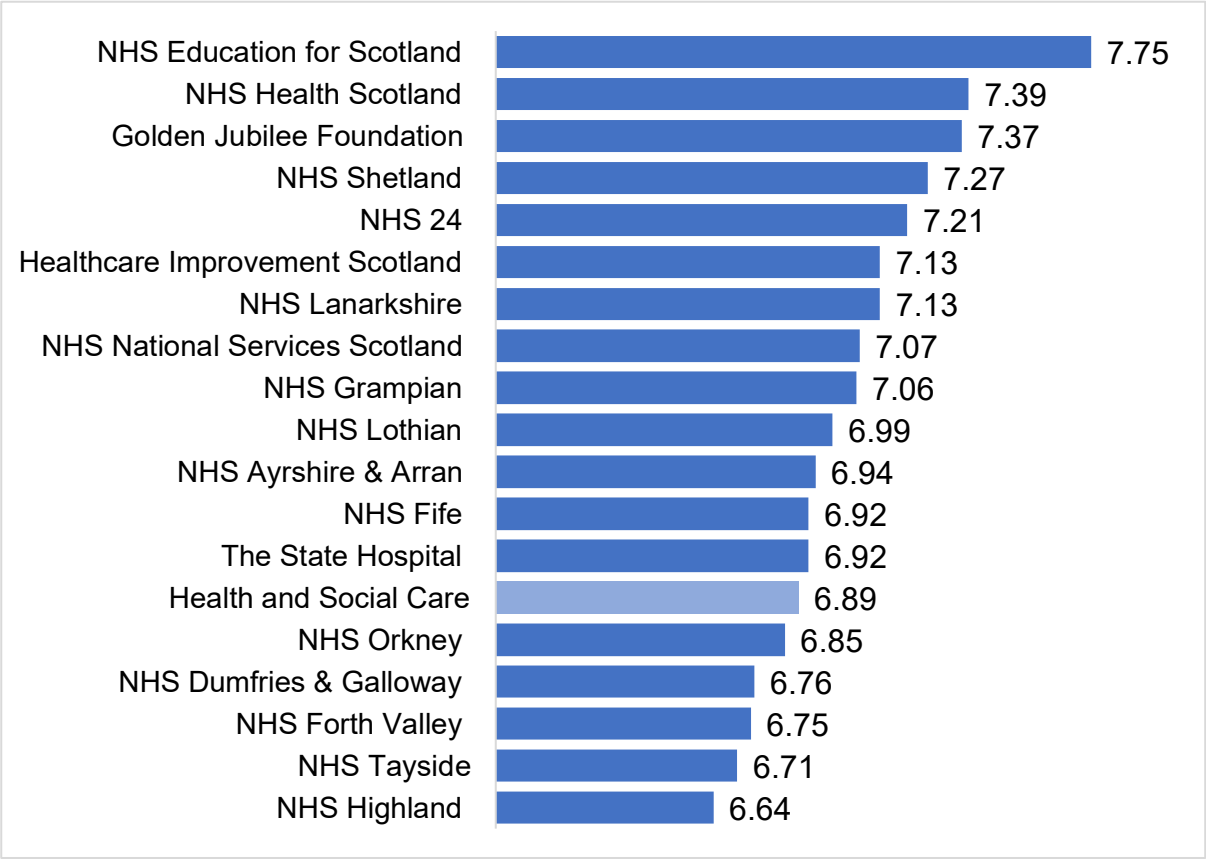
Percentages based on all Teams receiving a report		Strive & Celebrate 67-100	Monitor to Further Improve 51-66	Improve to Monitor 34-50	Focus to Improve 0-33
Golden Jubilee Foundation	2017	95%	4%	1%	0%
	2018	93%	6%	1%	0%
	2019	**91%**	**7%**	**2%**	**0%**
Healthcare Improvement Scotland	2017	90%	10%	0%	0%
	2018	93%	7%	0%	0%
	2019	**88%**	**11%**	**1%**	**0%**
NHS 24	2017	87%	13%	0%	0%
	2018	89%	11%	0%	0%
	2019	**91%**	**9%**	**0%**	**0%**
NHS Education for Scotland	2017	93%	6%	1%	0%
	2018	94%	6%	0%	0%
	2019	**99%**	**1%**	**0%**	**0%**
NHS Forth Valley	2017	90%	10%	0%	0%
	2018	87%	12%	1%	0%
	2019	**87%**	**12%**	**1%**	**0%**
NHS Grampian	2017	91%	7%	0%	0%
	2018	93%	7%	0%	0%
	2019	**91%**	**9%**	**0%**	**0%**
NHS Health Scotland	2017	100%	0%	0%	0%
	2018	100%	0%	0%	0%
	2019	**100%**	**0%**	**0%**	**0%**
NHS Lanarkshire	2017	93%	7%	0%	0%
	2018	95%	5%	0%	0%
	2019	**94%**	**5%**	**1%**	**0%**
NHS Lothian	2017	90%	10%	1%	0%
	2018	91%	8%	0%	0%
	2019	**90%**	**9%**	**1%**	**0%**
NHS National Services Scotland	2017	93%	7%	0%	0%
	2018	91%	9%	0%	0%
	2019	**92%**	**7%**	**1%**	**0%**
NHS Orkney	2017	74%	10%	1%	0%
	2018	96%	4%	0%	0%
	2019	**91%**	**9%**	**0%**	**0%**
The State Hospital	2017	87%	12%	1%	0%
	2018	90%	8%	1%	0%
	2019	**93%**	**7%**	**0%**	**0%**

Overall Experience

The overall experience question has shown a small improvement from 2018 to 2019 with an increase in the mean of 0.1 to 6.89. This increase is being driven by small increases in the percentages scoring 9 or 10 and a decrease in the percentages scoring 2 or 3.



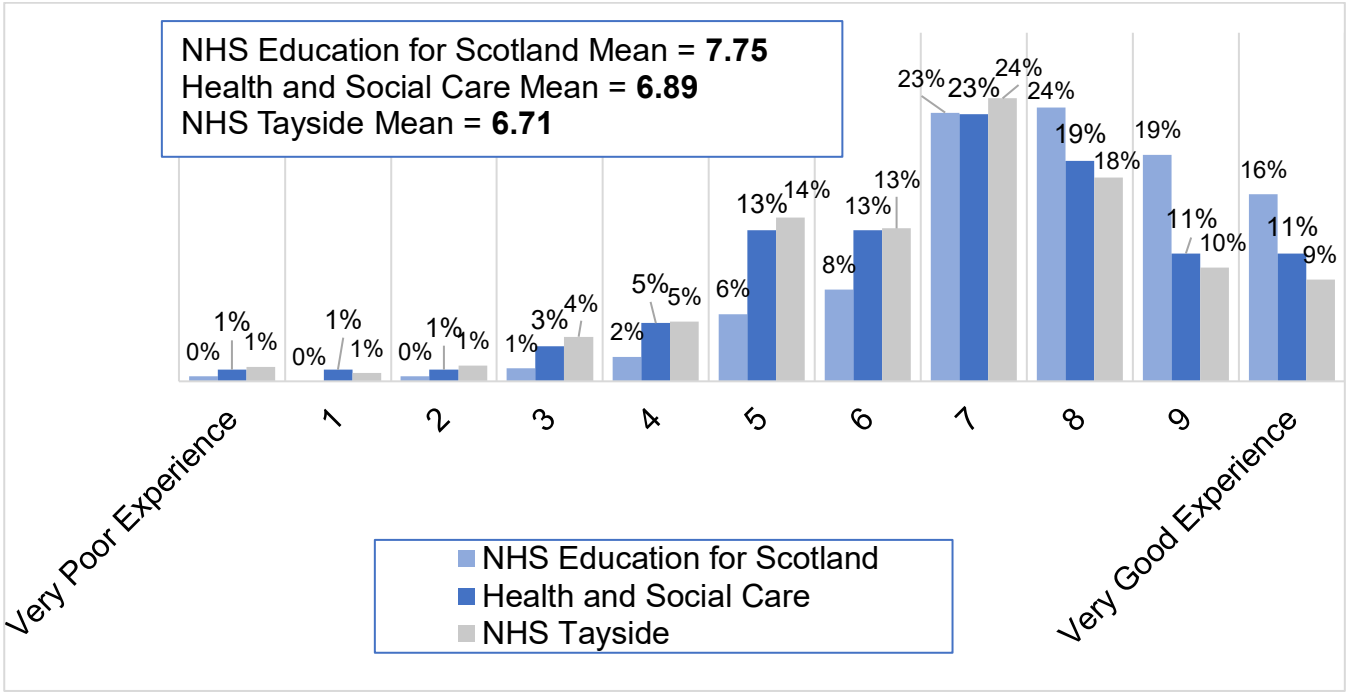
Across the Boards receiving a report, the overall experience mean score ranges from 7.75 for NHS Education for Scotland to 6.64 for NHS Highland.



The distribution of responses across the 11 point scale illustrates the differences between the highest and lowest scoring Boards. To demonstrate this point, the chart below compares the distributions for NHS Education for Scotland and NHS Tayside with the overall NHS Scotland distribution.

The high NHS Education for Scotland score is driven by a greater proportion of staff using the top end of the scale, with 59% of staff in this Board scoring 10, 9 or 8, compared to 41% of Health and Social Care staff overall. In contrast only 37% of NHS Tayside staff score 8, 9 or 10.

Distributions for all Boards receiving an EEI report are shown in Appendix 6.



Summary

The 2019 iMatter EEI score for Health and Social Care is 76, one point higher than the last reported score of 75 from 2017. Of the Boards that received an EEI score the highest is NHS Education for Scotland at 82 and the lowest NHS Dumfries and Galloway and NHS Highland, both with a score of 74. Five Boards have an improved EEI score this year, 8 are unchanged and 4 have a lower score than last time they received a report.

Several Boards show evidence of continuous improvement year on year in their EEI score, with individual Team Stories illustrating how this can be achieved through continued long-term commitment to improvement Action Plans.

At team level, the vast majority (89%) of those that receive a report score in the Strive and Celebrate band (67-100) with just 60 teams across the whole of Health and Social Care scoring 50 or less.

Staff Governance Standards – Components

Staff Governance is a key component of the governance framework used to monitor and manage the performance of NHS Scotland organisations. Staff Governance considers both how *effectively* staff are managed and also how staff *feel* they are managed. The standard was underpinned in legislation in 2004 and its component strands as shown below continue to be monitored, both locally and nationally.

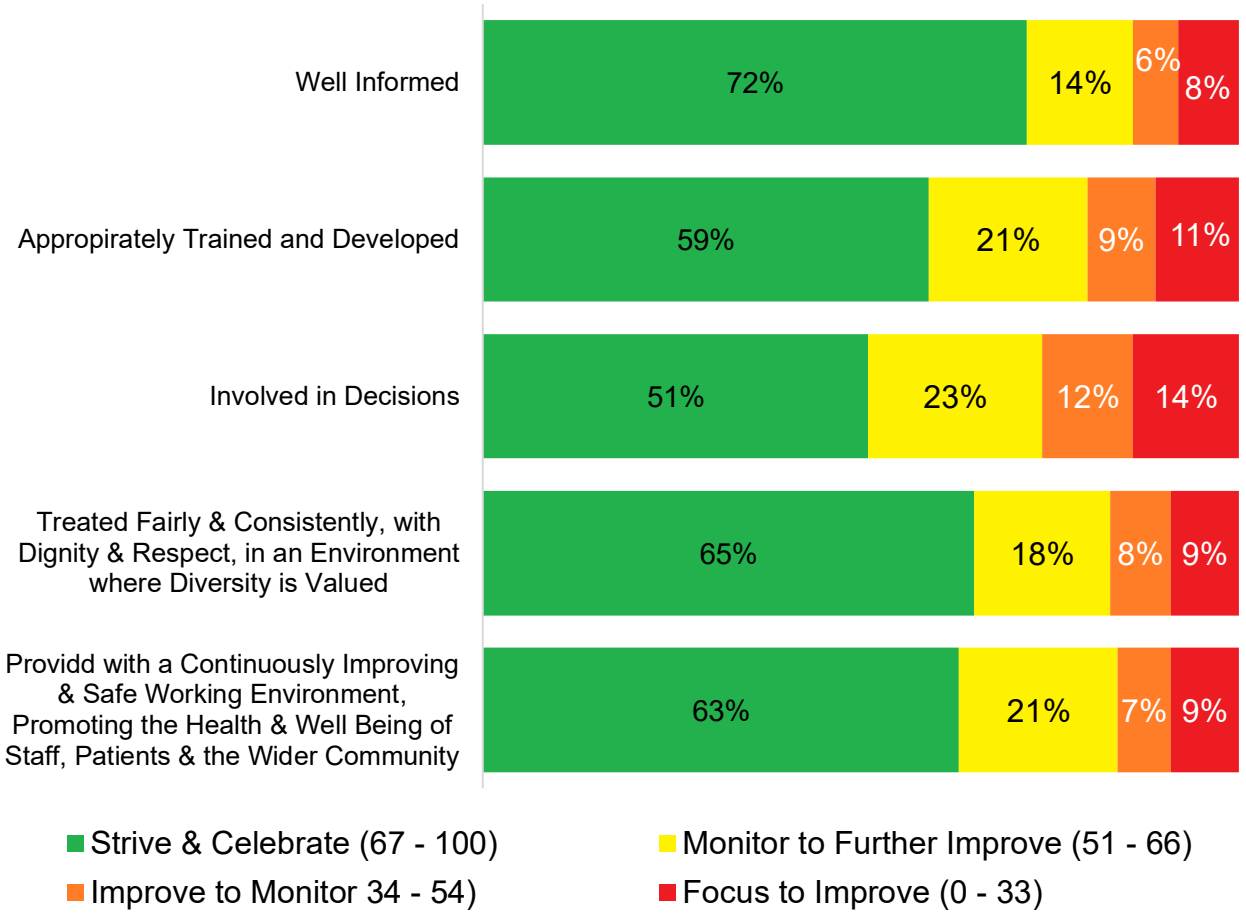
Staff Governance Standard – Scores

The strands of the Staff Governance Standard were mapped against the 20 components forming part of the Staff Experience Framework (see Appendix 7). The 28 questions were then mapped to the 20 components and Staff Governance Standards to provide a measure of Employee Engagement (see Appendix 8).

All five Staff Governance Standard Strand reported scores remain unchanged from 2018, with being 'Well Informed' the highest scoring Strand (80) and being 'Involved in decisions' (71) remaining an area for future focus.

Staff Governance Standards – Scores	Weighted Index Value		
	2017	2018	2019
Well informed	80	80	80
Appropriately trained and developed	73	74	74
Involved in decisions	71	71	71
Treated fairly & consistently, with dignity & respect, in an environment where diversity is valued	77	77	77
Provided with a continuously improving & safe working environment, promoting health & wellbeing of staff, patients & the wider community	76	77	77

The distribution of scores reflects this with 72% scoring in the Strive to Celebrate band for the ‘Well-Informed’ Strand and only 51% for the ‘Involved in Decisions’ Strand.



Staff Governance Standard - Experience as an individual

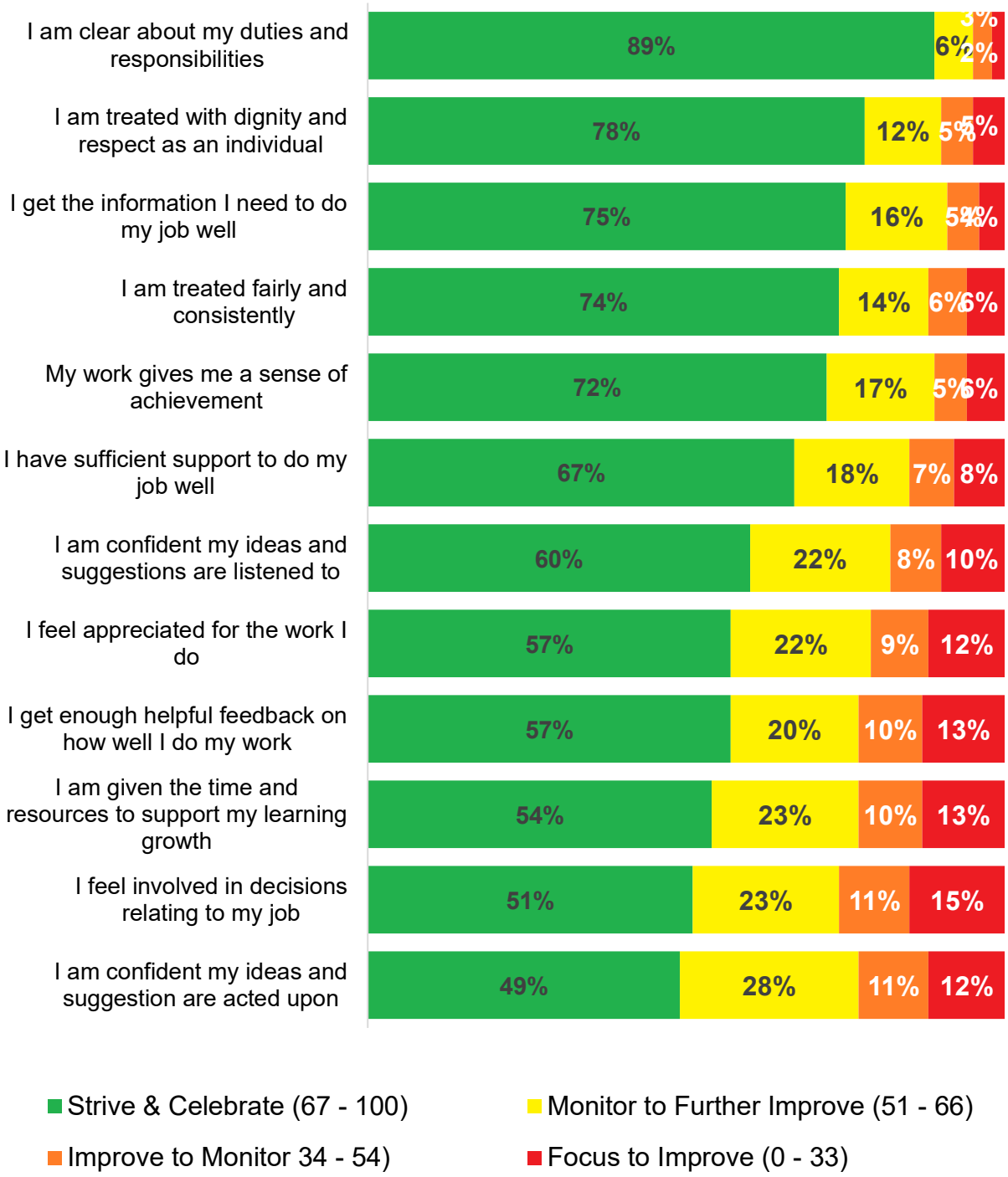
Results are aggregated for each question presented under the heading 'As an Individual'.

