Agenda

B/23/11

NSS BOARD FORMAL MEETING
FRIDAY 30 JUNE 2023 COMMENCING 0930HRS, 2 SWINHILL AVENUE, LARKHALL, ML9 AND TEAMS

Lead: **Keith Redpath, NSS Chair**

In Attendance: Hayley Barnett, Assoc. Dir Governance and Board Services (Board Secretary)
Gordon Beattie, Director National Procurement
Martin Bell, Director Practitioner and Counter Fraud Services
Susi Buchanan, Director National Services Division
Julie Critchley, Director NHS Assure
Steven Flockhart, Director Digital and Security
Laura Howard, Associate Director of Finance
Jacqui Jones, Director of HR and Workforce
Brian McCabe, Associate Director of Finance
Lee Neary, Director SPST
Jacqui Reilly, Director of Nursing
Karen Nicholls, Committee Services Manager [Minutes]

Apologies:

Observers: Nia Morgan, Member of the Public (via TEAMs)
Linda Elverson, Member of the Public (via TEAMs)
Mark Gilliland, Member of the Public (via TEAMs)
Carole Grant, Audit Scotland
Liz McConachie, Audit Scotland
Stephanie Knight, Scottish Government

0930 – 1100 hrs

1. Welcome and Introductions

2. Items for Approval

2.1 Minutes of the previous meeting held on 9 March 2023 and Matters Arising **[B/23/12 and B/22/13]** - **Keith Redpath**

2.2 NSS Annual Whistleblowing Report 2022-23 **[B/23/14] – Jacqui Reilly**

2.3 NSS Quality Management Framework and Quality Improvement Strategy **[B/23/15] – Lee Neary**

3. Items for Scrutiny

3.1 Chairs Report - **Keith Redpath** (verbal)

3.2 Chief Executive's Report - **Mary Morgan** (verbal)

3.3 Integrated Performance Report May 2023 **[B/23/16]** – **Lee Neary**

3.4 Annual Reports from Committees 2022-2023 **[B/23/17]** – **Keith Redpath**

- NSS Audit and Risk Committee – to follow;
- NSS Clinical Governance Committee;
- NSS Finance, Procurement and Performance Committee;
- NSS Remuneration and Succession Planning Committee;
- NSS Staff Governance Committee.

4. Items for Information

4.1 Public Inquiries Update **[B/23/18]**

4.2 NSS Committees Approved and Draft Minutes **[B/23/19 A-J]**

4.3 Board Forward Programme **[B/23/20]**

5. Any other business

5.1 Date of next meeting: Wednesday 27th September 2023 at 09:30 am – Hybrid Meeting

In Private Session – *under NSS Standing Orders paragraph 5.22.1 and 5.22.4*

6. Annual Report and Accounts **[IPB/23/01]** - **Carolyn Low** to follow.

7. Audit Scotland NSS Annual Audit Report 2021/22 **[IPB/23/02]** - **Carolyn Low** to follow.

8. NSS Medium Term Plan (incorporating the NSS Annual Delivery Plan) **[IPB/23/03]** – **Lee Neary**

Minutes DRAFT

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NHS NATIONAL SERVICES SCOTLAND BOARD

MINUTES OF MEETING HELD ON THURSDAY 9 MARCH 2023 IN BOARDROOMS 1&2, GYLE SQUARE, EDINBURGH AND VIA TEAMs DIGITAL PLATFORM AT 0930 HRS

B/23/12

Present:
Keith Redpath, NSS Chair
Lisa Blackett, Non-Executive Director
Julie Burgess, Non-Executive Director
Ian Cant, Employee Director
John Deffenbaugh, Non-Executive Director
Gordon Greenhill, Non-Executive Director
Arturo Langa, Non-Executive Director
Beth Lawton, Non-Executive Director
Carolyn Low, Director of Finance
Mary Morgan, Chief Executive
Lorna Ramsay, Medical Director
Alison Rooney, Non-Executive Director

In Attendance:
Hayley Barnett, Assoc. Dir. Governance and Board Services (Board Secretary), (SPST)
Martin Bell, Director Practitioner and Counter Fraud Services (P&CFS)
Susi Buchanan, Director National Services Directorate (NSD)
Julie Critchley, Director NHS Assure
Jacqui Jones, Director HR and Workforce Development
Lee Neary, Director Strategy, Performance and Service Transformation (SPST)
Matthew Neilson, Assoc. Dir. Customer & Stakeholder Engagement, SPST
Karen Nicholls, Committee Services Manager [Minutes]
Steven Flockhart, Director Digital & Security (D&S)
Marc Turner, Director Scottish National Blood Transfusion Service (SNBTS)

Apologies:

Observers:
Ann Hargie, Member of the Public
Stephanie Knight, Scottish Government
Andrew Polson, Member of the Public
13 NSS Staff

1. WELCOME AND INTRODUCTIONS

1.1 K Redpath welcomed all to the meeting.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest or transparency statements made in respect of any item on the agenda.

3. MINUTES OF THE PREVIOUS MEETING HELD 9 DECEMBER 2022 AND MATTERS ARISING [Papers B/23/ and B/23/ refer]

3.1 Members approved the minutes as a true reflection of the meeting.

Decision: To approve the minutes of the Board meeting held on 9 December 2022.

4. NSS CORPORATE GOVERNANCE FRAMEWORK [paper B/23/37 refers]

4.1 Members were presented with the NSS Corporate Governance Framework (CGF). A full review of NSS's key corporate governance documentation had been carried out and brought together under the framework. The report also detailed the approach that NSS will take to achieve the Blueprint for Good Governance in NHS Scotland, Second Edition.

4.2 Members discussed the framework in full. It was noted that the Code of Conduct was included in the framework and provided clarity on the roles and responsibilities of Non-Executive Directors, and that it was important to acknowledge and build on the progress the Board had made since the first edition of the Blueprint for Good Governance in NHS Scotland.

Decision: To approve the Corporate Governance Framework with the following amendments:

4.2.1 Update terms of reference for the NSS Finance, Procurement and Performance Committee (FPPC) to include delegated authority to approve the NSS Annual Delivery Plan;
4.2.2 Addition of Beth Lawton as Vice Chair of the NSS Audit & Risk Committee (ARC);
4.2.3 Page 61, 6.5.7 change to read Caldicott Guardians reporting to ARC;
4.2.4 Update Finance, Procurement and Performance Committee (FPPC) terms of Reference at 1.2 to include Sustainability

Decision: To agree the approach that NSS will take to achieve the Blueprint for Good Governance in NHS Scotland, Second Edition, outlined in the Executive Summary of paper B/23/37.

Action: H Barnett to update the CGF accordingly and publish.

5. NSS BUDGET 2023-24 (Presentation)

5.1 C Low provided a presentation on the proposed NSS Budget for 2023-24 and highlighted the following;

5.1.1 Plans were in place to realise Cash Releasing Efficiency Savings (CRES) for 2023-24;

5.1.2 Discussions to rationalise additional allocations to baseline funding were ongoing with relevant sponsors;
5.1.3 All revised method of forward planning, including financial and workforce, had been done at a service level rather than by directorate;
5.1.4 COVID legacy funding was being managed appropriately and further discussions continued with Scottish Government to bring this to a BAU state;
5.1.5 Shared Services discussions continued and SLA's were being reviewed;
5.1.6 The budget will would be submitted to Scottish Government on 16th March 2023 with a final version ready for 31st March 2023.

5.2 Members reviewed the position and asked for further detail in relation to the Centre for Precision Medicine Cell Therapy for the Liver (PRACTICAL) project led by the University of Edinburgh and NHS Lothian. Members were supportive of this project but asked that the project be discussed further at the NSS Clinical Governance and Quality Improvement Committee (CGQIC). J Burgess asked that her concerns with regards to formally approving the project without these additional discussions be recorded.

Decision: To approve the balanced Revenue Budget position for 2023/24 to 2025/26.

To approve SNBTS's participation in the 'Centre for Precision Medicine Cell Therapy for the Liver' ('PRACTICAL') project.

To note the progress being made to secure agreement with Public Health Scotland in respect of Corporate Shared Services.

To note the continued funding risk in respect of additional allocations.

To note the further work underway to finalise operational budgets for both revenue and capital expenditure.

Action: Board Services to add PRACTICAL project to the next available NSS CGQIC agenda.

6. CHAIR'S REPORT

6.1 The Chair provided a verbal update for Members and highlighted the following:

6.1.1 Whole system pressures remained high;

6.1.2 NSS mid-year review with the Cabinet Secretary had been postponed;

6.1.3 NSS Excellence Awards had taken place and were well received;

6.1.4 The next Board Seminar would be focused on Risk and take place on 20 April 2023.

Decision: To note the update provided.

7. CHIEF EXECUTIVE'S REPORT

7.1 The Chief Executive provided Members with a verbal update on activities since the last Board meeting as follows, and was intended to augment other substantive Board agenda items.

7.2 Jennifer Thomson, Legal Advisor to NHSScotland had joined and the current interim arrangements for CLO would continue on a permanent basis, with reporting to the Director of Finance. Gordon James, Director of Procurement, Commissioning and Facilities Directorate had been successful in obtaining the role of Chief Executive at the Golden Jubilee Hospital and as a result this role had been de-established. The Directors of National Services Directorate, NHS Assure and National Procurement would now report permanently to the NSS CEO and were members of the EMT.

7.3 It had been a relatively constrained period due to the pressures experienced across the health system and since the Board last met, only one external event had been attended:31st January 2023 – Digital Leaders Forum as part of the Alumni event.

7.4 The Chief Executive advised the Board that NSS had successfully defended a legal challenge to a major re-procurement process and the procurement process had now resumed to plan.

7.5 The Chief Executive confirmed that the purchase of the Shotts site and sale of the site at Ellen's Glen Road were concluded.

7.6 Covid 19 Inquiry activity was intensifying. NSS were asked to provide evidence and witnesses to the Scottish Parliament COVID 19 Recovery Committee – the Chair of the Long Covid Network and Associate Director for Strategic Networks attended to contribute to the meeting earlier in February.

7.7 A Board seminar is to be arranged to focus on Data Strategy and Digital Roadmap for Financial Sustainability.

Decision: To note the update provided.

8. NSS INTEGRATED PERFORMANCE REPORT [paper B/23/05 refers]

8.1 Members discussed and scrutinised the report in detail and noted that NSS performance was positive across most areas. Those that were behind target had mitigating plans in place, or would be discussed further with government colleagues where timelines did not sit within NSS.

8.2 Members discussed and scrutinised a number of areas in more detail and asked for further detail on sustainability mitigation plans and use of graphical representation of trends and analysis for future reporting.

Decision: To note NSS performance in the NSS Integrated Performance Report for January 2023 (M10).

9. NSS ANNUAL DELIVERY PLAN (ADP) 2022/23 ROLL FORWARD [paper B/23/10 refers]

9.1 Members were informed that NSS had received a letter from Scottish Government in November 2022 recognising the system pressures and finances, and asking Boards to roll forward their ADP into the next financial year for the first quarter. The report provided reflected this request setting out the items that would be carried forward into Q5.

Decision: To approve the extension of the NSS ADP 2022-23 by one quarter at request of Scottish Government.

10. RISKS AND ISSUES REPORT [paper B/23/06 refers]

10.1 Members were asked to scrutinise the risk and issues for Month 10, January 2023 to assure themselves that corporate and strategic red risks were being managed appropriately and suggest any improvements to the report.

10.2 Members scrutinised the movement of risk as presented in the Executive Summary provided. After discussion Members asked that for all future reporting for Board and Committees authors were to include a professional statement to provide further assurance to Members.

Decision: To note the report.

Action: All authors to include 'professional statement' for reports.

11. ITEMS FOR INFORMATION

11.1 Members considered in full, the contents of the following papers which had been presented for information:

- Public Inquiries **[paper B/23/09 refers]**
- NSS Committees Approved and Draft Minutes **[paper B/23/07 refers]**
- Board Forward Programme **[paper B/23/08 refers]**

Decision: To note the items provided for information.

12. ANY OTHER BUSINESS

12.1 There was no other competent business to discuss.

Meeting closed 1159.

B/23/13

NSS BOARD

Meeting type: Formal

No	Date	REPORT TITLE	ACTION	ACTION OWNER	DEADLINE	CURRENT STATUS
1.	9.3.23	NSS Corporate Governance Framework [B/23/37]	To update framework with comments from Members and publish.	Hayley Barnett		**Recommend for Closure.** Complete as at 22.6.23
2.	9.3.23	NSS BUDGET 2023-24 [Presentation]	PRACTICAL project to be added to CGQIC forward programme for a future meeting.	Board Services	Immediately.	**Recommend for Closure.** Complete as at 22.6.23
3.	9.3.23	Risks and Issues [B/23/06]	Include 'professional statement' for all future reporting.	Hayley Barnett	Future reporting	In progress.

NHS National Services Scotland

Meeting:	**NSS Board Meeting**
Meeting date:	**30 June 2023**
Title:	**2022-23 Whistleblowing Annual Report**
Paper Number:	**B/23/14**
Responsible Executive/Non-Executive:	**Jacqui Reilly, Director of Nursing and NSS Whistleblowing Executive Lead**
Report Author:	**Lynn Morrow, Corporate Affairs and Compliance Manager** (Reviewed by: Hayley Barnett, Associate Director for Governance and Board Services and NSS whistleblowing ambassador)

1. Purpose

1.1 The Whistleblowing Annual Report for 2022-23 is presented to the NSS Board for approval. The Annual Report was scrutinised by the Staff Governance Committee at its meeting on 30 May 2023.

2. Recommendation

2.1 It is recommended that the Board approve the Whistleblowing Annual Report for 2022-23 for publication.

Statement from the Whistleblowing Champion
As Whistleblowing Champion, I am assured that whistleblowing activity and cases are being managed appropriately by officers, in accordance with the Whistleblowing Standards, with learning being identified and improvements implemented.

3. Executive Summary

3.1 In line with the National Whistleblowing Standards launched on 1 April 2021, NHS National Services Scotland is required to publish an Annual Report by 30 June 2023.

3.2 Since April 2022, NSS has been contacted, either through the Whistleblowing helpline or the Confidential Contacts Service on 13 occasions, four of these concerns were raised under the auspices of whistleblowing. Two met the criteria and were investigated as whistleblowing concerns (one Stage 1 and one Stage 2). The number of whistleblowing concerns NSS received in 2022-23 deceased from the previous year.

4. Impact Analysis

4.1 Quality/ Patient Care

4.1.1 Lessons learned from managing cases will continue to be used to ensure the whistleblowing process within NSS is improved and the outcomes from cases are used for organisational learning.

4.2 Equality and Diversity, including health inequalities

4.2.1 An impact assessment has been completed on whistleblowing. This has assessed the impact of the whistleblowing standards on staff and those who provide services on behalf of the NHS.

4.3 Data protection and information governance

4.3.1 A Data Protection Assessment has been undertaken and signed off by the NSS Data Protection Officer. A review will be undertaken during 2023.

5. Risk Assessment/Management

5.1 There is one corporate risk relating to whistleblowing. This relates to the development of a corporate tool for reporting of WB concerns.

5.2 This work was paused due to a reprioritisation of work during the pandemic. The development of a tool is part of a wider programme of work relating to several Corporate Reporting Systems. Officers leading this work have engaged with the whistleblowing team to reconfirm the requirements of a recording tool/system. The rescoping exercise and proposals for a Corporate Reporting Systems Programme was approved at the Executive Management Team on 20 June 2023. This work, including a tool for whistleblowing recording, will be progressed.

5.3 The interim solution of an excel spreadsheet which is populated via the confidential contact and WB service, with the IG provision as specified above, remains in place.

6. Financial Implications

6.1 There are no financial implications directly associated with this paper.

7. Workforce Implications

7.1 There are no workforce implications directly associated with this paper.

8. Climate Change and Environmental Sustainability Implications

8.1 There are no climate change and environmental sustainability implications directly associated with this paper.

9. Route to Meeting

9.1 Staff Governance scrutiny of this paper, prior to submission to the NSS Board for final approval is the agreed governance route for this annual report.

10. List of Appendices and/or Background Papers

10.1 Appendix 1 – 2022-23 Annual Report

Whistleblowing Annual Report

April 2022 to March 2023

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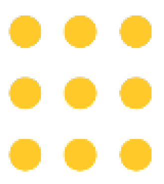


1. Introduction

This is our second annual whistleblowing report since the new Independent National Whistleblowing Officer (INWO) National Standards came into force on 1 April 2021.

We support and encourage an environment where employees, both current and former, bank and agency workers, contractors (including third sector providers), trainees and students, volunteers, and anyone working alongside our staff can raise concerns.

Our aim in this report is to be transparent about how we handle whistleblowing concerns, highlight actions taken and improvements to our services as a result of whistleblowing concerns raised and lessons learned.

In line with the national standards requirements, details are shared at a level which ensures we protect the whistleblower's identity and to make sure the report does not identify anyone who has contributed to an investigation.

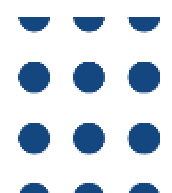
The reporting period includes activity between 1 April 2022 and 31 March 2023.

2. Background

Whistleblowing is an important process to enable a person to speak up about any whistleblowing concerns they may have in the organisation with respect to quality and safety in patient care and our service delivery. The way we respond to whistleblowing concerns raised is important, so that individuals feel that their concerns will be valued and handled appropriately, and that the organisation will take on board what they have to say.

In line with the organisation's values, we encourage whistleblowing concerns to be dealt with at the earliest opportunity and where possible in real time within the management structures that our staff work in within the organisation. Alternate routes for raising whistleblowing concerns include with more senior managers, trade unions and other staff.

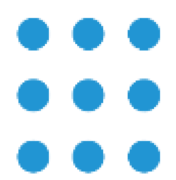
In support of providing alternate routes, we have recruited Confidential Contacts as an additional source of support for colleagues to talk about any workplace concerns or issues. We also have in place a dedicated whistleblowing telephone and email line. The whistleblowing telephone line is supported by the Whistleblowing Support Team and monitored daily during office hours.



Our Staff Governance Committee (SGC), together with our Whistleblowing Champion (WBC), who is a member of the SGC, have scrutinised this report, including performance against the requirements of the National Whistleblowing

Standards, key performance indicators (KPIs) as part of the Board's ongoing work to promote a 'Speak Up' culture. The WBC has been proactive in engaging with the organisation and raising awareness of Speaking Up and in providing oversight of governance mechanisms for reporting, including production of quarterly and annual reports, to complement the oversight provided by the Board.

3. Whistleblowing 2022-23 – At a Glance



4. Concerns Received

Since 1 April 2022, our Confidential Contact service and our whistleblowing helpline have been contacted on 13 occasions, four of these concerns were raised under the auspices of whistleblowing. Two of these were assessed as not meeting the whistleblowing definition and referred to HR or the complaints process. Of the remaining two, one related to NSS employed staff and the second related to contracted services.

There were no reports received from students, trainees or volunteers.

Contractors (both NSS specific and those with national contracts) were all contacted on a quarterly basis to obtain information on any whistleblowing concerns received during the reporting period in question. As detailed above, only one concern was received.

Over the relevant reporting period in the year to 31 March 2023, two whistleblowing concerns were investigated; this compares to four in the 2021-22 year. Feedback from our Confidential Contact service and our analysis of the range of concerns raised in the organisation, indicates that there have been no anonymous concerns raised by our staff who feel able to speak up in using the Confidential Contact service.

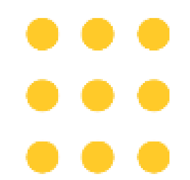
One concern was investigated as Stage 2 from the outset due to its complexity. The second concern, raised anonymously with the supplier related to contracted services was investigated as a Stage 1 concern.

Based on findings during the investigation, neither concern was upheld.

The details of the Key Performance Indicators (KPIs) associated with the concerns reported in their totality, those which were raised under the auspices as whistleblowing concerns and those which were investigated as whistleblowing concerns are given in section 6.

5. Findings by INWO

On 24 August 2022, the INWO laid her investigation report into our handling of a whistleblowing concern raised in 2021-22 before Parliament. INWO upheld two elements of the complaint and made recommendations for improvement in relation to the handling of the concern in line with the National Whistleblowing Standards; specifically, in relation to retaining the confidentiality of the whistleblower and witnesses and providing clarity on roles and responsibilities. A third element was not upheld. INWO also identified areas of good practice from NSS. (See Section 7).



Details of INWO's report can be found at https://inwo.spso.org.uk/nhs-national-services-scotland

Following publication, we met with INWO to discuss learnings for us and INWO. This was a worthwhile exercise and allowed both parties to reflect on the process, provide feedback and progress the report's recommendations. INWO took on board our comments and used our feedback in their October 2022 Newsletter.

In November 2022, we also received formal notification from INWO that they were satisfied that we had taken on board and addressed all recommendations contained within their investigation report and formally closed the case.

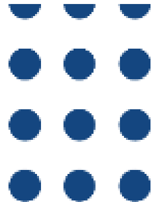
6. Key Performance Indicators

These following Key Performance Indicators (KPIs) are reviewed by the SGC quarterly, at each meeting.

6a. Concerns Received

	Q1	Q2	Q3	Q4	Total
Total number of concerns received	**4**	**1**	**1**	**7**	**13**
Number of potential whistleblowing concerns	**0**	**1**	**0**	**1**	**2**
No. classed as whistleblowing	0	1	0	1	2
No. reviewed at Stage 1 (5 days)	0	1	0	0	1
No. reviewed at Stage 2 (20 days)	0	0	0	1	1
No. classed as anonymous/unnamed	0	1	0	0	1
Number not classed as Whistleblowing	**4**	**0**	**1**	**6**	**11**

The remainder of this report is based on those concerns related to whistleblowing and referred to the whistleblowing service via the Confidential Contacts or raised with the whistleblowing service directly by the individual raising the concern.



6b. Whistleblowing Internal/External/Contracted Services Cases

	Q1	Q2	Q3	Q4	Total
No. of concerns – Internal	0	0	0	1	1
No. of concerns – External	0	0	0	0	0
No. of concerns – Contracted Services	0	1	0	0	1

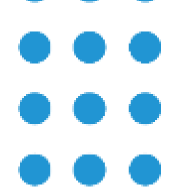
Internal refers to NHS National Services Scotland (NSS) staff in NSS Services, and external refers to non-NSS staff in NSS services (e.g. volunteers/students, etc).

6c. Whistleblowing Concerns Closed

	Q1	Q2	Q3	Q4
No. and % closed at Stage 1	0(0%)	1(100%)	0(0%)	0(0%)
No. and % closed at Stage 2	0(0%)	0(0%)	0(0%)	1(100%)

6d. Status of outcome of Investigation

	Q1	Q2	Q3	Q4	Total
Stage 1					
Upheld	0	0	0	0	0
Partially Upheld	0	0	0	0	0
Not Upheld	0	1	0	0	1
Stage 2					
Upheld	0	0	0	0	0
Partially Upheld	0	0	0	0	0
Not Upheld	0	0	0	1	1
TOTAL	**0**	**1**	0	**1**	2



6e. Response timescales

	Q1	Q2	Q3	Q4
Stage 1 (5 days)				
Average time in working days for responses	0	5	0	0
No. of cases closed at Stage 1 within timescale (%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
No. of Stage 1 cases extended	0	0	0	0
Stage 2 (20 days)				
Average time in working days for responses	0	0	0	51*
No. of cases closed at Stage 2 within timescale (%)	0(0%)	0(0%)	0(0%)	0(0%)
No. of Stage 2 Cases extended (%)	0(0%)	0(0%)	0(0%)	1* (100%)

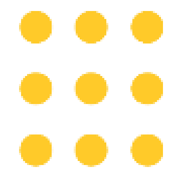
* The timescale for the Q4 case required to be extended to enable a full and thorough investigation to be carried out as the Investigating Manager was required to meet with additional witnesses. The Whistleblower was kept informed throughout and confirmed they were satisfied with the timescales.

6f. Cases under consideration by INWO

	Q1	Q2	Q3	Q4	Total
Internally raised Cases	0	0	0	0	0
Externally raised Cases	0	0	0	0	0
Contracted Services raised Cases	0	0	0	0	0

6g. INWO Referred Case at

	Q1	Q2	Q3	Q4	Total
Stage 1	0	0	0	0	0
Stage 2	0	0	0	0	0



7. Key Themes Arising from Whistleblowing Concerns Raised

As detailed above, only a small number of concerns have been received over this period and individual learning on each case was shared with the relevant individuals and teams within NSS.

Wider system learning and key process learning points were identified in relation to NSS project management processes and document recording and storage. These wider areas for improvement identified were not considered to have impacted on the outcome of the concerns investigated but may have resulted in a shorterinvestigation process.

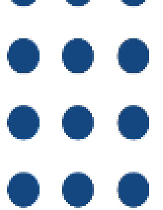
8. Learning, Changes or Improvements

We seek to continually improve processes and the support provided to individuals raising concerns and those involved as witnesses.

In line with reporting requirements, quarterly reports, including lessons learned, are provided to the NSS SGC, on behalf of the NSS Board, as well as direct to the INWO. Internal Standing Operating Procedures (SOPs) and processes based on learning from investigations undertaken are reviewed annually.

In response to the INWO report recommendations, detailed under section 5, and findings from both whistleblowing concerns investigated in 2022-23, in the past year, we have:

- Reviewed and refined the roles and responsibilities of those directly involved in whistleblowing to ensure that we mirrored the structure and roles outlined in the Standards and guidance issued by INWO. This included the separation of the Executive Lead responsibilities and clear processes for raising concerns, including those relating to Board Members. We have now established a Whistleblowing Ambassador role who has direct contact with staff and leadership of the confidential contact service, ensuring all staff have access to the support services available to them when they raise concerns. The role of the Investigation Manager was also clarified.



8a. Experience of those involved:

We have:

- Improved the experience of witnesses involved in the whistleblowing process, this included creating a whistleblowing witness briefing document and amending template letters to provide more assurance around confidentiality.
- Provided a named support person for witnesses.
- Created of an Investigating Manager briefing pack.
- Adopted INWO best practice detailed in their newsletters and on their website to update our guidance and processes.

We aim to continuously improve the way we do things. Areas of improvement work following the second year of learning include:

- Reviewing communication methods with whistleblowers to ensure that issues are identified from the outset.
- Identifying and actioning, as early as possible, any new elements of concern that emerge during an investigation.
- Considering how outcomes of investigations are communicated (thus providing assurance that concerns have been taken seriously).

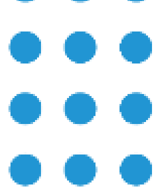
9. Staff Perceptions, Awareness and Training

We actively encourage staff to undertake the NHS Education for Scotland (NES) developed whistleblowing training in TURAS which provides learning on both the Standards and the role of INWO.

The Whistleblowing training figures, provided by Human Resources, as of 31st March 2023 were:

Whistleblowing	TURAS Headcount	Complete	Compliance %
Employee/ Managers	3,256	1,529	48%
Managers	756	513	68%

In April 2023, INWO launched a range of new resources to support training and development of staff. We played a key role in the development of a guide to whistleblowing for anyone delivering NHS Services. These resources were co-produced with involvement from INWO (the Improvement, Standards and Engagement team), NHS Highland, NHS Greater Glasgow and Clyde, NHS



Education for Scotland, Public Health Scotland and NSS. These resources will be promoted in NSS over 2023-24.

10. Working with Contractors

We identified current in scope service contracts and communicated whistleblowing requirements to all contracted suppliers to ensure compliance with the policy requirements. We undertake this work for NSS contracted services and for national contracts on behalf of NHS Scotland.

We collate reports of any concerns reported by the contractors and on an annual basis send all in scope suppliers of contracted services an electronic form, requiring detail of any whistleblowing concerns raised during the financial year, or confirmation of a nil response.

For the 2022-23 reporting year, there was one whistleblowing concern raised by the identified NSS in-scope suppliers, as detailed above.

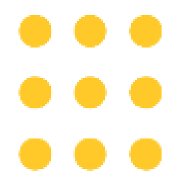
11. Communications

A Speak Up Communications strategy has been created to promote and encourage speaking up in the workplace. The aim of this strategy is to:

- To promote and encourage speaking up in the workplace;
- To highlight the difference speaking up can make;
- To provide a way for individuals to have their voices heard;
- To highlight the different routes available to staff to speak up and how to access them (depending on the nature of the concern).

Throughout 2022-23 there were regular staff messaging (via all staff emails and Stay Connected Staff Newsletter) including:

- To remind staff about the Standards and where to find them
- To remind staff about our eLearning programme and how to access i
- The promotion of the recruitment of Confidential Contacts and updates of the service.
- Independent National Whistleblowing Officer (INWO) monthly updates shared with all staff with option to sign up
- Activities around Speak Up Week 2022 (Twitter and LinkedIn activities).
- geNSS homepage updated with direct links to HR Connect pages on Whistleblowing and Confidential Contacts – **geNSS (scot.nhs.uk)**



Further examples of communication activity include:

- A Stay Connected article published during Speak Up week highlighting the benefits of speaking up and the difference it can make. The article included an interview with the Chief Executive, Whistleblowing Executive Lead and Whistleblowing Champion. Links to the National Whistleblowing Standards Training, the Whistleblowing Annual Report and the INWO website were also included.

- The WBC has attended all directorate ‘Townhalls’. Townhalls are live events held across the organisation and allow Directors to reach out to their local teams. These have been interactive sessions enabling Speak Up issues to be “brought to life” and has raised the profile of the learning that has taken place and improvements in action.

This annual report will be published on the NSS website.

For alternative formats please contact **NSS.EqualityDiversity@nhs.scot**

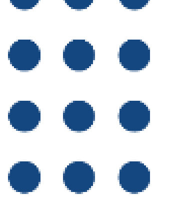
12. Confidential Contacts

With the introduction of the Once for Scotland policies in March 2020 and the Whistleblowing Standards in April 2021, all health boards across Scotland were to implement a Confidential Contact Service or similar service to the workplace for all employees to have access to. Following agreement by the NSS Workforce Policy Terms and Conditions (WPTC) Group and NSS Partnership Forum in March 2021, this service was developed and implemented within the Human Resources (HR) function.

During 2022-23, the Confidential Contact Service transferred from HR to Corporate Governance to allow separation between HR policies and speaking up. This move was well received by those involved.

Our Confidential Contacts listen, support and signpost options under the relevant policies to staff who wish to raise concerns. They undertake this role on a voluntary basis, in addition to their substantive role.

The confidential contacts received training on the role of the confidential contact, HR policies, whistleblowing and listening skills. Confidential contacts utilise an electronic recording form to enable anonymous recording of contacts being made.



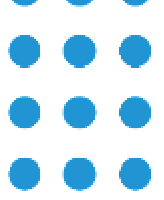
The Chief Executive; Executive Lead for Whistleblowing and WBC meet with the Confidential Contacts, at least twice per annum, to discuss the support they are providing to staff. This has been especially valuable as it has further enhanced a deeper understanding of the experiences of the Confidential Contacts.

A recruitment process was held in March 2023 and following significant interest from staff across NSS, four new Confidential Contacts have been appointed.

Feedback from confidential contacts included:

"I wanted to be a CC as I feel it is important for staff to have a safe place to speak freely. I have found the experience interesting and informative so far."

We are capturing the themes from comments raised by Confidential Contacts.



13. Our services

We are a national NHS Board operating right at the heart of NHS Scotland. Through our services we provide invaluable support and advice through our Directorates and Corporate functions. A role that is also extended to the wider public sector. Our services include:

Digital and security

Our expertise in digital services includes end-to-end business solutions, technology and data for clinical settings, and digital security options. Our innovative and person-centred scalable technology is delivered through local and national digital solutions, providing clinical informatics, cyber security and information governance.

Primary Care Support

We support general practitioners, dentists, opticians, community pharmacies and dispensing contractors to deliver primary care across Scotland. This includes managing contractor payments, maintaining an up-to-date patient registration database, medical record transfers and clinical governance for dental services.

Specialist healthcare Commissioning

We commission a range of specialist and rare condition treatments supporting NHS Scotland to ensure equitable and affordable access to these services when needed. We also co-ordinate a range of screening programmes.

Legal

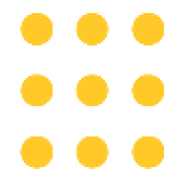
We provide specialist legal advice and assistance in every area of law relevant to the public sector. With many years of experience, we advise clients on all aspects of the law, and with close links to the Scottish Government, we also counsel on wider policy issues.

Programme management services

We act as a national delivery provider and work with our partners to offer total solutions in portfolio, programme, project management and transformation services. By equipping our clients with the right people and approaches we can support the delivery of complex and challenging change programmes.

National procurement

We provide a single procurement service across NHS Scotland. We work collaboratively to provide best quality, fit for purpose and best value commercial solutions – weighing up cost and added value. Our expert logistics services include distribution, supply chain and warehouse operations, fleet management and ward product management.



Fraud prevention

We work in partnership with NHS Scotland and across the Scottish public sector to provide a comprehensive service to reduce the risk of fraud and corruption. We are responsible for checking patient exemptions in respect of NHS Scotland patient charges and collecting payments for incorrectly claimed exemptions.

Blood, tissues, and cells

The Scottish National Blood Transfusion Service provides blood, tissues, and cells to NHS Scotland, ensuring they are available, 24 hours a day, every day of the year throughout Scotland. We also provide specialist treatment and therapeutic solutions, and specialist testing and diagnostic services appropriate for all Scottish patient needs.

Corporate services

We provide corporate shared services to other health boards. Our offer brings together five vital services: HR, Digital and Security, Facilities, Procurement and Finance.

The Board Services team provides essential support for the effective functioning of NHS Scotland Committees and the NSS Board and Committees. They work closely with the Corporate Governance Directorate to uphold high corporate governance standards.

NHS Scotland Assure

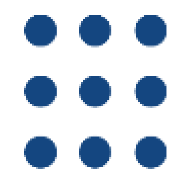
We work with health boards and partners to support a ‘Once for Scotland’ approach ensuring healthcare buildings are safe and ensure patient safety. The service unites professionals from different backgrounds, such as infection, prevention and control, construction, capital planning, facilities and catering, decontamination, and sustainability, to reduce risk and improve quality in Scotland’s buildings and estates.

Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland

ARHAI Scotland is responsible for coordinating national surveillance, reporting of healthcare associated infections and monitoring antimicrobial resistance and prescribing. As part of NHS Scotland Assure, we also provide evidence-based guidance and expert advice on infection prevention and control to reduce healthcare-associated infection (HAI).

Health Facilities

As part of NHS Scotland Assure, Health Facilities Scotland provides a range of specialist and technical services supporting NHS Scotland’s built environment. This includes advice on capital projects, engineering advice, equipment provision and facilities management.



APPENDIX – KPI Checklist

As per INWO Guidance

KPI	Requirement	See Section
1.	A statement outlining learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns.	Section 8, Page 9
2.	A statement to report the experiences of all those involved in the whistleblowing procedure (where this can be provided without compromising confidentiality).	Section 8a, Page 10
3.	A statement to report on levels of staff perceptions, awareness and training.	Section 9, Page 10
4.	The total number of concerns received	Section 6a, Page 6
5.	Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed.	Section 6c, Page 7
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.	Section 6d, Page 7
7.	The average time in working days for a full response to concerns at each stage of the whistleblowing procedure.	Section 6e, Page 8
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.	Section 6e, Page 8
9.	The number of concerns at Stage 1 where an extension was authorised as a percentage of all concerns at Stage 1.	Section 6e, Page 8
10.	The number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at Stage 2.	Section 6e, Page 8

NHS National Services Scotland

Meeting:	**NSS Board**
Meeting date:	**30th June 2023**
Title:	**NSS Quality Management Framework, Quality Improvement Strategy and Quality Improvement 2023/24 Delivery Plan**
Paper Number:	**B/23/15**
Responsible Executive/Non-Executive:	**Lee Neary Director, SPST (QM exec lead)** **Jacqui Reilly, Director of Nursing (Qi exec lead)**
Report Author:	**Lorna Brady, Programme Manager** **Matthew Neilson, Associate Director, SPST**

1. Purpose

1.1 This report presents to the NHS National Services Scotland (NSS) Board:

- 1.1.1 A Quality Management Framework for NHS NSS (Appendix 1)
- 1.1.2 A Strategy for Quality Improvement in NSS (Appendix 2)
- 1.1.3 A 2023/24 Delivery Plan for Quality Improvement in NSS (Appendix 3)

1.2 These documents will support achievement of the NSS Strategic Objectives; primarily Service Excellence, and also Financial, Workforce and Climate Sustainability, by enabling the development of structures, processes and culture for continuously improving the way we do things in the organisation.

1.3 This report also seeks the Board's approval to amend the Terms of Reference of the Clinical Governance and Quality Improvement Committee (Appendix 4).

1.3 Endorsement of the recommendations below will ensure that a focus on Quality is treated as a priority across NSS and that sufficient resources are allocated to enable the delivery of the programme.

2. Recommendations

2.1 The NSS Board is recommended to:

2.1.1 endorse the NSS Quality Management Framework, QI Strategy and 2023/24 Delivery Plan, and approve the governance arrangements proposed in the Quality Management Framework to support their successful execution.

2.1.2 approve the amended Terms of Reference of the Clinical Governance and Quality Improvement Committee, Corporate Governance Framework.

3. Executive Summary

3.1 NSS operates within the Healthcare Quality Strategy for NHS Scotland (2010). The reliable delivery of high-quality care and services requires organisations to have a consistent and coordinated approach to managing quality that is applied from team through to board level. To achieve this, we will adopt the Scottish Quality Management System Framework (2022) and support the move from quality improvement to quality management. The NSS Quality Framework, based on the national requirements, can be found in Appendix 1.

3.2 The purpose of quality in NSS is defined by the NHS Scotland Quality Ambitions (2010) and our Service Excellence strategic objective:

3.2.1 *"We will continuously improve the way in which we deliver existing and new services, with a focus on quality, to ensure they are safe, efficient, effective and meet the needs of our service users, partners and stakeholders."*

3.3 There is an opportunity for a range of programmes across NSS to align themselves with the NSS Quality Management Strategy (QMS). In turn they will play an important part in establishing the quality management system that underpins the framework.

3.4 It will be important that this work is closely aligned and coordinated with other strategic and organisational development work underway in NSS. This includes: Quality Improvement, Data Governance, Corporate Systems, Service Transformation and Leadership Development. In addition, we will need to consider what quality resources are needed across the organisation to ensure its successful implementation.

3.5 A Quality Improvement Strategy for NSS has been developed, which can be found in Appendix 2, together with a Delivery Plan for 2023/24, which can be found in Appendix 3. The Delivery Plan was developed based on the recommendations from the QI Discovery maturity assessment exercise, which was undertaken in 2022, to determine the extent to which quality improvement is embedded in the culture of NSS.

3.6 During 2023/24, the Quality Delivery Plan will focus on laying the foundations for the development of a quality culture throughout NSS, e.g. by mapping out the various quality management systems being implemented across NSS, agreeing

performance metrics for quality, working with Directorates to understand their capacity and capability for QI, giving staff access to QI tools and guidance to promote more consistent approaches to QI, developing learning and development opportunities for staff in QI, and building networks and relationships both within NSS and to other organisations.

3.7 At it's meeting on 1 June 2023, the Clinical Governance and Quality Improvement Committee agreed to recommend to the NSS Board that the Quality Improvement reference in the Committee's title is removed as this focus sits across NSS. This aligns with the documents presented within this report and commentary above.

4. Impact Analysis

4.1 Quality/ Patient Care

4.1.1 Quality improvement activity is essential to achieving the triple aim of improving the health of the population, enhancing patient experiences and outcomes, and reducing the per capita cost of care, and to improving provider experience.

4.2 Equality and Diversity, including health inequalities

4.2.1 Quality covers 6 domains including explicit description of opportunities to improve equity and so applied QI has the potential to address or improve areas of disparity. We will seek to explicitly invite diversity and wide participation for QI work, including in the membership of the Delivery Group. There is no EQIA required for this framework and strategy these will be done for specified work packages as required.

4.3 Data protection and information governance

4.3.1 Until specific improvement projects are identified, it is not known at this stage whether there will be any changes to information collected about individuals or the way in which the data is collected. Therefore at this time it is assessed that a Data Protection Impact Assessment is not required. DPIAs will be done as necessary for individual projects as required.

5. Risk Assessment/Management

5.1 There are potential risks and consequences of not delivering on the service excellence ambition in our refreshed strategy for NSS, by not being able to prioritise quality improvement over operational pressures. Proactively planning quality, identifying our priorities and ensuring we deliver on those are key in mitigating the strategic risks.

5.2 Without a relentless focus on Quality Improvement (service users, flow, eliminating waste and reducing variation), we will find it extremely challenging to achieve future service excellence ambitions.

5.3 It is important that the work is complementary to existing QI work to date and to work on the wider NSS objectives of financial, climate and workforce sustainability; and therein forms part of the NSS board assurance framework.

5.4 COG oversight of the Quality Programme will be required to ensure all our strategy and corporate change programme work across NSS is aligned in this regard.

5.5 A risks, issues and opportunities log has been developed to support delivery.

6. Financial Implications

6.1 One of the central components to Quality Improvement is the realisation of value. Programme Management resources have been agreed to support QI works for 23/24 and any additional programme resources as required will be requested from the change management fund through the COG approval process and considered in a risk based and proportionate way to meet service excellence delivery.

7. Workforce Implications

7.1 Programmes of learning around QI will be required throughout the organisation but will not impact on workforce numbers. Applying QI approaches can lead to better joy in work, meaning, wellbeing and commitment. In short, it should be seen as meaningfully contributing to NSS being a great place to work.

7.2 The plan will also develop a confident and competent QI focused workforce in NSS to enable service excellence.

8. Climate Change and Environmental Sustainability Implications

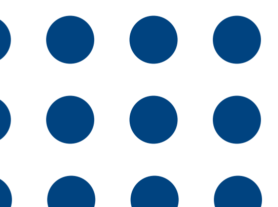
8.1 It is expected that as a result of quality improvement activity, there will be a resulting contribution to our climate change and environmental sustainability objectives.

9. Route to Meeting

9.1 Quality Improvement Delivery Group – 28th March and 24th April 2023
9.2 Quality Improvement Oversight Group – 17th April 2023
9.3 Change Oversight Group – 19th April 2023
9.4 NSS Executive Management Team – 22nd May 2023
9.5 NSS Partnership Forum – 23rd May 2023
9.5 NSS Board – 30th June 2023

10. List of Appendices and/or Background Papers

10.1 Appendix 1 - A Quality Management Framework for NHS NSS
10.2 Appendix 2 - A Strategy for Quality Improvement in NHS NSS
10.3 Appendix 3 - A 2023/24 Delivery Plan for Quality Improvement in NHS NSS
10.4 Appendix 4 – Quality Improvement Discovery Report
10.5 Appendix 5 – Terms of Reference, Clinical Governance and Quality Improvement Committee, Corporate Governance Framework.



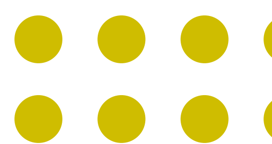
Quality Management Framework

Lee Neary, Director of Strategy, Performance & Service Transformation

Jacqui Reilly, Director of Nursing

Matthew Neilson, Associate Director of Strategy, Performance & Communications

May 2023



Purpose

The purpose of quality in NSS is defined by the NHS Scotland Quality Ambitions (2010) and our Service Excellence strategic objective (2022).

NHS Scotland Quality Ambitions

Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

NSS Service Excellence

“We will continuously improve the way in which we deliver existing and new services, with a focus on quality, to ensure they are safe, efficient, effective and meet the needs of our service users, partners and stakeholders.”

Service Excellence

Our aim is to deliver a Quality Management Framework to ensure achievement of our service excellence strategic objective.

DEFINITION

A way of working focused on delivering improvements in care quality and safety by the everyday, ongoing use of continuous improvement techniques that are driven and owned by frontline staff and enduringly supported by the entire organisation and board*

OBJECTIVE

We will continuously improve the way in which we deliver existing and new services, with a focus on quality, to ensure they are safe, efficient, effective and meet the needs of our service users, partners and stakeholders.

METRICS

A new set of performance measures based on service performance, improvement and productivity.

* KPMG definition of 'operational excellence' in healthcare. Creating a Culture of Excellence (April 2019).

Goal

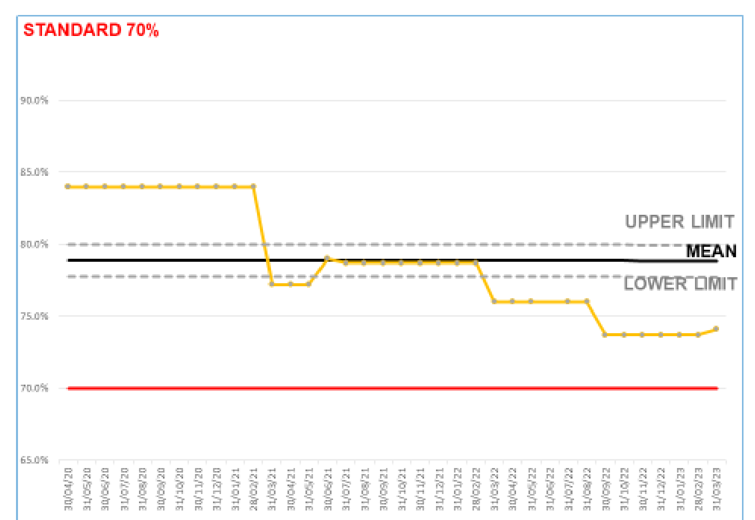
Our goal is for all our services to be achieving above sector performance for satisfaction.

Measures in our existing Service Excellence report show that although our services are meeting standards, they are not viewed as positively as before the pandemic. Quality Management will seek to address that gap.

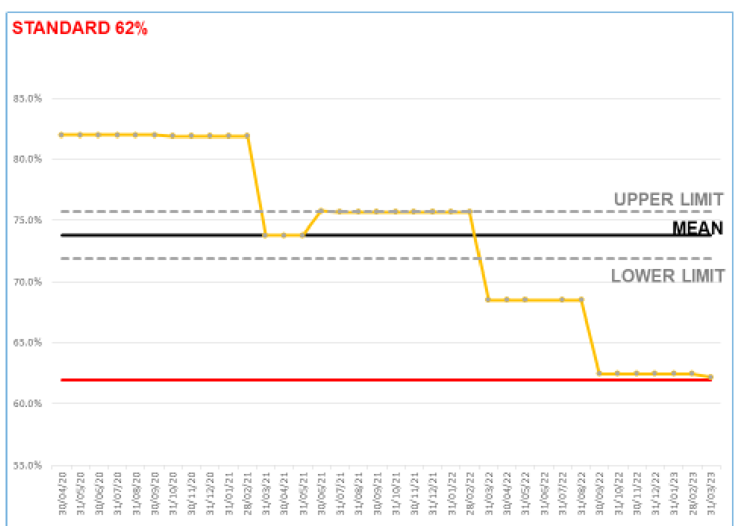
Currently NSS averages 74.1 for satisfaction against a UK public services (national) sector average of 75.1. There is high variation in service satisfaction scores for NSS, which range from 57.9 to 99.2.

IN the future we will include measures that account for the experience of the people who deliver our services.

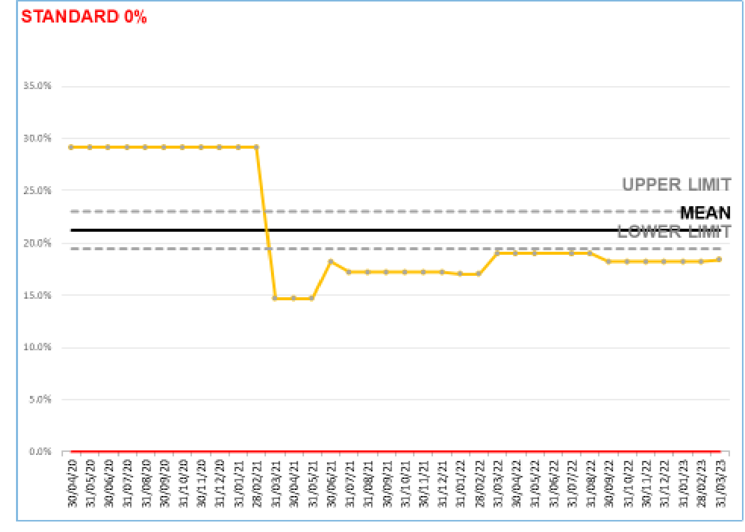
NSS User Insight
Satisfaction (M12 FY23)



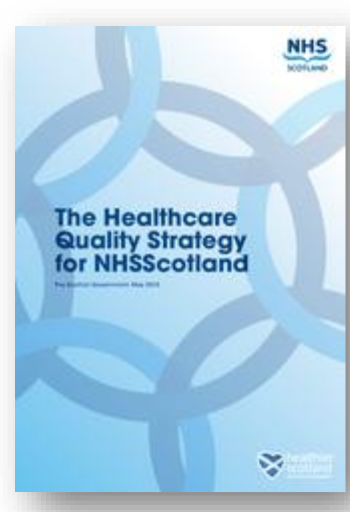
NSS User Insight
Effort (M12 FY23)

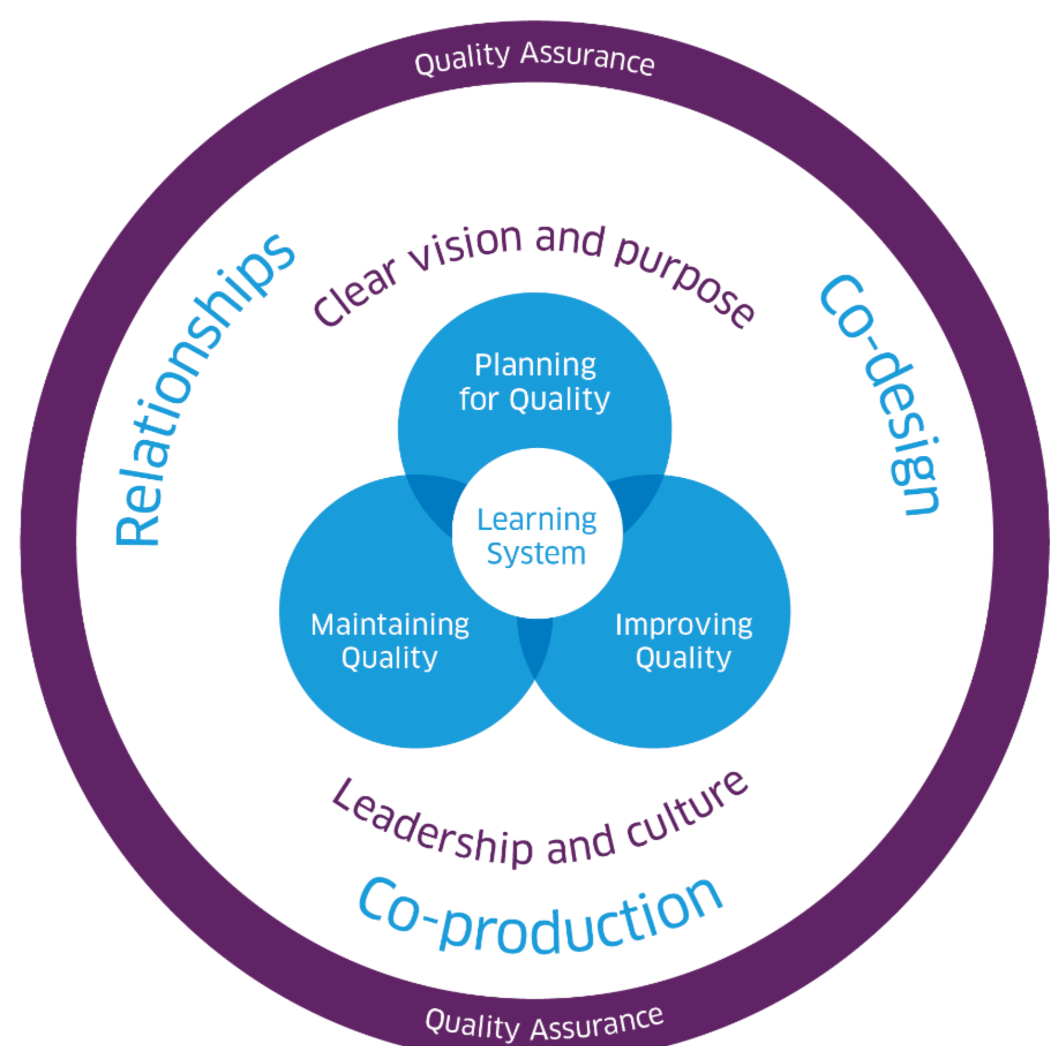


NSS User Insight
Advocacy (M12 FY23)



Our strategic framework





NSS operates within the Healthcare Quality Strategy for NHS Scotland (2010).

The reliable delivery of high quality care requires organisations to have a consistent and coordinated approach to managing quality that is applied from team through to board level. This is known as a Quality Management System.

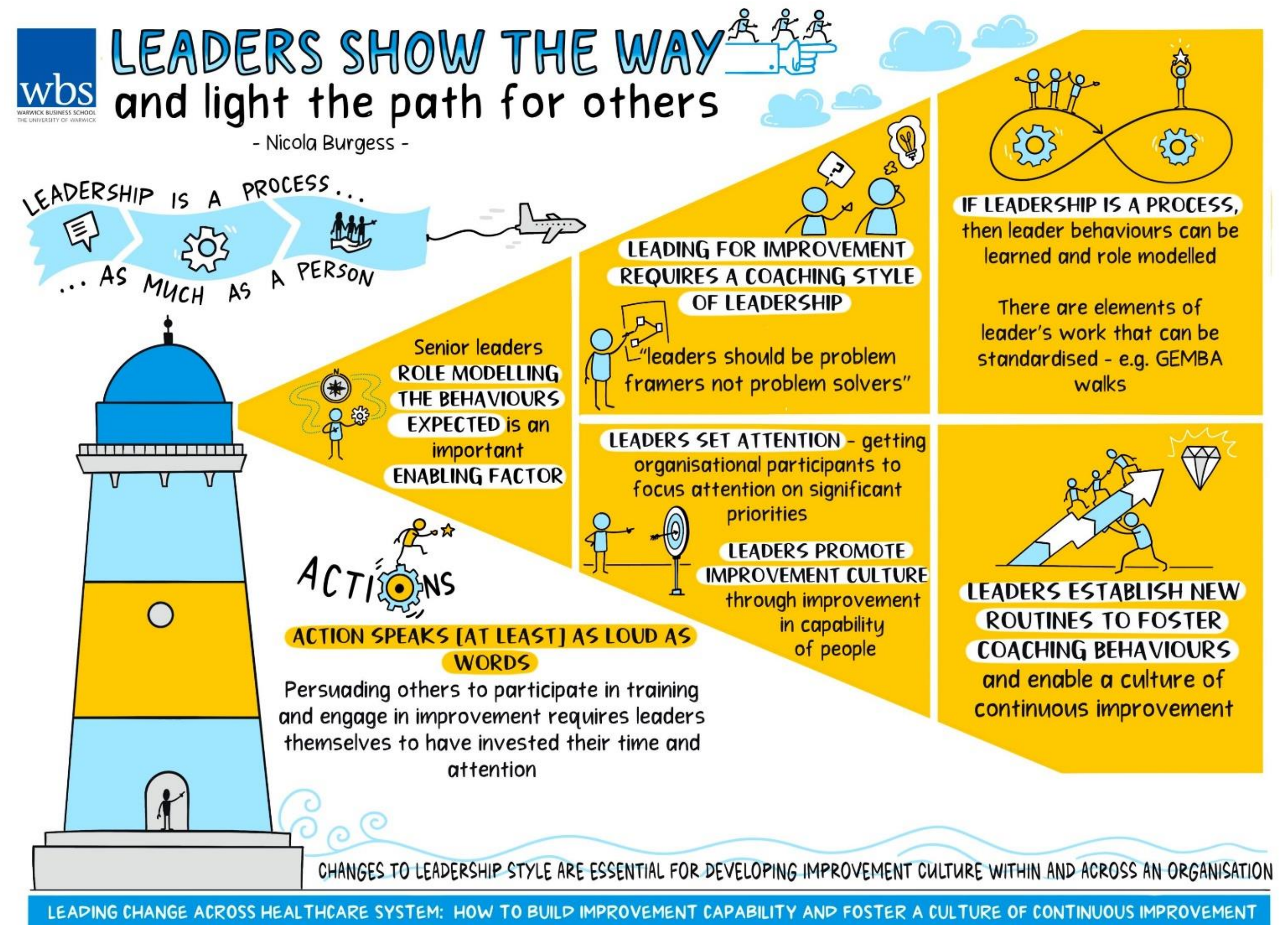
To achieve this, we recommend NSS adopts the Scottish Quality Management System Framework (2022) and adapts/translates it for NSS use.

Leadership and culture

Any effective approach to quality management in health and care must recognise the vital role leadership behaviours and organisational cultures play.

We will be adopting the learnings identified by the Warwick Business School from the five-year long NHS partnership with the US Virginia Mason Institute – Leaders Show the Way and Light the Path for Others.

The Quality Improvement Leadership and Culture workstream is working with NSS Learning & Development to ensure that quality improvement leadership behaviours are embedded in to the NSS Senior Leadership Development Programme.



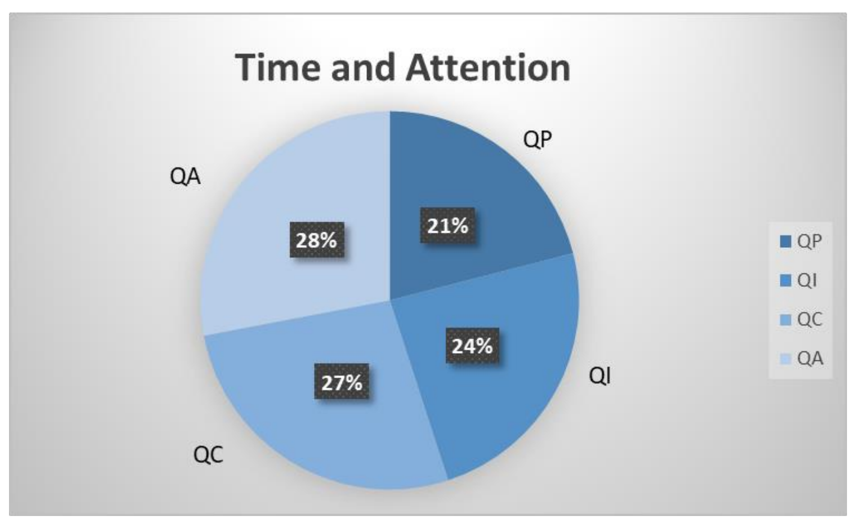
Leadership and culture

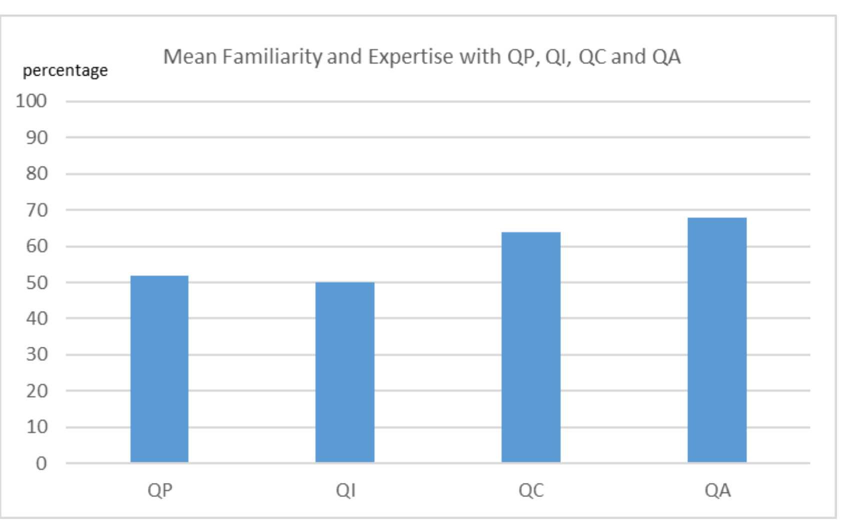
NSS began to assess its leadership position on quality and identify opportunities and actions at its informal Executive Management Team (EMT) session on 2 April.

The EMT's time and attention on quality areas – planning (QP), improvement (QI), control (QC) and assurance (QA) – is relatively well balanced. However, familiarity and expertise was weighted more towards control and assurance and indicates development opportunities in planning and improvement areas.

In terms of development, there was an overwhelming appetite for a structured quality approach with most support for embracing existing quality methodologies, learning from other organisations and becoming lean leaders.

We will formulate plans to support these requirements through the Quality Governance workstreams.



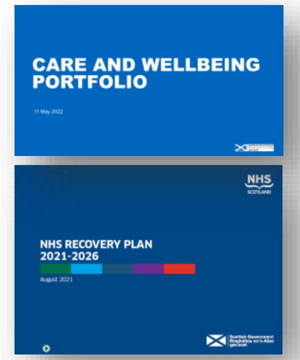


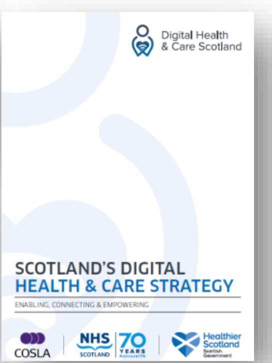
Planning for quality

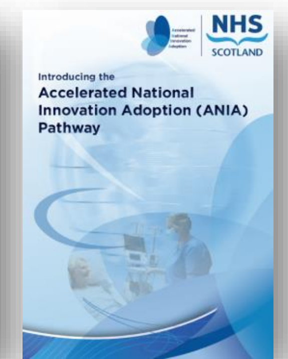
Quality planning is the mechanisms by which a team, service, organisation or system chooses its priorities for improvement and then designs appropriate interventions to deliver those improvements. There are three primary sources when considering quality planning.

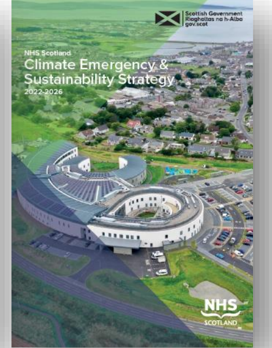
- Quality control and/or quality assurance mechanisms.
- Work to understand the population/customers' needs and assets.
- Government strategies and targets.

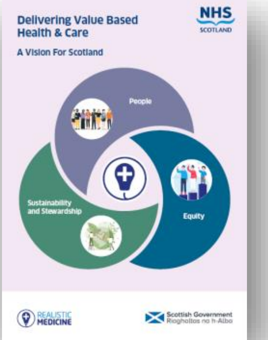
We will redesign our planning and performance management approaches to account for quality requirements. PGMS can also support with service design and service transformation services.

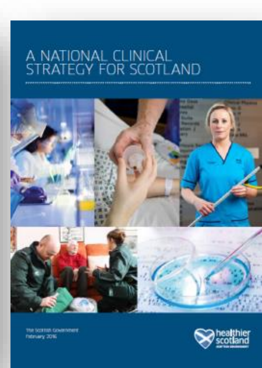










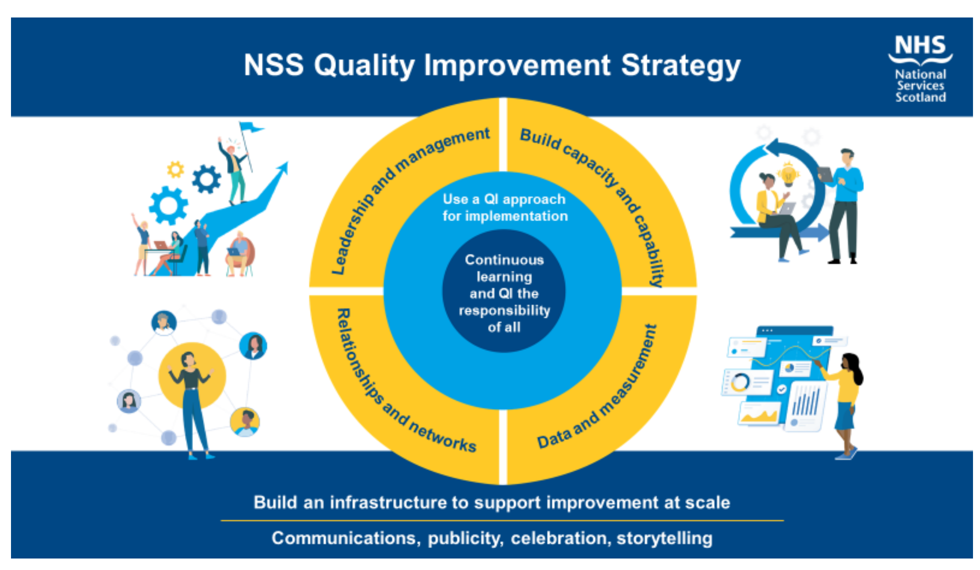


Improving quality

NSS defines quality improvement as "taking a systematic and coordinated approach to identifying and solving problems using specific methods and tools to achieve measurable improvements".

We have developed a Quality Improvement Strategy that is aligned to the Scottish Quality Management System Framework and based on the following principles.

- A mindset of curiosity and learning.
- A systematic methodology with consistent methods and tools.
- Engages those people closest to the quality issue (both users and staff) in discovering solutions to complex problems.
- Involves testing ideas to generate learning and understanding and seeing whether they help improve things.
- Involves having clear ways of knowing whether things are changing and using measurement to understand variation.



We are supporting Directorates to develop Quality Improvement Plans for the end of June.

Maintaining quality

This covers the processes in place to monitor performance in real time and then take action when results do not match the agreed performance standards.

Quality control processes:

- Owned by those directly providing the service.
- Services/teams understand what good looks like.
- Have real-time data (quantitative and qualitative).
- Know if they are meeting those performance standards.
- Have the skills and permission to address any quality/performance problems within their control.
- Know who else to involve in addressing the ones beyond their control.

We will undertake Quality Improvement Preparedness Assessments to determine what Directorates are doing now, e.g. existing quality standards/systems (ISO, BSI, regulatory) and tools (kaizen, lean, customer experience). This will help us to understand what is already happening across NSS, what Directorates would like to do next and how we can support them.

Learning system

Health and Social Care is a complex operating environment and needs systems that enable staff at every level to continually review how well their service is doing (quality control), identify their priorities for improvement and design appropriate interventions (quality planning), and test ideas to make care better (quality improvement).

These are the critical components for an effective learning system:

- A measurement system that enables learning about what is and isn't working.
- Access to relevant evidence to inform decision making.
- Systems for identifying where improvement is happening and assessing the generalizable learning for spread.
- Approaches to enable those working on similar problems to connect with each other and exchange insights (e.g. communities of practices, events to exchange learning).
- A culture where reflective and reflexive practice is valued and enabled.
- Psychological safety.

The Quality Improvement Learning & Development workstream will be considering professional and leadership development opportunities, along with specific training on quality tools and techniques, to help foster a positive culture of quality practice across NSS.

Social processes

Any effective approach to Quality Management in health and care must recognise the vital role that interactions between people (social processes) play including the impact of leadership behaviours and organisational cultures.

Critical actions for increasing the focus on relational approaches to manage quality include:

- Co-designing improvements to services with the individuals who use them and the staff who deliver them.
- Co-producing outcomes the individuals and communities who interact with our services.

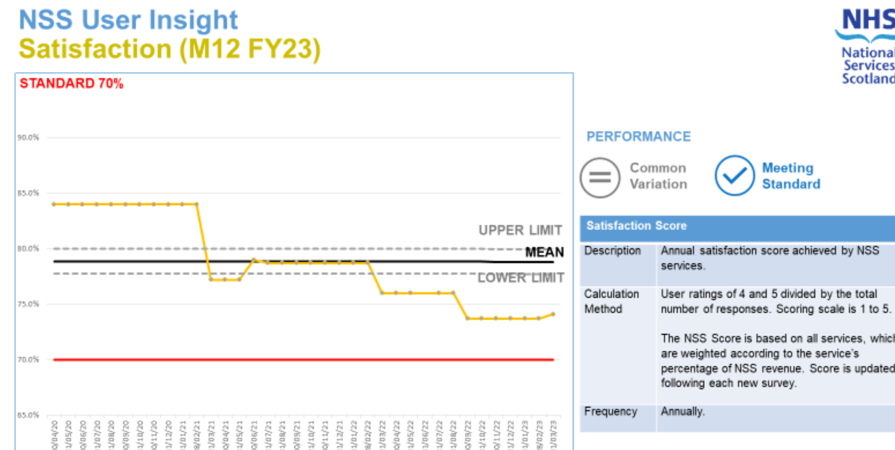
We will refocus our customer experience team on quality and widen the use of customer experience methodologies and tools, quality function deployment (voice of the user) while also ensuring we meet our public involvement and equality responsibilities.

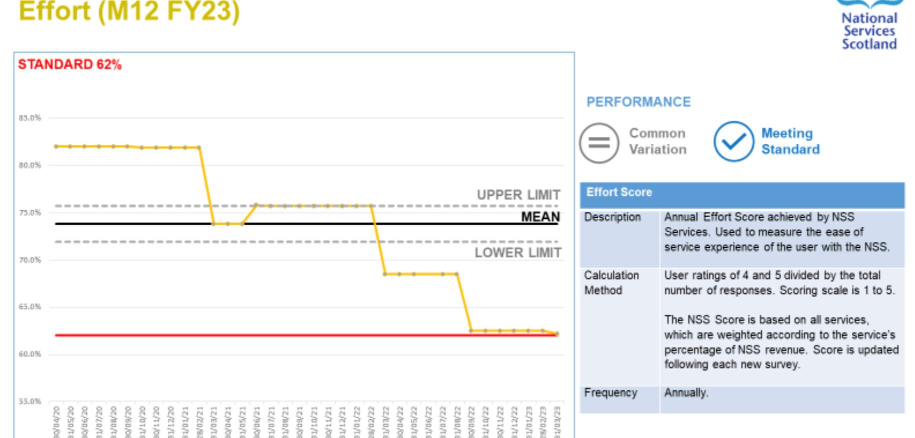
Quality assurance

To assure the effective functioning of a team/organisation/systems approach to managing quality. This should align with other assurance mechanisms in NSS, and in particular the NSS Board Assurance Framework and The Blueprint for Good Governance (Second Edition, 2022).

Potential improvements could be made in performance monitoring, the use of statistical process control, how we triage and achieve evidence based assurance and more independent assurance through benchmarking and other independent audits (e.g. ISO assessments) to account for quality requirements.

We are redesigning the NSS Service Excellence report to better reflect service performance and quality measures. An informal EMT session is being planned to consider new metrics and the first changes will appear in the Q1 FY24 report.





Quality governance

Our aim is to assure the effective functioning of a team/organisation/systems approach to managing quality.

It also needs to align with other governance mechanisms in NSS.

This is the proposed governance structure for quality in NSS.

It recognises that quality is a key part of the NSS Board Assurance Framework and that success is dependent on building a culture of quality.

Working Groups

Leadership & Culture (Lead TBC)	Quality Management Systems (Lead TBC)	Quality Improvement Toolkit (Lead TBC)	Quality Improvement Learning & Development (Lead TBC)	Quality Improvement Preparedness (Lead TBC)	Directorate 1 Quality Improvement Pilot (Lead TBC)	Directorate 2 Quality Improvement Pilot (Lead TBC)	Directorate 3 Quality Improvement Pilot (Lead TBC)

Delivering quality

Alongside the activities already underway in Directorates, which we will identify through the Quality Improvement Plans and Preparedness Assessments, there are a number of corporate or cross-organisational NSS programmes that could potentially support our transition to a quality management culture. Further consideration is being made by the programme on how to harness their potential.

Additionally, considerations are being made within SPST to bring together the planning and performance team with the customer solutions and experience team for the ongoing management of quality requirements across NSS. This ensures quality is fully integrated into planning and reporting, remains aligned to NHS Scotland strategies and NSS Board assurance, and is driven by user and community insight.

Delivering the framework

Q1 FY24	Q2 FY24	Q3 FY24	Q4 FY24
• NSS Quality Management Framework • NSS Quality Improvement Strategy • Directorate Quality Improvement Plans	• Preparedness Assessment and Analysis • New Service Excellence Report with Quality Metrics • Quality Improvement Leadership Action Plan • Quality Improvement Training Plan	• Quality Improvement Pilots Completed • Quality Improvement Toolkit	• SPST Planning and Quality Team established • Ongoing quality infrastructure needs identified • Quality Plans for FY25 agreed and captured as part of the NSS ADP FY25

Annual Delivery Plan 2023/24 and Medium Term Plan 2023-26

Quality Improvement (QI)
A Strategy for NHS National Services Scotland
To pursue the aim of an organisational culture of QI across NSS

Version 0.4
11 May 2023

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Background

This strategy was developed in the light of an organisational strategic commitment to continuously improving the way we do things with the aim of our strategic objective of delivering service excellence.

The QI strategy has been informed by an NSS service design maturity assessment undertaken in 2022 on where NSS was with QI organisationally, recommendations arising from a 2022 KPMG audit of clinical governance and QI in NSS to date, and wider learnings from the published evidence of embedding approaches to QI in organisations.

The initial draft was developed by the QI clinical lead in the organisation and then the Quality Improvement Development Group (QIDG), established in 2022 and representing the QI leads for each directorate in NSS, contributed to its development. The NSS Quality Improvement Oversight Group (QIOG) connected this to wider NSS strategy and considered organisational needs as part of the Quality Management approach in NSS.

The route to governance for this strategy was the NSS Change Oversight Group (COG) and EMT to ensure organisational buy in at all levels to the principles outlined here.

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1. Context

NHS National Services Scotland (NSS) provides national infrastructure services and solutions which are integral to the delivery of health and care services in Scotland – locally, regionally and nationally. NSS provides national solutions to improve the health and wellbeing of the people of Scotland. NSS has four strategic aims, including service excellence. QI is an essential enabler for service excellence.

As an organisation, NSS contains multiple and varied directorates (previously known as strategic business units). Directorates have diverse functions, and different and distinct leadership teams and governance arrangements, processes, regulatory requirements, cultures and ways of working. Whilst the Directorates share the same Board, executive leadership and corporate governance, there are degrees of variation, autonomy and independence in how the Directorates operate. The organisational make up characteristics of NSS makes this organisational approach to QI work particularly complex.

This strategy for an NSS wide organisational approach to QI, seeks to establish generic principles whilst emphasising that the co-creation of bespoke approaches tailored to each particular context (or directorate) will be required during implementation phases.

The work of creating a QI culture will require a redistribution of our resources, so that time and resource can be freed to work on improvement.

This work will incur significant opportunity costs by shifting time and effort towards QI. The resource to do this work will in all likelihood need to be released from directorates, perhaps supported by a central team. In this way, the delivery of this strategy carries some risks. Creating an organisational QI approach will not necessarily provide quick fixes or magic solutions, the benefits can take some time to be realised and may take some years to be fully apparent. In many ways QI can be seen as a shift from short term thinking to longer term solution thinking. Successfully incorporating a QI mind-set into standard NSS thinking would then create the conditions for it to become part of 'the job', rather than an add-on.

Reconciling these realities at a time of financial pressure and scarcity whilst making progress in pursuit of better will be the most challenging aspect of this work.

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2. QI and a balanced Quality Management System

For the purposes of this strategy, QI is defined as "a systematic approach that uses specific techniques to improve quality". For the purposes of this document we would identify QI as having the following features (see Figure 1):

1. A mindset of systems thinking, curiosity and learning
2. A systematic methodology with consistent methods and tools
3. Engagement with those people closest to the quality issue (both staff and users) in discovering solutions to complex problems
4. An iterative development and testing approach, involving testing ideas to generate learning and understanding whilst allowing for adaption to context
5. Having clear ways of knowing whether things are changing and using measurement to understand variation

The Health Foundation (2013) define the principles of QI as:

- Understanding the problem, with a particular emphasis on what the data tell you
- Understanding the processes and systems within the organisation – particularly the patient, service user or customer pathway – and whether these can be simplified
- Analysing the demand, capacity and flow of the service
- Choosing the tools to bring about change, including leadership, clinical and workforce engagement, skills development, and staff and patient, service user, customer participation
- Evaluating and measuring the impact of a change

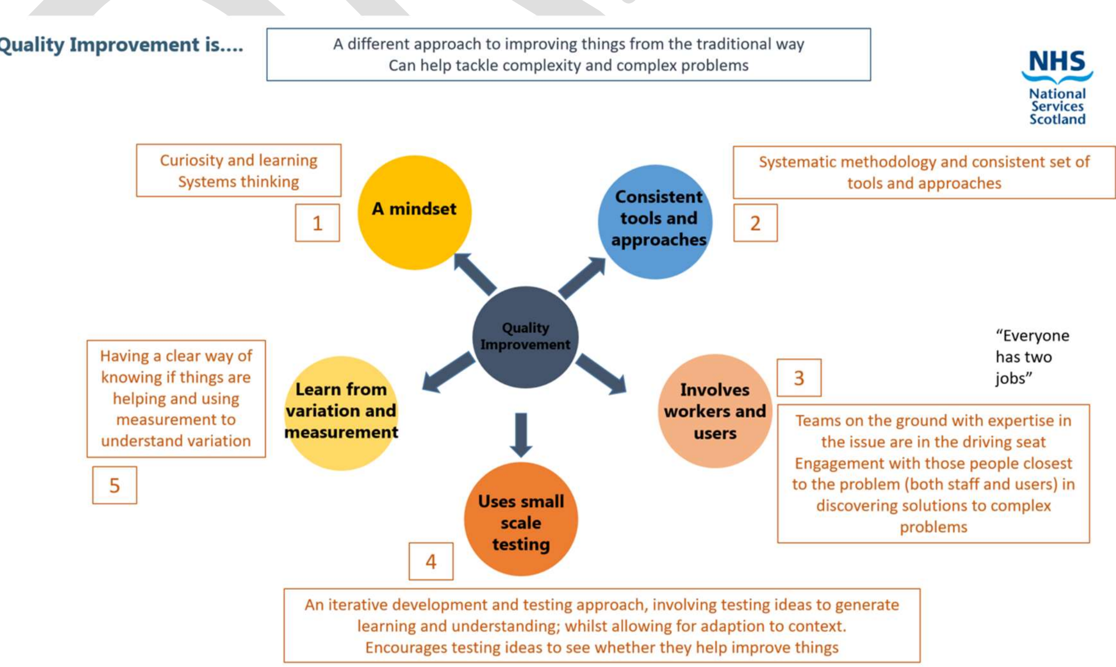

Figure 1 – Components of QI

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This QI strategy should be considered as an integral part of a balanced Quality Management System: that is Quality Planning, Quality Improvement and Quality Control. The Healthcare Improvement Scotland QMS model[1] is depicted below (Figure 2). A full description of the balanced QMS model is beyond the scope of this paper and is addressed in the NSS Quality Strategy.

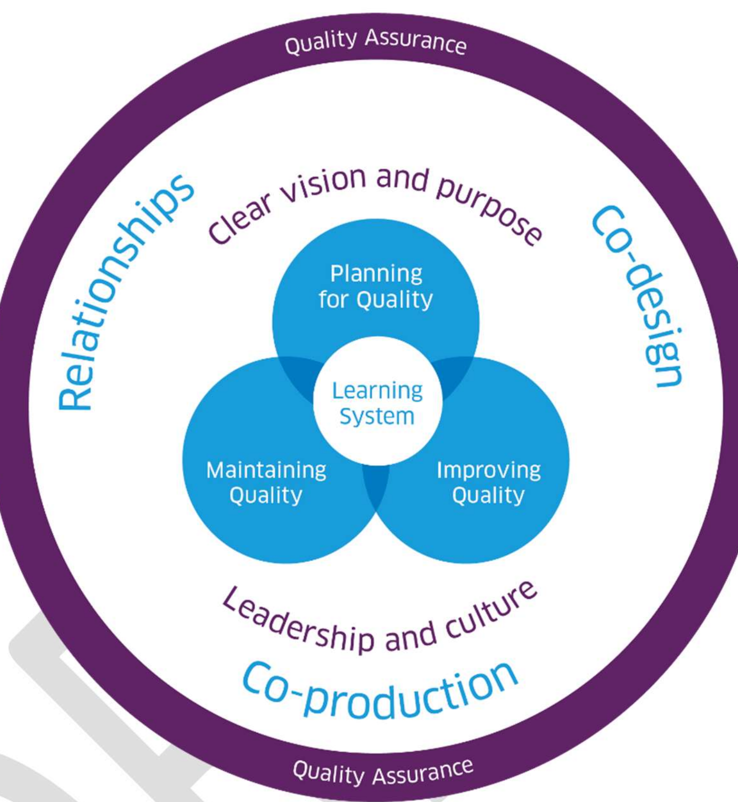

Figure 2 – High level Quality Management System Framework (working draft 4)

3. The challenge of an organisational approach

It is *relatively* straightforward to encourage QI at individual level or in pockets amongst small numbers of energised and motivated people. When considering the implementation of an organisational approach to QI the task is many fold more complex and challenging. Embedding a culture of QI is not a magic bullet or quick fix, it will be a slow burn and a long journey of many years. Embarking on this road requires courage, evolution of mind-sets and culture and different approaches to those previously and currently used.

Pursuing an organisational approach to QI requires ownership and absolute commitment to that journey from the influential leaders and managers who make decisions, set direction and expectations, exhibit behaviours and enable or impede the development of a culture of continuous improvement in an organisational unit or directorate.

Co-production *with* those affected by these approaches is essential for any quality improvement initiative and this will require a shift in culture and behaviours.

Co-production helps ensure that all stakeholders are involved in the process and committed to achieving the desired outcomes. When stakeholders are engaged, they are more likely to provide valuable insights and perspectives that can help identify issues and potential solutions. Meaningful engagement also helps create a culture of continuous improvement by encouraging ongoing feedback and collaboration. This allows for a more thorough and comprehensive approach to QI, as all perspectives are considered, and all stakeholders have a vested interest in the process. In addition, engagement can help ensure the success of QI initiatives by fostering a sense of ownership and accountability. When stakeholders are engaged, they are more likely to take ownership of the process and feel accountable for its outcomes, which can help drive progress and sustain improvements over time.

Given the complexities of embedding QI in organisational culture, it is essential to simultaneously embrace the principles which underpin co-production throughout the culture change process. It is vital to move from an organisation which largely informs, to one which co-designs with those impacted by change from the outset.

4. Implementing Strategy – requires intentionality and planning for scale up and spread

The Institute for Healthcare Improvement (IHI)'s model for adoption, scale up and spread of innovation describes the importance of prototyping, piloting and testing new models of working in scalable units before spreading, scaling up, implementing and sustaining. Implicit in this approach is an assessment of "degree of belief" or "ability to predict what will happen". When testing new approaches the risk of adverse unintended consequences can be mitigated using a stepped approach whereby evaluation is performed and learning generated at each step so as to inform the ongoing design and implementation.