From 2018 to 2019 there has been very little movement in the components that comprise the 'Experience as an Individual' Strand. The highest scoring component 'I am clear about by duties and responsibilities' has dropped one point as has the lowest scoring component 'I feel involved in decisions relating to my job'.

Experience as an Individual	2017	2018	2019	Movement 2019 – 2018
I am clear about my duties and responsibilities	88	88	87	-1
I am treated with dignity and respect as an individual	82	83	83	0
I am treated fairly and consistently	81	81	81	0
My work gives me a sense of achievement	81	81	81	0
I get the information I need to do my job well	81	81	81	0
I have sufficient support to do my job well	77	78	78	0
I am confident my ideas and suggestions are listened to	75	75	75	0
I feel appreciated for the work I do	73	74	74	0
I get enough helpful feedback on how well I do my work	73	73	73	0
I am given the time and resources to support my learning growth	71	72	72	0
I am confident my ideas and suggestion are acted upon	71	71	71	0
I feel involved in decisions relating to my job	71	71	70	-1

From these scores it is evident that staff generally feel they are treated fairly and with respect and that they are clear about their responsibilities. The greater challenge is ensuring staff feel they have a voice and are given the feedback and support they feel they need.

Across the distribution of scores for each component in ‘Experience as an Individual’ there is considerable variation in the share of staff rating each component as Strive & Celebrate. At the top end, 89% of staff score in the Strive & Celebrate band for role clarity, whist only half of staff do so for feeling involved in decisions and confidence that their suggestions and ideas are acted on.



Scores for this component are consistent between National and Geographic Boards with the exception of the Scottish Ambulance Service that typically scores lower (see following for details). Staff working in Geographic Boards are usually more positive about the sense of achievement they get from their work than staff in National Boards.

Experience as an Individual Geographic Boards	NHS Greater Glasgow & Clyde	NHS Lothian	NHS Grampian	NHS Tayside	NHS Lanarkshire	NHS Ayrshire & Arran	NHS Fife	NHS Highland	NHS Forth Valley	NHS Dumfries & Galloway	NHS Borders	NHS Shetland	NHS Western Isles	NHS Orkney
Number of Responses	25,420	16,149	10,851	8,701	8,653	7,931	6,786	6,184	4,341	2,965	1,774	935	553	492
I am clear about my duties and responsibilities	88	88	87	86	89	88	88	86	87	85	87	87	87	85
I get the information I need to do my job well	81	82	81	80	84	82	81	79	80	79	80	83	81	78
I am given the time and resources to support my learning growth	71	74	74	71	75	74	72	71	70	70	71	73	72	72
I have sufficient support to do my job well	77	79	79	78	81	79	78	76	76	76	76	80	77	75
I am confident my ideas and suggestions are listened to	74	76	76	75	77	75	75	75	75	73	74	78	75	75
I am confident my ideas and suggestion are acted upon	70	72	72	71	74	71	71	70	70	69	70	74	72	72
I feel involved in decisions relating to my job	69	72	72	70	73	71	70	70	69	69	70	74	72	72
I am treated with dignity and respect as an individual	82	84	84	83	85	83	83	82	82	81	83	85	82	84
I am treated fairly and consistently	80	82	82	81	83	81	81	80	80	79	81	83	81	82
I get enough helpful feedback on how well I do my work	72	74	75	73	76	74	73	72	71	71	74	77	72	73
I feel appreciated for the work I do	72	75	75	74	76	74	73	73	72	72	75	78	73	76
My work gives me a sense of achievement	80	82	82	81	82	81	81	80	80	80	81	85	82	84

Experience as an Individual National Boards	Scottish Ambulance Service	NHS National Services Scotland	Golden Jubilee Foundation	NHS 24	NHS Education for Scotland	The State Hospital	Healthcare Improvement Scotland	NHS Health Scotland
Number of Responses	2,838	2,811	1,167	1,039	709	506	429	276
I am clear about my duties and responsibilities	84	85	89	89	87	90	83	85
I get the information I need to do my job well	72	79	83	82	82	84	79	81
I am given the time and resources to support my learning growth	56	74	75	72	80	76	75	78
I have sufficient support to do my job well	68	78	79	82	82	82	79	80
I am confident my ideas and suggestions are listened to	61	75	74	72	84	77	79	82
I am confident my ideas and suggestion are acted upon	57	71	71	68	79	73	75	77
I feel involved in decisions relating to my job	56	70	70	64	79	75	74	78
I am treated with dignity and respect as an individual	75	84	82	82	89	84	84	90
I am treated fairly and consistently	71	81	81	80	88	82	83	86
I get enough helpful feedback on how well I do my work	57	75	73	80	81	79	79	81
I feel appreciated for the work I do	61	75	74	75	82	77	79	81
My work gives me a sense of achievement	79	78	82	80	84	80	78	81

Staff Governance Standard - My Team / My Direct Line Manager

Results are aggregated for each question presented under the heading 'My Team / My Direct Line Manager'.

There is no reported movement in components in this Staff Governance Strand. Staff continue to be very positive about their line manager and their relationship with their line manager. Staff are less sure that performance is managed across their team or their level of involvement in decisions that affect them.

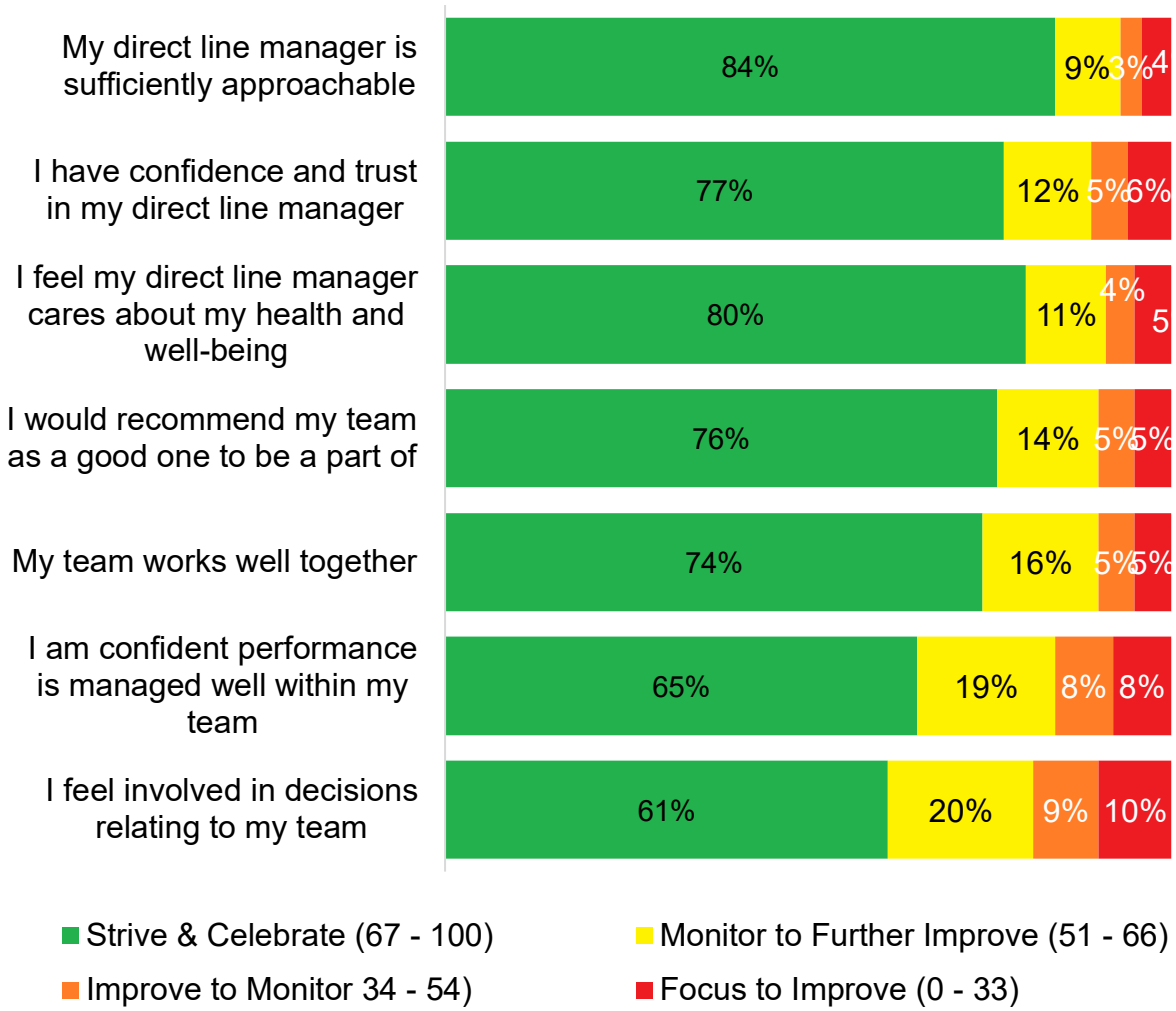
My Team/My Direct Line Manager	2017	2018	2019	Movement 2019 – 2018
My direct line manager is sufficiently approachable	86	87	87	0
I feel my direct line manager cares about my health and well-being	84	84	84	0
I have confidence and trust in my direct line manager	83	84	84	0
I would recommend my team as a good one to be a part of	82	83	83	0
My team works well together	81	82	82	0
I am confident performance is managed well within my team	77	77	77	0
I feel involved in decisions relating to my team	75	76	76	0

The importance of the line manger relationship is illustrated in this example from a team story focused on communications:

"We strongly believe we get a high iMatter score because we have a manager who fully supports us, is approachable and values our individual contributions."
NHS Education for Scotland, CPD Connect Team. Better communication means better staff experience

---

The distribution of responses for each component (shown overleaf) illustrate the high level of positivity towards line managers, with 84% of staff scoring 'My line manager is sufficiently approachable' as Strive to Celebrate and 80% doing so for 'My line manager cares about my health and wellbeing'.



Staff working in National Boards, with the exception of the Scottish Ambulance Service, typically score around 3 points higher than those working in Geographic Boards for the three line manager components. The following tables show component scores for each Geographic and National Board.

My Team/ My Direct Line Manager Geographic Boards	NHS Greater Glasgow & Clyde	NHS Lothian	NHS Grampian	NHS Tayside	NHS Lanarkshire	NHS Ayrshire & Arran	NHS Fife	NHS Highland	NHS Forth Valley	NHS Dumfries & Galloway	NHS Borders	NHS Shetland	NHS Western Isles	NHS Orkney
Number of Responses	25,420	16,149	10,851	8,701	8,653	7,931	6,786	6,184	4,341	2,965	1,774	935	553	492
I feel my direct line manager cares about my health and well-being	84	85	84	84	87	85	84	83	83	82	84	86	83	84
My direct line manager is sufficiently approachable	87	87	86	87	89	87	86	85	85	85	86	87	85	85
I have confidence and trust in my direct line manager	83	84	84	83	86	84	83	82	82	81	83	84	82	81
I feel involved in decisions relating to my team	75	77	77	75	79	76	75	75	75	74	75	78	75	76
I am confident performance is managed well within my team	77	78	78	76	81	78	77	76	76	74	76	78	75	75
My team works well together	82	83	81	82	84	83	82	81	81	80	81	83	80	81
I would recommend my team as a good one to be a part of	82	84	83	83	85	84	83	82	83	82	83	84	81	82

My Team/ My Direct Line Manager National Boards	Scottish Ambulance Service	NHS National Services Scotland	Golden Jubilee Foundation	NHS 24	NHS Education for Scotland	The State Hospital	Healthcare Improvement Scotland	NHS Health Scotland
Number of Responses	2,838	2,811	1,167	1,039	709	506	429	276
I feel my direct line manager cares about my health and well-being	79	87	83	90	91	87	90	91
My direct line manager is sufficiently approachable	83	88	86	92	91	90	91	92
I have confidence and trust in my direct line manager	79	85	83	90	89	86	88	88
I feel involved in decisions relating to my team	67	76	75	77	82	80	81	84
I am confident performance is managed well within my team	69	77	77	84	82	81	78	82
My team works well together	75	81	81	80	86	85	81	85
I would recommend my team as a good one to be a part of	77	82	82	84	87	86	83	86

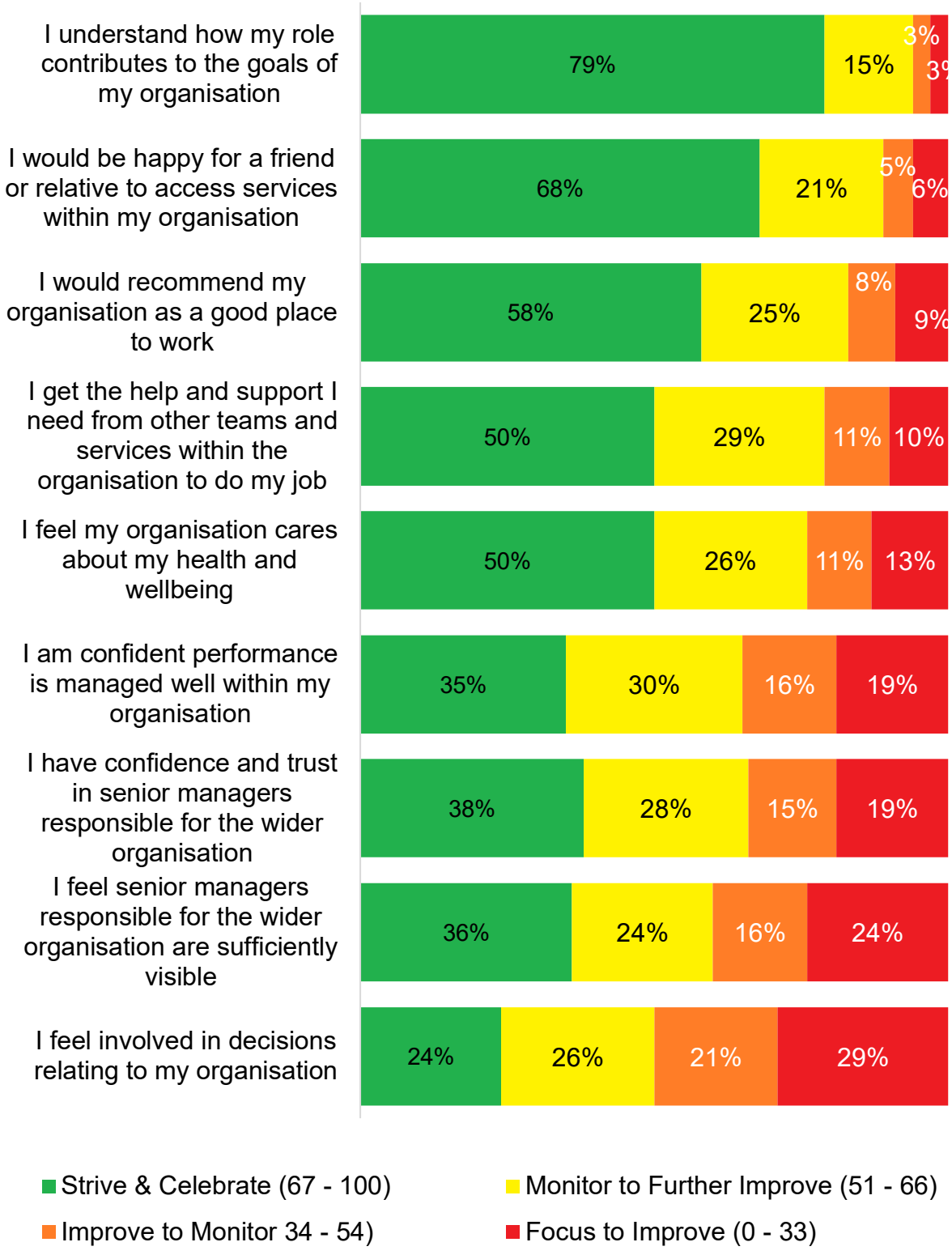
Staff Governance Standard - My Organisation

Results are aggregated for each question presented under the heading 'My Organisation', where Organisation refers to and includes both the relevant NHS Board and Health & Social Care Partnership(s). 'Senior Managers' refers to the Chair, Chief Executive, Non-Executives and Directors/Chief Officer.

Although reported movements are only one point, it is notable that the scores for half of the components in this strand have declined. The highest scoring competent remains staff's understanding of how their role contributes to the organisation's goals, though it has dropped from 83 to 82.

My Organisation	2017	2018	2019	Movement 2019 – 2018
I understand how my role contributes to the goals of my organisation	82	83	82	-1
I would be happy for a friend or relative to access services within my organisation	78	78	78	0
I would recommend my organisation as a good place to work	74	74	74	0
I get the help and support I need from other teams and services within the organisation to do my job	71	72	71	-1
I feel my organisation cares about my health and wellbeing	70	71	70	-1
I am confident performance is managed well within my organisation	64	64	64	0
I have confidence and trust in senior managers responsible for the wider organisation	64	65	64	-1
I feel senior managers responsible for the wider organisation are sufficiently visible	62	62	62	0
I feel involved in decisions relating to my organisation	57	57	57	0

Staff in National Boards, with the exception of Scottish Ambulance Service, are more likely than those in Geographic Boards to say they would recommend the organisation as a good place to work.