Social science tells us that the adoption of innovation is a social phenomenon, starting with innovators, early adopters and thereafter an early majority. In the set up phase of this work we should intentionally focus on willing, early adopters and innovators to prototype, pilot, assess and learn. Currently the infrastructure to support improvement endeavours in minimal and the maturity assessment indicated that there is currently minimal capacity and capability within NSS for QI.

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5. Strategy Overview

The thematic analysis of the NSS service design maturity assessment, undertaken in 2022, the KPMG audit of clinical governance and QI, and wider learnings from the published evidence generated the following themes for the NSS QI strategy considerations:

- Leadership management and ownership for improvement
- Capacity and Capability for QI
- Evaluation, Intelligence, Measurement and Data
- Relationships, Networks, Staff Wellbeing
- Build an infrastructure to support improvement at scale
- Communications, Celebration, Stories

These themes are depicted in the schematic representation in Figure 3 below, and these represent areas of NSS development opportunity if our strategy is to be translated to implementation.

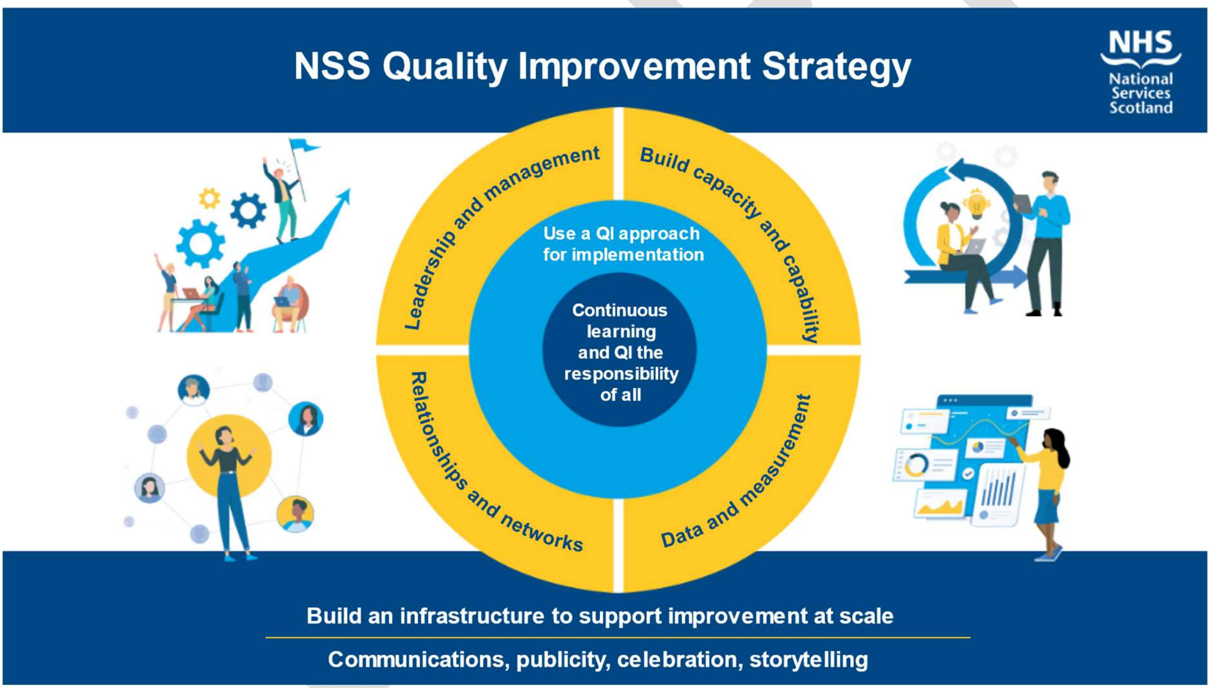

Figure 3. QI strategy

6. Leadership management and ownership for improvement

An organisational approach to QI requires intentional steps and absolute leadership commitment and ownership. NSS has many operational units and teams distributed amongst directorates working on specialised services with distinct stakeholder groups. A “one size fits all” approach is unlikely to work.

Leadership and management practices have a significant impact on quality improvement. Leaders in directorates, and teams will need to create the right context and conditions to enable QI. QI is not a project, rather it needs to be an integrated expectation and part of the standard work, embedded into daily routines and behaviours. To be successful we will need engaged and improvement fluent leaders who will show the way, going first and role modelling the importance of QI.

Our workforce need to be inspired and empowered to lead improvement. Embracing QI requires a change in traditional approach to leadership at all levels in the organisation, so that those closest to the problems (staff, patients, customers, service users) can help devise the best solutions and implement them. Workforce engagement, empowerment, vitality and resilience are essential prerequisites for success. Integration of the QI work to our NSS workforce strategy is therefore key and embedding QI in our leadership development programme organisationally important too.

As we embark on this journey it is important to assess readiness and the current maturity of continuous quality improvement in and across individual teams, directorates and operational units. This will inform plans and allow local assessment of relative priorities, value and benefits from pursuing a systematic approach to quality improvement.

Individual directorates will need to align and prioritise their own improvement activities and generate a constancy of purpose. This will mean stopping or reducing some activities, redesigning some systems built for assurance and shielding teams from distraction. Directorates will need to plan to allow for release of staff for training and to work on improvement.

Thus; whilst unified NSS QI strategy is necessary, each directorate will need its own locally tailored QI action plan, designed and owned by local leadership and management teams. Some teams may not be ready and because of other priorities some teams may not have the bandwidth or capability to realistically focus on the work required to create a systematic approach to QI.

The NSS Board and EMT understanding of, and commitment to an organisational approach to QI is a fundamental pre-requisite for success. The IHI High Impact Leadership Framework

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(Figure 4) is a useful model when considering leadership for improvement and can be used to inform our planned approach and roadmap.

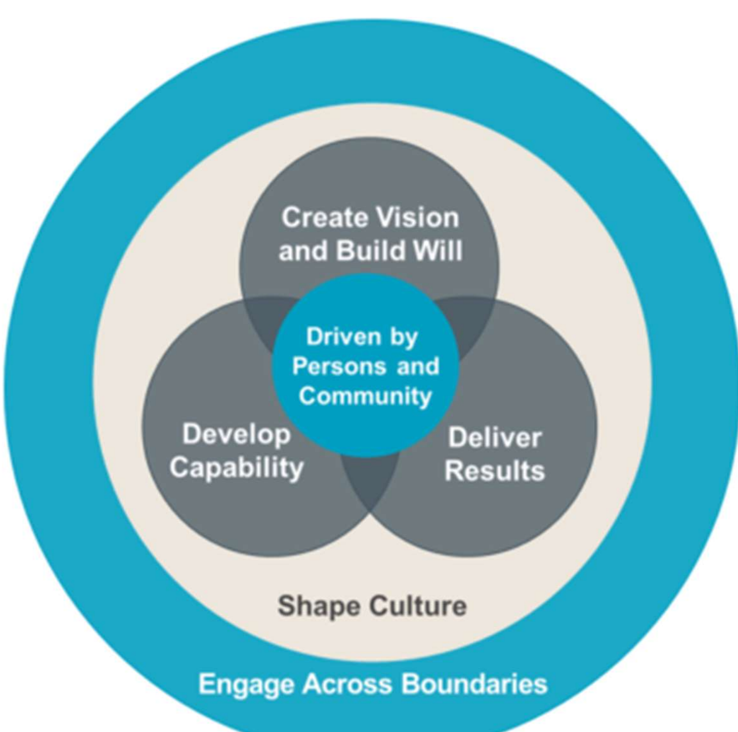

Figure 4. IHI High Impact Leadership Framework

7. Capacity and Capability for QI

Knowledge of improvement methods and how to use them will be a requirement at all levels of staff. Currently this is not the case across NSS, and in order to achieve this we will need to build the skills, capacity and capability for improvement across the organisation.

Benefits will be greater if QI techniques are applied consistently and systematically across directorates, organisational units and the wider NSS.

Success is more likely if there is fidelity to a chosen improvement method with sustained commitment over time. We don't currently have an agreed "improvement approach" in any one directorate or the wider NSS, so defining our approach and the tools and methods we will use is an essential landmark. It is quite possible that teams and Directorates will use a blend of methods and approaches including those taught by NES and IHI, based on the Model for Improvement and the Improvement Guide[2], lean / six sigma, as well as microsystems improvement approaches.

Applied training in these improvement methods will be essential. Training is necessary, but alone will be insufficient. Staff members who participate in training need to be hosted in teams that create the conditions and expectation for continued use and application of QI principles as part of daily work. This means helping to unblock barriers as they are encountered. This will also need the support of a strong and appropriately resourced visible and accessible QI team whose goals are integrated into the Board's operational infrastructure and aims. Training and toolkits will need fidelity with the chosen improvement method(s) and then to be applied as part of daily work and standard operations with directorates.

8. Evaluation, Intelligence, Measurement and Data

A fundamental prerequisite for quality improvement is to analyse and evaluate systems. To do this we can use qualitative (descriptive) and quantitative (data and measurement) approaches. Question two of the "Model for Improvement" asks "how do you know a change is an improvement?".

Information is specific data or narrative coming from one source. It is sometimes confusing and often contradictory and complex. Depending on the source, it can also be incomplete. Intelligence is the product of combining this information from different sources (qualitative and quantitative) to create something greater than the sum of its parts.

Robust measurement (quantitative evaluation) can powerfully underpin QI and system analysis. There are different complementary approaches by which data can be presented to support understanding and improvement. Examples include frequency plots, Pareto charts, scatter charts, line graphs, box plots and multivariate plots.

However one essential improvement tool is the visualisation of variation in data over time in the form of statistical process control charts ("SPC" charts), sometimes called Shewhart Charts. A simple form of SPC chart is called a "run" chart. This analytical tool is fundamental for our understanding of variation and systems.

Whilst SPC charts are not *always* the most appropriate approach to use (depending on the data and purpose), in many cases they are an essential tool to aid understanding of systems, variation and patterns. In this regard they underpin our ability to encourage the organisation to act with the intention to improve. This ability to assess data over time is critical to support NSS strategic goals of service excellence and financial, workforce and environmental sustainability. There are opportunities in Directorates to use data to measure our current processes to allow us to better understand variation and to identify opportunities for improvement.

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We will aim to generate meaningful measurement and data for improvement in all areas. We will encourage a more prevalent use of run charts and SPC (statistical process control) charts at the Board and EMT and other fora and a greater emphasis on measurement that matters.

Charts alone are insufficient, the analysis, responses and questions generated by data are the cultural change that we seek. Thus *"the purpose is not to have charts but to make good decisions"* that is… generating charts to show variation is the initial step, but the key step is to interpret meaningfully, and take the right action (s). In this sense, data and measurement are intimately associated with our ability to understand variation, test change, understand if things are getting better and generate learning.

We will seek to openly display improvement data with teams, customers and service users / patients. Data needs to be meaningful (with clear definitions), accessible, understood, locally owned and managed appropriately. The burden of data and unhelpful data needs to be recalibrated so as to allow staff to use data that supports improvement.

Quantitative data may not naturally fit with certain work and there are many instances where qualitative approaches might be better suited or where a blend of qualitative and quantitative approaches can be used. Teams should be enabled to measure improvement in the best way for their work. There are opportunities to build capacity in evaluation and evidence gathering and knowledge and use of robust and verifiable evidence.

In order to change our approach to data and measurement we require a change in mindset and an infrastructure to support people and teams to understand and use measurement for improvement. Our QI work will need to be integrated into the NSS data strategy for this reason as that work is considered.

9. Relationships, Networks, Staff Wellbeing

Creating a culture of continuous improvement will be as much a social change as technical. Positive relationships, transparency and trust are essential pre-requisites.

Networks support the rapid spread of innovation and ideas, cross boundaries, flatten hierarchies, focus on shared purpose and bring diversity and collective impact. As such they are the vitally important organising system to effect impactful change. In order to engage across boundaries (both internal and external) – we will require vibrant and active networks. An NSS QI Network is currently operational as a volunteer coalition of the interested and willing whose purpose is to create a culture of continuous quality improvement across NSS. The network has 41 members including representation from seven NSS directorates.

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Working in health and care has been, and remains demanding; this may be physically, emotionally and intellectually. Staff will not be able to give what they don't have. Burnout and harm from work is a reality. Thus opportunities to learn and use QI should be framed as an invitation. Participating in QI can help re-connect with purpose and internal motivation and build joy and satisfaction from work.

The "Quadruple Aim"[3] includes a focus on the experience and wellbeing of staff. Knowledge and practice of compassionate inclusive leadership will be required to make sure that QI opportunities are genuine ways to build well-being and satisfaction.

The Triple Aim framework was published in 2008 with the intent to guide the redesign of healthcare systems and the transition towards population health. This was a response to the observation that healthcare systems globally grapple with the challenges of improving the health of populations while simultaneously lowering healthcare costs. The three goals of the triple aim are improving the individual experience of care; improving the health of populations; and reducing the per capita cost of healthcare.

The triple aim was modified in 2016 to include and explicitly acknowledge the critical requirement of an engaged and productive workforce in healthcare delivery and transformation. The 'Quadruple Aim' includes the fourth aim: improving the experience of providing care. For NSS this care can be direct clinical care, such as that in SNBTS, or indirectly through our wider service delivery in support of health and care. The notion of evolving from the Triple to the Quadruple Aim recognises the broader transformation required in our healthcare system towards high value care. While the first three aims provide a rationale for the existence of a health system, the fourth aim becomes a foundational element for the other goals to be realised.

The core of workforce engagement is the experience of joy and meaning in the work of healthcare. This is not synonymous with happiness, rather that all members of the workforce have a sense of accomplishment and meaning in their contributions. "Meaning" is the sense of importance of daily work. "Joy" is the feeling of success and fulfilment that results from meaningful work. The NHS has captured this with the notion of an engaged staff that 'think and act in a positive way about the work they do, the people they work with and the organisation that they work in'

The requirement for joy and meaning is to ensure that the workforce has physical and psychological freedom from harm, neglect and disrespect. For a health system aspiring to the Triple Aim, fulfilling this precondition must be a non-negotiable, enduring property of the system.

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QI methods provide simple and powerful way of enabling teams to make changes to their local systems to improve joy at work. In this context the QI delivery plan needs to be connected to the NSS workforce plan and HR led people report.

10. Build an infrastructure to support improvement at scale

Doing QI at scale requires locally accessible support infrastructure and improvement support system. A strong QI infrastructure effectively means having the correct funding, resources, people, expertise and priority committed to promoting, supporting and driving a well organised organisational approach to QI. Warwick Business School have recently described an improvement infrastructure as being comprised of a number of routines and practices that enable continuous improvement. Essential infrastructure elements include leadership routines, a dedicated improvement team, capability building routines (such as training and rapid process improvement workshops), routines for strategic alignment. A delivery plan has been drafted for this QI strategy to be operationalised, which will be reviewed inclusive of required resourcing.

11. Communications, Celebration, Stories

Implementing a QI strategy will require a relentless drumbeat approach to communications including an innovative and optimistic campaign. An ability to publicise and share learning, from failure and success is essential. The QI programme will therefore need to be embedded in the NSS communications strategy and the QI programme have a communications strategy connected to the QM strategy to ensure reach and impact.

12. References

1) Moving from Quality Improvement to Quality Management. Ruth Glassborow, Healthcare Improvement Scotland 2022
2) The Improvement Guide, Langley, Moen, Nolan, Nolan, Norman, Provost. Second Edition, Jossey Bass 2009
3) The Quadruple Aim: care, health, cost and meaning in work Sikka, Morath, Leape. BMJ Qual Safe June 2015

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Document Control Sheet

Key Information

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Approver	Jacqui Reilly, Director of Nursing, NHS National Services Scotland
Contact	Lorna Brady, Programme Manager, NHS National Services Scotland
File Location	QI Team

Revision History

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0.1	27/01/2023	Initial Draft	A Longmate	
0.2	20/03/2023	Comments from QIDG	A Longmate	Suggested changes incorporated into document
0.2	20/03/2023	Added a document control sheet	F Hunter	
0.3	27/03/2023	Comments from QIOG	A Longmate	Suggested changes incorporated into document
0.4	11/05/2023	Figure 3 updated	L Brady	

Approvals

This document requires the following signed approvals:

Version	Date	Name	Role
0.3	21/03/2023	Jacqui Reilly on behalf of EMT	QI Executive Lead
0.3	27/03/2023	Quality Improvement Delivery Group	
0.3	17/04/2023	Quality Improvement Oversight Group	

Distribution

This document has been distributed to:

Version	Date of Issue	Name	Role / Area
0.2	21/03/2023	Quality Improvement Oversight Group	
0.3	27/03/2023	Quality Improvement Delivery Group	
0.4	22/05/2023	NSS Executive Management Team	

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NHS
National Services Scotland

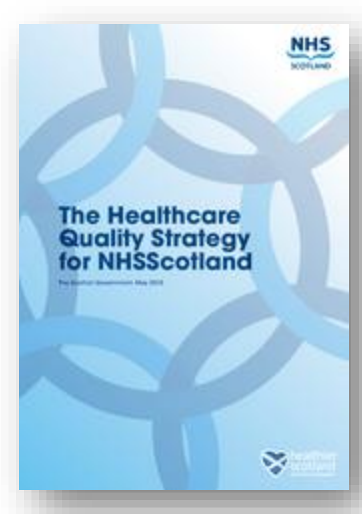
Quality Improvement in NSS

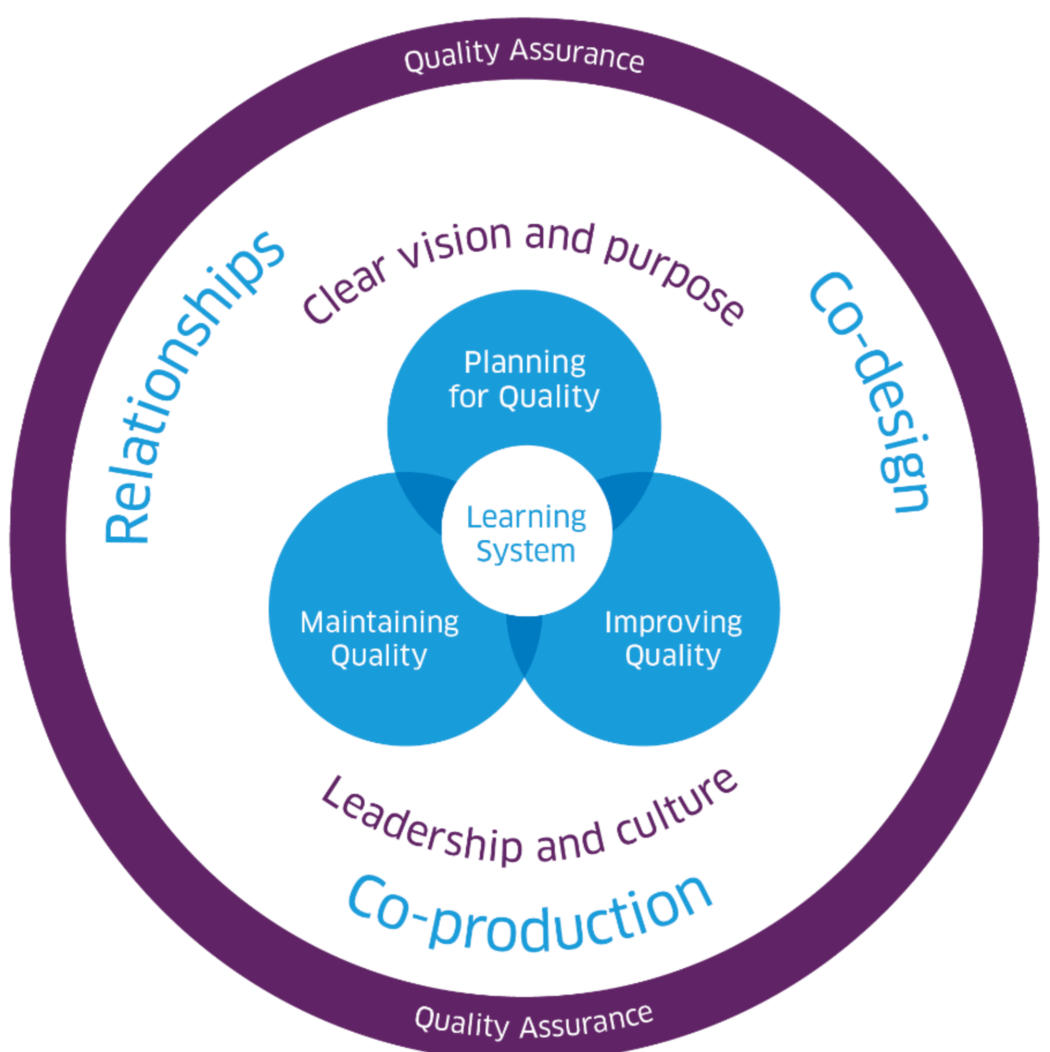
NSS QI Plan 2023/24

Draft – v0.6

Introductory Slides

Our strategic framework



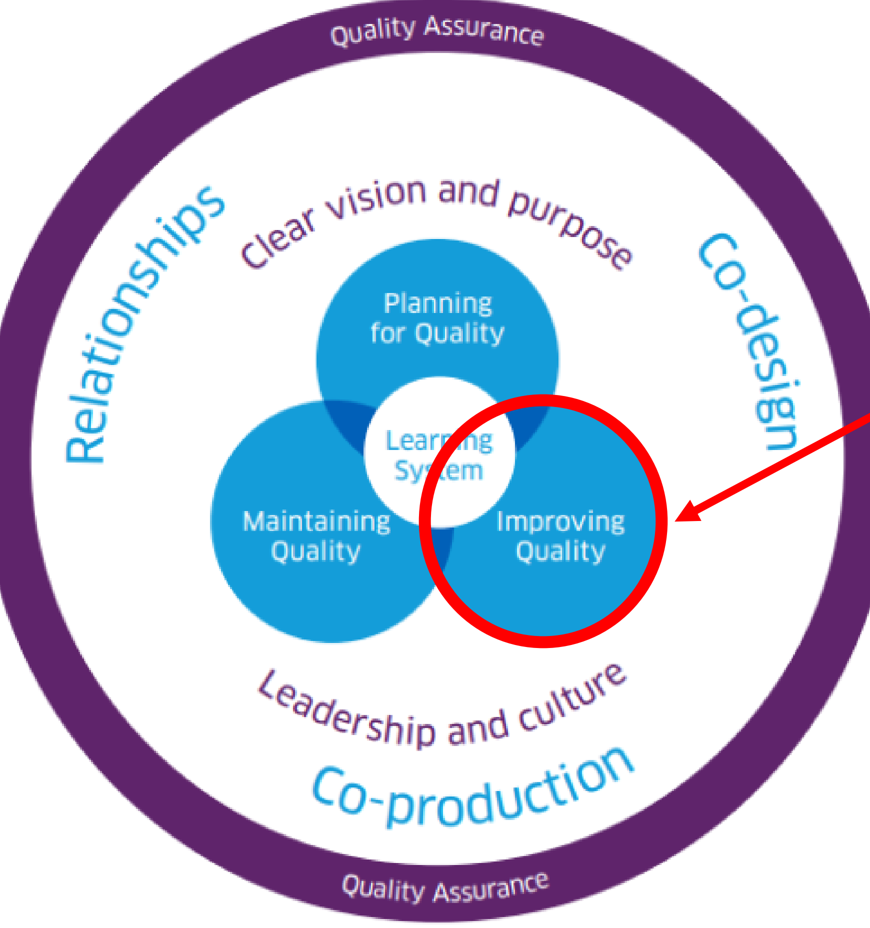


NSS operates within the Healthcare Quality Strategy for NHS Scotland (2010).

The reliable delivery of high quality care requires organisations to have a consistent and coordinated approach to managing quality that is applied from team through to board level. This is known as a Quality Management System.

To achieve this, we will adopt the Scottish Quality Management System Framework (2022) and support the move from quality improvement to quality management.

High-level Quality Management System Framework (working draft 4)



Quality Improvement is <u>one element</u> of the wider Quality Management Framework, which also includes Quality Control, Quality Planning and Quality Assurance

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Please note: The QMS Framework is continuously evolving, for the most up to date version please visit: https://ihub.scot

Figure 1: The QMS Framework (working draft 4)

What is Quality Improvement?

Improving quality is about making health care **safe, effective, patient-centred, timely, efficient and equitable** by giving the people closest to problems affecting care quality the time, permission, skills and resources they need to solve them.

Quality improvement involves **taking a systematic and coordinated approach to identifying and solving problems using specific methods and tools to achieve measurable improvements**.

Quality Improvement seeks to **reduce variation, waste, and losses, and to standardise** processes and structure (e.g. technology, culture, leadership, knowledge and physical capital).

Key principles of Quality Improvement

1. A mindset of curiosity and learning
2. A systematic methodology with consistent methods and tools
3. Engages those people closest to the quality issue (both users and staff) in discovering solutions to complex problems.
4. Involves testing ideas to generate learning and understanding and seeing whether they help improve things
5. Involves having clear ways of knowing whether things are changing and using measurement to understand variation

NSS Quality Improvement Strategy

Scotland

Leadership and management

Build capacity and capability

Relationships and networks

Data and measurement

Use a QI approach for implementation

Continuous learning and QI the responsibility of all

Build an infrastructure to support improvement at scale

Communications, publicity, celebration, storytelling

The NSS Quality Improvement Strategy covers the following key themes:

1. Leadership and management
2. Building capacity and capability
3. Data and measurement
4. Relationships and networks
5. Infrastructure
6. Communications
7. Continuous learning

…ideally all implemented using a Quality Improvement approach

This NSS QI Implementation Plan for 2023/24 covers all of the above themes, and each NSS Directorate is required to have their own QI Plan for 2023/24 by end June 2023.

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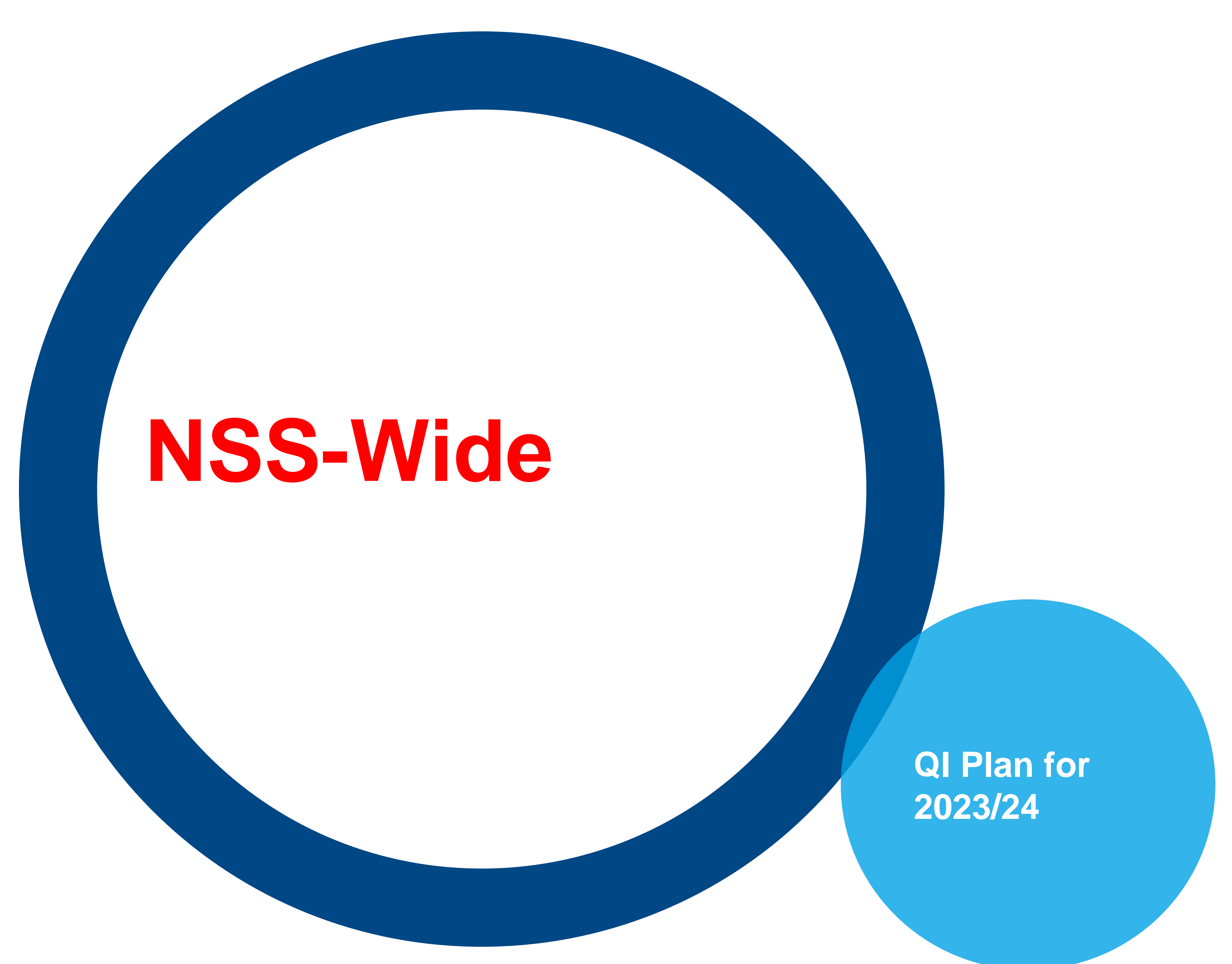
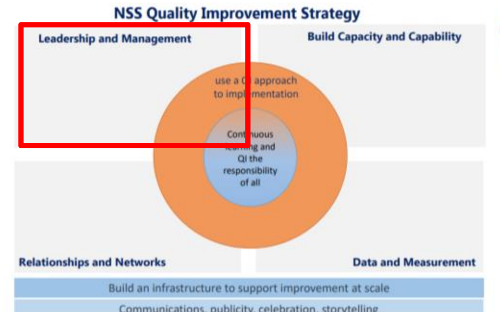
National Services Scotland





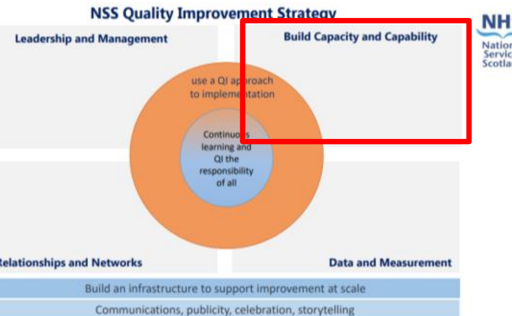
NHS National Services Scotland

Leadership and management

During 2023/24, we will…

Do (what)	By (when)
Ensure that the Executive Management Team have Quality Improvement in their objectives for 2023/24 and that these are cascaded down through their staff	Complete
Develop an NSS-wide QI Strategy and Plan for 2023/24	Complete
Share NSS QI Strategy & Plan with EMT	Complete
Ensure that each Directorate has a QI Plan for 2023/24	End June 2023
Share NSS QI Strategy & Plan with NSS Board	End June 2023
Ensure QI is embedded in the Senior Leadership Development Programme and support delivery	End June 2023
Develop a leadership QI action plan for EMT and SLF to engage with the wider organisation and promote QI activity, and then implement the plan	End July 2023

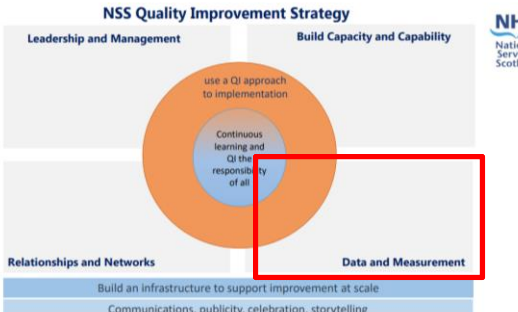
Capacity and capability



During 2023/24, we will…

Do (what)	By (when)
Hold structured conversations with each directorate to assess their capability, capacity and readiness for QI	End June 2023
Take a collaborative approach to developing QI training within NSS (initially with PgMS & SNBTS)	End June 2023
Identify 1-3 Directorates (or part of) to test an integrated QI approach and prioritise others for QI support	End June 2023
Quantify QI training needs across NSS from Directorate QI Plans	End July 2023
Explore training options and develop a training implementation plan	End September 2023
One member of QI Programme Management team to complete SCLIP course on Cohort 34	End November 2023
Develop central repository (Toolkit) for QI resources in response to directorate requirements	End December 2023
Develop a QI opportunities pipeline and governance mechanism for assessing and prioritising delivery	End December 2023
Trial implementation of an integrated QI approach in 1-3 directorates	End December 2023
Deliver some training tailored to directorate requirements	End March 2024
Evaluate impact of integrated QI approach with the Directorates we have been actively working with	End March 2024

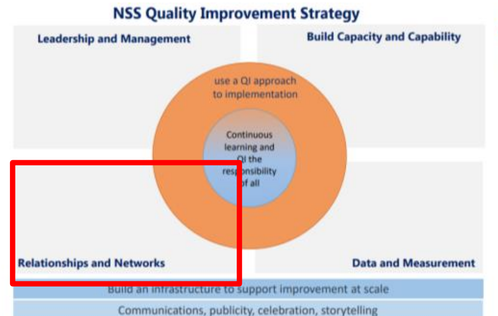
Data and measurement



During 2023/24, we will…

Do (what)	By (when)
Engage with DaS colleagues to ensure that interdependencies between the NSS Digital Strategy, Data Governance Programme and QI Programmes are identified	End May 2023
Identify performance measures, data & measurement requirements to support deployment of QI approaches, including effectiveness measures for the QI Programme itself	End August 2023
Ensure QI training offerings cover data and measurement	End September 2023
Ensure central QI repository (Toolkit) include tools, templates and guidance covering data and measurement	End December 2023

Relationships and networks



During 2023/24, we will…

Do (what)	By (when)
Engage with QI Network, including adding QI programme to standing agenda and QI Programme Management Team attendance at QI Network meetings	Complete
Connect with colleagues from other organisations with QI programmes, e.g. Golden Jubilee, Lothian, HIS	End May 2023
Harness expertise in QI Network to support development of QI approaches, framework and toolkit	Ongoing

Infrastructure to support QI

During 2023/24, we will…

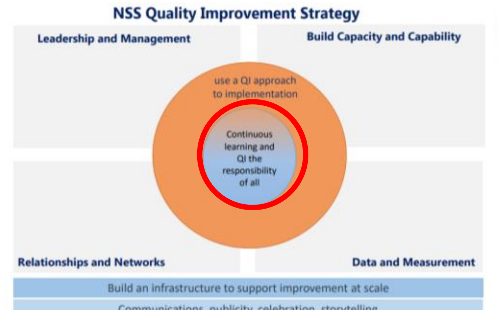
Do (what)	By (when)
Appoint an Improvement Advisor (IA) (Pending funding from the Change Fund)	End August 2023
Map out the Quality Management Systems being used across NSS	End September 2023
Develop infrastructure to support maximising participation on NES training courses	End December 2024
IA to seek areas related to value based healthcare (VBHC) and realistic medicine (RM) where QI can be used to enable and implement the principles of RM and VBHC	End March 2024
Consider key components of a QI Infrastructure	End March 2024

Communications and engagement

During 2023/24, we will…

Do (what)	By (when)
Develop a Communications Strategy for the QI Programme	End June 2023
Develop a Communications Plan for the QI Programme	End July 2023
Implement Communications Plan	Ongoing
Engage with other Strategic Corporate Programmes to ensure interdependencies are identified and managed	Ongoing

Continuous learning



During 2023/24, we will…

Do (what)	By (when)
Link into NSS Quality Framework Continuous Learning Pillar	End July 2023
Develop a mechanism to share learning between QI projects across NSS Directorates as part of the central repository of QI resources (QI Toolkit)	End December 2023

Date: May 2023

NSS Quality Improvement Programme March 2023 to March 2024 – Draft v0.6

Workstream	March	April	May	June	July	August	September	October	November	December	January	February	March
Leadership, Management & Culture	NSS QI Strategy & Plan for 2023/24 developed QI in EMT objectives for 2023/24	Informal EMT meeting to share QI Strategy & Plan	Formal EMT meeting to share QI Strategy & Plan	Finalise Directorate QI Plans for 2023/24 QI embedded in Senior Leadership Dev Prog QI Strategy & Plan shared at NSS Board meeting	Leadership QI Action Plan developed								Finalise NSS QI Strategy & Plan for 2024/25 Finalise Directorate QI Plans for 2024/25 QI in EMT objectives for 2024/25
Directorate Preparedness Assessments				Complete preparedness assessments of all directorates Identify 1-3 directorates to test integrated QI approach									
Capacity & Capability					QI Training needs from QI plans quantified		QI training implementation plan developed		QI Prog team member completes SCLIP	Complete trial of integrated QI approach in 1-3 directorates Launch QI Toolkit & Opportunities Pipeline			Complete evaluation of integrated QI approach Some internal QI training has been delivered
Data & Measurement			Establish links to NSS Digital Strategy & Data Governance Programme			Performance measures, data & measurement requirements identified, inc. measuring effectiveness of QI prog							
Relationships & Networks		Establish links into NSS QI Network	Establish links into other NHS organisations with QI programmes										
Infrastructure						Improvement Advisor appointed (pending funding)	Map out the Quality Management Systems being used across NSS			Infrastructure in place to maximise participation on NES training courses			Infrastructure required to support QI identified Opportunities identified for QI to support VBHC & RM
Comms & Engagement				Programme Comms Strategy finalised	Programme Comms Plan finalised								
Continuous Learning					Link into NSS Quality Strategy Continuous Learning Pillar								

Produced by: Programme Management Services (PgMS)

Key: Critical Path Milestone | Completed Milestone | Delayed Milestone | Milestone (On track) | Meeting

NSS Quality Improvement

Discovery Report

Service Design Hub

Executive summary

From May to September 2022, the Service Design Hub worked with senior Quality Improvement (QI) leaders across National Services Scotland (NSS) to baseline the maturity of QI in NSS, using the Scottish Approach to Service Design (SAtSD) [2] framework. The research sought to establish

> “*the extent to which quality improvement is embedded in the individual Strategic Business Units (SBUs) and organisational units of NSS*”

For the purposes of this work, the research team reviewed against the four cornerstones of QI as set out in the April 2022 EMT paper (see appendix 5).

1. Mindset, culture, and principles
2. Engagement of those closest to the issues
3. Consistent methods and tools
4. Testing and measurement

Working within the SAtSD framework, the research team undertook user research in the form of an open access electronic survey, seven focus groups, and rapid literature review. Researchers gained a breadth of information from the staff wide survey and built depth to the research through focused group discussions with special interest groups and wider staff engagement sessions

Across all methods we have engaged with a total of 257 individuals, this represents 7% of NSS employee headcount (based on SBU headcounts as of 30 April 2022 see appendix 7).

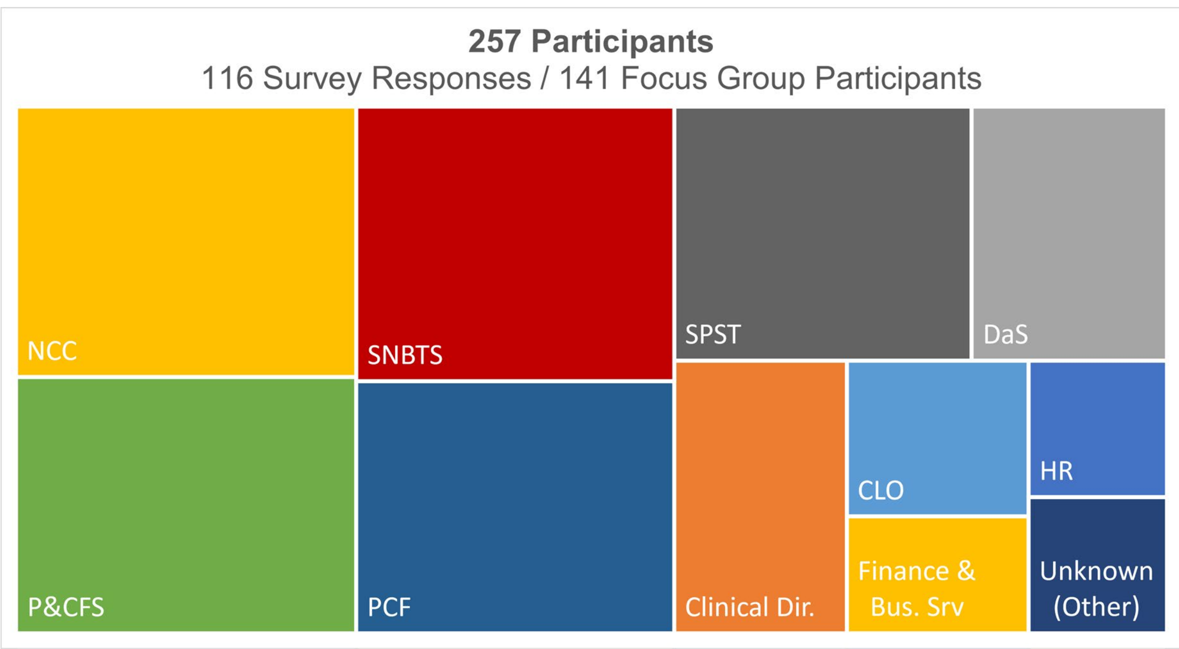


Fig 1. Proportion of participants by SBU

Key findings

Six key themes emerged during our discovery research and each section below will guide the reader through the strengths, challenges, and potential opportunities for NSS:

1. Creating an organisational culture for QI
2. Establishing leadership and ownership for change
3. Engaging and empowering the workforce to make improvements
4. Strengthening the organisational approach to QI through frameworks and toolkits
5. Using data to support change and improvement
6. Cultivating a culture of learning and sharing knowledge

These themes broadly correspond with the six organisational enablers found by the literature review: time and resources, culture, leadership, collaboration, training, and data, highlighting that in general, the organisational enablers within NSS correspond with those in other health organisations seeking to embed a QI culture.

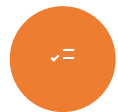
Overall, the research team were met with a great deal of enthusiasm from staff at all levels regarding QI, who were keen to share their experiences and talk about their own improvement projects. There was a desire to build on pockets of good practice and to support each other to carry out QI projects using appropriate tools. There was a level of confidence in already existing QI skills, and an appetite to learn more.

Despite this enthusiasm, there was a lack of a collective understanding of QI, and little practical experience of the tools and methodologies available to support quality improvement initiatives amongst most participants. We know from the literature review that organisations who successfully embed QI in business-as-usual rely on more than just having the right QI strategy, framework, or toolkit. The enablers of success are also determined by the over-riding culture of an organisation, including its leadership, how it prioritises work, its ability to collaborate with those who run and use services and the quality of the data it uses. Our research documents suggestions for improvement in all these areas. These enablers and recommendations will not, in isolation, be the key to QI success; there is a dynamic, complex relationship at play between the enablers. QI is an art that takes commitment to discovery and experimentation along the QI journey to learn and adapt within a supportive environment.

Key recommendations

The recommendations are detailed in the conclusions section of this report and a detailed breakdown of staff suggestions has also been included in appendix 4. Below we have highlighted key recommendations in two distinct areas, those from the findings and more practical considerations on next steps.

Key recommendations technical


Establish baselines for individual SBUs and directorates through local level surveys that encourage mandatory participation.

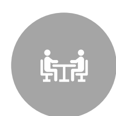
Consider piloting QI changes with areas that demonstrated the highest levels of engagement and interest in QI

Establish an NSS wide QI strategy and framework

Develop a range of tools which SBUs can select from to suit their needs

Training and coaching development

The challenges around data should be addressed at organisational level


Create a culture which gives the time and resource to implement QI in an environment which is comfortable with testing change, taking risks and learning as it goes.

Key recommendations practical

Sharing of this report with NSS EMT as many of the suggestions for improvement are wider than QI

Creation of a delivery group which reflects the diversity of the participants in the research (across SBUs and staffing groups)

The delivery group should reflect on the discovery findings, review, elaborate on and prioritise the suggestions for improvement to set direction for QI

Qi leads should consider widening membership of the existing NSS core QI group to reflect the diversity of staff with an interest in QI

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Introduction

In November 2019 NSS launched the Clinical Governance and Quality Improvement Framework [1] The framework set out how Clinical Governance and Quality Improvement would progress over a 5-year period to 2024.

The framework was set within the context of continuously striving to improve the safety and quality of products and services delivered by NSS, it was underpinned by NSS strategy and informed by the key national policy and guidance documents in NHSScotland.

Shortly after the framework was launched the COVID 19 pandemic hit all NSS services who moved into "response mode" which meant the focus was solely on supporting NHSScotland to manage the pandemic.

In 2021 as the organisation moved towards "recovery mode" the Clinical Directorate undertook a self-assessment to measure how embedded Quality Improvement (QI) was within the directorate. The findings suggested that tools and support were available, but that QI had not been adopted as part of business-as-usual activities.

As QI is core to the NSS strategic theme of Service Excellence the leadership of NSS were interested in understanding the extent to which QI had been embedded across the whole organisation. As a result, NSS Executive Management Team (EMT) commissioned a discovery and baselining exercise on the maturity of QI in NSS, using the Scottish Approach to Service Design (SAtSD) [2] framework in May 2022.

The research sought to establish

> "***the extent to which quality improvement is embedded in the individual SBUs and organisational units of NSS"***

For the purposes of this work, the research team sought to review against the four cornerstones of QI as described in the original papers to EMT in April 2022:

1. Mindset, culture, and principles
2. Engagement of those closest to the issues
3. Consistent methods and tools
4. Testing and measurement

Project overview

The Scottish Approach to Service Design (SAtSD) [2] informed the design approach considered when looking to assess the use of QI within NSS. Working within the SAtSD framework, the research team undertook user research in the form of an open access electronic survey, seven focus groups, and rapid literature review. The purpose of user research is to connect the people designing the service with the people who use it. This ensures that recommendations for change are led by service user experiences.

The overall approach to the discovery was to maximise input from as many staff as possible across NSS given that QI is relevant for all roles.

We gained a breadth of information from the staff wide survey and built depth to the research through focused group discussions with special interest groups and wider staff engagement sessions.

Focus groups were designed in a progressive and iterative manner, based on the data and feedback gathered to date to maximise representation and depth of findings. This work was further supported through a rapid literature review and development of case studies of QI conducted within NSS.

Timeline

The discovery project has broadly followed the plan shared with EMT in August 2022. With some alterations being made to accommodate the summer period to maximise engagement with employees across NSS.

NSS Quality Improvement Discovery – Plan on a Page

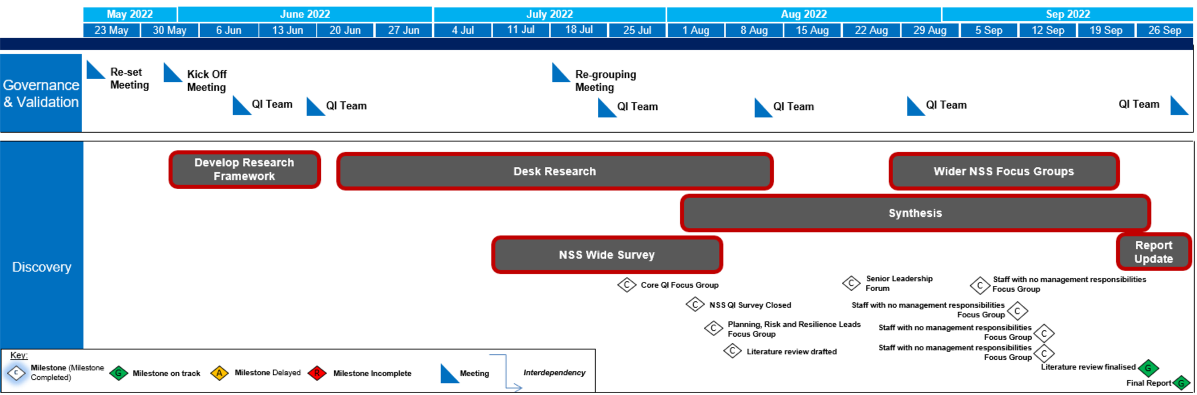


Fig 2. Project plan on a page

Methods

The Scottish Approach to Service Design (SAtSD) framework formed the basis for the discovery work. The Design Council's Double Diamond model outlines the design stages.

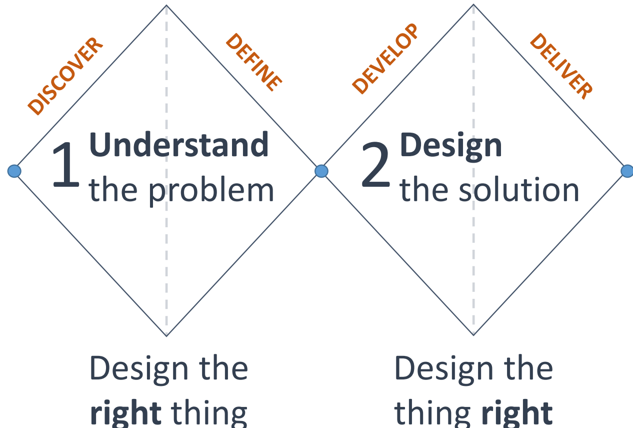


Fig 3. Design Council Double Diamond

It shows the importance of taking time to **understand the problem before moving on to define, develop and deliver solutions.**

The SAtSD is an **iterative approach** to developing services keeping **users involved throghout.**

For the discovery research, three research methods have been employed. A direct access electronic survey, facilitated focus group discussions and a rapid literature review.

Survey

A survey was developed using Microsoft Forms and shared with all NSS staff (3,646) through the Stay Connected SWAY issued on 11 July 2022. The survey was open to all staff for three weeks, closing on 1 August 2022.

The Stay Connected SWAY was viewed by a total of 1,550 staff, the average time spent reading the document was 4 minutes with 59% of individuals reading the full document (approximately 59% of 1550).

In total we received 116 responses to the survey across 10 Strategic Business Units (SBU) and directorates. This is approximately 3% of the entire NSS employee population.

Questions within the survey were developed and aligned to the four cornerstones of QI:

1. Mindset, culture, and principles
2. Engagement of those closest to the issues
3. Consistent methods and tools
4. Testing and measurement

Quantitative survey data was analysed using descriptive statistics and Power BI. For the surveys qualitative responses, we conducted inductive thematic analysis (Braun, V. and Clarke,V. [2006]) [3] using a collaborative whiteboard.

Focus Groups

In total seven focus groups were conducted with 141 participants, six over Microsoft Teams and one in person. Three focus groups were with special interest groups including:

- Core QI Group
- Planning, Risk and Resilience Leads
- Senior Leadership Forum

A further four focus groups which gathered views of staff with no management responsibilities (Bands 3 to 6).

Each focus group covered two to three of the following topics:
- Toolkits and framework
- Data
- Testing and improving
- Ownership and support
- Learning culture
- Appetite for change and barriers

The focus group discussions were facilitated in a semi-structured manner, encouraging open discussion with the help of ice breakers and prompt questions.

All focus group discussions were developed iteratively to build upon findings at each stage and add depth to the research.

Detailed notes were taken during focus group discussions, using a collaborative whiteboard to facilitate analysis. Data from the focus groups were thematically analysed. The analysis was conducted on an ongoing basis, using an inductive approach, with input and feedback from the whole research team. Consensus of the key themes was attained through team discussion.

Literature review

As part of the discovery work, a desk-based literature review was conducted concurrently with other data collection methods. The literature review focused on identifying ***"What are the organisational enablers of Quality Improvement?"***

The literature review included publications from academic peer reviewed journals, public sector, and professional consultancy.

A search strategy was developed which identified the key terms ("quality improvement" OR "continuous improvement") AND (enable* OR facilitate*). Academic articles were searched for in Google Scholar and Web of Knowledge; public and not-for-profit sector literature along with professional consultancy reports which were identified in Google.

In total, 46 articles published in English from across the world between 2016 and 2022 were identified: 36 academic articles and seven public and not-for-profit sector and three professional consultancy publications.

Data extraction (see Appendix 3 in the literature review) identified key enablers related to: Time and resources, Culture, Leadership, Collaboration, Training and Data (see Table 1. in literature review). These were organised in order of most to least frequently cited.

Engagement methods and participation

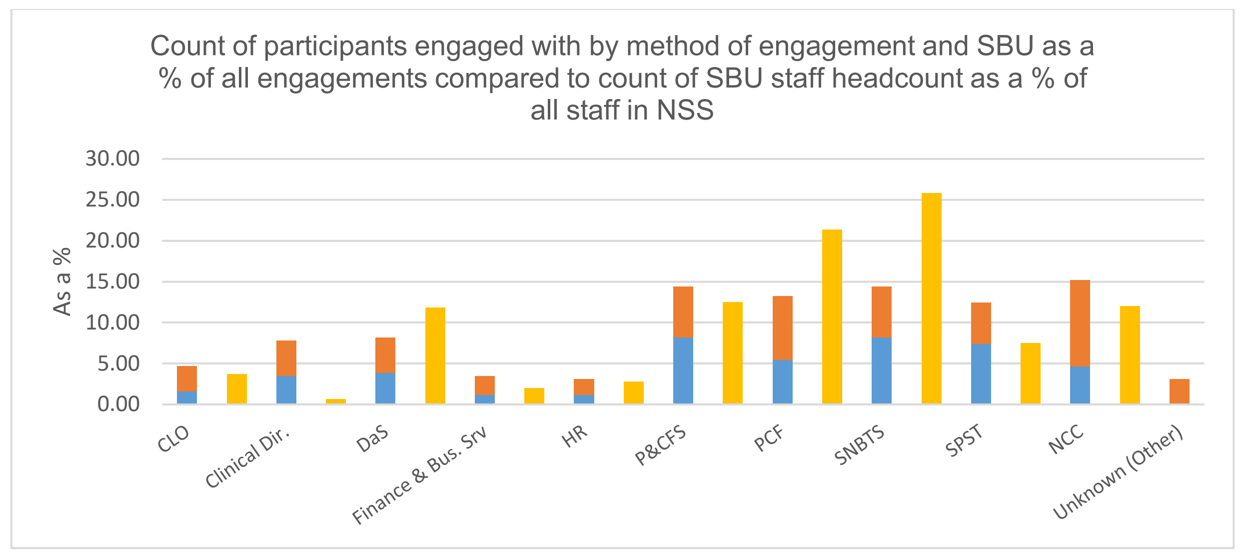
Across all methods we have engaged with a total of 257 individuals, this represents 7% of NSS employee headcount (based on SBU headcounts as of 30 April 2022 see appendix 7).

We recognise that a small number of individuals may have contributed through more than one engagement mechanism. If one fifth of participants contributed through more than one mechanism we would conservatively expect to have engaged with approximately 200 separate individuals or 5.5% of the employee population as a minimum.

Figure 4 shows the proportion of responses received by method of engagement for each SBU and compares this with the proportion of staff (headcount) of each SBU as part of NSS (see table 1 in the appendix 2 for further detail).

Figure 5 shows the proportion of responses received by method of engagement as a proportion of all engagement by role type (see table 2 in the appendix 2 for further detail).

These highlight where an SBU or role type has been over or underrepresented in our engagements.



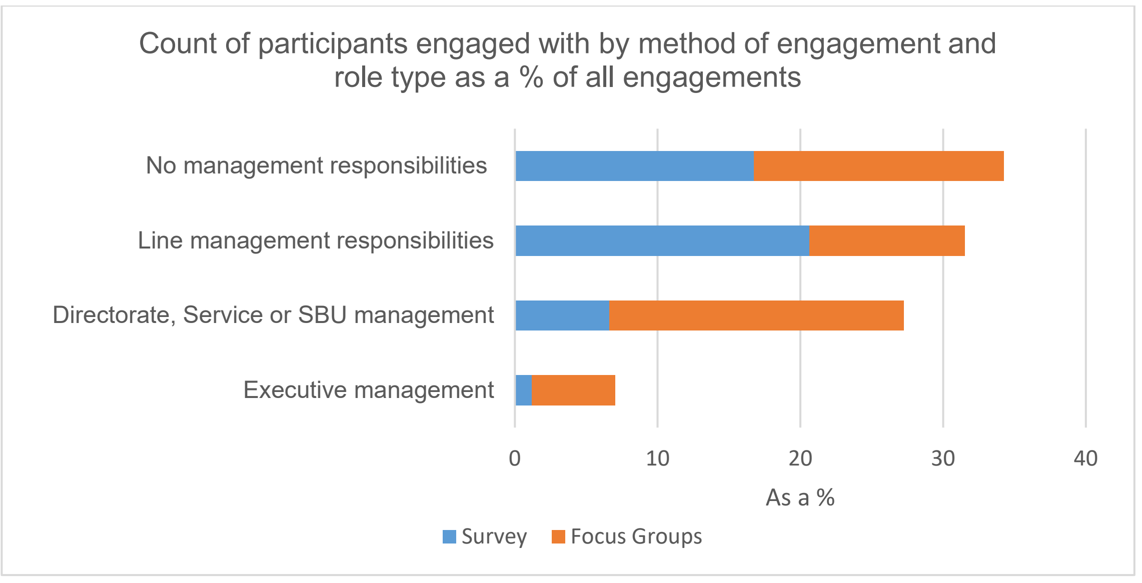
Count of participants engaged with in Survey as a % of all responses by SBU

Count of participants engaged with in Focus groups as a % of all responses by SBU

Count of SBU staff headcount as a % all staff in NSS

Fig 4. Count of participants engaged with by method of engagement and SBU as a % of all engagements compared to count of SBU staff headcount as a % of all staff in NSS

Fig 5. Count of participants engaged with by method of engagement and role type as a % of all engagements



Ethical considerations

The research was conducted with careful ethical considerations.

The research team ensured that all materials were presented in an accessible format for participants. Platforms for data collection (i.e. Microsoft Forms for the survey and Microsoft Teams for the focus group) were chosen to maximise the convenience of participation.

The research data was treated with the utmost confidentiality by the research team. Any personal identifiable information collected throughout the research (during recruitment and data collection) was stored in a secure folder on SharePoint, only accessible by the research team. This information will be deleted in accordance with the data wash up process of the Service Design Hub.

Extra steps were taken to de-identify the research findings. No personal identifiable information was captured during the focus groups. Where necessary, findings were aggregated with data deemed to pose risks of identifying participants due to low participation rates.

What does QI mean for NSS staff?

We asked survey respondents to describe what QI meant for them. In general, there were high levels of consensus and awareness around the definition, enablers, and benefits of QI.

"Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them.

It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement"

(3:2021, The Health Foundation)

Most respondents described QI as a continuous, cyclical, and ongoing process of improvement. The subject of improvement may be:

- The service
- Processes
- Ways of working
- The whole system

Some respondents also thought QI may be applied to improve the workforce, data, standards, performance, products, user experience and perceptions, and to reduce risk. This was thought to be done primarily through introducing lean methodology and efficiency.

Most respondents thought that QI benefits a range of people, most prominently service users, including customers and patients, as well as staff, the organisation, and the taxpayer.

Respondents said that conducting QI may involve the following methods and methodologies:

- Reviewing and evaluating current practices, processes, and services to understand issues and identify opportunities for improvement
- Implementation of improvements
- Evaluation of changes, for instance, through small tests of change

Many respondents said that QI necessitated an evidence-based, structured approach, including a standardised set of tools, tests, guidance, and standards, and driven by data (e.g. feedback, complaints, and performance indicators).

The sharing of learnings was also mentioned as an essential part of QI.
Finally, respondents highlighted the collaborative nature of QI, meaning that it should be conducted in engagement with staff at all levels and service users.

Research findings

Six key themes emerged during our discovery research. These are listed below (please note, these are not in hierarchal order):

1. Creating an organisational culture for QI

2. Establishing leadership and ownership for change
3. Engaging and empowering the workforce to make improvements
4. Strengthening the organisational approach to QI through frameworks and toolkits
5. Using data to support change and improvement
6. Cultivating a culture of learning and sharing knowledge

Each theme will be explored in detail throughout the remainder of the results section, combining findings from our focus group discussions with staff, the NSS wide survey and the literature review which was undertaken as part of this work.

Theme 1: Creating an organisational culture for QI

An organisation which can empower its people to challenge the norm, to make things happen and participate was a central theme in the literature review. An organisation that uses feedback and learning to take ownership of its environment and makes quality improvements part of day-to-day work was cited frequently as a mark of success.

Focus group participants felt that there was a strong appetite and high staff enthusiasm across NSS to carry out QI. However, they suggested that the current organisational culture did not always enable improvements, due to the prioritisation of business-as-usual activities over QI.

In the survey, 49% of 43 respondents with no line management duties said that they were not aware of QI projects in their SBUs. This might suggest a problem with communication with staff at this level, or a difference in understanding the organisation's approach to QI.

Some participants in the focus groups observed that although there were pockets of organisational culture that drove forward values consistent with QI, in general, they described the organisation as tending to be reactive, risk averse and hierarchical; all of which posed a cultural barrier to QI. In addition, silo working was mentioned as a persistent organisational obstacle to improvement, exacerbated by home working conditions introduced during the COVID-19 pandemic.

Focus group participants acknowledged that NSS had to operate within the boundaries of a complex political, legislative, and regulatory landscape that shaped the extent to which it could propose and implement innovations and improvements.

There were different opinions around whether regulation out with NSS enabled or posed a barrier to QI. Participants recognised that NSS must abide by directives set out by the Scottish Government, even if these impacted resource availability and side-lined long-term innovation. However, regulation was also seen to encourage innovation to be carried out safely. Additionally, QI methods such as Six Sigma and Plan Do Study Act (PDSA) were mentioned as opportunities to enact improvements within the limits of regulation.

To embed QI, focus group participants said it was essential to create an organisational culture that challenged the status quo, better articulated and communicated the importance of change, and brought in fresh ideas by involving new staff in improvement.

Amongst focus group participants, the COVID-19 pandemic was often cited as proof that it was possible to introduce radical changes to one's ways of working over a short period of time. Many participants felt that it was important to learn from the pandemic and evaluate the changes that should be taken forward. These include:

- Maintaining a less hierarchical organisational structure
- Making use of the new lines and platforms of communication
- Empowering staff to embrace and make changes

Focus group participants further emphasised that an enabling organisational culture should build QI into its business-as-usual activities. Findings from the survey show that just over half of respondents (55%, n=63) said they felt that QI was already part of business-as-usual. However, 47% of directorate, service or SBU management respondents disagreed with this statement, indicating that this group did not feel that QI was strongly embedded as part of business-as-usual activity. There was also less agreement among survey respondents on the question of whether QI was embedded in the culture of their SBUs or directorate.

Focus group participants indicated that enabling QI within the culture may involve building a safe and collaborative environment with dedicated time and resources set aside for QI, making improvement the right and effective thing to do.

Participants felt that promoting QI did not necessitate substantial changes, as they thought most staff already sought out and implemented improvements as part of their work. Introducing QI as a large project posed the danger of QI being seen as a top-down initiative, and belittling current improvements happening at an operational level. Instead, they suggested that to

celebrate the work staff are already doing and reassure them that they are not asked to undertake extra work.

The literature review reiterates the importance of collaboration and networking, testing smaller QI projects, inter-departmental coordination, building on success, and dedicated time for QI as key enablers. It further highlighted the following facilitators related to organisational culture:

- Democratic prioritisation of QI interventions
- Institutional incentive programme (e.g. productivity credit, monetary incentives, and rewards)
- Reconciling conflicting interests

Theme 2: Establishing leadership and ownership for change

The role of leaders providing inspiration and support cannot be underestimated in relation to QI. Ensuring quality improvement activity is considered as an end-to-end managed process, creating a clear vision, being visible and by committing to fewer priorities in order to deliver, demonstrate the benefits, then celebrate change, can create motivation for staff and leaders alike. Leaders should be champions of quality improvement linking quality improvement initiatives to strategy and communicate effectively at all levels of their organisation.

The literature review emphasises the central role that the leadership plays in creating a positive culture for QI (i.e. one that is inclusive, just, and tolerant of mistakes for learning). It also corroborates organisational buy-in, committed leadership, local ownership and champions, a structure of accountability, and having a dedicated transformation and quality committee as key facilitators for QI.

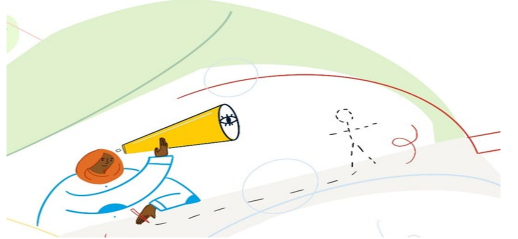
Additional enablers related to leadership and ownership identified were:

- Understanding of leader's perspectives
- Empowering local leaders

Findings specifically from our discussions with senior leaders highlighted that leaders have a resolve to lead on QI work across NSS as part of their day-to-day role and that there is a willingness to do so. However, this does not necessarily guarantee that QI is prioritised or implemented across the organisation.

During the Senior Leadership Forum (SLF) and staff focus group discussions, participants noted that there is a lack of clarity and understanding of, and buy-in to, the NSS QI vision at all levels of the organisation. Participants perceived the current vision of QI in NSS as a concept rather than a tangible strategy. It was suggested that the NSS QI vision needs to be agreed upon by senior staff and clearly communicated to all staff, helping to make QI a priority for all.

Buy-in to the vision was thought to only work if there was endorsement of that vision by senior staff and involvement of the whole team in delivering the vision. Under such conditions, participants believed innovation and QI could thrive. At the present time, lack of buy-in and prioritisation of QI can mean that improvement work is not actioned or is slow to be acted upon. Staff can be left feeling demotivated and “weary”. Despite these points, there is a clear appetite for change and improvement across the organisation.



A clear vision and commitment to delivering that vision, in combination with established ownership and leadership for change could cultivate a strong environment for QI across NSS.

Focus group participants commended managers and senior staff on their support of QI work in NSS. Support was recognised to be offered in a variety of different ways, for example:

- A commitment to support QI work is embedded within NSS policies
- Suggestions for improvement being welcomed and encouraged by managers

However, it was noted that in practice, there were difficulties for managers in being able to consider or implement any suggested changes due to other priorities taking precedence. As such, the commitment and support offered by managers and senior staff in relation to QI work was felt to be "watered down." A handful of participants felt that carrying out improvement work can often fall on the person who suggested it, which made some staff feel reluctant to suggest improvements.

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One participant discussed how their suggestion of rolling out QI training across the organisation was met with support and enthusiasm by colleagues, but that the responsibility to do so would have to fall upon their shoulders. It was seen as a supplementary piece of work as opposed to an essential piece of work that could be incorporated into that person's role. Without dedicated time and practical support from others, this task was perceived to be too large for one person to tackle alone in-between other work activities. This is just one example of how improvement work can become shelved.

There was also a feeling amongst participants that managers may not fully understand what QI is or what it means, and that QI can sometimes be used as a "buzz word" to define work being done across the organisation. However, there was doubt as to whether all work that is currently defined as QI in NSS is truly improvement work. Participants at all levels suggested the need for senior management to participate in training in QI methods and approaches, as well as training in general coaching and facilitation skills, so that they may effectively support staff in delivering QI work.

Ownership of QI in NSS was a strong theme during focus group discussions with staff at all levels. In an ideal world, there would be holistic ownership of QI which transcends the organisational hierarchy i.e. where quality is owned by everyone across the organisation (organisational ownership). However, the current situation in NSS was felt to be far from this ideal.

There was a strong belief amongst participants that there is currently a lack of ownership, accountability, and leadership of QI work in NSS. Participants identified that clear ownership is required to drive through change and embed improvements. Some felt that senior leaders or managers in NSS were in a good position to own and drive QI work, although one participant felt that when senior staff do take lead on QI work, it did not work well in practice. Others felt that there needs to be collaboration to support ownership at an operational level.

There were other suggestions as to who would be best placed to "own" QI work in NSS. **Having a core QI team in NSS or QI champions embedded within SBUs who could offer guidance to others was suggested as ways in which QI could be "owned" by everyone within the organisation.** The wealth of experience that such a team of individuals could bring to the organisation was thought to be of great benefit to all those conducting QI work in NSS***.***

Some focus group participants suggested that a heightened awareness of QI, and of methods and toolkits to support QI, is required across the organisation to cultivate and strengthen ownership*.* This might be achieved through communications to all staff via Stay Connected, developing case studies to showcase QI work being conducted across the organisation and running educational sessions for all staff on QI approaches.

Theme 3: Engaging and empowering the workforce to make improvements

Whether discovering, designing, implementing, or sustaining quality improvement, the inclusion of those who deliver or receive the service is vital to understand the problems, requirements and aspirations to deliver quality improvement. Co-production and the involvement of multidisciplinary teams is an essential component of quality improvement initiatives.
An engaged and empowered workforce was considered fundamental for embedding an organisational approach to QI. Focus group participants felt strongly that staff needed be empowered in order make suggestions for change. This included creating a less hierarchical culture, with work relationships less defined by micromanagement, and more by trust and autonomy.

The survey results suggest that most staff feel able to make suggestions for improvement (76%, n=90), and are encouraged to try new ways of working (71%, n=82). Respondents in executive management roles (n=3) strongly agreed with both statements. However, only 26% of those with no management responsibilities felt that they were able to make suggestions for improvement.

Focus group participants discussed four different aspects of staff engagement and empowerment:

- Involving staff of all levels in making improvements
- Increasing engagement through good communication
- Creating supportive team structures
- Allocating time and resources for improvements

These aspects are detailed below.

Involving staff of all levels in making improvements

Focus group participants highlighted the importance of senior management engaging with staff more by involving staff at all levels across the board, allowing and encouraging people to come forward with improvements, ensuring that staff felt that their ideas were valued and that they felt listened to. Some participants noted that not being listened to could make them feel disheartened, alienated, and could impact their mental health. On the other hand, extending staff involvement was seen to increase staff motivation, communicate that everyone's ideas are valued, and make decisions feel less top-down.

Survey results suggest that there is scope to improve involvement: only 39% of the survey respondents rated staff involvement as "good" or "excellent" (n=46)

Focus group participants suggested that a way of bringing in new ways of thinking was through capturing the ideas of staff on the ground, especially of those who are not normally involved in conversations around QI.

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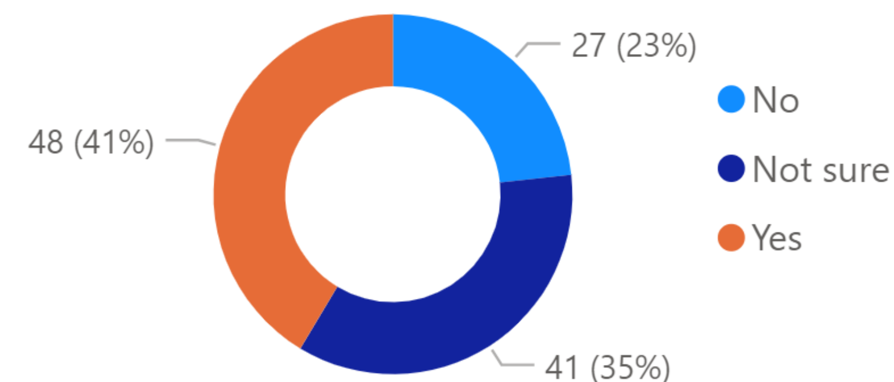
Fig 6. Count of survey respondents as a percentage who answered, yes, no or not sure as to whether there is a process or group in their directorate to capture ideas for improvement.

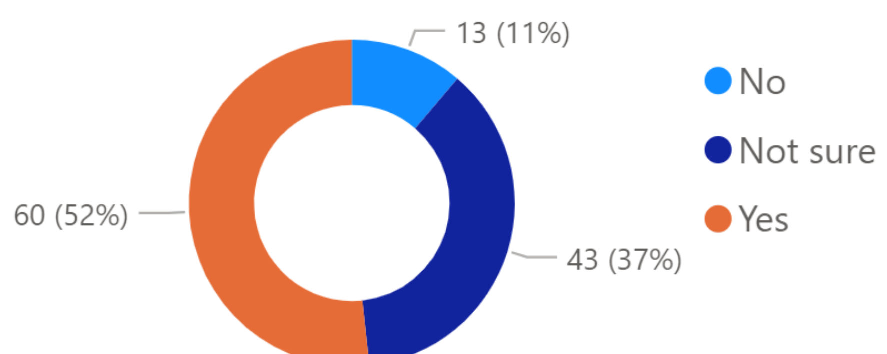


However, 41% of survey respondents (n=48) thought that either there was no process or group to capture ideas for improvement in their directorates, or they were not sure if there was one (23% and 35% respectively).

Within the focus groups, some participants said that they felt encouraged to come forward with ideas, but they were not aware of any changes being actioned.
These discussions underline the staff's need to be informed about how their suggestions for improvements are taken forward and implemented.

Only 52% of the survey respondents (n=60) said that feedback from service users informed changes in their directorates. 11% of the respondents said no (n=13), and 37% were not sure (n=43). The survey results further indicate that feedback informs changes more so for those in clinical roles (68%, n=17) than for those in non-clinical roles (47%, n=43).

Fig 7. Count of survey respondents as a percentage who answered, yes, no or not sure as to whether feedback informed change within their directorate.



53% of respondents with no management duties (n=23) said they were not sure whether feedback informed changes, this was much lower among respondents with line management duties (32%, n=17) and respondents from directorate management (18%, n=3). These results indicate the need to improve arenas for feedback for operational level staff.

To the question on how often feedback was gathered, eight respondents with no line management duties said they were not sure (57% of responses to this question). This percentage was slightly lower among respondents with line management duties (52%, n=17), and lowest among respondents from directorate management (10%, n=1). All these results may indicate a hierarchical blocker in understanding how feedback is used within QI.

Increasing engagement through good communication

Effective communication was key to encouraging staff engagement. In the focus groups, participants said they would welcome more transparency around decision-making processes and would like to see more senior management communication around rationale for changes made in ways of working; otherwise, staff might feel that certain decisions are handed down to them.

Whilst the survey results indicate that the most common methods used for communication are group discussions (36%, n=79), written communications (33%, n=72), and one-to-one meetings (28%, n=61)) the focus group discussions suggest that use of these mechanisms is not widespread across NSS.

Suggestions to improve communication included:

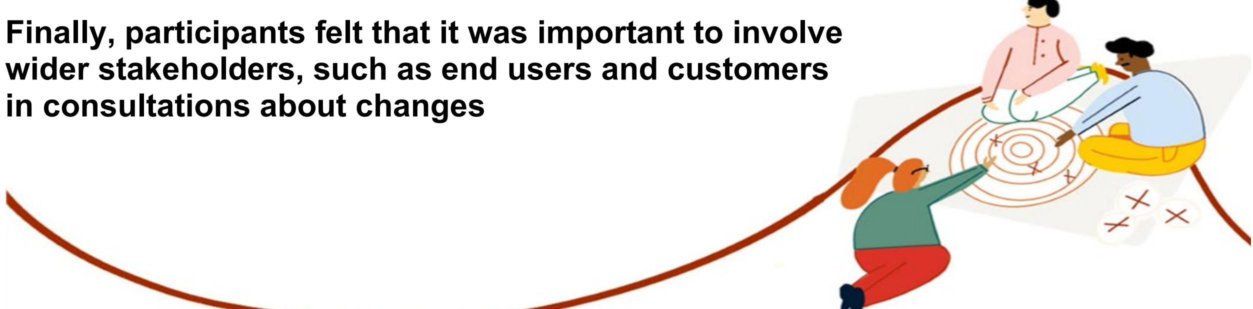
- **Consulting staff of all levels – including operational level staff – about changes**
- **Creating channels through which staff could feedback on changes, for instance via Microsoft Teams channels**

One example of successful communication discussed within the focus groups included collecting staff feedback through a form in monthly meetings with other departments.

Participants from one SBU suggested the following to improve the two-way communication between managers and staff:

- **Open forums and town halls**
- **Regular team meetings that included team leaders and management**
- **Collaborative spaces**

Finally, participants felt that it was important to involve wider stakeholders, such as end users and customers in consultations about changes



Creating supportive team structures

Participants from bands 3-6 discussed how team structures impact the extent to which they feel empowered to make improvements.

In general, being embedded in a supportive team helped participants overcome barriers in their roles. A supportive team structure was described as including regular team meetings and check-ins to help staff with forecasting tasks and tracking deadlines. These meetings were also a platform for team members to flag up potential issues, identify where extra support may be required, and make suggestions for improvements. Regular meetings further enabled peer support, learning, and communication. On the other hand, a lack of clarity and transparency on team structure and activities were thought to prevent staff members from identifying and suggesting improvements, as it was difficult to identify who made decisions

Having a supportive team leader was central to supporting staff making improvements. Participants felt that a supportive team leader was someone who was approachable, open to suggestions for improvement, communicative, and ensured information was shared. They also thought it was important that team leaders understood the work and pressures operational staff faced.

Allocating time and resources for improvements

Not only does the success of quality improvement rely on finances and other resources but also commitment to protected time. Quality improvement should be seen as part of everyone's role. Other important resources could include access to business function support; administrative or IT to efficiently utilise skills to support ongoing quality improvement. The lack of time and resources was identified as primary barriers to staff engagement and empowerment. Participants in all focus groups recognised that staff might feel stretched and may not have the time and the headspace to reflect and undertake potential improvements in addition to their day jobs. Similarly, many participants felt that it was difficult to justify investment in QI activities, with business-as-usual activities taking priority.

The people we spoke to emphasised that to embed QI within NSS, there needs to be an organisational culture that recognises the time and resources needed for undertaking improvement. **Participants suggested resource management could be made more efficient, for instance, by making use of better IT systems and digital technology; this would allow protected time to be set aside for QI activities.**

The literature review cites adequate resources, reflection and feedback mechanisms, building and supporting local teams, and engaging everyone proactively in their role as some of the most often mentioned key enablers for QI. It further reiterates the central role that open mindset and communication play in enabling improvement.

Other organisational facilitators related to workforce engagement and empowerment included:

- Workflow optimisation
- Developed relationships

Theme 4: Strengthening the organisational approach to QI through frameworks and toolkits

Training in QI methods and tools, knowledge of quality improvement initiatives in the organisation and a consistent approach and understanding among staff is imperative to a supportive quality improvement organisation.

An overarching framework and a standardised toolkit were discussed as ways to introduce a systematic approach to QI. However, some participants felt that the complexity of NSS as an organisation, the variation between and within SBUs, and the resulting lack of consistency in ways of working posed a major challenge to this.

Most focus group participants felt that there was a lack of an overarching QI framework within NSS, and where there was a framework in place, it was not consistently applied. However, participants suggested that some staff were doing it anyway despite the lack of a formal framework or toolkit: pockets of good practice and innovation could be seen across the organisation where individuals were taking the lead (as an example, see case studies in appendix 9).

An overall QI framework was proposed to promote a consistent and holistic approach to QI within NSS. Such a framework would help articulate the standards and clear goals for QI for NSS by:

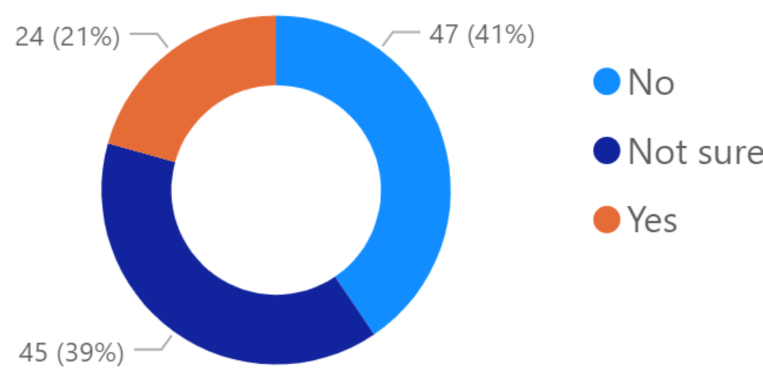
- **Joining up the currently disjointed efforts for QI**
- **Sharing tools and improvements across NSS**
- **Providing guidelines that SBUs could adapt for their own needs**
- **Allowing for the application of different QI methodologies and approaches**
- **Embedding QI in ways of working**
- **Enabling the measurement of improvements**

There was less consensus regarding the need for a standardised QI toolkit. Some participants said that an overarching toolkit with guidelines would help the standardisation of QI efforts. However, the majority highlighted that due to the diversity of services within NSS, a single toolkit may not be able to address the diverse needs of different SBUs and directorates. Engagement with individual SBUs was therefore essential to understand their needs, priorities, and requirements regarding QI tools.

Focus group participants discussed where the ownership of toolkits might sit. Suggestions included **having one SBU (such as Strategy, Performance and Service Transformation) who would be responsible for developing QI toolkits. They would then seek feedback from other SBUs as to whether their data would fit with the proposed toolkits. The toolkits could then be refined using that feedback to ensure they are fit for purpose. An alternative offered to this was to ask those with a corporate view of the whole organisation to lead on developing QI toolkits.** Finally, other focus group participants felt that that a range of QI tools were readily available to them, including Six Sigma and LEAN methodology, PDSA, service audit reviews.

In contrast, 41% of survey respondents reported that they do not use a standard QI toolkit (n=47) and 39% were unsure if there was a toolkit available to them (n=45). Besides respondents from the Clinical Directorate, 56% of whom said that they have a standard quality improvement tool kit (n=5 respondents), other SBUs are widely disbursed across ‘yes’, ‘no’ and ‘not sure’. Where QI tools were utilised, it was reported that they may not be widely shared or used, or staff may not be aware of them.

Fig 8. Count of survey respondents as a percentage who answered, yes, no or not sure as to whether a standard quality improvement toolkit was available.



During focus group discussions, staff reiterated the **need to raise awareness of existing tools and supporting staff capabilities** to ensure they understand and can select the right methods and use them in a consistent and standardised manner.

81% of survey respondents said they used work instructions, guides, and Standard Operating Procedures (SOPs) in their departments (n=94). SOPs are reported to be used more often by staff in clinical roles than those in non-clinical roles (92% or 23 respondents compared to 78% or 71 respondents respectively). Staff with no managerial duties were less aware of SOPs being used in their departments (67%, n=29) compared to those with management responsibilities (89%, n=65). 100% of Executives and 88-89% of directorate, service or SBU

managers and line managers acknowledge that SOPs are used in their departments. This raises questions as to why those with no line management duties are less aware of SOPs being used.

Staff in the Scottish National Blood Transfusion Service (SNBTS) and Clinical Directorate are more likely to refer to SOPs than other SBUs; with clinical staff more likely to refer to SOPs during their work than non-clinical staff.

Some focus group participants found SOPs useful for troubleshooting and ensuring consistency. Where SOPs were not available, for instance in newly developed and appointed functions, participants expressed the need to develop guidelines to maintain standards and benchmarks. However, it was important that the guidelines and SOPs were kept up to date and allowed flexibility within project teams. From the survey, we observed little consistency across the board around how often SOPs were updated, other than that they tended to be updated when a change to process is made.

To strengthen the organisational approach to QI, the literature reiterated the need to incorporate a QI model or established QI tools such as PDSA, Lean and Six Sigma into practice, and to adopt QI designed tools. In addition, two papers included in the literature review also recommended the need to pilot everything using an iterative and collaborative approach. This process of continually refining and improving processes was seen as being crucial to the success of QI work.

Theme 5: Using data to support improvement

For the purposes of discovering, designing, implementing, or sustaining quality improvement, the measurement and leveraging of the right data is essential. Data should be timely, accurate and robust, with a benchmark created and consequences tracked prompting reaction.

The importance of data to support quality improvement across NSS was a strong theme throughout our research. Many focus group participants recognised the need for data to support QI and a small number offered their own experience of using data to drive change, measure improvement or described instances where they had used data to identify areas for future improvement.

For most focus group participants, using data to support QI was reported to be difficult in practice for several reasons, including:

- Issues with data quality
- Collecting, measuring, and accessing data
- Data systems
- Limitations in staff capabilities to handle, analyse and interpret data

These are described in detail below.

Data Quality

Focus group participants noted that the data available to support QI work was often of poor quality in relation to the accuracy and comparability of the data, which reduced staff's confidence in using data to drive change.

Data quality was perceived to be affected by the variability in data collection both across and within SBUs, and by human error at various points of the data journey including data entry and data cleansing. Manual data entry was reported to be common and was thought to result in the duplication of data and numerous errors existing within datasets. There was recognition that data cleansing took a lot of effort. However there were attempts to try and use intelligence from these experiences to improve the data entry process, or to understand why those errors were occurring and what could be improved upon.

For example, one SBU mentioned that they send out an annual survey to their clients. An improvement that they have made to their data entry process for the survey data is a new system which does not permit staff to input incorrect data, thus reducing data entry errors.

There was a feeling among some participants that senior staff were not always aware of data quality issues, nor the effort required to pull different sources or types of data together.

Collecting, Measuring and Accessing Data

Staff who spoke to us during focus group sessions noted that there was a wealth of data potentially available for staff to use to support QI work.

- 54% of survey respondents answered questions relating to the data available to them (n=63). Of those: 73% agreed or strongly agreed to having access to data when needed (n=46)
- 65% agreed or strongly agreed that data was kept up to date (n=41)
- 62% agreed or strongly agreed that data was clear to understand (n=39), while 30% did not agree or disagree with this statement (n=19)
- 52% of those who had access to data agreed or strongly agreed that data provided sufficient detail (n=n=33)

However, access to data was reported to be challenging, particularly, real-time data. Some participants noted that this could be attributed to the fact that there is no one place which hosts data but multiple data systems which do not communicate with one another. This will be explored in further in 'Data Systems' below.

Types of Data

User statistics and customer insights or feedback were noted by focus group participants to be available to staff and were used for some improvement work across NSS.

68% of survey respondents (n=79) noted that they have goals, targets, or Key Performance Indicators (KPIs) for the work they are involved in. Those in clinical roles were 10% more aware of targets and KPIs than non-clinical staff. 25% of those with less than 1 years' service and 21% of those with no management responsibilities were unsure whether they had goals, targets or KPIs in place. This could signify that there is a problem in setting or sharing targets with those newest to the organisation or with those working at an operational level. When cross referenced with the outcomes from the questions around standard operating procedures it may suggest that SBUs with more measurable processes in place are better able to set and track KPIs or targets.

63 of the 79 survey respondents who reported having goals, targets or KPIs reported that information relating to their progress against these was available to them. This consisted of:

- A mixture of qualitative and quantitative data (44%)
- Quantitative data only (38%)
- Qualitative information only (18%)

Although the survey suggests that both qualitative and quantitative data are available to staff in relation to KPIs, it does not fully address whether that data is of good quality, as measured against the six quality dimensions of completeness, uniqueness, consistency, timeliness, validity, and accuracy defined by DAMA UK and referenced by the UK Government [3].

Measuring the “right” thing

Measuring the “right thing" was a common theme during discussions we had with staff around data. The data available to staff wasn’t always fit for purpose or collected at the optimal point in the QI journey. On occasion, staff reported that they tried to shoehorn data to fit with their needs or felt that they did not use data in a meaningful way to help create change. Focus group participants identified existing KPIs as potential area for improvement given that they do not always answer the questions they are trying to address. Some participants highlighted that there is disagreement among staff regarding what data is required to effectively measure improvement, due to limited understanding of what measures are needed, the differing targets that are set out or a lack of clarity on service standards and approaches.

There was a sense that participants felt a heavy reporting burden, collecting and reporting on data to fulfil a business requirement rather than necessarily adding value. Several participants commented that data is not being actively used to effect change across the organisation while others remarked that they felt there is a lack of communication regarding how data is used in practice i.e. what is the impact of the data provided.

Data Systems

There appear to be multiple different systems which collect and host data across NSS which vary in terms of quality and which do not communicate with one another. This can make the data collection process difficult and time-consuming for staff who need to learn to navigate the (often complex) data journey. There were calls from participants to move away from manual data entry, which is cumbersome and where there is often duplication of effort, towards an automated data collection process, including an integrated data platform which pulls together data from multiple different systems. This could help make efficiencies and give staff more time to recognise improvement opportunities from existing data.

Staff Capabilities

There was recognition amongst participants that there is a need to upskill staff in relation to data analysis and in presenting or reporting results of analyses conducted.

One way in which participants felt this could be achieved would be to share skills and knowledge across the organisation, for example, a platform where staff could share

examples of best practice and "workarounds" to make analysis more streamlined and efficient.

The literature reiterated the following enablers to using data to support improvement work:

- The need to measure with and leverage data; data plays a key role in improving quality or measuring the impact of change and measuring the "right thing" is key to facilitating improvement.
- Accessibility of the required information
- Standardisation of information gathered during improvement work and in how data is collected and used to make improvements

Theme 6: Cultivating a culture of learning and sharing knowledge

Establishing a strong learning culture was reflected in the literature under culture and training tools and templates. I has been given a separate section in the findings due to the volume and depth of conversation it generated outside these core themes.

The senior leaders we spoke to felt that staff possessed excellent specialist knowledge and inherent skills needed to conduct QI, even if they may not be formally trained in QI methods. Indeed, two thirds (75 respondents or 65%) of NSS staff who completed the survey reported feeling fairly or completely confident that they have the knowledge and skills required to carry out QI work. This was greater amongst directorate, service or SBU management staff with 82% reporting that they were "completely or fairly confident" that they possess the necessary knowledge and skills to carry out QI work, compared to 70% among those with line management responsibilities (n=37) and 51% of those with no management duties (n=22).

Most survey participants said that new employees could use a multitude of different tools and training methods to help them carry out their role. The most popular of these were 1) learning from others (n=97), 2) induction (n=87), and 3) policies and job descriptions (n=84). Regular training (n=66) and having a training plan for QI (n=63) were also thought to be helpful for new members of staff.

Training was mentioned during focus group discussions as a key part of establishing a learning culture by helping staff fulfil their role and identify potential improvements. Senior leaders recognised the importance of further cultivating workforce capabilities by providing the right skills and tools to support staff involvement at all levels.

Through focus group discussions and communication with NSS colleagues we understand that there is no formal offering of QI training in NSS. Focus group participants spoke of the need to learn QI "off their own back" and participating in external QI training programmes or modules, for example, the Improvement Advisor Course offered by the Institute for Healthcare Improvement, or by pulling on experience and training from previous employment.

We were made aware of more local examples of QI training available to staff working in NSS. These are:

1. NHS Education for Scotland (NES) - Quality Improvement Zone
2. PgMS - Introduction to Lean

More details of these are in appendix 6.

Although most focus group participants we spoke to have not had QI training, they discussed their experiences with internal mandatory and optional training on TURAS in achieving

standards. The people we spoke to felt that currently mandatory training did not meet their needs because the modules:

- Could feel a tick-box exercise: they were too generic and were not always applicable to specific roles
- Did not consider individual skills, abilities, and learning styles: for instance, it did not cater for hands-on learners
- Were not engaging – one participant described current training as "death by PowerPoint"

Suggested ways of improving training to better embed QI included:

- **Tailoring training to learning styles and specific roles**
- **Maintaining consistency of learning through embedding training in practice**
- **Supporting staff development through a more structured approach to learning**
- **Reserving dedicated time for training**

Participants thought it was important to let staff know how training could benefit them, to motivate them to commit the time.

Some focus groups participants emphasised that formal training alone was not sufficient in embedding QI culture. Most band 3-6 participants spoke about the importance of learning from and being supported by their peers in their roles, for instance through formal or informal check-ins, tutorials, and regular team meetings and debriefs. Band 3-6 participants from one SBU mentioned buddying and establishing formal safe spaces as ways of establishing peer support. Finally, participants felt that being able to learn through practice was essential to consolidating skills and capabilities.

The limited sharing of knowledge was identified as a persistent barrier, which meant that good practice and innovation that happened at project team level was often lost.

For instance, one participant talked about being able to significantly shorten the time spent on data analysis by using an alternative software, thereby addressing a persistent issue mentioned by participants across multiple SBUs. However, this improvement was not shared beyond their project team, despite its potential to benefit the whole organisation *(*see case study in appendix 9 for more details).

The following enablers were highlighted for sharing knowledge:

- **Sharing case studies**
- **Establishing communities of practice**
- **Developing a framework that supports knowledge sharing**
- **Dedicate time for updates in regular team meetings**
- **Sharing learning on Intranet**

Finally, peer networks were also highlighted as a means of sharing learning in a way that makes use of their colleagues' expertise and tap into unwritten and undocumented knowledge.

The literature reiterated the need to offer QI training, coaching and support to staff involved in improvement work and to develop training programmes which meet different learning styles and preferences for learning. In addition, the literature also suggests that having access to an

engaged mentor could help support staff learning, promote evidence-based best practice and standardise approaches to QI.

Conclusion and recommendations

bookmark://appendix5/This discovery research set out to examine the extent to which QI is embedded within NSS. This report provides an overview of the embeddedness of QI in the different SBUs and directorates around six key themes:

1. Creating an organisation culture for QI
2. Establishing leadership and ownership for change
3. Engaging and empowering the workforce to make improvements
4. Strengthening the organisational approach to QI through frameworks and toolkits
5. Using data to support improvement
6. Cultivating a culture of learning and sharing knowledge

These themes broadly correspond with the six organisational enablers cited by the literature review: time and resources, culture, leadership, collaboration, training, and data.
It transpires from the findings that there is great variation between the various SBUs and directorates, and further variation exists within each theme. This echoes the wider literature which states that QI is a dynamic process, one which is a result of complex interactions between organisational enablers. What may work well to enable QI in one SBU or directorate will differ, depending on leadership, staff, and existing ways of working. Although there appears to be a high level of understanding of what QI means and what it entails, there seems to be variation in the way staff apply their understanding of QI and its methodologies.

The case studies submitted for the discovery research particularly reflect the sentiment repeated in focus groups that staff are already doing improvement work, which can be considered QI, but are currently not recognised as such, as they do not use recognised QI methodologies. This raises questions about whether in order to introduce an organisational approach to QI, NSS should have a clearer definition of what QI means and what it entails, one that acknowledges existing work as well as help guide future efforts.

The SBU- and directorate-level variation and the lack of organisational definition of QI mean that there are limitations around the extent to which conclusions can be drawn with regards to the overarching embeddedness of QI within NSS. There are some key findings that give indication on whether QI is embedded within the four pillars:

1. Mindset, culture, and principles
2. Engagement of those closest to the issues
3. Consistent methods and tools
4. Testing and measurement

Mindset, culture, and principles

The literature review clearly states the crucial role that an open mindset and communication play in enabling improvement. This report gave an overview on the extent to which NSS provides these.

Findings documented in the report demonstrate high staff enthusiasm and appetite as well as perceived inherent skills and expertise among staff to conduct QI, but these do not always translate into QI work. This might be in part due to an organisational culture that prioritises business-as-usual.

This means that there is space for the organisational culture to be transformed to promote QI, by making QI the effective and right thing to do. As the literature review highlights and as participants repeatedly pointed out, such transformation does not necessarily have to be a radical change for staff. Rather, it should comprise creating an organisational structure that is less hierarchical, more collaborative, with dedicated time set for QI work. This culture has to be democratically owned, with buy-in from staff of all levels.

Our research suggests that although there are pockets of innovation and good practice, the current overarching culture across NSS does not appear to be fully conducive to QI.

Engagement of those closest to the issue

Our research findings clearly show that staff are keen to be involved in QI. However, there seems to be variation among SBUs and directorates around whether staff feel empowered and engaged. There is space for improvement around extending staff involvement, through creating and strengthening platforms and mechanisms for capturing ideas.

There seems to be further disconnect between whether staff feel like they are able to make suggestions and being informed about how their suggestions can be turned into practice. The findings demonstrate a difference that staff feel between receiving nominal support for QI, e.g. in the form of encouragement, as opposed to tangible support that helps staff translate ideas into practice. Our research provides a number of examples for the latter that would be welcome by staff: regular meetings, platforms to capture ideas, better communication and more frequent consultations about changes, clear team structures, and most importantly, dedicated time and resources. There was a general consensus among participants that currently, there is inadequate time and resources allocated for QI, which poses a primary barrier to staff engagement in carrying out improvement.

Therefore, any future NSS policy to strengthen an organisational approach to QI needs to consider providing material support for staff engagement; without this, there a danger that QI becomes only a buzzword rather than translating into meaningful action.

Consistent methods and tools

We have identified that there is no universal framework or toolkit which is consistently used or embedded across the organisation to design and deliver QI . Participants identified a clear need for an overarching QI framework which would enable NSS to articulate best practice and standardise its organisational approach to QI. This framework is required to be flexible so that different SBUs can adapt it to fit with their needs and working styles. The most commonly cited QI approaches identified by our participants and the wider academic health literature were: Plan-Do-Study-Act, Lean and Six Sigma. The literature recommends that organisations should adopt one of these approaches for improvement work. However, our research highlights that given the complexity and variation of the work which the different composite parts of NSS undertake, there is no “one size fits all” approach for NSS to adopt as an organisation. It would be worth investing time and resource to develop a toolkit which offers a suite of QI methodologies, This would enable staff to choose approaches that best align with the improvement work they are leading on or are involved in.

QI specific training could help support the introduction of any overarching framework or toolkit. Although nearly two thirds of participants in the survey were “fairly or completely confident” that they have the necessary skills and knowledge to carry out QI work, we cannot assume that the survey cohort is representative of the whole NSS staff population given that those who answered the survey tended to be in more senior positions. The voice of those working in

lower staff-bands was included in our focus group discussions and suggested that more training in QI methodologies is required for those working at an operational level.

Implementing training could help to standardise the application of QI methodologies across NSS. Training is less successful when it is made mandatory and so it is recommended that QI training be offered to staff as a key part of their professional development. Ideally, this would be encouraged and formally supported by managers and senior leaders across the organisation. QI training would need to accommodate different learning styles and be embedded in practice. For training to be successful, it needs to be supplemented with peer support and practical "on the job" learning. Sharing of knowledge and experience, which is currently thought to be absent, is also strongly recommended.

We are aware that there is at least one internal QI training course being delivered in NSS: Lean training in PgMS. However, as an organisation, NSS currently lacks an internal QI training programme for all staff to use. Therefore, NSS may want to consider collaboration with other NHS bodies such as NHS National Education for Scotland (NES) who provide both formal (accredited) and informal QI training to those working in the health sector.

Testing and measurement

The extent to which testing is embedded across NSS is ambiguous given the variability we observed across the organisation. Participants did not seem to understand the concept of testing in relation to QI projects. The continuous cycle of improvement so commonly seen in other health settings was not evident from our discussions with staff across NSS nor through the case studies we developed.

Through our discovery work, using and leveraging (the right) data were identified as being key to improvement work. To support QI effectively, data is required to be timely, accurate and robust.

Those who participated in the survey, and had access to data, noted that the available data was kept-up-to date and was clear to understand. However, this is not representative of all staff across the organisation. During focus group discussions, staff from all levels reported that the quality of available data is variable and generally substandard. This was thought to be due in part to the lack of standardisation of data, limited access to data (particularly real-time data), and the common use of manual data entry processes which can be prone to human errors. It was believed among our participants that senior staff are not always aware of such issues.

More needs to be done to raise awareness amongst this cohort, perhaps through the development of platforms where NSS staff can share knowledge and experiences of using data to support QI work. Automating data capture was identified as one way in which data quality could potentially be improved by reducing human error. This could also facilitate the development of a data platform which hosts data captured from multiple sources, aiding access to (real-time) data.

Using data effectively to measure the impact of improvement is essential to QI, but there is little or no consensus amongst our participants as to what is required to evidence improvement or change. Data available to NSS staff is not always fit for purpose, and those we spoke to reported occasionally "shoehorning" data to fit with their project requirements. It is often believed to be difficult to baseline anything at the start of QI projects, without which it is difficult to ascertain the impact of any intervention which aims to improve the status quo.

Staff capabilities in data analysis, interpretation and reporting was identified as a key area where there is room for improvement. While it was recognised that many staff have excellent

and inherent data skills to support improvement work, there was a belief among those we spoke to that other staff members need support in this area. Dedicated time set aside for staff to participate in data skills training needs to be prioritised. Developing and enhancing the skills of NSS staff will only help to improve the quality of the improvement work we are doing.

Recommendations

Quality Improvement is an art that takes commitment to discovery and experimentation along the QI journey to learn and adapt within a supportive environment. The complexity of conducting QI means that no single recommendation should be read in isolation of the others. Rather, they are stepping stones on a road to a culture of continuous quality improvement.

Given the limitations of our research, we were not able to baseline data on the implementation of QI in individual SBUs. Rather, this report provides an impression on the current state of the organisation overall. Therefore, our primary recommendation would be to establish baselines for individual SBUs and directorates through local level surveys that encourage mandatory participation. In the absence of this micro level detail, NSS may consider piloting changes with areas that demonstrated the highest levels of engagement and interest in QI as a first step. This would be consistent with a central suggestions in the wider literature around the importance of carrying out small tests of change as part of QI. Recommendations from any such pilot work could be subsequently rolled out to other SBUs across NSS.

A key recommendation from this discovery research is to establish an NSS-wide QI strategy and framework, cognisant of the wider policy context where the approach can be embedded in SBUs when they are ready to commence their QI journey. Although the literature would suggest that a standard toolkit and methodology is essential, within the context of NSS, it would be more appropriate to have a suite of QI tools which SBUs can select from, given the diversity of the organisation and the needs of those who engaged in the research.

Training and coaching will be essential across the organisation as it seeks to embed QI. This would help improve the general understanding of the role of testing and measurement, and further cultivate the existing strong interest in QI. The challenges around data should be addressed at organisational level, as these may have an impact beyond QI.

There is also a need to create a culture in which staff are given the time and resources to implement QI techniques and methods in an environment which is comfortable with testing change, taking risks and learning as it goes. This is not something that can be done in isolation. It will require due consideration at senior level of the overarching culture which currently exists in NSS as this was only lightly touched upon in this work.

The research team would also like to offer some practical recommendations based on the findings presented in this report and work with the sponsors of this discovery research:

1. Sharing of this report with the NSS EMT, especially as many of the suggestions for improvement are wider than QI
2. Creation of a delivery group to oversee the embedding of QI in NSS which reflects the diversity of the participants in the research (across SBUs and staffing groups)
3. This group should reflect on the discovery findings, review, elaborate on, and prioritise the suggestions for improvement to set a direction for QI which reflects the main findings of the research
4. Consider widening membership of the core QI group to reflect the diversity of staff with an interest in QI

There is much to be celebrated across NSS in relation to quality improvement. However, more could be done to elevate the culture of QI across the organisation and enhance the skills and knowledge of those involved in designing and delivering improvement work in order to purely embed QI. Given the high levels of enthusiasm and engagement of staff in this discovery research, we believe that this can be achieved.

Appendix 1 - Project approach

Scottish Approach to Service Design (SAtSD)

The SAtSD ensures that service **users are supported and empowered** to actively participate in the discovery, definition, development, and delivery of services.

The SAtSD approach aims to ensure that we don't just design services in the right way, but that **we design the right service.** The approach has a set of founding principles:

1. We **explore and define the problem** before we design the solution
2. We design the **service journey around people** and now around how the public sector is organised
3. We seek **users' participation** in our projects from day one
4. We use **inclusive and accessible** research and design methods so users can participate fully and meaningfully
5. We use the **core set of tools and methods** of the SAtSD
6. **We share and reuse** user research insights, service patterns, and components wherever possible
7. We contribute to **continually building the SAtSD** methods, tools and community

Appendix 2 – Representation and engagement

Engagement across Strategic Business Units

The below table shows how representative the feedback is across NSS in relation to each SBU and their employee headcount.

Table 1. Comparison of employee engagement across NSS by SBU in relation to SBU headcount

Strategic Business Unit	Count of total participants engaged with	Employee Headcount as of April 2022	Count of all participants by SBU as a % of all those engaged with	SBU Staff headcount as a % all staff
Central Legal Office	12	134	4.67	3.68
Clinical Directorate	20	23	7.78	0.63
Digital and Security	21	431	8.17	11.82
Finance & Business Services	9	73	3.50	2.00
Human Resources	8	102	3.11	2.80
Practitioner and Counter Fraud Services	37	456	14.40	12.51
Procurement, Commissioning and Facilities	34	778	13.23	21.34
Scottish National Blood Transfusion Service	37	940	14.40	25.78
Strategy, Performance and Service Transformation	32	272	12.45	7.46
National Contact Centre	39	437	15.18	11.99
Unknown (Other)	8	N/A	3.11	
Total	**249**	**3646**		

Overall we have engaged with a greater number of employees in the Clinical Directorate and Strategy, Performance and Service Transformation than is proportionate to the employee headcount of the SBU.

Engagement with the Central Legal Office, Digital and Security, Finance and Business Services, HR, Practitioner and Counter Fraud Services and the National Contact Centre are within 3 percentage points of their employee headcount.

Engagement with Procurement, Commissioning and Facilities and Scottish National Blood Transfusion Service employees is lower than proportional to headcount. It is likely that this reflects that a higher proportion of staff within these SBUs are not desk based and is noted as a limitation of this research

Engagement across role types

The below table shows how representative feedback is across NSS in relation to role type. This is defined as Executive management, Directorate, Service or SBU management, Line management responsibilities and those with No management responsibilities.

Table 2. Count of participants by role type and method of engagement.

Role Type	Count of survey respondents	Count of focus group participants	Count of participants as a % by role type of all engagements
Executive management	3	15	7.00
Directorate, Service or SBU management	17	53	27.24
Line management responsibilities	53	28	31.52
No management responsibilities	43	45	34.24
Total	**116**	**141**	

Proportionately we have engaged with a greater number of line managers and employees with no management responsibilities overall (67.87%). However we recognise that this figure is lower than the proportion of employees within these positions in the organisation and does not fully reflect the organisational structure.

Appendix 3 - Research strengths and limitations

Strengths

- The discovery research combined several qualitative and quantitative methods to capture a wide range of relevant voices from across NSS staffing cohort regarding the current maturity of QI
- This included a literature review, stakeholder mapping, NSS wide survey, numerous stakeholder focus groups and regular engagement with the working group. The range of methods complemented each other to provide robust findings. Data analysis and synthesis was conducted by experienced user researchers with support from the project team, and all findings were reviewed and discussed to reach consensus on the final themes
- The use of a few open questions and listening/engagement activities across the range of research exercises meant that the project was led by the evidence, expertise and experience of staff members
- Comparative analysis was conducted where a staff group/SBU was significantly over-represented – the presentation of research findings was weighted for under- and over-represented SBUs
- The research team regularly fed back to the working group at bi-weekly meetings and at each stage of the research, creating a two-way process and building on their unique expertise
- Based on the impact factor of the journals in which the academic literature was published, the articles included in the literature review are likely to provide an acceptable level of quality

Limitations

- This was a rapid engagement, conducted over a period of 4 months during the annual summer break which significantly impacted on timelines and the availability of staff to participate
- Changes in personnel led to delays in the project commencing
- Different participation levels across SBUs may skew some of the results. For example, in the Band 3-6 focus groups staff from NCC contributed 27 of 141 responses
- The recruitment channels for broad staff engagement were less effective than anticipated. The survey via Stay Connected was completed predominantly by those in Agenda for Change Band 7 and above and the local level dissemination of focus group invitations shared via SLF representatives resulted in a total of 41 participants over the 3 available dates
- There were differences in role-based participation levels across each engagement exercise, for example, clinicians were more likely to have completed the survey
- Two researchers conducted the literature review; however, there was not the opportunity for them to work together to share learning and discuss findings.
- Although only two academic articles were not accessible during the literature review, more studies may have been identifiable in a wider range of electronic academic databases
- There was limited literature from the public and not-for-profit sector and professional consultancy. This led to a limited range of sources and less current literature
- The articles from the public and not-for-profit sector and professional consultancy were more challenging to judge the quality

Appendix 4 – Respondents suggestions for improvement

Formal ideation sessions are required to build upon the suggestions for improvement made by staff throughout the discovery. An opportunity card template can be provided by the Service Design Hub (SDH) to support this.

Based on the high-level suggestions made the SDH have grouped items by theme, removed duplication and sought to identify issues that are within the QI delivery groups circle or influence or control.

1. Learning from COVID

1.1 Maintaining a less hierarchical organisational structure

1.2 Making use of the new lines and platforms of communication

1.3 Empowering staff to embrace and make changes

1.4 Focus group participants indicated that enabling QI within the culture may involve building a safe and collaborative environment with dedicated time and resources set aside for QI, making improvement the right and effective thing to do.

1.5 Participants felt that promoting QI did not necessitate substantial changes, as they thought most staff already sought out and implemented improvements as part of their work. Introducing QI as a large project posed the danger of QI being seen as a top-down initiative, and belittling current improvements happening at an operational level. Instead, they suggested that to celebrate the work staff are already doing and reassure them that they are not asked to undertake extra work.

2. Leadership and ownership for change

2.1 It was suggested that the NSS QI vision needs to be agreed upon by senior staff and clearly communicated to all staff, helping to make QI a priority for all.

2.2 Participants at all levels suggested the need for senior management to participate in training in quality improvement methods and approaches, as well as training in general coaching and facilitation skills, so that they may effectively support staff in delivering quality improvement work.

2.3 Others felt that there needs to be collaboration to support ownership at an operational level.

There were other suggestions as to who would be best placed to “own” QI work in NSS. ***Having a core QI team in NSS or QI champions embedded within SBUs who could offer guidance to others was suggested as ways in which QI could be “owned” by everyone within the organisation.*** The wealth of experience that such a team of individuals could bring to the organisation was thought to be of great benefit to all those conducting QI work in NSS***. Some focus group participants suggested that a heightened awareness of QI, and of methods and toolkits to support QI, is required across the organisation to cultivate and strengthen ownership.***

This might be achieved through communications to all staff via Stay Connected, developing case studies to showcase QI work being conducted across the organisation and running educational sessions for all staff on QI approaches.

3. Engagement

3.1 Focus group participants suggested that a way of bringing in new ways of thinking was through capturing the ideas of staff on the ground, especially of those who are not normally involved in conversations around QI. However, 41% of survey respondents (n=48) thought that either there was no process or group to capture ideas for improvement in their directorates, or they were not sure if there was one (23% and 35% respectively).

3.2 Suggestions to improve communication included:

- Consulting staff of all levels – including operational level staff – about changes
- Creating channels through which staff could feedback on changes, for instance via Microsoft Teams channels

3.3 Participants from one SBU suggested the following to improve the two-way communication between managers and staff:

- Open forums and town halls
- Regular team meetings that included team leaders and management
- Collaborative spaces

Finally, participants felt that it was important to involve wider stakeholders, such as end users and customers in consultations about changes.

3.4 Supportive team structures

3.5 Participants suggested resource management could be made more efficient, for instance, by making use of better IT systems and digital technology; this would allow protected time to be set aside for QI activities.

4. QI framework

4.1 An overall QI framework was proposed to promote a consistent and holistic approach to QI within NSS. Such a framework would help articulate the standards and clear goals for QI for NSS by:

- Joining up the currently disjointed efforts for QI
- Sharing tools and improvements across NSS
- Providing guidelines that SBUs could adapt for their own needs
- Allowing for the application of different QI methodologies and approaches
- Embedding QI in ways of working
- Enabling the measurement of improvements

4.2 Engagement with individual SBUs was therefore essential to understand their needs, priorities, and requirements regarding QI tools.

4.3 Focus group participants discussed where the ownership of toolkits might sit. Suggestions included having one SBU (such as Strategy, Performance and Service Transformation) who would be responsible for developing QI toolkits. They would then seek feedback from other SBUs as to whether their data would fit with the

proposed toolkits. The toolkits could then be refined using that feedback to ensure they are fit for purpose. An alternative offered to this was to ask those with a corporate view of the whole organisation to lead on developing QI toolkits.

5. Data

5.1 One way in which participants felt this could be achieved would be to share skills and knowledge across the organisation, for example, a platform where staff could share examples of best practice and “workarounds” to make analysis more streamlined and efficient.

6. Learning culture

6.1 Suggested ways of improving training to better embed QI included:

- Tailoring training to learning styles and specific roles
- Maintaining consistency of learning through embedding training in practice
- Supporting staff development through a more structured approach to learning
- Reserving dedicated time for training

Participants thought it was important to let staff know how training could benefit them, to motivate them to commit the time.

6.2 The following enablers were highlighted for sharing knowledge:

- Sharing case studies
- Establishing communities of practice
- Developing a framework that supports knowledge sharing
- Dedicate time for updates in regular team meetings
- Sharing learning on Intranet

Finally, peer networks were also highlighted as a means of sharing learning in a way that makes use of their colleagues’ expertise and tap into unwritten and undocumented knowledge.

Appendix 5 - Previous Intelligence and EMT Paper

Previous Intelligence

In 2018 a survey was undertaken across NSS to establish the use and understanding of QI across directorates. It was not possible to validate the number of participants nor access the original data however the findings were summarised as follows:

- SBUs are trying to do the right thing and there are some good results
- No one single way of trapping improvements is used in NSS
- There is a lack of obvious strategy which is embedded and understood by all
- Inconsistency in application and depth of QI methodology
- There is still a lack of collaboration in QI
- QI versus Quality Assurance (QA) misunderstandings persist
- QI not necessarily seen as an opportunity to learn and grow
- Unclear if NSS as an organisation aspires to operate in the same QI space as partner boards and stakeholders

EMT Paper 18th April 2022

NHS National Services Scotland

Meeting: Executive Management Team

Meeting date: April 18h 2022

Title: Organisational Approach to Continuous Quality Improvement

Paper Number:

Responsible Executive/Non-Executive: Professor Jacqui Reilly and Lee Neary

Report Author: Dr. Andrew Longmate

1. Purpose

To update EMT on the ongoing development of NSS Quality Improvement and seek approval to scope and further develop work to deliver a consistent approach to, and understanding of, Quality Improvement in NSS.

2. Recommendation

That EMT is asked to endorse the actions contained in the appended SBAR **Appendix 1** on an organisational approach to embedding continuous Quality Improvement in NSS, namely:

- Form a QI Delivery Group to drive the implementation of QI within NSS with support from SBUs.

- Propose an SRO nomination from an SBU
- Agree reporting governance to COG
- Deliver on a Discovery and baselining exercise about maturity of QI in NSS following the Scottish Approach to Service Design (SAtSD) framework
- Develop an action plan for EMT endorsement and following ratification, progress to Phase 2: implementation.

The action plan should tap into the MDT resource in the Delivery Group membership to access SBUs to action the deliverables, in recognition of improvement being intrinsic to the function of NSS SBUs, and to bring quality into a singular approach across the organisation.

The Delivery Group will require resourcing; a more detailed description will be worked up once we have an agreed way forward.

3. Discussion

NSS has committed to whole systems “service excellence” and to “*continuously improve the way we deliver our services*” through our strategic objectives. A Clinical Governance and Quality Improvement Framework has been in place since 2019, which all clinical services are aligned to (**Appendix 3**). The current approach to, and understanding of Quality Improvement varies across NSS.

There are examples of excellent application of different Quality Improvement methodologies, but Quality Improvement as defined in **Appendix 2** is not embedded throughout the organisation and there is some confusion as regards the definition and applications of Quality Management Systems.

A consistent approach and application of Quality Improvement methodologies is required to fully realise the aspiration of continuous improvement

4. Impact Analysis

4.1 Quality/ Patient Care

Quality improvement activity is essential to achieving the triple aim of improving the health of the population, enhancing patient experiences and outcomes, and reducing the per capita cost of care, and to improving provider experience.

4.2 Equality and Diversity, including health inequalities

Quality covers 6 domains including explicit description of opportunities to improve equity and so applied QI has the potential to address or improve areas of disparity.

We will seek to explicitly invite diversity and wide participation for QI work, including in the membership of the Delivery Group.

There is no EDIA required for this work, these will be done for specified work packages as required.

5. Risk Assessment/Management

Whilst not described in detail there are potential risks and consequences of not delivering on the service excellence ambition in our refreshed strategy for NSS by not being able to generate an ability to continuously improve. Proactively planning quality, identifying our priorities and ensuring we deliver on those are key in mitigating the strategic risks. Without a relentless focus on **Quality Improvement** *(service users, flow, waste and reducing variation...)*, we will find it extremely challenging to achieve future service excellence ambitions.

It is important that the work is complementary to existing QI work to date on work on the wider NSS objectives of financial, climate and workforce sustainability and therein forms part of the NSS board assurance framework as this develops. If we are to deliver CRES recurrently year on year we need quality improvement. Further our contribution to net zero also needs to be captured. Thus we need to demonstrate that what we are doing is improving quality, saving money, sustaining our workforce and contributing to net zero. COG oversight of the QI programme will be required to ensure all out strategy work is aligned in this regard

A risk log will be developed to support delivery.

6. Financial Implications

One of the central components to Quality Improvement is the realisation of value. Resource has been agreed to support QI works for 22/23 as part of the NSS 2022/23/ Resource Allocation Meeting process. Further funding requirements will be assessed as the scoping and development work continues and considered in a risk based and proportionate way to meet service excellence delivery..

7. Workforce Implications

Programmes of learning around QI will be required throughout the organisation, but will not impact on workforce numbers.

Applying QI approaches can lead to better joy in work, meaning, wellbeing and commitment. In short, it should be seen as meaningfully contributing to NSS being a great place to work.

The plan will also develop a confident and competent QI focussed workforce in NSS to enable service excellence.

8. Route to Meeting

- Clinical Directorate/PGMS Quality Improvement working group
- Informal EMT 4/4/22

9. List of Appendices and/or Background Papers

Appendix 1
SBAR - Organisational Approach to Continuous Quality Improvement

Appendix 2
Different Approaches to Quality

Appendix 3
Clinical Governance and Quality Improvement Framework

Appendix 1

SBAR - Organisational Approach to Continuous Quality Improvement

1. Situation

This paper describes actions to:

- optimise our ability to continuously improve all services *and to*
- embed a culture of continuous quality improvement in NSS.

This paper:

1. Relates to Service Excellence, one of four strategic objectives for 2022-2025.
2. Defines Quality and Quality Improvement (QI) identifying its strategic importance in recognition of the differing understandings of QI across the organisation.
3. Defines Quality Management Systems (QMS)
4. Describes the collaborative intent of The Strategy, Performance and Service Transformation Corporate Team (SPST) and the Clinical Directorate (CD) to accelerate the use of continuous quality improvement approaches.
5. Invites wider participation from other SBUs, corporate areas and teams.
6. Describes next steps.
7. Seeks EMT direction and support

2. Background

Quality Improvement (QI) is the scientific basis of management; a systematic approach that uses specific techniques to improve quality. Quality improvement is an applied approach to solving complex issues, through testing and learning, measuring as you go and deeply involving those closest to the issue in the improvement process. It includes:

a) A mind-set, culture and set of principles
b) The application of consistent methods and tools
c) The engagement and participation of those people closest to the quality issue (both users and staff) in discovering solutions to complex problems
d) The testing of ideas and use of measurement to see if changes have led to improvement.

2.2 **Quality** is widely accepted as having six pillars, or lenses, by which it should be evaluated. These are; safe, person centred, effective, accessible, equitable and timely. Quality should also be seen through the seventh lens of environmental sustainability and planetary impact.

Further exploration of QI methods and Quality Management Systems are in **Appendix 2** and will be further assessed and considered during work proposed in the recommendations laid out in this paper.

3. Assessment

Whilst NSS has had a focus on transformation in recent times, there is s need to maintain and focus on those changes that are not necessarily transformational but for which improvement is essential to progress and grow.

We have the opportunity to build a culture of continuous quality improvement by strengthening and developing our organisational approach to quality improvement.

Though we can identify many areas of improvement in selected services, it is more difficult to identify an embedded organisational approach to quality improvement across NSS or indeed any one SBU or organisational group. We can identify variation and inconsistencies in approaches used and in training, education, practice and expectations.

Currently in NSS, there is no apparent clear fidelity to any given approach, although different approaches have been used to varying degrees and effect.

We have an opportunity to intentionally develop and grow our organisational competency and approach to Quality Improvement across SBUs and in Teams/Directorates, and offer a scalable service offering for NSS.

4. Recommendations

Proposed First Phase

We are seeking a commission from EMT to:

- Form a QI Delivery Group to drive the implementation of QI within NSS. The group should be a multidisciplinary team (MDT) with business users from across the SBUs and Subject Matter Experts to contribute expertise from across different areas of the business.
- We propose that the Executive sponsors will be Jacqui Reilly (Executive lead for QI) and Lee Neary (Executive Lead for Quality) with an SRO nomination to be sought from EMT.
- The Delivery Group will report progress to the Change Oversight Group (COG) – COG to make prioritisation decisions.
- The group will deliver a Discovery and baselining exercise following the Scottish Approach to Service Design (SAtSD) framework, mapping what the organisation currently has in place for QI so that we have a foundation to build a more detailed roadmap, the output of which will be:
    - A discovery report of the findings through a combination of interviews, surveys and workshops, developing recommendations from the output,
    - An Action Plan for delivery group to execute based on Discovery findings. This will take three months to conduct service design research, develop the report, recommendations and action plan for ratification by EMT/COG,
    - Following ratification, progress to Phase 2: implementation.

The action plan should tap into the MDT resource in the Delivery Group membership to access SBUs to action the deliverables, in recognition of improvement being intrinsic to the function of NSS SBUs, and to bring quality into a singular approach across the organisation.

The Delivery Group will require resourcing; a more detailed description will be worked up once we have an agreed way forward.

Appendix 2

Different QI methods exist; from the Institute for Healthcare Improvement's Model for Improvement to the Toyota Production System / Lean, Six Sigma and the Scottish Approach to Service Design. The evidence suggests that there is no significant difference in efficacy among these different methods, the key is to fidelity to a given method for a long period of time and across different staff groups to embed practices as part of organisational culture.

1.2 **Quality Management System (QMS).** Across NSS the term Quality Management System (QMS) has different meanings and interpretations, leading to misunderstanding. The two main meanings are as follows:

1.3 a) Juran's Quality Management System (QMS)

The basis of Healthcare Improvement Scotland (HIS) QMS approach has its roots in Joseph Juran's original description. The accepted understanding includes and distinguishes:

- Quality Planning (QP) –system analysis, evaluation and prioritisation
- Quality Improvement (QI) – application of Quality Improvement methods. Quality Improvement needs to be used alongside quality planning, quality assurance and quality control to create a single consistent management system.
- Quality Control (QC) – internal measurement of performance by the team owning the work, incorporating good operational management, monitoring performance in real time within the team, taking action when needed to bring the system back into control. A feature of a robust quality control system includes visual management that allows transparent display of key metrics, with regular huddles around the data to discuss and take action, and escalating rapidly when we can't solve the problem.
- Quality Assurance (QA) is sometimes included and / or conflated with QC and is important to distinguish. QA is helpful to ensure we are meeting set standards and identifying gaps that need addressing, it is not a mechanism to help us achieve new levels of performance. The occasional (often carried out by external agencies) checking process is not usually conductive to exploration, deeper insight and ownership of change.

Together, improvement, assurance, planning and control form the quality management system. The different components must be balanced and Quality Improvement can only work well if integrated with Quality Planning and Quality Control. By itself, Quality Improvement does not represent a holistic approach to managing quality.

1.4 b) Manufacturing, Pharmaceutical and Accreditation QMS

A GXP QMS is a detailed set of policies, standard operating procedures (SOPs) and functions which are designed to ensure that products are manufactured to tightly controlled quality and safety standards as evidenced by internal quality control and demonstrable compliance with external regulation and guidance.

These approaches are necessarily constraining and are essential to the requirement for GXP (Good Manufacturing Practice, Good Tissue Practice, Good Distribution Practice etc) as laid out in relevant legislation and guidelines and subject to licensure and accreditation by a number of bodies including the MHRA, HTA, HFEA, UKAS and JACIE. Senior management are responsible for ensuring an effective QMS is in place, whilst compliance with requirements is the responsibility of all staff. An independent Quality function representing around 5% of SNBTS workforce exists to assure compliance with the QMS. Any non-compliance is identified as an incident and must be investigated to determine root cause with appropriate corrective/preventive actions put in place to prevent recurrence.

In short, this type of QMS is designed primarily to ensure reproducible quality and safety of blood, tissue and cell products and compliance with all relevant legal and professional standards

Appendix 3

Clinical Governance and Quality Improvement Framework

2019-11 NSS CG and QI framework v1.pdf

http://genss.nss.scot.nhs.uk/pls/portal/url/ITEM/D1ED88A115B826C1E05400212814D70C

Appendix 6 - QI Training available

NES Quality Improvement Zone

The NHS Education for Scotland (NES) - Quality Improvement Zone [4] was developed by the Quality Improvement Team at NES.
This site provides learning materials and resources such as e-learning modules, QI tools, guides and frameworks, and up-to-date developments in QI to help people advance their knowledge and skills. The Quality Improvement Journey (see figure below) is core to the learning offered by NES.

Fig 9. NES Quality Improvement Journey [3]

There are six free e-learning modules available for anyone working in the public sector who is involved in improving local services using QI tools and methodology to work through. These modules combine QI theory with real-life examples:

1. Measurement for improvement
2. Understanding your system
3. Developing your aims and change ideas
4. Testing your change ideas
5. Implementation and Spread
6. Demand, Capacity, Activity and Queue (DCAQ)

In addition to the e-learning modules, there is an area on the website for staff who are leading QI teams, and who may promote and facilitate improvement strategies across their organisation. The "Learning Programmes" currently on offer are:

1. Scottish Improvement Foundation Skills (SIFS)
2. Primary Care SIFS
3. The Scottish Coaching and Leading for Improvement programme (SCLIP)
4. Scottish Improvement Leader Programme (ScIL)
5. Scottish Quality and Safety (SQS) Fellowship Programme

PgMS – Introduction to Lean

Within PgMS, there is currently introductory training available for staff interested in learning about Lean methodology and how they may apply this within their role. This course has been delivered via Teams five times to date and has been well attended. There is currently a waiting

list in operation due to the popularity of this course. The feedback has been incredibly positive to date. At the foundation of this course is the Lean project process flow which was developed by colleagues in PgMS. This covers eight key steps:

1. Request and Scoping
2. Planning and Training
3. Prepare
4. Diagnose (current state)
5. Redesign (future state)
6. Implementation
7. Sustainability
8. Review and Feedback

There are plans to develop PgMS Lean training by offering a suite of advanced training modules for staff.

There is no formal QI training offered by NSS Learning and Development.

Appendix 7 – References and Assumptions

References

1. Clinical Governance and Quality Improvement Framework 2019-2024, http://genss.nss.scot.nhs.uk/pls/portal/url/ITEM/D1ED88A115B826C1E05400212814D70C

2. Scottish Approach to Service Design (SAtSD), https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2019/04/the-scottish-approach-to-service-design/documents/the-scottish-approach-to-service-design/the-scottish-approach-to-service-design/govscot:document/Scottish+Approach+to+Service+Design.pdf

4. Braun, V. and Clarke, V. (2006) Using Thematic Analysis in Psychology. Qualitative Research in Psychology, 3, 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

3. NES Quality Improvement Zone, https://learn.nes.nhs.scot/741/quality-improvement-zone

Assumptions

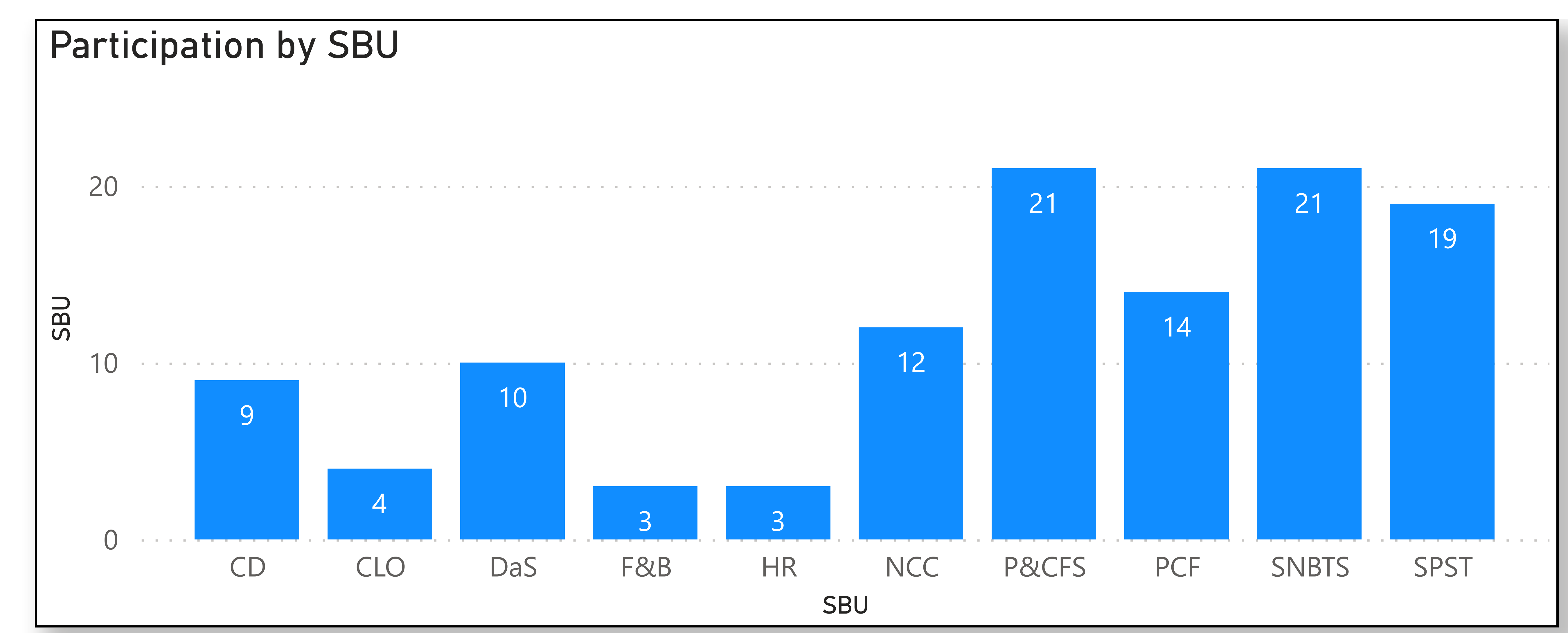
The following assumptions are referenced in this report.

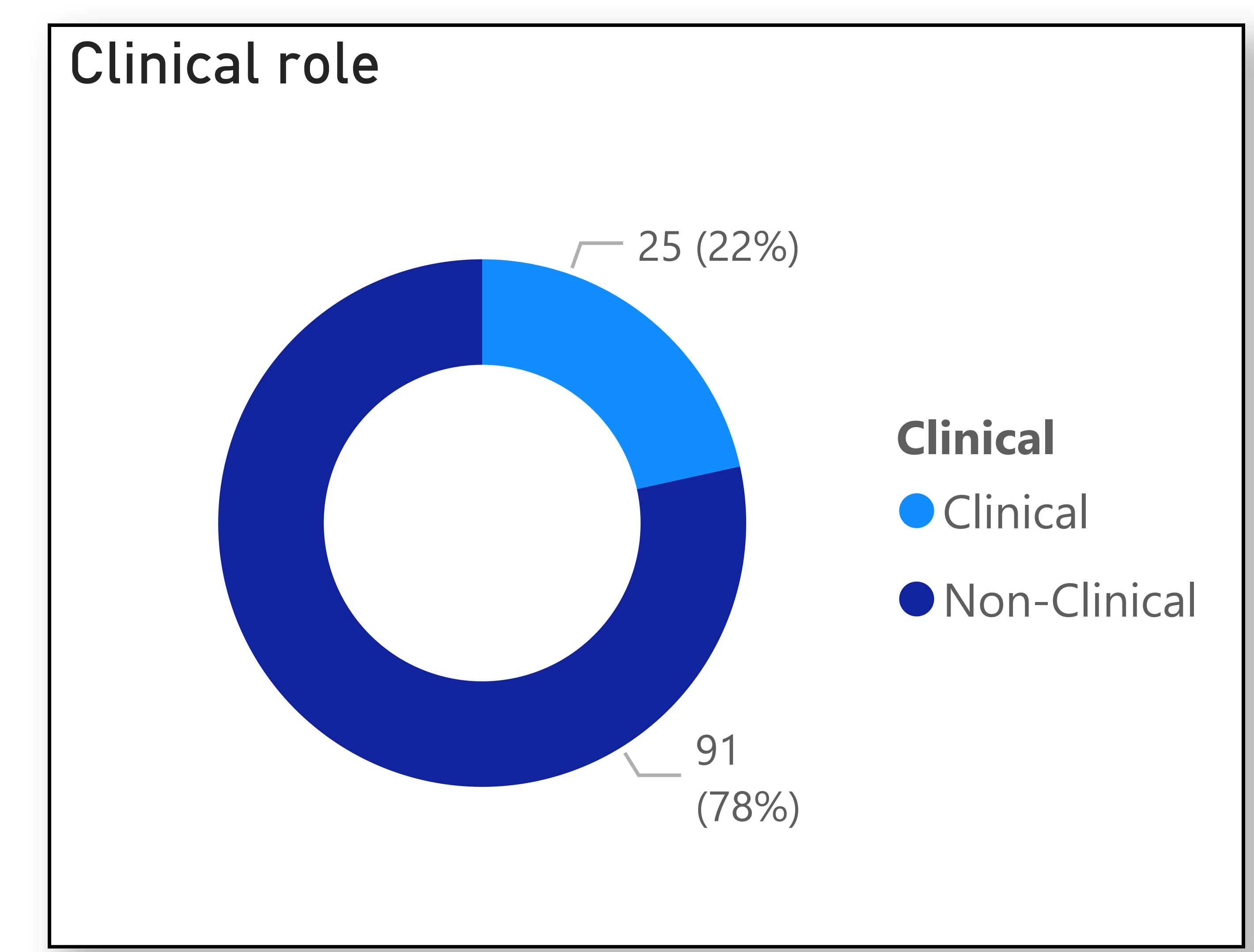
1. Strategic Business Unit Headcount as of 30 April 2022

Strategic Business Unit (SBU)	Headcount
Central Legal Office	134
Clinical Directorate	23
Digital & Security	431
Finance	73
Human Resources & Workforce Development	102
Practitioner & Counter Fraud Services	456
Procurement, Commissioning & Facilities	778
Scottish National Blood Transfusion Services	940
Strategy, Performance & Service Transformation	272
National Contact Centre	437
Other	0
Total	**3646**

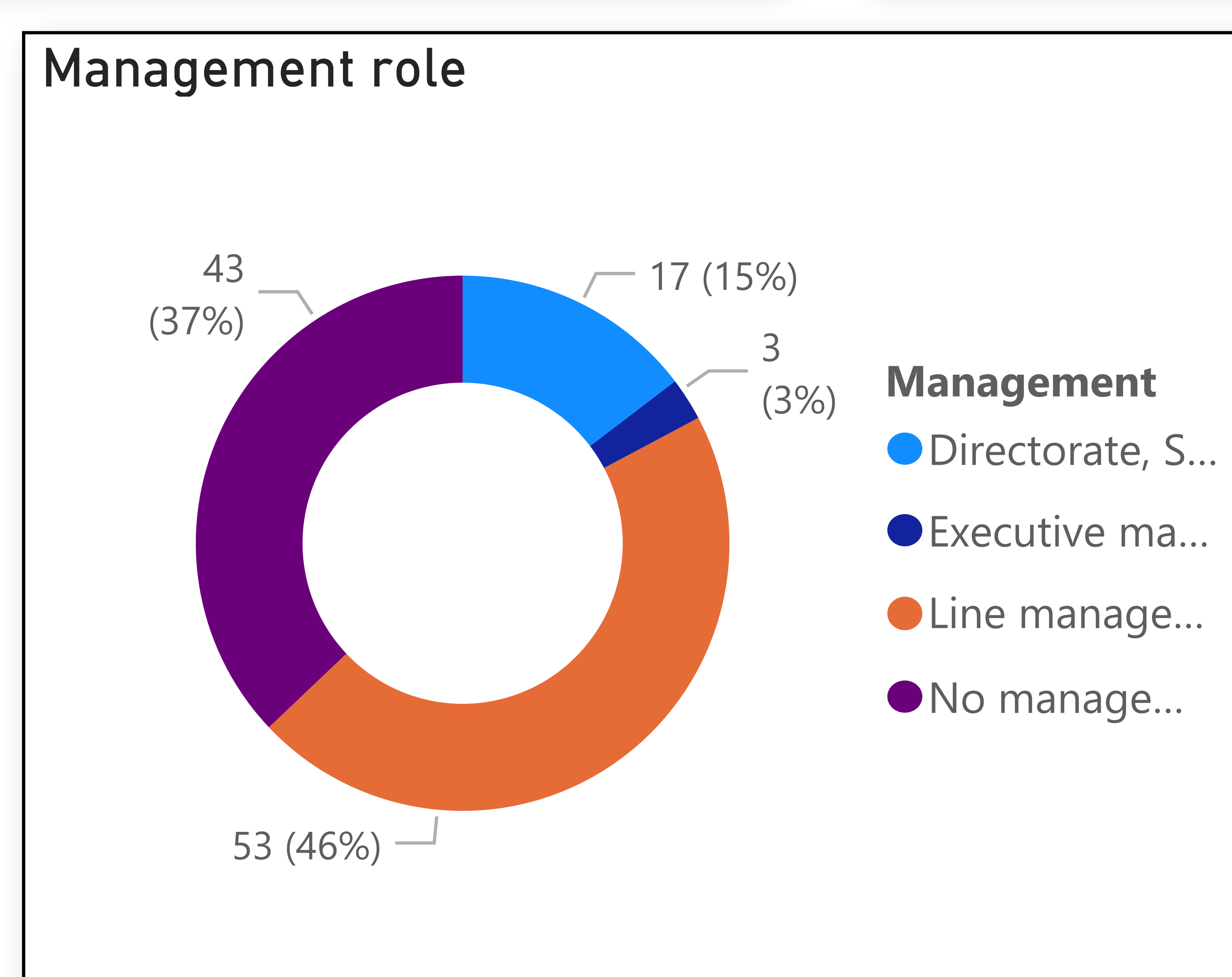
Appendix 8 – Survey Responses

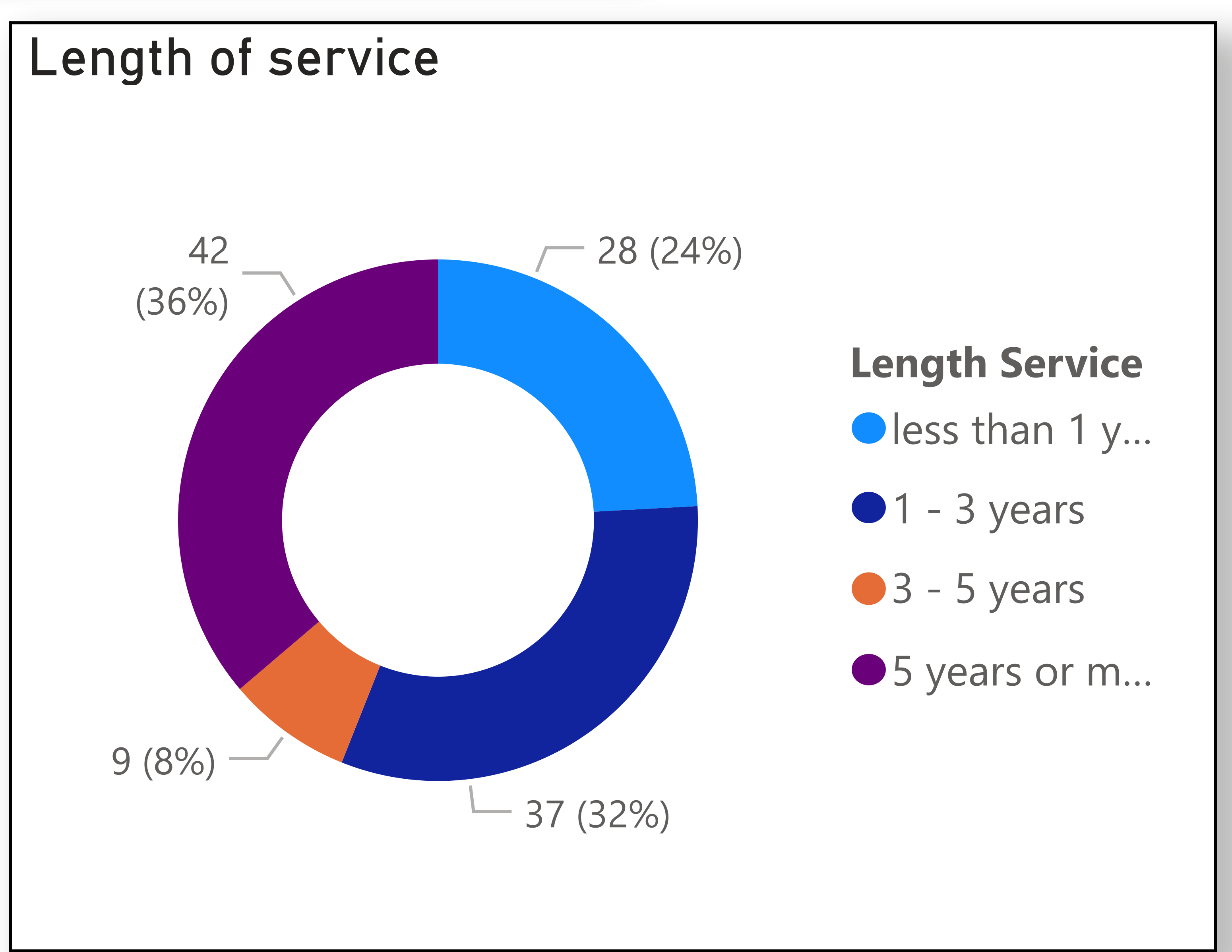
Quality Improvement survey analysis
Service Design Hub





The Me, Myself and QI survey was shared with all NSS employees (3,646) through the Stay Connected SWAY issued on the 11 July 2022. The survey was open to all employees for 3 weeks, closing on 1 August 2022. The Stay Connected Sway was viewed by a total of 1,550 employees, the average time spent reading the document was 4 minutes with 59% of individuals reading the full document (approximately 59% of 1550). In total we received 116 responses to the survey across 10 Strategic Business Units (SBU) and directorates. This is approximately 3% of the entire NSS employee population. Representation from the Clinical Directorate was the highest proportionally at 39%. The lowest was Digital and Security (DaS) Procurement Commissioning and Facilities (PCF) and the Scottish National Blood Transfusion Service (SNBTS) at 2% of the respective SBU population. This may reflect that a higher proportion of staff within these SBUs are not desk-based.





What does QI mean for NSS staff?

We asked survey respondents to describe what QI meant for them.

Most respondents described QI as a continuous, cyclical, and ongoing process of improvement.
The subject of improvement may be:

- The service
- Processes
- Ways of working
- The whole system

Some respondents also thought QI may be applied to improve the workforce, data, standards, performance, and to reduce risk. This was thought to be done primarily through introducing lean methodology and efficiency. Most respondents thought that QI benefits a range of people, most prominently service users, including customers and patients, as well as staff, the organisation, and the taxpayer.

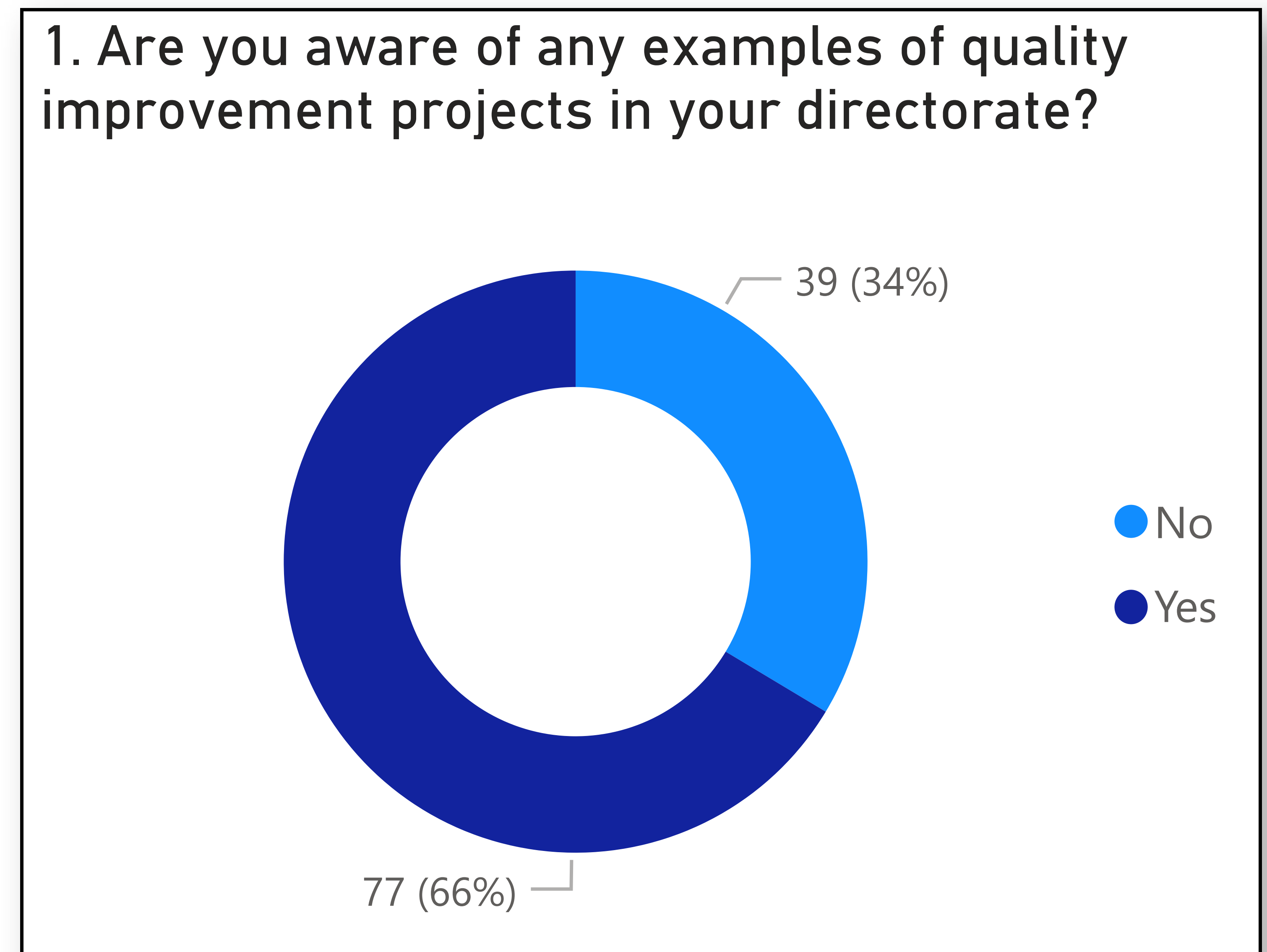
Respondents said that conducting QI may involve the following methods and methodologies:

- Reviewing and evaluating current practices, processes, and services in order to understand issues and identify opportunities for improvement
- Implementation of improvements
- Evaluation of changes, for instance, through small tests of change

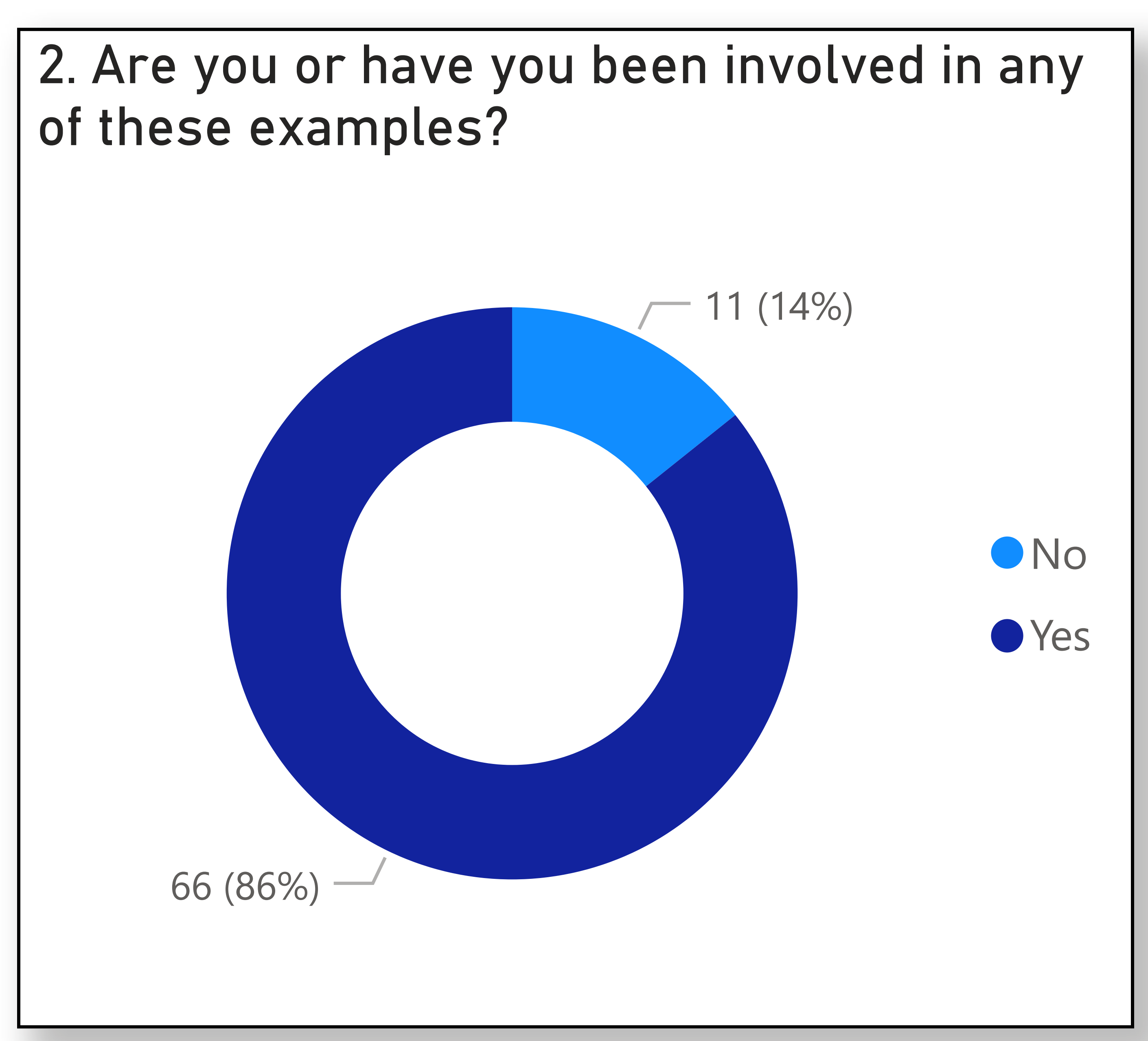
Many respondents said that QI necessitated an evidence-based, structured approach, including a standardised set of tools, tests, guidance, and standards, and driven by data (e.g. feedback, complaints, performance indicators). The sharing of learnings was also mentioned as an essential part of QI.

Finally, respondents highlighted the collaborative nature of QI, meaning that it should be conducted in engagement with staff at all levels, and in engagement with service users.

Culture



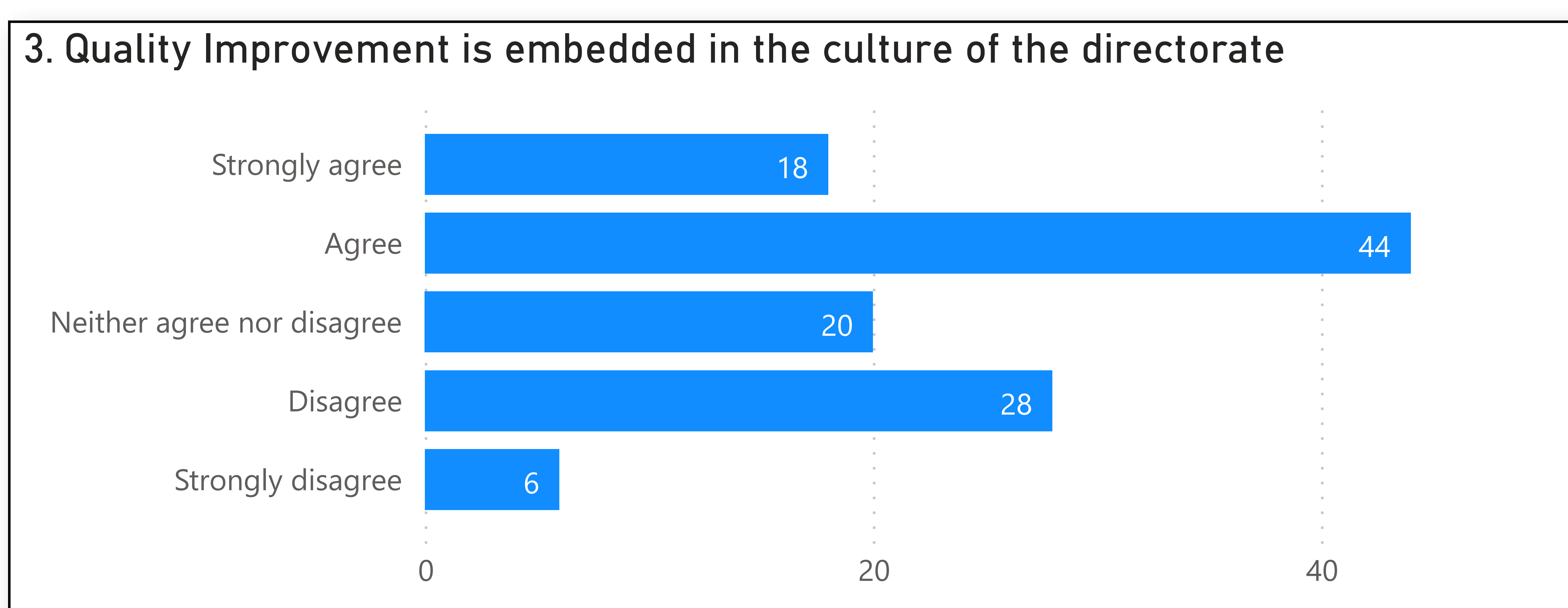
Culture 1.
77 out of the 116 asked replied 'yes' (66%). Respondents from SBUs who answered 'yes' to this question in the highest proportion are CLO and (F&B), both at 100% for all respondents, closely followed by PCF. SBUs who answered 'no' in the greatest numbers include HR at 67%, followed by DaS at 50% and SPST at 47%. Among those who answered 'yes', there was only a 2% difference in whether the respondent was in a clinical role or not. 89% of those who have served 3 – 5 years at NSS responded 'yes'; however, there is little variation in the other length of service responses which vary from 59% - 68%. Executives responded 100% 'yes' to this question with directorate management responding 'yes' on 65%. Those with no line management duties responded the lowest at 51%.



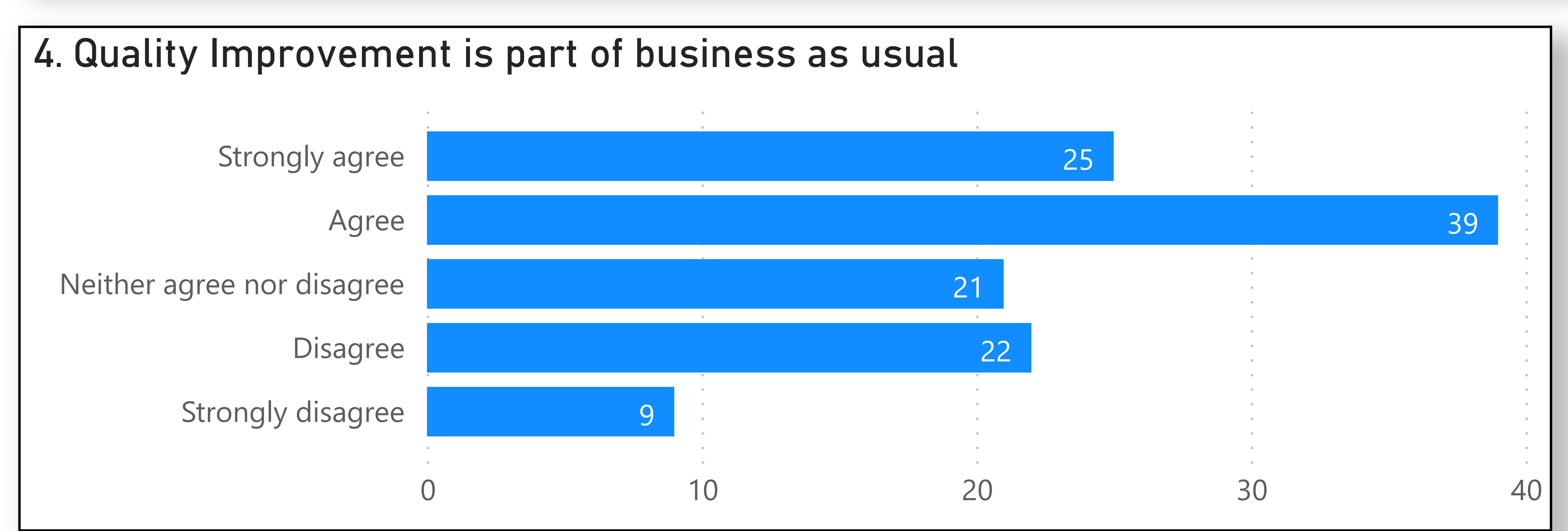
Culture 2.
66 out of the 77 who replied 'yes' to the previous question also replied 'yes' to this question (86%). If respondents answered 'yes' to the previous question, C2 was asked. Out of those who stated they were aware of quality improvement projects in their SBU, 100% of participants from CLO, DaS, F&B and HR stated that they have been involved in these projects. SPST and CD have the highest proportion of those who answered 'no' to this question, both at around 30% each. In terms of clinical roles, these respondents answered 'yes' 76% compared to non-clinical roles who responded 'yes' 88%. For length of service, 95% of those with less than 1 years' service replied 'yes' with 77% of those who have 1 – 3 years of service said they had been involved in QI projects. 67% of executive management and 100% of directorate management replied 'yes'.

Culture

Questions C3 – C6 require a response based upon how strongly the respondent agrees or disagrees with the statement. For analysis, those who respond 'strongly agree' and 'agree' will be considered a positive response. Those who respond 'neither agree nor disagree' will be considered a neutral response. Those who respond 'disagree' or 'strongly disagree' will be considered a negative response.

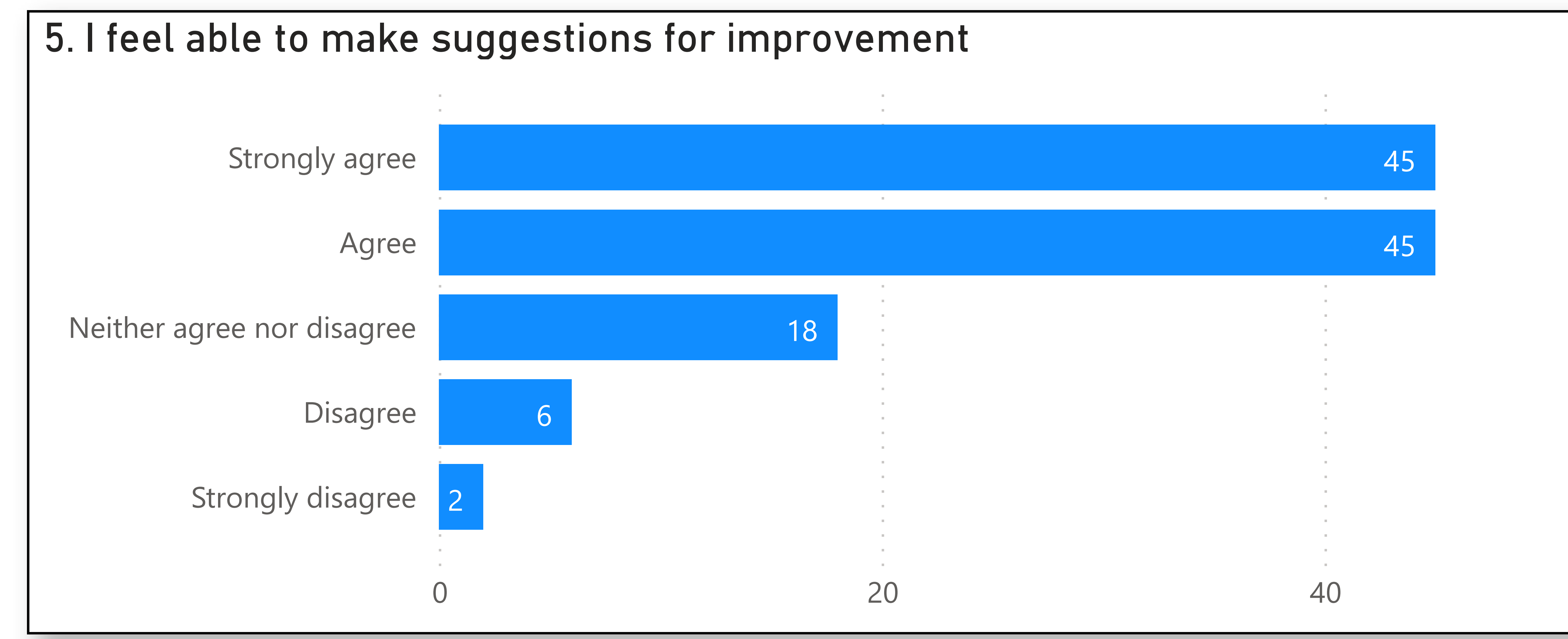


Culture 3.
Respondents from CLO selected either 'strongly agree' or 'agree', 100% positive response, whereas those in F&B responded 100% negatively with 'disagree' and 'strongly disagree'. NCC and SNBTS overall responded positively, the remaining SBUs yielded a mixed result. Clinical staff were more, positive on this question (64%); than non-clinical staff (51%). There was little difference in the way people with various length of service responded, however, those in 1 – 3 years of service responded more negatively than others; 43% either 'disagree' or 'strongly disagree' compared to other length of service categories which average 26% either 'disagree' or strongly disagree'. Two thirds of executives agree that QI is embedded in the culture of the directorate, with one third disagreeing. There is no major difference in the way people from various management levels responded.

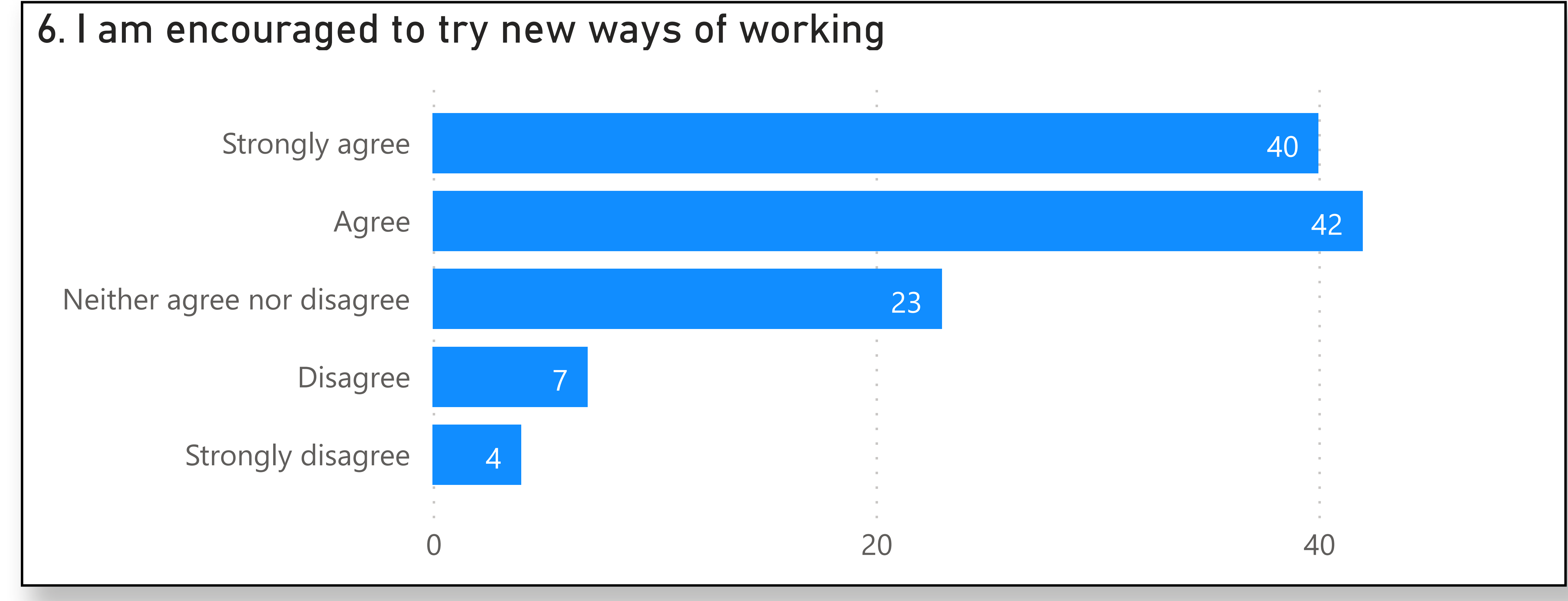


Culture 4.
100% of respondents from CLO selected a positive response. In contrast, 100% of those from F&B responded negatively. Other SBUs which responded more positively include SNBTS who responded 67% positively, followed at NCC at 66%. Respondents from NCC were among the most negative, with 33% negative responses, followed by SPST at 32%. Clinical staff replied slightly more positively (60%) than non-clinical staff (54%) on this question. Those who have served longer than 5 years were the most positive (69%) compared to others in the group averaging 50%. Directorate management responded the most negatively at 47% compared to others in the group averaging 26%.