I understand how my role contributes to the goals of my organisation
79%
15%
3%
I would be happy for a friend or relative to access services within my organisation
68%
21%
5%
6%
I would recommend my organisation as a good place to work
58%
25%
8%
9%
I get the help and support I need from other teams and services within the organisation to do my job
50%
29%
11%
10%
I feel my organisation cares about my health and wellbeing
50%
26%
11%
13%
I am confident performance is managed well within my organisation
35%
30%
16%
19%
I have confidence and trust in senior managers responsible for the wider organisation
38%
28%
15%
19%
I feel senior managers responsible for the wider organisation are sufficiently visible
36%
24%
16%
24%
I feel involved in decisions relating to my organisation
24%
26%
21%
29%
Strive & Celebrate (67 - 100)
Monitor to Further Improve (51 - 66)
Improve to Monitor 34 - 54)
Focus to Improve (0 - 33)

My Organisation Geographic Boards	NHS Greater Glasgow & Clyde	NHS Lothian	NHS Grampian	NHS Tayside	NHS Lanarkshire	NHS Ayrshire & Arran	NHS Fife	NHS Highland	NHS Forth Valley	NHS Dumfries & Galloway	NHS Borders	NHS Shetland	NHS Western Isles	NHS Orkney
Number of Responses	25,420	16,149	10,851	8,701	8,653	7,931	6,786	6,184	4,341	2,965	1,774	935	553	492
I understand how my role contributes to the goals of my organisation	83	83	83	81	85	83	83	81	81	81	82	84	82	82
I feel my organisation cares about my health and wellbeing	70	71	73	68	73	72	71	69	69	69	69	75	69	72
I feel senior managers responsible for the wider organisation are sufficiently visible	62	64	63	59	66	63	61	58	60	62	58	66	59	62
I have confidence and trust in senior managers responsible for the wider organisation	65	66	66	60	69	65	65	59	63	64	60	68	60	62
I feel involved in decisions relating to my organisation	57	58	59	54	61	57	56	54	55	57	53	61	55	57
I am confident performance is managed well within my organisation	64	66	66	61	69	65	65	59	63	63	59	67	59	61
I get the help and support I need from other teams and services within the organisation to do my job	71	72	72	70	74	72	71	69	70	71	70	75	72	72
I would recommend my organisation as a good place to work	74	76	76	72	77	75	75	72	73	74	73	78	73	75
I would be happy for a friend or relative to access services within my organisation	78	79	79	77	80	78	78	77	77	77	77	82	78	79

My Organisation National Boards	Scottish Ambulance Service	NHS National Services Scotland	Golden Jubilee Foundation	NHS 24	NHS Education for Scotland	The State Hospital	Healthcare Improvement Scotland	NHS Health Scotland
Number of Responses	2,838	2,811	1,167	1,039	709	506	429	276
I understand how my role contributes to the goals of my organisation	78	81	83	85	84	83	81	83
I feel my organisation cares about my health and wellbeing	58	75	73	73	81	69	75	80
I feel senior managers responsible for the wider organisation are sufficiently visible	50	64	64	67	70	63	66	71
I have confidence and trust in senior managers responsible for the wider organisation	52	66	68	69	73	62	68	70
I feel involved in decisions relating to my organisation	46	57	59	58	63	60	60	69
I am confident performance is managed well within my organisation	51	62	67	69	69	60	61	66
I get the help and support I need from other teams and services within the organisation to do my job	60	72	73	73	76	72	73	72
I would recommend my organisation as a good place to work	65	77	81	78	84	73	77	81
I would be happy for a friend or relative to access services within my organisation	71	79	85	85	85	71	79	82

Confidence and trust in senior managers has dropped back from 65 in 2018 to 64 in 2019 as it was in 2017, suggesting this is an area that still needs focus. It is important to take action in this area as it is a component that is important in driving staff's overall opinion of working in the organisation.

Two team stories provide examples of how the need to build visibility and ultimately trust in senior managers:

Previous senior team roadshows had been poorly attended and so a new approach was needed. Several specific actions were taken:
1. The Service Manager and Head of MHLDS made regular ward 'walk arounds' that highlighted how many staff didn't know who the senior management team were
2. Developed a 'Who's Who' board for the staff room with photos and role descriptions
3. A staff survey is being run to find out how staff would prefer senior management to communicate with them

NHS Grampian, Mental Health & Disabilities Drum Ward

In order to address concerns around senior staff visibility:

"The team suggested that senior managers could be more instantly visible to all staff if they embraced the "Hello my name is" badges and will seek to invite members of the senior management team to team meetings and consider what they wish to promote and share at these engagements."

NHS Greater Glasgow & Clyde, AHP Medicine

The component score for "I feel my organisation cares about my health and wellbeing" has reduced by 1 point in 2019 to 70. This is in sharp contrast to the equivalent rating for line managers caring about staff health and wellbeing which at 84 is one of the highest scoring components.

Staff feeling that the organisation cares about their health and wellbeing is a very important component in driving overall opinion and it is positive that several team stories focus in on health and well being. One particular story from the **Scottish Ambulance Service RUOK? Team** at **Livingston Station**, explores ways of supporting staff's health and wellbeing more effectively. It also demonstrates how the commitment of one individual can grow through their team to ultimately be rolled out across the whole Board and beyond. See overleaf for an introduction to the project and the impact it has had on staff:

"This is the story of how two colleagues identified a need for better welfare support and collaborated to improve staff experience whilst removing the stigma of mental health, not just in their own local teams, but throughout the Scottish Ambulance Service and extending to Ambulance Trusts across the UK. The introduction of iMatter gave them hope that they could discuss staff welfare and staff experience issues openly. Their journey demonstrates how individuals can engage in the workplace to effect change for the benefit of all."

"It was uplifting to hear you, it meant a great deal to me personally learning that I was not alone in the service and I was not unique having the dark time I had. Your work is vital and is without a doubt a lifesaver." – Paramedic

"Having someone who has been through it and is brave enough to speak about their experience really helped. I think it will help a lot of people feel confident to speak up." – Call taker

"You may feel that you are alone when you feel down but actually there is help." - Firefighter

Scottish Ambulance Service RUOK? Team at **Livingston Station**

Staff Groupings

For the first time in 2019, staff were asked to confirm which staff grouping they belonged to. This allows both comparison between Local Authority and NHSScotland employees and comparison of staff groupings within each employer.

Although these questions were optional almost all staff chose to answer them: 99% of staff confirmed whether they were NHSScotland or Local Authority Employees. Of those, 98% of the NHSScotland Employees and 99% of the Local Authority Employees identified which Staff Grouping they belonged to. Details of the number of responses from each staff grouping are shown in Appendix 5. Looking firstly at the comparison between Local Authority staff and NHSScotland employees:

	Local Authority	NHS Scotland	Difference
I am clear about my duties and responsibilities	87	87	0
I get the information I need to do my job well	80	81	-1
I am given the time and resources to support my learning growth	73	72	+1
I have sufficient support to do my job well	78	78	0
I am confident my ideas and suggestions are listened to	76	75	+1
I am confident my ideas and suggestion are acted upon	71	71	0
I feel involved in decisions relating to my job	70	70	0
I am treated with dignity and respect as an individual	83	83	0
I am treated fairly and consistently	81	81	0
I get enough helpful feedback on how well I do my work	76	73	+3
I feel appreciated for the work I do	75	73	+2
My work gives me a sense of achievement	82	81	+1
I feel my direct line manager cares about my health and well-being	86	84	+2
My direct line manager is sufficiently approachable	88	86	+2
I have confidence and trust in my direct line manager	85	84	+1
I feel involved in decisions relating to my team	77	75	+2
I am confident performance is managed well within my team	79	77	+2
My team works well together	82	82	0
I would recommend my team as a good one to be a part of	84	83	+1
I understand how my role contributes to the goals of my organisation	83	82	+1
I feel my organisation cares about my health and wellbeing	72	70	+2
I feel senior managers responsible for the wider organisation are sufficiently visible	64	62	+2
I have confidence and trust in senior managers responsible for the wider organisation	67	64	+3
I feel involved in decisions relating to my organisation	59	57	+2
I am confident performance is managed well within my organisation	67	63	+4
I get the help and support I need from other teams and services within the organisation to do my job	72	71	+1
I would recommend my organisation as a good place to work	75	74	+1
I would be happy for a friend or relative to access services within my organisation	78	78	0

From the previous table it is evident that Local Authority staff typically score a little higher overall than NHSScotland staff. There is only one component "**I get the information I need to do my job well"** where NHSScotland staff score higher. Local Authority staff score two components 3 points higher (**I have confidence and trust in senior managers responsible for the wider organisation**, **I get enough helpful feedback on how well I do my work**) and one where the score is 4 points higher (**I am confident performance is managed well within my organisation).**

Local Authority Staff

The table overleaf show how ratings differ across the staff groupings within the Local Authority staff. Overall staff in Criminal Justice and Strategic Development tend to score highest and staff in Older People tend to score lowest.

The components that show the greatest variation across staff groupings are

- 'I am confident performance is managed well within my organisation' ranging from 64 among Local Authority Senior Managers to 68 among Criminal Justice staff
- 'I feel my organisation cares about my health and wellbeing' with staff in Older People scoring 71 and Strategic Development scoring 75
- 'I would be happy for a friend or relative to access services within my organisation', varying from 77 among Older People staff to 81 for Strategic Development staff and Local Authority Senior Managers
- 'I am given the time and resources to support my learning growth' ranging from 72 for Older People staff to 76 among Criminal Justice and Strategic Development staff

The most consistent component across the Local Authority staff groupings is 'My direct line manager is sufficiently approachable'.

Local Authority Staff Groupings	Adult Services	Business Services	Childrens Services	Criminal Justice	Older People	LA Senior Managers	Strategic Dev	Difference highest to lowest
I am clear about my duties and responsibilities	86	87	87	88	86	87	88	2
I get the information I need to do my job well	80	80	80	81	79	79	81	2
I am given the time and resources to support my learning growth	73	73	73	76	72	73	76	4
I have sufficient support to do my job well	79	79	79	80	78	80	80	2
I am confident my ideas and suggestions are listened to	76	75	76	77	75	76	77	2
I am confident my ideas and suggestion are acted upon	71	71	72	73	71	72	74	3
I feel involved in decisions relating to my job	70	70	70	72	70	70	72	2
I am treated with dignity and respect as an individual	83	83	84	84	83	84	85	2
I am treated fairly and consistently	82	81	82	82	81	83	84	3
I get enough helpful feedback on how well I do my work	76	75	76	76	76	76	78	3
I feel appreciated for the work I do	76	75	76	77	75	78	78	3
My work gives me a sense of achievement	83	84	84	85	83	85	85	2
I feel my direct line manager cares about my health and well-being	86	85	86	87	86	87	88	3
My direct line manager is sufficiently approachable	88	88	88	89	88	89	89	1
I have confidence and trust in my direct line manager	85	84	85	86	85	87	87	3
I feel involved in decisions relating to my team	76	76	76	77	76	78	78	2
I am confident performance is managed well within my team	78	79	79	80	78	81	81	3
My team works well together	85	83	83	84	82	84	84	3
I would recommend my team as a good one to be a part of	84	85	84	86	84	86	86	2
I understand how my role contributes to the goals of my organisation	83	83	84	84	83	82	83	2
I feel my organisation cares about my health and wellbeing	72	72	72	74	71	73	75	4
I feel senior managers responsible for the wider organisation are sufficiently visible	63	62	63	63	62	61	63	2
I have confidence and trust in senior managers responsible for the wider organisation	66	65	66	67	65	65	66	2
I feel involved in decisions relating to my organisation	59	58	59	59	58	57	58	2
I am confident performance is managed well within my organisation	67	67	67	68	66	64	66	4
I get the help and support I need from other teams and services within the organisation to do my job	73	73	73	74	72	72	74	2
I would recommend my organisation as a good place to work	75	76	76	77	75	76	77	2
I would be happy for a friend or relative to access services within my organisation	78	79	79	80	77	81	81	4

NHSScotland Employees
The table overleaf shows component scores for each of the NHSScotland Employee Staff Groupings.

There are some considerable variations across the NHSScotland staff groupings with the Ambulance Services staff the least positive, typically scoring 10 points lower than the average of all NHSScotland employees. NHSSenior Managers are the most positive, typically 5 points above the average of all NHS Scotland employees.

There are some huge differences in individual component scores across the NHSScotland Staff Groupings, typically with the two mentioned groups being the highest and lowest. Of most note are those that differ by over 20 points:

- I feel involved in decisions relating to my job (26)
- I feel involved in decisions relating to my organisation (26)
- I get enough helpful feedback on how well I do my work (24)
- I feel senior managers responsible for the wider organisation are sufficiently visible (23)
- I am confident my ideas and suggestion are acted upon (23)
- I am confident my ideas and suggestions are listened to (23)
- I have confidence and trust in senior managers responsible for the wider organisation (22)
- I am given the time and resources to support my learning growth (22)
- I feel appreciated for the work I do (21)

Looking specifically at Scottish Ambulance Service staff, the highest scoring components are:

- I am clear about my duties and responsibilities (85)
- My direct line manager is sufficiently approachable (83)

The lowest scoring components for Ambulance Service staff are:

- I feel involved in decisions relating to my organisation (45)
- I fee senior managers responsible for the wider organisation are sufficiently visible (49)

NHSScotland Employee Staff Groupings	Admin Services	Health Professional	Ambulance Services	Health Sciences	Medical Dental	Medical & Dental Support	Nursing & Midwifery	Other Therapeutic	Personal & Social Care	NHS Senior Managers	Support Services	Difference high to low
I am clear about my duties and responsibilities	86	87	85	85	88	88	89	86	86	88	88	3
I get the information I need to do my job well	80	82	72	78	81	82	83	81	79	82	81	11
I am given the time and resources to support my learning growth	74	70	55	67	73	75	72	72	74	77	75	22
I have sufficient support to do my job well	78	78	67	75	75	80	79	78	78	78	78	13
I am confident my ideas and suggestions are listened to	75	77	60	72	73	73	76	78	75	83	71	23
I am confident my ideas and suggestion are acted upon	71	72	56	68	68	69	72	73	72	79	68	23
I feel involved in decisions relating to my job	70	72	55	67	71	69	71	73	71	81	68	26
I am treated with dignity and respect as an individual	83	85	74	81	83	81	83	86	82	87	79	13
I am treated fairly and consistently	81	83	71	78	81	79	81	84	80	86	78	15
I get enough helpful feedback on how well I do my work	74	74	56	69	72	72	74	74	73	80	71	24
I feel appreciated for the work I do	74	75	60	70	73	73	74	77	74	81	71	21
My work gives me a sense of achievement	78	83	79	78	82	80	82	81	84	85	78	7
I feel my direct line manager cares about my health and well-being	85	86	78	82	83	84	84	87	82	89	80	11
My direct line manager is sufficiently approachable	87	88	83	84	86	84	87	88	85	90	83	7
I have confidence and trust in my direct line manager	83	85	79	80	84	82	84	86	82	88	80	10
I feel involved in decisions relating to my team	75	77	66	71	75	73	77	77	75	84	73	18
I am confident performance is managed well within my team	77	78	68	71	76	76	79	77	78	81	76	13
My team works well together	81	83	75	77	82	80	83	81	80	82	79	8
I would recommend my team as a good one to be a part of	81	84	76	78	83	81	85	83	81	84	80	9
I understand how my role contributes to the goals of my organisation	82	86	78	81	79	83	83	82	83	88	83	10
I feel my organisation cares about my health and wellbeing	74	70	57	70	67	72	68	71	73	78	73	21
I feel senior managers responsible for the wider organisation are sufficiently visible	63	59	49	58	59	62	61	60	64	72	62	23
I have confidence and trust in senior managers responsible for the wider organisation	65	62	51	61	61	64	64	64	66	73	64	22
I feel involved in decisions relating to my organisation	56	55	45	52	55	55	55	54	59	71	58	26
I am confident performance is managed well within my organisation	63	62	50	60	61	64	62	62	66	67	65	17
I get the help and support I need from other teams and services within the organisation to do my job	72	71	60	68	69	71	71	71	72	75	69	15
I would recommend my organisation as a good place to work	76	74	65	72	73	74	74	75	76	80	75	15
I would be happy for a friend or relative to access services within my organisation	79	79	71	77	79	80	78	79	79	85	77	14

Summary

Staff Governance Stand Scores have all remained unchanged from 2018, with Well Informed continuing to be the highest scoring strand (80) and Involved in Decisions the lowest (71). Within each strand there is very little movement in individual components, with just 6 components having dropped by 1 point from 2018.

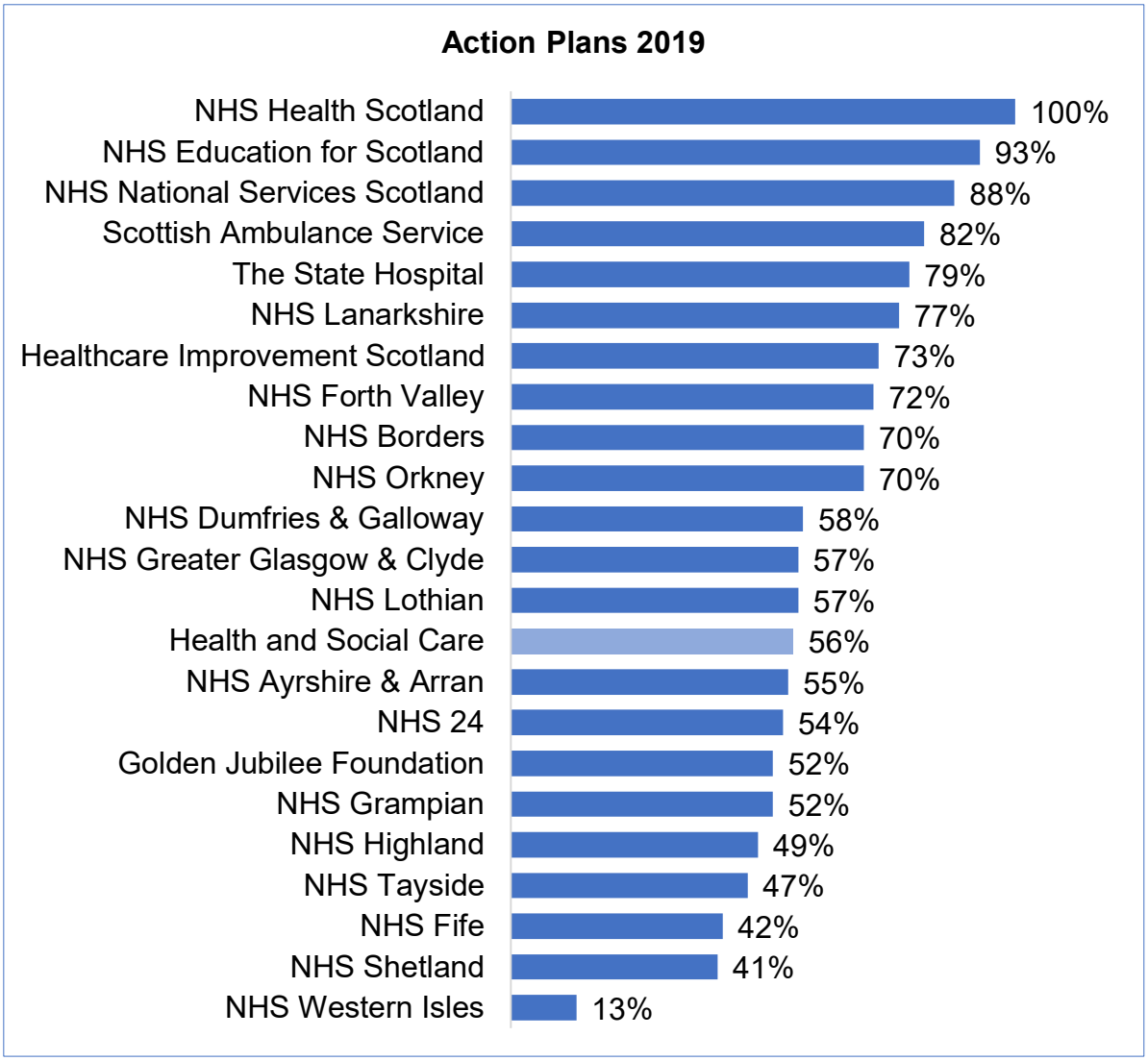
National Boards (with the exception of the Scottish Ambulance Service) typically score higher than Geographic Boards for line management components, but lower for the sense of achievement gained from their work.

The importance of staff feeling that the organisation cares about their health and wellbeing is evident and is well illustrated by the Scottish Ambulance Service RUOK? Team Story.

The inclusion of Staff Grouping analysis for the first time this year provides new insight into the views of staff in different roles. At an overall level Local Authority Staff tend to score slightly higher than NHSScotland Within the two Employer Groups, staff opinions differ considerably depending on their role. For example, within NHSScotland Senior Managers tend to be the most positive and those in Ambulance Services the least so. Among Local Authority Staff those in Criminal Justice and Strategic Development tend to score highest and those in Older People lowest.

Action Plans

The chart below shows the percentage of teams who completed an Action Plan within the 12 week requirement[2]. The 5 Boards with the highest percentage of teams with Action Plans are all National Boards. NHS Lanarkshire is the Geographic Board with the highest percentage of teams with Action Plans (77%). NHS Western Isles stands out in this analysis with only 13% of teams producing Action Plans, some 28 percentage points below any other Board.



[2] Some Action Plans are completed after the 12 week deadline. These are not included in the reported percentages of Action Plans completed

Percentage of Teams with Action Plans comparison over time

Across Health and Social Care 58% of teams have completed Action Plans within 12 weeks in 2019. This is an increase of 2 percentage points on 2018 and 15 percentage points on 2017.

	2017	2018	2019	Change from 2018 to 2019 (pp)	Change from 2017 to 2019 (pp)
Health and Social Care	**43%**	**56%**	**58%**	2	15
Golden Jubilee Foundation	63%	71%	52%	-19	-11
Healthcare Improvement Scotland	72%	89%	73%	-16	1
NHS 24	14%	66%	54%	-12	40
NHS Ayrshire & Arran	54%	60%	55%	-5	1
NHS Borders	26%	75%	70%	-5	44
NHS Dumfries & Galloway	13%	46%	58%	12	45
NHS Education for Scotland	73%	82%	93%	11	20
NHS Fife	40%	42%	42%	0	2
NHS Forth Valley	26%	80%	72%	-8	46
NHS Grampian	54%	49%	52%	3	-2
NHS Greater Glasgow & Clyde	44%	50%	57%	7	13
NHS Health Scotland	94%	90%	100%	10	6
NHS Highland	29%	48%	49%	1	20
NHS Lanarkshire	48%	67%	77%	10	29
NHS Lothian	33%	60%	57%	-3	24
NHS National Services Scotland	78%	76%	88%	12	10
NHS Orkney	81%	81%	70%	-11	-11
NHS Shetland	14%	45%	41%	-4	27
NHS Tayside	39%	41%	47%	6	8
NHS Western Isles	12%	14%	13%	-1	1
Scottish Ambulance Service	72%	86%	82%	-4	10
The State Hospital	78%	55%	79%	24	1

In 2019 10 Boards have increased the percentage of teams with Action Plans from 2018. The biggest increase is in The State Hospital with 79% of teams completing Action Plans in 2019, compared to 55% in 2018. The biggest decrease in the percentage of teams with Action Plans in 2019 from 2018 is in Golden Jubilee Foundation, down 19 percentage points form 71% in 2018 to 52% in 2019.

Following the increase from 14% in 2017 to 66% in 2018, NHS 24 dropped back to 54% Action Plan completion in 2019. Through 2019 the Board was delivering two significant strategic priorities alongside iMatter questionnaire and action plan completion, which they believe may have contributed to the decrease in response rate and completed action plans.

Notes:
1. The NHS Ayrshire and Arran 2018 No Report percentage was amended following the 2018 report publication from 60% to 61%"
2. Following removal of Chair Teams from the 2017 data, the No Report percentages for 11 Boards have changed from those reported in 2018

Looking at longer term progress from 2017 to 2019, all but three Boards have increased the percentage of teams with completed Action Plans. The largest increase is in NHS Dumfries and Galloway, having gone from 13% in 2017, 46% in 2018 to 58% in 2019, an overall increase of 45 percentage points over the three years. NHS Lanarkshire has also achieved large increases each year in the percentage of teams with Action Plans. Below are summaries of actions taken by these Boards:

Case Study 9: NHS Dumfries and Galloway – Increasing the percentage of teams with Action Plans

NHS Dumfries and Galloway have continued staff awareness session in 2019, with a focus on how to effectively action plan – particularly highlighting that small actions matter, small changes, not service changing.

Clear and easy-to-action communications have been created, including weekly all staff emails encouraging Action Plan completion.

The campaign has successfully led to a continued increase in Action Plan completion again in 2019.


NHS Dumfries & Galloway

iMatter

Action Planning

All teams who achieved greater than 60% response will have received their team report from noreply-imatter@pwbrogot.com

Managers with log in access can also access your team report and directorate report from the iMatter system or the full Board Report & Summary can be found on the Beacon iMatter Page

Action planning is your team chance to collectively celebrate your successes and make improvements to make your team an even better place to be!

No report – no problem! **All teams are expected to complete an action plan** with or without a team report. You can access your Directorate or Board Report or try the suggestions below.

How do you do your team action plan?

Give your team opportunity to reflect on your team report; set a date to all get together to reflect and set your actions. Think outside the box – how can you get everyone in your team to share their reflections if you can't get round the table; email, flipchart, post it's, multiple dates?

Questions you might want to consider:

- What surprised you about the results?
- What part had the most impact?
- What are your team strengths?
- What do you want to develop?
- What about the report makes you feel positive about the next 12months?

Your Action Plan requires a maximum of 3 actions – not costly or complex. What will make your day to day team experience even better?

It's often the small things!

Or think about your Team Journey – Where do you want to be?

- 3 things your team do well
- Where you want your team to be in 12months; how are going to get there?
- What Matters most to your team?

Once you have agreed your actions Managers are required to log in and upload your plan before the deadline. **Noon Monday 21st October**

What's next?

Set a date to review your actions in 12 weeks time and update the system – how have you done? Have you achieved your actions?

Print it off and pin it up!

Visit the iMatter Resource Page on Beacon for further guidance information

Visit www.imatter.scot to see other team stories from across Scotland

Any queries please contact the iMatter team: dumf-uhb.imatter@nhs.net

We want to hear from you – share your iMatter experience & team story with us!

Come along to one of the **iMatter Awareness Sessions** to find out more – check the latest CoreBriefing for dates & booking or visit the iMatter Beacon page

---

Case Story 10: NHS Lanarkshire – Increasing the percentage of teams with Action Plans

"Local champions, supported by the Op Lead and Board Administrator, are in place in each directorate / partnership area and have been key this year in recognising where support is required working with the managers ensuring they had the time and support to take things forward, asking for additional support from Op Lead if required. The impact of this was very noticeable within our Acute area where, although the overall response was below 60%, there was a big rise in action plans completed – the local champions put in place here were at Assistant Service Manager level and able ensure robust support was provided in pressure areas."

As Op Lead I keep in touch with managers and local champions during their 12 week action plan widow offering 1:1 or group support if required."

The Team Story below illustrates the pride in ensuring all HSCP teams complete an action plan:

The STARS service are the first in this Board to have every team complete a 2019-20 Action Plan, a significant achievement for a geographically dispersed team. The visual created to illustrate the Team story is both a recognition of the value of iMatter and an insight into the positive culture it is supporting.

NHS Dumfries and Galloway, HSCP Team - Short Term Reablement Service (STARS) – Striving for excellence in care

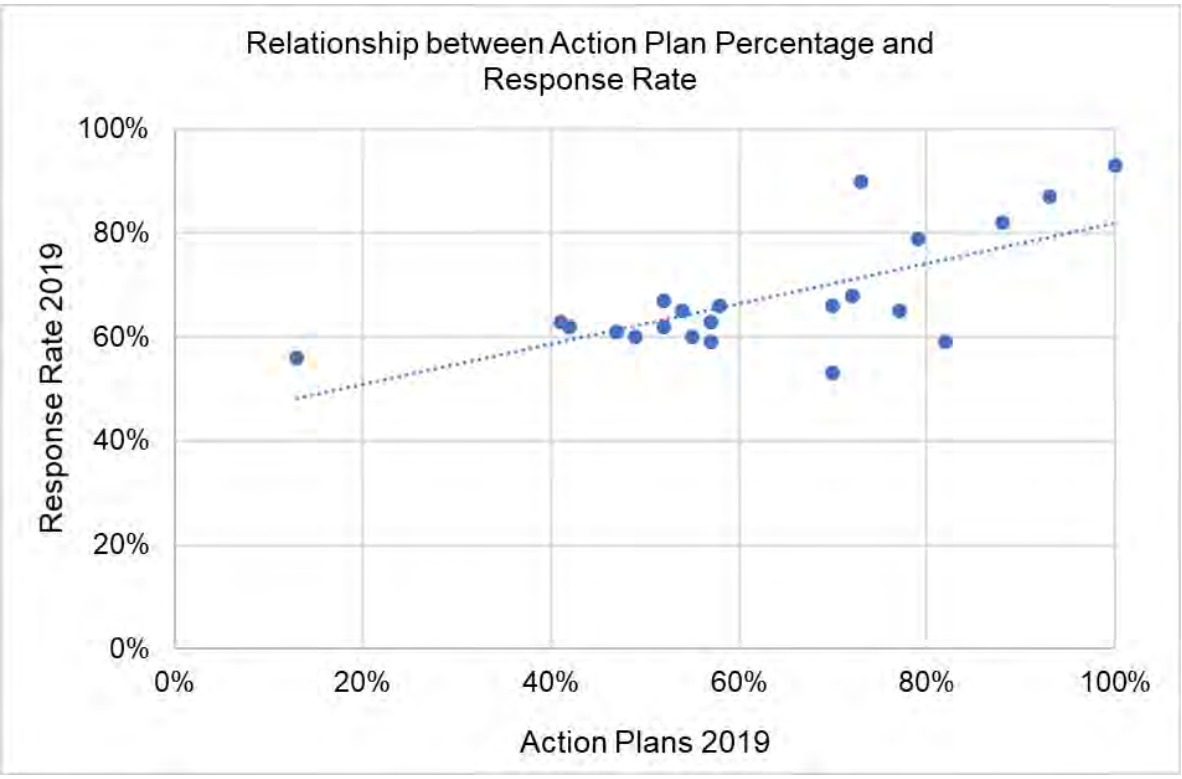
Relationship between Action Plan Percentage and other KPIs

Using the KPI data for each Board we can explore the relationship between the percentage of teams with Action Plans and each of the other KPIs:

Board	Response Rate	EEI	No Report*	Action Plans
Health & Social Care	**62%**	**76**	**34%**	**58%**
Golden Jubilee Foundation	67%	77	29%	52%
Healthcare Improvement Scotland	90%	78	19%	73%
NHS 24	65%	78	43%	54%
NHS Ayrshire & Arran	60%	76	34%	55%
NHS Borders	53%	No Report	47%	70%
NHS Dumfries & Galloway	66%	74	25%	58%
NHS Education for Scotland	87%	82	10%	93%
NHS Fife	62%	76	36%	42%
NHS Forth Valley	68%	75	26%	72%
NHS Grampian	62%	77	35%	52%
NHS Greater Glasgow & Clyde	59%	No Report	37%	57%
NHS Health Scotland	93%	81	0%	100%
NHS Highland	60%	74	37%	49%
NHS Lanarkshire	65%	79	30%	77%
NHS Lothian	63%	77	34%	57%
NHS National Services Scotland	82%	76	13%	88%
NHS Orkney	66%	75	30%	70%
NHS Shetland	63%	78	33%	41%
NHS Tayside	61%	75	38%	47%
NHS Western Isles	56%	No Report	43%	13%
Scottish Ambulance Service	59%	No Report	42%	62%
The State Hospital	79%	77	8%	79%

Relationship between Action Plan Percentage and Response Rate

The chart below shows the response rate and the percentage of teams completing an Action Plan for each Board. This suggests some positive relationship between the two measures as Boards with high response rates are most likely to have a high Action Plan completion. The three Boards with both the highest response rate and the highest percentage of Action plans are National Boards.

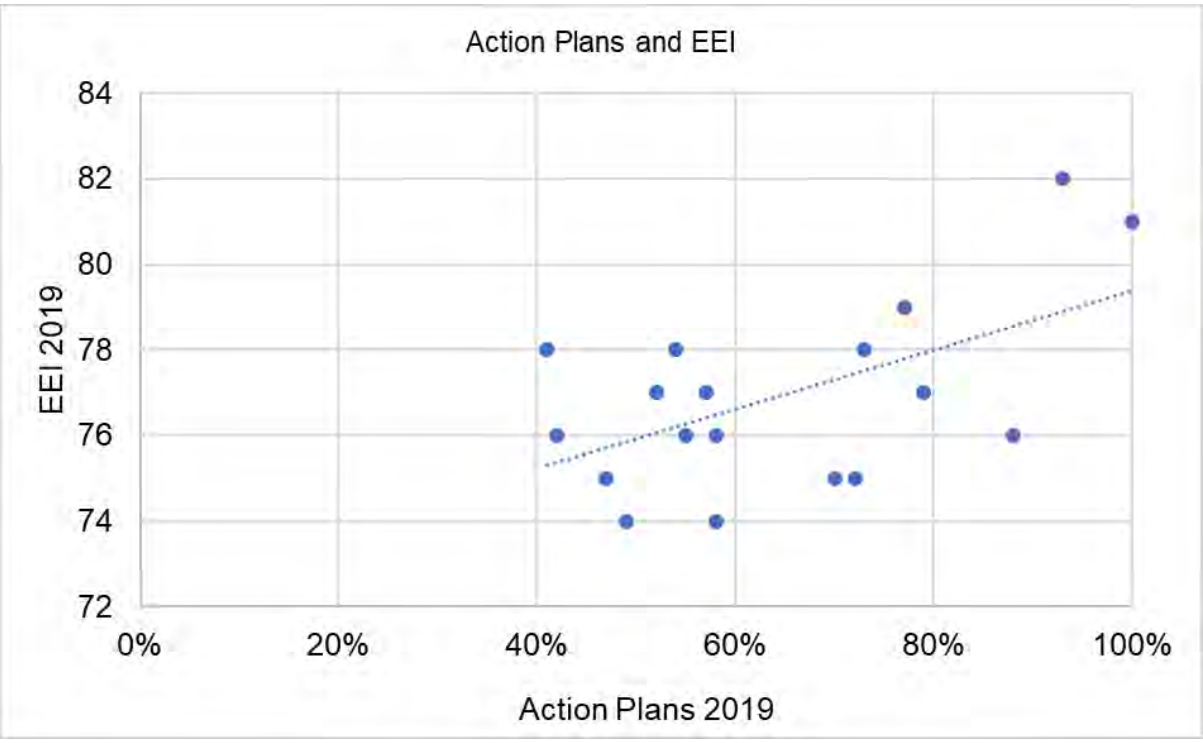


Whilst NHS Borders had the lowest response rate (53%) it has a good percentage of teams with Action Plans completed (70%). Similarly, the Scottish Ambulance Service only achieved a 59% response rate but has the fourth highest percentage of teams with Action Plans (82%).

Relationship between Action Plan Percentage and EEI

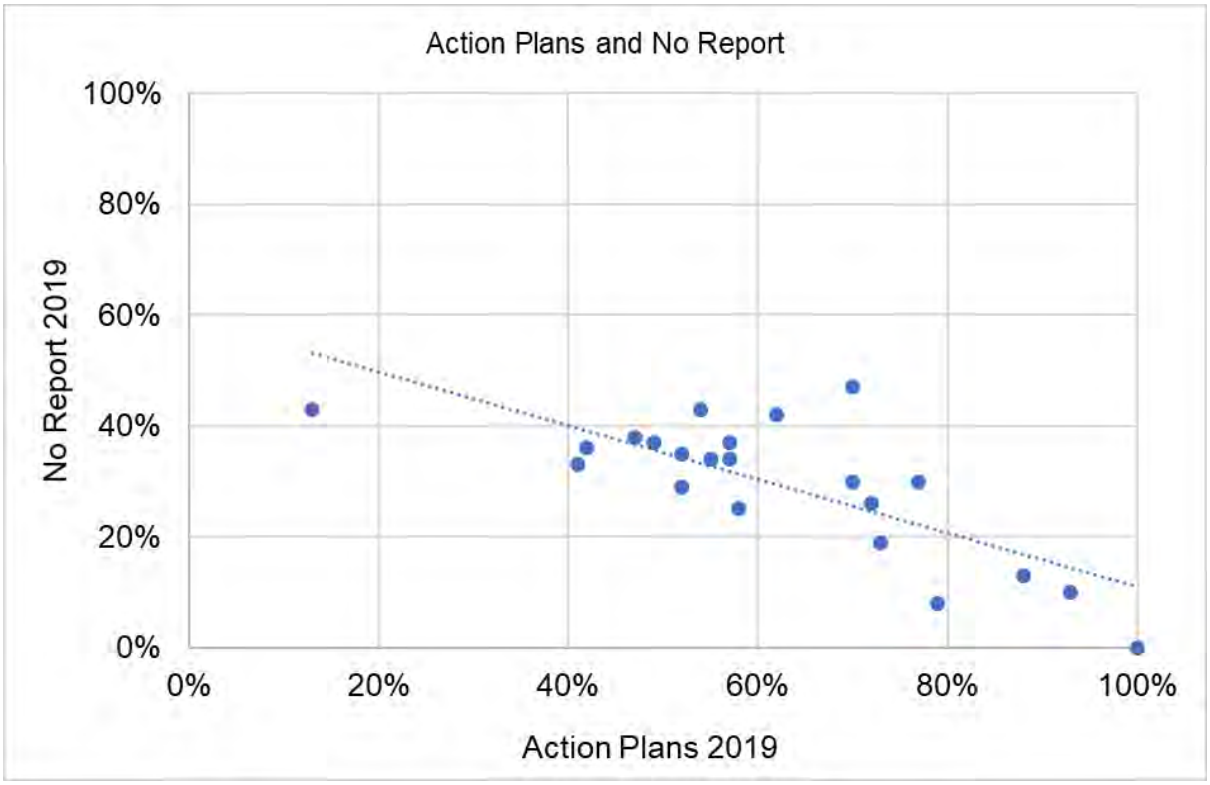
Comparing the percentage of teams with Action Plans and the EEI for each Board that received a report, the relationship is less strong, with examples of Boards such as

- NHS National Services Scotland having the third highest percentage of completed Action Plans, but an EEI score of 76.
- NHS Shetland with an EEI score of 78, but only 41% of teams with completed Action Plans.