Culture



Culture 5.
CLO responded with 100% ‘strongly agree’; CD and F&B responded 100% positively. DaS, HR, P&CFS, SNBTS responded either positively or neutrally, they did not respond with ‘disagree’ or ‘strongly disagree’. SPST and NCC responded the most negative with 21% and 25% respectively. Non-clinical staff responded more negatively than clinical staff, with no ‘disagree’ or ‘strongly disagree’ responses in the latter. There were no major differences in the responses of those in various length of service. Executives strongly agreed that they felt able to make suggestions for improvements. However, only 26% of those with no line management duties felt the same. 13% of those with line management responsibilities disagreed or strongly disagreed with this statement.



Culture 6.
100% of respondents from CLO replied with ‘strongly agree’. 90% of respondents from DaS and 87% of respondents from SNBTS gave a positive response. Other SBUS were mixed in their responses. There were no major differences in the responses from clinical and non-clinical staff and staff with various length of service. 100% of those in executive roles responded with ‘strongly agree’; directorate management responded the most negatively at 18%, followed by those with line management responsibilities at 13%.

Culture Summary

- The responses from the culture section in the survey suggest that CLO has a strong QI culture among its participants; all respondents were aware and had been involved in quality improvement projects in their directorates, and all have responded positively to the culture questions. It is important to bear in mind that there were only 4 participants which represents 3% of the CLO employee population, therefore the generalisability of these findings are limited.

- F&B however seemed to have responded the most negatively on questions relating to QI culture. Again, only 3 members of staff answered the survey, which represents 4% of the F&B employee population; therefore, caution should be taken when interpreting these findings. Although 100% of F&B respondents were aware and involved in QI projects in their area, the responses given to the questions were overall negative.

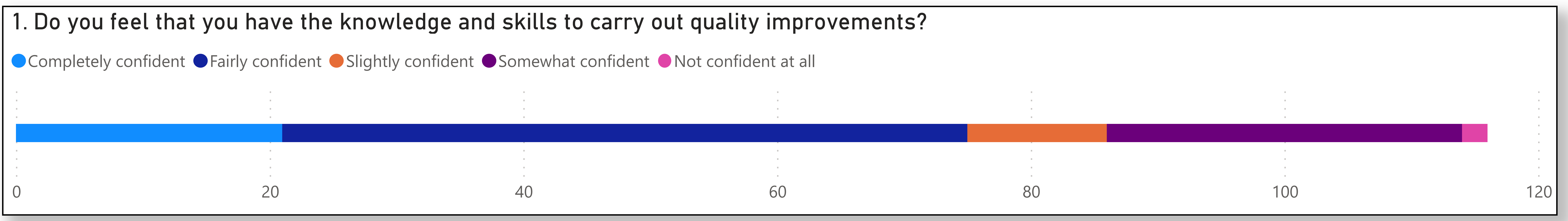
- The results for DaS show a spread in responses regarding the questions: 'Quality Improvement is embedded in the culture of the directorate' and 'Quality Improvement is part of business as usual'. The last two culture questions scored high (I feel able to make suggestions for improvement and I am encouraged to try new ways of working).

- The fact that 49% of those with no line management duties responded that they are not aware of QI projects in their SBU could suggest there might be a problem with communication at this level or potentially a difference in understanding of what QI is.

- With regards to the question: Is QI part of BAU - Directorate management responded the most negatively at 47%. Further research is required to understand why QI is not part of BAU and whether there are plans to address this.

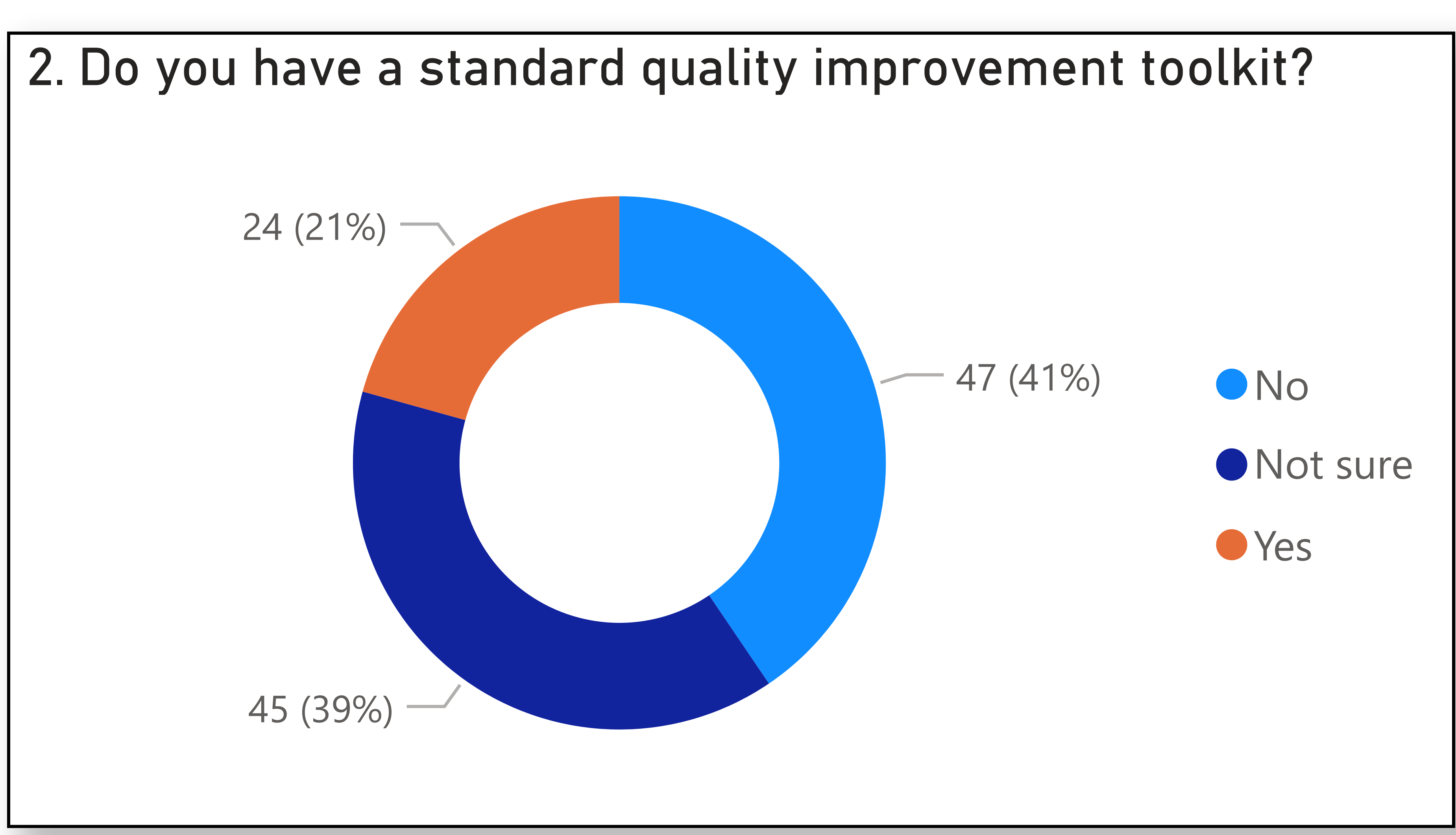
- On feeling able to make suggestions to improvements: Executives strongly agreed that they feel able to make suggestions for improvements, however only 26% of those with no management duties feel the same. Further research is needed to explore the reasons for this disjuncture.

Tools

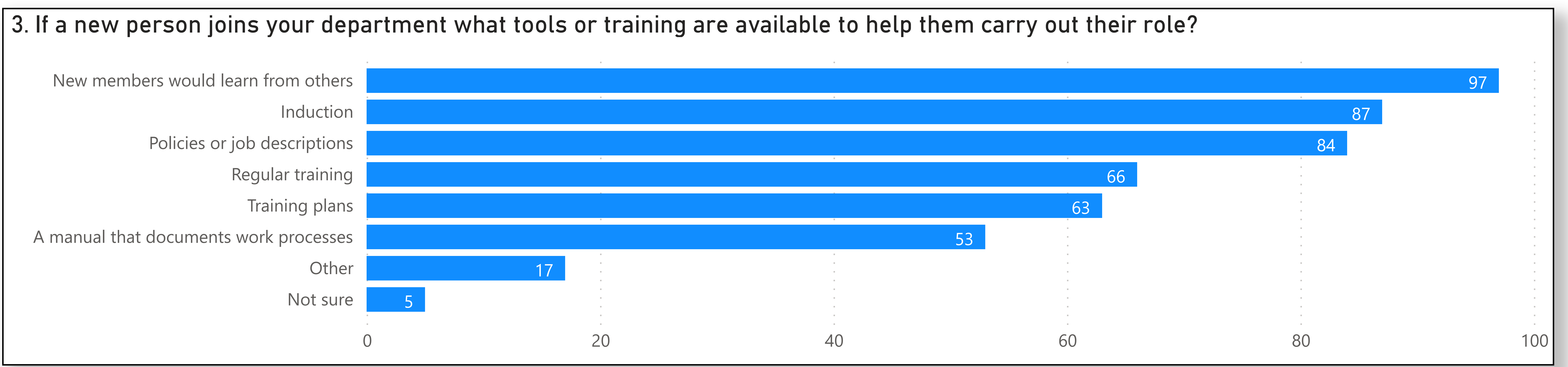


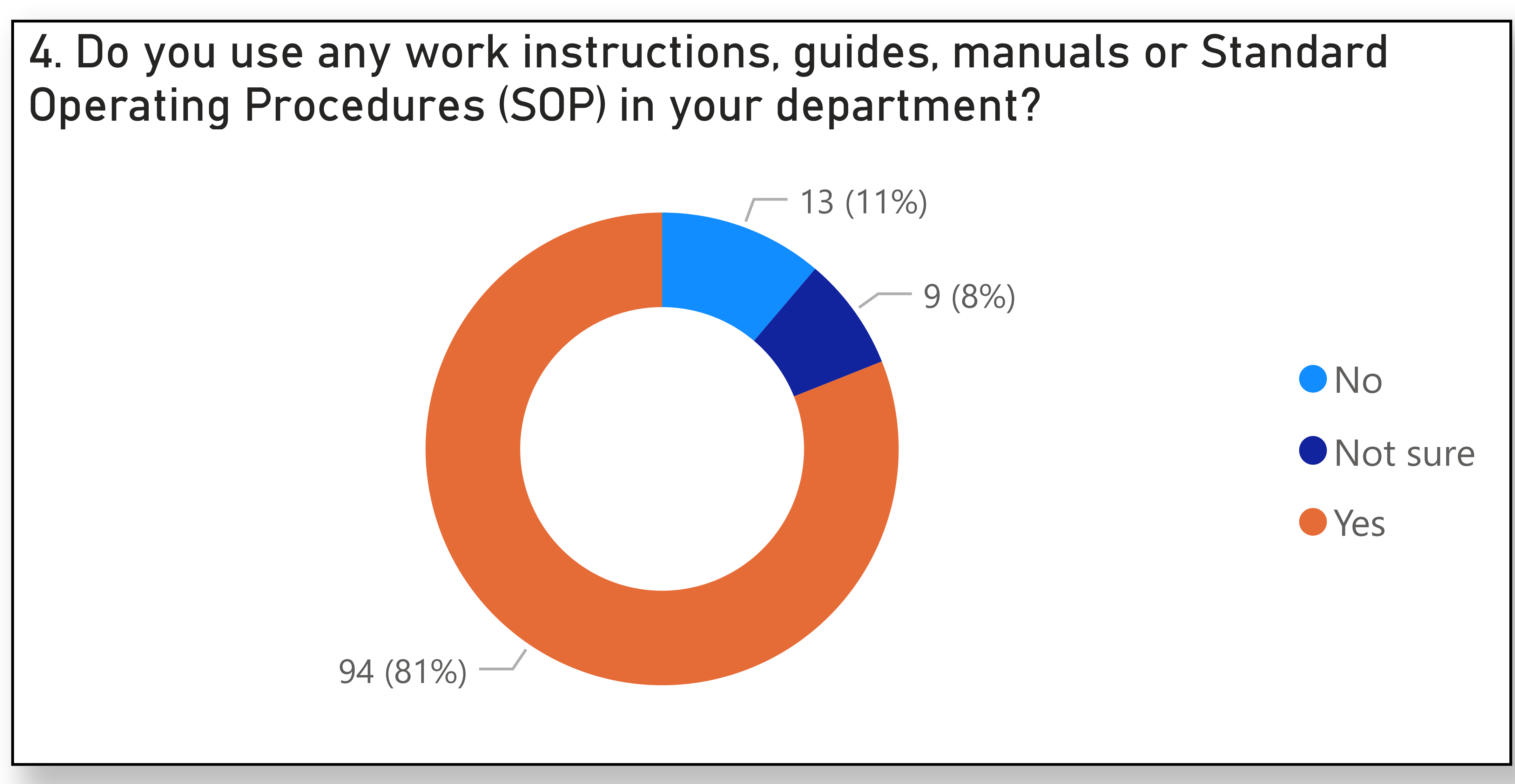
Tools 1.
Generally, all SBUs are at least fairly confident that they have the knowledge and skills to carry out quality improvement work. Responses from CLO, NCC and PCF indicate they are among the most confident, whereas those in SPST, P&CFS and DaS are among the least confident. Whether the respondent is in a clinical role or not does not seem to make major difference. Those with a length of service of less than a year appear to be the most confident overall, while those with 1 – 3 years service the least confident. Directorate management are the most confident among management splits.

Tools 2.
21% of all respondents replied that they do have a standard quality improvement toolkit. 41% replied 'no' and 38% replied 'not sure'. With the exception of the clinical directorate (CD), the majority of SBUs either replied 'no' or 'not sure' as to whether they had a standard quality improvement toolkit. Among clinical and non-clinical roles, there was no major difference, with 20% (non-clinical) and 24% (clinical) responding 'yes'. Those with less than 1 year of service said that they had a standard quality improvement toolkit in greater numbers (36%) than other groups. No one of those with 3 – 5 years of service said 'yes' to this question. Respondents in executive management roles responded 'yes' more than those with other or no management responsibilities (33%).



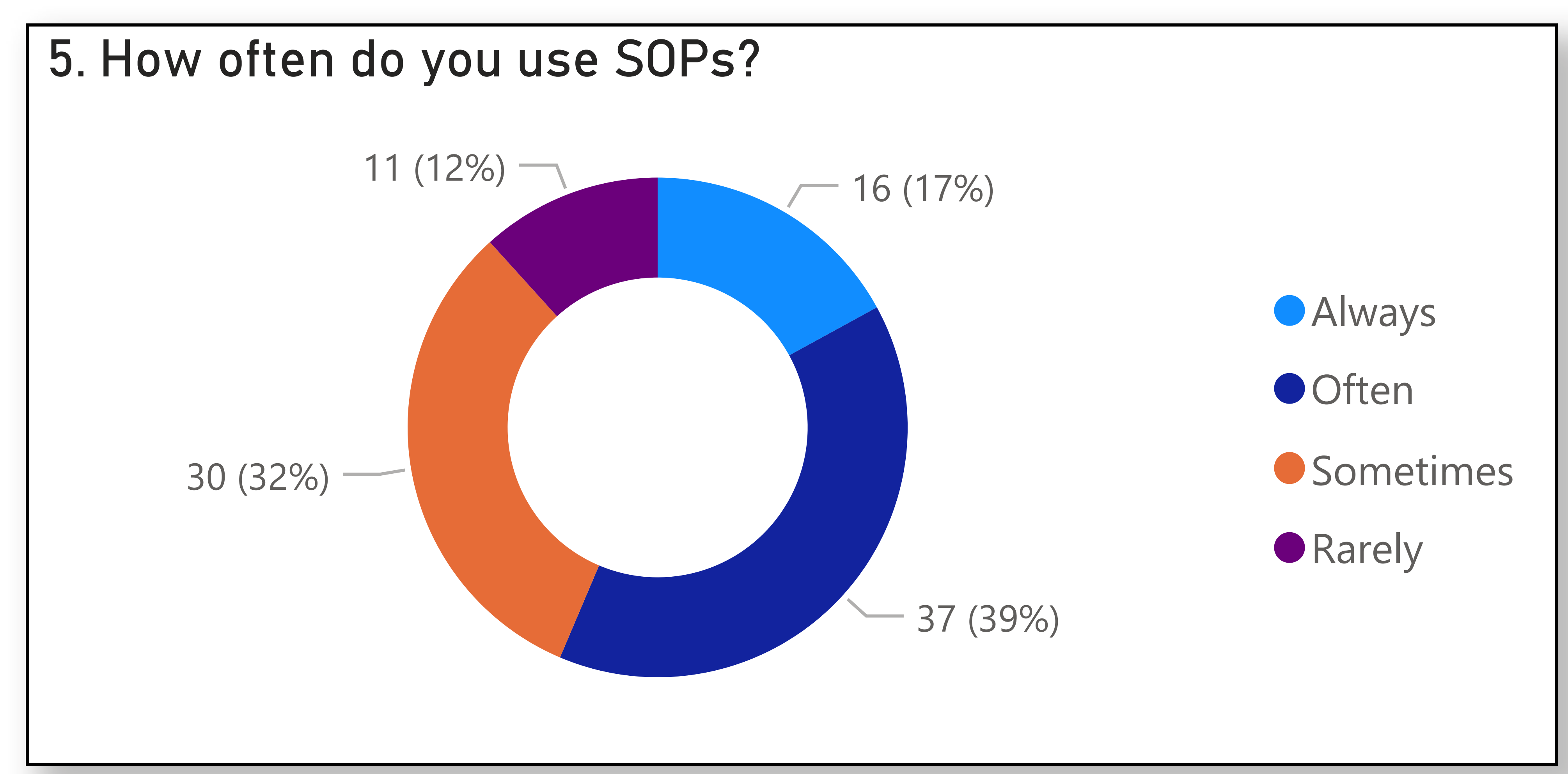
Tools



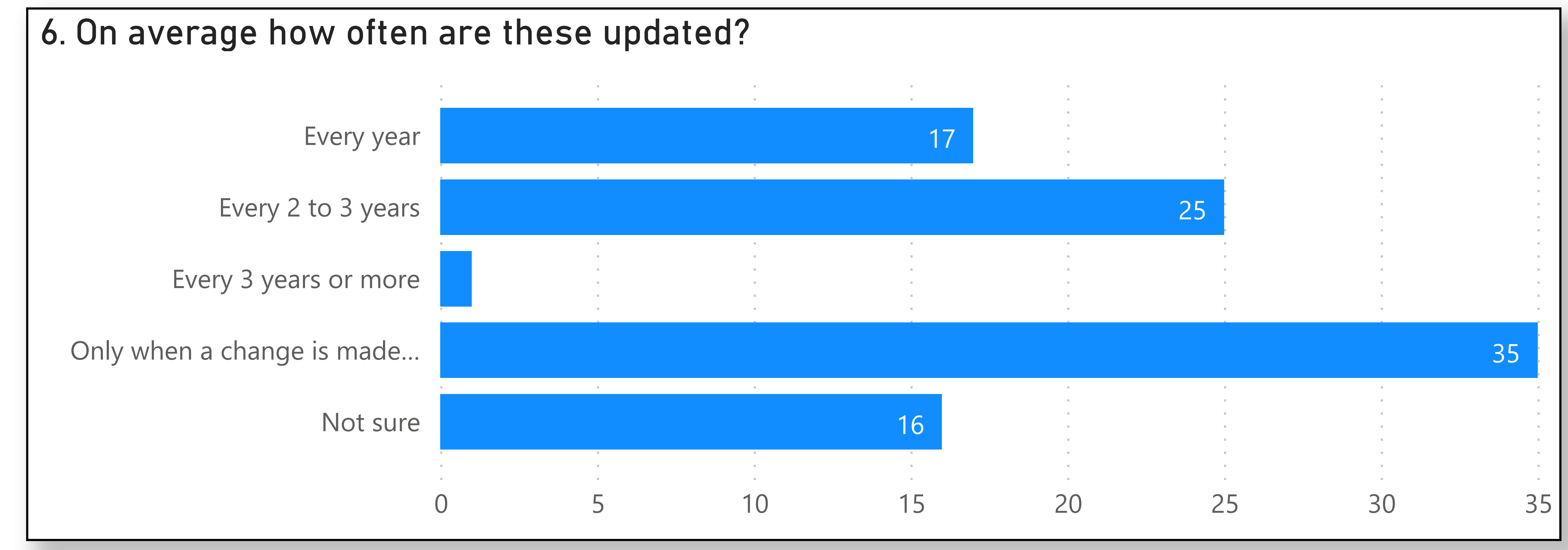


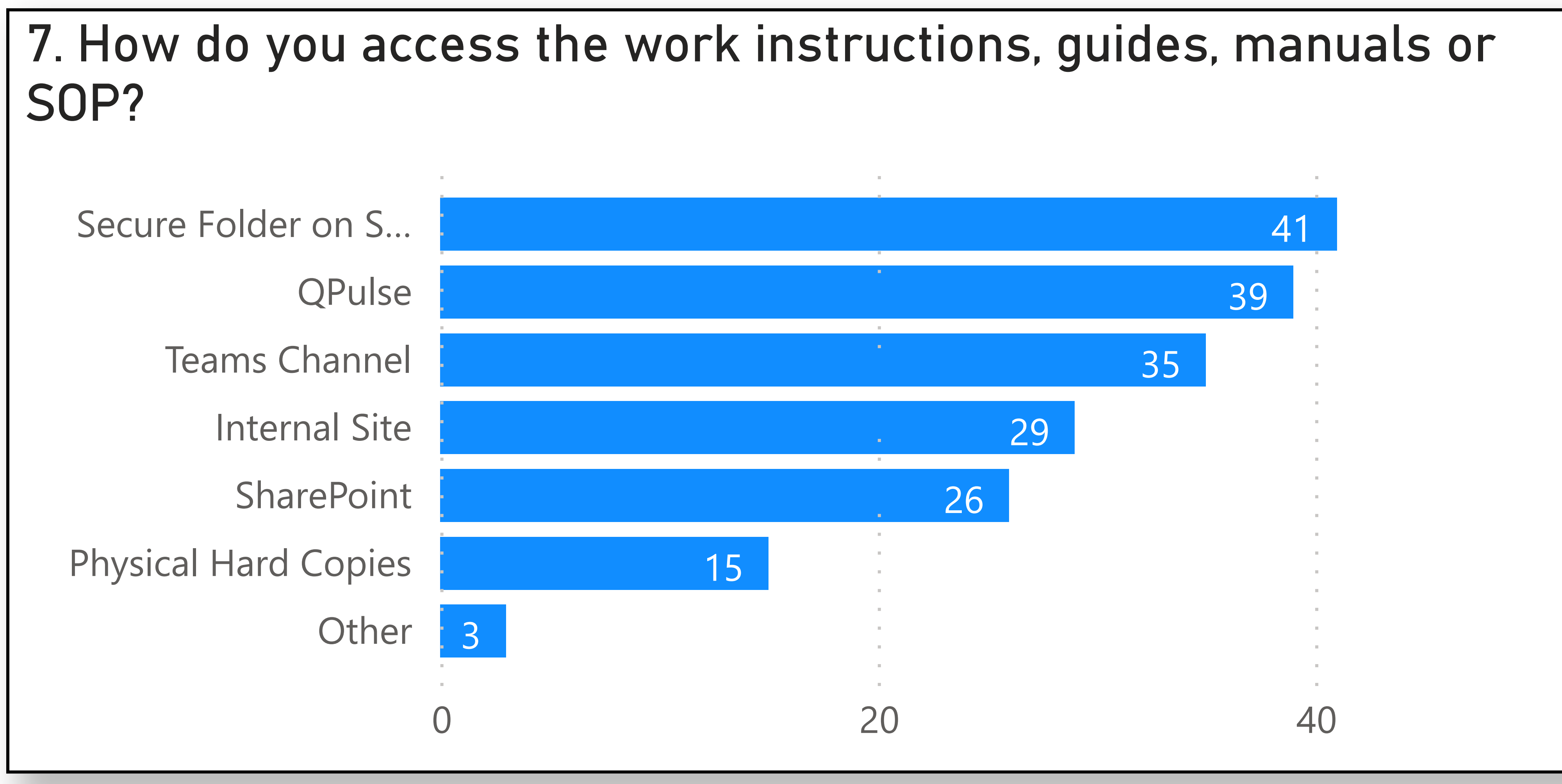
Tools 4.
81% of all respondents replied 'yes', 11% 'no' and 1% 'not sure'. 100% of the 21 SNBTS respondents replied 'yes' to this question, with CLO also at 100%. Those from PCF, NCC and P&CFS replied 'yes' with at least 80%. Respondents from HR, DaS, SPST and CD had the largest proportion of those who were unsure. Those in clinical roles replied 'yes' at 92%, whereas this percentage was 78% among respondents in non-clinical roles. There were no major differences found in length of service, but among management groupings, only 67% of those with no line management duties replied 'yes', which was lower than other management groups.

Tools



Tools 5.
Out of the 94 who replied 'yes' to the previous question, no respondents replied 'never' to this question. Respondents from SNBTS refer to SOPs either 'Always' or 'Often' with 90%. Respondents from CD responded with 100% 'Often'. Among those who rarely refer to SOPs, were HR, P&CFS, and CLO (25 – 50%). 91% of respondents in clinical roles refer to SOPS 'Always' or 'Often', whereas among non-clinical staff this percentage was 45%. Length of service and management groupings did not yield major differences.





Tools Summary

- There were high levels of confidence among most respondents in terms of having knowledge and skills to carry out QI. This was higher among directorate management (82% completely or fairly confident) compared to 70% among those with line management and 51% with no management duties.

- Besides respondents from CD, 56% of whom said that they have a standard quality improvement tool kit, other SBUs are widely disbursed across 'yes', 'no' and 'not sure'. This may imply that if there are tools, they may not be widely shared or used, and staff may not be aware of them.

- SOPs are widely used across NSS, with respondents replying 'yes' 81%. 100% of the four CLO and 100% of the 21 SNBTS respondents replied 'yes' to this question.

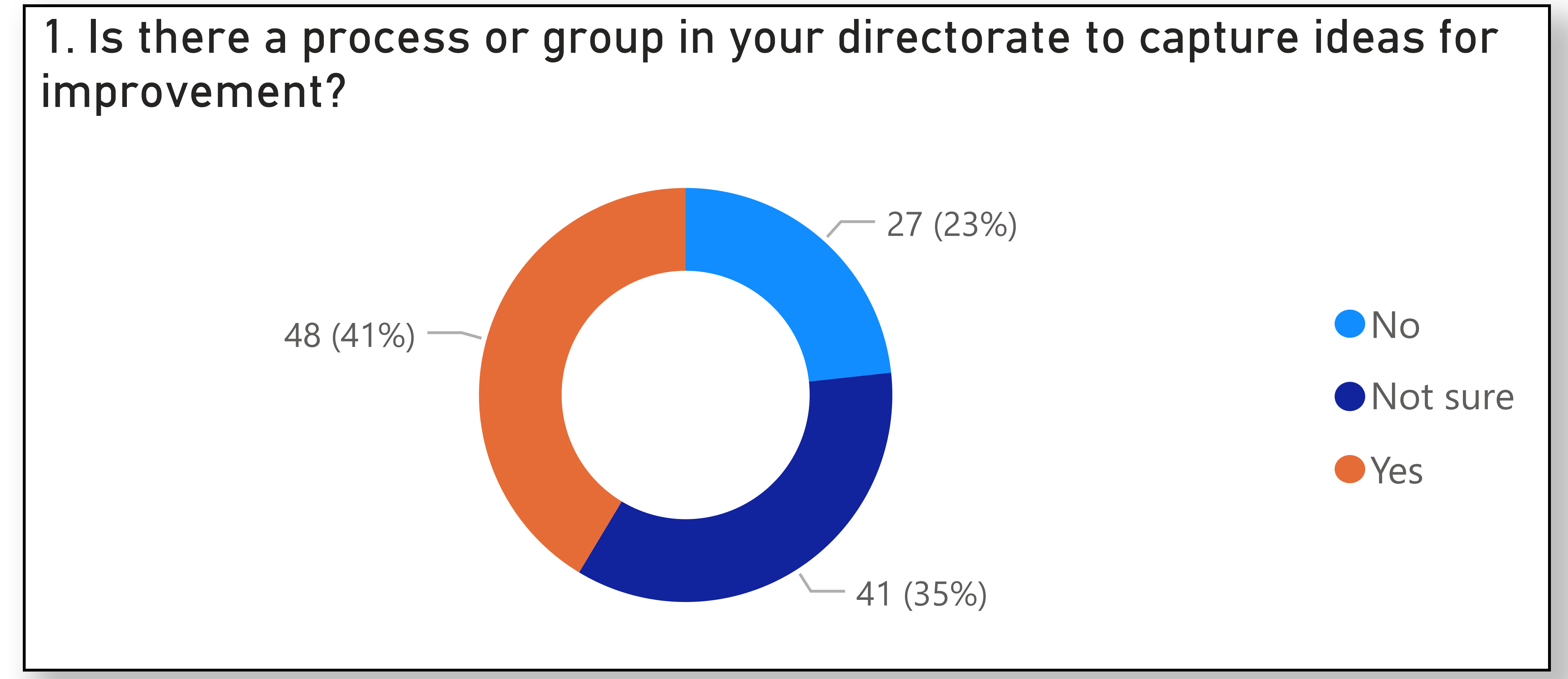
- SOPs are used more often in clinical roles with 92% answering 'yes', whereas this percentage was 78% among those in non-clinical roles.

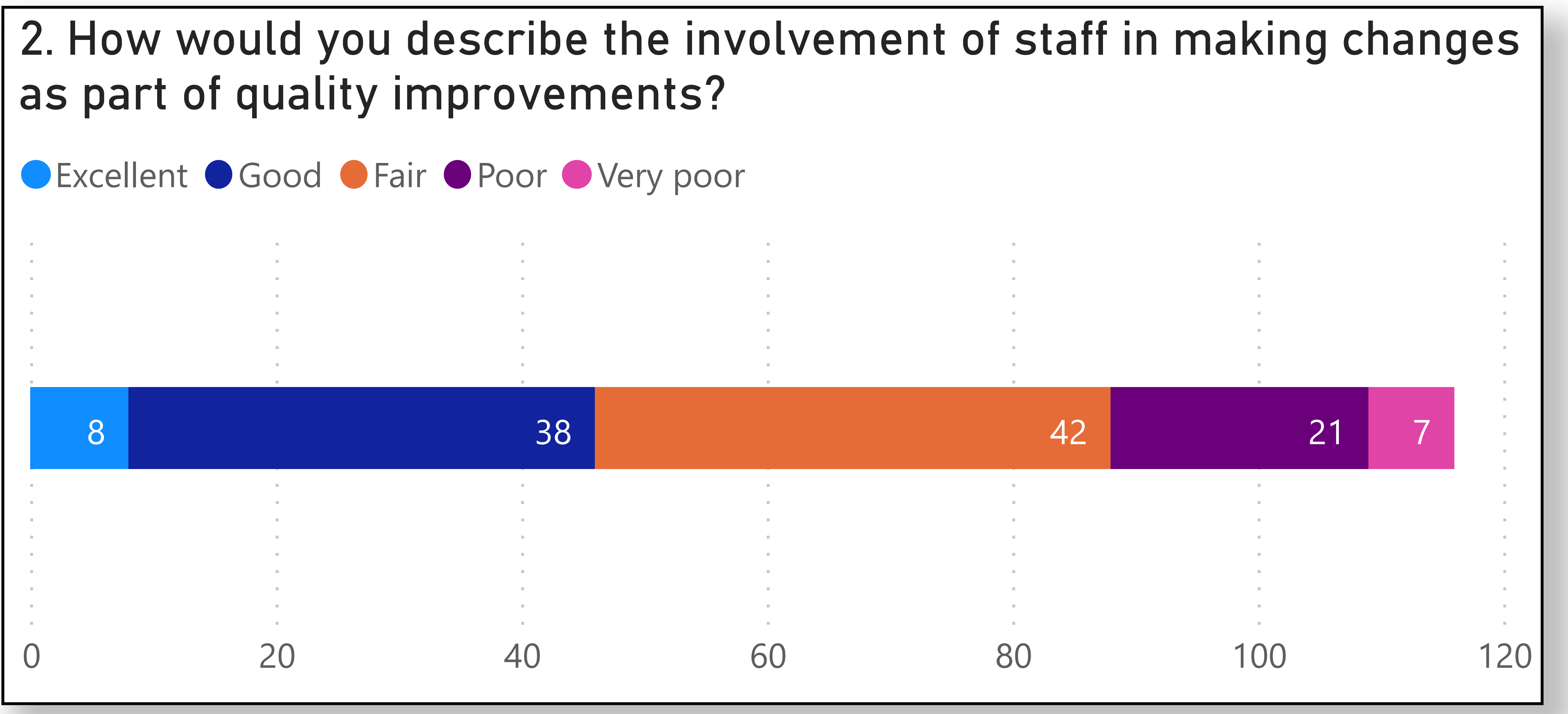
- Those with no managerial duties were less aware of SOPs being used in their departments. 100% of Executives and 88-89% of directorate managers and line managers agree SOPs are used. This raises questions as to why is this number is lower among those with no line management duties (67%).

- Staff in SNBTS and CD are more likely to refer to SOPs than other SBUs; with clinical staff more likely to refer to SOPs than no-clinical staff.

- There is little consistency across the board around how often SOPs are updated, other than that they are updated when a change to process is made.

Engagement



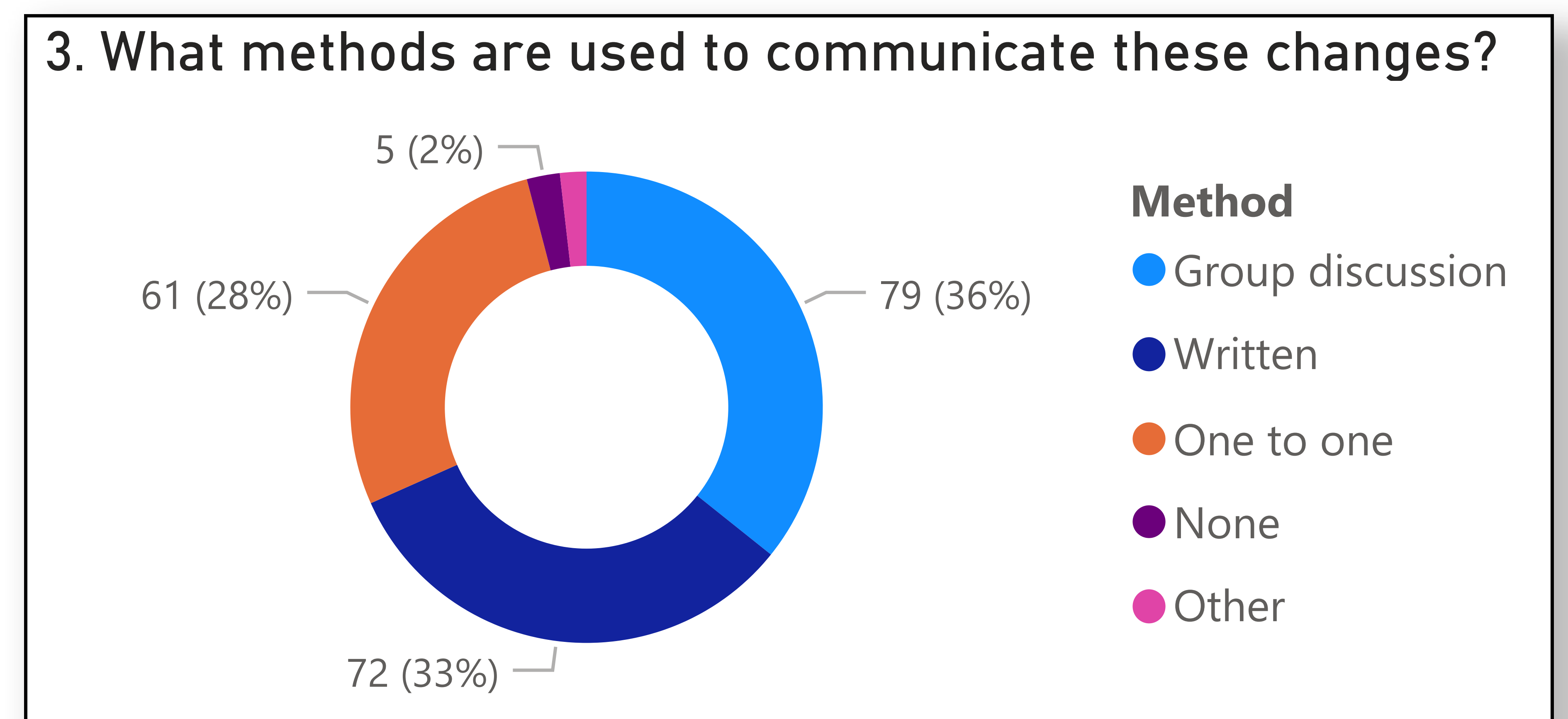


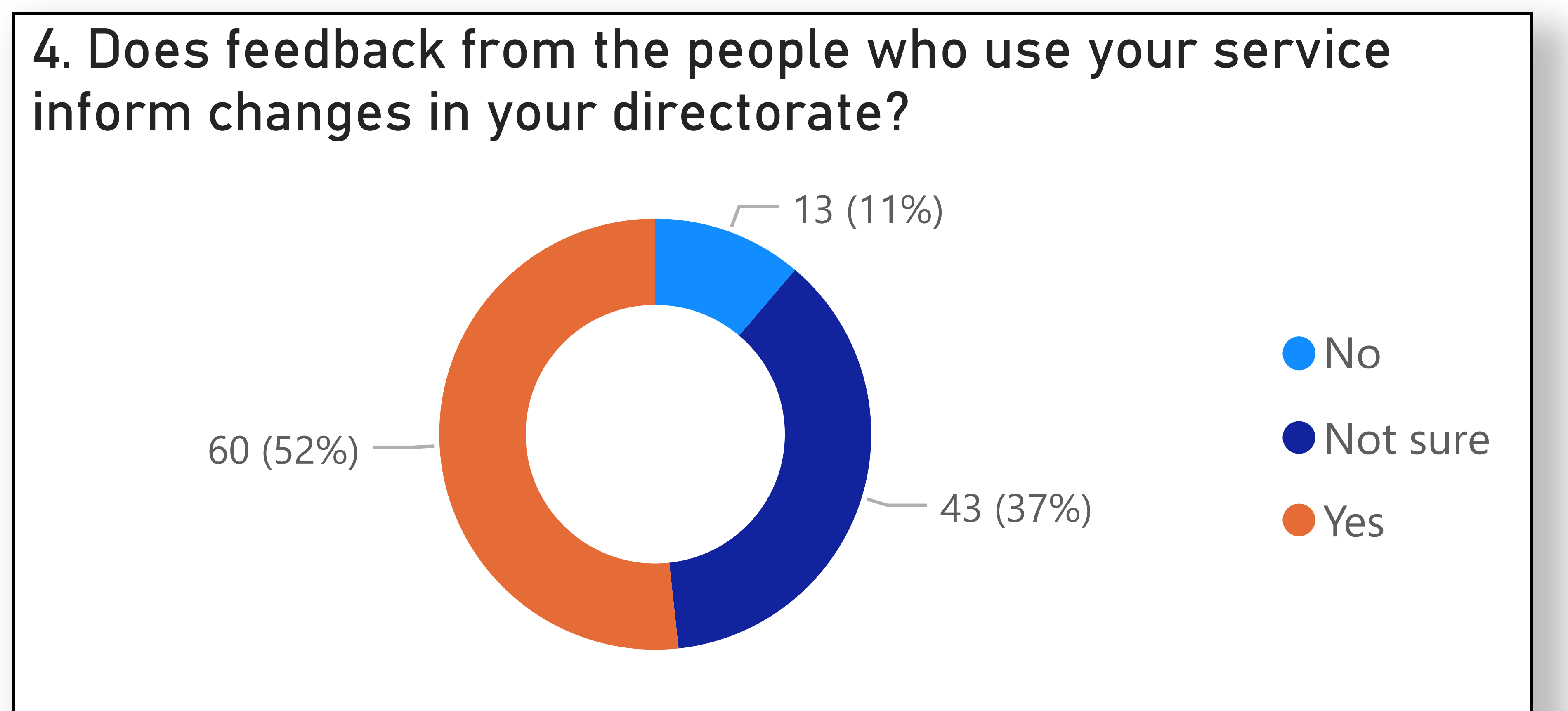
Engagement 1.
41% of all respondents replied 'yes' to this question. 23% replied 'no' and 35% 'Not sure'. Generally, replies are dispersed across yes, no and not sure across all categories.

Question E2 requires a response based upon how well the respondent believes staff are involved in making changes as part of QI. For analysis, those who respond 'excellent' and 'good' will be considered a positive response. Those who respond 'fair' will be considered a neutral response. Those who respond 'poor' or 'very poor' will be considered a negative response.

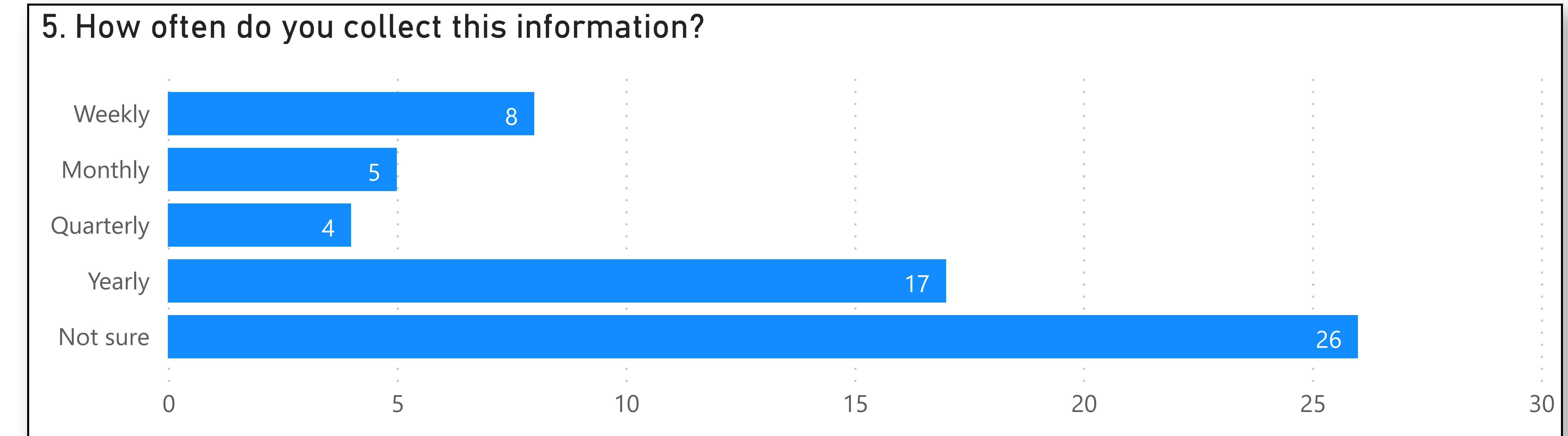
Engagement 2.
6% of the 116 respondents replied 'excellent'. The majority of replies were either 'good' 33% or 'fair' 36%. 12% replied involvement is 'poor' or 'very poor'. SBUs who say involvement of staff is either Excellent or good in the highest proportion is SNBTS (57%), CD (56%) and PCF (50%). Non-clinical staff replied more negatively (26%) than clinical staff (16%). Staff who have served 1- 3 years replied 32% poor or very poor, 33% for those who have served 3 – 5 years compared to 14% for those over 5 years. Directorate management replied less negatively than other management roles 12% compared to 29% average for other management roles.

Engagement





Engagement 4.
51% of the 116 respondents replied 'yes' to this question. 11% 'no' and 38% 'not sure'. SBUs who replied 'yes' in the greatest proportion were CLO (75%), SNBTS and F&B (67%). All of HRs 3 respondents said they were not sure. Around half of the respondents from P&CFS and SPST were unsure. Clinical roles replied 68% 'yes', whereas only 47% of non-clinical roles agreed. Length of service results did not provide much information other than those who have served 3- 5 years answered 'yes' in greater numbers. In terms of management, those with no line management duties replied 'not sure' 53%, followed by 32% for line managers and 18% for directorate management.

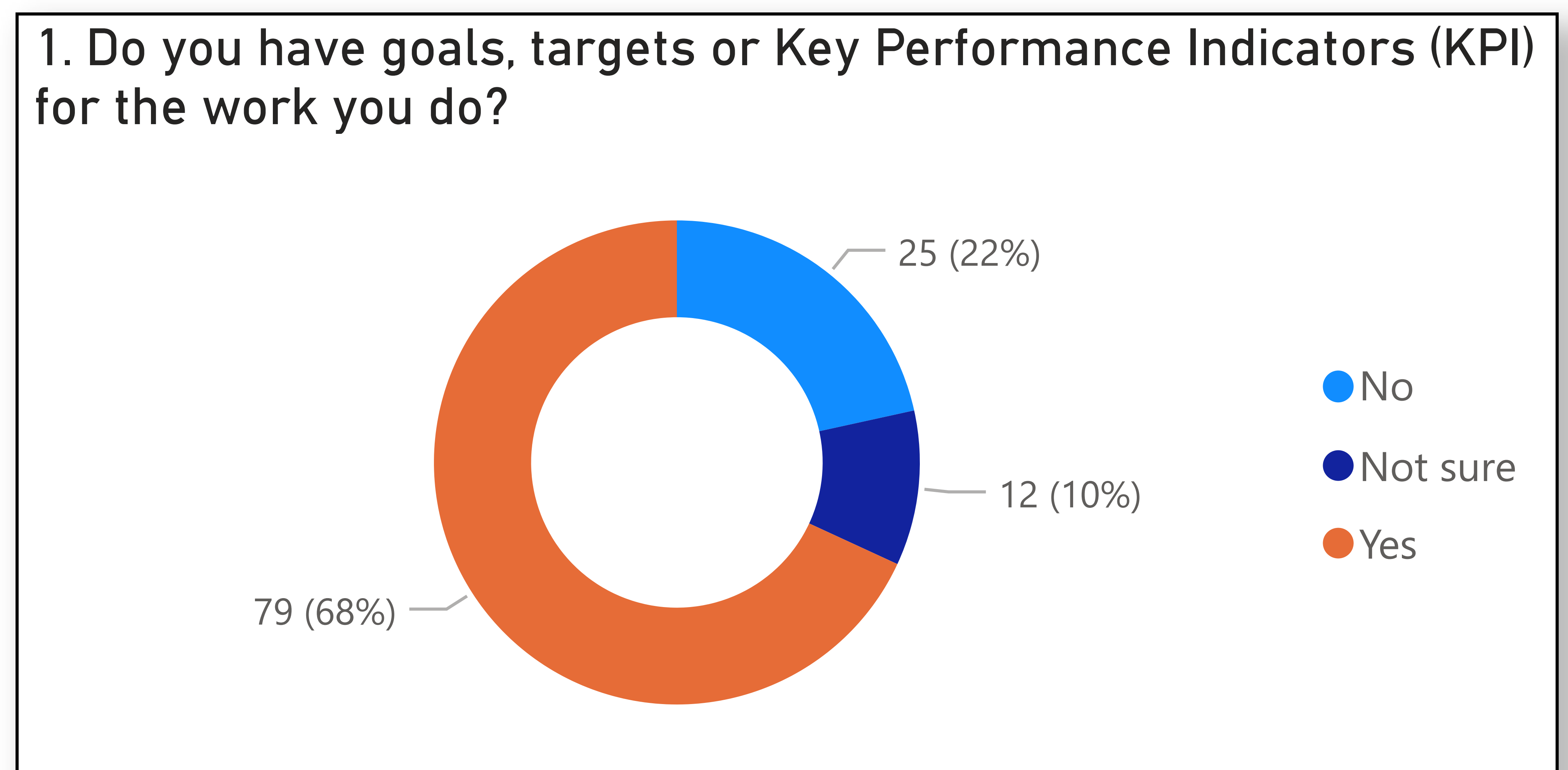


Engagement 5.
60 respondents answered this question, 43% responded 'not sure'. There is no major difference in the way people from clinical and non-clinical roles, nor length of service responded. In terms of management roles, those with no management duties replied not sure 57%; followed by line managers 52% then directorate management 10%.

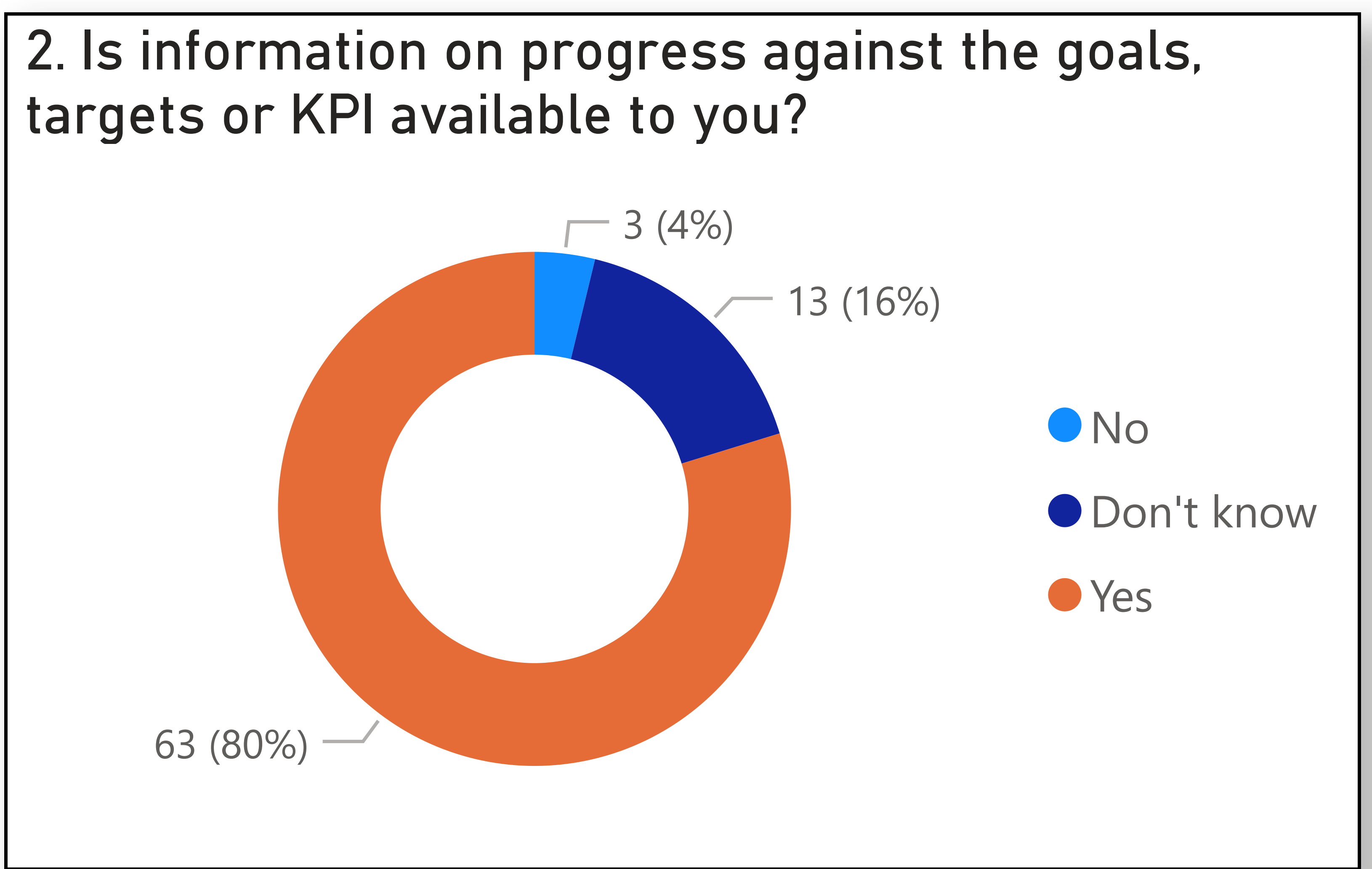
Engagement Summary

- Whether there is a process or group to capture ideas for improvements, replies were widely spread across all categories. Which could suggest that mechanisms for capturing improvement are not in place or not known about.
- Generally, whether staff are involved in making changes as part of QI or not, survey responses suggest that that engagement is good or fair. This is largely the picture across the board.
- Methods for how changes are communicated show that group discussions and written communications are generally used.
- Clinical roles replied 68% ‘yes, feedback does inform changes’, whereas only 47% of non-clinical roles agreed. In terms of management, those with no management duties replied ‘not sure' 53%, 32% for line managers and 18% for directorate management; this may indicate a hierarchical blocker, but further research is required to evaluate this.
- To the question on how often feedback is gathered, those with no management duties replied not sure 57%; followed by line managers 52% then directorate management 10%. This may also indicate the potential of a hierarchical blocker.
- Regarding questions related to engagement, less variation was found between the SBUs than in previous sections.

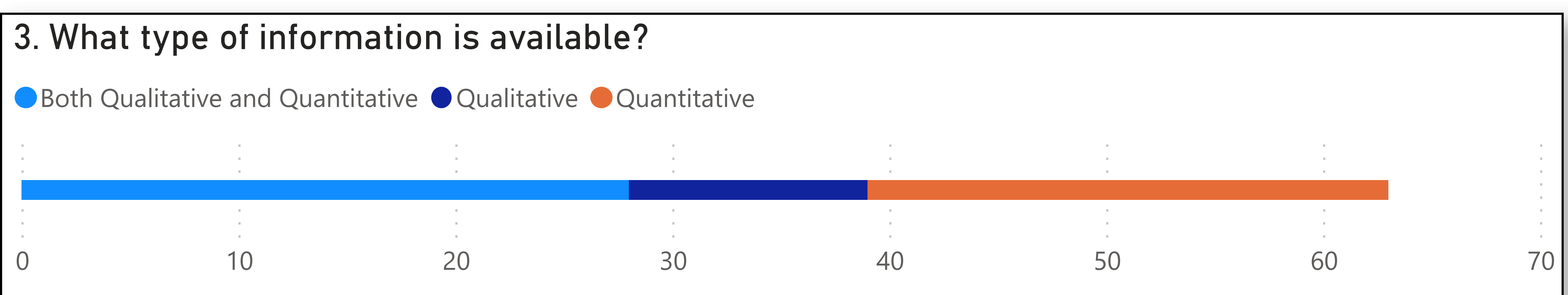
Testing



Testing 1.
68% of the 116 respondents replied 'yes', 22% 'no' and 10% 'not sure'. 42% of people who work in NCC replied that they have targets; 50% in DaS and 53% of staff in SPST. CLO responded 100% with 'yes'; followed by SNBTS and P&CFS at 81%. Those in clinical roles responded 76% 'yes', 10% higher than those in non-clinical roles. Of those who have less than 1 years' service, 25% were unsure if they have targets. Of those who have no line management duties, 21% were unsure.

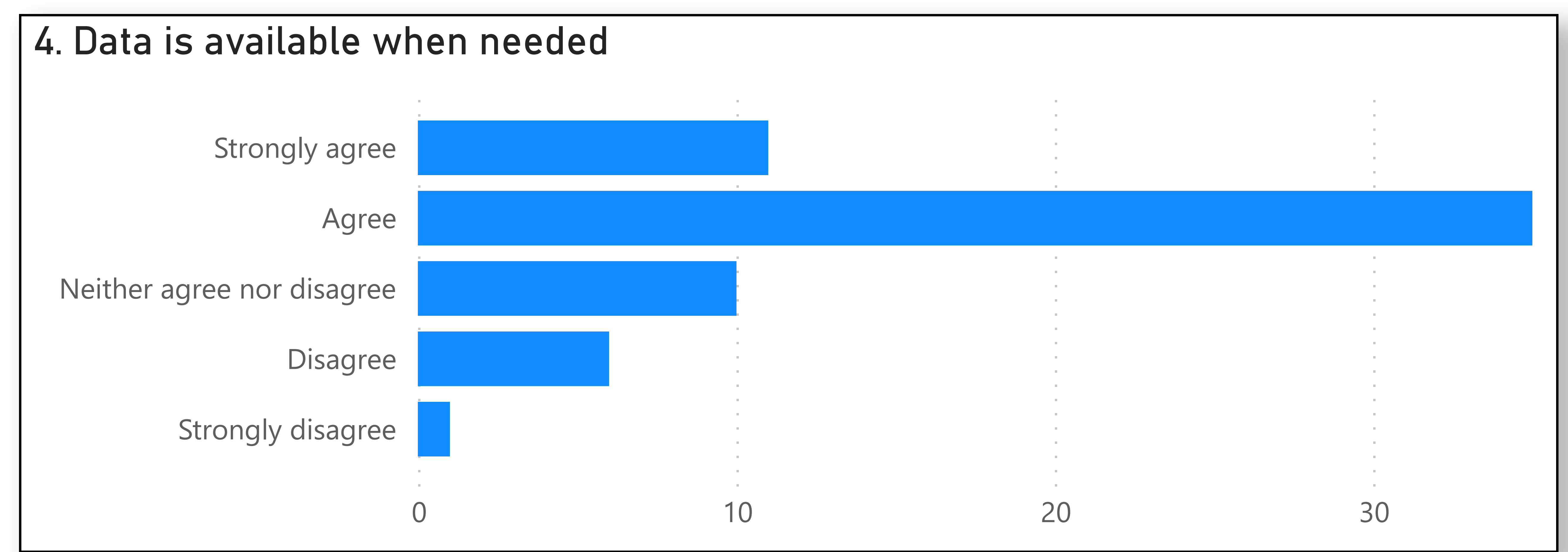


Testing 2.
79% of the 79 respondents who replied 'yes' to the previous questions replied 'yes' to this question. SPST and F&B replied 'not sure' more proportionally than other areas. 20% of those in non-clinical roles were unsure compared to 5% in clinical roles. Those with no line management duties and line management duties were unsure, with 20% and 21% respectively.

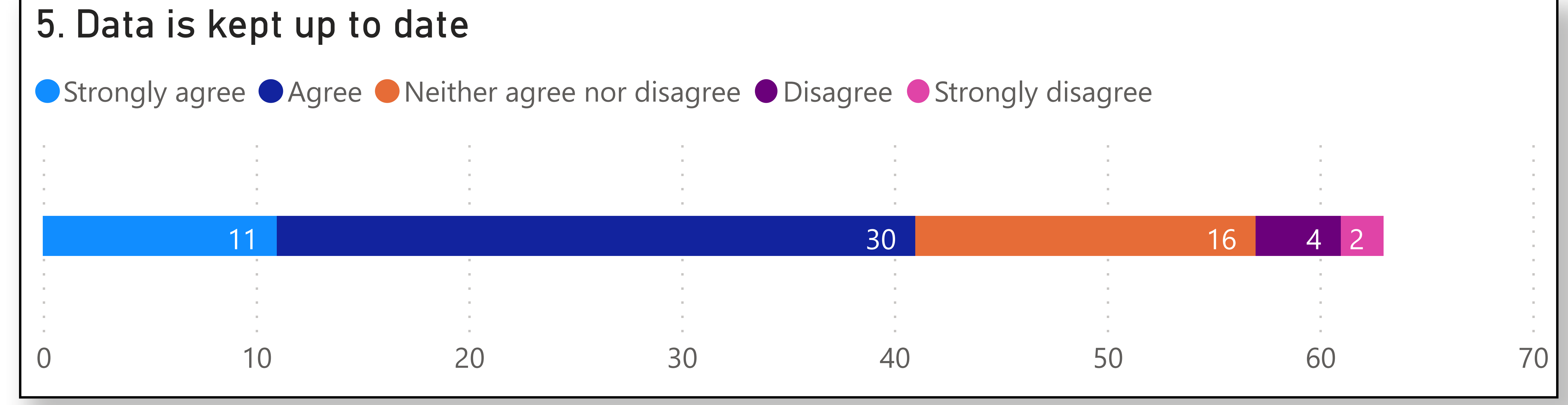


Testing

Questions T4 – T7 require a response based upon how strongly the respondent agrees or disagrees with the statement. For analysis, those who respond 'strongly agree' and 'agree' will be considered a positive response. Those who respond 'neither agree nor disagree' will be considered a neutral response. Those who respond 'disagree' or 'strongly disagree' will be considered a negative response.

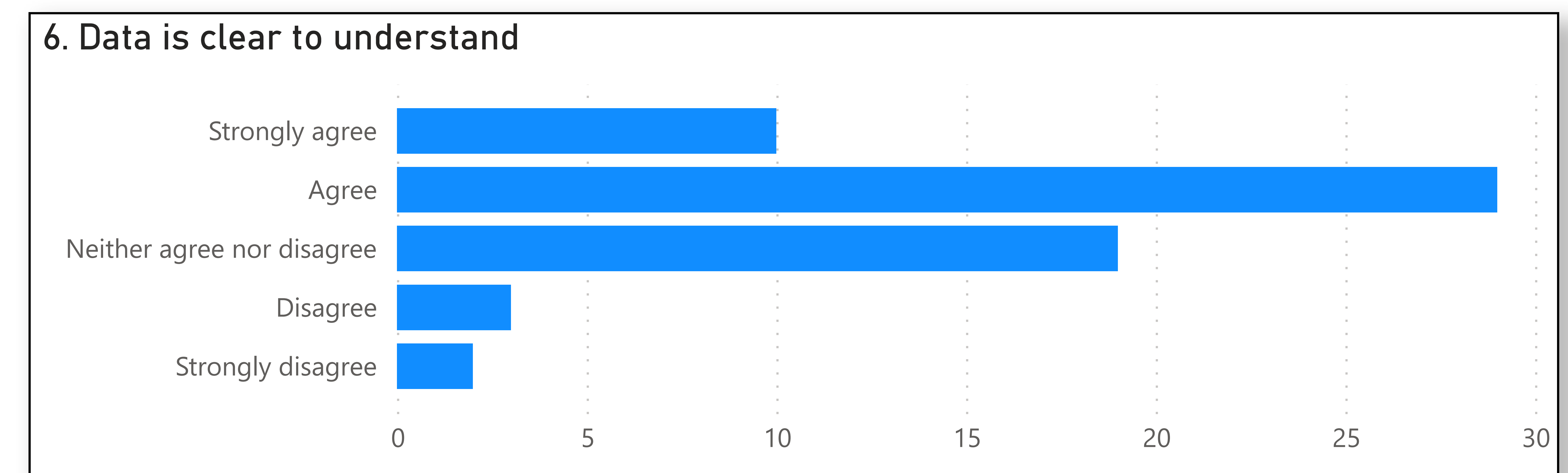


Testing 4.
63 of the 79 who replied 'yes' to the previous question replied to this question. 73% of those who responded replied positively. Respondents in clinical roles replied slightly more positively at 81%, compared to 70% of those in non-clinical roles. All of those who have served between 3 -5 years replied positively, although the latter were represented by a considerably smaller sample size. Directors responded 100% positively, with those with no management duties responding the most negatively with 23%.

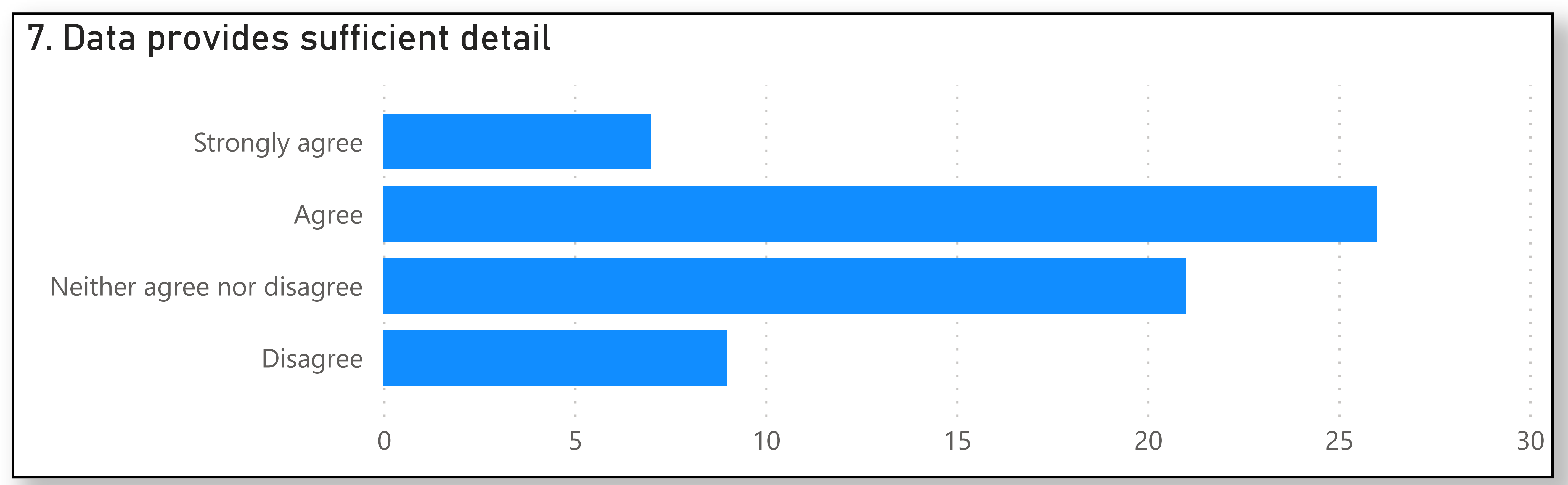


Testing 5.
65% of respondents answered 'yes'; those from NCC were the most positive at 100% and SNBTS with 81%. No major difference was found in replies from clinical roles and non-clinical roles. Again, 100% of those who have served between 3 -5 were positive, although they were represented by a considerably smaller sample size. Those with no management responsibilities were the most negative with 22%.

Testing



Testing 6.
62% of the respondents replied 'yes'. Those in non-clinical roles were more positive (64%) than those in clinical roles (56%). Those with less than 1 year service far were less positive that the others in the group (47% as opposed to 62-75%). Those with no management responsibilities the most negative with 17%.



Testing 7.
Most of the respondents strongly agreed or agreed with the statement (53%).

Testing Summary

- Only 79 of the 116 (68%) are aware of targets or KPIs for the work they do. The fact that those with less than 1 years' service or those with no management responsibilities replied
the highest 'unsure' in the categories could suggest there is a problem in setting targets

- Those in clinical roles were 10% more aware of targets and KPIs than non-clinical staff. When cross referenced with the outcomes from the questions around standard operating procedures it may suggest that SBUs with more measurable processes in place are better able to set and track performance indicators or targets.

- Those with no line management responsibilities were only 58% aware of targets and KPIs and those who have less than 1 years service were 64% aware. This could suggest that those who are in more junior roles or newer to the organisation may not be supported or encouraged to understand targets and utilise data.

- Although the survey suggests that both qualitative and quantitative data are available in some cases, it does not address whether available data is of good quality, valid, and reliable.

- By structuring the questions the way we did the sample size for most of the questions was cut considerably – almost by half from the second question. The small sample sizes made the data difficult to interpret and generalise.

Appendix 9 – Case Studies

Complaints reporting

CHALLENGE

- Extraction of complaints data from SeviceNow was not efficient
- Cleansing of data required significant manual intervention and took a considerable time (1st April to 1st of June for the 2022 report)
- The system limitations resulted in risk of human error, little resilience in the team preparing the data, an inability to provide real time data and no confidence in the data quality.

ACTION

- The Customer Experience team worked with the SBUs to understand their challenges with recording complaints, reinforce the importance of accurate recording and train new staff
- The Customer Experience team and DaS revised the ServiceNow tool including changes to mandatory fields to ensure important KPI and reporting information is captured.
- PCF data feed went live in August 2022

RESULT

- The Complaints reporting ServiceNow tool is in the final stages of development for its minimum viable product.

ANTICIPATED BENEFITS

- The solution will be live of 2023 reporting and is expected to deliver the following benefits (the case study will be updated to so actual benefits in 2023):
- Reduced risk of error
- Quicker reporting
- More time to focus on analysis of the data to drive quality improvement

Created by the PgMS Service Design Team
2022 for Customer Engagement Team

Improving "Point of Care" clinical governance

CHALLENGE

- Point of Care testing is the term used to described diagnostic testing close to the patient and majority of examples has been in secondary care for some years.
- There was a large expansion in Point of Care testing during COVID, which was necessary to meet demand, which was implemented at speed, without a specific clinical governance framework in place
- POC testing is not currently accredited in the same way as medical labs testing, resulting in variations in practice, incomplete electronic patient records, and some issues with quality and reliability of tests completed by non-laboratory staff.

ACTION

Action taken by the team is in its infancy and has been multi-faceted including:

- National policy home found
- National framework developed
- Supporting Health Boards to develop local policies based on the principles

Further work will include:

- Support for education and awareness
- POC equipment roll out
- Support to develop E-Health connectivity solutions

ANTICIPATED BENEFITS

- Increased patient access to diagnostic testing, closer to their home
- Increased clinical decisions benefitting patient management and flow
- Accreditation of tests will lead to
  - Increased reliability of testing
  - Increased quality of testing
  - Increased data
  - Complete patient records with full test histories

Created by the PgMS Service Design Team
2022 for Ryan Cooper Programme Lead Point of Care Team

Appendix 10 – Literature Review

ORGANISATIONAL ENABLERS OF QUALITY IMPROVEMENT: A LITERATURE REVIEW

NSS PgMS
Service Design Hub
September 2022

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Executive summary

In May 2022, the National Services Scotland (NSS) Executive Management Team asked the PgMS Service Design Hub to undertake a discovery phase of research exploring the maturity of quality improvement (QI) in NSS. The research question agreed was:

'What are the organisational enablers of quality improvement?'

The work directly relates to the NSS strategic aim of recognising that continuous improvement is intrinsic to achieving service excellence. As Scotland embraces the government's 'Covid Recovery Strategy: For a fairer future,' HIS is developing its' strategy for 2022-2027 aiming to continue 'to improve health outcomes for people and to tackle deep-rooted inequalities.'[6,7] It is within this context in Scotland that this literature review was conducted.

This desk-based literature review was conducted concurrently with other user research data collection activities (case studies, a survey). Together these make up the Discovery phase following the Scottish Approach to Service Design (SAtSD) methodology. A search strategy was developed which identified the key terms ("quality improvement" OR "continuous improvement") AND (enable* OR facilitat*). Academic articles were searched for in Google Scholar and Web of Knowledge; public and not-for-profit sector literature along with professional consultancy reports were identified in Google.

Thirty-six academic articles and 9 reports were included in the literature review, subject to data extraction and narrative synthesis. The articles were from around the world and used qualitative, quantitative, mixed and QI methodologies as well as literature reviews and case studies.

The key enablers identified related to: Time and resources, Culture, Leadership, Collaboration, Training and Data. These enablers will not in isolation be the key to QI success; there is a dynamic, complex relationship at play between the enablers. QI is an art that takes commitment to discovery and experimentation along the QI journey to learn and adapt within a supportive environment.

A recommendation from this literature review would be to establish an NSS wide quality improvement strategy, cognisant of the wider policy context, where the approach, tools and methods are embedded in training and coaching for all NSS Strategic Business Units (SBU) and NSS directorates. A baseline needs to be established for each SBU which can then be monitored. Organisational buy-in and leadership creating a culture which is given the time, resource, culture and leadership as well as collaboration, training and leveraging of data in an NSS supportive of QI.

Background

The research question

In May 2022, the National Services Scotland (NSS) Executive Management Team asked the PgMS Service Design Hub to undertake a discovery phase of research exploring the maturity of quality improvement (QI) in NSS. The research question agreed was:

'What are the organisational enablers of quality improvement?'

The context

The work directly relates to the NSS strategic aim of recognising that continuous improvement is intrinsic to achieving service excellence.[1] In 2018, the Scottish Government produced a progress report on the, 'The Scottish Improvement Journey: a nationwide approach to improvement.'[2] It recognised 50 years of clinical audit and improvement programmes, across the public and not-for-profit sector, in response to demands on services, funding and resources. Quality improvement continues to be encouraged across the public and not-for-profit sector but most prominently in health and social care in Scotland. The iHub at Healthcare Improvement Scotland (HIS) and the QIZone at NES (NHS Education for Scotland) provide a range of resources and support to health and social care staff and organisations.[3,4] Public Health Scotland's (PHS) areas of work are all about improving well-being and reducing inequalities by providing reliable, robust, timely evidence, based on comprehensive data.[5] As Scotland embraces the government's 'Covid Recovery Strategy: For a fairer future,' HIS is developing its' strategy for 2022-2027 aiming to continue 'to improve health outcomes for people and to tackle deep-rooted inequalities.'[6,7] It is within this context in Scotland that this literature review was conducted.

Methods

Methodology

This desk-based literature review was conducted concurrently with other user research data collection activities (case studies, a survey). Together these make up the Discovery phase following the Scottish Approach to Service Design (SAtSD) methodology.[8]

Search strategy

A search strategy was developed (Appendix 1) which identified the key terms ("quality improvement" OR "continuous improvement") AND (enable* OR facilitat*). Searches for academic literature were conducted in Google Scholar and Web of Knowledge, limited to full text, peer reviewed articles from 2020 onwards, in English language, with no study type limitations. Articles for inclusion were exported to RefWorks, duplicates were removed, exclusions were recorded with reasons. The remaining articles were subject to data extraction followed by narrative synthesis.

Similar searches were conducted in Google to identify public and not-for-profit sector and professional consultancy articles in English language on QI enablers.

Results & Discussion

Searches

Searches returned academic articles from Google Scholar (n=11) and Web of Knowledge (n=61) which were exported to RefWorks (n=72). Duplicates were removed (72 – 13 = 59). There were exclusions (n=23; see Appendices 1 & 2 for details) with the remaining articles (n=36) included in the review. Data extraction is captured in Appendix 3.

Similar searches with wider date parameters identified public and not-for-profit sector (n=7) and professional consultancy (n=3) literature on enablers of quality improvement or continuous improvement. Data extraction is captured in Appendix 4.

When & Where

The academic articles included were published in 2020 (n=11),[9-19] 2021 (n=15)[20-34] and 2022 (n=10).[35-44]

The articles from the public and not-for-profit sector and professional consultancy were published in 2016,[45] 2017,[46,47] 2018,[48] 2019,[49,52] 2021,[50] and 2022.[51,53,54]

The articles were from several countries: Australia (n=2),[29,31] China (n=2),[34,44] UK (n=3),[15,18,26] USA (n=17),[9-12,14,16,19-21,23,25,30,32,36,39,40,42,43] review articles featuring multiple countries (n=2)[24,35] with Canada,[17] India,[13] Ireland,[38] Israel,[33] Norway,[37] Spain,[41] Sweden,[22] Vietnam,[28] and Low and Middle Income Countries (Nepal, Bangladesh)[27] all featured in one academic article. Clearly, the field of quality improvement research is dominated by the USA (n=17/36).

The articles from the public and not-for-profit sector and professional consultancy were from England,[45-48] or the UK,[49-51] or global.[52-54]

How & What

There were a similar number of quantitative studies (n=15)[9,10,15,19,21,22,25,26,32,33,36,38,39,41,43] and qualitative studies (n=12)[13,14,16,18,20,23,27,28,31,34,37,44] in the academic literature. Also quantitative combined with QI methodologies (n=1)[11] or mixed methods combined with QI (n=1)[30] or purely mixed methods (n=1)[40] or purely as QI (n=3)[17,29,42] with a single case study (n=1)[12] and literature reviews (n=2).[24,35]

In some cases, the articles from the public and not-for-profit sector and professional consultancy were less forthcoming about how the evidence was gathered. There were case studies,[45,48,51] round tables,[46] interviews,[46,48,52] literature reviews,[47,48] site visits,[52,53] benchmarking studies,[54] and learnings gathered from own previous work.[49]

Only a few of the academic articles used alternatives to QI as their main focus such as PEQI[16] for a pilot of four Patient Engagement QI interventions in primary care or QIC[24] for QI collaboratives considering stroke patient pathways in a systematic review. Another variation was mQI,[29] or multicomponent QI, also looking at stroke care which looked at the role of external facilitation in hospital settings but found no change in adherence to processes of care. Two articles looked primarily at Continuous Improvement (CI).[38,41] In the Pharma industry in Ireland, CI was combined with Lean Six Sigma (LSS) but the study found management could be doing more to train and educate on the use of these tools.[38] A hospital based article also used LSS, but with QI, using safety barrier analysis to identify and mitigate for risks.[39] The other CI article, published in a Business Process Management journal, conducted a Delphi study amongst organisations with more than 20 staff who were practising CI. The article provided a wealth of historical context, including Kaizen, with the nature and classification of facilitators of CI.[41]

The articles from the public and not-for-profit sector and professional consultancy all spoke in terms of QI[45-51,53] or CI.[52,54]

The focus of the academic studies varied greatly. From radiology (n=2)[9,17] to surgery (n=1),[10] paediatrics (n=2)[11,42] to forming a QI Specific Ethics Committee (n=1),[12] palliative care (n=1),[13] cardiology (n=2),[14,44] stroke (n=2)[24,29] and healthy hearts (n=1),[32] special care dentistry (n=1),[15] mental health (n=2),[18,30] cancer screening (n=1),[25] early discharge from hospital (n=1),[26] burns services (n=1),[27] Crohn's Disease (n=1),[33] geriatric care (n=1)[34] and venous thromboembolism prophylaxis (n=1).[39]

The articles from the public and not-for-profit sector and professional consultancy were associated with healthcare,[45-47,49-51,52] health and adult social care,[48] pharma industry[53] and digital world class companies.[54]

Alongside those very specifically focused academic studies was more QI focused research into the role of QI in team culture and leadership (n=9)[20-22,28,31,35-37,38] and the role of QI facilitation (n=6)[16,19,23,40,41,43] in improving health and social care.

Several of the academic articles refer to the use of research frameworks such as the Consolidated Framework for Implementation Research (CFIR)[44] and Theoretical Domains Framework (TDF)[28,34] which one study combined with the Aged Care Clinical Mentoring model (ACCM).[34]

The articles from the public and not-for-profit sector and professional consultancy were about engaging with NHS Trusts,[45] embedding a culture of QI,[46,53] improving care during challenging times,[47,52,54] to encourage improvement,[48] reacting to policy changes,[49] sharing effectiveness of QI and habits of improvers.[50]

Who & Why

There is little sign of programmes of research amongst the academic articles. However, authors such as Alexander (n=3),[20,35,36] McHugh (n=2),[14,43] Walunas (n=3)[14,32,43] and Ye (n=2)[32,43] feature in multiple articles. The articles from the public and not-for-profit sector and professional consultancy were multiple from the King's Fund,[45-47] The Health Foundation,[49-51] with single publications from the Care Quality Commission,[48] KPMG,[52] McKinsey & Company[53] and The Hackett Group.[54]

The journal titles (Appendix 5) publishing the academic articles provide evidence of the multi-professional nature of QI including: medicine, nursing, dentistry, business process management, human factors, health policy & management, quality management, education, quality and safety, public participation, implementation science, patient and public participation in research.

While several academic articles met the specificity of this literature review – QI enablers (n=5)[10,31,34,38,44] – it was usually termed facilitators (n=9)[13,20,24,28,30,35,36,37,41] and combined with considering barriers (which are outwith the scope of this review). One article noted that the way a phrase is framed will determine whether it is a facilitator or barrier depending on the person's perspective.[28] Some academic articles were about the role of QI facilitation, with trained QI facilitators, working with organisational staff to promote QI interventions (n=10).[14,16,18,21,23,25,29,32,40,43] The remainder of the articles demonstrate the sensitivity of the searches in picking up academic articles which may still hold valuable insight in addressing the research question (n=12).[9,11,12,15,17,19,22,26,27,33,39,42]

The articles from the public and not-for-profit sector and professional consultancy were less abundant so the date limits had to be extended which may impact the currency of recommendations.

Enablers or facilitators identified in the full set of articles included are mapped in Table 1.

Table 1. Enablers and facilitators of QI from the academic literature

Enablers referenced between 14 and 9 times	Enablers referenced between 8 and 3 times	Enablers referenced between 3 and 1 times	Categories mentioned
Adequate resources[18,21,25,28,30,33,36,40,43,44,46,49,52,53]	Understanding of needs, goals and concerns[14,28,37,43,47,50,52,54]	Adopting QI designed tools[19,25,43]	Process, patient and other [24]
Role of leadership in creating a positive culture[10,20,32,34,35,36,41,43,44,45,46,47,48,49,51,52,53]	Collaborations and networking[13,21,22,24,45,48,50,51]	A structure for accountability[13,30,54]	Organisational support, evidence-based practice, proactivity, supervision and feedback[34]
QI training, coaching and support[13,16,28,30,32,35,36,38,41,47,48,49,51]	Measuring with & leveraging data[13,34,36,47,50,51,54]	Committed leadership[13,38,47]	3 Factors: Cultural facilitators, Tactical facilitators, Human resource involvement[41]
Organisational buy-in[13,20,34,35,36,40,43,44,45,49,51,53,54]	Open mindset & communication[10,22,41,43,44,45]	Dedicated time for QI[16,36,48]	
Reflection and feedback mechanisms[14,17,24,28,34,36,38,41]	Trained facilitators[14,16,25,41,43,47]	Build on success[31,46]	
Educational interventions which meet different learning styles[11,16,23,35,37,38,41,47,48,49,51]	Accessibility of required information[15,18,30,31,42]	Creation of tangible products[12]	
Building & supporting local teams[13,18,29,34,36,41,43,45,46,47,48,49,50,51,53]	Engaged mentors[13,25,34,35,36]	Empowering local leaders[13]	
Democratic prioritisation of QI interventions[10,22,23,27,31,36,44,46,50,51]	Communicate[23,31,36,37,52]	Improve productivity and quality[38]	
Engage everyone proactively in their role[23,27,28,34,37,44,46,47,50,54]	Workflow optimisation[11,42,48,49,50]	Interdepartmental coordination[13]	
Local ownership & champions[13,25,27,35,36,40,45,47]	Developed relationships[14,16,23,27]	Pilot everything[23]	
	Incorporate a model or established tools[23,26,38,39]	Plan in advance and have backup plans[23]	
	Institutional incentive program[11,30,34,44]	Reconciling conflicting interests[12]	
	Standardisation[9,15,33,42]	Having a dedicated transformation & quality committee[47,54]	
	Understanding of leaders perspectives[14,16,43,46]		
	Smaller QI projects[16,45,47,52]		

Quality

While journal Impact Factors (IF) have their limitations, they can give a broad indication of the expected quality of peer review of an academic journal (Appendix 5). Analysis of the journal titles of the included articles shows many have an IF of 3 or more (n=14, range 3.13 - 8.03) with slightly more having an IF of less than 3 (n=16; range 1.028 - 2.839) while for others the IF was unclear (n=6). The references for these IF groups are provided in Appendix 5. Overall, this suggests the included articles are likely to provide an acceptable level of quality leading to a reliable basis for findings based on the academic literature included in this review.

The articles from the public and not-for-profit sector and professional consultancy were more challenging to judge the quality. Some were very detailed in the methods and clearly used a wealth of data on which to found their recommendations.[45,48,50,54] There is no doubt that all the organisations involved are held in high regarded.[45-54]

Limitations

All studies have limitations. Although two researchers conducted the literature review there was not the opportunity for them to work together to share learning and discuss findings. Although only two academic articles were not accessible more studies may have been identifiable in a wider range of electronic academic databases. There was a paucity of literature from the public and not-for-profit sector and professional consultancy. This led to a limited range of sources and less current literature.

Conclusions

The original research question was:

'What are the organisational enablers of quality improvement?'

The enablers identified within the literature review are critical components of creating, embedding and sustaining an organisation which embraces continuous improvement:

- **Time and resources**: not only does the success of quality improvement rely on finances and other resources but also commitment to protected time dedicated to quality improvement. Quality improvement should be seen as part of everyone's role. Other important resources could include access to business function support; administrative or IT to efficiently utilise skills to support ongoing quality improvement.

- **Culture**: an organisation which can empower its people to challenge the norm, to making things happen and participate. Using feedback and learning to take ownership of their environment to make quality improvements part of day-to-day work.
- **Leadership:** the role of leaders providing inspiration and support cannot be underestimated. Ensuring quality improvement activity is considered as an end-to-end managed process, creating a clear vision, being visible and by committing to fewer priorities in order to deliver, demonstrate the benefits, then celebrate change, can create motivation for staff and leaders alike. Leaders should be champions of quality improvement linking quality improvement initiatives to strategy and communicate effectively at all levels of their organisation.
- **Collaboration:** whether discovering, designing, implementing, or sustaining quality improvement, the inclusion of those who deliver or receive the service is vital to understand the problems, requirements and aspirations to deliver quality improvement. Co-production and the involvement of multidisciplinary teams is an essential component of quality improvement initiatives.
- **Training**: whether specific training in QI methods and tools, or sufficient training and knowledge of quality improvement initiatives throughout the organisation, ensuring a consistent approach and understanding among staff is imperative to a supportive quality improvement organisation.
- **Data**: for the purposes of discovering, designing, implementing, or sustaining quality improvement, the measurement and leveraging of the right data is essential. Data should be timely, accurate and robust, with a benchmark created and consequences tracked prompting reaction.

These enablers will not in isolation be the key to QI success; there is a dynamic, complex relationship at play between the enablers. It is important to remember that organisations are not all the same; their leadership and staff also vary. What works well in once place might not be effective in another. QI is an art that takes commitment to discovery and experimentation along the QI journey to learn and adapt within a supportive environment.

A recommendation from this literature review would be to establish an NSS wide quality improvement strategy, cognisant of the wider policy context, where the approach, tools and methods are embedded in training and coaching for all NSS Strategic Business Units (SBU) and NSS directorates. The enablers highlighted in this review should be referenced and addressed directly as they apply to each SBU. A baseline needs to be established for each SBU which can then be monitored. Organisational buy-in and leadership creating a culture which is given the time, resource, culture and leadership as well as collaboration, training and leveraging of data in an NSS supportive of QI.

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Appendix 1. QI Literature Review Scoping Searches for peer reviewed academic articles

Search #	Key term	Alternatives	Google Scholar – no date restriction	Google Scholar – from 2020	Google Scholar – from 2022	Web of Knowledge – no date restriction	Web of Knowledge – from 2020	Web of Knowledge – from 2022
S1	Quality improvement		2,210,000	116,000		496,529	93,569	
	OR	• Continuous improvement	927,000	28,900		257,738	50,254	
	("quality improvement" OR "continuous improvement")		17,300	16,400		726,622	140,123	
S2	Organisational		1,030,000	33,000		38,722,437	5,529,721	
	OR	• Organi* • NHS • Health*	1,030,000 2,200,000 7,380,000	33,000 65,800 1,100,000		38,722,437 1,109,247 51,375,621	5,529,721 136,282 8,142,227	
	(Organi* OR NHS OR Health*)		1,030,000	32,900		75,208,099	11,098,925	
S3	Enablers		258,000	26,300		302,953	71,101	
	OR	• Facilitators	859,000	40,400		631,001	125,931	
	(enable* OR facilitat*)		217,000	21,300		134,145	37,010	
S4 (S1 AND S2 AND S3)	("quality improvement" OR "continuous improvement") AND (organi* OR NHS OR Health*) AND (enable* OR facilitat*)		17,300	16,800	13,100	50,864	11,154	2,808
S5 (S1 AND S3)	("quality improvement" OR "continuous improvement") AND (enable* OR facilitat*)		17,700	16,900	14,600	174,632	43,654	12,076
S5 (S1 AND S2 AND S3) **in title**	("quality improvement" OR "continuous improvement") AND (organi* OR NHS OR Health*) AND (enable* OR facilitat*)		22	3	0	65	15	1
S5 (S1 AND S3) **in title**	("quality improvement" OR "continuous improvement") AND (enable* OR facilitat*)		62	11	3	193	61	17

Appendix 2. The excluded academic articles

Total (n=23) including conference proceedings or notes from a webinar (n=12); study protocols (n=2); a book chapter (n=1); full text was not readily available (n=2); discipline specific or lacking in clear direct relevance (n=5)

1. Criscione Naylor, N. (2020). Kaizen (continuous improvement) and systems thinking: Exploring how kaizen facilitators operationalise values and assumptions. *International Journal of Management Practice, 13*(5), 547. doi:10.1504/IJMP.2020.10030189 Full text not readily available
2. Damush, T. M., Homoya, B., Penney, L., Miech, E., Rattray, N., Cheatham, A., . . . Bravata, D. (2020). Abstract WP333: The impact of external facilitation on implementation: Findings from the protocol-guided rapid evaluation of veterans PREVENT quality improvement program. *Stroke (1970), 51* doi:10.1161/str.51.suppl_1.WP333 Conference proceedings
3. Duncan, S. (2020). Notes and actions from patient safety programme webinar 29 september 2020 facilitator: Dawn hart, senior clinical and quality improvement lead, hospice UK. Notes from a webinar
4. Espuny Pujol, F., Pagel, C., Brown, K. L., Doidge, J. C., Feltbower, R. G., Franklin, R. C., . . . Crowe, S. (2022). Linkage of national congenital heart disease audit data to hospital, critical care and mortality national data sets to enable research focused on quality improvement. *BMJ Open; BMJ Open, 12*(5), e057343. doi:10.1136/bmjopen-2021-057343 Focused on linkage of data not QI
5. Gibbs, J., Berger, K., Greany, C., & Falciglia, M. (2020). Using a clinical support system to facilitate nurses' adherence to treatment protocols for hypoglycemia.(continuous quality improvement). *Medsurg Nursing, 29*(6), 381-410. Full text not readily available
6. Hambleton, A., Davenport, T., LaMonica, H., Ottavio, A., Healey, N., & Hickie, I. (2021). Technology-enabled service models for quality improvements in Australian mental health care delivery. *International Journal of Integrated Care, 20*(3), 176. doi:10.5334/ijic.s4176 Conference proceedings
7. Holcomb, J. L., Walton, G. H., Sokale, I. O., Ferguson, G. M., Schick, V. R., & Highfield, L. (2021). Developing and evaluating a quality improvement intervention to facilitate patient navigation in

the accountable health communities model. *Frontiers in Medicine; Front Med (Lausanne), 8*, 596873. doi:10.3389/fmed.2021.596873 Study Protocol

8. Johnson, G., Hickey, K., Azin, A., Guidolin, K., Shariff, F., Gentles, J., . . . Lenet, T. (2021). *2021 canadian surgery Forum01. design and validation of a unique endoscopy simulator using a commercial video game03.* Conference proceedings
9. Kothari, A. N., Arvide, E. M., Trans, A., Newhook, T. E., Bruno, M. L., Dewhurst, W. L., . . . Tzeng, C. D. (2021). 309 implementation of an automated data abstraction workflow to facilitate quality improvement and research. *Gastroenterology (New York, N.Y.1943), 160*(6), S-883; 883. doi:10.1016/S0016-5085(21)02838-9 Conference proceedings
10. Lenka, R. K., & Panda, A. K. (2021). Grid power quality improvement using a vehicle-to-grid enabled bidirectional off-board electric vehicle battery charger. *International Journal of Circuit Theory and Applications, 49*(8), 2612-2629. doi:10.1002/cta.3021 Specific unrelated technology
11. Light, A., Donaldson, C., Khatana, U., Nizar, Z., & Nadeem, I. (2020). 34 Use of the DECAF score to facilitate early discharge for acute exacerbation of COPD patients: A quality improvement project at a district general hospital. *BMJ Leader, 4*, A13. doi:10.1136/leader-2020-FMLM.34 Conference proceedings
12. Liu, C., Dunsmuir, D., Krepiakevich, A., Kissoon, T., Ansermino, M., & Trawin, J. (2021). P0541 / #835: Development of a survey reporting process to facilitate health systems strengthening and quality improvement. *Pediatric Critical Care Medicine, 22*, 270. doi:10.1097/01.pcc.0000740504.82641.3a Conference proceedings
13. Michel, J. J., Schwartz, S. R., Dawson, D. E., Denneny, J. C., Erinoff, E., Dhepyasuwan, N., & Rosenfeld, R. M. (2022). Quality improvement in Otolaryngology–Head and neck surgery: Developing registry-enabled quality measures from guidelines for cerumen impaction and allergic rhinitis through a transparent and systematic process. *Otolaryngology-Head and Neck Surgery; Otolaryngol Head Neck Surg, 166*(1), 13-22. doi:10.1177/01945998211011987 Technical description of discipline specific development of quality measures

14. Modi, N. (2021). Facilitating quality improvement through routinely recorded clinical information. *Seminars in Fetal & Neonatal Medicine; Semin Fetal Neonatal Med, 26*(1), 101195. doi:10.1016/j.siny.2021.101195 Conference proceedings
15. O'Grady, M.,A., Lincourt, P., Greenfield, B., Manseau, M. W., Hussain, S., Genece, K. G., & Neighbors, C. J. (2021). A facilitation model for implementing quality improvement practices to enhance outpatient substance use disorder treatment outcomes: A stepped-wedge randomized controlled trial study protocol. *Implementation Science: IS; Implement Sci, 16*(1), 5. doi:10.1186/s13012-020-01076-x Study protocol
16. Parapini, M., D'Souza, K., Do, U., Muaddi, H., Abou Khalil, M., Mistry, N., . . . Hagen, J. (2021). 2021 Canadian surgery Forum01. design and validation of a unique endoscopy simulator using a commercial video game03. is ethnicity an appropriate measure of health care marginalization?: A systematic review and meta-analysis of the outcomes of diabetic foot ulceration in the aboriginal population04. racial disparities in surgery — a cross-specialty matched comparison between black and white patients05. starting late does not increase the risk of postoperative complications in patients undergoing: Virtual, online sept. 21–24, 2021. *Canadian Journal of Surgery, 64*(6), S80-S159. doi:10.1503/cjs.021321 Conference proceedings
17. Patt, D. A., He, B., Garey, J. S., Rowan, P., Swartz, M. D., Linder, S., . . . Neubauer, M. A. (2020). Driving quality improvement: How clinical decision support can facilitate compliance with evidence-based pathways. *Journal of Clinical Oncology, 38*(15), 2045. doi:10.1200/JCO.2020.38.15_suppl.2045 Conference proceedings
18. Raess, P. W., & Sirintrapun, S. J. (2022). Quality assurance and quality improvement enabled by whole slide imaging. *Whole slide imaging* (pp. 163-177) Springer. Book chapter
19. Verstovsek, S., Jacobson, A., Carter, J. D., & Sapir, T. (2020). Facilitating team-based care coordination and collaboration in myelofibrosis: Findings from a quality improvement study in three US community oncology systems. *Blood, 136*, 32-33. doi:10.1182/blood-2020-136432 Conference proceedings

20. Walsh, L. Using social media to facilitate consumer engagement in Australian public hospital service design and quality improvement. Conference proceedings

21. Wernimont, S. A., Sheng, J. S., Fleener, D., Summers, K. M., Syrop, C., & Andrews, J. I. (2020). Cellular-enabled glucometers and maternal glucose control: A quality improvement initiative. *Journal of Diabetes Science and Technology; J Diabetes Sci Technol, 14*(1), 77-82. doi:10.1177/1932296819856360 Technical description of medical device

22. Williams, S. A., Johnson, A. D., & Cross, L. B. (2021). Meta-techniques for faculty development: A continuous improvement model for building capacity to facilitate in a large interprofessional program. *Journal of Interprofessional Education & Practice, 24*, 100444. doi:10.1016/j.xjep.2021.100444 Education specific without covering QI enablers

23. Wood, M. J. M., Levene, A., & Greaves, S. (2022). 29 Overcoming resistance to change: How COVID-19 enabled a hospice quality improvement digital health intervention project. *BMJ Supportive & Palliative Care, 12*, A12. doi:10.1136/spcare-2021-MCRC.29 Conference proceedings

Appendix 3. Data extraction from included peer reviewed academic articles

Lead author, year & reference	Population / Organisation	Intervention / focus of Interest	Comparison / Context	Outcome - Enablers	Study type
Apler et al. 2020[9]	Radiology CT & MRI reports, USA	QI	Use of preferred phrases	Equivocal phrases were used less frequently in abdominal CT and MRI reports for both attending radiologists and trainees after the intervention ($p < 0.05$, SPC); Use of the term “normal” increased for reports generated by attending radiologists alone but decreased for reports created with trainee participation ($p < 0.05$, SPC); Frequency of pertinent negatives increased for reports with trainee participation ($p < 0.05$, SPC); A QI intervention decreased use of equivocal terms and increased use of preferred and acceptable phrases when communicating normal findings in abdominal CT and MRI reports.	Quantitative, statistical analysis of report templates
Bababekov et al. 2020[10]	Departments of surgery, USA	QI	Open innovation contest	It also enabled the leadership to re-afrm [*sic* re-affirm] a positive culture of inclusivity, maintain an open-door policy, and also democratically vet and prioritize solutions for quality improvement.	Quantitative, anonymous online crowd-voting to rank ideas, 152 ideas from 95 staff (faculty, residents, and other critical role groups)
Bauer et al. 2020[11]	Hospitalized Pediatric Patients, USA	QI	Facilitate penicillin allergy delabeling	• Development of a multidisciplinary clinical care pathway to identify eligible patients • Workflow optimization to support delabeling • Educational intervention • Institutional quality improvement incentive program	QI & Quantitative methodologies; 701 patients who reported a penicillin allergy at the time of admission over the 12-month period after pathway implementation, 82 (11.7%) had their penicillin allergy removed from their records
Bottrell et al. 2020[12]	QI specific Ethics Committee, USA	QI	Ethical quality improvement initiatives	• Clarifying and marketing the committee's role to users • Reconciling conflicting interests between site-based team members and cross-site evaluators • Separating ethics guidance from regulatory oversight • Addressing the ethics of evaluative design • Adjusting the intensity of the committee's work over time • Creating tangible products	Case Study report, Interviews (n=5), survey Response rate not provided

Giannitrapani et al. 2020[13]	Independent palliative care clinics, large academic institutions, and oncology hospitals, India	QI	Barriers & Facilitators to foster locally initiated innovation	The following factors important in the success of quality improvement initiative: leveraging clinic level data, QI methods training, provider buy-in, engaged mentors, committed leadership, team support, interdepartmental coordination, collaborations with other providers, local champions, and having a structure for accountability; Empowering local leaders and medical personnel to champion, design, and iterate using QI methods represents a promising powerful tool to spread palliative care services in developing countries.	Qualitative, interviews, 44 across 7 sites with organizational leaders (n = 8), clinic leaders (n = 12), and PC-PAICE participating clinical team members (n = 24)
McHugh et al. 2020[14]	Preventive cardiology within primary care practices (H3), USA	QI	QI Practice Facilitation; Contrasting perspectives between practice leaders and practice facilitators	A better understanding of practice leaders' perspectives may help practice facilitators conduct more effective implementation planning; Practice facilitators could receive additional training in motivational interviewing to support improved communication with practice leaders; Gain a better understanding of needs, goals, and concerns; Practice facilitators could be encouraged to share their reflections on the practices' progress toward implementation and request similar reflections from practice leaders; Planners should try to address some of the issues that may drive contrasting perspectives, such as having practice facilitators establish relationships with multiple individuals within a practice, so that turnover is less likely to disrupt their work.	Qualitative, interviews with practice leaders (n=17/33) and their corresponding practice facilitator to complete a separate telephone interview. Interview data was paired for comparison then subject to summative content analysis
Nic Iomhair & John 2020[15]	Special Care Dentistry, UK	QI	QI using PDSA to design a patient needs assessment tool	The use of a Patient Needs Assessment pro-forma can achieve significant improvements in the extent and accessibility of information available to assist in planning and delivering appropriate and equitable care for Special Care Dentistry patients; The PNA allows all the relevant information to be collated in one identifiable location, improving accessibility to the information required; Reducing the potential for variability, reliance on memory and improving visibility has been shown in this project to allow improvements in the performance of individuals within a system;	Quantitative, performance improved from 30% of relevant care needs assessed for new patients at baseline to 90% after two cycles of change
Phandi et al. 2020[16]	Primary Care team clinics, USA	PEQI	Pilot of 4 QI interventions	Recruitment was most successful when there was a pre-existing relationship or via a warm handoff introduction from a known entity; It is important to understand the relationship between practices and the recruitment partner; There is a need to understand motivations for participation at multiple levels (system leadership, clinic leadership, and grassroots team members); QI facilitation and dedicated time can help primary care teams identify and overcome barriers to PEQI; Teams that completed the intervention required a resource-intensive combination of QI training, patient engagement resources, and regular contact with a QI coach;	Qualitative, site visits, interviews, observations, journaling; primary care clinics (n=8) at state wide locations experienced barriers to successful recruitment, implementation, and retention encountered

		QI		Clear explanations about the purpose and expectations of this study; Detailed understanding of the ways in which core components of an intervention are actually implemented in different contexts is critical for the scalability of practice transformation efforts; Education about the distinctions between patient engagement and patient activation or satisfaction and training in QI methods appears to be critical in order for practices to understand the "why" and "how" of involving patients in practice transformation efforts; Smaller sized project teams with a clear champion were most successful.	
Srivastava et al. 2020[17]	Radiology departments in local hospitals, Canada	QI	Reducing neuro-imaging in FEP	• Reducing guideline-inconsistent testing may be achieved through infographics employing minimally-invasive feedback mechanisms (audit and feedback, education, and reminders) with visual prompts in physical spaces	QI methodology, radiology report audit & chart review in local hospitals (n=2), stakeholder engagement, literature review
Todd et al. 2020[18]	A mental health trust, a social enterprise providing community care and an acute hospital foundation trust, UK	QI	PPIF roles and responsibilities	• Patient and public involvement facilitators capture and hold information that can be used in service improvement • They work with limited resources and support • Health-care organizations need to offer more practical support to PPIFs in their efforts to improve care quality, particularly by making their role integral to developing QI strategies	Qualitative, 27 interviews and 48 observations
Xie et al. 2020[19]	Hospital Physicians, USA	QI	Feasibility of using the survey-based WSA for large-scale dissemination of QI programme	• WSA tool could help participating hospitals understand their current BC ordering practices • A survey-based WSA tool can be used to facilitate future large-scale intervention dissemination efforts • All 12 hospitals (100%) indicated that they would use a similar WSA to facilitate future QI efforts	Quantitative, WSA survey, clinicians (n=347); hospital physician champions (n=12/15) evaluated the use of the WSA survey
Alexander et al. 2021[20]	Nurses and leaders involved in direct patient care, USA	QI	Barriers & Facilitators	A leader's influence on a QI culture. Subthemes: creating buy-in, support of a just culture and working in partnership with nurses; Creating a just culture and building the infrastructure to support nurse engagement is critical for success.	Qualitative, focus groups (n=6); 24 nurses, 8 nurse leaders
Foote et al. 2021[21]	Medical Residents, USA	QI	QI initiative; CareZooming, an online platform to share project ideas within the hospital and nationally	A 3-fold increase in resident participation (5 to 17 residents) and resident leadership (3 to 10 residents) in QI projects over 3 years; More than 40 new resident-led ongoing QI efforts and fostered more than 30 collaborations across the country; Over 75% (20 of 26) of polled internal medicine residents believe that the Think Tank has directly facilitated resident QI participation and is independently responsible for improved resident well-being; The Think Tank also initiated a hospital-wide effort to provide each resident team with a care transition specialist to perform administrative tasks.	Quantitative, surveys, no response rate stated Short communication

Gremyr et al. 2021[22]	Sweden	QI	Professionals' perception on patient involvement in QI	Increased patient involvement in QI is a means of strengthening the patient role and supporting a more equal relation between patients and healthcare professionals; Empirical evidence shows that the healthcare professionals' experiences in the area of improvement science support a strengthened patient role and a more equal power relationship; The mindset of professionals is key; To gain as many benefits as possible from QI, it needs to be practiced not only as a dual actor but also as a bidirectional effort.	Quantitative, survey, 3 regions, healthcare professionals (n=155); 45.8% nurses; 12.3% physicians; and the remaining group included physiotherapists, occupational therapists and psychologists
Hartman et al. 2021[23]	Community Living Centres, USA	QI	A set of principles for virtual external implementation facilitation	Success in virtual external implementation facilitation may be achieved by facilitators applying three overarching principles: pilot everything, incorporate a model, and prioritize metacognition. Five practical principles also help: plan in advance, communicate in real time, build relationships, engage participants, and construct a virtual room for participants. We present eight concrete suggestions for enacting the practical principles: (1) assign key facilitation roles to facilitation team members to ensure the program runs smoothly; (2) create small cohorts of participants so they can have meaningful interactions; (3) provide clarity and structure for all participant interactions; (4) structure program content to ensure key points are described, reinforced, and practiced; (5) use visuals to supplement audio content; (6) build activities into the agenda that enable participants to immediately apply knowledge at their own sites, separate from the virtual experience; (7) create backup plans whenever possible; and (8) engage all participants in the program. External facilitation team members should also take responsibility for other roles to keep the virtual activities flowing smoothly. This works best if team members have opportunities to practice the roles ahead of time. The following is a selection of important roles that apply in various situations; a team member can have more than one role. 1. Attendance monitor and facilitator (contacts noshows if attendance is mandatory and keeps a database for monitoring the facilitation's reach) 2. Recording manager (starts and stops the recording if the interaction will be recorded) 3. Chat box moderator (moderates and monitors the chat box or other communication mechanism and informs the facilitator(s) if there are issues or questions that need to be addressed) 4. Presentation moderator (shares screens and advances slides) 5. Technical trouble shooter (helps team members and participants with technical connection or other issues)	Qualitative, since 2018, CONCERT has held successful 6- to 9-month long learning collaboratives to help CLCs implement evidence-based practices

Lowther et al. 2021[24]	Stroke Care Pathway, multiple countries	QIC	Effectiveness, Facilitators & Barriers	The effectiveness of QICs was categorised into three types of outcomes: process, patient, and other; QIC participation was associated with improvements in clinical processes but improvements in patient and other outcomes were limited; Key facilitators were inter- and intra-organisational networking, feedback mechanisms, leadership engagement, and access to best practice examples; Short-term nature of QIC means uncertainty remains as to whether they benefit patient outcomes.	Systematic Review, papers (n=20) describing QIC (n=12)
Morley et al. 2021[25]	Primary care practices involved with PBRN, USA	QI	QI intervention to improve breast, cervical, and colorectal cancer screening rates using PF and AD	Overall results were mixed; Enough improvement was seen to indicate that engagement of safety-net primary care practices by academic centers can have a beneficial impact on promoting screening for colorectal and breast cancer; External funding is often required to activate such projects, the interventions presented are likely achievable by an academic health center or health system that sits at the core of a primary care network; Dedication of external attention, knowledge, and skills brought to safety-net practices by trained facilitators and clinical educators can yield benefits in terms of screening rates; This may be particularly important for safety-net practices exploring how to provide patient-centered screening options to their underserved population of care recipients.	Quantitative, PBRNs (n=3) including up to 29 practices for up to 7 years
Nadeem et al. 2021[26]	District General Hospital, UK	QI	QI using PDSA with DECAF scoring system to facilitate early discharge in acute exacerbation of COPD patients	DECAF score can help clinicians in deciding the best possible care these patients receive, whether that is usual inpatient care or facilitated early discharge; Potential benefits to both the patient and hospital without worry of adverse events.	Quantitative, Low number of participants stated as limitation
Potakar et al. 2021[27]	Burn services, LMIC (Nepal, Bangladesh)	QI	Development of DAT to facilitate QI	Full engagement with local teams and empowerment of local stakeholders to make decisions on issues within their gift to change can lead to continuous and sustainable improvements; Developing close working relationships with local teams, especially in the early phases of this work, took time and sensitivity. The focus of the early work was to ensure that local teams appreciated that this was not about external international staff coming to criticise or judge their practice, but about developing a tool that would allow capacity building and service development to take place in a constructive and sustainable way, under local ownership.	Qualitative, participatory focus group discussion, in Nepal 13 surgeons attended ABC (Surgery), 31 nurses attended ABC (Nursing) and 373 health professionals attended EBC; in Bangladesh 8 surgeons attended ABC (Surgery), 30 nurses attended ABC

					(Nursing) and 316 health professionals attended EBC. 6 hospitals in Nepal (n=3684 inpatients, n=7110 outpatients) and 5 hospitals in Bangladesh (20,775 inpatients, 141,830 outpatients)
Shapiro et al. 2021[28]	Hospital, Vietnam	QI	Facilitators & Barriers	• Many phrases and sentiments represent both facilitators and barriers depending on how they are framed (eg, regarding the "distance from the hospital or clinic affects the ability to follow up with a patient" belief—patients living close to the hospital represent a facilitator, whereas patients living far away represent a barrier) • Skills: Prior knowledge and experience are used to collect outcomes; It is important to understand what skills are needed to collect outcomes • Social/Professional role and identity: Outcome collection is part of a doctor or surgeon role • Beliefs about consequences (anticipated outcomes): Collecting outcome data affects the treatment outcome and results; Collecting outcome data helps me improve my skills, etc • Intentions: Outcome collections help with physician learning • Environment context & resources: Adequate technological support tools or lack thereof affect outcome collection; Availability of team members, physician, and hospital support staff/resource affects the ability to collect outcomes; Patent resources (social support, insurance, etc) affect outcome collection • Emotion: I feel good or happy about outcome collection • Beliefs about capabilities: I feel confident about outcome collection • Optimism: Confidence that collecting outcomes is for the best and will help attain goals • Goals: The goal of outcome collection is to improve the health and wellness of patients • Reinforcement: Showing good outcomes will increase volume in the future (word of mouth, patients return if the perceive care is good, etc; Collecting outcomes is required; Collecting outcome is driven by finances	Qualitative, interviews with local surgeons and administrative staff (n=9), volunteer surgeons (n=3), and patients (n=5) based on Theoretical Domains Framework (TDF)
Thayabaranathan et al. 2021[29]	Stroke care in hospitals, Australia	QI	mQI, process evaluation for the mQI intervention (Enhanced	• There was no relationship between the amount of external facilitation and change in adherence to PoCs • In the Stroke123 study, the amount or type of external facilitation did not influence action plan development, and the amount of support did not influence the changes achieved in adherence to PoCs	QI methodology, staff from 19 of 23 eligible Queensland hospitals participated (urban hospitals: 55%; rural

			StrokeLink program) of a pre–post observational study with audit and feedback	• Remote support may not add value for mQI	hospitals: 45%; 16% were teaching hospitals); nine different external facilitators provided support to the 19 hospitals. Activities provided were educational outreach (42%), followed by interprofessional collaboration (30%), review of audit data (11%), and reminders (6%)
Van Wert et al. 2021[30]	Mental Health Clinics, USA	QI	Barriers & Facilitators	• ROM now mandatory component of care in psychiatry • Facilitators included increased access/ease of use, training and support, measure relevance/validity, and accountability • To deal with time and motivational challenges, some providers suggested productivity credit and monetary incentives to providers for participation	Mixed methods QI, Clinical and administrative staff (n=138; 63%)
Walsh et al. 2021[31]	Hospital service providers and consumer representative, Australia	QI	Barriers & Enablers	(1) hospitals facilitating access and use; (2) making discussions safe; (3) cultivating a social media community; and (4) building on success	Qualitative, Interviews (n=26)
Walunas et al. 2021[32]	Healthy Hearts in the Heartland Study, USA	QI	Impact of specific practice facilitation strategies	• There was no association between number of strategies performed by practice facilitators and number of QI interventions implemented • Practices that engage in more coaching-based strategies with practice facilitators are more likely to implement more QI interventions • Practice receptivity to these strategies was not dependent on basic practice demographics	Quantitative, Mapping- & regression tree analysis on practice facilitation activities (n=27)
Yogev et al. 2021[33]	Children with Crohn disease attending outpatient clinics, Israel	QI	Quality in pediatric inflammatory bowel disease (QPID)	• Quality improvement nationwide programs can be implemented with limited resources while facilitating standardization of care • These may be associated with improvements in measured indicators	Quantitative; PIBD facilities (n=21) formed a Delphi group to select quality indicators; indicators were reported based on 3254 visits of 1709 unique patients
Zhao et al. 2021[34]	Geriatric care, China	QI	Enablers & Barriers	• “organizational support”, “the evidence-based practice ability”, “proactivity”, “nursing supervision and feedback” • The biggest enablers were the proactivity of the participants to the project and managerial support	Qualitative, nursing home managers (n=8; interviews) with clinical nurses (n=50; focus groups) and nurse

				• Environmental constraints: organizational support was helpful, particularly in the form of rewards for outstanding mentors or mentees and the implementation of regular meetings; all of the nurse managers showed that they were willing to try and support this QI program, which was helpful to care quality • Behavior Regular [*sic* Regulation]: Some participants discussed the value of nursing supervision and the feedback. Close teamwork between nursing assistants and nurses is beneficial to the implementation of ACCM model; some nursing assistants suggested that assigning the most experienced and enlightened nursing assistants at each care unit as site champions, who would monitor other nursing assistants (mentees) and share feedback • NB other domains from the TDF were included but all as barriers rather than enablers	assistants (n=64; focus groups); use of ACCM and TDF
Alexander et al. 2022[35]	Nurse engagement in QI in clinical settings, Multiple countries	QI	Barriers & Facilitators	• Top facilitators were leadership, education and training, culture, mentors, and champions	Literature review of 9 articles
Blok et al. 2022[36]	Nurses, Advanced Practice Nurses and Nurse Leaders working at Healthcare sites, USA	QI	Facilitators	• Dedicated time for QI (n = 3,958, 68.2%); • Adequate resources (n = 3,329, 57.4%); • Access to a QI mentor (n = 2,730, 47.0%); • APRNs were more likely to report dedicated time for QI as a facilitator (73.8%), compared with nurse leaders (71.4%) and clinical nurses (67.5%); • Nurse leaders were more likely to report access to a QI mentor (51.2%) and access to data (47.4%) as facilitators of engagement in QI, compared with APRNs (44.5%; 42.6%) and clinical nurses (46.5%; 38.4%) for QI mentor and for data access, respectively. APRNs and clinical nurses were more likely to identify leadership support (33.7%; 31.6%) and supportive QI organizational culture (26.7%; 22.3%) as facilitators of QI engagement than nurse leaders (22.8% and 17.9%), respectively for supportive leader and for supportive QI culture, respectively. • Nurse leaders (42.6%) and clinical nurses (41.2%) both reported the need for QI education and training, significantly more often than APRNs (32.2%); • The facilitator of nurse ownership of QI was significantly different among the three roles, with nurse leaders reporting the highest ownership (n = 330, 42.2%), followed by clinical nurses (n = 1,454, 30.2%) and APRNs (n = 45, 22.3%). • Additional facilitators were reported by 139 (2.4%) respondents. Of these, 23 (16.5%) reported the facilitator of having what they need to engage in QI. Others (n = 18, 12.9%) indicated that a department-level	Quantitative, survey, 66 sites (n=5,973), frontline nurses (n=4,975), advanced practice nurses (n=204) and nurse leaders (n=794)

				approach and support would facilitate engagement. Respondents wanted leadership in their respective health systems to ask for their feedback, identify projects that are important to frontline staff, value their input, and desire their direct participation (n = 9, 6.5%). Some respondents (n = 6, 4.3%) noted communication and feedback about the results of previous QI initiatives as an important facilitator.	
Harbin et al. 2022[37]	Nursing Homes and municipal acute care units, Norway	QI	Barriers & Facilitators, one-year antibiotic quality improvement program	Barriers and facilitators 1) at the clinical level, 2) at the resident level, 3) at the next of kin level, and 4) at the organisational level; Increased knowledge and awareness, appropriate use of point-of-care tests; Increased availability of the permanent nursing home physician; Early and frequent dialogue with the residents' next of kin were emphasized as facilitators of appropriate antibiotic use; The influence of nurses in the decision-making process regarding infection diagnostics and treatment was by both professions (nurses, physicians) described as profound; Importance of the patient's voice even if cognitively impaired.	Qualitative, focus group (n=6) interviews with physicians (n =11) and nurses (n =14) in 10 NHs and 3 MACUs
McDermott et al. 2022[38]	Pharma industry, Ireland	CI, LSS	Barriers & Enablers	45% of participants perceived that a highly regulated environment could be a barrier to continuous improvement implementation; highest motivation for CI…is to improve Productivity and Quality; CI LSS tools are very strongly integrated into…corrective and preventative action system, deviations, and internal audit systems; Management could be doing more to train and educate on CI within their organisations.	Quantitative, survey (n=80; 53%)
Moore et al. 2022[39]	Hospital, USA	QI, LSS	QI intervention using safety barrier analysis to improve venous thromboembolism prophylaxis	Safety barrier analysis helped inform solutions to improve venous thromboembolism prophylaxis at the study institution and can be a useful adjunct to standard lean Six Sigma methodologies for quality improvement in health care.	Quantitative, Bow-Tie Analysis used to identify and mitigate for hazards
Perry et al. 2022[40]	Primary care practices, USA	QI	QI under varying types of health organisational ownership	FQHCs had significantly lower participation in facilitation than clinician-owned practices across two measures; There were no significant differences between system-owned and clinician-owned practices; Adjusting for cooperative fixed effects and practice characteristics did not substantially change the difference across the three measures by ownership; Adjusting for number of practices belonging to the same health system/FQHC resulted in non-significant differences across the three measures by ownership; Practice ownership shaped how but not how much practices participated in external facilitation;	Mixed methods, association between facilitation and ownership (n = 1117 practices), 50% of practices were clinician owned, 22% were FQHCs, and 28% system owned; interviews with EvidenceNOW leadership (n = 12) and facilitators (n = 51) and observed facilitators (n = 64).

				Highlights importance of tailoring facilitation approaches based on ownership-related characteristics; Different patterns of participation in facilitation by ownership: recipient of the intervention, practice decision-making authority, and centralized health information technology; Did not identify any differences in participation patterns between system-owned and FQHC practices.	
Sanchez-Ruis et al. 2022[41]	Firms with 20+ staff practising CI, Spain	CI	Kaizen, nature and classification of facilitators of CI	Regarding the meaning of the factors: 1. Factor 1: “Cultural facilitators”: It includes facilitators that foster the creation of a CI culture that extends over time. This factor includes items such as “implementing a culture tolerant with mistakes for learning”, “integrate continuous improvement objectives in strategic objectives”, “motivation”, “recognising the achievements and learning from the continuous improvement itself”, “leadership” and “establishing measurement system”. 2. Factor 2: “Tactical facilitators”: This includes the facilitators that help the company focus its efforts on what is really important: the customer, the processes and quality improvement. It is made up of three items “existence of quality improvement systems”, “focusing on stakeholders, mainly the customer” and “focusing on critical processes”. 3. Factor 3: “Human resources involvement”: integrates facilitators that help to involve the company's human resources in the process of CI. It is made up of three items: “training”, “team work” and “open communication”.	Literature review followed by Quantitative, Survey / Delphi (n=109) Good source of historical info on QI
Siddiqui et al. 2022[42]	Local institutional echocardiogram protocols, Cincinnati Children’s Hospital Medical Center, USA	QI	To improve complete adherence to universal and protocol-specific measures for echocardiograms	• Improvement from 60% to 93% in completion sustained over 9 months • All sonographers reported improved awareness of the required measures and ease of locating measures. For the remaining five sonographers who joined our institution after the change in the toolbar tab, none reported that measurement completion impeded workflow • quality improvement methodology can improve adherence to echocardiographic protocol measurements within a short period • These improvements can facilitate the consistency of echocardiographic quality and reporting	QI methodology, PDSA cycles; Included 4023 studies for analysis. Of these studies, 2113 (53%) were first-time studies, and the remaining 1910 (47%) were cardiomyopathy studies. Sixteen cardiac sonographers performed echocardiograms included in our study
Ye et al. 2022[43]	Primary care practices, USA	QI	To design and develop a framework that identifies contextual	• Practice leader, staff, and practice facilitator all saw value in the quality improvement program and practice facilitation • Practice facilitators are key liaisons to help the quality improvement program; they help all stakeholders work toward a shared target and leverage tailored strategies	Quantitative, Framework design; Primary care practices (n=226)

			factors, challenges, and strategies that impact practice facilitation, implementation of QI interventions, and clinical measure performance	• Taking advantage of resources from competing, yet complementary, programs as additional support may accelerate the effective achievement of quality improvement goals • Practice facilitation–supported quality improvement programs may be opportunities to assist primary care practices in achieving improved quality of care through focused and targeted efforts • The framework can support a better understanding of contextual factors for practice facilitation, which could enable well-prepared and more successful quality improvement programs for primary care practices	
Zhou et al. 2022[44]	Acute Coronary Syndrome in hospitals, China	QI	Barriers & Enablers	Enablers of intervention implementation were: • inner motivation for change (intervention sources) • evidence strength and quality of intervention, relatively low cost (cost) • individual knowledge and beliefs regarding the intervention, pressure from other hospitals (peer pressure) • incentives and rewards of the intervention, and involvement of hospital leaders (leadership engagement, engaging)	Qualitative, CFIR; Survey in cities (n=6), interviews (n=165) including directors and coordinators of chest pain centers (CPCs) in 90 hospitals

Abbreviations: CI = Continuous Improvement; **LSS** = Lean Six Sigma; **QI** = Quality Improvement; **MRI** = Magnetic Resonance Imaging; **CT** = computerized tomography; **CHD** = Congenital Heart Disease; **CLC** = Community Living Centre; **CONCERT** = Community Living Centers' Ongoing National Center for Enhancing Resources and Training; **TQM** = Total Quality Management; **QIC** = Quality Improvement Collaboratives; **H3** = Healthy Hearts in the Heartland; **PBRN** = Practice-based research networks; **PF** = Practice Facilitator; **AD** = Academic Detailing; **COPD** = Chronic Obstructive Pulmonary Disease; **PDSA** = Plan Do Study Act; **PNA** = Patient Needs Assessment; **PEQI** = Patient Engagement Quality Improvement; **FQHC** = Federally Qualified Health Centers; **LMIC** = Low to Middle Income Countries; **DAT** = Delivery Assessment Tool; **EBC** = Essential Burns Care; **ABC** = Advanced Burns Care; **FEP** = First-Episode Psychosis; **mQI** = multicomponent Quality Improvement; **PoC** = Processes of Care; **PPIF** = Patient and Public Improvement Facilitators; **ROM** = Routine Outcome Measures; **TDF** = Theoretical Domains Framework; **WSA** = Work System Assessment; **BC** = Blood Culture; **PIBD** = Pediatric Inflammatory Bowel Disease; **QPID** = Quality in Pediatric Inflammatory bowel Disease; **ACCM** model = Aged Care Clinical Mentoring model; **CFIR** = Consolidated Framework for Implementation Research; **CPC** = Chest Pain Centers

Appendix 4. Data extraction from included public and not-for-profit sector and professional consultancy articles

Organisation, year & reference	Population / Organisation	Intervention / focus of Interest	Comparison / Context	Outcome - Enablers	Study type
The King's Fund 2016[45]	Healthcare, England	QI	Engaging with an NHS Trust	• Building leadership at all levels was a critical part of the process • Creating a 'coalition of the willing' from the five directorates enabled a sense of shared ownership • Embedding a quality-focused approach in day-to-day work made it a part of 'business as usual' as opposed to a tick-box exercise • Engaging in the process built rapport between directorates and this, in turn, facilitated conversations about the importance of creating the right infrastructure for quality improvement • Directorates reported that participating in this process had captured the energy and imagination of many clinicians in a way that other initiatives had not • Directorates reviewed the number of quality improvement projects (more than 300) and were able to reduce them by 50 per cent • Work remained to be done on developing meaningful measures, and devising a single repeatable process and language around quality improvement	Report, Case study with an action learning approach, very detailed explanation of the research approach
The King's Fund 2017[46]	Healthcare, England	QI	Embedding a culture of QI	The report identifies relevant learning from organisations that have already adopted QI approaches. Successful launching a QI Strategy: Having a clear rationale; Ensuring staff are ready for change; Understanding the implications for the leadership team in terms of style and role Key enablers for embedding a culture of QI were highlighted as: 1. Developing and maintaining a new approach to leadership that moves away from the imposition of solutions from the top down; instead, recognising that that frontline teams, service users and their carers are often better placed to develop solutions through a process of discovery 2. Allocating adequate financial and human resources and time for QI, thereby re-affirming leadership and organisational commitment to QI activities 3. Ensuring that patients, service users and their carers are central to the QI strategy 4. Engaging staff in a continued commitment to QI by celebrating successes, and ensuring that staff are able to take ownership and feel proud of their achievements 5. Committing to continuous improvement and fidelity to the method.	Report, Roundtable event, interviews with senior NHS leaders and stakeholders Small sample of senior leaders from NHS and community health trusts ; does not include the views of operational staff carrying out QI work, nor empirical evidence to substantiate the organisational enablers

					cited by the participants. Therefore, the generalisability of these findings are limited.
The King's Fund 2017[47]	Healthcare, England	QI	The challenge of improving quality of care while coping with the biggest funding squeeze in its history	10 lessons for NHS leaders: • Make quality improvement a leadership priority for boards • Share responsibility for quality improvement with leaders at all levels • Don't look for magic bullets or quick fixes • Develop the skills and capabilities for improvements • Have a consistent and coherent approach to quality improvement • Use data effectively • Focus on relationships and cultures • Enable and support frontline staff to engage in quality improvement • Involve patients, service users and carers • Work as a systemic A framework from the Institute of Medicine defines six domains of health care quality (Institute of Medicine 2001). • **Safe**: avoiding harm to patients • **Effective**: providing evidence-based care and refraining from providing services that are unlikely to be of benefit • **Patient-centred**: ensuring that care is responsive to individual patient preferences, needs and values • **Timely**: reducing waiting times for care and avoiding harmful delays • **Efficient**: avoiding waste • **Equitable**: ensuring that care is of the same quality regardless of personal characteristics such as gender, ethnicity, location or socio-economic status Key principles that are common include: • training staff in the nature of systems • using data to understand variation • giving all staff the opportunity to contribute and act on ideas for improvement • using many small-scale trials and tests as a way to learn and improve • ensuring a continuous focus on the needs and experiences of the people served by the system (Ham et al 2016). Features of boards that are successful in driving quality improvement include: • having clear goals for improving quality (and making them a top priority) • regularly reviewing quality performance in meetings	Review of existing literature

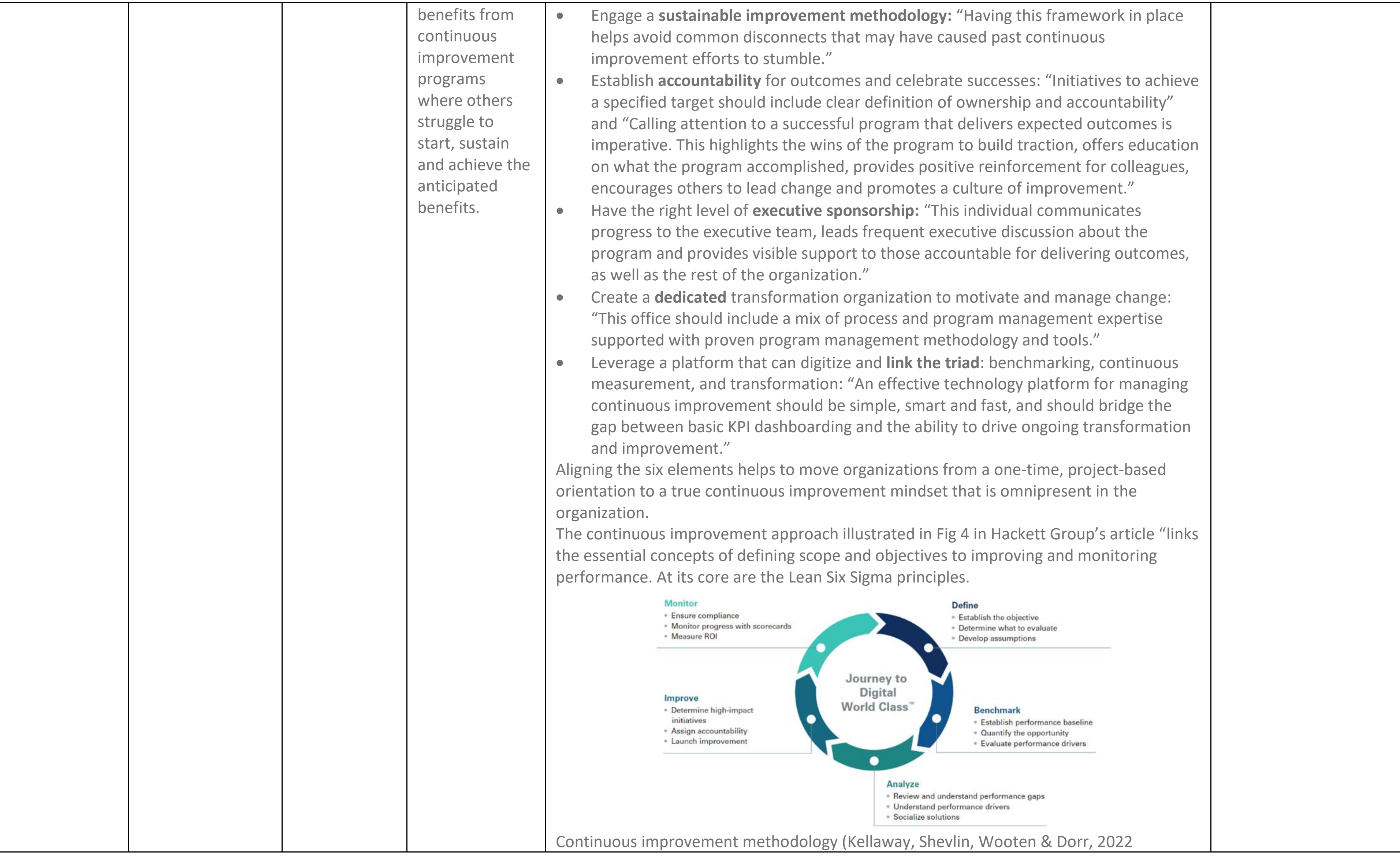
				• having a dedicated quality committee • having board members with experience and training in quality improvement 1. Make quality improvement a leadership priority for boards 2. Share responsibility for quality improvement with leaders at all levels 3. Don't look for magic bullets or quick fixes 4. Develop the skills and capabilities for improvement 5. Have a consistent and coherent approach to quality improvement 6. Use data effectively 7. Focus on relationships and culture 8. Enable and support frontline staff to engage in quality improvement 9. Involve patients, service users and their carers 10. Work as a system	
The Care Quality Commission 2018[48]	Independent regulator of health and adult social care in England	QI	To encourage improvement	QI brings genuine staff engagement, with leaders and staff working together on problems. Staff are empowered when: • improvement skills are built across and throughout the organisation • a coaching style of leadership is used, which is modelled by senior leaders • decision making is integrated and redistributed closer to where problems are being experienced • they feel trusted and secure in delivering improvement • the leadership model focuses on supporting staff do good work, and take away blockages to improvement 1. QI should not be an optional extra for hospitals, but considered essential to providing sustainable high-quality care 2. QI is not a magic bullet – these trusts have shown that it is not an easy journey 3. QI is a strategic decision that requires commitment of senior leaders with behaviours that model improvement and coach staff to solve problems for themselves 4. Effective leadership for QI develops a culture where staff are engaged, empowered and ultimately enabled to deliver improvements with the greatest impact and value at the frontline 5. Building improvement skills and the systematic use of a QI methodology will require this enabling leadership model 6. An understanding of quality requires meaningful patient involvement in service development, which is systematically integrated into the QI methodology, and a commitment to improve patient experience and health outcomes, by collaborating for improvement across the health system	Report, extensive detail of data gathering processes inc. multiple case studies, engagement with stakeholders and literature
The Health Foundation 2019[49]	People in the UK	QI	Recent policy focus has been to reduce variation between	Four key elements that underpin organisational approaches to improvements: • **Leadership and governance**; "there needs to be visible, focused leadership for improvement at board level, right from the start."	Learning report based on own previous work

			providers and boost performance	• **Infrastructure and resources**; "in addition to securing sufficient money, time and physical space to drive improvement, organisations need effective mechanisms for deciding between competing requests for resources." • **Skills and workforce; "**all staff should have at least a basic grasp of improvement approaches and tools" and "there also needs to be sufficient capability and capacity to analyse data to continually monitor quality and performance" • **Culture and environment;** "the presence of a supportive, collaborative and inclusive workplace culture has a significant bearing on an organisation's ability to deliver improvement" with a "need to focus on developing a learning climate" Six key steps for an organization to plan, deliver and sustain QI programmes: • Assessing readiness; "This is the extent to which the organisation is both psychologically prepared for change (shown by the maturity of its learning climate), and has the right infrastructure, governance arrangements and leadership in place." • Securing board support; "A strong clinical voice at board level can often be useful in persuading the board to make QI a priority." • Securing wider organisational buy-in and creating a vision; "improvement leaders need to understand and tap into the intrinsic professional motivations of staff at each level of the organisation, and ensure that any initiative does not become caricatured as a top-down programme, or driven by cost-cutting" • Developing improvement skills and infrastructure; "investment in improvement skills needs to be accompanied by the development of measurement systems able to collect, analyse and feedback data on the effects of improvement activity, and the capability and capacity to make full use of these systems" • Aligning and coordinating activity; this "coordinating role… is necessary to ensure that individual initiatives are consistent with the trust's overall strategy and mission, and that improvement teams and other organisational development activities are not pulling in different directions." • Sustaining an organisation-wide approach; "Maintaining momentum over that time, and ensuring that staff, patients and external stakeholders remain engaged and supportive of the programme, arguably requires as much effort and skill as it takes to get it underway"	
The Health Foundation 2021[50]	People in the UK	QI	10 principles to underpin the effectiveness of QI; The Habits of improvers	The report describes some of the popular approaches to QI and explores some of the factors that can help ensure successful implementation. They suggest the following 10 principles to underpin the effectiveness of QI. 1. **Understanding the problem**; the use of fishbone diagrams, process mapping and interviews is useful. 2. **Designing improvement**; plan with clear aims 3. **Data and measurement** for improvement; vital elements of any attempt to improve performance of quality begin with capturing a baseline	Report, providing a comprehensive overview of relevant approaches, methods and tools to support QI in healthcare settings.

				4. **Implementing reliability**; this mitigates against waste and defects in the system, and reduces error and harm 5. **Demand, capacity and flow**; there needs to be a detailed understanding of the variation and relationship between demand, capacity and flow 6. **The relational aspects of improvement**; specifically, how communication and support can influence success 7. **Involving and engaging staff**; Breaking down traditional hierarchies for this multidisciplinary approach is essential 8. **Co-producing environment**; through creating a shared purpose with a multidisciplinary team 9. **Building effective teams**; by treating each other with respect and courtesy and valuing ideas. These behaviours can be critical to working effectively, disagreements should be resolved through open discussion 10. **Collaboration**; Working collaboratively and outside of traditional organisational boundaries often provides the basis for understanding and addressing improvement challenges The report emphasises the importance of both technical and relational skills for conducting QI; they highlight key improvement habits, which are summarised in Figure 2 below in order to successfully launch and sustain QI activities: The Habits of improvers (Jones, Kwong & Warburton, 2021)	The authors do not detail how they identified these nor how they determined which ones were relevant to their report.
The Health Foundation 2022[51]	People in the UK	QI	An organisational culture of improvement	Three important enablers for building and sustaining organisation-wide improvement: 1. a strong culture of peer learning and knowledge sharing 2. a visible and sustained leadership commitment to improvement programmes 3. focused improvement priorities and metrics, aligned with organisational and national objectives Five recommendations for national and local leaders: 1. Improvement and innovation initiatives at organisation, system and national level should be part of an integrated transformation strategy and delivery agenda	Case study

				2. Organisation- and system-wide transformation initiatives should be prefaced by efforts to foster a culture in which peer learning and knowledge sharing are encouraged and supported 3. New leaders in challenged organisations and systems need strong, visible and sustained support from local partners and national bodies while they establish themselves and build their strategic confidence 4. Middle managers need to be closely involved from the start in the planning and implementation of organisation- and system-wide transformation initiatives 5. Strengthening the priority setting and measurement capability of organisations and systems needs to be a priority	
KMPG 2019[52]	Healthcare organisations, global	CI	Improvement culture during global healthcare challenges	*"Building a continuous improvement culture is not a turnaround project or a quick fix but a journey which never really ends, requiring commitment, investment, and persistence… **Continuous improvement is driven and owned by frontline staff, reinforced by specialised, ongoing training and supported by the entire organisation** - starting with the board and the chief executive and permeating everywhere from the finance and HR departments to the IT team." – (18:2019, KPMG)* 12 'foundational truths' to launch or sustain continuous improvement: On Implementing a continuous improvement culture: 1. Creating a new **end-to-end management system** – not just a process improvement team 2. Get **senior leaders' commitment to change themselves**, not just changing others 3. Go slower to go fast – **balance** thinking, planning, and doing over a multi-year journey 4. Create a **common language** staff understand – communicate to get staff buy -in 5. **Tailor the training** – anticipate staff engaging differently and plan ongoing coaching and support to develop the continuous improvement habit 6. Demonstrate early impact – **measure and report** On Sustaining a continuous improvement culture: 7. Pick fewer priorities and stick to them – **focus efforts** to drive real change 8. **Embed change at all levels** – support middle managers to understand the change process **9.** Align your organisation to deliver your 'True North' – ensure that improvement work on the shop floor reflects the **overall strategy** 10. **Engage and empower** patients – help them to help staff focus on improvement work 11. Technology can support improvement, but get your **management systems and culture** in order first	Report, interview senior health system leaders (n=20), site visits

				12. Remember there are no quick fixes – **allow time** for your organisation to understand, adapt and reflect. Leadership behaviors are central to success Personal A3 & self assessment; Constancy of purpose; True north — strategic aims; Transparency through visual management; Focus on the process; Scientific thinking; Lead with humility; Seek perfection; Ensure quality at the source; Think systemically; Leader standard work; Respect for every individual Leadership behaviours are central to success (Burrill, Parker & Fitzgerald, 2019)	
McKinsey & Company 2022[53]	Pharma Industry, global	QI	How to embed quality culture	Three challenges to building a culture that's receptive to QI: • Difficulties in sustaining QI seen as burdens for functions outside quality specific roles • Focus on direct organisational costs • Seen as a non-core effort and undertaken with the minimum effort Successful organizations design and tailor approaches that match their unique cultures. While these approaches vary, they share three major phases: 1. **Assessments of mindsets, behaviors, and capabilities**; undertaking of a multifaceted assessment of key practices to surface cultural and structural issues. "When carrying out these assessments, it's important to surface insights at the unit level. While the overall architecture of the effort needs to be consistent across the organization, function and unit-specific assessments are critical for customizing initiatives to address localized issues" 2. **Pan-enterprise visioning**; establishing a pan-enterprise vision that is shared and aligned across the organisation. "Visioning and aspiration-setting workshops can identify gaps between the desired end state and current performance levels" 3. **Cultural and structural quality interventions**; With "leaders to jointly design and deploy cultural and structural interventions to deliver against the aligned goals" utilizing "adaptive approaches… algorithmic learning… leading-outcome metrics and indicators"	Report, assessed 34 pharmaceutical plants worldwide using undisclosed analysis and observation techniques The findings in this report are based on the assessment of global pharmaceutical companies. The extent to which they are relevant and applicable to the context of UK-based healthcare sector is questionable
The Hackett Group 2022[54]	Digital world class companies	CI	Digital World Class organizations excel at realizing	Six enablers of continuous improvement have been identified: • Define credible and **measurable** opportunities: "Targets for improvement must start with the business strategy" and "The right metrics and measures are key to facilitating improvement." The article stress "To sustain progress, it is important to aim for quick wins while pursuing the larger, long-term opportunity."	Enterprise strategy, 19,750 benchmarking studies

			benefits from continuous improvement programs where others struggle to start, sustain and achieve the anticipated benefits.	• Engage a **sustainable improvement methodology:** "Having this framework in place helps avoid common disconnects that may have caused past continuous improvement efforts to stumble." • Establish **accountability** for outcomes and celebrate successes: "Initiatives to achieve a specified target should include clear definition of ownership and accountability" and "Calling attention to a successful program that delivers expected outcomes is imperative. This highlights the wins of the program to build traction, offers education on what the program accomplished, provides positive reinforcement for colleagues, encourages others to lead change and promotes a culture of improvement." • Have the right level of **executive sponsorship:** "This individual communicates progress to the executive team, leads frequent executive discussion about the program and provides visible support to those accountable for delivering outcomes, as well as the rest of the organization." • Create a **dedicated** transformation organization to motivate and manage change: "This office should include a mix of process and program management expertise supported with proven program management methodology and tools." • Leverage a platform that can digitize and **link the triad**: benchmarking, continuous measurement, and transformation: "An effective technology platform for managing continuous improvement should be simple, smart and fast, and should bridge the gap between basic KPI dashboarding and the ability to drive ongoing transformation and improvement." Aligning the six elements helps to move organizations from a one-time, project-based orientation to a true continuous improvement mindset that is omnipresent in the organization. The continuous improvement approach illustrated in Fig 4 in Hackett Group's article "links the essential concepts of defining scope and objectives to improving and monitoring performance. At its core are the Lean Six Sigma principles.  Continuous improvement methodology (Kellaway, Shevlin, Wooten & Dorr, 2022	

Appendix 5. Impact Factors of academic articles included

Impact Factor range	Impact Factor & Journal (no. of times journal features in included articles) (n=1) where not stated
3 and over (n=14)	8.03 Hospital Pediatrics[11] 6.582 American Journal of Roentgenology[9] 5.128 Journal of General Internal Medicine (n=2)[13,40] 4.525 Implementation Science (n=3)[24,32,44] 3.97 BMC Geriatrics (n=2)[34,37] 3.747 Surgical Endoscopy[10] 3.464 Business Process Management Journal[41] 3.325 Nursing Management[36] 3.325 Journal of Nursing Management[35] 3.13 BDJ Open[15]
Less than 3 (n=16)	2.839 Journal of Pediatric Gastroenterology and Nutrition[33] 2.753 Processes[38] 2.744 Burns[27] 2.51 JMIR Human Factors[43] 2.419 International Journal of Health Policy and Management[31] 2.194 Healthcare[29] 2.012 Healthcare: The Journal of Delivery Science and Innovation[12] 1.728 Journal of Nursing Care Quality[20] 1.681 Journal of Evaluation in Clinical Practice[30] 1.51 BMJ Open Quality (n=2)[17,22] 1.252 American Journal of Medical Quality (n=2)[16,39] 1.14 Hand[28] 1.056 Journal of Graduate Medical Education[21] 1.028 Journal for Healthcare Quality[14]
Unclear (n=6)	Pediatric Quality & Safety (n=2)[19,42] Journal of Public Participation in Health Care and Health Policy[18] Journal of Patient-Centered Research and Reviews[25] Implementation Science Communications[23] Future Healthcare Journal[26]

CLINICAL GOVERNANCE COMMITTEE TERMS OF REFERENCE

1. Remit

1.1 The National Services Scotland (NSS) Clinical Governance Committee (CGQIC) is established in accordance with the guidance given in MEL (1998) 75, reinforced by MEL (2000) 29, and is established as a committee of the NSS Board.

1.2 The purpose of the Committee is to provide assurance to the NSS Board that the clinical activities of NSS are appropriately governed and monitored as to their safety, quality and effectiveness and that Quality Improvement and Realistic Medicine are at the core of its work.

2. Membership

Membership

2.1 Membership shall comprise six non-executive members of the Board, including the Board Chair. The Committee Chair shall be nominated by the Board Chair and thereafter confirmed by the Board. The Committee will then select a Vice-Chair from among the membership to deputise for the Committee Chair as required.

Attendees

2.2 The Medical Director and Director of Nursing shall be the lead executive officers to the Committee and will arrange for such other officers to attend as required by the business of the committee.

3. Quorum

3.1 The Committee is quorate when there are three non-executive Board members present.

4. Meetings

Frequency of Meetings

4.1 The Committee shall meet as required but not less than four times a year.

Minutes of Meetings

4.2 Minutes of the proceedings of the Committee shall be drawn up by or on behalf of the Board Secretary and submitted for approval to the next meeting of the Committee.

4.3 The Minutes of the Committee will be presented for information to the next scheduled meeting of the NSS Board, in either confirmed or

unconfirmed format, as the means of updating the Board on the work of the Committee.

Private Meetings

4.4 The Committee may agree to meet in private to consider certain items of business without any non-members present.

4.5 The minutes of the meeting will reflect when the Committee has resolved to meet in private.

5. Reporting

5.1 The CGC is to report activities and progress annually to the NSS Board as described in these terms of reference. The CGC is to determine the style and content of these reports, subject to guidance and direction by the NSS Board.

5.2 The CGC will produce an Annual Report of the Committee's activities to provide assurance as set out in remit at 1 above for inclusion in NSS Annual Report and Accounts.

6. Key Duties

6.1 The CGC will provide assurance to the Board that:

6.1.1 Process and reporting arrangements are in place, as required, in order to provide assurance that the clinical and related activities under NSS direction and control are at all times appropriately governed and monitored as to their safety, quality and effectiveness.

6.1.2 All aspects of clinical Quality Management are reflected including Quality Planning, Quality Improvement and Quality Control and the application of the principles of Realistic Medicine.

6.1.3 Clinical activity is challenged from the perspectives of equity, inequality/ equality, diversity, and value (expressed as triple value).

6.1.4 Services compliance with clinical regulatory requirements is in place.

6.2 The CGC will provide advice, as required, to the Board on the clinical impacts of any new service developments proposed for adoption by NSS.

6.3 In order to assure themselves, the CGC will review and scrutinise reports on:

6.3.1 Clinical adverse events, Duty of Candour events, clinical risks and complaints (related to safety of services or clinical staff fitness to

practice) including their identification, causes, management, learning identified and service improvement and implementation.

6.3.2 Blood and tissue safety to satisfy itself that appropriate action is being taken to provide an adequate and safe supply.

6.3.3 Healthcare Acquired Infection in NSS as per required national policy on HAI, using the HAI reporting template.

6.3.4 Major NSS programmes in support of clinical services.

6.3.5 Activity relating to national clinical governance functions delivered by NSS, e.g., screening, and dental.

6.3.6 Annual reports on:

- Infection Prevention and Control
- Duty of Candour
- Research, Development, and Innovation
- Clinical Professional Appraisal and Revalidation
- Medical Staff Revalidation and Appraisal
- Patient Group Directions Audit
- IR(M)ER Advisory Group
- Relevant Intellectual Property activity facilitated by SNBTS.

NHS National Services Scotland

Meeting:	**NSS Board**
Meeting date:	**30 June 2023**
Title:	**Integrated Performance Report – May 2023 (M2)**
Paper Number:	**B/23/16**
Responsible Executive:	**Lee Neary, SPST Director**
Report Author(s):	**Caroline McDermott, Head of Planning**
Reviewed by:	**Carolyn Low, Finance Director** **Jacqui Jones, HR & Workforce Development Director** **Julie Critchley, NHS Scotland Assure Director**

1. Purpose

1.1 The Integrated Performance Report (IPR) summarises NSS service, finance, people, and environmental performance at the end of May 2023 (M2) and also references achievements at year end, March 2023 (M12), where appropriate.

2. Recommendation

2.1 It is recommended that the Board scrutinise and note NSS performance at the end of May 2023 and where applicable March 2023.

3. Executive Summary

3.1 NSS performance is positive across the majority of areas

3.1.1 NSS performance remains positive with 22 out of 26 performance indicators across service, finance, people, and environmental measures achieving or exceeding targets. This is an improved position since the last report which showed 19 out of 27 indicators as achieving or exceeding targets (with the removal of the Covid-19 revenue indicator). and shows that our ongoing focus on performance management at all levels of the organisation is helping to avert the potential adverse impacts identified in the previous report.

3.1.2 Highlights for this report include:

- 94% of our Annual Delivery Plan 22/23 (ADP) has been achieved or continues as planned, which is beyond 90% standard we set ourselves.

- Service user engagement scores remain above standard and stable. There has been a small increase in satisfaction and net promoter score with a small reduction in effort scores due to further surveys within Practitioner and Counter Fraud (PCFS) services.

- We achieved in full all statutory financial targets for 2022/23 and at this early stage of the year are also forecasting to achieve these targets in 2023/24.

- NSS remains in a positive and improved position on a range of workforce areas with statutory and mandatory training achieving or exceeding standards. Turnover has reduced since the last report.

- NSS climate sustainability indicators continue to demonstrate a reducing trend in fuel CO2 emissions, with the impacts of increased office use and seasonal variations noted.

3.1.3 Generally, performance is stable across all indicators with four indicator ratings improving since the last report – Annual Delivery Plan performance; sickness absence; turnover and annual leave utilisation.

3.1.4 Overall, this is a good position for NSS given the challenges in the wider macro-economic and health and social care environment in which we operate.

3.2 Workforce indicators are improving.

3.2.1 The fiscal year-to-date sickness absence rate for May 2023 was 4.04%, marginally above the NHS Scotland standard of 4%. The mean across all services is 3.0% with most directorates sickness absence at or below this rate. Procurement, Commissioning and Facilities (PCF) at 5.90%. P&CFS and SNBTS are also above the mean. With HR support, interventions have been in place in PCF to reduce sickness absence and this has improved from a position of 6.50% in May 22. The focus in SNBTS is on helping them to address the recruitment challenges they face in Patient Services Laboratories) and Manufacturing. Based on the previous three years of absence data the forecast is to finish the year at 3.69% for NSS.

3.2.2 As can be seen from the tables below, since the last report there is an improving position in relation to turnover, at 1.46% in May, which is in part be due to the refocused role of NCC. Directorates have been asked to push for an improved position on appraisal, objective setting, and PDP compliance.

3.3 Climate Sustainability targets impacted by increased useage

3.3.1 Due to a rise in office attendance from the previous years, the Domestic Waste Total (tonnes) category saw an increase in total waste. In addition, Gas CO2 (tonnes) - Metered Sites saw an increase in gas use from previous years, likely

due to January 2023 and March 2023 having lower outside temperatures. Furthermore, the Water M3 (volume) - Metered Sites saw an increased in use due to changes in estimated billing across all sites, plus increased usage at JCC which was reflected in the annual demands.

3.4 Service Excellence (Appendix A)

Performance Indicator	Standard	This report	Last report
Annual Delivery Plan Completion (Quarterly: Q4 position)	**90%**	**94%**	81%
User Satisfaction Score (Rolling: M12 position)	**70%**	**74.1%**	73.9%
User Effort Score (Rolling: M12 position)	**62%**	**62.2%**	65.3%
Net Promoter Score (Rolling: M12 position)	**0%**	**18.4%**	18.2%
Complaints Responded to Within 3 Days (Quarterly: Q4 position)	**90%**	**100%**	90%
Staff Behaviour and Attitude Complaints (Quarterly: Q4 position)	**10**	**6**	10

3.5 Financial Sustainability (Appendix B)

Performance Indicator	Forecast	This report	Last report
NSS Revenue Outturn (Core) (Monthly: M2 position)	**£0m**	**£(0.7)m**	£8.9m
NSS CRES Savings Total (Monthly: M2 position)	**£7.8m**	**£0.9m**	£4.8m
NSD CRES Savings Total (Monthly: M2 position)	**£10.4m**	**£0m**	£7.9m
NSS Capital Outturn (Monthly: M2 position)	**£0m**	**£0.02m**	£0.3m

Please note there is an overspend of £726k in month 2, however the forecast remains break even.

3.6 Workforce Sustainability (Appendix C)

Performance Indicator	Standard	This report	Last report
Sickness Absence (Monthly: M2 position)	**4%**	**3.98%**	4.3%
Staff Turnover (Cumulative: M2 position)	**7%**	**1.64%**	27.8%
Annual Leave Utilisation (Cumulative: M2 position)	**100%**	**18%**	77%
Appraisal Compliance (Monthly: M2 position)	**90%**	**78%**	79%
Objective Setting Compliance (Monthly: M2 position)	**90%**	**80%**	79%
Personal Development Plan Compliance (Monthly: M2 position)	**90%**	**80%**	77%
Statutory Training Compliance (Learnpro Monthly position at 20 February)	**90%**	**94%**	94%
Mandatory Training Compliance (Learnpro Monthly position at 20 February)	**90%**	**90%**	90%

3.7 Climate Sustainability (Appendix D)

Performance Indicator	Target	This report	Last report
Domestic Waste Total (tonnes) (Rolling: March position)	**Reduce**	**254.7**	258
Domestic Waste to Landfill (Rolling: March position)	**≤5%**	**0%**	0%
Domestic Waste Recycled or Composted (Rolling: March position)	**>70%**	**80%**	81%
Fuel National Procurement Fleet CO2 (tonnes) (Rolling: March position)	**Reduce**	**1,274**	1,290
Fuel SNBTS Fleet CO2 (tonnes) (Rolling: Feb position)	**Reduce**	**337**	343
Gas CO2 (tonnes) – Metered Sites Only (Rolling: March position)	**Reduce**	**2,158.3**	1,856
Electricity CO2 (tonnes) – Metered Sites Only (Rolling: March position)	**Reduce**	**1,647**	1,862
Water M3 (volume) – Metered Sites Only (Rolling: March position)	**Reduce**	**19,794**	13,706

4. Impact Analysis

4.1 Quality/ Patient Care

4.1.1 The Clinical Governance Committee provides oversight for all quality and patient care performance.

4.2 Equality and Diversity, including health inequalities

4.2.1 Projects and services associated with the measures covered by this paper are required to carry out an equality impact assessment. There are no specific issues arising from this performance paper.

4.3 Data protection and information governance

4.3.1 This paper contains management information only. All projects and programmes of work covered by this paper are reviewed for any data protection or information governance risks or implications and are therefore reported at a programme/project level. These are therefore not reported in this document.

5. Risk Assessment/Management

5.1 Risks are managed in line with the Integrated Risk Management Approach

6. Financial Implications

6.1 Details within Finance Report.

7. Workforce Implications

7.1 Details within People Report.

8. Climate Change and Environmental Sustainability Implications

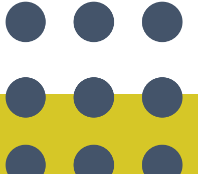
8.1 Details within Sustainability Report.

9. Route to Meeting

9.1 This paper was discussed at the Executive Management Team at their meeting in June. The supporting reports included in the Appendix have been discussed at EMT and respective Committee meetings.

10. List of Appendices and/or Background Papers

10.1 Appendix A – NSS Service Excellence (M2)
Appendix B – NSS Financial Sustainability (M2)
Appendix C – NSS Workforce Sustainability (M2)
Appendix D – NSS Climate Sustainability (M12)

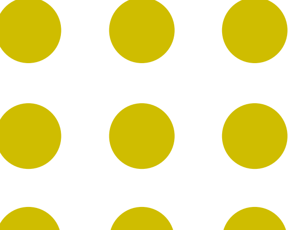


Service Excellence M2 FY24 & Annual Delivery Plan M12 FY23

APPENDIX A

NSS Planning and Performance

June 2023



May Update

M2 FY24

- **For Service Excellence,** all performance standards continue to remain on target, apart from **FOI Acknowledged.**

- **ADP 22 / 23 at M12,** showing **94% of milestones** have been achieved.

- **FOI Reponses within 20 Days** has begun the year on target continuing their strong and consistent performance from last year. **FOI Requests Acknowledged within 3 days** was below standard for the month (M2) due to two requests not being addressed to the FOI team directly and required to be rerouted. The correct process has been reclarified to the receiving area for one request. The other requests was contained in legal correspondence and was not identified as an FOI request in the first instance. This process has also been clarified.

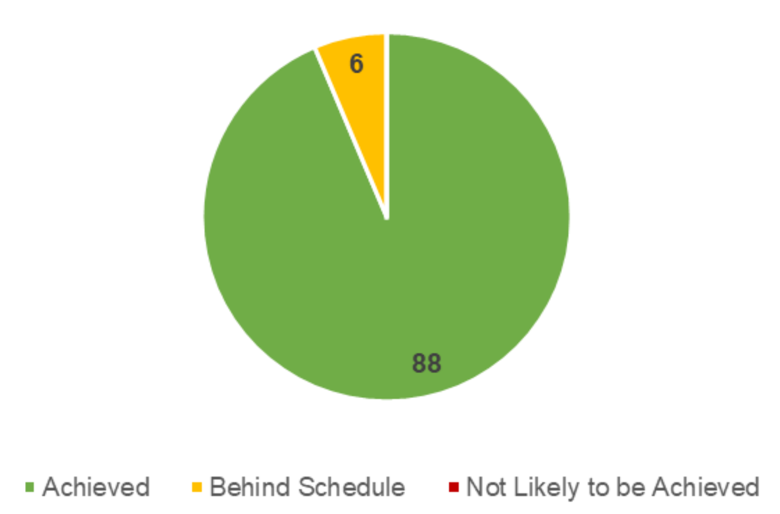
- After the considerable improvement throughout the year in **User Effort** scores and with **User Satisfaction** scores remaining stable, overall **Customer Insight** performance finished the year above target for all metrics.

- **Complaints Acknowledgment** achieved standard in every quarter this year.

- **Complaints regarding Staff Behaviour & Attitude** have reduced over the last quarter and are now ahead of standard.

Annual Delivery Plan Performance

End of Year 2022/23 Summary



We achieved the majority of the 94 milestones in our Annual Delivery Plan for 2022/23 (FY23):

- **94% (88)** of milestones were achieved or were on target at year end (green) – see slides 4, 5 and 6.
- **6% (6)** of milestones were behind schedule (amber) – see slide 7.
- **0% (0)** of milestones were not likely to be achieved (red).

- This year our performance was measured against 94 milestones. Originally there were 88, however, changes were agreed with Scottish Government to amend several milestones and increasing the overall total for FY23 – see slides Appendix 1.

- Our results also exclude 5 milestones that are being carried forward into FY24 and 2 milestones that were paused (Appendix 1).

- The following milestones are being carried forward due to their continuous nature and recent agreement on funding (for cancer pathways).
  - Improving the security of supply of immunoglobulin.
  - Implementing the NHS Scotland Capital Delivery Strategy over the next 5 years.
  - Implementing the Community Health Index (CHI) system.
  - Implementing new cancer pathways for genomic testing.

- Two CIVAS+ Programme milestones are paused following recommendations to the NHS Scotland Board Chief Executives by the Programme Board – see Appendix 1.

Annual Delivery Plan Performance

2022/23 achievements

- **Deliver improvements in support of the Primary Care Portfolio Plan.** All milestones achieved including new model of eyecare services and improvements in payment processing and achieving 99.5% accurate payments processing.
- **Deliver at least £4 million of savings through counter fraud measures**. £4.5m achieved.
- **Develop a procurement net zero transformation T-Map.** T-Map finalised in April 2022 and approvals gained by June 2022.
- **Deliver social value in 90% of all procurement contracts worth over £1m.** Achieved. Training, communication and all contracts over £1m included a social value element from March 2023.
- **Deliver £10m of secured savings and £20m of cost avoidance savings in procurement to support NHS Scotland achieve financial sustainability.** Achieved.
- **Implement a payroll service for South East Scotland.** First phase completed with staff TUPE transferred to NSS in February.
- **Progress financial sustainability.** On track for break even. Financial Sustainability Action Plan developed and implemented and work will continue to support financial stewardship. We have agreed a balanced 3 year budget.
- **Deliver agreed work plans for each of the 6 ARHAI priority programmes.** Achieved.
- **Develop and implement a NHS Scotland Climate Emergency and Sustainability Strategy and associated delivery plans for 2022-2026**. Strategy and delivery plans delivered.
- **Deliver a minimum viable product for Scotland Innovates to provide oversight and guidance on pan public sector, supplier led innovations across Scotland.** Digital portal in place and in use across public sector. Project to be closed following agreement with Scottish Government.
- **Establish and provide Innovation Services and resources to improve the pace of delivery and adoption of health and care innovations across Scotland.** Tools, resources and approach agreed and innovation canvas in place. Continued working with ANIA partners.

Annual Delivery Plan Performance

2022/23 achievements

NHS National Services Scotland

- **Provide international and cross border Mesh removal services**. Access gained to Bristol Spire and to service in the US.
- **Deliver National Strategic Networks for neonatal and maternity care with agreed governance and accountability arrangements**. Objectives and workplan agreed.
- **Ensure commissioned specialist services are at 80% of pre-COVID-19 service agreement activity levels.** High priority services were at 87% and diagnostic services achieved 100%.
- **Ensure nationally commissioned screening programmes are achieving 80% of pre-COVID 19 activity levels.** Breast Screening allocations are at 97.5% and bowel screening has achieved 106% against pre-pandemic levels.
- **Design and implement a new Scottish Cancer Network (SCN**). Managed Clinical Networks are in place for 5 cancers. A repeatable national Cancer Management Pathways approach has been developed and applied in 3 cancer areas – lung, breast and neuro-oncology – and are ready for local board and/or regional adoption.
- **Deliver year 2 of the Digital Prescribing and Dispensing Pathways workplan.** NSS partnered with NES Technology to complete activity on service design and levels 1 and 2 solution architecture design to replace paper prescriptions with a digital solution in all community settings. A benefits and measurement strategy is in place. The initial focus is on the end-to-end pathway across in-hours static GP practice prescribing and community pharmacy dispensing.
- **Delivery year 1 of the Scan for Safety workplan to improve patient safety.** NSS led a national programme to enhance the traceability of medical devices through point of care scanning and digital data capture by utilising GS1 global standards. New standards are ready, suppliers are aware and an inventory management system has been implemented. A Medical Devices Data Hub has been designed.
- **Lead the development of a 10 year National Board Property and Asset Management Strategy.** Outline business case complete.

Annual Delivery Plan Performance

2022/23 achievements

- **Provide programme management and service transformation services to Radiology to support the effective delivery of national health and care programmes.** Imaging AI Playbook published with toolkit deployed. National dashboard recommendations agreed. Golden Jubilee part of Radiographers information Bank. 'Advancing Radiographers' project to look at demand/workforce pressures ongoing.
- **Deliver the GPIT & PACS national digital programmes in support of the Digital Strategy for Health and Social Care.** Programmes remain on schedule.
- **Deliver the Business Systems digital programmes in support of the Digital Strategy for Health and Social Care.** Outline business case agreed.
- **Continue the rollout of the Cyber Centre of Excellence (CCoE) programme and build maturity in cyber security**. On track. New Centre opened in December.
- **Continued NIS audit compliance and action plan implementation for NSS**. On track.
- **Enable COVID-19 recovery and future preparedness across health and care in Scotland.** Autumn/Winter 2022/23 vaccination programme complete with uptake of 72%+ across all cohorts (80%+ in over 75s and 90%+ in care home residents). Supported targeted outbound calls to high risk patients. Delivered digital platform changes to support forthcoming COVID-19 booster Spring 2023 campaign. Wastage review of flu and COVID-19 vaccines delivered. Remaining Test & Protect services operating in line with Scottish Government steady state. Support for Isolation Support Grant and Pulse Oximetry digital onboarding decommissioned. VAM (variants and mutations services) in place. Funding confirmed and right-sizing exercise carried out to reduce core staff to 63WTE. Staff bank closed. Procurement of two new contact centre contracts for 2023/24 completed – existing contractor retained and new contractor onboarding to start in April 2023.
- **Implement new cancer pathways for genomic testing.** New cancer pathways have been mapped and costed and the implementation phase will be captured in our FY24 ADP following agreement and allocation of funds.

Annual Delivery Plan Performance

Milestones that were behind schedule at year end

Deliverable	Milestone	Commentary
Provide programme management and service transformation services to Radiology to support the effective delivery of national health and care programmes.	Deliver the first iteration of a Diagnostic Imaging Workforce Plan by March 2023.	Delayed to April 2023 due to the additional time required for a comprehensive review of the plan.
Deliver the eRostering national digital programmes in support of the Digital Strategy for Health and Social Care.	Rollout Year 1 of the implementation plan with suppliers and successful integrate National Board systems.	An outline business case was delivered. Implementation is proceeding but has been delayed to September 2023 due to issues with supplier engagement support.
Deliver NSS SharePoint migration.	Complete SharePoint migration in NSS.	Migration behind schedule due to resourcing and budget issues, mitigation plan in place to return to schedule.
Deliver the seer v2 migration national digital programmes in support of the Digital Strategy for Health and Social Care.	Migration to seer v2 by March 2023.	seer v2 migration was delayed for technical reasons and we expect to complete the programme by July 2023. seer v1 supporting infrastructure has been upgraded to ensure continuity of service.
Deliver the Child Health national digital programme in support of the Digital Strategy for Health and Social Care.	Continue to deliver Child Health to plan.	A new delivery timeline is pending approval by Health Boards and the Programme Board. The design phase nearing completion and the build and test phase is expected to begin within the next month. The new target go-live date is winter 2024 with a deadline of March 2025.
Ensure the recovery and effective remobilisation of all Specialist and Screening Services in support of NHS Scotland.	All commissioned specialist services at 80% of pre-COVID-19 service agreement activity levels by March 2023.	Elective services were at 75% at year-end due to Boards needing to make decisions in line with the clinical prioritisation process for non-urgent surgery. Updated remobilisation plans are in place within each board and we are regularly reviewing action plans.