Relationship between Action Plan Percentage and No Report

As might be expected there is an inverse relationship between the percentage of teams with Action Plans and the percentage with No Report. There are some exceptions, for example NHS Borders, where 47% of teams did not get a report but still 70% of teams completed an Action Plan. The case study below illustrates the proactive steps taken by NHS Borders to encourage Action Plan completion.



Case Study 11: NHS Borders – Encouraging Action Plan Completion

"Within NHS Borders we are very clear with managers and their teams that whilst completing the survey is voluntary, there is an expectation that each team will submit an action plan.

In 2018 our HR Business Partners provided a great deal of support to services within their area to encourage them to complete an action plan. In 2019 we deliberately took a step back from this approach because we wanted to encourage ownership for the iMatter process both within a management and team level (although of course support was still available through the iMatter team). Despite this step back, we still had a high action plan conversion rate."

Summary

The level of Action Plan completion has risen in 2019 to 58% from 56% in 2018. At individual Board level there is considerable variation from 100% in NHS Scotland to only 13% in NHS Western Isles.

There are examples of how Boards have encouraged their teams to develop Action Plans and this is reflected in increased percentages of teams with Action Plans in many Boards. However, there are a number of Boards that have notable decreases in the percentage of teams with Action Plans, which warrants further review prior to commencement of the 2020 iMatter programme.

Action Plan Content Analysis

As a Test and Learn project for 2019, automated analysis has been carried out on the text contained in all the Action Plans completed within the 12 week timing. The output of this analysis is presented as Word Clouds in which the size of a word directly corresponds to the number of times a word has been used across all the Action Plans; the larger the word, the more times it appears in the Action Plans. A separate Word Cloud is provided for each of the four sections in the Action Plan template:

- What we do well
- Areas for improvement
- Desired Outcome
- Action

This process of analysis counts the number of times a word is used across all Action Plans. The system incorporates 'stemming' whereby words that are similar are grouped together. For example; Manager, Management, Managerial etc. will all be grouped and shown collectively as 'Management'. Similarly, Communicate, Communication, Communications are grouped and shown collectively as 'Communication'.

As this analysis is automated and is based on single words it gives an indication of the topics that are covered in Action Plans. However, it does not give full insight into the themes or the sentiment contained within Action Plans.

What we do well

The most used words in the 'What we do well' section are based on 'team' and 'work'. 'Support', 'staff' and 'together' are also used frequently. This suggests an emphasis around how team do (or do not) work well together and how they do (or do not) support each other.

Areas for Improvement

In this section of the Action Plan, words relating to ‘decisions’, ‘communications’ and ‘organisation’ are used more, along with ‘staff’ and ‘team’. This suggests that many Action Plans explore a desire to make decision making and communication as effective as possible within or across teams. This is a topic that is referenced in many of the team stories.
The word ‘involve’ is also used a lot, again reflecting many of the team stories that reference whole team collaboration.

Desired Outcome

Amongst the key words used in the Desired Outcomes section alongside ‘staff’ and ‘team’ is ‘improve’, highlighting the aim of many Action Plans to deliver an improvement in some aspect of the team’s working environment.

Action

It is notable that words stemming from ‘meet’ are most frequently used in the Action section. It is evident from many of the Team Stories that establishing more regular meetings or meetings with more focussed purposes (e.g. getting to know the team or senior management, sharing successes etc.) is at the heart of many of the success stories. Hence the prevalence of ‘meet’ and also ‘regular’ and discuss’ in this section of the Action Plans.

Appendix 1: iMatter Survey Method

The process for distributing the iMatter questionnaire begins with a team confirmation period. Managers (at individual team level) were required to confirm their teams to ensure accuracy and that respondent information is updated. This was conducted for a period of 4 weeks where managers are required to remove any staff who have left the team, exclude staff who will not be available during the questionnaire stage and add any new staff that have joined the team. Once this process was completed, the online questionnaire was issued to all respondents with an email entered on the system and remained open for a period of 3 weeks. The paper version was also available to be printed and distributed on the same day, with the deadline to receive paper copies set for 1 week after the questionnaire closing date. All paper responses received within the deadline were also input within 1 week of the receipt deadline. Reminders were issued each week over the 3 week period.

Week Number	Action
1	Managers confirm team details to ensure accurate respondent information: - remove staff who have left - exclude staff who will not be available during fieldwork Add new staff
2	
3	
4	
5	Fieldwork window: - email electronic questionnaire/print & distribute paper version Reminders issued each week to non-responders
6	
7	
8	Additional week for Webropol to receive paper responses
9	All response data input to system

The iMatter questionnaire and data collection process was undertaken by Webropol, an independent company, to ensure full anonymity for the respondents. All processes have been fully assessed to ensure compliance with General Data Protection Regulation (GDPR) Principles. In order to keep the reports within small teams of 4 or less anonymous, the response rate for team reports to be published must be 100%. The reports are published at team level and available to that team only. The response data contained in team reports informs reports at both Directorate and Organisational level.

Appendix 2: Team story links.

To read any of the Team Stories in full, click on team photo to enter iMatter website, then click on button “download our story” - Download our Story

To read any of the Team Stories in full, click on team photo to enter iMatter website, then click on button “download our story” -

Download our Story

To read any of the Team Stories in full, click on team photo to enter iMatter website, then click on button “download our story” -

Download our Story

To read any of the Team Stories in full, click on team photo to enter iMatter website, then click on button “download our story” -

Download our Story

To read any of the Team Stories in full, click on team photo to enter iMatter website, then click on button “download our story” -

Download our Story

To read any of the Team Stories in full, click on team photo to enter iMatter website, then click on button “download our story” -

Download our Story

Appendix 3: Statistical Notes

Significance Testing

Significance testing has been carried out on the iMatter data, to assess whether the movements in results from 2018 to 2019 are likely to be 'true', rather than 'chance'. Specifically, a series of t-tests has been used to examine the size of change needed to give us a very high level of confidence that a 'true' change has happened.

The key element here is the number of responses – the larger the number of responses, the smaller the minimum change that can be deemed statistically significant (meaning that the change is highly likely to be 'true').

Overall Health and Social Care Level Data

- A change of 0.3, or even 0.2 at times, is significant across Health and Social Care as a whole. This generally means any change reported from 2018 to 2019 is likely to be a 'true' change.
- However, the above finding highlights a slight challenge, since iMatter reporting is based on whole integers, and therefore some significant movements may not be visible in the report. We therefore recommend that future reporting is to one decimal place, in order that all significant movements can be reported.

Board Level Data

As noted above, the number of respondents (the achieved sample size) is key to the level of movement year on year that is significant. Therefore, for individual Boards, significant movements are:

- Boards with less than 800 responses per year: movements of 3 points are significant
- Boards with between 800 and 2,800 responses per year: movements of 2 points are significant
- Boards with over 2,800 responses per year: movements of 1 point are significant

Movements of 3pp are significant	Movements of 2pp are significant	Movements of 1pp are significant
NHS Health Scotland (276 responses in 2019)	NHS Shetland (935 responses in 2019)	NHS National Services Scotland (2,811)
Healthcare Improvement Scotland (429)	NHS 24 (1,039)	Scottish Ambulance Service (2,838)
NHS Orkney (492)	Golden Jubilee Foundation (1,167)	NHS Dumfries & Galloway (2,965)
The State Hospital (506)	NHS Borders (1,774)	NHS Forth Valley (4,341)
NHS Western Isles (553)		NHS Highland (6,184)
NHS Education for Scotland (709)		NHS Fife (6,786)
		NHS Ayrshire & Arran (7,931)
		NHS Lanarkshire (8,653)
		NHS Tayside (8,701)
		NHS Grampian (10,851)
		NHS Lothian (14,183)
		NHS Greater Glasgow & Clyde (25,420)

Regression Analysis

Regression analysis has been carried out on the 2019 iMatter data to examine the extent to which the overall thermometer question is related to the individual component questions. The scores for the thermometer question ('Overall, working within my organisation is a ..very poor experience (0) . . . very good experience (10)') were compared to each of the component scores (6 for Strongly Agree . . . 1 for Strongly Disagree) for each respondent.

The analysis looks at the degree of 'similarity' between the overall score and the component scores - that is, the extent to which respondents giving a high (or low) overall score also gave a high (or low) component score. In practical terms this provides insight into which components have the greatest influence on staff's overall experience of working within their organisation.

Unsurprisingly, responses to 'I would recommend my organisation as a good place to work' were most closely related to the overall score, reflecting their broadly similar nature. The other components are shown below in order. For example, 'I feel my organisation cares about my health and wellbeing' has the next strongest influence on the overall score.

1. I feel my organisation cares about my health and wellbeing
2. I would be happy for a friend or relative to access services within my organisation
3. My work gives me a sense of achievement
4. I am confident performance is managed well within my organisation
5. I have confidence and trust in senior managers responsible for the wider organisation
6. I have sufficient support to do my job well
7. I would recommend my team as a good one to be a part of
8. I feel appreciated for the work I do
9. I feel involved in decisions relating to my organisation
10. I am treated fairly and consistently
11. I am given the time and resources to support my learning growth
12. I have confidence and trust in my direct line manager
13. I am treated with dignity and respect as an individual
14. I get the information I need to do my job well
15. I get enough helpful feedback on how well I do my work
16. I am clear about my duties and responsibilities
17. I feel my direct line manager cares about my health and well-being
18. I am confident performance is managed well within my team
19. I am confident my ideas and suggestions are listened to
20. My team works well together
21. My direct line manager is sufficiently approachable
22. I feel involved in decisions relating to my job
23. I am confident my ideas and suggestion are acted upon
24. I feel involved in decisions relating to my team
25. I get the help and support I need from other teams and services within the organisation to do my job
26. I feel senior managers responsible or the wider organisation are sufficiently visible
27. I understand how my role contributes to the goals of my organisation

Appendix 4: Response Volumes by Method

NHS Scotland	Sent surveys					Responses				
	Online	**Paper**	**Total**	**Online Share**	**Paper share**	**Online**	**Paper**	**Total**	**Online Share**	**Paper share**
Health and Social Care	153,989	25,464	179,453	86%	14%	102,099	9413	111,512	92%	8%
Golden Jubilee Foundation	1,506	226	1,732	87%	13%	1,020	147	1,167	87%	13%
Healthcare Improvement Scotland	479	0	479	100%	0%	429	0	429	100%	N/A
NHS 24	1,590	0	1,590	100%	0%	1,039	0	1,039	100%	N/A
NHS Ayrshire & Arran	11,068	2077	13,145	84%	16%	7,113	818	7,931	90%	10%
NHS Borders	2,836	503	3,339	85%	15%	1,636	138	1,774	92%	8%
NHS Dumfries & Galloway	4136	343	4,479	92%	8%	2,839	126	2,965	96%	4%
NHS Education for Scotland	815	0	815	100%	0%	709	0	709	100%	N/A
NHS Fife	9,345	1641	10,986	85%	15%	6,325	461	6,786	93%	7%
NHS Forth Valley	6,026	372	6,398	94%	6%	4,205	136	4,341	97%	3%
NHS Grampian	14189	3336	17,525	81%	19%	9,368	1483	10,851	86%	14%
NHS Greater Glasgow & Clyde	34,986	8273	43259	81%	19%	22,766	2656	25,422	90%	10%
NHS Health Scotland	297	0	297	100%	0%	276	0	276	100%	N/A
NHS Highland	9283	1097	10,380	89%	11%	5,839	345	6,184	94%	6%
NHS Lanarkshire	11,520	1847	13,367	86%	14%	7,885	768	8,653	91%	9%
NHS Lothian	21,192	4265	25457	83%	17%	14,183	1966	16,149	88%	12%
NHS National Services Scotland	3,361	56	3417	98%	2%	2,783	28	2,811	99%	1%
NHS Orkney	736	5	741	99%	1%	492	0	492	100%	0%
NHS Shetland	1,419	64	1,483	96%	4%	919	16	935	98%	2%
NHS Tayside	13,012	1150	14,162	92%	8%	8,418	283	8,701	97%	3%
NHS Western Isles	833	152	985	85%	15%	529	24	553	96%	4%
Scottish Ambulance Service	4,729	46	4,775	99%	1%	2,828	10	2,838	100%	0%
The State Hospital	631	11	642	98%	2%	498	8	506	98%	2%

Appendix 5: Staff Grouping Response Volumes

	Responses	Percentage
Total Responses	**111,512**	
Total answering this question	**110,801**	**99%**
Local Authority Employees	**14,873**	**13%**
NHS Scotland Employees	**95,928**	**87%**
Local Authority Employees	**14,873**	
Total answering this question	**14,533**	**98%**
Adult Services	6,557	44%
Business Services	1,091	7%
Children's Services	2,022	14%
Criminal Justice	689	5%
Older People	3,884	26%
Local Authority Senior Managers	113	1%
Strategic Development	177	1%
NHS Scotland Employees		
Total answering this question	**95,010**	**99%**
Admin Services	19,996	21%
Health Professional	11,347	12%
Ambulance Services	2,619	3%
Health Sciences	3,502	4%
Medical Dental	6,673	7%
Medical & Dental Support	1,007	1%
Nursing & Midwifery	35,750	37%
Other Therapeutic	3,576	4%
Personal & Social Care	1,233	1%
NHS Senior Managers	1,106	1%
Support Services	8,201	9%

Note: These questions were optional on the 2019 survey.

Appendix 6: Distribution of Thermometer Question Responses

	Thermometer Score										
Board	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Golden Jubilee Foundation	1%	0%	1%	2%	4%	9%	10%	21%	23%	14%	15%
Healthcare Improvement Scotland	1%	0%	1%	4%	3%	8%	11%	23%	26%	12%	10%
NHS 24	1%	1%	1%	3%	3%	10%	9%	22%	21%	13%	15%
NHS Ayrshire & Arran	1%	1%	1%	3%	5%	13%	13%	23%	19%	11%	11%
NHS Dumfries & Galloway	2%	1%	2%	3%	4%	13%	14%	23%	19%	11%	8%
NHS Education for Scotland	0%	0%	0%	1%	2%	6%	8%	23%	24%	19%	16%
NHS Fife	1%	1%	1%	3%	4%	13%	13%	23%	19%	11%	11%
NHS Forth Valley	1%	1%	2%	4%	5%	14%	13%	23%	17%	10%	10%
NHS Grampian	1%	0%	1%	2%	4%	12%	12%	23%	21%	12%	11%
NHS Health Scotland	1%	0%	0%	1%	2%	8%	10%	28%	27%	13%	10%
NHS Highland	1%	1%	2%	4%	6%	15%	13%	22%	18%	9%	10%
NHS Lanarkshire	1%	0%	1%	3%	4%	11%	11%	23%	20%	12%	13%
NHS Lothian	1%	1%	1%	3%	4%	12%	13%	23%	20%	11%	11%
NHS National Services Scotland	1%	1%	1%	2%	4%	10%	12%	23%	22%	12%	11%
NHS Orkney	1%	1%	1%	3%	4%	13%	14%	25%	21%	10%	8%
NHS Shetland	0%	1%	1%	2%	3%	11%	10%	22%	22%	14%	13%
NHS Tayside	1%	1%	1%	4%	5%	14%	13%	24%	18%	10%	9%
The State Hospital	2%	1%	1%	3%	4%	10%	12%	25%	17%	12%	12%

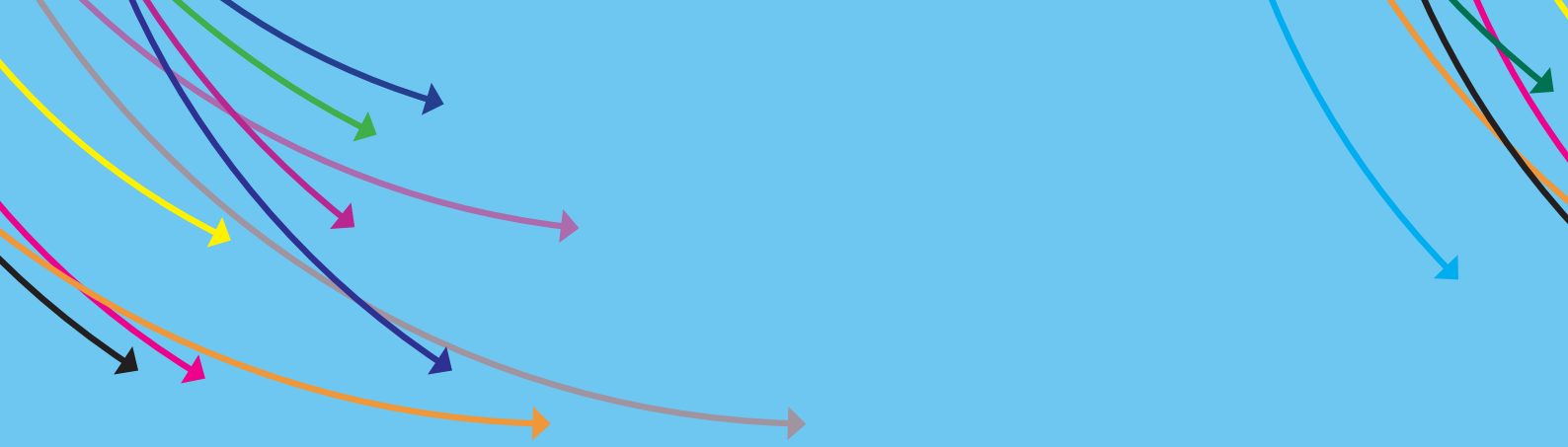
Appendix 7: Staff Experience Framework

Staff Experience Continuous Improvement Framework																				
Health Care Quality Strategy 2010 3 Quality Ambitions	Person-Centred, Safe & Effective																			
MacLeod Enablers/ Healthy Working Lives	MacLeod: Leadership				MacLeod: Engaging Managers				MacLeod: Employee Voice				MacLeod: Integrity to the Values & Purpose				Health and Well-being			
Staff Governance Standard Strands	SG1: Well Informed				SG2: Appropriately Trained & Developed				SG3: Involved in Decisions				SG4: Treated Fairly & Consistently, with Dignity & Respect, in an Environment where Diversity is Valued				SG5: Provided with a Continuously Improving & Safe Working Environment, Promoting the Health & Wellbeing of Staff, Patients and the Wider Community			
Staff Experience Components	Visible & Consistent Leadership	Sense of Vision, Purpose & Values	Role Clarity	Clear, Appropriate & Timeously Communication	Learning & Growth	Performance Development & Review	Access to Time & Resources	Recognition & Rewards	Confidence & Trust in Management	Listened to & Acted Upon	Partnership Working	Empowered to Influence	Valued as an Individual	Effective Team Working	Consistent Application of Employment Policy & Procedures	Performance Management	Appropriate Behaviours & Supportive Relationships	Job Satisfaction	Assessing Risk & Monitoring Work Stress & Workload	Health & Well-being Support
KSF Core Dimensions	C1	C1	C2	C1	C2	C2	C2	C2	C6	C4	C4	C4	C6	C5	C6	C5	C6	C5	C3	C3