NSS Performance

M2 FY24

Key Performance Indicators	Latest	Standard	Variation	Assurance	M7 Performance
NSS User Satisfaction Score (Rolling: M12 FY23 position)	**74.1%**	**70%**			**Meeting Standard**
NSS User Effort Score (Rolling: M12 FY23 position)	**62.2%**	**62%**			**Meeting Standard**
NSS Net Promoter Score (Rolling: M12 FY23 position)	**18.4%**	**0%**			**Meeting Standard**
NSS Complaints – Acknowledged Within 3 Days (Quarterly: Q4 FY23 position)	**100%**	**90%**			**Meeting Standard**
NSS Complaints – Staff Behaviour and Attitude (Quarterly: Q4 FY23 position)	**6**	**10**			**Meeting Standard**
NSS FOI – Requests Acknowledged Within 3 days (Monthly: M2 FY24 position)	**94.1%**	**100%**			**Meeting Standard**
NSS FOI – Responses Greater than 20 Days (Monthly: M2 FY24 position)	**0**	**0**			**Meeting Standard**

KEY

VARIATION

Area of Improvement
Results are showing a general Positive trend in performance.

Area of Concern
Results are showing a general negative trend in performance.

Common Variation
Results show no major change in either direction at present.

ASSURANCE

Meeting Standard
The metric is consistently meeting the agreed standard.

Missing Standard
The metric is consistently missing the agreed standard.

Variable Achievement
Results are mixed and it is unclear if the standard will be consistently achieved.

NSS Freedom of Information

Requests acknowledged within 3 days (M2 FY24)

STANDARD 100%

101.0%
99.0%
97.0%
95.0%
93.0%
91.0%
89.0%

MEAN

LOWER LIMIT

31/01/22 28/02/22 31/03/22 30/04/22 31/05/22 31/06/2022 31/07/22 31/08/22 30/09/22 31/10/22 30/11/22 31/12/22 31/01/23 28/02/23 31/03/23 30/04/23 31/05/23

PERFORMANCE

Common Variation

Variable Achievement

FOI Requests acknowledged in 3 days	
Description	Freedom of Information (FOI) requests received from the public for which the acknowledgement time was greater than 3 working days. Requests are received in writing, through email or through social media.
Calculation Method	FOI requests acknowledged within 3 working days divided by the total number of FOI requests received in the period.
Frequency	Monthly.

NSS Freedom of Information

Responses greater than 20 days (M2 FY24)

STANDARD 0

3
2
2
1
1
0

UPPER LIMIT

MEAN

31/01/22 28/02/22 31/03/22 30/04/22 31/05/22 31/06/2022 31/07/22 31/08/22 30/09/22 31/10/22 30/11/22 31/12/22 31/01/23 28/02/23 31/03/23 30/04/23 31/05/23

PERFORMANCE

FOI responses greater than 20 days	
Description	Freedom of Information (FOI) requests received from the public for which the response time was greater than 20 working days. Requests are received in writing, through email or through social media. Requests for any information held by NSS.
Calculation Method	Count of requests with a response time greater than 20 working days.
Frequency	Monthly.

NSS User Insight
Satisfaction (M12 FY23)

STANDARD 70%

90.0%
85.0%
80.0%
75.0%
70.0%
65.0%

UPPER LIMIT
MEAN
LOWER LIMIT

30/04/20 31/05/20 30/06/20 31/07/20 31/08/20 30/09/20 31/10/20 30/11/20 31/12/20 31/01/21 28/02/21 31/03/21 30/04/21 31/05/21 30/06/21 31/07/21 31/08/21 30/09/21 31/10/21 30/11/21 31/12/21 31/01/22 28/02/22 31/03/22 30/04/22 31/05/22 30/06/22 31/07/22 31/08/22 30/09/22 31/10/22 30/11/22 31/12/22 31/01/23 28/02/23 31/03/23

PERFORMANCE

Satisfaction Score	
Description	Annual satisfaction score achieved by NSS services.
Calculation Method	User ratings of 4 and 5 divided by the total number of responses. Scoring scale is 1 to 5. The NSS Score is based on all services, which are weighted according to the service's percentage of NSS revenue. Score is updated following each new survey.
Frequency	Annually.

NSS User Insight
Effort (M12 FY23)

STANDARD 62%

UPPER LIMIT
MEAN
LOWER LIMIT

85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%

30/04/20, 31/05/20, 30/06/20, 31/07/20, 31/08/20, 30/09/20, 31/10/20, 30/11/20, 31/12/20, 31/01/21, 28/02/21, 31/03/21, 30/04/21, 31/05/21, 30/06/21, 31/07/21, 31/08/21, 30/09/21, 31/10/21, 30/11/21, 31/12/21, 31/01/22, 28/02/22, 31/03/22, 30/04/22, 31/05/22, 30/06/22, 31/07/22, 31/08/22, 30/09/22, 31/10/22, 30/11/22, 31/12/22, 31/01/23, 28/02/23, 31/03/23

PERFORMANCE

Effort Score	
Description	Annual Effort Score achieved by NSS Services. Used to measure the ease of service experience of the user with the NSS.
Calculation Method	User ratings of 4 and 5 divided by the total number of responses. Scoring scale is 1 to 5. The NSS Score is based on all services, which are weighted according to the service's percentage of NSS revenue. Score is updated following each new survey.
Frequency	Annually.

NSS User Insight
Net Promoter (M12 FY23)

STANDARD 0%

35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

UPPER LIMIT
MEAN
LOWER LIMIT

30/04/20, 31/05/20, 30/06/20, 31/07/20, 31/08/20, 30/09/20, 31/10/20, 30/11/20, 31/12/20, 31/01/21, 28/02/21, 31/03/21, 30/04/21, 31/05/21, 30/06/21, 31/07/21, 31/08/21, 30/09/21, 31/10/21, 30/11/21, 31/12/21, 31/01/22, 28/02/22, 31/03/22, 30/04/22, 31/05/22, 30/06/22, 31/07/22, 31/08/22, 30/09/22, 31/10/22, 30/11/22, 31/12/22, 31/01/23, 28/02/23, 31/03/23

PERFORMANCE

Net Promoter Score	
Description	Percentage of users who would recommend the NSS to a friend or a colleague. Also known as User Advocacy.
Calculation Method	Percentage of promoters (5 rating) minus the percentage of detractors (1 to 3 rating). Scoring scale is 1 to 5. The NSS Score is based on all services, which are weighted according to the service's percentage of NSS revenue. Score is updated following each new survey. The score can range from -100% to 100%.
Frequency	Annually.

NSS Complaints
Acknowledged within 3 days (Q4 FY23)

STANDARD 90%

100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%

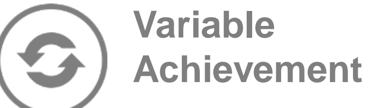
MEAN

LOWER LIMIT

30/06/20 30/09/20 31/12/20 31/03/21 30/06/21 30/09/21 31/12/21 31/03/22 31/06/22 30/09/22 31/12/22 31/03/23

PERFORMANCE

Common Variation


Variable Achievement

Response to Complaints	
Description	Part of Model Complaints Handling Procedure (MHCP). Tracks the percentage of complaints received which are acknowledged within 3 working days.
Calculation Method	Percentage acknowledged within 3 working days divided by the total number of complaints received.
Frequency	Quarterly.

NSS Complaints
Staff behaviours and attitudes (Q4 FY23)

STANDARD 10

18
16
14
12
10
8
6
4
2
0

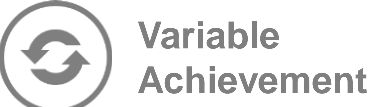
MEAN

LOWER LIMIT

30/06/20 30/09/20 31/12/20 31/03/21 30/06/21 30/09/21 31/12/21 31/03/22 31/06/22 30/09/22 31/12/22 31/03/23

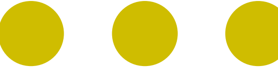
PERFORMANCE

Common Variation



Response to Complaints	
Description	Part of Model Complaints Handling Procedure (MHCP). Tracks complaints received regarding staff attitude and behaviour. Feeds into training requirements based on identified issues.
Calculation Method	Count of staff complaints received.
Frequency	Quarterly.

Appendix 1 - ADP



Appendix 1

Deliverable	New Milestone(s)	Change
Ensure the recovery and effective remobilisation of all Specialist and Screening Services in support of NHS Scotland	All nationally commissioned screening programmes are within 80% of pre-COVID-19 activity levels by March 2023. Milestone 1: Breast Screening – percentage of allocated appointments for each centre in 2022/23 as compared to the 2018/19 average. Milestone 2: Bowel Screening – number of tests performed in 2022/23 as compared to the 2018/19 total.	The milestone was split in two as the main pre-COVID-19 screening programmes are measured differently. This also enables us to better compare performance against pre-COVID-19 activity levels.
Ensure the recovery and effective remobilisation of all Specialist and Screening Services in support of NHS Scotland.	All commissioned specialist services at 80% of pre-COVID-19 service agreement activity levels by March 2023. Milestone 1: high priority services. Milestone 2: elective services. Milestone 3: lab diagnostic services.	The new milestones clarified the services being assessed and how they would be assessed. They also allow us to more accurately compare performance against pre-COVID-19 activity levels.
Implement 12 new cancer pathways for genomic testing.	Planning, mapping, and costing of cancer pathways delivered as per plan.	The funding for the programme along with an implementation plan was agreed with Scottish Government and the strategic network oversight board in the final quarter of FY23. The new milestone reflects the preparatory work undertaken in FY23. The implementation plan will feature in our FY24 ADP.

Appendix 1

Milestones we agreed changes to with Scottish Government

Deliverable	New Milestone(s)	Change
Improve the security of supply of immunoglobulin to NHS Scotland patients.	Support the UK tender process for a new immunoglobulin manufacturer.	The milestone now reflects our role in the UK procurement process and our support to UK Government who will be making the appointment.
Deliver year 2 of the Digital Prescribing and Dispensing Pathways (DPDP) workplan.	Develop the end-to-end DPDP Solution Architecture Indicative Design - Level 1 Design - September 22 - Level 2 Design - December 22	The Level 3 Design requirement was removed following a review by the DPDP Programme Board and funding was returned. It will now feature in our FY24 ADP.
Provide programme management and service transformation services to the Scottish Radiology Transformation Programme (SRTP).	Ensure Reporting Radiographers are part of the information bank where board regulations have been amended.	The revised milestone clarifies how we will measure performance and aligns with governance requirements in each health board.
Deliver the Community Health Index (CHI) & Child Health (CH) national digital programmes in support of the Digital Strategy for Health and Social Care.	Milestone 1: Community Health Index delivered to plan Milestone 2: Child Health delivered to plan	The milestones reflect the formal separation of the two programmes.

Appendix 1

Milestones that were paused

Deliverable	Milestone	Commentary
Provide programme management and service transformation services to support the effective delivery of the nCIVAS national health and care programme.	Produce an Initial Final Design. Deliver a complete Outline Business Case.	A decision was taken at the NHS Scotland Board Chief Executives meeting on 11th April 2023 to pause the programme. On this basis, the two milestones will not be taken forward.

NSS Financial Performance

APPENDIX B

May 2023

NHS National Services Scotland – Executive Management Team
Financial Performance – May 2023
Executive Summary

Performance Summary

At this early stage in the Financial Year, NSS is on track to meet it statutory Financial Targets:

Revenue

In the first reporting cycle of the year (May-23), NSS is overspent by £726k year to date but is still forecasting a break-even position for FY23/24

The main driver of the adverse YTD position is DaS (£1.2m over) where the Directorate has been unable (due to resource issues) to capture and supply information to allow Finance to process recharges for income generating services. DaS has confirmed that this information will be available and complete for Q1 reporting.

Capital

The capital plan is currently **oversubscribed by £0.1m** due to slippage from FY22/23. However, NSS is anticipating additional funding from SG (see Appendix 2) to cover the equipment replacement in SNBTS which is currently covered by NSS formula allocation

CRES

There are currently no concerns in terms of CRES delivery across core NSS and NSD targets – a key focus in FY23/24 is the enhanced tracking and reporting of savings.

Risks and Issues

Although NSS continues to forecast a break-even position in-line with its balanced budget for FY23/24, **this remains a challenge with challenging macro-economic conditions and other NHS Scotland budgets in deficit.** It is clear that NSS must continue to drive its Financial Sustainability objective across all areas of service

Although NSS has not yet received an allocation letter – baseline funding has been confirmed. The allocation tracker reports c£259m revenue funding from SG still outstanding – this is normal at this stage in the Financial Year – but there remains a risk until allocations are confirmed / received in full

NSS Targets	YTD £000's	Forecast £000's	RAG
Revenue **Outturn**	(726)	0	G
NSS CRES **Total**	868	7,804	G
NSD CRES **Total**	0	10,445	G
Capital **Outturn**	20	0	G

Key Messages

Detailed Budgets for FY23/24 has been finalised and loaded to the ledger ahead of the first reporting cycle of the year – **Budget Holders should access this detail via the Finance Dashboard**

The "one-off" payment for A4C staff was processed in April and was fully funded by SG with budget allocations to match expenditure

Finance continues to **drive the Financial Sustainability agenda** in a number of ways through an agreed action plan (see Appendix 1).

We are looking to **reduce reporting cycle times overall and have earlier / more dialogue with Key Decision Makers and Directors** in terms of their respective budgets and financial positions / forecasts. We aim to shift more time and focus from **YTD to Forecast** reporting

Clearly, **responsibility and accountability for budgets sits with delegated budget holders, not Finance**. We do understand that Directorates are at different stages of Financial Management maturity and **aim to work collaboratively around the principles set out in the Finance Charter** with actions for the business and actions for Finance aligned to respective responsibilities.

NHS National Services Scotland – Executive Management Team
Financial Performance – May 2023
SBU Operational Performance

Main Movements by SBU

The overall Directorate Trading position is a **YTD overspend of £0.7m**

DaS – the overspend of £1.2m is due to DaS resourcing issues - the recharges for income generating services were not completed for May's accounts, this is being addressed and will be processed for M3

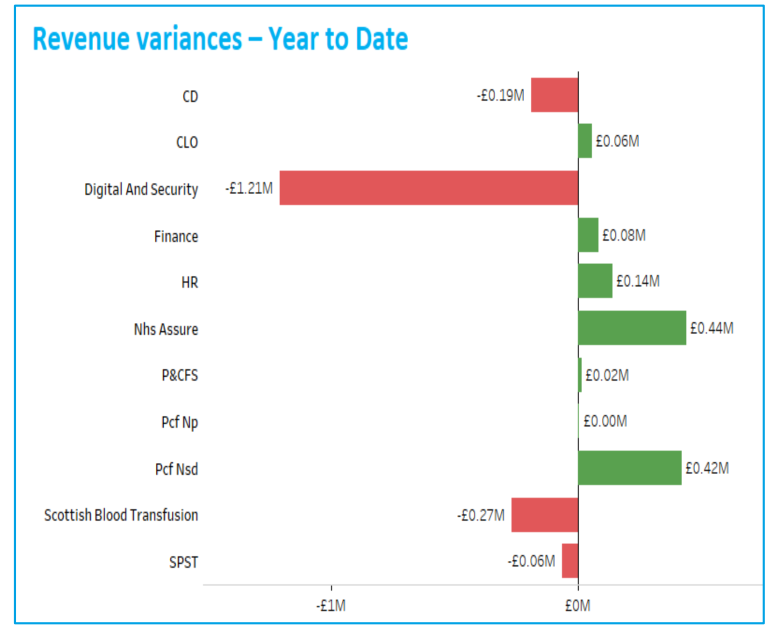
NHS Assure – reporting an underspend (£0.4m) mainly due to pay savings £0.5m with vacancies and recruitment the main drivers

NSD – £0.4m underspend relates to Pay vacancies and £0.2m and Non-Pay £0.2m due to under accrual of costs

SNBTS - deficit of £0.3m being driven Non Pay pressures (£0.5m) which are being investigated (some relate to coding / hierarchy changes and will be corrected for M3), offsetting this current pressure is additional HB and 3rd party customers Income £0.3m.

SPST - reporting a small pressure of £62k, this is mainly due to the under-recovery of income by PGMS within month 2 of £0.2m, which has been offset by vacancies in the other areas of SPST

NP – A breakeven position is reported for period 2 based on actual income and costs through the ledger. Detailed budgets are being finalised and checked with the business. These will be entered on the ledger for period 3 reporting.



Finance – £85k underspend due to vacancies £30k and additional Income on SLA's and SE Payroll income. The income variance will likely rectify in M3 as this was based on opening estimates

HR – reporting a YTD £142k underspend - predominantly driven by an underspend on pay due to vacancies

P&CFS – YTD a small underspend of £16k, This is due to vacancies which have been offset by overtime worked, in the main, by the Pharmacy Keying teams.

Clinical –YTD position is an overspend of circa £188k. The majority of this spend (totalling £176k) relates to Scottish Cancer Network - a project that sat within Clinical Directorate last year but has subsequently been moved to NSD. This expenditure will be transferred across to NSD once staff have been permanently moved across on all systems

CLO – is reporting underspend of circa £57k. This underspend is underpinned by three main variances. Firstly, income is sitting favourable to budget by £20k, secondly DAS have yet to charge us for the first two months of their services (estimate £12k) and we have not yet incurred any costsof the new Civica licenses (c£15k).

NHS National Services Scotland – Executive Management Team Financial Performance – May 2023

Revenue Analysis

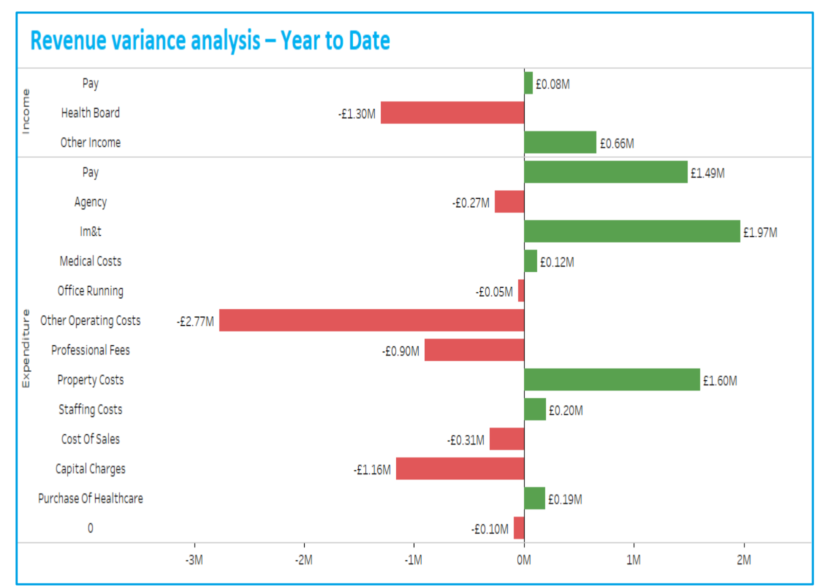
Health Board Income - The variance across Health Board Income are the key variances are DAS (£2m) relating to ATOS and recharges for work completed for boards still to be accounted offset by CLO Outlays Income £0.8m

Other Income - Higher income in year than planned from the SWAN, CLO and PGMS

Total Pay – the overall payroll underspend of £1.4m includes £1.6m through payroll with a number of vacancies, with £0.3m spend on agency in filling some of these gaps. A4C One-off payments were processed in April Pay.

IM&T – Underspends relates mainly to ATOS £2m & GPIT £0.8m and additional costs for e-Rostering £1.2m, these mostly offset HB Income variance above

Property Costs and Capital Charges variances relate to change in accounting treatment of Leases between the categories



Other Operating Costs The majority of the adverse position relates to DaS recharge which are still to calculated, to be actioned for M3

Cost of Sales relates to plasma products higher costs and increased oxygen concentrator costs, both of which are recharged in full to Boards with no impact to NSS bottom line for FY23/24

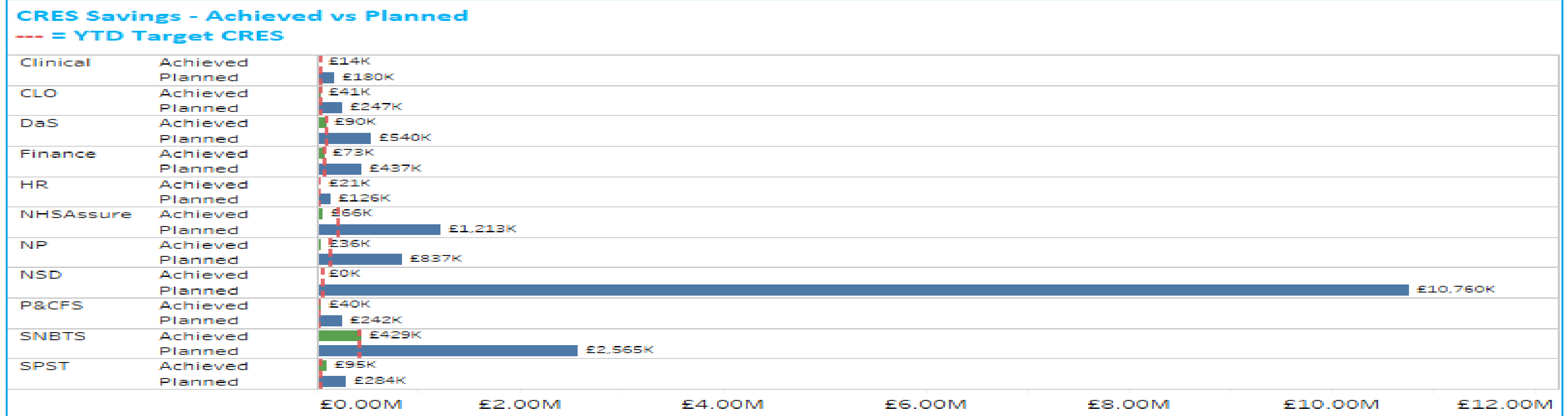
Covid-19 funding for C-19 services continues to reduce in-line with post pandemic position, NSS is currently forecasting SG Allocations of £86m covering:

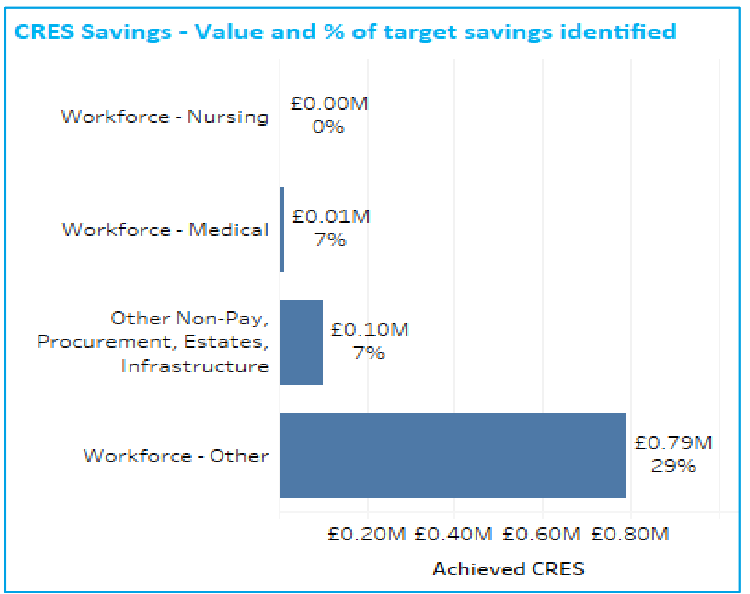
- Test, Protect and Vaccinate £61m
- PPE £25m

NHS National Services Scotland – Executive Management Team Financial Performance – May 2023

Delivery of Cash Releasing Efficiency Savings

For FY23/24, NSS has taken a different approach to CRES: rather than a 5% target being applied to all baseline funded services, specific identified savings have been identified and planned for with Directorate targets summarised below





The **NSD annual savings target is £10.8m** – savings plans have still to be provided but no concerns have been raised and NSD is still forecasting to break-even overall.

The SBU CRES target is £7.8m – including £5.5m planned savings and £2.3m savings to be identified **which Business Controllers are working with SBU to evidence.**

PgMS has started supporting Finance to plan and implement the PMO approach to improve the tracking and reporting of CRES across NSS, which is a key component of the organisation's Financial Sustainability Action Plan. This work and support will also cover Cost Pressures and Business Cases / Investment Demand

NHS National Services Scotland – Executive Management Team
Financial Performance – May 2023
Services delivered on behalf of NHS Scotland

FY22/23 Outturn

- NSS manages services on behalf of NHS Scotland with a **full year budget of £679m.**
- eHealth SLA, e-Rostering, NDC, O365, ATOS and Scotcap, are all delivering within plan or very small overspends.
- CHI £12k, MESH £2k and PAC's £15k underspend, but expected to breakeven at year end.
- There are overspends in SIBBS £1k, expect full year breakeven.
- NDC is showing a YTD breakeven, due to Budgets to be finalised

Services delivered on behalf of Scotland - YTD Position

Hosted Fund	Expenditure	Variance
ATOS	£4,721,420	-£56
CHI	£690,437	£11,818
eHealth	£4,985,388	£0
eRostering	£947,273	£0
MESH	£16,147	£2,438
NDC	£34,670,051	£0
NSD	£50,648,057	£419,884
O365	£6,404,475	-£165
PAC's	£78,373	£14,642
SIBBS	£3,160,526	-£1,113
Grand Total	£106,322,147	£447,448

NSD

In total NSD are £420k underspent, this relates to £205k under on pay costs at end of P2. Also showing a £213k under spend on Non-Pay costs, but this is inflated by £135k as an accrual for a Long Covid on-line tool was missed. The Non-Pay costs should show a £78k under spend at the end of P2. Healthcare spend is in the ledger as break even, as funding transfers and forecasts are yet to happen. The £40k 'under' on healthcare is down to an under spend on Adult ECMO - which is the only service that has provided a forecast, at this point. NSD intend to break-even this year, but may need to hand-back funding to HBs in order to achieve a break-even position.

NHS National Services Scotland – Executive Management Team Financial Performance – May 2023

Scottish Government Funding Allocation Tracker

Baseline

23/24 Baseline has been confirmed at £379m, with an additional £10m added for Recurring allocations received in 22/23.

Outstanding

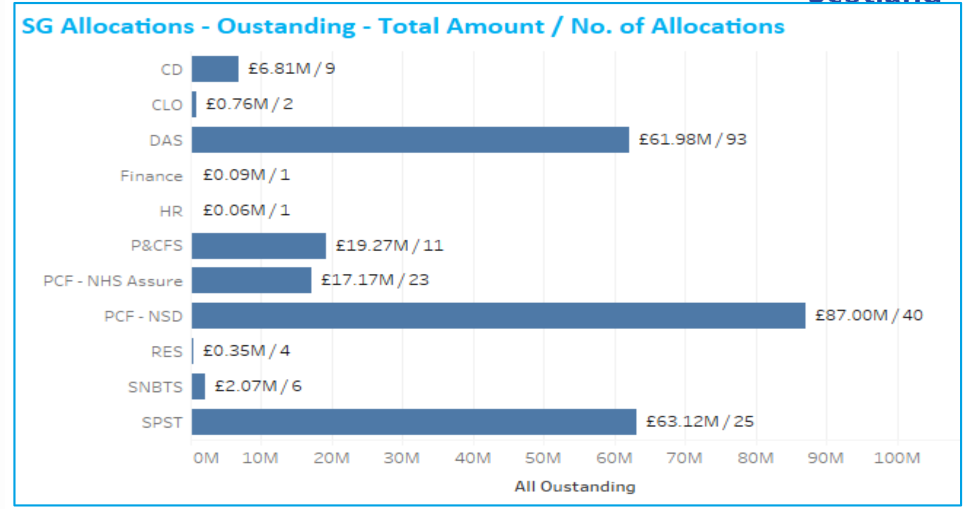
At M2 no allocation letter has been received, this is expected in M3

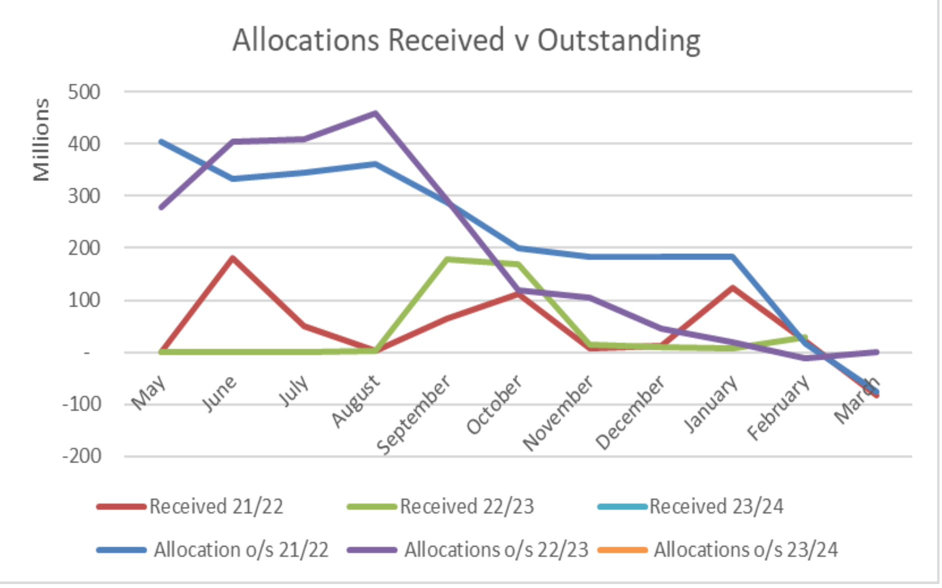
Baseline Changes and 'Bundling'

SG Finance have advised they still plan to maximise NSS' baseline moving forward where possible and it is hoped that certain adjustments can be agreed for FY23/24 onwards. As above no M2 allocation letters has been issued to Boards across Scotland – this is partly due to on-going work to review potential baseline adjustments, as well as further due diligence on recurring pay funding for A4C staff in-line with the FY22/23 and FY23/24 settlements

More widely, SG is focussed on a 'bundling' approach to allocations, moving away from low value, multiple allocations to higher value bundles where Boards have more flexibility to deliver outcomes and more certainty in terms of budgets, supporting longer term planning

SBU	Green	Amber	Red	Total
SNBTS	531	1,534		2,065
Reserves	291	63		354
DaS	365	61,753		62,118
P&CFS	242	19,027		19,268
SPST	218	62,899		63,117
Clinical	16	6,796		6,813
Finance	92			92
HR	59			59
CLO	102	657		758
NHS Assure	201	16,973		17,173
NSD	81	86,922		87,003
	2,197	256,623		258,821





NHS National Services Scotland – Executive Management Team
Financial Performance – May 2023
Capital Programme Delivery

FY23/24

NSS formula allocation of £2.927m has been prioritised and awarded. This is currently over allocated due to 22/23 slippage of £77k. NSS Finance is awaiting confirmation of the final cost of SNBTS slippage and if additional requirement for Breast Screening units is required.

In addition **£3.775m** of capital projects are being delivered during 23/24 via additional funding from other sources. **SG Digital Health & Care** have approved funding of **£ 2.067m**, £1.567m for CHI AND £0.5M for Seer's. The **ATOS Tech refresh**, **£1m**, will be funded from a transfer from revenue.

NSS have requested additional capital funding for 23/24 via the **NIB – Equipment**. The total requested of **£2m** covers replacement equipment and fleet which could not be funded from the NSS allocation. The timing of any additional funding has yet to be confirmed. Where possible information on lead times could ensure NSS are able to utilise this spend.

Compensation for Breast screening equipment is also being negotiated which potentially may increase capital funding availability this financial year.

Annually NSD receive a £800k capital allocation from the SG. This is prioritised and distributed to boards.

Appendix 2 contains information on **capital requested but not yet approved/Funded**. This includes information on next steps if capital still required and any progress. Please review for your directorate.

SG have requested all boards produce a long term capital plan in order to receive capital funding in future. The **NSS Whole system Programme** is set to commence in the coming weeks.

NSS CAPITAL DEVELOPMENT FUNDING		Budget	FY	Movement
Opening position	Opening AOP	2,927	2,927	0
	Opening position total	**2,927**	**2,927**	**0**
Critical projects approved	nDCVP		0	0
	SNBTS Equipment Rolling Replacement	-333	-333	0
	SNBTS - Clinical Apheresis Machines	-1,728	-1,728	0
	Breast Screen Unit	-800	-800	0
	DaS Network Replacement	-20	-20	0
	Move to Titan	-54	-54	0
	SNBTS 22/23 slippage	-77	-77	0
	Committed	**-3,012**	**-3,012**	**0**
Available for Developments		-86	-86	0
				0
Capital Funding Remaining		-86	-86	0

OTHER CAPITAL DEVELOPMENT FUNDING APPROVED		Budget	FY	Movement
SG	Breast Screen Unit - additional	135	135	0
SG	Shott's clinical waste site	200	200	0
SG Digital Health & Care	CHI	1,567	1,567	0
Proceeds Ellens Glen Rd	Meridian Court Replacement	323	323	0
Transfer from revenue	ATOS Tech Refresh	1,000	1,000	0
SG Digital Health & Care	SEER's	550	550	0
		3,775	3,775	0

NHS National Services Scotland – Executive Management Team
Financial Sustainability Action Plan Update

APPENDIX 1

Action	RAG	Comments
Reduce reliance on non-recurring funding		Like all Boards, NSS has not received a formal allocation letter as at M2. This is mainly due to the fact that SG has still to finalise it's review of c£600m allocations across NHS Scotland which could be bundled from FY23/24 onwards SG Finance has also reiterated its intention to increase NSS' baseline (where possible) by converting on-going non-recurring funding streams, including the "bundling" of certain allocations, but no revised allocations have currently been made However, the on-going work and progression is significant and supports NSS' ambition and need to reduce its reliance on non-recurring funding
10 Year Capital Investment Plan		Our Finance Business Partner (Assets & Infrastructure) has assessed the current asset register in terms of future reinvestment requirements, working with Directorates to develop a robust forward plan. They are also working closely with SG colleagues around 'Whole System Planning' to ensure investment plans are aligned and extend to the longer term
Business Intelligence and Analysis – Financial and Non-Financial Information		Finance is leveraging 'Blackline' to match and reconcile corporate data sets, as we await the full implementation of SEER and associated benefits: **Monthly On-Going Reconciliation** – Key Fields between eEES and ePayroll to ensure we understand differences but more importantly ensure corrections are made at source to align data across corporate systems **One Off Exercise** – adding Budgets Establishment information to the match with eEES and ePayroll data to have an objective position for each Directorate to confirm the 'truth' allowing NSS to undertake an agreed and co-ordinated update of systems, addressing any current misalignment, rebasing to support on-going reconcilaition

NHS National Services Scotland – Executive Management Team

Financial Sustainability Action Plan Update

APPENDIX 1

Action	RAG	Comments
Activity Based Costing		The project team has met with each Directorate to better understand readiness in terms of data maturity and capacity. This has informed a detailed roll out plan during FY23/24 which is being finalised The project has highlighted a number of financial structural / hierarchical inconsistencies across NSS which has been addressed through the FY23/24 budget process
Business Finance PMO		PgMS and Finance have has initial kick-off meetings and a workshop in June to develop, implement and embed a PMO within Finance covering • CRES – more rigorous tracking of actual savings delivery covering (1) Directorate Savings Plans including ROI from planned investments (2) Contract Approval Savings (3) Cost & Commercial Steeting Group • Cost Pressures – similar to CRES, a more robust way of recording all Cost Pressures to support budget decisions and better understand cost drivers • Business Cases / Funding Requests – Finance leading but working with others to review existing processes end to end with a One NSS lens We also recognise the need for consolidated NSS savings reporting into Boards / SG to summarise the favourable impact our services make to the wider budget

NHS National Services Scotland – Executive Management Team
Financial Sustainability Action Plan Update (2)

APPENDIX 1

<table>
<tr><th>Action</th><th>RAG</th><th>Comments</th></tr>
<tr><td>Increased Financial “Grip & Control”
• Systems & Processes
• Roles & Responsibilities</td><td></td><td>This is a broad, overlapping action with various on-going elements such as:
• Corporate Data reconciliation (as per previous slide)
• Finance Charters – summarising and confirming roles and responsibilities
• Systematic Review of Aged & High Value Accruals
• Pecos Approval Rules & Limits
• Increased scrutiny and controls over discretionary non-pay spend (CCSG)
• Corporate Joiners, Movers, Leavers (CJML)
• Workforce governance oversight:
    • Refined support and information for Vacancy Review Panel
    • Requirement for organisational change to be at least cost neutral reinforced.</td></tr>
<tr><td>Directorate Service Transformation</td><td></td><td>Finance continues to support emerging future NSS planning work supported by PgMS.
Finance is working closely with all Directorates (and DaS; SNBTS; and NSD in particular) to transform Financial Management arrangements – with both Finance and Service Areas recognising the changes needed to support improved practice and ensuring roles and responsibilities as outlined in the Finance Charter are delivered in practice.
Our Lean work is focusing on (1) the annual planning process, working with key stakeholders to ensure this is as efficient and effective as possible for the forthcoming FY24/25+ cycle and (2) implementing changes to the month end Financial Management Cycle - with aims to reduce the cycle time; improve report content and timing; give early awareness of material issues to Key Decision Makers for information and/or decision making. It is crucial that delegated budget holders are supported and informed to make the decisions around their delegated budgets by Finance – but Finance do not make decisions for the business.</td></tr>
</table>

NHS National Services Scotland – Executive Management Team Capital Project Pipeline Up-date

APPENDIX 2

Directorate	Name of Intiative/Service	Stage	Funding	Demand Ref No 23/24	FY23/24	Next Steps	Progress Up-date May 23
DaS	Rolling Replacement of Network Infrastructure	Project - proposed	NSS		**155,000**	Request via service now for finance support and prioritisation	No Further Information received
NSD	Rolling Replacement - Breast Screening	Project - proposed	NSS		**350,000**	Request via service now for finance support and prioritisation	No Further Information received
PCF	Backlog Maintenance (funded from EGR £7.5m)	Project - Proposed	SG - Ellen Glen Rd		**1,500,000**	Request via service now for finance support and prioritisation	Paper to SIB 10th July
PCF	Rolling Replacement - NP	Project - Proposed	NSS		**119,000**	Request via service now for finance support and prioritisation	No Further Information received
PCF SNBTS	Electric Vehicle Charging Infrastructure	Project - Proposed	Other		**550,000**	Once Grant Confirmed submit via service now and await VAT funding approval	Up-dated BC to Transport Scotland. Await confirmation of success. Paper to Assets & Infrastructure Group 19th June
PCF SNBTS	Electric Vehicle Charging Infrastructure - VAT	Project - Proposed dependant on success of bid to SFT	NSS		**11,000**	Request via service now for finance support and prioritisation	As above - Funding would be required for VAT element
SNBTS	SNBTS Rolling Replacement - Equipment	Project - proposed	NSS	FDMD0000208	**436,867**	Await confirmation of funding	Additional Funding requested via NIB-Equipment
SNBTS	SNBTS Rolling Replacement - Fleet	Project - proposed	NSS	FDMD0000209	**554,000**	Await confirmation of funding	Additional Funding requested via NIB-Equipment
SNBTS	SNBTS Rolling Replacement - Website/IT Related	Project - proposed	NSS	FDMD0000212	**185,000**	Await confirmation of funding	Await confirmation of funding
SNBTS	SNBTS Emvironmental Monitoring System	Project - proposed	NSS	FDMD0000221	**248,750**	Await confirmation of funding	Additional Funding requested via NIB-Equipment

NSS
Finance

NSS People Report – May 2023

APPENDIX C

Summary

Headcount

The current headcount for NSS is **3,374** and the total WTE is **3,128**. Last month there were a total of **3,370** staff with a WTE of **3,128**. Please note the headcount on the dashboard does <u>not</u> include agency and bank staff.

Turnover

NSS has recorded **69** new starts, **50** leavers and a turnover rate of **1.64%** this financial year. May recorded **16** new starts, **17** leavers and a turnover rate of **0.58%**.

Agency Staff and Fixed Term

There are currently **161** agency employees across NSS (**152** last month), the majority of these are within PCF (**86**), DaS (**38**) and SP&ST (**20**). **12** agency employees have been with NSS for more than four years (**nine** last month). There are a total of **278** employees on fixed term contracts (**279** last month). The majority of these are within DaS (**67**), PCF (**58**), SPST-NCC (**53**) and SNBTS (**43**). There are **48** fixed term contracts expiring in the next six months. **39** fixed term contracts have been with NSS for more than four years (**34** last month).

Statutory and Mandatory Training

At NSS level, the Statutory Training Compliance is above the **90%** target at **94%** (same last month). The 3 Year Mandatory compliance has remained the same at **90%** and meets the target. This is after the inclusion of the new Stay Safe Online module. **Note:** The data in the report is up to date until 20th February 2023. Please refer to the slide 12 for more information.

Recruitment

In May there were **45 jobs** advertised (**33** last month) and **57 vacancies** in total (**39** last month). For the financial year, the total is **78 jobs** and **94 vacancies**. **21** of the **78 jobs** are currently 'live' and at the 'advert' stage, **61%** of the jobs are for permanent positions and **37%** are for fixed-term (or secondment) posts and **2%** are for 'other' contract types.

Sickness Absence

The total sickness absence rate for the fiscal year is **4.04%** (**3.86%** last month), breaching the **4.00%** NSS target by **0.04%**. The total sickness absence rate for the month of May is **3.98%** (**3.86%** last month). The total cost of absence for the fiscal year is **£864k**. This time last year, the total cost of absence was **£786k**. May 2023 recorded a sickness absence cost of **£426k (£385k** last month).

Appraisal, PDP and Objectives

The compliance rates are currently at **78%** for Appraisal (**75%** last month), **80%** for PDP (**82%** last month) and **80%** for Objective (**83%** last month).

Sickness Absence - Statistical Process Control

The total sickness absence rate for the fiscal year is **4.04%** (**3.86%** last month), breaching the **4.00%** NSS target by **0.04%**. The total sickness absence rate for the month of May is 3.98% (**3.86%** last month).

Below Lower Limit (0.42%)	Between Lower Limit and Mean (0.42% - 3.00%)	Between Mean and Upper Limit (3.00% - 6.42%)
Clinical	CLO, DaS, Finance, HR & SP&ST	P&CF, PCF & SNBTS

PCF's absence has gradually decreased in the past 12 months, from **6.50%** in May 2022 to **5.98%** in May 2023. HR are working with PCF to develop interventions to improve sickness absence levels.

Forecast - Based on the previous three years of absence data, year to date sickness absence is forecast to finish the year at **3.69%** for NSS.

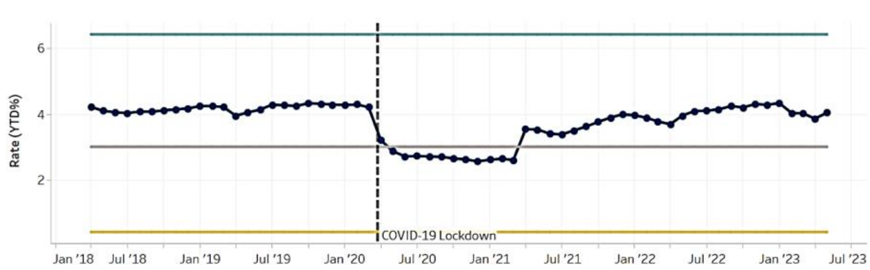
Short Term / Long Term Sickness Absence Rates

Month	Short Term	Long Term
May 2023	Month: **1.39%** FY: **1.34%**	Month: **2.63%** FY: **2.73%**
April 2023	Month: **1.60%** FY: **1.60%**	Month: **2.26%** FY: **2.26%**

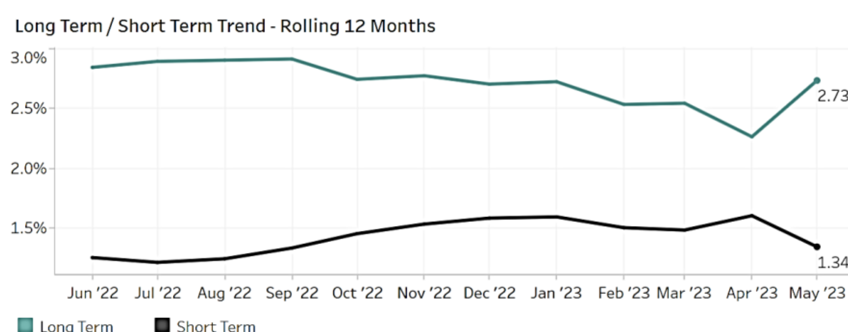
Trends & 5 Year Comparison - Sickness absence data is now performing similarly to pre-pandemic levels. The sickness absence rate this month is **4.04%**, compared to **4.05%** in May.

Sickness absence rates historically rise after each reporting month due to retrospective absence updates from line managers to SSTS. HR re-run sickness absence reports each month to maximise accuracy and capture retrospective changes.

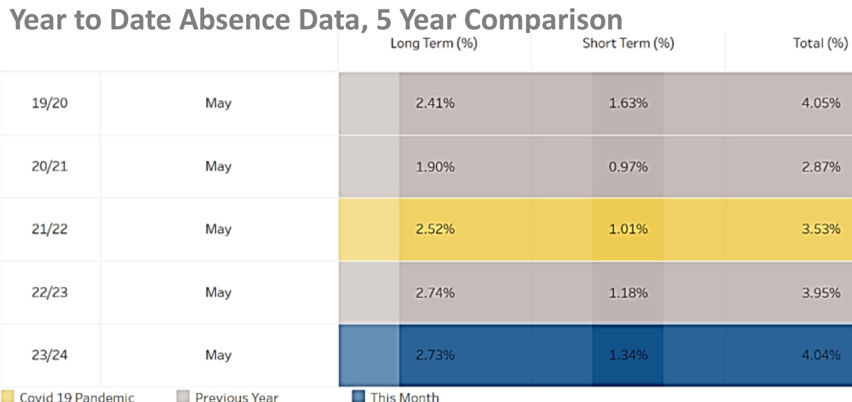
PCF Year to Date Total Sickness Absence SPC



NSS Long and Short Term Year to Date Absence Rates



Year to Date Absence Data, 5 Year Comparison

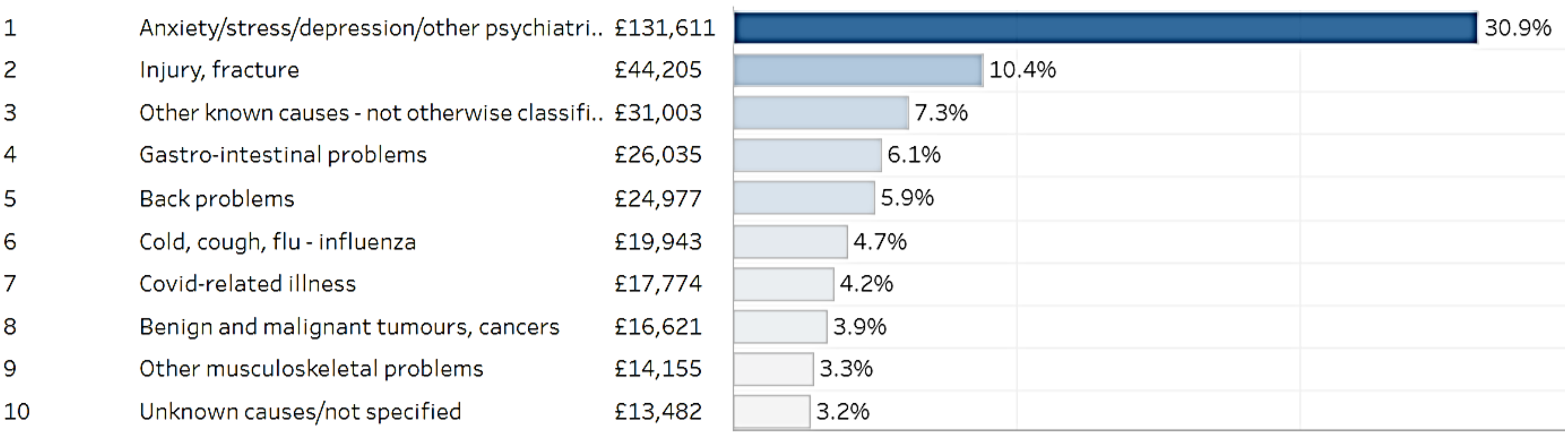


		Long Term (%)	Short Term (%)	Total (%)
19/20	May	2.41%	1.63%	4.05%
20/21	May	1.90%	0.97%	2.87%
21/22	May	2.52%	1.01%	3.53%
22/23	May	2.74%	1.18%	3.95%
23/24	May	2.73%	1.34%	4.04%

Sickness Absence Cost

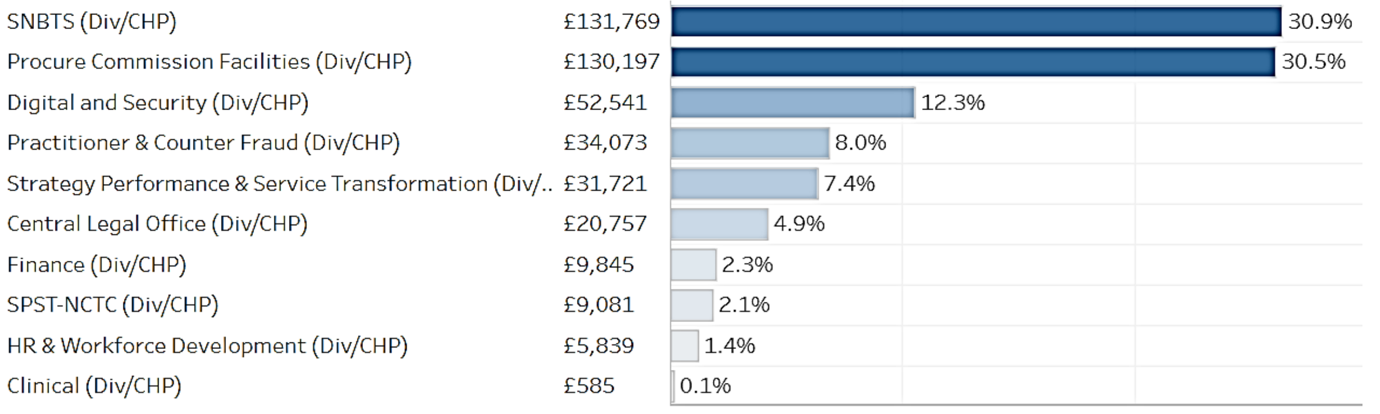
The total cost of absence for the fiscal year is **£864k**. This time last year, the total cost of absence was **£786k**. May 2023 recorded a sickness absence cost of **£426k (£385k** last month).

Top Reasons For Absence



Rank	Reason	Cost	%
1	Anxiety/stress/depression/other psychiatri..	£131,611	30.9%
2	Injury, fracture	£44,205	10.4%
3	Other known causes - not otherwise classifi..	£31,003	7.3%
4	Gastro-intestinal problems	£26,035	6.1%
5	Back problems	£24,977	5.9%
6	Cold, cough, flu - influenza	£19,943	4.7%
7	Covid-related illness	£17,774	4.2%
8	Benign and malignant tumours, cancers	£16,621	3.9%
9	Other musculoskeletal problems	£14,155	3.3%
10	Unknown causes/not specified	£13,482	3.2%

The Directorates with the highest cost of absence are SNBTS with **£131k** and PCF with **£130k**. Please see breakdown below:



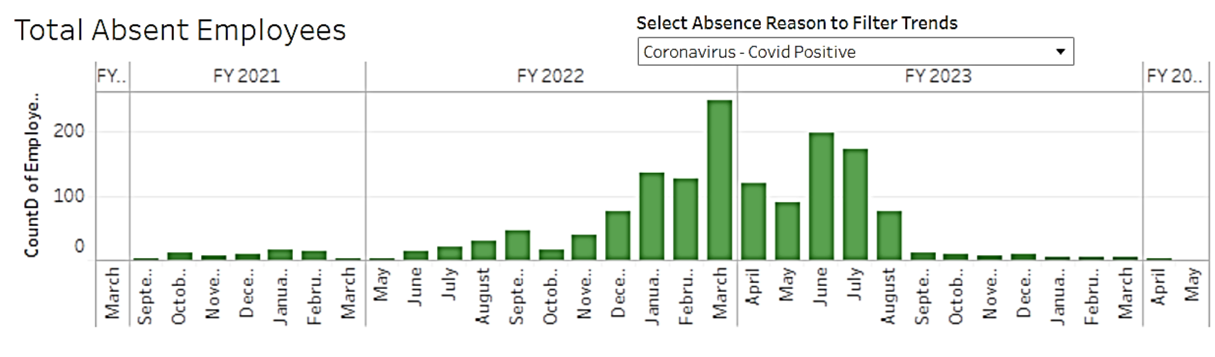
Directorate	Cost	%
SNBTS (Div/CHP)	£131,769	30.9%
Procure Commission Facilities (Div/CHP)	£130,197	30.5%
Digital and Security (Div/CHP)	£52,541	12.3%
Practitioner & Counter Fraud (Div/CHP)	£34,073	8.0%
Strategy Performance & Service Transformation (Div/..	£31,721	7.4%
Central Legal Office (Div/CHP)	£20,757	4.9%
Finance (Div/CHP)	£9,845	2.3%
SPST-NCTC (Div/CHP)	£9,081	2.1%
HR & Workforce Development (Div/CHP)	£5,839	1.4%
Clinical (Div/CHP)	£585	0.1%

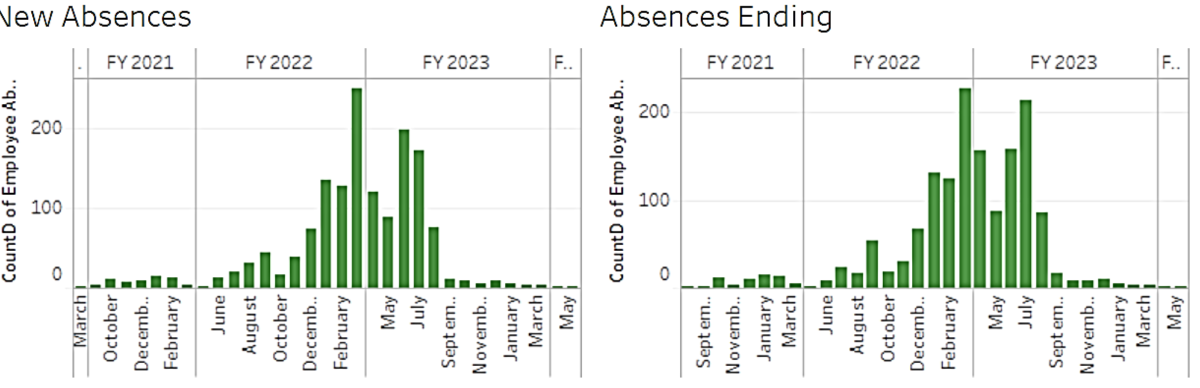
COVID-19 Special Leave

Monthly Special Leave
There was **one Special Leave, 'Covid Positive' absence recorded in May 2023** (two last month). This absence came from SNBTS.

HR & Workforce Development have created a monthly reporting process in order to check that the new approach to COVID-19 is being adhered to and where possible ensure that managers record absences correctly. This ensures that COVID-19 absences are recorded as sickness absence where appropriate. **All monthly figures are subject to change as any incorrect COVID-19 absences entries are rectified.**

Absence Cost
The cost of COVID-19 special leave in May is **£803.00** with a total of **44 hours lost**. April 2023 recorded an absence cost of **£2.4k** and **81 hours lost**. These figures are subject to change as data is scrutinised and rectified by HR, Business Partners and Line Managers.





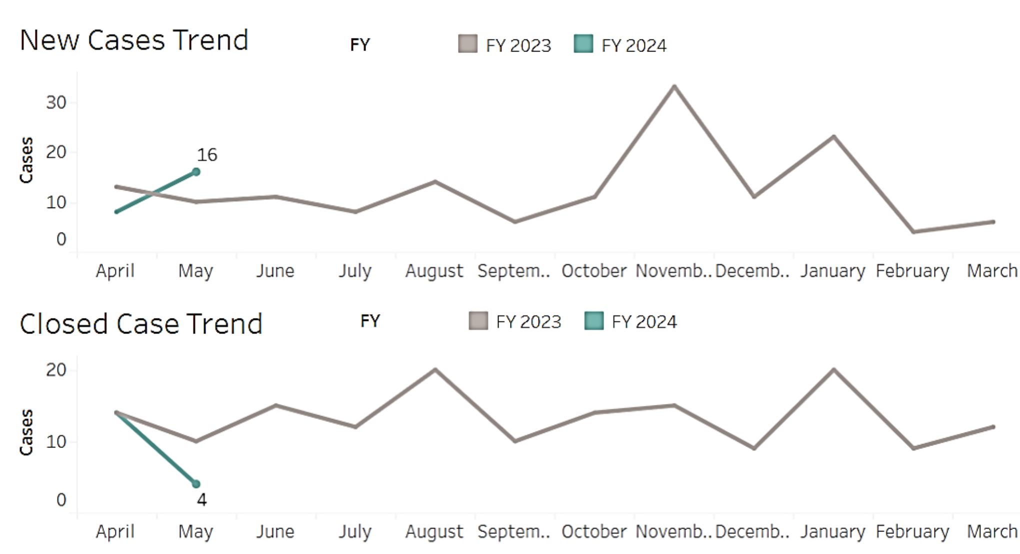
Absence Cost Chart related to Covid 19 Special Leave

Case Management

Case Management

There are currently **141** active cases, with **16** cases opened and **four** cases closed in May 2023. There were **127** cases active in April, which indicates a rise in the case load numbers this month (**14** more).

Case data is updated retrospectively on a frequent basis and data quality checks can be actioned which, in addition to cases opened and closed that month, helps explain the change in numbers between each monthly report.

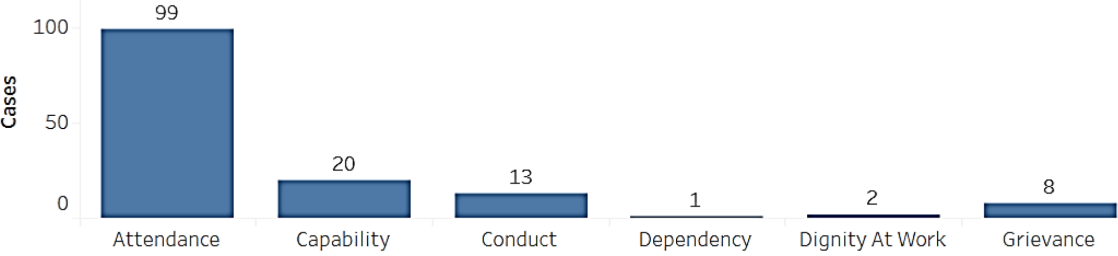


Absence Triggers

There are a total of **204** employees who have breached sickness absence triggers this month, of which **42** (**21%**) have active cases with HR. A total of **549** employees have reached an absence trigger in the rolling year, of which **125** (**23%**) have active cases with HR.

Active Cases by Directorate (Top 3)

Directorate	Active Cases
PCF	56
SNBTS	44
SPST-NCC	14



Turnover

Turnover Insights

NSS has recorded **69** new starts, **50** leavers and a turnover rate of **1.64%** this financial year. May recorded **16** new starts, **17** leavers and a turnover rate of **0.58%**. Of the **50** employees who left, **24%** were on a Fixed Term contract and **76%** were on a Permanent contract.

The turnover forecast for the end of the financial year 2023/24 is **15.03%**, which is higher than the agreed target of **14.00%**.

Division	Count leavers in FY (overall)	Count new starters in FY (overall)
Central Legal Office	0	0
Clinical	0	0
Digital and Security	7	4
Finance	2	5
HR & Workforce Development	5	3
Practitioner & Counter Fraud	8	4
Procure Commission Facilities	9	38
SNBTS	13	8
SPST-NCTC	2	1
Strategy Performance & Service Transformation	4	6
Grand Total	50	69

Turnover by Directorate

Directorate	Turnover This Month (FY)	Turnover Last Month (FY)
CLO	0%	0%
Clinical	0%	0%
DaS	1.55%	0.66%
Finance	1.32%	1.35%
HR	4.71%	1.18%
P&CF	2.17%	1.96%
PCF	1.09%	0.61%
SNBTS	1.62%	1.08%
SPST-NCC	4.51%	1.45%
SP&ST	2.37%	1.58%

Top 5 Reasons for Leaving (FY)

Reason	Leavers
New Employment with NHS Scotland	11
Vol. Resignation - Other	10
Other	7
Retirement – Age	6
Death in Service, Dismissal, Ill Health or Other	6

Notes

- Turnover rates are produced from eEES National Team turnover reports and include bank staff. Therefore, NCC rates include bank.
- The new starts and leavers data is taken from the NSS Staff List data.
- HR WIS implemented a change in the reports to use ‘Last day of working’ instead of ‘Effective End Date’ for the new starts and leavers table counts.
- The turnover percentage includes bank staff.

Agency Length of Service

Agency

There are currently **161** (**161** WTE) agency employees across NSS. There were **152** agency staff last month. **135** (**84%**) of agency contracts are due to end within the next six months.

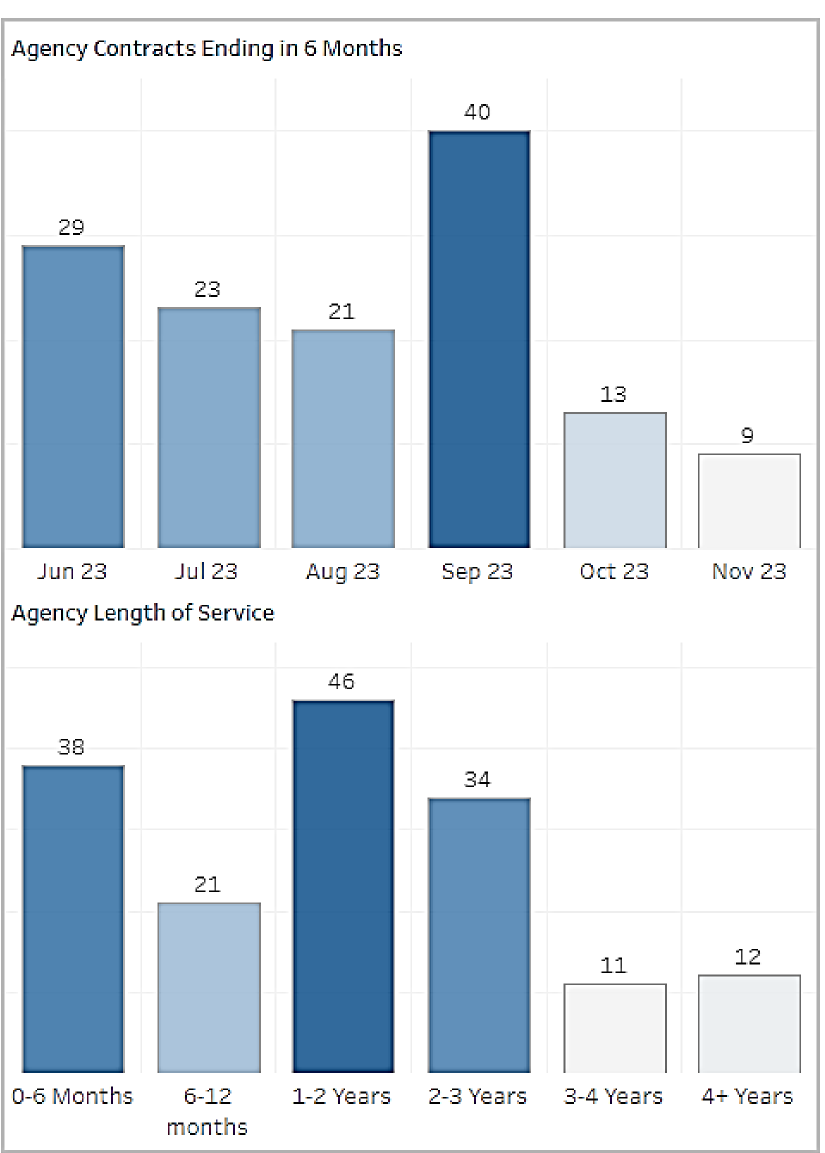
12 agency employees have been with NSS for more than four years (**nine** last month) in the following Directorates:

Directorate	Agency Headcount
PCF	6
DaS	4
SNBTS	1
SP&ST	1

Agency Staff by Directorate (Main)

Directorate	Agency Headcount
PCF	86 (77 last month)
DaS	38 (38 last month)
SP&ST	20 (19 last month)
P&CF	14 (14 last month)

Note: *Work is being done to collate the data on agency staff to provide framework details.*



Fixed Term Length of Service

Fixed Term
There are currently **278** (**209** WTE) fixed term employees across NSS. There were **279** fixed term staff last month.

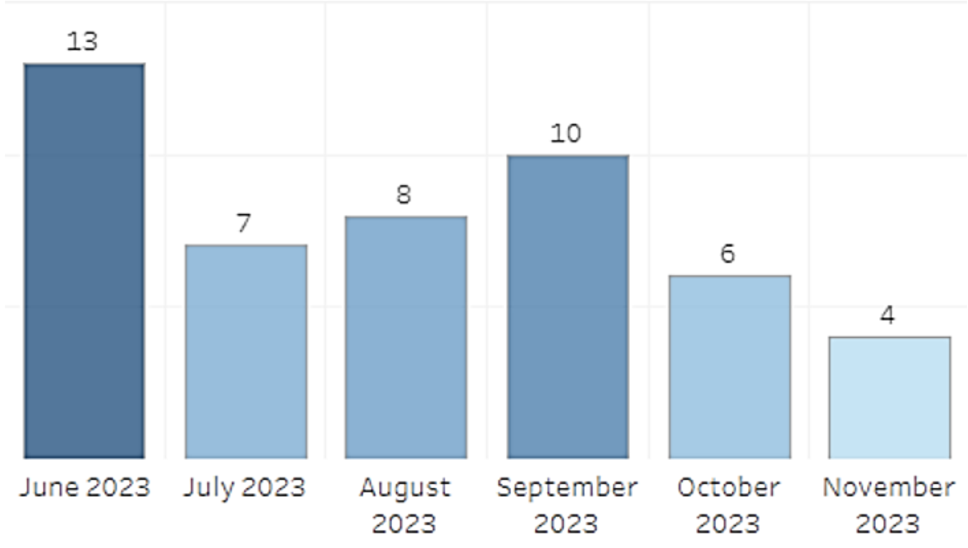
48/ (**17%**) fixed term contracts are due to end within the next six months.

39 fixed term contracts have been with NSS for more than four years (**35** last month) in the following Directorates:

Directorate	Headcount
SNBTS	8
DaS	8
PCF	7
P&CF	7
SP&ST	4
CLO	2
Clinical	1
HR	1
Finance	1

Fixed Term Staff by Directorate (Main)

Directorate	Headcount
DaS	67 (68 last month)
PCF	58 (56 last month)
SPST-NCC	53 (56 last month)
SNBTS	43 (44 last month)



Recruitment

Highlights

In May there were **45 jobs** advertised (**33** last month) and **57 vacancies** in total (**39** last month). For the financial year, the total is **78 jobs** and **94 vacancies**. **21** of the **78 jobs** are currently 'live' and at the advert stage, **61%** of the jobs are for permanent positions and **37%** are for fixed-term (or secondment) posts and **2%** are for 'other' contract types.

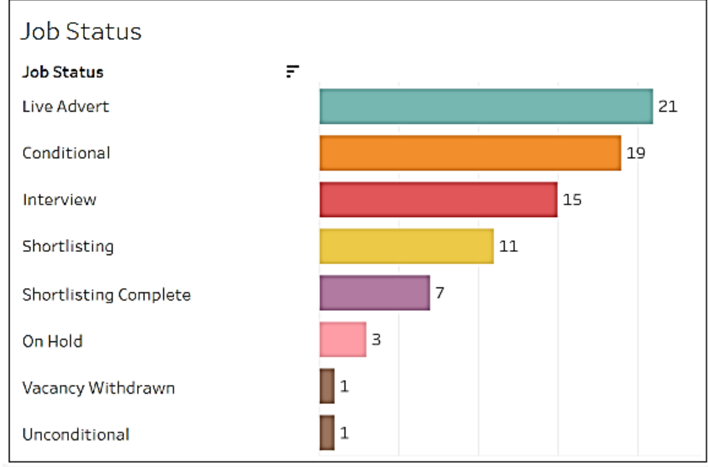
The current average time to hire for the last two years (24 month rolling sample), inclusive of HR and Hiring Manager involvement, is **78** working days (**76** working days last month).

Included within this timeframe is:

Status	Working Days (Average)
Time for Advert	33
Shortlisting	2
Interview Emails Sent	2
Job Offer	15
Process Conditional Offer	3
Candidate Accepting Offer	2
Pre-Employment Checks	15
Onboarding	8

Jobs and Vacancy Breakdown by SBU

Job Division	Count Job Reference	Number of Vacancies
Central Legal Office (Div/CHP)	1	2
Digital and Security (Div/CHP)	9	12
HR & Workforce Development (Div/CHP)	9	10
Practitioner & Counter Fraud (Div/CHP)	7	8
Procure Commission Facilities (Div/CHP)	23	23
SNBTS (Div/CHP)	19	22
SPST-NCTC (Div/CHP)	4	7
Strategy Performance & Service Transformation (Div/CHP)	6	10



Note: In October 2022 report the time to hire analysis period moved from the full job train data set over four years to the 'last two years' or 24 month rolling sample. This provides a more accurate and recent time to hire and reflects improvements in recruitment processes.

Redeployment

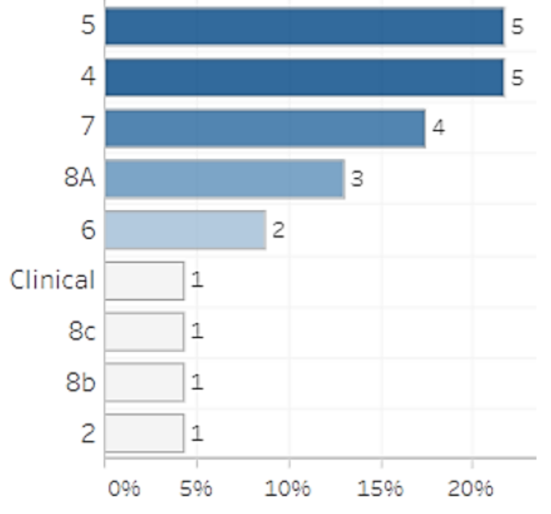
Highlights

The total number of redeployees added to the register in May is **five** (**two** last month), which makes **seven** for the fiscal year. See trend graph on the right.

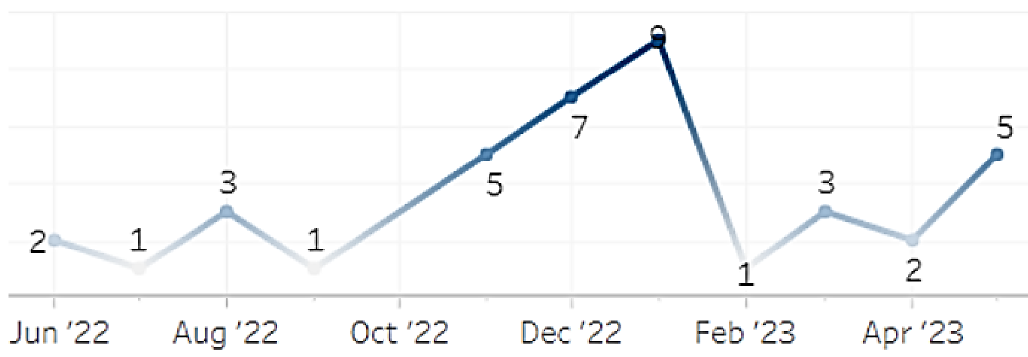
There are currently **23 active redeployees** on the register, **30%** of which are on a temporary work assignment, **30%** are on secondment, **30%** are seeking opportunities and **10%** are on a trial period.

61% of active redeployees are on the register due to organisational changes, **26%** due to their fixed term contracts expiring, **9%** is for 'other' reasons and the remaining **4%** have returned to work after a career break.

Active Redeployees | Band



Redeployees | 12 Month Trend



Directorate	Active Redeployees
Central Legal Office (Div/CHP)	2
Clinical (Div/CHP)	2
Finance (Div/CHP)	4
HR & Workforce Development (Div/CHP)	2
Practitioner & Counter Fraud (Div/CHP)	7
Procure Commission Facilities (Div/CHP)	3
SNBTS (Div/CHP)	2
Strategy Performance & Service Transformation (Div/CHP)	1

Mandatory/Statutory Training

Note: The data in this slide is up to date until 20th February 2023 as any compliance after that date is being recorded in the new Turas Learn application. Work is being undertaken to make employee data complete within Turas Learn. For example, not all employee records have been fully migrated over. Once we have this data extract, we will then need to merge them with historical LearnPro data for full reporting. HR are currently gathering employee information that have incomplete records within Learn.

At NSS level, the Statutory Training compliance is above the 90% target at 94% (same last month). Mandatory (3 year) compliance has remained the same meeting the target of 90%.

Highlights: DaS and Finance are compliant in the Statutory category but are non-compliant in the 3 Year Mandatory category.

- **SPST** are non-compliant in both the Statutory and 3 Year Mandatory categories.
- **Every Directorate** is non-compliant in the new Stay Safe Online course.
- Bank Staff (**NCC Bank**) Learning is at 93% for 3 Year Mandatory Compliance (78% last month) and 100% for Statutory Compliance (89% last month).

The graphs show compliance rates by category and course for each Directorate.

Whistleblowing

Please see the table for current compliance figures for employees and managers combined. As of April 2023, ex-employees and bank workers have now been removed from the completed totals.

Compliance by SBU 3 Year

SBU	3 Year
Central Legal Office	92%
Clinical	94%
Digital and Security	88%
Finance	89%
HR & Workforce Development	95%
Practitioner & Counter Fraud	94%
Procure Commission Facilities	90%
SNBTS	91%
SPST-NCTC	95%
Strategy Performance & Service Transformation	86%

Compliance by SBU Statutory

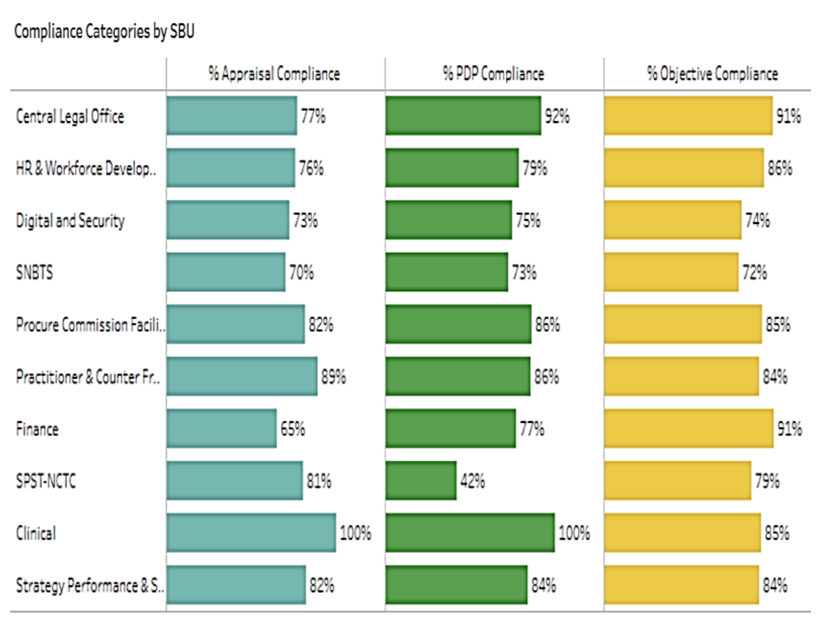
SBU	Statutory
Central Legal Office	98%
Clinical	94%
Digital and Security	91%
Finance	93%
HR & Workforce Development	95%
Practitioner & Counter Fraud	97%
Procure Commission Facilities	90%
SNBTS	96%
SPST-NCTC	96%
Strategy Performance & Service Transfor..	89%

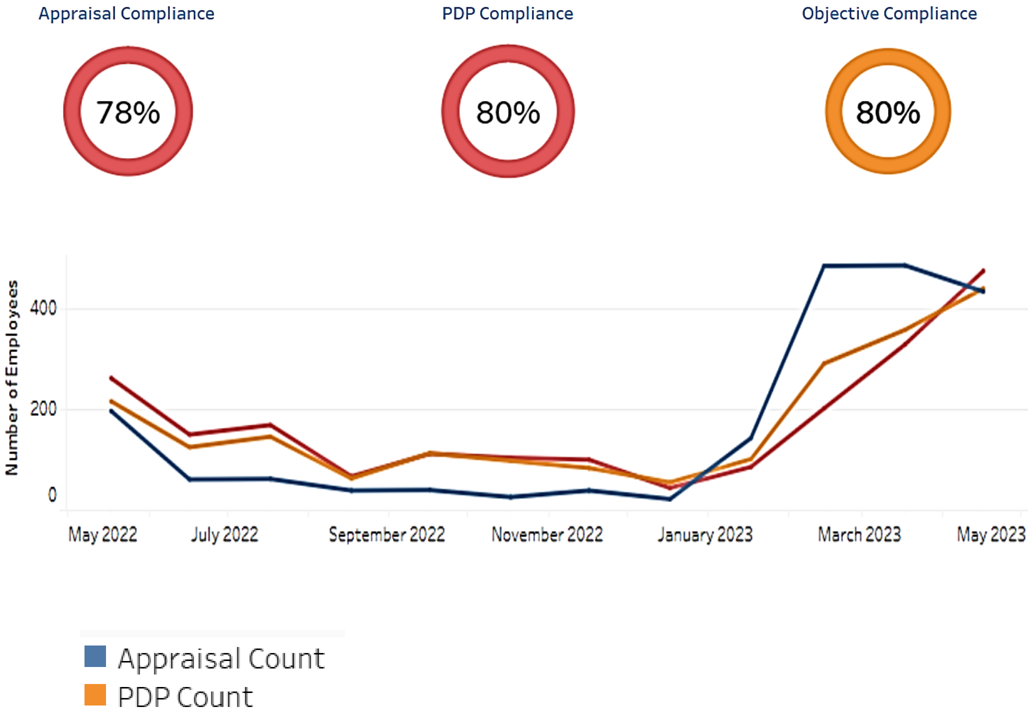
	NSS: Equality and Diver..	NSS: Freedom of Information	NSS: Health and Safety In..	NSS: Information Governance ..	NSS: Manual Handling ..	NSS: NHS Scotland Counter F..	NSS: Risk and Resilience	NSS: Standing Financial ..	NSS: Fire Safety	NSS: Stay Safe Online
Central Legal Office	93%	91%	94%	96%	95%	94%	91%	90%	98%	82%
Clinical	94%	94%	94%	94%	94%	94%	94%	94%	94%	86%
Digital and Security	90%	90%	89%	91%	90%	92%	87%	85%	91%	76%
Finance	89%	83%	92%	97%	99%	95%	93%	92%	93%	60%
HR & Workforce Devel..	95%	95%	93%	95%	95%	97%	95%	97%	95%	87%
Practitioner & Counter ..	95%	95%	95%	98%	96%	94%	94%	94%	97%	86%
Procure Commission F..	92%	92%	94%	96%	93%	95%	91%	88%	90%	73%
SNBTS	90%	91%	92%	95%	94%	94%	92%	88%	96%	82%
SPST-NCTC	96%	98%	98%	98%	100%	100%	98%	94%	96%	76%
Strategy Performance ..	92%	88%	88%	93%	90%	91%	86%	85%	89%	62%

Whistleblowing	TURAS Headcount	Complete	Compliance %
Employee/ Managers	3,099	1,712	55%
Managers	687	578	85%

Turas Appraisal

NSS Compliance Rates





Additional Information:

- 348 employees started in the last 12 months
- 365 employees have no Appraisal history
- 323 employees have no PDP history
- 279 employees have no Objective history

Note: The above compliance has been calculated with excluding the staff groups that are new starts, maternity leave, long term sick, career breaks, medical and Dental staff and movers within the organisation (same as new start).

Tableau Dashboards will be in place in Q2 including the above exclusions.

Annual Leave

May 2023 indicates that approximately **15%** of annual leave has been planned, **18%** already taken and **66%** remaining for this fiscal year.

Directorate	Planned %	Taken %	Remaining %
Central Legal Office (Div/CHP)	21%	15%	65%
Clinical (Div/CHP)	7%	25%	69%
Digital and Security (Div/CHP)	19%	12%	69%
Finance (Div/CHP)	22%	10%	68%
HR & Workforce Development (Div/CHP)	18%	12%	69%
Practitioner & Counter Fraud (Div/CHP)	21%	14%	66%
Procure Commission Facilities (Div/CHP)	12%	21%	66%
SNBTS (Div/CHP)	8%	25%	67%
SPST-NCC (Div/CHP)	2%	41%	57%
Strategy Performance & Service Transformation (Div/CHP)	25%	14%	61%
-	-	-	-
NSS	**15%**	**18%**	**66%**

Note: Information collated in this exercise is a combination from Crown Flexi and eESS/SSTS. This is only an estimate of employees of NSS and excludes Bank Staff, contingent workers, honorary contracts and secondees. Where employees don't use Flexi, eEES system data is used.

Health & Safety - Accident / Incident Management

RIDDOR

There has been **one** RIDDOR submitted this financial year to the Health & Safety Executive (HSE). This RIDDOR occurred at the new Clinical Waste site which NSS took possession of before the clearing and waste removal was completed. There is a full action plan in place and NSS Facilities are working with SEPA to ensure that the site is cleared safely.

Accidents

A total of **10** accidents have been submitted in May and **20** for this financial year, resulting in **nine** days absence this fiscal year.

The accident rate was **2.66** in May and **5.32** for this fiscal year which is well below the fiscal year target of **35.42**. The average time to close an accident is **19 days** this fiscal year, which is **11 days** below the agreed **30-day KPI**.

A summary of this financial year's figures are presented in the charts:

FY 2024

Total Reports

Chosen Dime...
RIDDOR

Month	RIDDOR
April	1 (100%)

Division	
Procure Commission Facilities	1 (100%)

Location	
Other	1 (100%)

Category of Event	
Exposure to/contact with a biological agent	1 (100%)

FY 2024

Total Reports

Chosen Dimen..
Accident

Month	Accident
April	10 (100%)
May	10 (100%)

Division	
SNBTS	10 (50%)
Procure Commission Facilities	9 (45%)
Practitioner & Counter Fraud	1 (5%)

Location	
NDC Coddington	6 (30%)
External Blood ..	5 (25%)
Inverness Blood..	2 (10%)
National Distrib..	2 (10%)
Dundee Blood D..	1 (5%)
Edinburgh Bloo..	1 (5%)
Glasgow Blood ..	1 (5%)
Gyle Square	1 (5%)
NHS National S..	1 (5%)

Category of Event	
Cut with sharp obje..	5 (25%)
Contact with a clini..	4 (20%)
Slip, trip, fall on the..	3 (15%)
Null	2 (10%)
Lifting/handing/car..	2 (10%)
Collision with Objec..	2 (10%)
Fall from height	1 (5%)
Contact with hot /v..	1 (5%)

Health & Safety - Accident / Incident Management

Incidents/near misses

A total of **20 incidents/near misses** have been recorded in May and **28** in total for this financial year. The average time to close an Incident/near miss is currently at **nine days** for this fiscal year. A summary of this financial year's figures are presented in the charts:

FY 2024

Total Reports

Month	Total Reports
April	8 (100%)
May	20 (100%)

Chosen Dimen..
Incident / n..

Division	
Procure Commission Facilities	19 (68%)
SNBTS	9 (32%)

Location	
NDC Coddington	14 (50%)
SNBTS National..	3 (11%)
External Blood ..	2 (7%)
Gyle Square	2 (7%)
National Distrib..	2 (7%)
Aberdeen Blood..	1 (4%)
Dundee Blood D..	1 (4%)
Edinburgh Bloo..	1 (4%)
Inverness Blood..	1 (4%)
Other	1 (4%)

Category of Event	
Collision with Objec..	7 (25%)
Violence/Aggressio..	
Struck by a moving/..	3 (11%)
Exposure to fire	3 (11%)
Struck by a moving ..	
Other	2 (7%)
Null	
Exposure to/contac..	2 (7%)
Slip, trip, fall on the..	
Cut with sharp obje..	1 (4%)
Contact with movin..	
Contact with hot /v..	1 (4%)

Occupational Health Activity

Management & Self Referral/Review Appointments

In May there have been a total of **51** (**36** last month) appointments booked, of which:

- **43** were attended (**20**)
- **4** were DNA appointments (**4**)
- **2** future pending appointments (**11**)
- **1** was rescheduled (**1**)
- **1** was cancelled (**0**)

Management and Self Referrals

During May there have been 26 new referrals received (39 last month), 67 referrals this fiscal year. The breakdown for this month is as follows:

- Management Referrals: **24 (92%)**
- Self Referrals: **2 (8%)**

The main reasons for referrals in May are in relation to:

- Other musculoskeletal problems – **35%**
- Anxiety/stress/depression and other psychiatric illness – **27%**
- Benign and malignant tumours, cancer – **15%**

The **average time taken to triage** was **two days** in May, with **two days** on average for this fiscal year overall.

Pre Placements

20 pre-placements have been received in May (**25** last month) with **20** cleared (**100%**). There have been **66** pre-placements this year.

SNBTS, DaS and PCF accounted for **64%** of the pre placements received in May.

Appointment information overview this fiscal year

Referral Appointments

Board	SBU/Directorate	Month	Quarter	Year
NHS National Services Scotland	All	May	All	FY 2024

N.

Total Appointments	Total Attended Appointments	Total DNA Appointments	Total Rescheduled Appointments	Total Pending Appointments	Total Cancelled Appointments
51	43	4	1	2	1

Attended Appointments by SBU/Directorate

SBU/Directorate	Attended
SNBTS (Div/CHP)	16 - 37%
Procure Commission Facilities (Div/C..	10 - 23%
Strategy Performance & Service Tra..	4 - 9%
Central Legal Office (Div/CHP)	4 - 9%
SPST-NCTC (Div/CHP)	3 - 7%
Practitioner & Counter Fraud (Div/C..	3 - 7%
Digital and Security (Div/CHP)	2 - 5%
Finance (Div/CHP)	1 - 2%

Attended Appointment Outcomes

Outcome	Total	Discharge	Review
Remain at work	13	13	
Remain off work	8	3	5
Return to work	6	4	2

Total 27: Discharge 20 (74%), Review 7 (26%)

Attended Appointment Trend
(Select month to filter dashboard)

May 2023: 43

Cancelled Appointment Trend
(Select month to filter dashboard)

May 2023: 5 (DNA 4, Cancelled 1)

NHS
National Services Scotland

NHS Scotland Assure
Quality in the healthcare environment

Electricity Consumption

Quarterly Electricity Consumption

(June 2019 – March 2023)

Figure 1 - Quarterly Electricity Consumption Across NSS

- Current total number of sites included in analysis is 15.
- Not currently including Ninewells, Foresterhill, Pentland, ERI, Lauriston Place and Broxburn.
  - These sites are intertwined with other NHS locations and we often get provided with the costs of use as opposed to usage of electricity.

Important Building Notes

- The Louisa Jordan Hospital was purchased to assist with COVID-19 and returned to SHSC in 2021.
- An additional two warehouses and the Livingston Donor Centre were purchased at the same time as the Louisa Jordan Hospital.
- The leases of 10 South Gyle, Bain Square and Meridian Court all end this year and will therefore NSS will no longer be in possession.

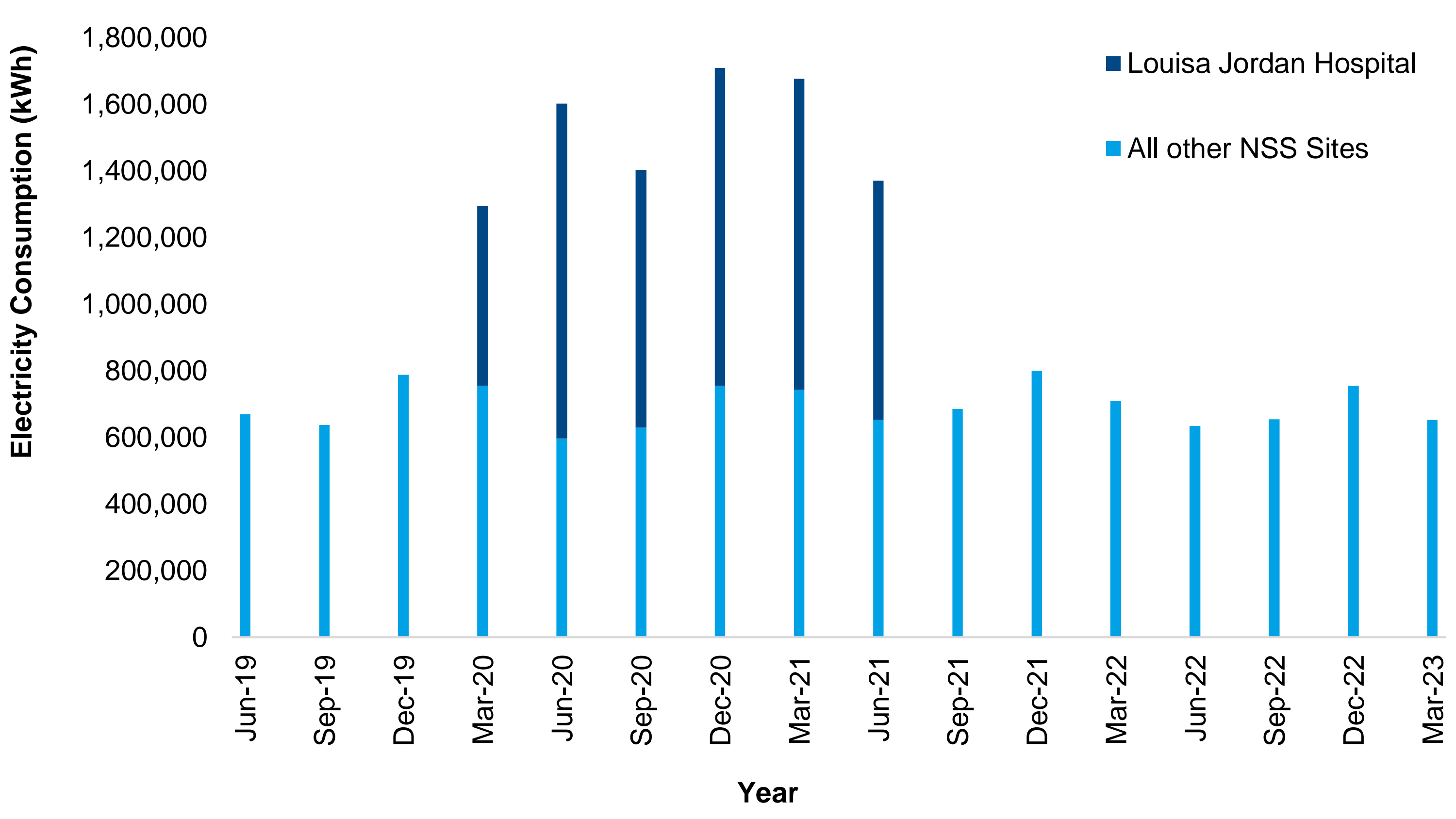
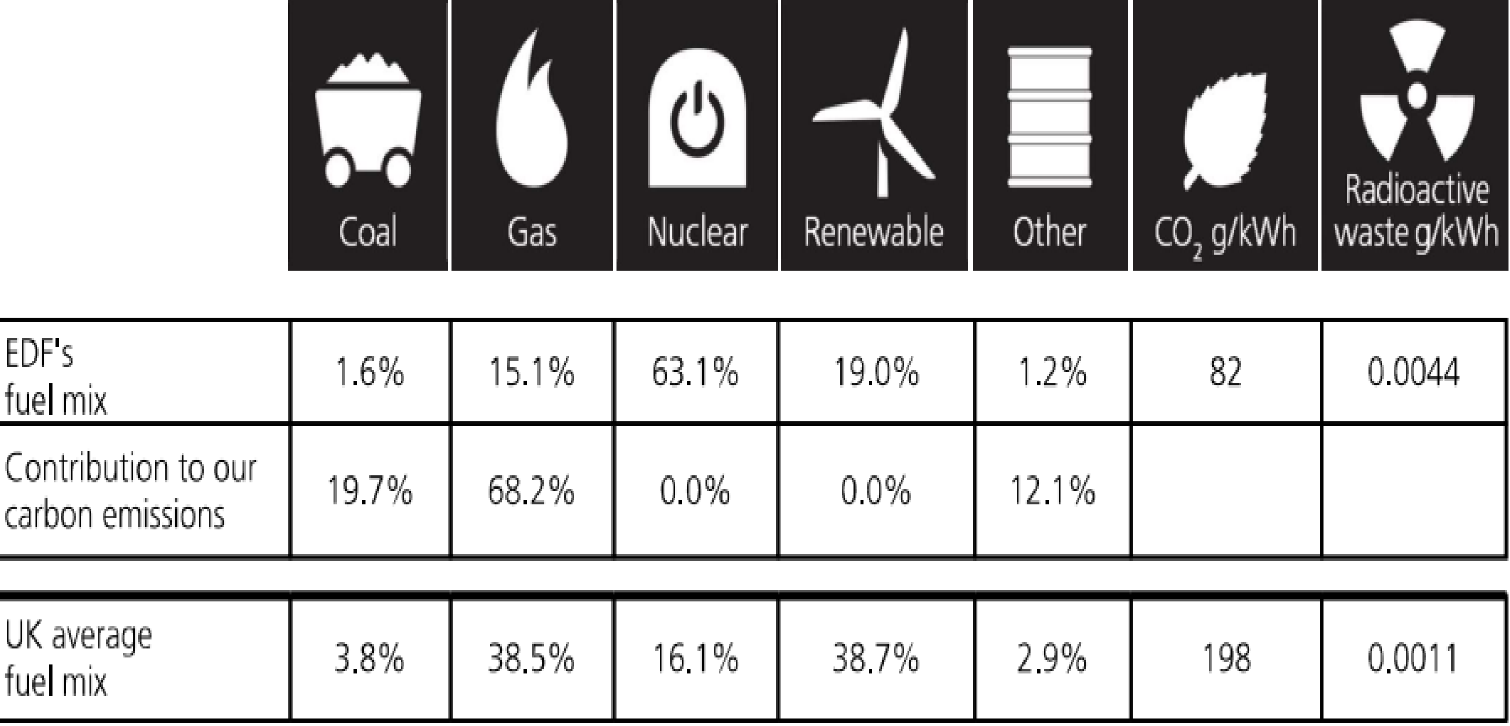


Figure 1: Quarterly Electricity Consumption Across NSS Between June 2019 and March 2023.

EDF Energy Customers Ltd

(April 2021 - March 2022)

- NSS electricity consumption data was provided by EDF Energy Customers Ltd.
- **Figure 2** demonstrates the breakdown of energy generation sources.
- The fuel mix shown is from April 2021-March 2022.
    - For the share of electricity generation for April 2022 - March 2023 will be published on 1 October 2023.



	Coal	Gas	Nuclear	Renewable	Other	CO_2 g/kWh	Radioactive waste g/kWh
EDF's fuel mix	1.6%	15.1%	63.1%	19.0%	1.2%	82	0.0044
Contribution to our carbon emissions	19.7%	68.2%	0.0%	0.0%	12.1%		
UK average fuel mix	3.8%	38.5%	16.1%	38.7%	2.9%	198	0.0011

Figure 2: Share of Electricity Generation by EDF

Quarterly Electricity Consumption by Building
(June 2021 – March 2023)

- **Figure 3 -** Quarterly Electricity Consumption for the Top Five Electricity Consuming Buildings
    - Meridian Court, the second highest electricity consuming building, will no longer be used by NSS from September 2023.

- **Figure 4 -** Quarterly Electricity Consumption for Jack Copland Centre
    - JCC consumes an average of 33% of total electricity consumption over all 15 NSS buildings that we can measure electricity consumption between April 21 – March 23 (based on information from the previous graph).
    - Working with external stakeholders to better understand methods to improve our electricity (and gas) consumption to improve efficiency of use.

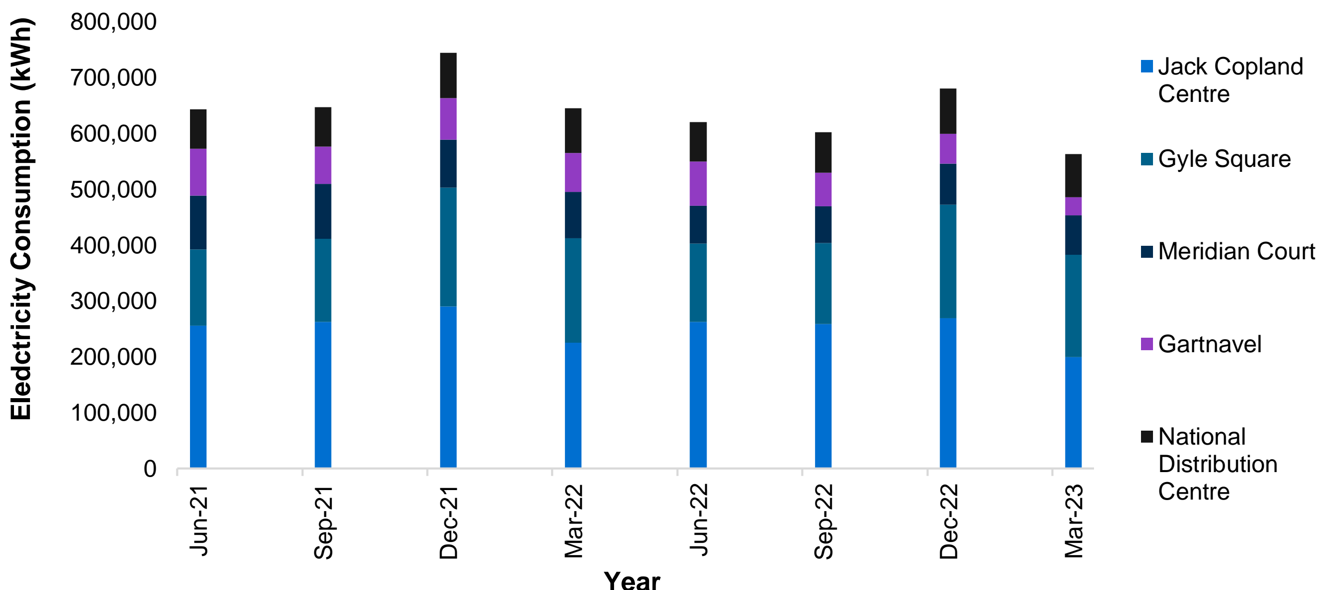


Figure 3: Quarterly Electricity Consumption for the Top Five Electricity Consuming Buildings Between June 2021 and March 2023

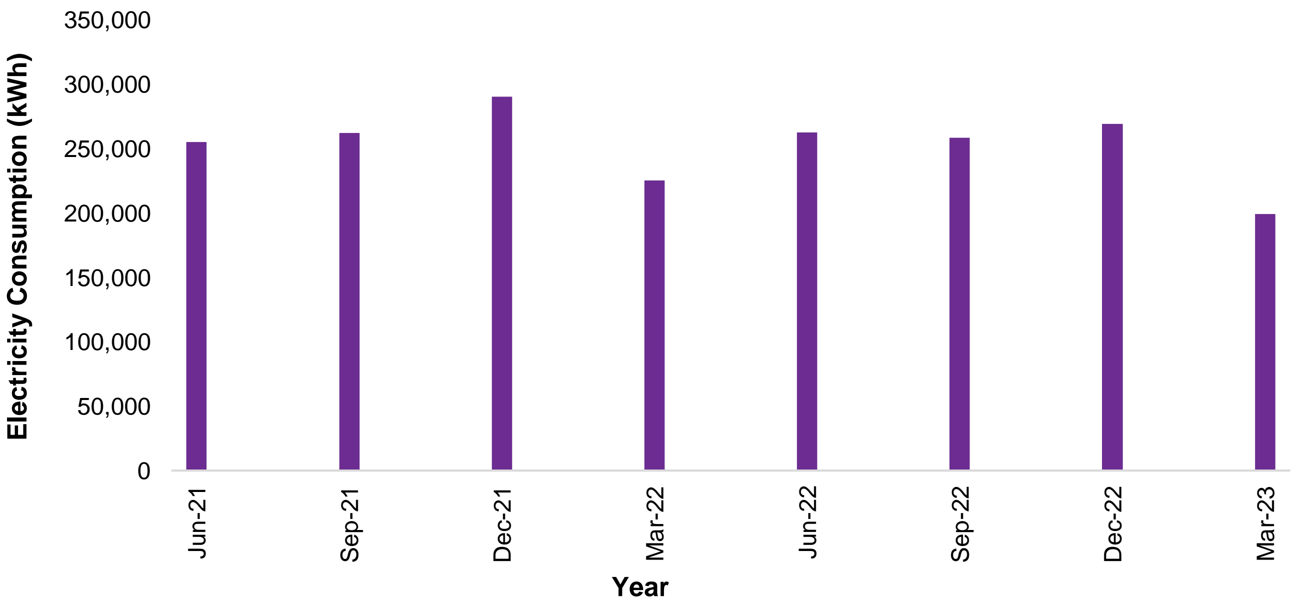


Figure 4: Quarterly Electricity Consumption for Jack Copland Centre Between June 2019 and March 2023.

Solar PV Electricity Generation at Jack Copland
(April 19 – March 23)

Electricity Generation (kWh)

25,000
20,000
15,000
10,000
5,000
0

Apr-19 Jul-19 Oct-19 Jan-20 Apr-20 Jul-20 Oct-20 Jan-21 Apr-21 Jul-21 Oct-21 Jan-22 Apr-22 Jul-22 Oct-22 Jan-23

Year

Figure 5: Total Electricity generated by Solar PV at Jack Copland Centre between April 2019 and March 2023

Gas Consumption

Quarterly Gas Consumption
(June 2019 – March 2023)

- **Figure 6 -** Quarterly Gas Consumption Across NSS
  - Current total number of sites included in analysis is 9 based on what sites currently use gas.

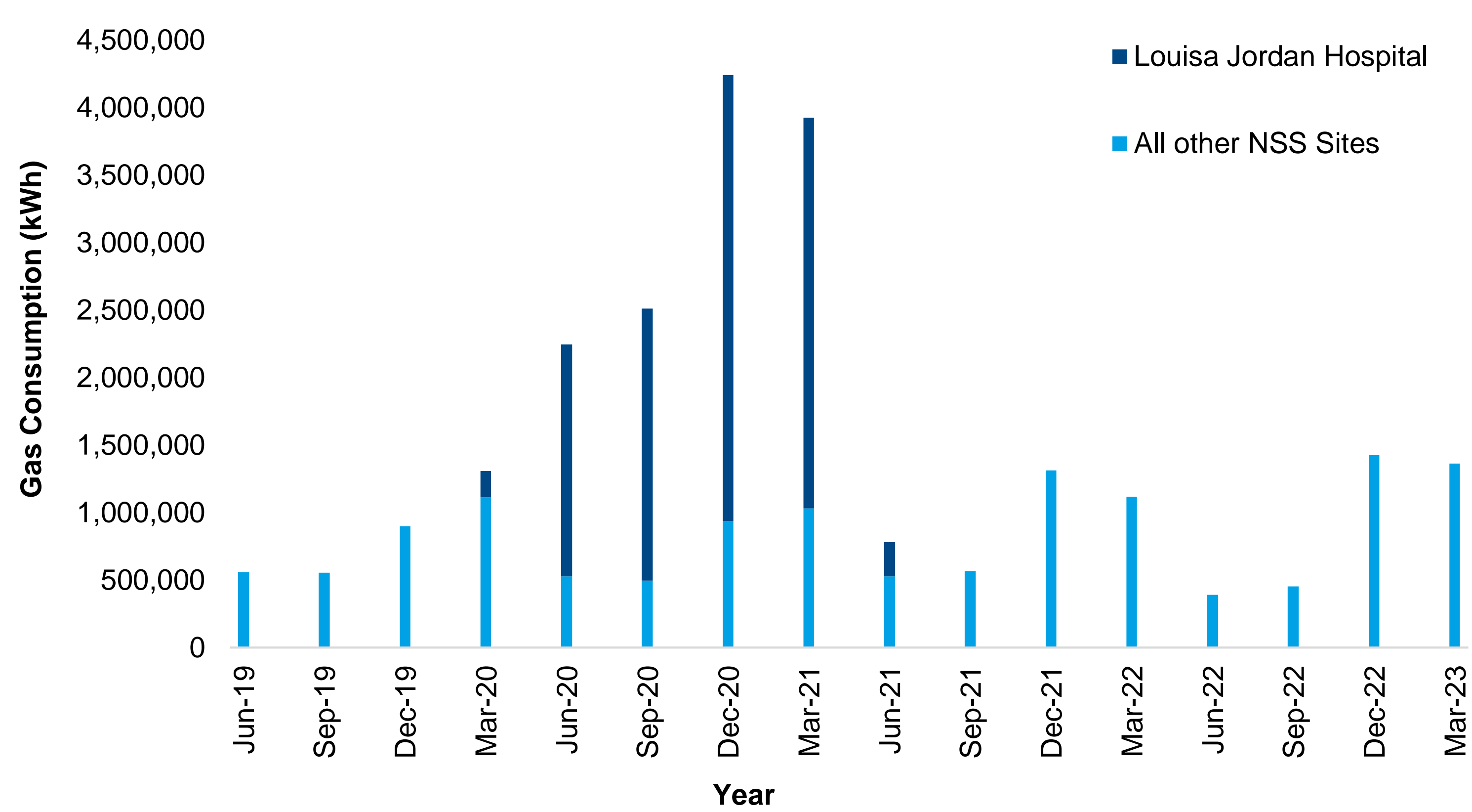


Figure 6: Quarterly Gas Consumption Across NSS Between June 2019 and March 2023.

Gas Consumption by Building

(June 21 – March 2023)

- **Figure 7 - Quarterly Gas Consumption for the Top Five Gas Consuming Buildings**
  - The same top 5 electricity consuming buildings were the highest gas consuming buildings.
  - Meridian Court, the third highest electricity consuming building, will no longer be used by NSS from September 2023.
- **Figure 8 - Quarterly Gas Consumption for Jack Copland Centre**
  - JCC consumes an average of 58% of total gas consumption over all 9 NSS buildings that we can measure gas consumption between April 21 – March 23 (based on information from the previous graph).
  - Some of the gas is used to generate the electricity needed.
  - Reduced Climate Change Levey due to the use of Combined Heat & Power plant (CHP).

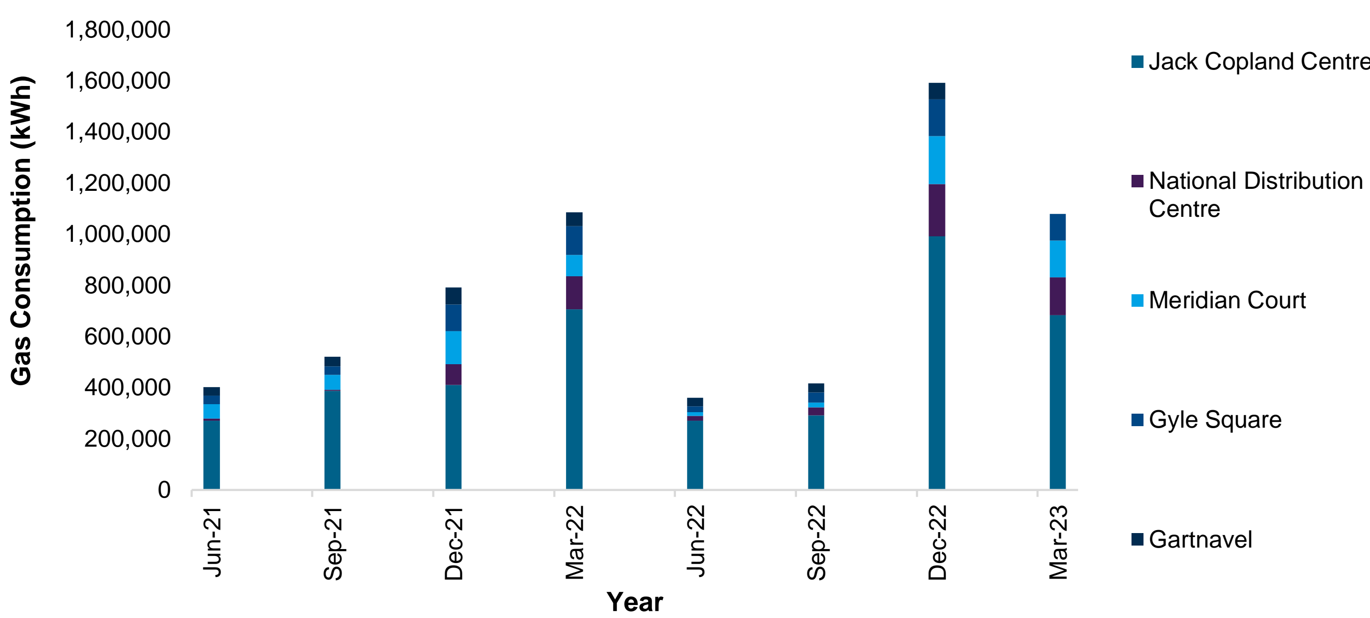


Figure 7: Quarterly Gas Consumption for the Top Five Gas Consuming Buildings Between June 2021 and March 2023.

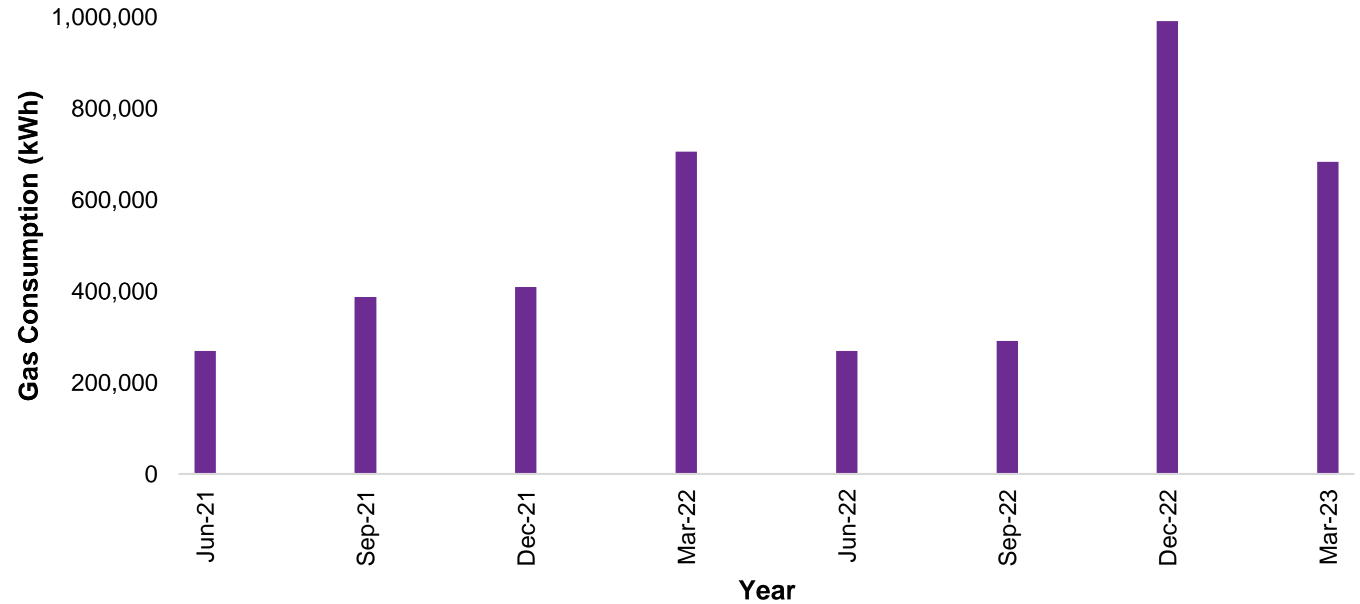


Figure 8: Quarterly Gas Consumption for Jack Copland Centre Between June 2021 and March 2023

Water Consumption

Water Consumption

(April 19 – Feb 23)

- Historically, water has been poorly reported and bills have been brought in at different times making reporting somewhat inconsistent.
- Water use across the majority of sites is based on estimates, this causes unnecessary peaks/dips in reporting.
    - The installation of Automatic Meter Readers (AMR's) will help in providing more accurate trend analysis.
- Follows COVID-19 trends between April 2020 and August 2021 and the use of the Louisa Jordan Hospital.

Figure 9: Quarterly Water Consumption Across all NSS Sites Between June 2021 and March 2023.

Waste

Total Waste by Type
(June 2019 – March 2023)

Waste (tonnes)

100
90
80
70
60
50
40
30
20
10
0

Jun-19 Sep-19 Dec-19 Mar-20 Jun-20 Sep-20 Dec-20 Mar-21 Jun-21 Sep-21 Dec-21 Mar-22 Jun-22 Sep-22 Dec-22 Mar-23

Year

Food waste
General waste
Recyclable Waste

Figure 10: Total Clinical, Food, General and Recyclable Waste Across all NSS Sites Between April 2019 and March 2023. ***Note: Clinical Waste was Only included in Reporting from January 2022 onwards.***

General Waste

- Due to reporting quarterly, not seen here is a spike in October 2021.

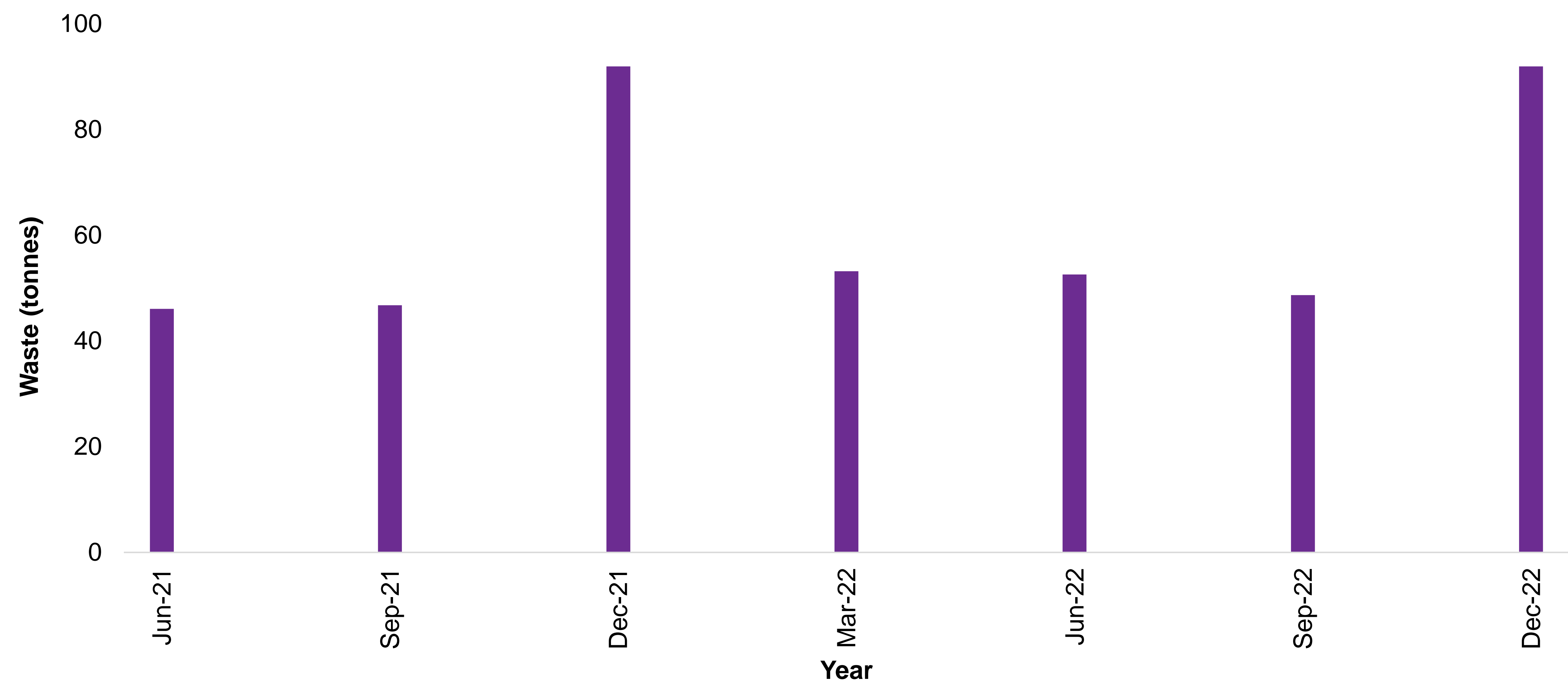


Figure 11: Total General Waste for all NSS Buildings Between June 2021 and December 2022

Recyclable Waste

(June 19 – March 23)

- For waste, there have been peaks and troughs between 2019 to 2023. This is likely due to buildings collating their recyclable waste (i.e., cardboard, scrap metals etc) and then recycled all at the same time. This often happens every three to four months.
- These graphs also show the assumed average weights.

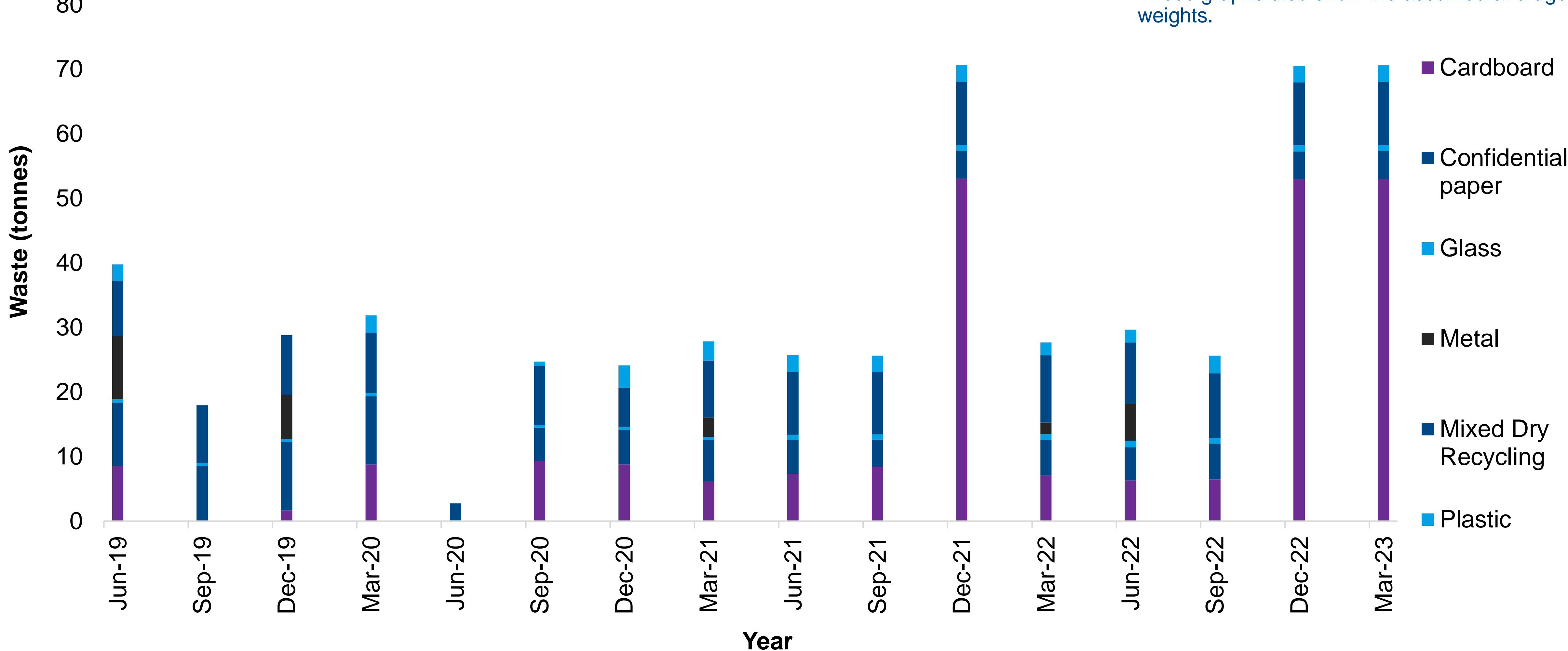


Figure 12: Total Recyclable Waste Across all NSS Sites Broken Down by Material Between April 2019 and March 2023

Food Waste

(June 19 – March 23)

Figure 13: Total Food Waste Across all NSS Sites Between June 2019 and March 2023.

NHS National Services Scotland

Meeting:	**NSS Board**
Meeting date:	**Friday, 30th June 2023**
Title:	**NSS Committee Annual Reports to the Board**
Paper Number:	**B/23/17**
Responsible Executive/Non-Executive:	**Julie Burgess, Chair of Audit and Risk Committee; Lisa Blackett, Chair of Staff Governance Committee; Gordon Greenhill, Chair of Finance, Procurement and Performance Committee; Alison Rooney, Chair of Clinical Governance and Quality Improvement Committee; Ian Cant, Chair Remuneration and Succession Planning Committee.**
Report Author:	**Karen Nicholls**
	[Reviewed by **Hayley Barnett, Assoc. Dir. Governance and Board Services (Board Secretary)**

1. Purpose

1.1 The NSS Corporate Governance Framework requires each Committee of the NSS Board to provide an annual report to the Board.

2. Recommendation

2.1 The Board is recommended to scrutinise and approve the Annual Reports from all NSS Committees for 2022-2023.

3. Executive Summary

3.1 This report provides a compilation of the following reports;

- NSS Audit and Risk Committee Annual Report 2022-23*;
- NSS Clinical Governance and Quality Improvement Committee Annual Report 2022-23;
- NSS Staff Governance Committee Annual Report 2022-23;
- NSS Finance, Procurement and Planning Committee Annual Report 2022-23;
- NSS Remuneration and Succession Planning Committee Annual Report 2022-23

3.2 The reports are prepared by the Committee Chairs to provide assurance to the NSS Board that they are fully meeting their obligations. The information collated into the annual report highlights the work done during the year and provides evidence of adherence to the Terms of Reference (NSS Corporate Governance Framework Appendices 3.1, 3.2, 3.3, 3.4 and 3.5).

4. Impact Analysis

4.1 Quality/ Patient Care

4.1.1 There are no direct impacts on quality or patient care associated with this report.

4.2 Equality and Diversity, including health inequalities

4.2.1 There are no direct impacts in relation to equality and diversity, or health inequalities associated with this report.

4.3 Data protection and information governance

4.3.1 There are no direct impacts in relation to data protection and information governance.

5. Risk Assessment/Management

5.1 Any risks associated with these reports are discussed and managed by the relevant Committees using the NSS approach to risk management.

6. Financial Implications

6.1 There are no direct financial implications in relation to these reports. However, any financial issues are dealt with by each Committee in line with the NSS

Standing Financial Instructions and the NSS Corporate Governance Framework.

7. Workforce Implications

7.1 There are no direct workforce implications in relation to these reports. Any workforce issues are dealt with by the relevant Committees in line with NHS Scotland Workforce Policies.

8. Climate Change and Environmental Sustainability Implications

8.1 There are no direct climate change of environmental sustainability implications in relation to these reports.

9. Route to Meeting

9.1 Each of the reports contained in the appendices of this paper were discussed and approved at the relevant Committee meetings. Additionally the NSS Remuneration and Succession Planning Committee draft report was presented for comment and scrutiny to the NSS Staff Governance Committee held on 30th May 2023.

9.2 The reports were approved on the following dates:

- NSS Audit and Risk Committee, 26 June 2023*;
- NSS Clinical Governance and Quality Improvement Committee, 1 June 2023;
- NSS Staff Governance Committee, 30 May 2023;
- NSS Finance, Procurement and Performance Committee, 31 May 2023;
- NSS Remuneration and Succession Planning Committee, 23rd June 2023.

10. List of Appendices and/or Background Papers

- Appendix A - NSS Audit and Risk Committee Annual Report 2022-2023*;
- Appendix B - NSS Clinical Governance and Quality Improvement Committee Annual Report 2022-2023;
- Appendix C - NSS Staff Governance Committee Annual Report 2022-2023;
- Appendix D - NSS Finance, Procurement and Performance Committee Annual Report 2022-2023;
- Appendix E - NSS Remuneration and Succession Planning Committee Annual Report 222-2023.

Note: * Appendix A NSS Audit and Risk Committee Annual Report is to be approved at the meeting to be held on Monday 26th June 2023 and will be forwarded to Members separately. This will be published separately.

NHS National Services Scotland

APPENDIX B

NSS Clinical Governance and Quality Improvement Committee 2022/23 Annual Report to the NSS Board

1. INTRODUCTION

NSS has a duty to have in place appropriate arrangements to meet its clinical governance responsibilities. Clinical governance is the framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, defined as "corporate accountability for clinical performance". It is not intended to replace professional self-regulation and individual clinical judgement, but to add an extra dimension that will provide the public with assurance that relevant, safe, and effective systems and processes are in place. Within NSS this serves to support NSS in delivering effective national and specialist services which enable and support improvements in the health and wellbeing of all the people of Scotland.

Clinical Governance within NSS is overseen by the Clinical Governance and Quality Improvement Committee, a committee of the NSS Board. The committee, chaired by a non-executive member of the Board, receives reports, questions and where appropriate challenges the executives in attendance on aspects of the quality assurance of services likely to have a direct or indirect impact on health and wellbeing and, through its minutes, reports to the NSS Board on all relevant issues.

The Committee met formally on four occasions during 2022-23, on 30 May 2022, 7 September 2022, 30 November 2022, and 28 February 2023. Development Sessions were also held on 22 May 2022, 11 July 2022, 31 October 2022, and 30 January 2023.

During the 2022-23 period, the following were Members and regularly In Attendance at meetings:

Members:

Alison Rooney, Non-Executive Director and Committee Chair
Lisa Blackett, Non-Executive Director
Gordon Greenhill, Non-Executive Director
Arturo Langa, Non-Executive Director
Beth Lawton, Non-Executive Director (from 1 September 2022)
Mark McDavid, Non-Executive Director (until 31 August 2022)
Keith Redpath, NSS Chair

In Attendance:

Lorna McLintock – SNBTS Medical Director (from 30.11.22)
Mary Morgan, Chief Executive
Lorna Ramsay, Medical Director and Executive Lead for Clinical Governance
Jacqueline Reilly, Director of Nursing and Executive Lead for Quality Improvement
Megan Rowley, Interim SNBTS Medical Director (from 12.5.22 until 30.11.22)
Calum Thomson, Associate Director for Nursing, Clinical Governance and Quality Improvement
Marc Turner, Medical Director – Scottish National Blood Transfusion Service (until 11.5.22)

2. COMMITTEE ACTIVITIES IN 2022-2023

2.1 Clinical Adverse Events, Risks and Complaints

Item	Description	Evidence
ToRs (a)	Assure that process and reporting arrangements are in place, as required in order to provide assurance that the clinical and related activities under NSS direction and control are at all times appropriately governed and monitored as to their safety, quality, and effectiveness	**Standing Items**: Medical Director's Report, Clinical Governance and Quality Improvement Plan; Clinical Adverse Events Report; Clinical Risks Report, HAI Report; Duty of Candour Annual Report; Blood and Tissue Quality, Safety and Sufficiency Report. Also see detail under Section 2.2 – Additional Highlights
ToRs (b)	Assure all aspects of Quality Management are reflected including Quality Planning, Quality Improvement and Quality Control and the application of the principles of Realistic Medicine	**Standing Item:** Medical Director's Report, Clinical Governance and Quality Improvement Plan;
ToRs (c)	Assure advice is provided, as required, to the Board on the clinical impacts of any new service developments proposed for adoption by NSS.	**Standing Item**: Medical Director's Report
ToRs (d)	Challenge clinical activity from the perspectives of equity, inequality/ equality, diversity and value (expressed as triple value).	**Standing Item:** Medical Director's Report, Clinical Governance and Quality Improvement Plan;
ToRs (e)	Review compliance with clinical regulatory requirements.	**Standing Items:** Blood and Tissue Quality, Safety and Sufficiency Report; Clinical Staff Revalidation Report and the Medical Staff Revalidation Report; Medical Director Report and relevant Annual Reports (i.e. Infection Prevention and Control; Duty of Candour; Research, Development and Innovation; Clinical Professional Appraisal and Revalidation; Patient Group Directions Audit) Also see detail under Section 2.2 – Additional Highlights

2.2 Additional Highlights

Over the course of the year, the development sessions covered the following topics:

- Healthcare Associated Infection and Infection Prevention and Control
- National Services Directorate (purpose, services, strategic direction, roles, responsibilities, governance, and reporting)
- Clinical Directorate overview

- Clinical Governance Audit
- Medical Device Regulations and compliance

2.3 Relationships with other Board Committees

The Committee continues to recognise the overlap in its responsibilities in respect of certain matters with the Audit and Risk and Staff Governance committees and has in place an agreed memorandum of understanding with these two committees. Cross reference to matters of mutual interest discussed in other committees of the Board (particularly relating to Staff Governance or Audit and Risk) were addressed as necessary.

3. CONCLUSIONS AND ASSURANCE TO BOARD

The Clinical Governance Committee concludes that: Clinical Governance structures and processes continue to be reviewed and monitored across NSS by clinical leaders, executive directors, and the Clinical Governance Committee. Progress continues to be made in the understanding and reporting of clinical risks within the corporate risk register.

The committee feels able to assure the NSS Board that substantial attention is given by the organisation to its clinical governance arrangements, that this is proportionate to the nature of each Strategic Business Unit's role, and that the Clinical Governance and Quality Improvement Committee's monitoring responsibilities are being met.

Alison Rooney
NSS Clinical Governance and Quality Improvement Committee Chair
June 2023

APPENDIX C

NSS STAFF GOVERNANCE COMMITTEE ANNUAL REPORT 2022-2023

1. INTRODUCTION

1.1 The Staff Governance Committee, on behalf of the NSS Board, is charged with satisfying itself that NSS has processes in place to manage staff effectively and to comply with the Staff Governance Standard. As such, the Committee reviews NSS's performance in meeting the Staff Governance Standards, which require that staff are:

- Well informed;
- Appropriately trained and developed;
- Involved in decisions;
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued;
- Provided with a continuously improving and safe working environment, promoting the health and well-being of staff, patients and the wider community.

1.2 The following are/were members of the Staff Governance Committee during the period 1 April 2022 to 31 March 2023.

- John Deffenbaugh, Non-Executive Director (Committee Chair until 8 September 2022, Member from 9 September 2022)
- Lisa Blackett, Non-Executive Director (Member until 8 September 2022, Committee Chair from 9 September 2022)
- David Allan, Trade Union Representative (from 1 September 2022)
- Ian Cant, Employee Director
- Susan Cook, Trade Union Representative (until 31 August 2022)
- Tam Hiddleston, Trade Union Representative
- Arturo Langa, Non-Executive Director
- Beth Lawton, Non-Executive Director (from 1 September 2022)
- Gerry McAteer, Trade Union Representative
- Mark McDavid, Non-Executive Director (until 31 August 2022)
- Suzanne Milliken, Trade Union Representative
- Keith Redpath, NSS Chair

In addition, Mary Morgan (Chief Executive) and Jacqui Jones (Director of HR and Workforce Development) attended meetings as required.

1.3 Meetings during 2022/23 were held on the following dates: 12 May 2022, 9 September 2022, 25 October 2022 (ad-hoc), 24 November 2022 and 9 February 2023.

2. AIM

2.1 The aim of this report is to provide assurance to the Board that NSS complies with the Staff Governance Standard. In addition, this report summarises those

matters which were considered and discussed by the Staff Governance Committee. The format for the report this session will reflect the 'Key Duties" section from the Committee Terms of Reference as follows:

a) Ensure an effective system of Governance and oversight for the management, safety and welfare of the workforce including a strategic workforce planning strategy.

b) Oversee the development of frameworks which ensure delivery of the Staff Governance Standard.

c) Review evidence of attainment and maintenance of the Staff Governance Standard through the Great Place to Work Plan (Staff Governance Action Plan). Where there is evidence of shortfalls the Staff Governance Committee will ensure that causes are identified and remedial action recommended.

d) Oversee the development and monitoring of all organisational policy related to workforce, ensuring compliance with National Workforce Policies.

e) Consider any policy amendment, funding, or resource submission to achieve the Staff Governance Standard, providing support as required to drive forward.

f) Establish detailed and timely staff governance data reporting standards, ensuring that information is provided to support both NSS operating activities and national monitoring.

g) Provide staff governance information for the Statement of Internal Control.

h) Review quarterly staff risks contained in the NSS Corporate Risk Register and set out in the Integrated Risk Management Approach, identifying and reporting on specific areas of concern.

i) Review quarterly the NSS complaints report in the context of staff risk.

j) Oversee the NSS values programme, ensuring that the values are embedded within NSS structures and processes.

k) Review Quarterly and Annual Whistleblowing Reports

Members are asked to note the evidence provided in Appendix A which is mapped against the criteria above.

Appendix A

The NSS Staff Governance Action Plan forms part of the NSS Great Place to Work Plan and is based on the results of the NSS iMatter staff experience survey.

NSS has adopted a different approach to Staff Governance reporting and no longer reports against the five strands of the Staff Governance Standard.

However, for the purposes of providing assurance to the NSS Board, the Staff Governance Committee have aligned the actions taken during the year with the five strands of the Standard and the outcomes will be measured on evidence submitted by Directorates.

Staff governance standard strand	Action	Evidence	Expected outcome/ current status
Well Informed/Involved in Decisions	Overall iMatter Score	2022/23 75% 2021/22 74% 2020/21 60% 2019/20 82% 2018/19 76%	Response Rate Target for 2023/24 - 74%
	Implement iMatter Staff Survey	iMatter survey ran in June/July 2022	NSS iMatter survey to be launched in June 2023.
	Team Action Plans	Team Action Plans completed for NSS – 90% completion	
	Employee Engagement Index (EEI)	2022/23 78 2021/22 78 2020/21 76 2019/20 76 2018/19 76	EEI 2023/24 target - 78

	Team Action Plans	2022/23 90% 2021/22 90% 2020/21 N/A 2019/20 88% 2018/19 76%	Team action plan completion target for 2023/24 - 90%
	Well Informed Overall iMatter score 80	2022/23 80 2021/22 80 2020/21 79 2019/20 79 2018/19 20	Well Informed Target for 2023/24 - 80
	Involved in Decisions Overall iMatter score 73	2022/23 73 2021/22 73 2020/21 71 2019/20 71 2018/19 72	Involved in Decisions Target for 2023/24 - 73
	Introduce all NSS Board members to staff via all staff communication	Completed through fortnightly Stay Connected Sway document.	
	Explain roles and responsibility of Board members and difference of Non-Executive and Executive Board members	Video presentations created to introduce Non-Executive members to staff.	Further ways of increasing Board members visibility being scoped. Following Pulse Survey in December 2022 and analysis of this further ways of increasing Board members / Non-Executives visibility being scoped.

	NSS performance dashboard to be made available to all staff	Paused due to reduced team resources	Carry forward to GPTW Plan 2023/24
	Provide a summary of NSS Partnership Forum key areas of discussion and agreements to all staff on a regular basis		Carry forward to GPTW Plan 2023/24
	Deliver Chief Executive and Employee Director Stay Connected Sessions	Delivered	These will continue in 2023/24.
	Provide regular communications on key areas of delivery including COVID-19 update for staff	Delivered	Communications on key areas of delivery will continue in 2023/2024.
	SBU Townhall meetings via Digital First Approach and where appropriate face to face	Delivered	
	Develop digital approach to Partnership Working Training	Paused due to reduced team resources	Carry forward to GPTW Plan 2023/24.
	Implement revised organisational change and TUPE toolkits	Updated Toolkits agreed and implemented in partnership by deadline	
	Consult with all staff on any changes to NSS Workforce Policies	Monitor progress of schedule agreed by WPTC and Once for Scotland Policies – Consultation completed for	Awaiting information from Scottish Government Policy Development Group to implement the soft launch of

		Supporting Work Life Balance (SWLB) suite of policies and feedback provided to Scottish Government	these policies in autumn 2023/2024. Continue to review and engage with staff on all Partnership Information Network (PIN) and Non PIN Policies in 2023/24.
Staff governance standard strand	**Action**	**Evidence**	**Expected outcome/ current status**
Appropriately Trained and Developed	Overall iMatter score 77	2022/23 77 2021/22 76 2020/21 76 2019/20 76 2018/19 76	2023/24 – 80
	All staff to have objectives and PDPs set via TURAS appraisal	All staff are to use the TURAS appraisal platform to record their development planning reviews	For 2022/23 - 80% appraisal completed; 82% PDP; 84% Objective setting.
	Staff undertake requirements for all Statutory and Mandatory training	Statutory and Mandatory Training is monitored and reported regularly.	For 2022/23 - we have reached a 3-year Mandatory Compliance 90% and Statutory Compliance 94%.
	Develop Early Careers Strategy proposals with focus on frameworks for Modern Apprentices (MAs) and Graduate Apprentices	Strategy signed off. Scottish Apprenticeship Week publicised on Social Media and Stay Connected	For 2023/24 - Review of Young Persons Guarantee criteria. Meetings set up with

			MAs and Line Managers to create a network community.
	Embed digital first approach to HR Policy Training	eLearning module for Conduct launched	Final eLearning module of the big five (Capability) has been scoped and anticipated in Q1 of 2023/24.
	Revised Workforce Support Programme for staff impacted by Organisational Change and Redeployment	Paused due to reduced team resources	Carry forward to 2023/24.
	Design and implement NSS Digital Skills Gap Analysis and Assessment frameworks	Paper created that needs further consideration with Head of Organisational Effectiveness	
	Implement Corporate and Local Induction Programmes for all new staff and line managers	Delivered	
	Roll out the E&D Digital Training Module	Delivered	
Staff governance standard strand	**Action**	**Evidence**	**Expected outcome/ current status**
Treated Fairly and Consistently	Overall iMatter Score 80	2022/23 80 2021/22 79 2020/21 78 2019/20 77	2023/24 - 79

		2018/19 77	
	Implement Values Based Recruitment	Values based recruitment carried out for Executive and Senior Management recruitment	Paused for other staff groups.
	Embed Equality and fairer Scotland Duty Impact Assessment process across NSS	There have been 56 equality impact assessments (EQIAs) completed	All completed EQIAs are forwarded to the NSS Head of Equality, Engagement and Experience for review. A short-life working group (SLWG) convened in Q4 2022 to carry out a review of the NSS EQIA process. The SLWG will conclude the review by Q1 2023. Progress update to be included in forward plan
	Implement Race Equality Strategy	The strategy has been implemented and will be monitored and reported through the People Report to the Staff Governance Committee	
	Deliver Equal Pay Gap Report and Equality Mainstream Report	Delivered	
	Implement remaining Once for Scotland Policies using e-learning packages	Conduct eLearning launched	Final eLearning module of the big five (Capability) has been

			scoped and anticipated in Q1 of 2023/24.
	Implement Hybrid Working Protocol fully ensuring regular reviews and changes are taken into consideration fully including EQIA approach	An initial EQIA of hybrid working was completed and reviewed by the future ready working group.	The Personal emergency evacuation plan (PEEP) arrangement for hybrid working was discussed at the NSS Equality and Diversity steering group and at the NSS disability staff network meeting.
		All line managers are responsible for working with their staff to review individual requirements as part of working in a hybrid way. This includes any reasonable adjustments that may need to be made and/or reviewed. This should be captured as part on ongoing 1-2-1 meetings and at mid-year and annual review meetings.	The NSS ethnic cultural diversity and friends network carried out a survey regarding hybrid working of the members in the reporting period.
	Review Confidential Contact process ensuring feedback from pilot is taken on board	Completed. Confidential Contact Service established and reviewed. Service has now been passed to SPST with support from HR on training of new Confidential Contacts.	

	Continue to support, develop and engage with the staff equality networks to help shape and inform policy and practice in NSS	Leadership and support provided to all volunteer co-ordinators. All of our volunteers are now members of the national staff network which is facilitated by NES. This is an opportunity to learn from others, build capacity and rollout good practice across NHSS.	The ethnic cultural diversity and friends' network will implement their agreed action plan. The disability staff network will implement their agreed action plan. The LGBTQ+ staff network will continue to support LGBT History month, pride activity and the rollout of the SG Pride badge initiative.
Staff governance standard strand	**Action**	**Evidence**	**Expected outcome/ current status**
Provided with a continuously improving and safe working environment, promoting health and wellbeing of staff, patients and wider community	Overall iMatter score – 80	2022/23 80 2021/22 79 2020/21 78 2019/20 78 2018/19 78	2023/24 – 79
	Implement the NSS Wellbeing Framework across all key strands	Staff wellbeing remains a priority for NSS and this is reflective in the implementation and delivery of elements of the Wellbeing Framework – including the NSS Benefits Brochure,	NSS Wellbeing Framework covering all areas to be embedded in NSS ways of working.

		promotion of Talk Money Week, promotion of stress and mental health resources and refresher training for Mental Health First Aiders (MHFAs).	
	Review NSS Wellbeing Hub	Additional resources have been shared with staff on the Wellbeing Hub, across Comms, and in directorate-specific communications. Extra information about MHFAs, Confidential Contacts, and Whistleblowing has been promoted.	
	Further populate and promote, Physical Wellbeing, Stress and Mental Health, Wellbeing Self Care, Menopause, Drug, Alcohol and Tobacco awareness	Sessions delivered and initial network embedded. Menopause support network is used frequently and effectively. A variety of resources and live sessions have been held in the network.	
	Occupational Health & Safety support, advice and guidance for staff and line managers	Complete	
	Review NSS Safety Working Group Hub	Complete	

	Promote Display screen evaluation (DSE), Working at Home and Working in office environment guidance and support	The system is behind schedule due to other priorities within NSS and resources being aligned to other projects. Discussions will take place at EMT.	The system and process has been developed and tested in ServiceNow by the Healthy Working Lives team – currently out for wider NSS User Testing. Team are currently building the supporting documentation and undertaking the procedure and process review.
	Ensure Risk Assessments are carried out in relation to building reviews and Covid requirements.	Completed	
	Ensure that Healthy Working Lives services are equally accessible to all staff.	Completed	
Staff governance standard strand	**Action**	**Evidence**	**Expected outcome/ current status**
Provides a total benefits package that is attractive and supports retention of highly skilled workforce	Review the NSS Recognition Framework to ensure they remain relevant including:		
	Long Service Awards Excellence Awards Retirement Support including training	Long Service - Continues to be delivered in a timely manner to staff	Long Service paper to be submitted to June 2023 Partnership Forum.

		2022 Excellence Event delivered 25 January 2023.	2023 Excellence Event being planned
	Identify any proposed new recognition schemes	Focus Groups carried out April/May 2022 with data gathered on staff views of Long Service Awards and Recognition	Recognition schemes being researched for discussion at Partnership Forum in 2023/24
	Review the NSS Staff Benefits Framework	NSS Staff Benefits brochure produced	

APPENDIX D

Annual Report to NSS Board by NSS Finance, Procurement, and Performance Committee: 1 April 2022 – 31 March 2023

1. INTRODUCTION

1.1 The purpose of the annual report is to provide a summary of matters considered and to provide an assurance to the NSS Board that the Committee has fulfilled its remit.

2. MEMBERSHIP

2.1 The Members of the Finance, Procurement, and Performance Committee are:-

- Gordon Greenhill, Non-Executive Director and Committee Chair (Vice-Chair until 28 July 2022, then Committee Chair from 29 July 2022)
- Mark McDavid Non-Executive Director and Committee Chair (until 28 July 2022, then member until 31 August 2022)
- Lisa Blackett, Non-Executive Director
- Julie Burgess, Non-Executive Director
- Ian Cant, Non-Executive Director
- Beth Lawton, Non-Executive Director (from 1 September 2022 and also immediately appointed Vice-Chair)
- Keith Redpath, NSS Chair

2.2 The following NSS officers are normally in attendance at meetings of the Committee:-

- Chief Executive
- Director of Finance
- Director of Strategy, Performance, and Service Transformation
- Director of National Procurement

3. MEETINGS

3.1 The Committee met on the following dates:-

- 24 May 2022
- 24 August 2022
- 16 November 2022
- 3 February 2023.

4. COMMITTEE ACTIVITIES

4.1 The Committee discharged its key duties under its Terms of Reference as per the table overleaf:

Item	Description	Evidence
ToRs (a)	To review or recommend for approval the Annual 3-year or 5-year (as required) Operational Delivery Plan (ODP) and Financial Plans, prepared consistent with statutory financial responsibilities.	Due to changes to Scottish Government timing it was delayed and went directly to the July 2022 Board.
ToRs (b)	To review or recommend for approval the Draft NSS Annual Operating Plan for submission to the Scottish Government.	Due to changes to Scottish Government timing it was delayed and went directly to the July 2022 Board.
ToRs (c)	To review or recommend for approval the NSS Property and Asset Management Strategy and action plan.	NSS, in collaboration with the National Boards, has worked on the development of a Strategic Outline Case (SOC) with an aim of consolidating and rationalising the office-based accommodation. This work commenced in 2022. Final SOC was presented to the National Collaborative Programme Board in April 2023. Further agreements are required to develop the SOC into a National Boards Property and Asset Management Strategy.
ToRs (d)	To review or recommend for approval the NSS Climate Sustainability Strategy and action plan	**<u>Agenda Item:</u>** Sustainability Strategy – at 24 May 2022 meeting
ToRs (e)	To review or recommend for approval NSS Standing Financial Instructions, Standing Orders and Scheme of Delegation	**<u>Agenda Items:</u>** FPPC ToRs, Revised SFIS for Presentation to the Board and Revised Standing Orders for Presentation to the Board – at 24 May 2022 meeting SFI Revisions – at 3 February 2023 meeting
ToRs (f)	At the request of the Board or the Chair, under delegated authority, to approve any procurements which require the authority of the Board or the Chair of the Board under NSS Standing Financial Instructions.	**<u>Agenda Items:</u>** – Scotland Excel and National Services Scotland (National Procurement) Strategic Collaboration Framework - at 16 November 2022 meeting
ToRs (g)	At the request of the Board or the Chair, review the financial aspects and make recommendations for any Business Cases beyond the scope of delegated financial authority before it is presented to the Scottish Government for approval. All business cases shall comply with the Scottish Capital Investment Manual	No Business Cases of this nature arose in 2022/23

Item	Description	Evidence
ToRs (h)	To approve, at Outline Business Case or Full Business Case stage, property transactions undertaken in accordance with the NHS Scotland Property Transactions Handbook	**Agenda Item**: Meridian Court Staff Relocation: Business Case – at 16 November 2022 meeting
ToRs (i)	To approve the NHS Scotland Procurement Strategy, Workplan and Annual Report	**Agenda Item:** National Procurement Annual Report – at 24 August 2022 meeting
ToRs (j)	To approve the NSS Procurement Strategy, Workplan and Annual Report	**Agenda Item:** NSS Procurement Annual Report – at 24 August 2022 meeting
ToRs (k)	To regularly review financial and operational performance against plans and delivery against AOP targets, and to consider the appropriateness and effectiveness of current and planned management actions	**Agenda Items**: Service Excellence Report - at every meeting (dates noted under 3.1); NSS Performance End of Year Report – at 24 May 2022 meeting
ToRs (l)	To regularly review any occurrences where the Standing Financial Instructions have not been followed	**Agenda Item**: SFI Breaches/Adverse Events - at every meeting (dates noted under 3.1)
ToRs (m)	To regularly review the performance of programmes delivered by NSS on behalf of NHS Scotland	**Agenda Item**: Portfolio Management Group Report - at every meeting (dates noted under 3.1)
ToRs (n)	To regularly review delivery against the NSS Financial Sustainability Plan	**Agenda Item**: Finance Report - at every meeting (dates noted under 3.1)
ToRs (o)	To regularly review the Business risks contained in the NSS corporate risk register and associated management actions as set out in the Integrated Risk Management Approach	**Agenda Item**: Review of Business Risks - at every meeting (dates noted under 3.1)
ToRs (p)	To regularly review, and challenge as appropriate, the content of financial reporting and information presented to the Board	**Agenda Item**: Finance Report - at every meeting (dates noted under 3.1)

5. ADDITIONAL HIGHLIGHTS

5.1 The Committee continued to receive regular, focussed updates on the procurement contract schedule.

6. CONCLUSIONS AND ASSURANCE TO NSS BOARD

6.1 The Members of the Finance, Procurement, and Performance Committee can give assurance to the Board that, in line with their remit, they have kept under review the financial position of NSS and procurement activity to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of all resources, and that the arrangements are working effectively.

6.2 The Committee Chair also wishes to record their thanks to Committee members and NSS staff members whose work has contributed to achieving and maintaining this position.

Gordon Greenhill
Chair of the Finance, Procurement, and Performance Committee
May 2023

APPENDIX E

Annual Report to NSS Board and NSS Staff Governance Committee by the NSS Remuneration and Succession Planning Committee, April 2022-March 2023

1. INTRODUCTION

1.1 The purpose of the annual report is to provide a summary of matters considered and to provide an assurance to the NSS Board and NSS Staff Governance Committee that the NSS Remuneration and Succession Planning Committee has fulfilled its remit.

2. MEMBERSHIP

2.1 The Members of the Remuneration and Succession Planning Committee during the year were: -

Members:

Ian Cant	Employee Director and Chair of the Committee
Julie Burgess	Non-Executive Director
John Deffenbaugh	Non-Executive Director
Keith Redpath	NSS Chair
Alison Rooney	Non-Executive Director
Lisa Blackett	Non-Executive Director and Chair of the NSS Staff Governance Committee and appointed Remuneration and Succession Planning Vice-Chair in March 2023

In attendance:

Jacqui Jones	Director of HR and Workforce Development
Mary Morgan	Chief Executive

3. MEETINGS

3.1 The Remuneration and Succession Planning Committee met on the following dates:

24 June 2022
29 November 2022
6 March 2023

Additionally, Members attended a development session on 14 April 2022 to carry out a full review of the Terms of Reference.

4. MINUTES OF AND ACTIONS FROM MEETINGS

4.1 Detailed and comprehensive minutes are prepared after each meeting to provide a clear audit trail and as evidence if required by the Scottish Government.

4.2 An action register is prepared to manage actions agreed from each Committee meeting and is reviewed at each meeting.

5. COMMUNICATION TO BOARD AND STAFF GOVERANCE COMMITTEE

5.1 The minutes of the Committee must be kept confidential because they contain details of named individuals. However, the following procedures are followed to ensure members of the NSS Board and NSS Staff Governance Committee are appropriately informed and assured: -

(i) A verbal report is given to the Board meeting following the Committee meeting.

(iii) A verbal report is provided to the Staff Governance Committee by the Chair of the Remuneration and Succession Planning Committee. Additional assurance can be given to the Committee if required by the NSS Chair, who is also a member of the Remuneration and Succession Planning Committee.

6. OBJECTIVES AND PERFORMANCE APPRAISALS

6.1 The Committee is required to review the objectives set for members of the Executive Cohort and review their performance appraisals to satisfy itself that the performance management process and its application is transparent, rigorous, evidence-based, and fully documented. Information summarising final performance appraisals is then submitted to the National Performance Management Committee (NPMC) for their approval.

6.2 The Committee considered the year-end appraisals at its meeting in June 2022 and were satisfied that a rigorous performance management appraisal process had been applied in determining the scores and overall performance ratings for 2021/22. The NPMC confirmed by letter in June 2022 that it was content with the appraisal outcomes for NSS for 2020/21.

6.3 There was also a discussion with regards to the 2022/23 performance plans for individuals in the Executive Cohort. Several points were highlighted in respect of individuals' objectives and the overall performance plans. The Committee confirmed its support for the plans. Members noted that it was the remit of the NSS Staff Governance Committee to provide assurance to the NSS Board that appraisals and performance plans were being carried out across the rest of the organisation and was therefore outwith the Terms of Reference of this report.

6.4 The Committee also received an assurance from the NSS Chief Executive that the 2021/22 year-end performance appraisals for individuals in the Senior Management Cohort had been reviewed and appropriately 'Grandparented'.

6.5 It is the Committee's responsibility to satisfy itself that a process has taken place to formally assess the performance of NSS staff based at the Scottish Government Health and Social Care Directorates (SGHSC) at the end of the performance period. NSS only has one member of staff in this category and there were no issues with the assessment of their performance.

6.6 Mid-year reviews of performance for individuals in the Executive Cohort for 2022/23 were undertaken in November 2022 and the Committee was reassured that members of the senior team were delivering against objectives and remained on target. Having discussed several points in respect of individuals' performance, Members confirmed they were satisfied with the performance management process and overall mid-year results.

7. SUCCESSION PLANNING

7.1 Succession planning was a key element in workforce planning within NSS and this fed through all items discussed at the meeting. All Senior Management completed their own succession plans as part of the review cycle and this was reflected in the annual appraisals reviewed by the Committee. This was particularly important due to the success of NSS candidates in being promoted into senior posts with other Boards

8. APPOINTMENTS AND TERMINATIONS

8.1 As part of the process for authorising the recruitment of vacancies and salaries on appointment the Committee received regular monitoring reports outlining recruitment to new/additional posts created for Executive and Senior Managers or Agenda for Change band 8d and 9. This included an overview of key trends of recruitment for all diversity strands. The Committee were assured that the NSS recruitment process was fair, robust, and recognised the significant ask on the recruitment team during the continuing pandemic response. Members also noted that due to the success of NSS candidates being promoted into senior posts with other Boards a programme of work was to be put in place to ensure any gaps were appropriately managed.

8.2 At their meeting in November 2022, the Committee received an update on the programme of work for enhancing leadership capability within NSS and were content to approve the recommendations set out.

9. REMUNERATION AND TERMS AND CONDITIONS

9.1 The Committee was provided with the following NHS Circular during 2022/23 – PCS (ESM) 2023/1 Pay 2022-23 which announced the pay arrangements for 2022/23 in respect of the Executive and Senior Management Cohorts.

9.2 The Members of the Committee can give assurance to the NSS Board and NSS Staff Governance Committee that NSS is fully compliant with Government requirements on Pay and Terms and Conditions.

10. CONSULTANTS' DISCRETIONARY POINTS

10.1 Members were provided with assurance that the Discretionary Points process had been carried out appropriately and this was provided by a report discussed at the November 2022 meeting of the Committee. Members noted that there had been an appeal in relation to the process for awarding Discretionary Points during the period and confirmed that due process had been followed as per the findings of the Appeal Panel.

11. COMMITTEE'S TERMS OF REFERENCE AND PROCEDURES

11.1 The Committee Terms of Reference were reviewed as part of a larger project in relation to the new NSS Corporate Governance Framework which was approved by the full Board on 9 March 2023.

11.2 A forward programme of work for the Committee was produced during the year and discussions during meetings covered all aspects of the duties of the Committee, including the following:

- Review of Recruitment Activity – standing agenda item for all meetings.
- Homologation of decisions taken between Committee meetings.
- Review of Performance Appraisals and Objectives for the Executive Cohort.

12. CONCLUSIONS AND ASSURANCE TO BOARD AND STAFF GOVERNANCE COMMITTEE

12.1 The Members of the NSS Remuneration and Succession Planning Committee conclude that they have given due consideration to the effectiveness of the systems of control concerning remuneration, performance appraisal and succession planning within NSS and can give assurance to the NSS Board and NSS Staff Governance Committee that they have discharged their responsibilities on behalf of the Board and in line with their remit under the terms of the Standing Orders for NSS.

Ian Cant
Chair of the NSS Remuneration and Succession Planning Committee
June 2023

NHS National Services Scotland

Meeting:	**NSS Board Meeting**
Meeting date:	**Friday 30th June 2023**
Title:	**Public Inquiries Update**
Paper Number:	**B/23/18**
Responsible Executive/Non-Executive:	**Lee Neary, Director of SPST**
Report Author:	**Marie Brown, Head of Public Inquiries and Scrutiny**

1. Purpose

1.1 NSS is currently responding to 3 public inquiries; the UK COVID-19 Public Inquiry, the Scottish COVID-19 Public Inquiry and the Scottish Hospitals Public Inquiry. The Infected Blood Public Inquiry is due to publish their final report in autumn 2023. The purpose of the paper is to make the NSS Board aware of the current situation regarding NSS' response to ongoing public inquiries.

2. Recommendation

2.1 It is recommended that the Board note the content of the report.

3. Executive Summary

3.1. COVID-19 Public Inquiries Listening Exercises

3.1.1. Both the UK and Scottish COVID-19 Inquiries are inviting members of the public to share their experiences through a dedicated process.

3.1.2. The Scottish COVID-19 Inquiries listening exercise is called Lets be heard.

3.1.3. The UK COVID-19 Public Inquiries listening exercise is called Every Story Matters.

3.1.4. The inquiries listening exercises will be actively taking account of each other's findings. Both the Scottish and UK COVID-19 inquiries are bound by their respective Terms of Reference, there will be occasions where the inquiries will consider the same issues, including where those matters are devolved.

3.1.5. The Scottish inquiry investigation broadly relates to the devolved areas of health, education, welfare assistance and financial support. They will not

cover areas such as vaccine safety, international travel and border controls, which are matters for the UK Inquiry.

3.2. Scottish COVID-19 Public Inquiry

3.2.1. The Scottish COVID-19 Inquiry has appointed Ian Duddy as its Chief Executive. Ian will join the Inquiry from the Scottish Humans Rights Commission, where he is Chair. As Chief Executive, Ian will be the Inquiry's most senior official. He will be responsible and accountable for the administration and management of the Inquiry.

3.2.2. The Scottish Inquiry is taking a human rights-based approach where they are looking at people most impacted by the pandemic. The inquiry will focus on three themes. Health and social care, education and young people and business and welfare. For each theme, the Inquiry will first look at the impact of the pandemic, then the implementation of measures and finally key decision making.

3.2.3. Impact hearings will start late October 2023 and due to be completed by early December 2023. The investigations and hearings for the implementation of measures and key decision making will begin in February 2024.

3.3. UK COVID-19 Public Inquiry

3.3.1. UK Module 1 is investigating pre-pandemic planning and evidential hearings will commence on 13th June 2023 in London. NSS is a Core Participant however no witness from NSS has been called to give evidence at the hearings.

3.3.2. UK Module 2A will investigate Scottish Government decision-making and political governance and focus on Scotland's strategic and overarching issues, evidential hearings are scheduled for January 2024 in Scotland. NSS has been granted Core Participant status.

3.3.3. UK Module 3 will examine the impact of the COVID-19 pandemic on healthcare systems in the 4 nations of the UK. NSS is a Core Participant for Module 3. Evidential hearings are due to commence in January 2024. NSS has been granted Core Participant status.

3.3.4. UK Module 4 will examine vaccines and therapeutics. Applications for Core Participant status opened 5th June. Evidential hearings are planned for summer 2024.

3.3.5. UK Module 5 will investigate government procurement across UK and applications for Core Participant status opens 24th October. Evidential hearings are scheduled for early 2025.

3.3.6. UK Module 6 will investigate the care sector across UK and applications for Core Participant status opens 12th December. Hearings will begin spring 2025.

3.4. Scottish Hospitals Public Inquiry

3.4.1. NSS continues to support the Scottish Hospitals Inquiry in providing requested information.

3.4.2. The procedural hearing in relation to the Royal Hospital for Children and Young People (RHYCP) has concluded. NSS are currently reviewing evidence summaries for any action required.

3.4.3. Regarding the RHCYP, Lord Brodie confirmed he is seeking Closing Statements following on from the April hearings and that the aspiration is to conclude the public hearings in relation to RHCYP and Department of Clinical Neurosciences later this year, provisionally October.

3.4.4. Hearings on the Queen Elizabeth University Hospital (QEUH) run from 12th June 2023 to 30th June 2023. No witness from NSS has been called to give evidence.

3.5. Infected Blood Public Inquiry

3.5.1. The final report with recommendations from the Inquiry is due to be published autumn 2023.

4. Impact Analysis

4.1 Quality/ Patient Care

4.1.1 There is no impact on Quality/ Patient Care.

4.2 Equality and Diversity, including health inequalities

4.2.1 There is no impact on Equality and Diversity, including health inequalities.

4.3 Data protection and information governance

4.3.1 There is no impact on Data protection and information governance

5. Risk Assessment/Management

5.1 Risk assessment and management is managed through the NSS IRMA approach.

6. Financial Implications

6.1 Financial implications of responding to the COVID-19 Inquiries remains a corporate pressure.

7. Workforce Implications

7.1 Workforce implications continue to be managed through Directorates with any risks or issues escalated to the NSS EMT.

8. Climate Change and Environmental Sustainability Implications

8.1 There are no climate change and environmental sustainability implications.

9. Route to Meeting

9.1 EMT updated monthly on NSS' response to public inquiries. This report contains the most up to date information for the NSS Board.

10. List of Appendices and/or Background Papers

There are no appendices submitted for review.

Minutes

(Approved)

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www.nhsnss.org

NHS National Services Scotland

B/23/19 A

IN PRIVATE

NHS NATIONAL SERVICES SCOTLAND AUDIT AND RISK COMMITTEE (ARC)

MINUTES OF MEETING HELD ON TUESDAY 6 DECEMBER 2022 VIA TEAMs DIGITAL PLATFORM AT 0930 HRS

Members Present:
Julie Burgess – Non-Executive Director and Committee Chair
John Deffenbaugh – Non-Executive Director
Gordon Greenhill – Non-Executive Director
Arturo Langa – Non-Executive Director
Beth Lawton – Non-Executive Director
Alison Rooney – Non-Executive Director

In Attendance:
Carolyn Low – Director, Finance and Business Services
Lynsey Bailey – Committee Secretary [Minutes]

Apologies:
Mary Morgan – Chief Executive

Members agreed, in accordance with paragraph 5.22.2 of NSS's Standing Orders, to discuss this item in private.

(Standing Order 5.22.2: The business relates to the commercial interests of any person and confidentiality is required, e.g., when there is an ongoing tendering process or contract negotiation)

1. INTERNAL AND SERVICE AUDIT PROCUREMENT: INTERNAL AUDIT LOT [Paper AR-IP/22/101 refers]

1.1 Members were advised that the standstill letter for the internal audit procurement had not yet been issued due to delays in receiving the confirmation from another stakeholder, but it was hoped that this would come within the next couple of days. Members were advised that KPMG had performed very well, particularly during the presentation part of the process and were recommended for re-appointment. The detail of the evaluation was within the paper. Members were also advised of a cost increase; however, it was noted as not material and less than had been planned for.

Decision:

To note the outcome of the Tender Evaluation undertaken by the Chair of Audit & Risk Committee and the Director of Finance on behalf of NSS, in conjunction with representatives from HIS, NES, PHS and SAS.

To homologate the decision made by the Committee in correspondence to move to Standstill on 2nd December 2022.

To approve the appointment of KPMG as Internal Auditors following the standstill period and formal consideration by the Contracts Approval Board.

2. INTERNAL AND SERVICE AUDIT PROCUREMENT: SERVICE AUDIT LOT [Paper AR-IP/22/102 refers]

2.1 Members were advised that, in respect of Service Audit, the panel's recommendation was to change auditors to PricewaterhouseCoopers (PWC). PWC gave a strong presentation recognising the role of service audit and tailoring the report to the organisation. There was also recognition of the need to manage key messages for the intended audience and importance of the language used. They had also specifically addressed matters relating to South-East Payroll and laid out how they would manage it.

2.2 Members noted the price was higher overall which was driven by assumed higher number of audit days. The panel had felt this came from a more realistic understanding of the aims of service audit and there would also be an opportunity to manage this down slightly through planning. The panel had confidence that PWC could deliver to the standard required through an approach that worked best for NSS and its stakeholders.

2.3 Members discussed the risk of qualified opinions with a change in auditors and were reassured that all mitigating steps, in conjunction with the Deloitte actions, would reduce this risk to an acceptable level. Members expressed concerns about the increase in costs. Members were advised that this allowed for coverage of areas and processes that otherwise might need to be covered by separate internal audits and there was also the possibility of looking into sharing the costs.

Transparency Statement

AL made a transparency statement that his son had recently started as a trainee with PWC but would not have been involved in the tender process.

Decision:

To note the outcome of the Tender Evaluation undertaken by the Chair of Audit & Risk Committee and the Director of Finance and service representatives from P&CFS, DaS and Finance (Payroll Services).

To homologate the decision made by the Committee in correspondence to move to Standstill on 2nd December 2022.

To approve the appointment of PWC as Service Auditors following the standstill period and formal consideration by the Contracts Approval Board.

The meeting closed at 1157hrs.

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NHS NATIONAL SERVICES SCOTLAND AUDIT AND RISK COMMITTEE (ARC)

MINUTES OF MEETING HELD ON THURSDAY 23 FEBRUARY 2023 VIA TEAMs DIGITAL PLATFORM AT 0930 HRS

B/23/19 B

Members Present:
Julie Burgess – Non-Executive Director and Committee Chair
John Deffenbaugh – Non-Executive Director
Gordon Greenhill – Non-Executive Director
Arturo Langa – Non-Executive Director
Beth Lawton – Non-Executive Director
Alison Rooney – Non-Executive Director

In Attendance:
Scott Barnett – Head of Information & Cyber Security
Kevin Boyle – External Audit, Audit Scotland
Tim Colclough – Service Audit, KPMG
Steven Flockhart – Director, Digital and Security
Carole Grant – External Audit, Audit Scotland
Laura Howard – Associate Director, Finance
Carolyn Low – Director, Finance and Business Services
James Lucas – Internal Audit, KPMG
Liz Maconachie – External Audit, Audit Scotland
Mary Morgan – Chief Executive
Lynn Morrow – Corporate Affairs and Compliance Manager
Lee Neary – Director of Strategy, Performance and Service Transformation
Matthew Neilson - Associate Director of Strategy, Performance & Communications
Lorna Ramsay – NSS Medical Director and Caldicott Guardian
Thomas Tandy – Internal Audit, KPMG
Neil Thomas – Service Audit, KPMG
Gordon Young – Head of Counter Fraud Services
Lynsey Bailey – Committee Secretary [Minutes]

Apologies:
None

1. WELCOME AND INTRODUCTIONS

1.1 J Burgess welcomed all to the meeting, which was being held virtually via the TEAMs platform.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest or transparency statements made in respect of any item on the agenda.