Appendix 8: Mapping Staff Governance Standard

iMatter Staff Experience Components	iMatter Questions	KSF*
SG1: Well Informed		
Visible & Consistent Leadership	My direct line manager is sufficiently approachable. I feel senior managers are responsible for the wider organisation and are sufficiently visible.	C1
Sense of Vision, Purpose & Values	I understand how my role contributes to the goals of the organisation.	C1
Role Clarity	I am clear what my duties and responsibilities are.	C2
Clear, Appropriate & Timeously Communication	I get the information I need to do my job well.	C1
SG2: Appropriately Trained & Developed		
Learning & Growth	I am given the time and resources to support my learning and growth.	C2
Performance Development & Review	I get enough helpful feedback on how well I do my work.	C2
Access to Time & Resources	I have sufficient support to do my job well.	C2
Recognition & Rewards	I feel appreciated for the work I do.	C2
SG3: Involved in Decisions		
Confidence & Trust in Management	I have confidence and trust in my direct line manager. I have confidence and trust in senior managers responsible for the wider organisation.	C6
Listened to & Acted Upon	I am confident my ideas and suggestions are listened to. I am confident my ideas and suggestions are acted upon.	C4
Partnership Working	I feel involved in decisions relating to my organisation.	C4
Empowered to Influence	I feel involved in decisions relating to my job. I feel involved in decisions relating to my team.	C4
SG4: Treated Fairly & Consistently, with Dignity & Respect, in an Environment where Diversity is Valued		
Valued as an Individual	I am treated with dignity and respect as an individual.	C8
Effective Team Working	My team works well together.	C5
Consistent Application of Employment Policy & Procedures	I am treated fairly and consistently.	C6
Performance Management	I am confident performance is managed well within my team. I am confident performance is managed well within my organisation.	C5
SG5: Provided with a Continuously Improving and Safe Working Environment, Promoting the Health and Wellbeing of Staff, Patients and the Wider Community		
Appropriate Behaviours & Supportive Relationships	I get the help and support I need from other teams and services within the organisation to do my job.	C6
Job Satisfaction	My work gives me a sense of achievement.	C5
Assessing Risk & Monitoring Work Stress & Workload	I feel my direct line manager cares about my health & wellbeing.	C3
Health & Wellbeing Support	I feel my organisation cares about my health & wellbeing.	C3

* KSF – Agenda for Change Knowledge Skills Framework



Scottish Government
Riaghaltas na h-Alba
gov.scot

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-83960-090-6

This document is also available on The Scottish Government website:
www.gov.scot

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS626630 (01/20)

Staff Governance Committee

Item 9.1

DATE OF MEETING:	6 March 2020
TITLE OF REPORT:	Draft Staff Governance Action Plan 2020 – 21
EXECUTIVE LEAD:	Linda Douglas, Director of Workforce
REPORTING OFFICER:	Bruce Anderson, Head of Staff Governance

Purpose of the Report (delete as appropriate)		
	For Discussion	

SBAR REPORT

Situation

This report provides the Staff Governance Committee with the first draft of the Staff Governance Action Plan for 2020 - 21.

Background

NHS Fife must operate within the Governance Framework (Clinical Governance, Financial Governance and Staff Governance). Staff Governance is the strand that looks at how staff are managed and how they feel they are being managed.

The NHS Reform (Scotland) Act 2004 saw this commitment to staff governance being reinforced by legislation and supported by the introduction of the Staff Governance Standard, the aims of which are to improve how NHS Scotland's diverse workforce is treated.

To achieve the set standard and to maintain NHS Fife's status as an exemplary employer, evidence has to be made available to show that systems are in place to identify areas of concern, that actions plans are in place that show how improvements are being made and how they will continue to be made.

Assessment

The attached draft Staff Governance Action plan for 2020 – 21 builds on the plan from 2019 -20 and recognises the key areas for improvement highlighted by staff in the 2019 imatter responses. The plan needs to be presented and contributed to by the APF and LPF's for H&SCP and Acute Services Division before coming back to the Staff Governance Committee for sign off in May. The draft presented to the Committee in March allows any areas of focus to be included prior to the consultation with partnership fora.

The Annual Monitoring arrangements for this year are still to be confirmed by Scottish Government and will be circulated following confirmation of the arrangements in 2020. The May Staff Governance Committee will be where the members are asked to consider the final draft and approve it. The template is presented for information to the committee in advance of the

APF consultation process.
Recommendation The Staff Governance Committee is asked to: • Consider the content of the Draft Staff Governance Action Plan 2020 – 21 and seek any additional items for inclusion.

Objectives: (must be completed)	
Healthcare Standard(s):	Staff Governance Standards: Well Informed Appropriately Trained Involved in decision which affect them Treated fairly and consistently Provided with an improved and safe working environment
HB Strategic Objectives:	Ensure the Staff Governance arrangements within the Board are monitored and reported annually to Scottish Government. Meet Exemplar Employer Objectives

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to Health Board Meeting:	The Action Plan will be presented to the Area Partnership Forum for production and agreement and returned to the Staff Governance Committee for sign off in May.

Impact: (must be completed)	
Financial / Value For Money	None
Risk / Legal:	None
Quality / Patient Care:	Applying the principles within the Staff Governance Standards is likely to promote more engaged, motivated and caring staff delivering a higher standard of quality patient care.
Workforce:	The Staff Governance Standards and Staff Governance arrangements embedded in the Board together with the National Staff Survey provides staff with the opportunity to enhance their experience of working for the Board
Equality:	The application of the Staff Governance standard is applicable to all staff and helps ensure staff are treated fairly and consistently.

NHS FIFE STAFF GOVERNANCE ACTION PLAN 2020-21 Item 9.1 Appendix 1

WELL INFORMED

- All staff regularly receives accessible, accurate, consistent and timely information about their organisation.
- All staff has access to communication channels which offer the opportunity to give and receive feedback, either directly or via their trade union/professional organisation, on organisational and service delivery issues at all levels.
- All staff has access to a range of communication mechanisms. This will include IT systems and staff will be provided with appropriate training, and adaptation if appropriate, to use them.

OBJECTIVES	ACTIONS	COMPLETION/REVIEW DATE/TARGET/PROGRESS	OUTCOME	LEAD
Priorities for 2020-21 are all in areas which seek to improve what staff told us in their responses to the 5 least positive responses to the 2019 iMatter Board report. These were: • Staff feel the organisation cares about their health and wellbeing (71%) • Staff have confidence and trust in, senior managers responsible for the wider organisation (65%) • Staff are confident performance is managed well within my organisation (65%) • Staff feel senior managers responsible for the wider organisation are sufficiently visible (61%) • Staff are involved in the decisions relating to the organisation (56%) These fall broadly into well informed; Staff feedback, improving the confidence staff have and visibility of senior managers. Ensuring staff are involved in decisions which affect them at work.	Continue the Local Briefings presented by Directors of Acute Services, Health and Social Care and the Corporate Directors to their staff. Enhance the Executive walk about visits. Ensure the views and ideas of staff are heard through partnership fora, staff feedback, iMatter action plans and develop directorate action plans ensuring actions are followed through and communicated to staff Continue to promote the Bright Ideas initiative to hear staff suggestions and ideas for improvements to services	Review September 2020	Staff have the opportunity to hear directly from the Chief Executive, Employee Director and Executive Directors on key issues important to them and the future of the organisation. Staff have regular communication with their line managers through staff briefings which allow them to remain well informed and to provide an opportunity for their input and suggestions. Staff have access to information to keep them up to date with news, events and developments through the staff pages on the Intranet.	Directors, APF and LPF co-chairs

Continue to support the significant work in the development of the Health and Social Care Partnership. Keeping staff up to date with service developments. Communicate development of the Local Partnership structure to support continued staff involvement aligned with our Council Partners and respecting their Trade Union and Staff Side partners.	Continue to develop the Local Partnership Forum established with H&SCP.		Continue to develop the H&SCP staff website developed in partnership.	Director of Health and Social Care
Continue to engage with staff in addressing the financial challenges facing the Board in 2020-21	Work in close partnership with staff groups, trades unions and other professional organisations to develop greater detail around savings proposals and how best to deliver good quality services within the resources available. Develop greater detail around savings proposals.		Staff have regular updates on the progress being made to address the financial challenges.	Directors, APF and LPF co-chairs

B. APPROPRIATELY TRAINED

- All staff have a regular, effective Personal Development Plan and review discussion, in order to appraise past performance and identify any necessary learning and development opportunities.
- There is a workforce learning and development strategy in place which has been developed in partnership, includes mandatory training, reflects the outcomes of PDP discussions and identifies actions for implementation. This strategy should be reviewed and updated regularly.
- All staff have equity of access to training, irrespective of working arrangements or profession and without discrimination on any other grounds.
- Resources, including time and funding, are appropriately allocated to meet local training and development needs taking into account the current priorities of both the service and service users.

OBJECTIVES	ACTIONS	COMPLETION/REVIEW DATE/TARGET/PROGRESS	OUTCOME	LEAD
To ensure all staff receive the appropriate core and mandatory training over 2020/21.	• Continue to drive the improvement made in Core Skills compliance in the high risk / priority areas – HAI, CPR and Manual Handling. • Regular performance monitoring and review at APF, LPF'S and Staff Governance Committee.	Review September 2020	All staff remain up to date with core training.	Directors, APF and LPF co-chairs
Ensure all staff have meaningful conversation/discussion regarding performance and personal development. The implementation of the Learning and Development Framework strand of the Workforce Strategy supporting the	• Ensure the standards set in relation to eksf are maintained and improved following TURAS launch. Continue to monitor and report staff and manager engagement with TURAS and report to APF, LPF's and Staff Governance Committee progress being made. • Ensure the Directorate Workforce plans include a	Review September 2020	All staff have the opportunity at least once per year to discuss their performance and personal development with their line manager.	Directors, APF and LPF co-chairs

Clinical Strategy and Strategic Framework. Review Learning and Development infrastructure, processes, and resources to ensure prioritisation and alignment to delivery of the Clinical Strategy and the "exemplar employer" theme of the Strategic Framework. Review and refresh leadership and management development provision to ensure continuing relevance to support leaders at all levels to lead the development of a competent and confident workforce and delivery of new service models.	learning and development strategy. Continue to work with the regional Learning and Development community to develop consistent learning packages and opportunities to share learning and resources.			

C. <u>INVOLVED IN DECISIONS</u>

Draft Staff Governance Action Plan 2020 – 2021

- Staff are engaged and involved in decisions that affect them with the opportunity to influence such decisions.
- Staff are engaged and involved in strategic developments.
- Partnership working is embedded and mainstreamed within each NHS Board.
- Partnership Forums are in place within each NHS Board.
- Service development and organisational changes are planned and implemented in partnership and with effective staff engagement.
- A comprehensive workforce plan, based on these developments and changes, is developed in partnership.

OBJECTIVES	ACTIONS	COMPLETION/REVIEW DATE/TARGET/PROGRESS	OUTCOME	LEAD
Continue to improve the uptake of iMatter across the Board. Capture and promote good news stories which have iMatter at the centre of staff engagement within teams. Work in close partnership with staff groups, trades unions and other	Continue the implementation of iMatter across the organisation. Ensure the anniversary Cycle for the single system run in 2020 is effective. Ensure all Directorates have oversight of iMatter performance and focus on increased Action planning activity and the promotion of successful iMatter initiatives from teams. Report Directorate performance on Action planning and no reports to the APF, LPF's and Staff Governance Committee. Continue with the success of partnership	Review September 2020	All staff have had the opportunity to provide their views on their experience of working in NHS Fife, their views of their team and their views of the Executive Management Team and Board. All teams identified within iMatter have their annual action plans developed and progressed within the 12 month continuous improvement cycle. Staff are involved in the development of plans to achieve the efficiency savings within the Board. Seek to maintain or improve Employee Engagement scores in subsequent iMatter cycles.	Director of Workforce Directors, APF and LPF co-

professional organisations to meet the financial challenges in 2020-21.	finance workshops to support process Fully engage staff side representatives in the development of efficiency savings plans. Provide opportunities for staff representatives to input to efficiency savings initiatives on an ongoing basis within local and area forums.			chairs

D. TREATED FAIRLY AND CONSISTENTLY

- The Staff Governance Standard is embedded at all levels of the organisation and across all staff groups to ensure consistency of approach from all managers towards their staff.
- Workforce policies exist which meet or exceed the minimum standards set out within national PIN policies and current legislation. Where policies are developed locally, this must be undertaken in partnership.
- Workforce policies must be implemented fairly and consistently. They must be monitored and evaluated and subject to regular review to ensure their ongoing fitness for purpose.
- Staff have security of employment where a contractual relationship exists and experience no detriment through any organisational change policy.
- Pay and terms and conditions for all staff are applied fairly and equitably.
- A clear strategy and supporting policies are in place for the effective management of the workforce equality, diversity, human rights and dignity at work agendas.
- They identify and embed a core set of values and behaviours which are expected of all staff at every level, so as to ensure that staff are treated, and treat others, fairly, professionally and with dignity and respect.
- All staff feel valued as individuals, have trust placed in their ability and capability and are appreciated for their effort and contribution.
- The work environment and culture encourages individuals to treat each other with respect.

OBJECTIVES	ACTIONS	COMPLETION/REVIEW DATE/TARGET/PROGRESS	OUTCOME	LEAD
Attendance Management remains a significant challenge for the organisation and initiatives to improve this must ensure that we continue to treat our staff fairly and consistently while robustly managing attendance difficulties. Make improvements towards 4% Heat Standard.	Continue the scrutiny established by the Review & Improvement Panel meetings to examine absences across the organisation to ensure staff are treated consistently and fairly. Roll out the "Going Beyond Gold" initiative. Including the actions in line with specification, including Good Conversations Training Courses and	Review September 2020	Make improvements towards the Heat Standard for attendance. Improve the wellbeing of staff and ensure easy access to support for staff experiencing health and wellbeing issues.	Directors, APF and LPF co-chairs

	Mindfulness Training Courses. Continue the work of the Ageing Workforce Issues Short Life Working Group to consider the ageing workforce issues affecting NHS Fife, which is also aligned to the Well at Work activity. Ensure the development of a range of initiatives to support working well longer.			
We will continue to address staff concerns regarding staffing levels building on the successful work implementing clinical workforce tools, examining skill mix, staff shortages and recruitment and retention.	Continue the success of the Recruitment campaigns to recruit student nurses from University in the run up to qualification and registration. Report recruitment activity of key services to Staff Governance Committee in line with work plan.	Review September 2020	Continue to Monitor staffing levels and seek to attract and retain staff in line with minimum staffing establishment levels.	Directors, APF and LPF co-chairs

E. PROVIDED WITH A CONTINUOUSLY IMPROVING AND SAFE WORKING ENVIRONMENT

- The personal health, safety and wellbeing of patients and staff should be paramount in the design and operation of services.
- There are appropriate monitoring and audit arrangements in place and appropriate risk assessment and management arrangements are also in place.
- They proactively inform and support staff to manage and maintain their health, and to manage ill health.
- Ensure that it is safe and acceptable for staff to speak up about wrongdoing or malpractice within their organisation, particularly in relation to patient safety.
- They continue to work to attain Healthy Working Lives (HWL) awards for all acute services, working towards the Gold Award and attainment of the HWL Mental Health Commendation Award as set out in CEL 01 (2012).
- All staff have equal access to comprehensive, confidential and high quality occupational health and safety advice services as a means of improving the health and wellbeing of staff and promoting attendance.
- Resources, including time and funding, are appropriately allocated to implement the Occupational Health and Safety Strategic There will also be revisions to the "Live Positive" Stress Toolkit for staff, with the implementation of smart phone and tablet format and a programme and series of H&S initiatives, aimed at improving understanding and accountability at ward and department level."Framework at local level.

OBJECTIVES	ACTIONS	COMPLETION/REVIEW DATE/TARGET/PROGRESS	OUTCOME	LEAD
Build on the work that attained the Healthy Working Lives Gold award in 2017. Develop the Working well agenda as part of the projects within impact team. Roll out the “beyond gold” initiative.	Plan further APF attendance workshops to capture new well being initiatives in 2019. Build on the success of the Flu Fighters campaign and seek to improve immunisation uptake further.	Review September 2020	Retain the Healthy Working Lives Gold Award. Continue the development and promotion of staff well being initiatives.	Directors, APF and LPF co-chairs Working Well Group
Seek to reduce the frequency of physical and verbal abuse on our staff from patients, relatives and visitors which have not only an impact on providing a safe	Further develop a culture which encourages staff to complete Datix reports following incidents.	Review September 2020	Continue to monitor violence and aggression incidents against staff which are recorded in Datix and	Directors, APF and LPF co-chairs, Safety Advisors

working environment but increased absence rates following these actions.	Continue the Audit work focussed on the areas of highest recorded violence and abuse and seek to further reduce the instances against staff and increase reporting and follow up action Report to Violence and Aggression forum and Partnership fora.		review data at the Violence and Aggression group. Review with an expectation that a reduction in the number of Datix incidents indicates staff feel safer and are better protected at work.	

UNCONFIRMED MINUTES OF NHS FIFE AREA PARTNERSHIP FORUM MEETING HELD ON WEDNESDAY 22ND JANUARY 2020 AT 13:30 PM IN STAFF CLUB, VICTORIA HOSPITAL KIRKCALDY

Chair: Wilma Brown, Employee Director

Present:

Bruce Anderson, Head of Staff Governance
Helen Buchanan, Director of Nursing
Nicky Connor, Director of Health & Social Care
Willie Duffy, UNISON
Kevin Egan, UNITE
Andy Fairgrieve, Director of Estates, Facilities & Capital Services
Simon Fevre, British Dietetic Association
Neil Groat, Society of Radiographers
Paul Hawkins, Chief Executive
Paul Hayter, UNISON
Chu Lim, BMA
Angela Kopyto, British Dental Association
Wendy McConville, UNISON
Chris McKenna, Medical Director
Alison Nicoll, RCN
Louise Noble, UNISON
Morag Olsen, Interim Chief Operating Officer
Carol Potter, Director of Finance & Performance
Jim Rotheram, Head of Facilities
Andrew Verrecchia, UNISON
Rhona Waugh, Head of Human Resources

In Attendance:

Alan Wilson, Capital Project Manager (Presentation)
Susan Fraser, Associate Director of Planning & Performance (Value Work paper)
Janet Melville, Personal Assistant (minutes)

		Actions
01/20	**PRESENTATION**	
	A Wilson gave a brief presentation on the proposed Elective Orthopaedic Centre, outlining the procurement process and business case recently approved within NHS Fife and currently awaiting written approval from the Scottish Government. The timeline indicates the build would commence October 2020 with the centre opening in March 2022. A Wilson provided a virtual tour of the new build which has been designed in partnership with staff side colleagues and includes an outdoor terrace. Concerns were raised with regard to car parking as the Orthopaedic Centre is being located on one of the current car parks. A Wilson advised that a drop off area and car parking will be available close to the new centre and alternative car parking will be provided at Whyteman's Brae. A Fairgrieve confirmed that longer term plans for additional car parking at or near the Victoria Hospital site are under consideration. W Brown thanked A Wilson for his informative presentation and deemed the centre would be a valuable addition to NHS Fife.	
02/20	**WELCOME, APOLOGIES AND INTRODUCTIONS**	
	W Brown welcomed everyone to the meeting, especially M Olsen, attending her first NHS Fife Area Partnership Forum, and introductions were made. Apologies were noted from I Banerjee, L Douglas, D Milne, L Murray, S Robertson, G Tait and M Whyte.	

03/20	**MINUTES OF PREVIOUS MEETING AND ACTION LIST**		
	The minutes of the meeting held on 20th November 2019 were accepted as a true and accurate record. All updates were noted on the action list.		
04/20	**VALUE WORK**		
	S Fraser tabled a paper on organisational values. S Fraser explained that P Hawkins had asked her to review the complex Strategic Framework diagram compiled in 2013 to ascertain whether it is still relevant today. It was suggested that the topic is explored at the next APF staff side meeting to assist with the development of a consistent message regarding values and acceptable behaviours for NHS Fife.		**APF Staff Side**
05/20	**MATTERS ARISING**		
	a)	**Financial Workshop** C Potter proposed that the Financial Workshop is held in early March 2020, as the annual plan will be well-developed by then. C Potter confirmed that a wide range of individuals from NHS Fife, Health & Social Care and Staff Side will be invited, and small group discussions will be encouraged. M Olsen and N Connor will give short presentations to facilitate the discussions. It was acknowledged that it will not be easy to devise new initiatives to improve financial performance as most ideas have already been tried.	
	b)	**A&E Analysis** M Olsen advised that it has been a difficult time within the Acute Services Division, particularly during the last 3 weeks. However, she and N Connor have been working together to instigate changes in an attempt to alleviate pressures e.g. engaging the help of the Voluntary Sector to assist individuals at home in the short term, and to regularly reassess priorities and generate additional capacity as possible/ required. M Olsen indicated that Scottish Ambulance Service information will be used to help understand and address A&E challenges, an NHS Scotland-wide problem. Measures being considered include responding differently or preventing conveyances to hospital. M Olsen welcomed suggestions to improve the service.	**All**
	c)	**Once for Scotland Policies – Briefing Note** B Anderson informed colleagues that Phase 1 of the Once for Scotland Policies will be 'soft launched' on 1st March 2020. Two meetings have been held with HR team and staff side colleagues to analyse any differences with local policies and to prepare training for managers. Lunchtime sessions have been arranged to raise the profile of the new policies, to ensure key principles and values are understood, and that the policies are implemented in a supportive and flexible manner. B Anderson confirmed that the policies, national advice, guidance and FAQs will be available electronically; the link to the digital platform will be shared in due course. B Anderson advised that a number of managers and staff side colleagues had attended the workshops for development of Phase 2 of the Once for Scotland policies.	

	d)	**Non-Patient Catering Survey** J Rotheram explained that the survey was undertaken to determine staff likes and dislikes with regard to NHS Fife catering services. The Survey Monkey results revealed rather disappointingly, that the main responses were from existing customers; however, it is hoped to hold focus groups to ascertain why some staff don't use the canteen facilities in order to attract new customers to the dining areas. It is planned to develop the extremely successful 'Grab and Go' concept and to extend the range of 'green' initiatives.	
	e)	**Smoke Free Hospital Grounds Consultation** W Brown, having reviewed NHS Fife's response to the Scottish Government's consultation, recommended that the 'Don't Know' answer to Question 7 should be 'No'. APF colleagues agreed that vaping or e-cigarettes should be treated in the same way as tobacco smoking. R Waugh to advise D Milne of this decision so that the consultation response can be submitted to the Scottish Government.	**RW/ DM**
	f)	**Core Training Attendance** B Anderson noted that the main reason for the drop in attendance at 'core' training has been recorded as staff not being able to be released from work duties, this is especially prevalent within Acute Services. B Anderson observed that completion of elearning modules has increased. W Brown expressed her concern that resuscitation training attendance is at an unacceptably low level. M Olsen and N Connor were tasked with investigating the fall in core training attendance and implementing measures to improve the situation.	**MO/ NC**
	g)	**Absence Rates** W Brown advised that P Hawkins and L Douglas will lead a task force to address long term absence rates.	**PH/ LD**
	h)	**Staff Benefits Package** R Waugh confirmed that a package of staff benefits is being brought together, with Communications transforming it into a more attractive format. Such benefits will include access to reduced cost Stage Coach tickets, discounted gym memberships, the Kingdom Staff Lottery and salary sacrifice schemes e.g.to purchase a computer or a bicycle. Staff will be appropriately directed to the benefits on the Intranet. It was unclear whether the computer scheme was currently open; C Potter agreed to follow this up with M Doyle, Assistant Director of Finance.	**CW**
	i)	**Kingdom Lottery/ Endowment funding** It was acknowledged there is some confusion regarding where bids should be submitted to access the relevant funding. J Farr, Charity Manager has joined the Kingdom Lottery Committee and is happy to offer advice and guidance as required.	
	j)	**Flu Vaccination Levels** W Brown reported that 65.2% of NHS Fife staff have been vaccinated against flu this year, making it the most successful flu campaign to date. P Hawkins extended his thanks to all involved who had worked hard to surpass the Scottish Government 60% target.	

06/20	**INTEGRATED PERFORMANCE & QUALITY REPORT**	
	C Potter advised that there was an overspend of £7.5m at the end of November 2019, with the recently available December 2019 figures showing an overspend of just over £5m. C Potter warned that NHS Fife can give no assurance of breaking even by the end of the 2019/20 financial year as a result of ongoing challenges – especially within Acute Services and Social Care – and the complexity of the financial position. These include the provision of additional capacity and supplementary staffing to cope with winter pressures; covering the risk share agreement with the Integrated Joint Board; and not all savings initiatives have delivered as forecast. C Potter was disappointed to note that despite regular conversations with the Scottish Government, it is unlikely that any additional financial assistance will be forthcoming.	
	APF **noted** the report.	
07/20	**HEALTH & SOCIAL CARE PARTNERSHIP (H&SCP)**	
	N Connor highlighted three main areas being focussed on within the H&SCP: • Implementation of Redesign of Urgent Care services – the rotas are well-filled, staff are well-engaged and embracing change, clinical assurance is in place. • The Local Partnership Forum meets next week – discussions will include the medium-term financial strategy. • There is a requirement to review the Integration Scheme after the initial 5 year period, to assess progress and direction of travel.	
	APF **noted** the update.	
08/20	**ACUTE SERVICES DIVISION (ASD) UPDATE**	
	M Olsen indicated that within ASD: • There will be a review of how services operate to improve decision making and the flow of information to the Executive Directors Group. • There is a workshop next week with the Acute Services Management Group. • It was acknowledged that staff are exhausted coping with winter pressures; the resulting high absence rate will be followed up.	
	APF **noted** the update.	
09/20	**REGIONAL WORKING UPDATE**	
	a) JobTrain R Waugh reported that JobTrain went 'live' in all East Region Boards at the end of December 2019. 'Job Approval' functionality will soon replace the paper and email basis at the moment. JobTrain will be available to all Boards by March 2020.	

	b)	**Bank Update** R Waugh confirmed that NHS Fife has decided not to continue with the regional approach to the Nursing and Midwifery Bank, although participation in the Medical Bank is being considered; an options appraisal will be undertaken.	
	APF **noted** the update.		
10/20	**ATTENDANCE MANAGEMENT**		
	a)	**Attendance Management** R Waugh advised that the absence rate for November 2019 (5.57%) was a slight improvement, although the year-to-date figure remains static. There is a concern that the target trajectory for the year end (4.89%) will not be met. R Waugh confirmed that 'mental health' remains the top reason for absence. R Waugh was disappointed to note that despite all of the attendance management initiatives in place, the absence rate is not reducing. This led to a discussion about the pros and cons of 12 hours shifts were highlighted. It was suggested A Jones is invited to the next Promoting Attendance Event to talk about her research on working patterns and supporting an ageing workforce. P Hawkins noted that a high level of absence is attributable to employees aged 60+, a major concern given NHS Fife's number of older workers. P Hawkins requested that all absences are allocated a reason: 'unknown/ not specified' is unacceptable. R Waugh agreed to follow this up in terms of SSTS recording. It was hoped that the new Task Force and the launch of the Once for Scotland policies would help to address and reduce absence rates.	**RW**
	b)	**Well at Work** R Waugh drew attention to the *Culture of Kindness Event* being held at the Lochgelly Centre on 19th May 2020 at which Going Beyond Gold and Joy at Work will be showcased, tying in with the Values work. R Waugh encouraged APF colleagues to attend the conference.	**All**
	APF **noted** the updates.		
11/20	**iMATTER**		
	B Anderson confirmed that: • 48% of Action Plans were completed last year as at the Scottish Government deadline date. • Details of the key dates for the coming year are in the report. • A new communications strategy is under development to promote this year's iMatter cycle. • The national report, detailing all NHS Board's performance, will be published at the end of January 2020. • For those without computer access, the survey will be accessible through SMS messenger on mobile phones this year, • There has been a lot of discussion around Doctors and Dentists in Training undertaking iMatter, but agreement has been reached for		

	their participation with a 'go live' date of 15th February 2020.	
	APF **noted** the update.	
12/20	**DIGNITY AT WORK**	
	a) Sturrock Report – Next Steps B Anderson was disappointed to advise that the last meeting had been cancelled so there is no progress to report. P Hawkins encouraged all meetings to go ahead, with an alternative Chair if necessary.	
	b) Dignity at Work W Brown assured APF members that this will be taken forward as soon as possible.	
	APF **noted** the updates.	
13/20	**BREXIT UPDATE**	
	C McKenna informed colleagues that all of the NHS Fife 'Brexit' groups have been stood down, but will be re-established if required. In the meantime, it is 'business as usual'.	
	APF **noted** the information.	
14/20	**FINANCIAL HEALTH CHECKS FOR NHS FIFE STAFF**	
	W Brown explained that evidence shows that ensuring employees have access to financial support and benefits contributes to their overall wellbeing. It was noted that sessions previously provided by Lighthouse were well-received. The Endowment Fund bid is to commission Citizens Advice and Rights Fife to be accessible for staff support on NHS Fife sites. W Brown suggested that financial health checks should be open to all NHS Fife staff and not only to target those in bands up to and including Band 5, as the report proposes. C Potter to feedback to J Farr, Charity Manger with regard to this funding.	**CP**
	APF **noted** the report.	
15/20	**ITEMS FOR NOTING**	
	The following items were **noted** for information by APF: a. Going Beyond Gold Project Evaluation Report b. ASD & CD LPF – 19th December 2019 (Minutes and Action Lists) c. NHS Fife Well at Work Group – 22nd November 2019 (Minutes).	
16/20	**AOCB**	
	HR48 - NHS Fife Voluntary Retirement and Return to Part Time Working Policy W Brown perceived that since the inception of the policy there appears to	

	be an increasing expectation that everyone is entitled to retire and return to work. However, R Waugh highlighted from the policy: *No employee will have an automatic right to return following retirement. All requests to return to work following retirement should be considered on a case by case basis*. It was agreed, that given our ageing workforce, it is important to attract younger individuals to work in NHS Fife.	
17/20	**DATE OF NEXT MEETING**	
	The next Area Partnership Forum meeting will be held on Wednesday 18th March 2020 at 13:30 hrs in the Staff Club, Victoria Hospital.	

MINUTES OF THE ACUTE SERVICES DIVISION AND CORPORATE DIRECTORATES LOCAL PARTNERSHIP FORUM HELD ON THURSDAY 19 DECEMBER 2019 AT 2.00 PM IN TRAINING ROOM 1, DINING ROOM, VICTORIA HOSPITAL, KIRKCALDY.

Present:
Andrew Verrecchia (AV), Unison (**Chair**)
Andrew Mackay (AM), Deputy Chief Operating Officer (from 2.40 pm onwards)
Lynn Campbell (LC), Associate Director of Nursing
Paul Hayter (PH), Unison / Partnership Co-ordinator
Joy Johnstone (JJ), FCS
Miriam Watts (MW), General Manager – Emergency Care
Gemma Couser (GC), General Manager – Women, Children & Clinical Services
Susan Young (SY), HR Team Leader
Craig Webster (CW), H&S Manager
Paul Bishop (PB), Head of Estates

I**n Attendance:**
Gillian McKinnon (GMcK), Personal Assistant to Chief Operating Officer (**Minutes**)

Action

1 WELCOME & APOLOGIES

AV opened the meeting and welcomed everyone.

Apologies were received Morag Olsen, Andrew Fairgrieve, Jim Rotheram, Murray Cross, Leigh Murray, Louise Noble, Conn Gillespie and Neil Groat.

2 MINUTE OF PREVIOUS MEETING – 31 OCTOBER 2019

The Minutes of the Meeting held on 31 October 2019 were accepted as an accurate record.

3 ACTION LIST

3.1 **Application for Bereavement Leave across the Division**

- AV advised he had discussed with SY and there were no issues of concern or lack of consistency at this time. AV agreed to liaise with SY if any future concerns were raised. This action can be closed. **GMcK**

Attendance Management Update

• SY advised Rhona Waugh to have a discussion with MO. This action to be carried forward. • MW confirmed the ECD Review and Improvement Panels would reconvene in January 2020 after a couple of months of not having them following a rise in sickness absence levels. • GC advised 2020 WCCS Review and Improvement Panel dates have been agreed and hope these would take place in the new Level 11 Meeting Room. The Directorate was keen to discuss the top 100 absences split by service areas to improve and sustain performance.	**SY**
Attendance Management Update • Sickness absence updates were given at the November ASD Staff Governance Committee. This action can be closed.	**GMcK**
Attendance Management Update • It was noted there is 32 staff coded to the medical support family within Acute. In the main, these are Operating Department Practitioners, Theatre Technicians and Medical Physicians. This action can be closed.	**GMcK**
Feedback from NHS Fife Board & Executive Directors • MW advised Business Continuity Plans were more pertinent to pharmacy and supplies and Scott Garden was very aware of potential disruptions to medicine supplies. • MW advised details and information would evolve as the Brexit process progressed and plans would be updated once further information had been received. This action can be closed.	**GMcK**
Staff Briefings & Internal Communications • AV to pick up a discussion with MO/AM regarding the format of the formal briefings, but was keen for the monthly SLT walkrounds to continue. • LC advised MO was not likely to change anything significantly.	**AV**
Staff Governance Action Plan 2019/20 • AV advised he had met with AM. Further information was awaited from Bruce Anderson and consideration given as to how to present the Staff Governance Action Plan (SGAP) in a better way. • LC asked about timescales for the SGAP. AV advised this would require to be prepared by the time of the next meeting and would require to be submitted to the February 2020 APF.	**AV**

iMatter

- Added as Agenda item to the November ASD Staff Governance Committee meeting. This action can be closed. **GMcK**

Well at Work Update

- It was noted the Co-ordinator contacted and a number of additional clinics have been made available on the VHK site as well as roving vaccination opportunities. These have been well attended and figures as of 19 November 2019 show 40.9% uptake against 60% national target. NHS Fife target is 65% and note that peer vaccinator figures have not been fully gathered in the uptake to date. This action can be closed. **GMcK**

Adverse Events Report

- LC advised that in order to clarify monitoring any incident it was agreed that nursing staff would complete a V&A DATIX with a new drop down box to indicate whether security were in attendance or not. This reduces duplication and potential under- reporting and means follow-up on DATIX is led by clinical team. Security cross reference DATIX report with local daily log. Kenny Green noted the previous info to team but was to share information again with security team to reassure. This action can be closed. **GMcK**

How was Today's Meeting?

- This was discussed and way forward agreed at the last ASD Staff Governance Committee meeting. This action can be closed. **GMcK**

eESS

- It was noted it is possible for a manager to set vacation rules within the system when they go on planned absence. The facility is accessed by selecting the vacation rules link below their work list, but there are some important considerations when setting up vacation rules. There is often an issue when finding individuals as the name must be entered in the correct format i.e. surname comma first name. This action can be closed. **GMcK**

eESS

- It was noted whilst the functionality exists within eESS to allocate a proxy to enter information on behalf of the allocated

manager, NHS Fife's Executive Director Group agreed at the outset of the project that this functionality should not be permissible within NHS Fife. This action can be closed. **GMcK**

4 HEALTH & SAFETY:

4.1 Health & Safety Update Report (including RIDDOR Update)

- The Health & Safety Update Report was noted, for information.
- CW advised since the update report was produced the December edition of the Safety Newsletter has been published and is available on the Intranet, including useful advice and links for staff during periods of adverse weather.
- LC asked how the information on adverse weather could be communicated to staff who did not readily have access to a computer. CW agreed to circulate this information to LPF members for them to cascade through their own distribution lists to clinical teams. **CW**
- CW advised RIDDOR status and management was good across NHS Fife and in particular within Acute Services. There has been 1 RIDDOR reported since the last report but confirmed this had been reported correctly. 1 RIDDOR is being followed up but is not thought likely to be reportable.
- CW advised Phase 2 of the PIN Policies would commence. The Health & Safety Management Policy will be considered regionally and workshops held in January 2020.

5 STAFF GOVERNANCE 2019/20

A Well Informed

5.1 Chief Operating Officer's (ASD) Brief – Operational Performance

- LC advised MO was looking forward to attending the next meeting and had no issues to raise at this time.

5.2 Attendance Management Update

- The Attendance Management Update Report was noted, for information.
- SY advised there had been an increase in sickness absence in both Acute and Corporate areas, and higher than the same month in the previous year.
- SY advised the Acute Services Division has an average absence of 6.01% and Corporate Directorates of 5.27% in October 2019. Corporate Directorates is the second lowest area.

- SY advised anxiety, stress, depression remains the highest absence reason with Corporate and Acute areas and nursing/midwifery remains the highest sickness area.
- SY advised a soft launch of the PIN Policy on Attendance Management has taken place in readiness for launch with staff and managers on 1 March 2020.
- SY advised a new digital platform is being developed to support staff and managers.
- SY advised the return to work meeting has been changed to the welcome back to work meeting.
- SY advised the format of the Review and Improvement Panels are currently being discussed.
- LC advised a roster review had been commissioned and clinical areas were assessed against the 22% predicable absence. There are a couple of areas which require additional support and actions are being worked on. Broadly the exercise had provided a positive overview of the division.
- AV noted there had been no improvement in stress related sickness absence but advised this was not just attributed to work related stress. GC advised research shows there are different ways of working to make a happier and healthier workplace and we require to be more ambitious and try a different approach, e.g. reduction of hours. PH advised NHS Fife has a number of loyal staff who work extremely hard, but noted the number of vacant posts. LC confirmed there are difficulties in recruiting and retaining staff, but agreed a change of approach is needed. SY advised there are good examples of Manager's promoting flexible working and referred to the use of the Good Conversation approach to good effect. AV noted staff would prefer to speak first to staff side colleagues to check what their entitlements are before approaching their Manager.

5.3 Feedback from NHS Fife Board & Executive Directors

- LC advised MO had not as yet attended a NHS Fife Board Meeting but advised discussions at EDG continued to focus on performance, patient safety and finance.

6 B Appropriately Trained

6.1 Training Update

- AV advised at the last ASD Staff Governance Board meeting the training figures reported had been disappointing. LC advised we should keep in mind that training information was collated differently and therefore may not be a true reflection, with some areas perhaps performing significantly better than reported. Further work in this area is required.

- AV thanked AM/MW for their intervention and action into resolving a training incident which had been notified to him by a member of staff.
- MW advised within ECD training figures were identical to previous months and remained static. Turas performance is at 45% and is indicative of daily challenges; high agency spend to provide safe staffing; sickness absence at 6% and 10% vacancies.
- GC advised within WCCS she had a different portfolio from the other Directorates and had less ward based staff and therefore had a better ability to release staff for training.
- AM asked whether Directorates could dedicate a day for staff to cover all mandatory training in the same way as undertaken by Estates staff, and if there was a team that could come into ward areas to release staff for training. PB advised it was easier for Estates staff to undertake training on one day as they had fixed break times but asked whether ward staff could undertake training at staff handover. LC did not think this would be possible but further consideration is required on how we deliver core training differently to ward based staff and whether we could adopt a more blended approach including eLearning.
- It was agreed we required to formulate a plan locally but to escalate this issue to APF if not successful in improving training compliance.

6.2 Turas Update

- SY advised compliance remained low at 51% (Acute) and 50% (Corporate Services).

7 C Involved in Decisions which Affect Them

7.1 **Staff Briefings & Internal Communications**

- Discussed at Item 3 above.

7.2 **Staff Governance Action Plan 2019/20**

- Discussed at Item 3 above.

7.3 **iMatter**

- PH advised yesterday's meeting had been cancelled due to the number of apologies.
- SY advised 44% (Acute) and 64% (Corporate) action plans have been completed. Doctors and dentists in training would be included from February 2020 on a regional basis.
- GC advised it was difficult to obtain information from iMatter

and had no sense on the performance of Directorates. AM advised only 1-2 people have access to this information and SY to ask Bruce Anderson if the information could be shared wider. **SY**

8 D Treated Fairly & Consistently

8.1 **Current/Future Change Programmes**

- AM advised there were programmes ongoing within H&SC, Corporate and Acute Services.
- AM advised Jim Crichton has been appointed as Interim PMO to undertake an assessment across NHS Fife and provide an action plan and with the Integrated Transformation Board making collective decisions.

9 E Provided with an Improved & Safe Working Environment

9.1 **Well at Work Update**

- The Well at Work Update was noted, for information.
- SY confirmed the uptake of flu vaccinations had slightly improved. LC confirmed additional flu clinics have been made available and Craig Orr had returned and commenced roving vaccination opportunities.
- SY advised a coastal walk has been arranged for 18 January 2020.
- SY advised Brew Monday events were taking place on 20 January 2020.
- SY advised staff now had the opportunity to save money by purchasing an annual bus pass via the Cashier Office at VHK/QMH and deducted directly from their salary. AV advised this may help with identified staff absences at the end of the month and more work would be done to promote this scheme to lower paid staff.
- LC advised further work was required on staff breaks and hydration. PH advised staff were not always able to take regular breaks and were unable to have water bottles at the nurses' station. MW asked whether funding from endowment funds could be used to purchase water bottles and stored in a central point for staff to access. SY advised any discussions should link in with the work being taken forward by Yvonne Telfer to ensure this is co-ordinated. LC asked that any plans are mindful of infection control and that any concepts are considered by that team in advance of implementation.

9.2 **ASD & CD Well at Work Minutes**

- The ASD & CD Well at Work Minutes of 25 November 2019

were noted, for information.

9.3 **Capital Projects Report**

- The October 2019 Capital Projects Report was noted, for information.
- PB advised the first meeting would take place in the middle of January 2020 to consider next year's capital spend. Directorates have been asked to provide information as soon as possible to be added into the capital plan by end of December 2019.

9.4 **Adverse Events Report: November 2018 to October 2019**

- The Adverse Events Report for the period November 2018 to October 2019 was noted, for information.
- LC advised the top incident themes remain the same.
- LC advised the number of sharps incidents have dropped across areas and are down to 1.
- LC advised following a meeting between the security team and nursing staff to reduce the potential for duplication of V&A incidents nursing staff will report such incidents in Datix with a drop down box for security staff involved.
- LC advised there has been an increase in disruptive behaviours out of hours by local youngsters. PB advised youngsters come into the hospital site to use the free Wi-Fi and AV advised in the past eHealth had been able to block phones. It was noted Kenny Green was looking into these incidents.

9.5 **Violence & Aggression Report**

- The Violence & Aggression Report for the period July – September 2019 was noted, for information.

10 ISSUES FROM STAFF-SIDE

10.1 **Mandatory Training Compliance Rates**

- Discussed under Item 6.1 above.

11 MINUTES FOR NOTING

11.1 **Capital Equipment Management Group Minutes: 7 November 2019**

- The Capital Equipment Management Group Minutes of 7 November 2019 were noted, for information.

12 FUTURE DATES – 2020

The meeting dates for 2020 were noted, for information.

13 HOW WAS TODAY'S MEETING?

13.1 **Issues for Next Meeting**

- LC advised there had been a number of behavioural aspects highlighted across a range of staff in recent weeks that were not in keeping with our expectations. While the site has been under significant pressure a wider piece of work is required around organisational values and to consider work with staff side colleagues to reinvigorate them. It was agreed to add this as an Agenda item for the next meeting. **GMcK**

13.2 **Issues for Escalation to Area Partnership Forum**

- There were no issues for escalation to the Area Partnership Forum.

14 ANY OTHER COMPETENT BUSINESS

14.1 Scottish Living Wage

- SY advised work was ongoing to resolve the last few Band 1 staff to make them Scottish living wage compliant.

15 DATE OF NEXT MEETING

Thursday 20 February 2020 at 2.00 pm in Training Room 1, Dining Room, Victoria Hospital, Kirkcaldy.

NHS Fife

TABLE OF ACTIONS
ACUTE SERVICES DIVISION & CORPORATE DIRECTORATES LOCAL PARTNERSHIP FORUM

MINUTE REFERENCE	ACTION	LEAD	TIMESCALE	PROGRESS
19/12/19 Item 3.1	Attendance Management Update Rhona Waugh to have a discussion with MO regarding Review and Improvement Panels.	**SY**	Update at next meeting	
19/12/19 Item 3.1	Staff Briefings & Internal Communications AV to pick up a discussion with MO/AM regarding the format of the formal staff briefing sessions.	**AV**	Update at next meeting	
19/12/19 Item 3.1	Staff Governance Action Plan 2019/20 Further information awaited from Bruce Anderson and AV to give consideration as to how to present the Staff Governance Action Plan in a better way.	**AV**	Update at next meeting	
19/12/19 Item 4.1	Health & Safety Update Report CW agreed to circulate the adverse weather information to LPF members for them to cascade through their own distribution lists to clinical teams.	**CW**	**COMPLETED**	Circulated to LPF members on 20/12/19 for them to cascade through their own distribution lists.
19/12/19 Item 7.3	iMatter SY to ask Bruce Anderson if iMatter information could be shared wider.	**SY**	Update at next meeting	
19/12/19 Item 13.1	Issues for Next Meeting LC advised there had been a number of behavioural aspects highlighted across a range of staff in recent weeks that were not in keeping with our expectations. While the site has been under significant pressure a wider piece of work is required around organisational values and to consider work with staff side colleagues to reinvigorate them. It was agreed to add this as an Agenda item for the next meeting.	**GMcK**	**COMPLETED**	Added to 20 February 2020 Agenda.

Unconfirmed

HEALTH AND SOCIAL CARE LOCAL PARTNERSHIP FORUM
WEDNESDAY 29 JANUARY 2020 AT 2.00 PM IN COMMITTEE ROOM 2, FIFE HOUSE, NORTH STREET, GLENROTHES

PRESENT: Simon Fevre, Staff Side Representative (Chair)
Nicky Connor, Director of Health & Social Care
David Heaney, Divisional General Manager (East)
Claire Dobson, Divisional General Manager (West)
Julie Paterson, Divisional General Manager (Fife Wide)
Alison Nicoll, RCN
Audrey Valente, Chief Finance Officer, H&SCP
Bruce Anderson, HR Head of Staff Governance, NHS Fife
Debbie Thompson, Joint Trades Union Secretary
Dr Chuchin Lim, Consultant Obstetrics & Gynaecology
Hazel Williamson, Communications Officer
Kenny McCallum, UNISON Fife
Linsey Gilmartin, HR Lead Officer, Fife Council
Louise Noble, UNISON Health
Mary Whyte, RCN
Wendy Anderson, H&SC Co-ordinator (Minute Taker)

APOLOGIES: Eleanor Haggett, Staff Side Representative
Gillian Tait, RCN
Helen Hellewell, Associate Medical Director
Karen Rennie, HR Business Partner, Fife Council
Lynne Parsons, Society of Chiropodists and Podiatrists
Scott Garden, Head of Pharmacy & Medicine
Wilma Brown, Employee Director, NHS Fife

NO	HEADING	ACTION

1 APOLOGIES

As above.

2 PREVIOUS MINUTES

2.1 Minute from 16 October 2019

Alison Nicoll asked that her job title be changed from OT Child Health to RCN. Once this has been updated the Minute of this meeting is approved.

2.2 Minute from 11 December 2019

Three small changes were to be made – Alison Nicoll's job title, DH changed to DT in Item 2 and Psychiatry replaced with Physiotherapy and Dietetics in Item 11. This Minute was then approved.

Debbie Thompson requested that for future meetings all documents are shown on screen within meeting room to reduce printing required. This was agreed.

NO	HEADING	ACTION

3 JOINT CHAIRS UPDATE

Simon Fevre advised that this item had been added to the agenda to allow the Chairs to update the group on specific items affecting the partnership. It was hoped that it might also generate ideas for future agenda items.

Debbie Thompson expressed her disappointment that, in Eleanor Haggett's absence, an invitation had not been extended to other Fife Council colleagues take part in Agenda Setting meetings. Nicky Connor recognised that this was an oversight and would be rectified. Wendy Anderson to forward appointments to Debbie Thompson. **WA**

4 MATTERS ARISING (NOT ALREADY ON AGENDA)

4.1 Fife Council Training

Bruce Anderson advised that he needs data on Fife Council Training, this will need to be collated to ensure compliance and more information would be brought to the next meeting. **BA**

Linsey Gilmartin advised Fife Council does not have this data as yet. Data would be checked by Managers before release.

4.2 eESS / Job Train

Bruce Anderson confirmed that Job Train is now established. Some support and training still required by Managers as they become familiar with the system. This is speeding up the recruitment process but requires a cultural change to ensure this continues.

5 FINANCE

5.1 Financial Update

Audrey Valente gave an update on the financial monitoring position from September 2019 as December 2019 figures are currently being finalised. Projected overspend in September was £11.8m. Further savings proposals of £1.8m were presented to the IJB meeting in December 2019. Projected outturn by end of financial year is currently £10m and the position is improving.

Audrey Valente then presented information on the Change Plan which had been discussed at the previous meeting. There are 19 items within the Change Plan, classed as either Service Change or Service Transformation and each item was discussed in order. Proposals for these are being pulled together and should be available in the near future.

Debbie Thompson requested that Fife Council's HR Service are sighted on these proposals before they are discussed at IJB. Bruce Anderson requested the same for NHS Fife's HR Service.

NO	HEADING	ACTION

5.2 Consultant, Locum and Agency Spend

This information had been circulated previously. Nicky Connor requested that Acute information is edited out in future.

5.3 Engagement / Communication

Nicky Connor advised she is seeking the thoughts of the LPF on what we need to do to ensure wider engagement and communication on budget issues.

Debbie Thompson reiterated that until proposals are ready it is difficult to know what the priorities will be and how much engagement will be required for each one.

Simon Fevre suggested that the meeting on 17 March could be used to have a more indepth discussion on budget proposals.

6 WINTER PLANNING

Claire Dobson updated on the challenge for services over the festive period and beginning of the year. Although there was increased demand, staff coped well and should be commended for the work done.

David Heaney gave an update on Care at Home where Total Mobile has proved challenging with some external care providers. Recruitment of staff has been more challenging this year as it is difficult to recruit staff for such relatively short term.

7 TRANSFORMATION

7.1 Transformation Board Update

Nicky Connor advised that there had been no meeting of the Board since December 2019. The next meeting is on 26 February 2020 and an update will be provided to the next LPF meeting on 17 March 2020.

7.2 Urgent Care

Claire Dobson advised that Phase 1 is underway and activity data is being collated for the next Clinical & Care Governance Committee. This data will be shared with the LPF. **CD**

7.3 Community Hospitals

David Heaney provided an update on this item which has been ongoing over the last three and a half years. The review has been broken down into phases to allow progress to be made. Staff updates will be provided in due course.

Simon Fevre asked if this would go to Integration Transformation Board and David confirmed that it would. David agreed to circulate a draft of the strategy for information. **DH**

NO	HEADING	ACTION

8 LPF ACTION PLAN

Bruce Anderson advised that the Action Plan had been updated and significant improvement was being made with appraisals and training within NHS Fife. iMatter figures have not improved. Going forward SMS messaging has been suggested as a route to distribute staff surveys as this has been proven to get better return rates.

Nicky Connor asked if the Action Plan could be circulated to the group and Bruce Anderson agreed to do this. **BA**

Several other Services hold regular meetings to discuss their action plan and issues such as absence, training and registration. It was suggested that a group be formed to look at doing this in the future. This will be discussed further at the Agenda Planning Meeting on 25 February 2020. **NC/SF/ DT/BA/ EJ**

9 ABSENCE / ATTENDANCE MANAGEMENT

9.1 H&SCP Attendance Figures

These had been circulated previously and Bruce Anderson advised that there has been no great improvement in figures.

Discussion took place around the main causes of absence and what staff and managers can do to take ownership of workloads and absence.

Julie Paterson advised that the Absence Management Strategy is being finalised and will be shared with the Senior Leadership Team in the first instance.

10 HEALTH & SAFETY

10.1 H&SCP Health & Safety Forum – Unconfirmed Minutes

Meeting took place on 28 January 2020, so no minute was available. Nicky Connor gave a short update which included discussions around the Corona virus which Public Health are monitoring.

11 iMATTER UPDATE

No update available on this.

12 DIVISIONAL UPDATES

Fife-Wide

Julie Paterson advised that a Social Work Celebration was taking place on Thursday 27 February 2020 which will include staff awards.
The Mental Health Strategy will be taken to the Integration Joint Board meeting on Friday 28 February 2020 for approval and a Voluntary Sector review on mental health provision will follow.

A Mental Health event is being planned for March 2020 in conjunction with Police Scotland.

NO	HEADING	ACTION

12 DIVISIONAL UPDATES (Cont)

East

David Heaney advised of three senior staff changes in his Section.

Louise Bell retires in February and her replacement is John Cooper.

Marion Bell retires in March.

Gordon McKenzie is leaving Fife to take up a post in Falkirk.

Debbie Thompson commended the work Louise and Marion had done during their time with the Council and David will pass this back to them both.

West

Updates on the Winter Plan and Urgent Care had been provided earlier in the meeting.

13 AOCB

Kenny McCallum raised an issue regarding the payment of allowances to Home Care staff over the festive period, which had been a problem in previous years. Cindy Graham tackled this issue and it was highlighted that there were only three queries raised this year.

Trade unions advised that proposals to align Public Holiday allowances for the festive period 2020/2021 are being looked at.

14 DATE OF NEXT MEETING

Tuesday 17 March 2020 at 10.00am in Committee Room 1, 5th Floor, Fife House, North Street, Glenrothes, Fife, KY7 5LT