3. MINUTES AND ACTION LIST [Papers AR/23/02, and AR/23/03 refer]

3.1 Members considered the draft minutes from the previous meeting on 6 December 2022. They were content to approve them as an accurate record, subject to the following amendments:

- Minute 3.2 – text that says "September action" to either be removed or expanded on.

3.2 Following a brief discussion about the private minutes, it was acknowledged these would be dealt with separately outwith the meeting.

3.3 Members noted that most actions had either been completed or were covered by the agenda and forward programme. They asked to check the update against action 13.2 and ensure it was completed as noted.

Decision: To approve the minutes as a true reflection of the meeting following the amendment of the September action reference in paragraph 3.2 - September

Decision: To agree to update action 13.2 as complete and to otherwise note the action list.

4. INTERNAL AUDIT PLAN AND CHARTER [Paper AR/23/04 refers]

4.1 J Lucas spoke to the paper, which presented the Draft Internal Audit Plan 2023 for approval. Members were advised that the plan had been drafted at pace due to the recent tendering process and reappointment, and that minor adjustments may be needed as the year progressed. Members sought and received clarification about the plans for initial auditing of the new South-East Payroll team.

4.2 Members were also presented with the Internal Audit Charter which defines the operation of internal audit and the responsibilities of key stakeholders.

4.3 Members provided some minor feedback on layout and formatting for the finalised version to be brought back to the May 2023 ARC meeting for noting.

Decision: To approve the draft Internal Audit Plan as presented, acknowledging minor adjustments would be made for the final version to be brought back to the May 2023 ARC meeting for noting.

Decision: To approve the continued use of the Internal Audit Charter.

[**Secretary's Note:** The Chair agreed to bring the following two items forward to accommodate G Young's availability]

5. FRAUD REPORT [Paper AR/23/13 refers]

5.1 Members were provided with an update on the fraud prevention activity undertaken since the last meeting in December 2022. Members acknowledged the link with Whistleblowing and were given an overview of how that would be managed.

5.2 Members scrutinised the report and endorsed the outcome of the National Counter Fraud Standard self-assessment for 2022/23.

Decision: To note the contents of the Fraud Report.

Decision: To approve the National Counter Fraud Standard self-assessment for 2022/23.

6. COUNTER FRAUD SERVICES UPDATE AND INVESTIGATORY POWERS COMMISSIONER'S OFFICE REPORT [Paper AR/23/14 refers]

6.1 G Young spoke to his presentation which detailed Counter Fraud Services' (CFS) work in implementing the Counter Fraud Standards and progressing CFS's identified strategic priorities. Members sought and received further detail on the future loss prevention figure projections, training and support for the self-assessment completion, and an overview of the prevention messaging.

6.2 Members welcomed the positive nature of the Investigatory Powers Commissioners Office (IPCO) report. They also sought and received clarification on the distinction between fraud and unjustified enrichment.

Decision: To note the presentation on CFS activities and the Investigatory Powers Commissioner's Office report

7. INTERNAL AUDIT PROGRESS [Paper AR/23/05 refers]

7.1 T Tandy spoke to the paper, which provided a summary of progress against the current year's internal audit plan. Members were advised the work was on-track to close the 2022/23 audit plan and start work on the 2023/24 plan. Members were provided with updates on the outstanding actions, seeking and receiving assurance around the actions which had their dates revised at the December 2022 ARC meeting.

7.2 Members discussed value for money and incorporating and taking on board the logic model feedback previously provided. M Morgan suggested that she, J Jones, J Deffenbaugh and L Blackett would discuss how to articulate this.

Decision: To agree officers should meet to discuss how best to articulate the value for money and logic model in respect of the Leadership and Management Development audit actions. - M Morgan, J Deffenbaugh, J Jones and L Blackett

Decision: To note the progress against the Internal Audit Action Plan, namely six verified audit actions confirmed as complete and no significant findings.

8. INTERNAL AUDIT: IT INFRASTRUCTURE [Paper AR/23/06 refers]

8.1 Members were presented with the Internal Audit: IT Infrastructure report which had an overall audit assessment of 'partial assurance with improvements required'. Members advised that they would have liked to see more concise recommendations and clear agreed management actions.

8.2 Members were also keen to see a plan addressing what NSS could do directly to manage the risks within its own internal infrastructure and identifying what was for NSS influence at a national level. In particular, Members expressed concerns about the lack of visibility of obsolete equipment and the potential information governance risks associated with that. In response, S Flockhart provided an overview of a plan to take forward the actions

and highlighted the potential financial implications. Members suggested that IT infrastructure may also be useful to have as a topic at a board seminar.

8.3 Members briefly discussed the number of partial assurance ratings over the year and their potential impact on the overall audit opinion. They acknowledged that it was a testament to both the relationship with management and how the audits were now being targeted at areas that were challenging and would benefit from an internal audit review, rather than targeting areas of less concern to management.

Decision: To endorse the improvement actions proposed by management in response to the IT Infrastructure Internal Audit report.

Decision: To agree Digital and IT will be a subject for a future Board seminar.

9. SERVICE AUDIT STEERING GROUP UPDATE [Paper AR/23/07 refers]

9.1 C Low updated Members on activity overseen by the Service Audit Steering Group since the last NSS Audit and Risk Committee meeting. Members welcomed the positive progress and the plan for integration of South-East Payroll into the main payroll service audit. Members were also updated on the positive engagement taking place to enable the transition to PricewaterhouseCoopers.

Decision: To note the positive progress made in Service Audit.

10. SERVICE AUDIT: PROGRESS UPDATE [Paper AR/23/08 refers]

10.1 Members noted and scrutinised the update from KMPG on progress within Service Audit. They sought and received reassurance that there were currently no exceptions or indications that there would be any findings that would be cause for concern.

Decision: To note the positive progress in Service Audit

11. EXTERNAL AUDIT PLAN [Paper AR/23/09 refers]

11.1 C Grant spoke to the draft annual external audit plan. Members were advised that the plan was presented for information and outlines: high level financial statements and wider dimension risks identified from the planning work undertaken so far; planned audit work to address those risks; and, details of the planned materiality levels and proposed audit fees.

11.2 Members were advised that the finalised external annual audit plan would be finalised and return to the ARC meeting, May 2023. Members agreed with the proposal to circulate a finalised version (with any changes highlighted) and then bring that back to the next meeting. They also noted the increase in fees.

Decision: To note the draft external annual audit plan.

12. EXTERNAL AUDIT RECOMMENDATIONS [Paper AR/23/10 refers]

12.1 Members were taken through the paper, which updated on the responses to the recommendations from the external audit report. Members were advised that all actions were complete.

Decision: To note the quarterly update on progress of external audit actions.

13. INFORMATION GOVERNANCE AND SECURITY UPDATE [Paper AR/23/11 refers]

13.1 Members considered the paper, which updated on key aspects of enabling and underpinning activity in Information Security and Governance. Members sought and received a brief update on actions from the Information Commissioner's Office following the decision on the COVID-19 Status App.

Decision: To note the Information Governance and Security Update

Decision: To agree that ICO action updates are included in future Information Governance and Security reports, assurance is highlighted upfront in the cover report and a professional assurance statement is included.

14. RISK MANAGEMENT [Paper AR/23/12 refers]

14.1 Members scrutinised the paper, which updated on corporate red risks and issues and all corporate rad and new amber reputational risks and issues at the end of Quarter 3 (31 December 2022). Members provided feedback on the front cover report including the volume of content. This would be discussed further at the Risk Seminar planned for April 2023.

Decision: To note the risks and issues update for Quarter 3 2022/23.

15. FORWARD PROGRAMME [Paper AR/23/15 refers].

15.1 Members were presented with the forward programme J Burgess advised that she was keen to undertake the self-assessment of Committee effectiveness in time for transition to a new ARC Chair.

Decision: To agree the ARC self-assessment should take place before the change in Chair takes place and to otherwise note the forward programme.

16. EXTERNAL AUDIT FEES [Paper AR/23/16 refers].

16.1 Members were presented with a letter advising of the External Audit fees

Decision: To note the external audit fee letter.

17. ANY OTHER BUSINESS

17.1 C Low provided a brief overview of the issues and challenges around the updating of NSS's financial ledger. Members were advised that this had now been addressed and there would be no impact on External Audit as a result.

There being no further business, the meeting closed at 1145hrs.

Minutes
(Draft)

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NHS NATIONAL SERVICES SCOTLAND AUDIT AND RISK COMMITTEE (ARC)

MINUTES OF MEETING HELD ON WEDNESDAY 17 MAY 2023 VIA TEAMs DIGITAL PLATFORM AT 0930 HRS

B/23/19 C

Members Present:
Julie Burgess – Non-Executive Director and Committee Chair
John Deffenbaugh – Non-Executive Director
Gordon Greenhill – Non-Executive Director
Arturo Langa – Non-Executive Director
Beth Lawton – Non-Executive Director
Alison Rooney – Non-Executive Director

In Attendance:
Hayley Barnett – Board Secretary
Scott Barnett – Head of Information and Cyber Security
Martin Bell – Director, PCFS
Kevin Boyle – External Audit, Audit Scotland
Tim Colclough – Service Audit, KPMG
Steven Flockhart – Director, Digital and Security (DaS)
Carole Grant – External Audit, Audit Scotland
Laura Howard – Associate Director, Finance
Carolyn Low – Director, Finance, Governance and Legal Services
James Lucas – Internal Audit, KPMG
Liz Maconachie – External Audit, Audit Scotland
Stephen Mitchell – Operations Manager, National Procurement (on behalf of G Beattie)
Mary Morgan – Chief Executive
Lynn Morrow – Corporate Affairs and Compliance Manager
Lee Neary – Director of Strategy, Performance and Service Transformation
Matthew Neilson - Associate Director of Strategy, Performance & Communications [Item 11]
Lorna Ramsay – NSS Medical Director and Caldicott Guardian
Keith Redpath – NSS Chair [Items 1 – 8]
Thomas Tandy – Internal Audit, KPMG
Marc Turner – Director, Scottish National Blood Transfusion Service (SNBTS)
Lynsey Bailey – Committee Secretary [Minutes]

Apologies:
Gordon Beattie – Director, National Procurement
Neil Thomas – Service Audit, KPMG

1. WELCOME AND INTRODUCTIONS

1.1 The Committee Chair welcomed all to the meeting, which was being held virtually via the TEAMs platform. Members were advised that item 17 required to be ruled as urgent, as per Standing Order 4.2. of the NSS Corporate Governance Framework - Standing Orders, to allow it to be considered in advance of the Annual Accounts in June 2023.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest or transparency statements made in respect of any item on the agenda.

3. MINUTES AND ACTION LIST [Papers AR/23/18, AR-AP/23/01, and AR/23/19 refer]

3.1 Members considered the draft minutes from both the previous meeting on 23 February 2023, and the meeting on 6 December 2022 held In Private under section 5.22.2 of the Standing Orders.

3.2 Members considered all actions, which were recommended for closure.

Decision: To approve the minutes of the 23 February 2023 meeting, and the meeting on 6 December 2022 held In Private, as true reflections of the meetings.

Decision: To note the action list and agree the closure of actions recommended for closure.

Action: To mark the actions recommended for closure as complete – Board Services

4. INTERNAL AUDIT PROGRESS [Paper AR/23/20 refers]

4.1 T Tandy spoke to the paper, which summarised progress against the internal audit plan. In respect of thought leadership, Members asked about benchmarking against other organisations. The impact of COVID-19 was acknowledged, and T Tandy gave an overview of the areas given particular focus. The mix of partial and significant assurance reports through the year indicated a good relationship between auditors and management, and that the right areas were being audited.

4.2 Members discussed the composition and skill sets of the ARC, the upcoming self-assessment, and succession planning for Non-Executives whose terms were coming to an end in the coming year. Members recognised that while some difficult areas had been targeted, some positive actions had emerged and were being progressed well. They were therefore hopeful of an overall opinion of significant assurance with minor opportunities for improvement.in the annual report due in June 2023.

Decision: To note that:

- **twelve audit actions were verified and confirmed as implemented, with good progress demonstrated on actions scheduled for completion by the end of June 2023;**
- **no audit actions completion dates required to be extended;**
- **there were no significant actions to highlight.**

5. INTERNAL AUDIT: CORE FINANCIAL CONTROLS - NATIONAL DISTRIBUTION CENTRE INVENTORY CONTROLS [Paper AR/23/21 refers]

5.1 Members were presented with the Core Financial Controls: National Distribution Centre Inventory Controls audit report which had an overall audit opinion of “significant assurance with minor improvement opportunities”. Members sought and received clarification on the types of high-value items counted daily and the standard which the pick error rate had been benchmarked against.

Decision: To endorse the actions proposed by management in response to the National Distribution Centre Inventory Controls internal audit report.

Action: To pass on the Committee's thanks on behalf of the Board for the work undertaken by the packers via an electronic thank you card or letter – Board Services on behalf of the Committee Chair

6. INTERNAL AUDIT: SNBTS JACK COPLAND CENTRE (JCC) [Paper AR/23/22 refers]

6.1 Members were presented with the SNBTS JCC audit report, which had an overall audit opinion of "significant assurance with minor improvement opportunities". Members sought and received clarity around the timescales for reduction or removal of the first recommendation around benefits realisation. They were also given an overview of how some of the work to address this had already been done.

6.2 Members highlighted the need to be mindful of the time context of this audit and its relationship to the earlier benefits realisation assessment which had been done. They also recognised the need to address the challenges in accurately identifying what could be could be definitively measured at a later date, and how to make some of the anecdotal and qualitive evidence measurable.

6.3 Members briefly discussed additional capacity and usage of the facilities, and the priority being given to maximising this. The Director of SNBTS provided an overview of the history of this and the intentions for the future.

Decision: To endorse the actions proposed by management in response to the SNBTS JCC internal audit report.

7. INTERNAL AUDIT: BUSINESS CONTINUITY ARRANGEMENTS [Paper AR/23/23 refers]

7.1 Members were presented with the Business Continuity Arrangements internal audit report which had an overall audit opinion of "significant assurance with minor improvement opportunities". Members requested clarity about the governance route and frequency for progress reporting but were otherwise content with the report.

Decision: To endorse the actions proposed by management in response to the Business Continuity Arrangements internal audit report.

Action: To clarify the governance route for progress reporting – Board Secretary

8. SERVICE AUDIT MANAGEMENT [Paper AR/23/24 refers]

8.1 Members considered the paper, which provided an update on the work undertaken to achieve a successful Service Audit outcome for 2022/23 and manage the transition to new Service Auditors for 2023/24. T Colclough briefly spoke to the final reports and Members welcomed the unqualified opinions for all three reports. Members were also provided with an overview of the progress achieved in PCFS. In respect of Payroll, Members were updated on the management of those working remotely and the impact of the pressure caused by the late confirmation of the pay award.

8.2 Members commended and congratulated all involved in the work to achieve this position. Members also thanked the KPMG Service Audit team for all their efforts.

Decision: To approve the issue of the three Service Audit reports presented by KPMG to Health Boards and their External Auditors.

Decision: To note the progress made in preparing for Service Audit activity in the coming year.

DRAFT

9. EXTERNAL AUDIT PROGRESS: INTERIM AUDIT MANAGEMENT LETTER [Paper AR/23/25 refers]

9.1 Members discussed the paper, which shared the findings from the interim audit test of controls carried out by Audit Scotland as part of the audit of the NSS Annual Report and Accounts for 2022/23. Members wished to thank all involved for their efforts to get this first stage complete. Members were advised there was a good early relationship with the new audit team and Management had welcomed the findings from this testing. They received an overview of the work to date and the initial findings.

9.2 Members sought and received assurance about controls which could be put in place to address the exception highlighted regarding inadvertent delays in the processing of staff changes, and NSS's position on recovery of any resulting overpayments. The Electronic Employee Support System (eESS) was the prime system in this process so needed to be updated on a timely basis. To make that more visible, errors were being managed as financial incidents which would allow identification of the root causes and appropriate actions to be taken. Members were advised recovery was always pursued through the most appropriate means. Members also recognised that this reinforced the need to focus on the information received as Payroll controls had worked exactly as intended.

9.3 Members were supportive of the actions proposed. However, it was recognised that since the information on eESS was entered by Managers, communication, education and engagement with Managers would be key going forward.

Decision: To note the management actions proposed to address the points raised within the Audit Scotland report.

10. INFORMATION SECURITY AND GOVERNANCE REPORT [Paper AR/23/26 refers]

10.1 Members considered the paper, which updated on key aspects of enabling and underpinning activity in Information Security and Governance. DaS colleagues were in the midst of the 2023 network and information systems audit and Members received an overview of the current status and timescales for its completion. Members were advised that there was a possible change to the ratings and were provided with explanation for that, acknowledging clarity around the messaging would be important.

10.2 In respect of risk 6121 (Unstructured and Unclassified Data), Members were provided an overview of progress and advised there was no additional risk within this area. Members asked about the upcoming Information Commissioner's Office Audit and were advised that it would start on 19 June 2023. It was anticipated that risk management and training and awareness be areas highlighted for improvements.

10.3 Members observed that there was no mention of risk 6282 (Windows 10 devices) which was reported on in the risk paper [**AR/23/27** refers], and it was proposed that this information should be cross referenced in future. Members also discussed the mention of the reduction in the volume of adverse events from NCC, and the impact of that, and suggested it could be worth having a sentence to summarise that in future reports.

Decision: To note the Information Governance and Security Update

Action: To ensure that risks included in the report are cross-referenced with the formal risk report for future reporting and no highlights are used in Executive Summary – Head of Information and Cyber Security

Action: To provide a statement in relation to information governance adverse trends with future reports – Director of Digital and Security.

11. RISKS AND ISSUES REPORT [Paper AR/23/27 refers]

11.1 Members scrutinised the paper, which updated on corporate red risks and issues, along with all corporate red and new amber reputational risks and issues, as at 31 March 2023. The following points were highlighted:

- Risk 7066 (Funding for Clinical Apheresis machines) had since been closed;
- Risks 6544 (Patient Services Lab Cover) and 7037 (Staffing Levels in Manufacturing) were showing some positive progress had been made;
- In respect of risk 6121 (Unstructured and Unclassified Data), the migration to OneDrive was nearing completion, which was positive move towards closure;
- 90% compliance for risk and resilience training.

11.2 Members had some feedback on the layout of the report, but it was agreed to defer that to the next risk workshop being planned. Members also sought and received clarification on the reporting mechanism for real-time responses to risks which may arise between the report publication and a committee meeting.

Decision: To note the risks and issues update as at 31 March 2023.

12. FRAUD REPORT [Paper AR/23/28 refers]

12.1 Members were provided with an update on the fraud prevention activity undertaken since the last meeting in February 2023. Highlights included:

- Two new cases had been raised, with investigations currently in early stages;
- Good progress had been made with implementation of the standards;
- The target compliance rate for mandatory training had been exceeded;
- NSS was making good progress with the National Fraud Initiative work and had until end of December 2023 to complete this.

12.2 Members asked about how a situation of undeclared overpayments would be dealt with and were advised that it was not fully fraud in the eyes of the Crown Office but would be treated as “unjustified enrichment”.

Decision: To note the contents of the Fraud Report.

13. NSS ACCOUNTING POLICIES 2022-23 [Paper AR/23/29 refers]

13.1 Members considered the paper, noting no major changes and that this was simply for implementation. Members discussed the Trinity Park Foundation and were given an overview of background, the intended process for closure, and future plans for managing any altruistic donations. G Greenhill volunteered to be appointed to fill a Trustee vacancy to allow progress to be made.

Decision: To note the accounting policies, which supports the NSS Annual Report and Accounts for 2022-23.

Action: To appoint G Greenhill as a Trustee of the Trinity Park Foundation to allow progress to be made on future arrangements for the charity – Associate Director of Finance

14. INTERNAL AUDIT PLAN [Paper AR/23/30 refers]

14.1 This paper was presented for information only as the final draft document had been considered at the last meeting

Decision: To note the Internal Audit Plan

DRAFT

15. EXTERNAL AUDIT PLAN [Paper AR/23/31 refers]

15.1 This paper was presented for information only as the final draft document had been considered at the last meeting.

Decision: To note the External Audit Plan

16. FORWARD PROGRAMME [Paper AR/23/32 refers].

16.1 Members were presented with the forward programme for information.

Decision: To note the forward programme.

17. ANY OTHER BUSINESS

17.1 Members had no further business to raise.

18. SERVICE AUDIT: NSI FINANCE SYSTEM [Paper AR/23/33 refers].

18.1 The Director of Finance, Governance and Legal Services spoke to the paper and provided some further detail on issue with implementation of the new finance system. Members expressed their disappointment at how this had been dealt with from a lessons-learned perspective and that e-mail had been the only communication channel. Members also expressed concerns that there had been no disaster testing, and the subsequent impact should have led to a qualification. That it was also not on the auditor's letterhead was also concerning from a governance perspective. Members felt that the letter took a narrow view of the security and indicated a failure to understand that the controls were inadequate. It was highlighted that although there were delays, NSS was able to evidence that its own controls were not impacted.

18.2 Members discussed their options for putting forward their position, along with any recommendations. L Maconachie agreed to look into this and get back with any further advice, but noted that external auditors were likely to be doing additional testing. Members agreed that the letter, as presented, only provided them with limited assurance and there was a need to seek further assurances about the practices going forward and ensure NSS engaged more effectively.

Decision: To request further assurance on the NSI Finance System.

Action: To draft a response in relation to: Committee's limited assurance; management concern about the actions attributed to Financial Leads and future working relations – Board Secretary and Director of Finance, Governance and Legal Services

Action: To report back with any further advice identified on actions that NSS should take in relation to this report – L Maconachie, Audit Scotland

There being no further business, the meeting closed at 1200hrs.

DRAFT

Minutes
(Approved)

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NHS NATIONAL SERVICES SCOTLAND CLINICAL GOVERNANCE AND QUALITY IMPROVEMENT COMMITTEE (CGQIC)

MINUTES OF MEETING HELD ON TUESDAY 28 FEBRUARY 2023 VIA TEAMs DIGITAL PLATFORM AT 0930HRS

B/23/19 D

Present:
Alison Rooney – Non-Executive Director [Chair]
Lisa Blackett – Non--Executive Director
Gordon Greenhill – Non-Executive Director
Arturo Langa – Non-Executive Director
Keith Redpath – NSS Chair

In Attendance:
Hayley Barnett – Board Secretary
Anna Lamont – Procurement, Commissioning and Facilities (PCF) Medical Director
Lorna McLintock – Scottish National Blood Transfusion Service (SNBTS) Medical Director
Lorna Ramsay – NSS Medical Director & Executive Lead for Clinical Governance
Jacqui Reilly – Director of Nursing & Executive Lead for Quality Improvement
Calum Thomson - Associate Director for Nursing, Clinical Governance and Quality Improvement
Lynsey Bailey – Committee Secretary [Minutes]

Apologies:
Beth Lawton – Non-Executive Director
Mary Morgan – Chief Executive

1. WELCOME AND INTRODUCTIONS

1.1 A Rooney welcomed all to the meeting. Apologies were noted as above.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest or transparency statements made in respect of any item on the agenda.

3. MINUTES AND MATTERS ARISING [Papers CG/23/02 and CG/23/03 refer]

3.1 Members approved the minutes from the previous meeting on 30 November 2022 as a correct record.

3.2 Members noted that there were no actions outstanding.

Decision: To approve the minutes as an accurate record of the meeting

Decision: To note the action updates provided

4. MEDICAL DIRECTORS REPORT [Paper CG/23/04]

4.1 L Ramsay spoke to her report which provided an update on clinically-related areas of NSS strategic/enabling activity and on relevant aspects of business as usual areas from a clinical perspective. Members scrutinised the report and sought and received further detail on the following:

- The new specialist doctor contract (noting that NSS already supports requirements so main task is the transition of staff to the new T&Cs);
- Monitoring of professional registration and join up with the Boards for those within NSS who have cross-Board links;
- Patient Safety Commissioner and IRIC role session at Health, Social Care and Sport Committee;
- Safe Staffing in specific areas and how this would be applied within NSS;
- Digital prescribing – complexity of standardising local processes and challenges securing specialist resource impact on pace of one aspect but now an improving position;
- Whether the Chief Scientist Office’s framework had now fully been stood down and replaced by the UK Policy Framework for Health and Social Care Research.

Decision: To note the Medical Director’s Report.

5. BLOOD AND TISSUE QUALITY, SAFETY AND SUFFICIENCY REPORT [Paper CG/23/05]

5.1 L McLintock spoke to the report which confirms that NSS continued to meet all requirements in respect of quality, safety and sufficiency. Members discussed blood bank sustainability, recognising the long-term nature of the challenges and the need to consider the role SNBTS could play in a national strategy.

5.2 Members wished to record their appreciation for SNBTS colleagues’ work on the response for the UK Infected Blood Inquiry (IBI). Members also acknowledged the high level of donor satisfaction in the recently conducted survey and briefly discussed the potential for expanding future surveys to identify why people stopped donating. Members suggested that having an SNBTS focussed seminar which covered the learning from the IBI and looked at the blood sufficiency strategies and research on donor motivation, could be useful.

Decision: To note the quality, safety and sufficiency of the blood and tissue products detailed in the Blood and Tissue Quality, Safety and Sufficiency Report.

Decision: To accept the assurances given in the Blood and Tissue Quality, Safety and Sufficiency report that the service continues to meet all the requirements placed upon it.

Action: To consider an SNBTS focus for a future seminar.

6. CLINICAL ADVERSE EVENTS AND COMPLAINTS [Paper CG/23/06]

6.1 Members discussed the paper, which provided details of Clinical Adverse Events and Complaints. Members sought further detail on QIN 15651 (ABO incompatible red cell transfusion) but were advised that this was still being investigated by the local Board, supported by SNBTS colleagues, and therefore the final report was still to come.

Decision: To note the most recent information on clinical adverse events and complaints set out in the Clinical Adverse Events and Complaints Report.

Decision: To accept the management actions identified in the Clinical Adverse Events and Complaints report provide assurance that such events are being appropriately managed in accordance with NSS processes and best professional practice.

7. CLINICAL RISKS Q4 QUARTERLY REPORT [Paper CG/23/07]

7.1 Members discussed the paper, which provided details of corporate clinical risks on the NSS Risk Register together with an opportunity to review all red and new amber clinical risks and challenge the actions taken. Members sought and received additional clarification on risk 6953 (Diabetic Eye Screening Autograder Non-Compliance with Medical Device Regulations), noting that it had been transitioned to a green risk.

Decision: To note most recent information on clinical risks set out in the Clinical Risks Report.

Decision: To accept the management actions identified in the Clinical Risks report provide assurance that corporate clinical risks are being appropriately managed in accordance with NSS processes and best professional practice.

8. HEALTHCARE ASSOCIATED INFECTON (HAI) QUARTERLY REPORT [Paper CG/23/08 refers]

8.1 Members discussed the paper, which updated on compliance with all current policy related to infection prevention and control, as well as performance against reportable Key Performance Indicators in SNBTS. Members were advised that the Scottish Government had also issued a quality document and work continues to respond to that. Members commended the work done on HAI and the positive outcomes achieved.

8.2 Members welcomed the approach of a professional assurance statement and were keen to see that consistency introduced across all Committees.

Decision: To note the most recent information on HAI set out in the HAI Quarterly Report.

Decision: To accept the professional assurances given within the HAI Quarterly report that the service continues to meet all the requirements placed upon it.

9. FORWARD PROGRAMME [Paper CG/23/09]

9.1 Members were presented the schedule of meetings provided.

9.2 **Decision: To note the CGQIC Forward Programme.**

10. ANY OTHER BUSINESS

10.1 Members had no further business to raise at this point.

11. DATE OF NEXT MEETING:

11.1 1 June 2023 at 0930hrs

The meeting finished at 1058hrs

Minutes
(Draft)

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NHS NATIONAL SERVICES SCOTLAND CLINICAL GOVERNANCE AND QUALITY IMPROVEMENT COMMITTEE (CGQIC)

MINUTES OF MEETING HELD ON THURSDAY 1ST JUNE 2023 VIA TEAMs DIGITAL PLATFORM AT 0930HRS

B/23/19 E

Present:
Alison Rooney – Non-Executive Director [Chair]
Lisa Blackett – Non--Executive Director
Gordon Greenhill – Non-Executive Director
Arturo Langa – Non-Executive Director
Beth Lawton – Non-Executive Director
Keith Redpath – NSS Chair

In Attendance:
Hayley Barnett – Associate Director of Governance and Board Services (Board Secretary)
Anna Lamont –NP, NSD & NHSS Assure Medical Director
Luis Loureiro, Scottish Leadership Fellow
Lorna McLintock – Scottish National Blood Transfusion Service (SNBTS) Medical Director
Mary Morgan – Chief Executive
Lorna Ramsay – NSS Medical Director & Executive Lead for Clinical Governance
Jacqui Reilly – Director of Nursing & Executive Lead for Quality Improvement
Calum Thomson - Associate Director for Nursing, Clinical Governance and Quality Improvement
Karen Nicholls – Committee Services Manager (Minutes)

Apologies:

1. WELCOME AND INTRODUCTIONS

1.1 A Rooney welcomed all to the meeting. Members were informed that a request had been made prior to the meeting to move an agenda item, Blood and Tissue Safety Report [paper **CG/23/24** refers] to the start of the meeting due to availability of the speaker. After consideration the Chair had agreed to this change of business.

2. DECLARATIONS OF INTEREST

2.1 There was one declaration of interest made in respect of agenda item 11 (Section 13 of these minutes) – Research Governance Annual Report [paper **CG/23/21** refers]. G Greenhill declared an interest in this item due to a potential conflict of interest in relation to a family member.

2.2 No other declarations of interest or transparency statements were made in respect of any agenda items.

Chair Keith Redpath
Chief Executive Mary Morgan

NHS National Services Scotland is the common name of the Common Services Agency for the Scottish Health Service.

3. BLOOD AND TISSUE QUALITY, SAFETY AND SUFFICIENCY REPORT [Paper CG/23/24]

3.1 L McLintock took Members through the report and highlighted the following:

- Infected Blood Inquiry interim report;
- Occult Hep B Lookback was in progress;
- Staff shortages and related risks.

3.2 Members discussed the staff shortages and the mitigation plans that had been put in place to manage these for the specific areas identified.

3.3 Members wished to record their appreciation for SNBTS colleagues' work on the Clinical Apheresis Units, reflected by the excellent Patient Feedback Survey results.

Decision: To note the quality, safety and sufficiency of the blood and tissue products detailed in the Blood and Tissue Quality, Safety and Sufficiency Report.

Decision: To accept the assurances given in the Blood and Tissue Quality, Safety and Sufficiency report that the service continues to meet all the requirements placed upon it.

4. MINUTES AND MATTERS ARISING [Papers CG/23/11 and CG/23/12 refer]

4.1 Members considered the draft minutes from the previous meeting on 28 February 2023, and were content to approve as an accurate record.

4.2 Members considered all actions, which were recommended for closure.

Decision: To approve the minutes of 28 February 2023as a true reflection of the meeting.

Decision: To note the action list and agree the closure of actions recommended for closure.

Action: To mark the actions recommended for closure as complete – Board Services

5. NSS CLINICAL GOVERNANCE AND QUALITY IMPROVEMENT COMMITTEE 2022/23 ANNUAL REPORT TO THE BOARD [paper CG/23/13 refers]

5.1 Members considered the NSS Clinical Governance and Quality Improvement Committee 2022-23 Annual Report for submission to the NSS Board meeting in June 2023.

Decision: To approve the report to be presented to the Board.

6. NSS CLINICAL GOVERNANCE FRAMEWORK AND DELIVERY PLAN 2023/24 [paper CG/23/14 refers]

6.1 Members were reminded that this had been discussed in detail at the recent development session held on 26 April 2023 and that the recommendations had now been included in the final version. L Ramsay advised that a new quarterly report

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would be presented to the Committee giving an update on progress against the delivery plan including milestones and specific key performance indicators. She advised that this would mature and change as the new framework became embedded in the organisation.

Members were advised of the recommended update to the title of the Committee and removal of the specific reference to Quality Improvement (QI). It was recognised that all areas of NSS would be focusing on QI. Members were advised that this could not be formally approved by the Committee as this was a Board level decision.

Decision: To approve the NSS Clinical Governance Framework

To approve the Clinical Governance Framework Delivery Plan 2023/24

To agree to add a quarterly update on the delivery plan to the Committee's forward plan

To note the progress made in delivery of the management actions relating to the KPMG audit.

To recommend to Board a return to the Committee's previous title, i.e Clinical Governance Committee.

Action: Board Services to add a new standing item to the forward programme of business for the Committee on this item.

7. COMMITTEE TERMS OF REFERENCE [paper CG/23/15 refers]

7.1 Members were presented with an updated Committee Terms of Reference. Members asked for one change to item 6.1.2 of the Terms of Reference to include the word 'clinical' and were content to approve the paper in line with the recommendations.

Decision: To approve the Committee Terms of Reference incorporating 'clinical' at 6.1.2.

Action: L Ramsay to update the Terms of Reference and provide final version to Board Services for submission to the Board.

8. INFECTION PREVENT AND CONTROL ANNUAL REPORT 2022/23 AND HAI QUARTERLY REPORT [paper CG/23/16 refers]

8.1 Members discussed the report and asked for clarity on the risks associated with estates and buildings outwith NSS control. J Reilly advised that the risks were low and mostly related to aesthetics. The backlog of repairs and maintenance as a result of the pandemic were now being actioned and if there were any significant concerns these would be raised appropriately. Members also welcomed the strong links with NHS Assure in relation to sustainability.

Decision: To note the SNBTS quarter 4 report setting out the most recent information on HAI.

Decision: To approve the SNBTS IPC Annual Report 2022-23

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Decision: To accept the professional assurances given that the service continues to meet all the requirements placed upon it.

Action: J Reilly to feedback Committee thanks to relevant officers for the excellent work undertaken in this area.

9. DUTY OF CANDOUR 2022/23 ANNUAL REPORT [paper CG/23/17 refers]

9.1 Members considered the report as presented.

Decision: To note the report setting out the annual position on duty of candour

Decision: To accept the assurance that the duty of candour has been managed in accordance with NSS and national policies and legislation.

Decision: To approve the report and allow for its publication on the NSS website.

Action: To publish the report as approved – C Thomson

10. PATIENT GROUP DIRECTIONS (PGD) 2022/23 ANNUAL REPORT [paper CG/23/18 refers]

Members scrutinised the report as presented.

Decision: To note the report setting out the annual position on Patient Group Directions.

To agree that assurance has been provided that Patient Group Directions have been managed in accordance with NSS and national policies and guidelines.

11. CLINICAL STAFF REVALIDATION 2022/23 ANNUAL REPORT [paper CG/23/19 refers]

11.1 Members scrutinised the report as presented.

11.2 Members asked for further assurance on the possible implications of the Educational Framework for Scotland for Healthcare Support Workers. Officers advised noted that NSS was already fully engaged in relation to training and scrutiny and would provide further opportunities for those posts.

Decision: To note the report setting out the annual position on clinical and healthcare support worker staff

To agree that assurance has been provided that regulatory and policy requirements in relation to Clinical and Healthcare Support Worker staff had been met.

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12. MEDICAL AND DENTAL STAFF REVALIDATION 2022/23 ANNUAL REPORT [paper CG/23/20 refers]

12.1 Members scrutinised the report as presented and were assured by the information received.

Decision: To note the report setting out the annual position on medical and dental staff

To agree that assurance has been provided that regulatory and policy requirements in relation to medical and dental staff registration, revalidation and enhanced appraisal have been met for 2022-23.

13. RESEARCH GOVERNANCE 2022/23 ANNUAL REPORT [paper CG/23/21 refers]

13.1 D Stirling took Members through the report in detail highlighting the following;

- Publications and Grant Activity –highlighting that further work in relation to publications by NSS staff was ongoing;
- Grant applications – a new process was being put in place in relation to the governance approach for grants to ensure the Committee was involved and aware appropriately;
- Intellectual Property – work was in progress to provide more detail for future reporting to include areas such as NSS Digital & Security programmes/applications;

Decision: To note the report setting out the results of a self-assessment against the principles of the policy framework.

Decision: To agree that assurance has been provided that research governance has been managed in accordance with national policies.

Decision: To note the extent of the research activity carried out within NSS during 2022-23.

14. IONISING RADIATION (MEDICAL) EXPOSURE REGULATIONS (IR(M)ER) ADVISORY GROUP 2022/23 ANNUAL REPORT [paper CG/23/22 refers]

14.1 Members considered the annual report and the following highlights:

- Outstanding entitlement of operators in Greater Glasgow & Clyde had now been resolved;
- Training on new equipment had been delayed;
- Record of approval of the National Diagnostic reference levels had now been reached;

14.2 Members discussed the reported breast screening adverse event, which had a positive outcome.

Decision: To note the Ionising Radiation (Medical) Exposure Regulations (IR(M)ER) report including the internal audit.

To agree that the management actions identified in the report provide assurance that compliance with the regulations is being appropriately managed.

15. MEDICAL DIRECTOR'S REPORT [paper CG/23/23 refers]

15.1 Members considered the report as presented and the following highlighted items:

- Scottish Government had confirmed that the proposed new dental governance work for NSS would not now be taken forward;
- The Scottish Cancer Network programme had now been formally commissioned as an ongoing service by Scottish Government;

15.2 Members discussed a number of areas for awareness that may have a public interest including;

- A Freedom of Information request in relation to the transgender healthcare pathways guidance – this was owned by Scottish Government who had not yet published the document;
- National Complex Mesh Removal Surgical Service – Members were advised that clinical decisions, procedures and aftercare were the responsibility of those carrying out the surgery and NSS was the commissioner of the service;
- Screening equipment (within mobile units) was being managed appropriately.

15.3 Members asked that for future reporting, updates on sustainable healthcare be included where appropriate. Members also requested that the presentation on the National Services Division (NSD) strategy, discussed at the Committee Seminar held on 11 July 2022 be re-circulated for information.

Decision: To note the Medical Director's Report setting out the most recent information on clinically relevant areas of NSS activity.

Action: To provide a briefing paper for Committee Members outwith the meeting cycle on NSS role and responsibilities in relation to commissioning of Complex Mesh Services and Transgender Healthcare Pathways. - A Lamont

Action: To circulate presentation on NSD Strategy - L Ramsay

16. CLINICAL ADVERSE EVENTS AND COMPLAINTS REPORT: QUARTER 4 [paper CG/23/25 refers]

16.1 Members noted the report and were assured that clinical adverse events were being managed appropriately.

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Decision: To note the most recent information on clinical adverse events and complaints set out in the Clinical Adverse Events and Complaints Report.

Decision: To accept the management actions identified in the Clinical Adverse Events and Complaints report provide assurance that such events are being appropriately managed in accordance with NSS processes and best professional practice.

17. CLINICAL RISK REPORT: 1 FEBRUARY TO 30 APRIL 2023 [paper CG/23/26 refers]

17.1 Members scrutinised the report and were assured that clinical risk was being managed appropriately.

Decision: To note most recent information on clinical risks set out in the Clinical Risks Report.

Decision: To accept the management actions identified in the Clinical Risks report provide assurance that corporate clinical risks are being appropriately managed in accordance with NSS processes and best professional practice.

18. FORWARD PROGRAMME [paper CG/23/27 refers]

18.1 Members noted the forward programme which was presented for information.

Decision: To note the CGQIC Forward Programme.

19. ANY OTHER BUSINESS

19.1 There was no other competent business to discuss.

20. DATE OF NEXT MEETING:

20.1 Thursday, 7th September 2023 at 0930hrs

The meeting finished at 1150 hrs

DRAFT

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(Approved)

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IN PRIVATE

NHS NATIONAL SERVICES SCOTLAND FINANCE, PROCUREMENT AND PERFORMANCE COMMITTEE (FPPC)

MINUTES OF MEETING HELD ON WEDNESDAY 16 NOVEMBER 2022 VIA TEAMs DIGITAL PLATFORM AT 0930 HRS (Item from 1050hrs)

B/23/19 F

Present:
Gordon Greenhill– Non-Executive Director and Committee Chair
Julie Burgess – Non-Executive Director
Lisa Blackett – Non-Executive Director
Beth Lawton– Non-Executive Director
Keith Redpath – NSS Chair

In Attendance:
Gordon Beattie – Director of National Procurement
Steven Flockhart – Director of Digital and Security
Carolyn Low – Director of Finance
Mary Morgan – Chief Executive
Lynsey Bailey – Committee Secretary (Minutes)

Apologies:
Ian Cant – Employee Director

Members agreed, in accordance with paragraph 5.22.2 of NSS's Standing Orders, to discuss this item in private.

(Standing Order 5.22.2: The business relates to the commercial interests of any person and confidentiality is required, e.g., when there is an ongoing tendering process or contract negotiation)

1. NATIONAL PROCUREMENT CONTRACT SCHEDULE [Paper FFP-IP/22/01 refers]

1.1 GB presented the paper which gave an update on procurement performance across National Procurement, NSS Procurement, and NHS Assure/Health Facilities Scotland. The report highlighted the work done to mitigate inflation and price variation and manage the supply chain into the warehouse. GB noted the progress that had been made on community benefits the recent awards received.

1.2 Overall, there had been good performance in NSS procurement, with £37m of savings secured to date but it was expected that the impact of inflation may reduce that to £32m. Members asked about the Recyclates and Waste Management project which

was showing as both red and green. GB advised that this should have been more amber as retendering was underway.

Decision: To note the workplan and the challenges and risks associated with its delivery in the current remobilisation and economic environment.

Decision: To note the identified risks and issues in section 5 Risk Assessment/Management of the report.

Decision: To agree that the status the Recyclates and Waste Management project is confirmed and accurately reflected within the next report – GB.

1.3 Members provided with an update on the SWAN re-procurement exercise. SF presented slides which provided a high-level overview of the situation and the response agreed by the SWAN Programme Board based on expert advice received. Members were advised that the re-procurement exercise faced legal challenge from a supplier who had been rejected from the exercise earlier in the process. This would require NSS to defend the challenge in a court hearing.

1.4 Members discussed the risks associated with the legal challenge; specifically, the operational challenge of delays preventing the new contact being in place for 31 March 2023 and the financial risk. They were also provided with an overview of action which had been taken during the last re-procurement exercise which also faced legal challenge.

1.5 Members were advised that Scottish Government had been appraised of the situation and received assurance that NSS had the backing of all the stakeholders it was acting on behalf of. Members briefly discussed the relationship with Scottish Government around this.

1.6 Members acknowledged the work being done to manage the emerging situation, noting it was particularly challenging as its reach was wider than just Health and Social Care. There was a brief discussion about the risk register and how this matter would be recorded on it.

Decision: To note the update and detailed next steps provided on the SWAN re-procurement exercise and to agree that members would be updated on further developments.

There being no further business, the meeting closed at 1125hrs.

Minutes
(Approved)

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NHS NATIONAL SERVICES SCOTLAND FINANCE, PROCUREMENT AND PERFORMANCE COMMITTEE (FPPC)

MINUTES OF MEETING HELD ON FRIDAY 3 FEBRUARY 2023 VIA TEAMs DIGITAL PLATFORM AT 0930 HRS

B/23/19 G

Present:
Gordon Greenhill– Non-Executive Director and Committee Chair
Julie Burgess – Non-Executive Director
Lisa Blackett – Non-Executive Director
Keith Redpath –Chair
Ian Cant – Employee Director

In Attendance:
Hayley Barnett – Associate Director/Board Secretary
Gordon Beattie – Director of National Procurement
Julie Critchley – Director NHSS Assure
Steven Flockhart – Director of Digital and Security
Carolyn Low – Director of Finance
Mary Morgan – Chief Executive
Lee Neary – Director of Strategy, Performance and Service Transformation
Matthew Neilson – Associate Director of Strategy, Performance and Communication
Helen Newlands, Head of Business Development, SNBTS
Karen Nicholls, Committee Services Manager (Minutes)

Apologies:
Beth Lawton– Non-Executive Director (Note: due to error in meeting invite)

1. WELCOME AND INTRODUCTIONS

1.1 G Greenhill welcomed all to the meeting, which was being held virtually via the TEAMs platform. Apologies were noted as listed above.

1.2 Post Meeting Note: After carrying out a review of the meeting invite it was noted that B Lawton had dropped off the list so was not aware of the meeting date/time. All future invites were now being updated and cross checked for all Non-Executive Directors.

Action: Board Services to review all meeting invites.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest or transparency statements made in respect of any item on the agenda.

3. MINUTES AND MATTERS ARISING [Papers FPP/23/02 and FPP/23/03 refer]

3.1 Following a brief discussion, , Board Services were asked to provide an additional paragraph to reflect the In Private discussion held at the last meeting.

Decision: To approve the minute of the FPPC of the 16 November 2022.

Action: Board Services to provide an additional paragraph noting the In Private discussion to the next meeting.

4. MERIDIAN COURT RELOCATION - FULL BUSINESS CASE [Paper FPP/23/04 refers]

4.1 Members were asked to note the content of the full business case and approvals carried out outwith the meeting, as per the delegation agreed at the FPPC meeting of 16 November 2022.

Decision: To homologate the decision, agreed outwith the meeting, to approve Option 3A – One floor at Delta House, West Nile Street, plus retained estate, as the preferred solution to replace Meridian Court.

5. PUBLIC BODIES CLIMATE CHANGE DUTIES REPORT 21/22 SUBMISSION [Paper FPP/23/05 refers]

Members were advised that the paper had been considered by the NSS Executive Management Team and subsequently approved outwith Committee to meet timelines for submission to Scottish Government and publication, as per the delegation agreed at the FPPC meeting of 16 November 2022. It was noted that there had been positive feedback on the submission.

Decision: To homologate the decision by the Chair of FPPC and the Board Sustainability Champion to approve the Public Bodies Climate Change Duties report, attached at appendix 1 of the report.

6. ANNUAL HEALTH BOARD CLIMATE AND SUSTAINABILITY REPORT 2021-22 [papers FPP/23/15a and 15b refer]

6.1 The Committee agreed to consider item 16.1 at this point on the agenda.

6.2 Members were informed that Scottish Government had brought forward the reporting deadline for publication. The report submission had been postponed in 2020/21, but reinstated in December 2022 with a tight submission deadline. Members noted that the report would also be published on the NSS website.

6.2 Members discussed the report in full and asked for clarification on treatment and reporting of waste. The Director of NHSS Assure advised that the apparent discrepancy in reporting related to a reduction in food waste, but was off-set by an increased NSS footprint (i.e. additional warehouse and staff returning to buildings) with related increase in domestic waste, and this would be made clearer in future reporting.

6.3 Members were informed that the National Sustainability Assessment Tool (NSAT) return was due for submission in April 2023 with final submission to Scottish Government in August 2023. The Director of NHSS Assure to provide a draft report to next meeting for scrutiny. Future reporting would also include climate and sustainability performance.

6.4 Members described the report as positive and proposed this message should be shared with NSS staff. The Employee Director also asked for access to the climate literacy training programme.

Decision: To approve the Annual Health Board Climate and Sustainability Report, as set out in Appendix one of the report on behalf of NSS.

Action: The Director of NHSS Assure to liaise with the Employee Director in relation to Climate Literacy training access.

Action: Board Services to add the NSAT report to the FPPC Forward Programme for the next meeting.

7. FINANCE REPORT [paper FPP/23/06 refers]

7.1 The finance report was presented to committee for scrutiny. The report included the current position, financial performance against plan for the period 1 April to 31 December 2022, and forecasted a balanced budget for the Finance Year 2022-23.

Decision: To note the improving financial position reported.

8. NSS BUDGET 2023-24 PRESENTATION

8.1 The Director of Finance presented the proposed budget for 2023-24. Members held a full discussion on the proposals and welcomed the assurance provided and the new Budget Summit format for Directorate discussions of plans for savings and investments. The Director of Finance advised that the final position would be made to the Board at their meeting, 9 March 2023.

Decision: To note the proposed budget 2023/2024.

9. STANDING FINANCIAL INSTRUCTIONS ADVERSE EVENTS

9.1 There were no financial adverse events during the period.

10. STANDING FINANCIAL INSTRUCTIONS [paper FPP/23/14 refers]

10.1 Members were presented with the Standing Financial Instructions for 2023/24. The Director of Finance advised the Committee that there were no material changes from the 2022/23 version.

Decision: To approve the Standing Financial Instructions for 2023/24.

11. NATIONAL PROCUREMENT CONTRACT SCHEDULE [paper FPP/23/07 refers]

11.1 The report presented to members included an update on the national workplan for current financial year 2022-23, including challenges associated with delivery, and an update on procurement performance across National Procurement, NSS Procurement and NHS Assure. Information was also provided on the procurement activity planned for financial year 2023-24.

11.2 Members welcomed the streamlined report.

11.3 Members asked that a Committee Seminar be set up to look at the lifecycle of one programme in detail (e.g., Medicines Strategy or the Home Community Care programme) and to give an overview of how contracts are managed strategically.

11.2 The Board Chair queried an event being held in relation to construction consultancy frameworks and whether NHSS Assure had any links taking part.

Decision:

1) **To note the ongoing impact on the national workplan which will continue to recover in next financial year 2023-24 with analysis of future planning to be carried out.** ♣
2) **To note cost avoidance is currently forecasting under target, corrective action to review during Q4.**
3) **To note secured savings forecast for year end is £37m against target of £10m**
4) **To note identified risks and issues in section 5, Risk Assessment/Management.**
5) **To note the list of awards in Appendix 1 requiring CEO approval to advise if the Board would like to review at strategy stage.**
6) **To agree a FPPC Seminar on Procurement should be arranged.**

Action: The Director of National Procurement to liaise with Director of NHSS Assure on external event participation including construction consultancy frameworks..

12. PORTFOLIO MANAGEMENT GROUP REPORT [paper FPF/23/08 refers]

12.1 Members were provided with an overview of the delivery status of key national programmes being delivered by NSS on behalf of NHS Scotland, based on the position reported to the NSS Portfolio Management Group at their last meeting on 10th January 2023.

Decision: To note the improving position of key national programmes being delivered by NSS on behalf of NHS Scotland,

13. NSS 2022/23 QUARTER THREE SERVICE EXCELLENCE REPORT [Paper FPP/23/09 refers]

13.1 Members noted the report, which gave an overview of the delivery status of key programmes and performance metrics. Members scrutinised the report in full as per the recommendations and welcomed the progress made and the mitigating actions in relation to those areas that may not meet targets due to dependence on areas outwith NSS.

Decision: To note the Service Excellence Performance Report.

14. RESILIENCE REPORT [Paper FPP/23/10 refers]

14.1 Members noted the report, which updated on resilience activities that have taken place since the previous FPPC meeting on 16 November 2022, and highlighted any future potential issues. There had been no significant business continuity incidents requiring stand up of the NSS Resilience Management Team.

Decision: To note the Resilience Report.

15. REVIEW OF BUSINESS RISKS [Paper FPP/23/11 refers]

15.1 Members were taken through an overview of the activity in relation to the following highlighted risks and issues:

At 31 December 2022, there were five red corporate business risks and one issue on the NSS Risk Register.

- Risk 6205: Financial Sustainability in the Medium-Long Term.
- Risk 3816: Staffing Levels in Manufacturing.
- Risk 5671: nDCVP Programme.
- Risk 6554: Skilled Resources.
- Risk 6282: Devices with Win10 v1709 Build.
- Issue 6249: P&CFS Bespoke System (Oracle 12C & Windows 7/XP).

15.2 Members noted the mitigating actions and additional updates provided and asked for a Board Seminar be set-up to look at risk in more detail. There was also a request for future reporting the appendixes be abbreviated or shared for reference only. For the specific items relating to ‘Unstructured Data’ Members asked for a more detailed update including volumes of data involved.

Decision: To note the Corporate Business Risk & Issues Report.

Action: Board Services to liaise with the Director of Strategy, Performance and Service Transformation to confirm Risk Workshop meeting for Board.

Action: Director of Strategy, Performance and Service Transformation to review size and content of report/appendixes for future reporting.

Action: Director of Strategy, Performance and Service Transformation to liaise with Digital and Security to provide additional information in relation to risks associated with NSS data.

16. NSS/PUBLIC HEALTH SCOTLAND SERVICE LEVEL AGREEMENT (DRAFT) [Paper FPP/23/12 refers]

16.1 Members were asked to scrutinise the NSS/Public Health Scotland Service Level Agreement in full and welcomed the approach being put forward. Further clarity was sought on two roles in recruitment and were reassured that this would enhance the ongoing relationship between the Boards and support existing workloads etc.

16.2 Members discussed the benefits of joining up at a Non-Executive level and Director of Strategy, Performance and Service Transformation agreed to look at how this could be actioned.

16.3 As per the recommendations within the paper Members were content with the level of assurance provided and approved Section 5.0 as requested.

Outcome: To note the NSS/PHS Corporate Shared Services New Service Level Agreement.

Action: Director of Strategy, Performance and Service Transformation to review how to engage both sets of Non-Executives to establish ongoing relationships.

17. INTELLECTUAL PROPERTY BRIEFING [Presentation]

17.1 Members welcomed the Head of Business Development, SNBTS to the meeting who provided an overview presentation on Intellectual Property within NSS. After a short discussion, the Deputy Director of Finance agreed to work with the Head of Business Development, SNBTS to ensure all relevant assets were fully included in the NSS balance sheets and possible centralised NSS IP asset register.

Outcome: To note the presentation on Intellectual Property.

Action: Deputy Director of Finance to liaise with the Head of Business Development, SNBTS to review asset register and accounting processes.

18. FORWARD PROGRAMME [paper FPP/23/13 refers]

18.1 The Forward programme was presented. The Director of NHSS Assure advised that the was a sustainability report which would require to be added.

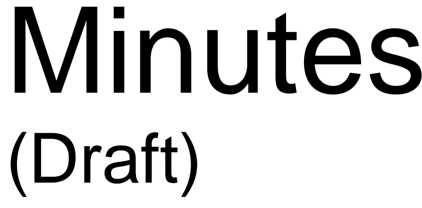
Decision: To agree the content of the Forward Programme, subject to the addition of a sustainability report as advised by the Director of NHSS Assure.

Action: Director of NHSS Assure to provide Board Services with the title of the sustainability report to be added.

19. ANY OTHER BUSINESS

19.1 Members had no further business to raise.

There being no further business, the meeting closed at 1140 hrs.



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NHS NATIONAL SERVICES SCOTLAND FINANCE, PROCUREMENT AND PERFORMANCE COMMITTEE (FPPC)

MINUTES OF MEETING HELD ON WEDNESDAY 31 MAY 2023 VIA TEAMs DIGITAL PLATFORM AT 0930 HRS

B/23/19 H

Present:
Gordon Greenhill– Non-Executive Director and Committee Chair
Lisa Blackett – Non-Executive Director
Julie Burgess – Non-Executive Director
Ian Cant – Employee Director
Beth Lawton– Non-Executive Director
Keith Redpath – NSS Chair

In Attendance:
Martin Bell – Director of PCFS (Item 12)
Steven Flockhart – Director of Digital and Security (Item 17)
Laura Howard – Associate Director, Finance
Carolyn Low – Director of Finance, Governance and Legal Services
Andy McLean – Deputy Director of Finance
Simon Mollart - Head of Strategic Sourcing (deputising for G Beattie)
Lee Neary – Director of Strategy, Performance and Service Transformation (SPST)
Neil Redhead – Interim Assistant Director Facilities Management (Item 11 – deputising for J Critchley)
Lynsey Bailey – Committee Secretary (Minutes)

Apologies:
Gordon Beattie – Director, National Procurement
Julie Critchley – Director, NHS Assure

1. WELCOME AND INTRODUCTIONS

1.1 G Greenhill welcomed all to the meeting, which was being held virtually via the TEAMs platform. Apologies were noted as listed above.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest or transparency statements made in respect of any item on the agenda.

3. MINUTES OF THE PREVIOUS MEETINGS HELD ON FRIDAY 3 FEBRUARY 2023 AND 16 NOVEMBER 2022 (HELD IN PRIVATE UNDER SECTION 5.22 OF THE NSS STANDING ORDERS), AND MATTERS ARISING [papers FPP/23/17, FPP-IP/23/01 and FPP/23/18 refer]

3.1 Following discussion, Members were content that the minutes were accurate records of the meetings.

3.2 Members noted the updates provided on the action tracker: The Chief Executive provided an additional, brief update to item 10, which Members agreed to recommend for closure.

Decision: To approve the minute of the FPPC of the in Private meeting held on 16 November 2022 and the meeting held on 3 February 2023.

Decision: To agree to close actions 1-4 and 7-11 which had been recommended for closure. Updates for the remaining actions were due for future meetings.

4. FINANCE, PROCUREMENT, AND PERFORMANCE COMMITTEE ANNUAL REPORT TO THE BOARD [Paper FPP/23/19 refers]

4.1 Members considered the report and approved its contents. G Greenhill expressed his thanks to all involved for all their work over the year.

Decision: To approve the report to be presented to the Board as a summary of the Committee's activities during 2022/23.

5. FINANCIAL PERFORMANCE TO 31 MARCH 2023 [paper FPP/23/20 refers]

5.1 The finance report was presented to committee for scrutiny. Highlights: small underspends and secured those being returned for the current year. Members were given an overview of NSS's revenue position. Members sought and received clarity regarding the mention of a lack of visibility of how the Cash Releasing Efficiency Savings were being delivered and the risks associated with that. Members wished to pass on their appreciation for achieving the current positive position.

5.2 Members asked about the Scottish Government allocations for 2023/24 and were advised that the first letter was due in the coming week, with a brief overview of what was anticipated to be in it. Members were pleased to see the NSS way of working seemed to be beneficial to this process.

5.3 Members asked for more detail around Test and Protect and were advised that an upcoming EMT paper could be summarised into a briefing note which then could be shared for information. B Lawton asked for more clarity about the Community Health Index (CHI) and eRostering underspend and agreed to follow this up outside of the meeting with the Deputy Director of Finance.

Decision: To note the achievement of statutory financial targets (subject to external audit review).

Action: To provide a briefing note to Members on Test and Protect for information - Director of SPST

Action: To follow up on clarification of CHI and eRostering underspend with the Deputy Director of Finance – B Lawton

6. STANDING FINANCIAL INSTRUCTIONS ADVERSE EVENTS

6.1 There were no financial adverse events during the period.

7. NATIONAL PROCUREMENT CONTRACT SCHEDULE [paper FPP/23/21 refers]

7.1 Members were taken through the paper which provided an update on the national workplan for the close of last financial year 2022-23 and the procurement activity planned for current financial year 2023-24. Members briefly discussed the highlighted risks and were satisfied with the mitigations.

7.2 Members asked about the savings in medicines and how frequently this was reviewed. They were advised that this was led by the expiry of contracts and patents. They also sought and received clarification that the nurse figures quoted were for across NHSScotland.

7.3 Members commended the work on the recent, successful Procurement event and looked forward to more of these in future. Moving on to sustainability, Members were given a brief overview of the approach and they expressed their appreciation for the work being done in this area.

7.4 Members sought and received clarification around IT procurement and re-procurements and how they would appear on the workplan. They also discussed examples of community benefits and how these were showcased. Finally, they sought and received clarification of the proportion of projects with a "red" resource RAG rating.

Decision: To note:-

- **the secured savings achieved in the last financial year, 2022-23;**
- **the ongoing impact on the national workplan which will continue to recover in 2023-24 with an analysis and prioritisation exercise underway;**
- **the identified risks and issues in section 5 Risk Assessment/Management;**
- **the project summary provided for SWAN at Appendix 1;**
- **the list of awards in Appendix 2 requiring CEO approval, with none requiring Board review at strategy stage;**
- **the NSS Contracts Awarded for more than £1m detailed at Appendix 3.**

8. PORTFOLIO MANAGEMENT GROUP REPORT [paper FPF/23/22 refers]

8.1 Members were provided with an overview of the delivery status of key national programmes being delivered by NSS on behalf of NHS Scotland, based on the position reported to the NSS Portfolio Management Group at their last meeting on 15 May 2023. Members' attention was directed to the particular highlights for the CHI, Child Health and Endoscopy programmes. They also sought and received assurance around the funding and staffing in place

Decision: To note the improving position of key national programmes being delivered by NSS on behalf of NHS Scotland.

9. SERVICE EXCELLENCE REPORT: QUARTER 4 2022/23 [Paper FPP/23/23 refers]

9.1 Members considered the report, which gave an overview of the delivery status of key programmes and performance metrics. In particular, Members focussed on the highlighted performance in respect of Freedom of Information (FOI) requests, along with the downward trend in complaints in staff behaviour and attitude. They commended the 94% delivery rate (88 of 94 deliverables). Members sought and received clarification about the mention of incorrect dates on FOIs and whether the response had led to much follow up. They also asked for the March 2023 date in the paragraph on social value to be checked and corrected if necessary, and that the total number of FOI requests be shared for context.

Decision: To note the Service Excellence Performance Report.

Action: To check March 2023 date in the paragraph on Social Value and correct if necessary – Director of SPST

Action: To provide members with the specific number of FOI requests for context – Director of SPST

10. RESILIENCE REPORT [Paper FPP/23/24 refers]

10.1 Members noted the report, which updated on resilience activities that had taken place since the previous FPPC meeting on 3 February 2023, and highlighted any future potential issues. There had been no significant business continuity incidents requiring stand up of the NSS Resilience Management Team.

10.2 Members were given an overview of the response to IT incidents which had been addressed by Digital and Security colleagues. They were also advised that the Executive on-call arrangements continued to work well, and consideration was being given to holding an organisation--wide cyber security resilience exercise.

10.3 Members discussed the highlighted findings and recommendations from KPMG's internal audit. They welcomed the assurance statement and positive feedback.

Decision: To note the Resilience Report.

11. CORPORATE BUSINESS RISK AND ISSUES REPORT: Q4 2022/23 [paper FPP/23/25 refers]

11.1 Members were taken through an overview of the activity in relation to the following highlighted risks and issues:

- 6282 (Windows 10 Devices) – Members were provided with an overview of the plan for managing the final, remaining devices which were still being used (predominantly in SNBTS)
- 6247 (Continued Use of Windows7) – Good progress had been made
- 6121 (Unstructured and Unclassified Data) – Significant progress had been made and the move to Sharepoint would close this off.

11.2 Members requested confirmation of the anticipated closure date for risk 6282 but were otherwise content with the update provided.

Decision: To note the Corporate Business Risk and Issues Report.

Action: To confirm an anticipated closure date for Risk 6282 (Windows 10 Devices) - Director of SPST

12. UPDATE ON THE NATIONAL SUSTAINABILITY ASSESSMENT TOOL [paper FPP/23/26 refers]

12.1 Members considered the paper, which provided information on the 2022/23 National Sustainability Assessment Tool (NSAT) score, along with feedback on the progress to date and highlighted any potential risks for mitigation. Members were advised that this was required every two years but NSS planned to monitor internally on an annual basis. It was also highlighted that the stated "Gold" position was still to be externally verified.

12.2 Members welcomed the highlighted improvements in capital projects, sustainable care and procurement. The areas of focus for future improvement would be green space and biodiversity. Members were advised of concerns about the new scoring system but were advised that this was being monitored. Members were taken through the highlighted risks and how they were being managed. Members briefly discussed the risk of a potential drop in the NSAT score following external verification but were given an overview of the robust measures taken to mitigate that. Members wished to record their acknowledgement and appreciation for the work being done in this area.

12.3 Members asked about the timeframe the score was based on and were advised it was based on the current position. However, a separate workstream was trying to get some focus on future strategy and the consideration could be given to how these two pieces could complement and support each other. Members discussed the risk that being seen to be doing so well might affect NSS's ability to get additional resource.

12.4 Members were advised that NSS should start to see the benefits of recent recruitment. It was suggested that sustainability might be a good possible topic for a future seminar.

Decision: To note the update provided on the National Sustainability Assessment Tool

Action: To consider sustainability as a potential seminar topic – G Greenhill/ Board Services

13. MERIDIAN COURT RELOCATION: FULL BUSINESS CASE [paper FPP/23/27 refers]

13.1 Members were presented with the final version of the Business Case, which provided an updated overview of savings and staff engagement. Members were made aware of the estate strategy being adopted across the public sector and were keen to have assurance that the Business Case was aligned with Scottish Government policy. Members discussed the difference in savings from the original business case, acknowledging it was due to more detailed information now being available, and asked for confirmation of how much it was.

Decision: To note that option 3A was still the preferred option and that all appropriate programme actions continued to be taken in line with agreed timescales

Action: To confirm the difference in savings figures from the initial business case – Director of Finance, Corporate Governance and Legal Services

14. FORWARD PROGRAMME [paper FPP/23/28 refers]

14.1 The forward programme was presented for information.

Decision: To note the Forward Programme.

15. ANY OTHER BUSINESS

15.1 Members had no further business to raise.

16. NSS ANNUAL DELIVERY PLAN 2023/24 [paper FFP-IP/23/02 refers]

16.1 Members agreed, in accordance with paragraph 5.22 of NSS's Standing Orders, to discuss this item in private

17. PICTURE ARCHIVING AND COMMUNICATION SYSTEM (PACS) REPROVISIONING PROGRAMME

17.1 Members agreed, in accordance with paragraph 5.22 of NSS's Standing Orders, to discuss this item in private

There being no further business, the meeting closed at 1159 hrs.

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NHS NATIONAL SERVICES SCOTLAND STAFF GOVERNANCE COMMITTEE

MINUTES OF MEETING HELD ON THURSDAY 9 FEBRUARY 2023, COMMENCING 0930 HOURS VIA TEAMS

B/23/19 I

Present:
Lisa Blackett – Non-Executive Director and Committee Chair
David Allan – Trade Union Representative
Ian Cant – Non-Executive Director
John Deffenbaugh – Non-Executive Director
Tam Hiddleston – Trade Union Representative
Arturo Langa – Non-Executive Director
Gerry McAteer – Trade Union Representative
Beth Lawton – Non-Executive Director
Keith Redpath – NSS Chair

In Attendance:
Hayley Barnett – Associate Director, Governance and Board Services (Board Secretary)
Jane Fewsdale - Head of People Insights, Performance & Systems
Jacqui Jones – Director of HR and Workforce Development
Mary Morgan – Chief Executive
Karen Nicholls - Committee Services Manager [Minutes]

Observer:
Gordon Greenhill – Non-Executive Director

Apologies:
Suzanne Milliken – Trade Union Representative

1. WELCOME AND INTRODUCTIONS

1.1 L Blackett welcomed all to the meeting, which was being held virtually via the TEAMs platform, noting the apologies as recorded above.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest or transparency statements made in respect of any item on the agenda.

Chair Keith Redpath
Chief Executive Mary Morgan

NHS National Services Scotland is the common name of the Common Services Agency for the Scottish Health Service.

3. MINUTES AND ACTION LIST [paper SG/23/02 and SG/23/03 refers]

3.1 Following a brief discussion, Members were content to approve the minutes from the meeting held on 24 November 2022.

3.2 Members noted the updates provided and had nothing further to add.

Decision: To approve the minutes as an accurate record of the meeting

Decision: To note the action updates provided

4. HOMOLOGATION OF SCOTTISH GOVERNMENT 2021/22 NATIONAL ANNUAL MONITORING RETURN [paper SG/23/04 refers]

4.1 Members were content to homologate the approval of the NSS Staff Governance Monitoring Return for 2021/22, granted via e-mail outwith the meeting. They also sought and received clarity about whether a response would be received from Scottish Government and the route that this would come through. They also wished to record that they were particularly impressed with the work on the Reasonable Adjustment Passport.

Decision: To homologate the approval of NSS's 2021/22 Staff Governance Monitoring Return

5. NSS PARTNERSHIP FORUM [paper SG/23/05 refers]

5.1 Members were pleased to note this continued to be a positive meeting and spotlight sessions from staff networks had been well received. Members asked how NSS partnership forum worked in comparison with other Boards and were advised NSS was in a fortunate position with good partnership working. Members expressed that they were keen to ensure that any staff wishing to be trade union representatives continued to be supported and enabled to do that. There was also a brief discussion about the training module being introduced to ensure partnership working was embedded.

Decision: To note the Partnership Forum Update

6. PEOPLE REPORT [paper SG/23/06 refers]

6.1 J Jones spoke to the paper, which covered all key issues around compliance with the Staff Governance Standard and best employment practice. Members asked about the turnover in specific areas due to losing talent to promoted posts in other organisations and were briefly updated on plans being developed to address this. Members suggested this could also be the topic of a future seminar.

6.2 Members asked about any correlation between sickness absence and other factors (e.g. high levels of overtime) and were advised that nothing had been identified yet. Members also commented that the way NSS had managed the reduction in staff for the National Contact Centre was a testament to its partnership working. However, a small degree of the associated staff risk remained.

6.3 Members asked for, and received, an update on the hybrid working model which was still evolving with a number of associated policies to be reviewed (home working, travel etc.). This would continue to be managed on a directorate-by-directorate basis and any major issues should be escalated to HR. They also received an update on the use

of fixed term contract/agency staff and balancing that with the need to maintain flexibility.

6.4 Members were advised that the Occupational Health team was considering whether there could be a beneficial way of contacting staff who have been off with anxiety or stress to follow up as to whether there was any further support that would have been helpful.

6.5 J Jones provided Members with a brief verbal update on the South-East Payroll team going live which had taken place in the preceding week.

6.6 Members requested a follow up on the increase in staff complaints and whether there were any trends to be aware of. J Jones to circulate any findings outwith the meeting.

Decision: To note the People Report.

Action: Consider recruitment and retention as a possible subject for a future seminar - Board Services

Action: To circulate follow up information to members on any possible trends driving the increase in staff complaints - J Jones

7. WHISTLEBLOWING QUARTERLY REPORT [paper SG/23/07 refers]

7.1 H Barnett briefly spoke to the paper, advising Members that there was a current live investigation which would be reporting in the following quarter. Members were provided with an overview of the structure and expansion of confidential contacts. Members were also updated on the move to Service Now as a reporting mechanism, noting the concerns from a data protection perspective.

7.2 Whistleblowing was suggested as another potential subject for a future seminar. A Langa provided positive feedback about his tour of Directorate townhall meetings. Members were pleased that NSS was proactive in this area, but H Barnett was still keen to work with HR colleagues to see what more could be done to improve the general awareness among staff. Members were also advised that a whistleblowing question was being included in the upcoming national iMatter survey.

Decision: To note the Whistleblowing Quarterly Report.

Action: Consider whistleblowing as a possible subject for a future seminar – Board Services.

8. STAFF RISKS QUARTERLY UPDATE [paper SG/23/08 refers]

8.1 Members were presented with the Staff Risk Quarterly Update. They commended the work and were satisfied that the actions seemed to be proportionate. Members asked about the potential re-categorisation or separation of some of the risks, noting that this was always a part of the ongoing review of staff risks.

8.2 In respect of staff wellbeing, there was acknowledgement of the need to consider whether this had moved from being a risk into an issue and Members were advised of HR's intention to discuss with trade union colleagues about where the tipping point might be. Members were reminded of the upcoming Board seminar on risk which would also be an appropriate forum for similar discussions.

Decision: To note the Staff Risks Quarterly Report.

9. GREAT PLACE TO WORK PLAN Q3 UPDATE 2022 [paper SG/23/09 refers]

9.1 A Stewart spoke to the report, which updated on the progress against the priority areas for improvement contained in NSS Great Place to Work Plan 2022/2023, highlighting the recently held NSS Excellence Awards. Members were advised that NSS was on track to meet targets except for the digital partnership module and dashboards, for which mitigations were in place. I Cant provided an overview of surgeries he would be holding in each directorate. Members suggested that HR consider greater emphasis around "Appropriately Trained and Developed" in the next Great Place to Work plan.

Decision: To note the Great Place To Work Plan Q3 Update.

Action: HR to consider greater emphasis around "Appropriately Trained and Developed" in the next Great Place to Work Plan.

<u>ITEMS FOR INFORMATION</u>

10. SENIOR LEADERSHIP FORUM [paper SG/23/10 refers]

10.1 J Jones briefly updated on the progress of this work, confirming it was anticipated that everything would be in place to go live with the Senior Leadership Development programme in April 2023. Following a brief discussion about seeking feedback from leavers about what worked well, J Jones advised that while exit interviews were offered, this was reliant on people taking that up and so encouraging the more general reflective conversations would also be key.

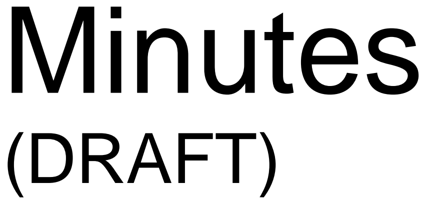
11. SCHEDULE OF MEETINGS [paper SG/23/11 refers]

11.1 Members noted the schedule of meetings.

12. ANY OTHER BUSINESS

12.1 Members had no further competent business to discuss at this time.

Meeting closed 1103hrs.



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NHS NATIONAL SERVICES SCOTLAND STAFF GOVERNANCE COMMITTEE

MINUTES OF MEETING HELD ON TUESDAY 30 MAY 2023, COMMENCING 0930 HOURS VIA TEAMS

B/23/19 J

Present:
Lisa Blackett – Non-Executive Director and Committee Chair
David Allan – Trade Union Representative
Ian Cant – Non-Executive Director
John Deffenbaugh – Non-Executive Director
Tam Hiddleston – Trade Union Representative
Arturo Langa – Non-Executive Director
Beth Lawton – Non-Executive Director
Gerry McAteer – Trade Union Representative
Keith Redpath – NSS Chair

In Attendance:
Hayley Barnett – Associate Director, Governance and Board Services (Board Secretary)
Jacqui Jones – Director of HR and Workforce Development
Mary Morgan – Chief Executive
Aileen Stewart – Associate Director of HR
Lynsey Bailey - Committee Secretary [Minutes]

Observer:
Alison Rooney – Non-Executive Director

Apologies:
Jane Fewsdale - Head of People Insights, Performance & Systems
Suzanne Milliken – Trade Union Representative

1. WELCOME AND INTRODUCTIONS

1.1 L Blackett welcomed all to the meeting, which was being held virtually via the TEAMs platform, noting the apologies as recorded above.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest or transparency statements made in respect of any item on the agenda.

3. MINUTES AND ACTION LIST [paper SG/23/13 and SG/23/14 refers]

3.1 Members considered the draft minutes from the previous meeting held on 9 February 2023

3.2 M Members considered the action updates provided and had nothing further to add.

Decision: To approve the minutes as an accurate record of the meeting

Decision: To note the action list and agree the closure of the actions recommended for closure.

4. STAFF GOVERNANCE COMMITTEE 2022/23 ANNUAL REPORT TO THE BOARD [paper SG/23/15 refers]

4.1 Members considered the report, which provided an overview of the Committee's activities during the 2022/23 financial year. They had nothing further to add and were content for it to be presented to the NSS Board.

Decision: To approve the report for presentation to the Board.

5. NSS PARTNERSHIP FORUM [paper SG/23/16 refers]

5.1 Members were advised that highlights from recent Partnership Forum meetings included presentations from the Disability, Menopause, and Veterans staff networks. The Partnership Forum had also agreed the finalised Retire and Return policy and had discussed the Great Place to Work Plan, Quality Management Framework, and data protection. Partnership working remained strong within NSS, but the Chief Executive and Employee Director were looking at ways of increasing earlier engagement.

Decision: To note the updates provided on the work of the Partnership Forum.

6. PEOPLE REPORT [paper SG/23/17 refers]

6.1 The Director of HR spoke to the paper, which covered all key issues around compliance with the Staff Governance Standard and best employment practice. Members welcomed the positive year-end position and the noted the following highlights:

- Good progress had been made on the Health and Safety management system, which was now in testing;
- The migration to Turas Learn had gone well and HR were working with NHS Education for Scotland on improvements;
- Work continued on managing staff turnover;
- The compliance rate for statutory and mandatory training remained good;
- There had been an incident reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) inherited upon acquiring a new site, which was due to incomplete clearing and waste removal prior to NSS moving in. Members requested a more detailed explanation of this to provide further assurance;
- The compliance rate for appraisals, PDPs and objectives had improved but there still work to do in this area;
- The sickness absence rate was still being closely monitored and HR were providing support to areas of particular concern.

6.2 Although the sickness absence rate was back to pre-pandemic levels, Members felt this provided reassurance that staff were not working at home through sickness and was also not surprising since absence due to COVID-19 was no longer monitored separately.

6.3 Members discussed turnover and if there was a way to have more detailed information. Members were advised that NSS was bound by the information staff were willing to give in exit interviews. It was acknowledged that the uptake of exit interviews and their completion could be better (although the figures were in line with other organisations). However, HR was looking at how to capture more data through different means and had re-based the turnover figures for the coming year to account for the buoyant job market. Members asked about the impact of the new Retire and Return policy on turnover but were advised that this would be minimal. Based on the information available, there was no evidence that staff were leaving due to issues with hybrid/flexible working. The reasons seemed predominantly to be promoted posts or other opportunities. The figures also remained much the same when excluding fixed term contracts.

6.4 Members went on to discuss comparing NSS's sickness absence rate with national picture, acknowledging that a like-for-like comparison was difficult due to the wide-ranging nature of the work done by the National Boards, as well as the difference from Territorial Boards. They also received a brief overview of the remaining issues with Turas Appraisal and how these were being addressed. Members also commended the reduction in the complaints figures.

Decision: To note the updates provided in the People Report.

Action: To circulate more detailed explanation of the RIDDOR – Director of HR

7. GREAT PLACE TO WORK PLAN 2022/23 END OF YEAR REPORT [paper SG/23/18 refers]

7.1 Members discussed the report, which updated on the progress against the priority areas for improvement contained in NSS Great Place to Work Plan 2022/2023. In particular, it highlighted the high level of engagement and how this had allowed the development of a strong plan that addressed the issues raised by staff. Members expressed their gratitude to staff for engaging, and to HR for their work in developing the plan in response. Members were pleased with the high level of achievement against the action plan.

Decision: To note the Great Place to Work End of Year Report.

8. GREAT PLACE TO WORK PLAN 2023/24 [paper SG/23/19 refers]

8.1 The Associate Director of HR spoke to the report, which sets out the priority areas for improvement during 2023/2024 based on analysis of the 2022 iMatter Survey results and Staff Governance Monitoring Return. Members were also mindful that the 2023 iMatter survey was imminent and acknowledged the plan may need to develop further in response to the results of that. Members were briefly updated on the discussions at Partnership Forum on alignment and amalgamation with the Workforce Plan. Members were pleased to see that this plan built on successes of the previous year and praised the iterative and improving nature of the process to develop the plan.

Decision: To approve the Great Place to Work Plan 2023/24.

DRAFT

9. WHISTLEBLOWING QUARTERLY REPORT [paper SG/23/20 refers]

9.1 The Associate Director for Governance and Board Services briefly spoke to the paper, which updated on NSS's performance for the fourth quarter of 2022-23 (January to March 2023) against the key performance indicators as required by the Independent National Whistleblowing Officer (INWO). Members' attention was drawn to the Stage 2 investigation and the Associate Director for Governance and Board Services also highlighted the positive feedback from the Whistleblower about the support they had received during the process.

9.2 Members were provided with an update on the recent discussions at the Change Oversight Group about the Enable programme, which Whistleblowing was a part of, and the progress being made in that area. A Langa also commented on project management improvement suggestions as part of the Stage 2 investigation. Although these were not formal recommendations, Members agreed that it would be helpful for the Committee to see progress/closure updates of these.

9.3 Following these discussions, Members confirmed they were assured by the updates provided and content to endorse the report.

Decision: To note and endorse the Whistleblowing Quarterly Report.

Action: To include progress/closure updates on the identified project management improvement suggestions within the next quarterly report – Associate Director for Governance and Board Services

10. WHISTLEBLOWING ANNUAL REPORT [paper SG/23/21 refers]

10.1 Members considered the paper, which summarised NSS's performance in 2022-23 and was required to be published in line with the National Whistleblowing Standards. Since issuing the paper for this meeting, guidance for reporting had been issued by INWO. Members were advised that, based on an initial review of the paper against this guidance, it contained all the required information although some presentational changes may be needed for the final version.

10.2 Members suggested reviewing some of the commentary provided in relation to the whistleblowing process in exit interviews as a potential source of additional relevant information. They also suggested considering the inclusion of some form of assurance statement from the Board Whistleblowing Champion within the final report to Board.

10.3 Following these discussions, Members confirmed they were content to endorse the Annual Report.

Decision: To endorse, subject to the required presentational changes, the Whistleblowing Annual Report for approval by the NSS Board.

Action: To liaise with HR colleagues to consider any commentary made in exit interviews regarding whistleblowing process. – Associate Director for Governance and Board Services

Action: To consider developing a form of assurance statement by the Whistleblowing Champion to be included in the final report to Board – Associate Director for Governance and Board Services

11. STAFF RISKS QUARTERLY UPDATE [paper SG/23/22 refers]

11.1 Members discussed the Staff Risk report, which provided details of the current situation for corporate red and amber staff risks recorded on the NSS Risk Register as of 30 April 2023. Members acknowledged the actions in place, and progress with red risk 7037 (staffing levels in manufacturing) and amber risk 6819 (resource for response to COVID-19 Inquiry). In respect of these risks, Trade Unions had received feedback from their stewards about the level and impact of staff pressures and had highlighted the need to monitor this. The Director of HR advised that this was being worked on and welcomed any further help from Trade Union colleagues. Members went on to discuss the challenges arising from the skill levels required for these roles and were provided with an overview of the training and development being offered to mitigate those.

Decision: To note the Staff Risks Quarterly Report.

12. EQUAL PAY GAP [paper SG/23/23 refers]

12.1 Members were briefly updated on the history of the report. They welcomed the improving position on the gender pay gap but acknowledged that there was more work to do in other areas, such as disability. Members asked about plans for monitoring the impact of Retire and Return on the pay gap but, it was not anticipated that this would involve a large number of staff. However, HR would look into this and could also take partial retirement into account as part of that.

Decision: To approve the Equal Pay Gap Report for publication.

Action: To consider how to monitor the potential impact of Retire and Return and partial retirement – Director of HR

13. SENIOR LEADERSHIP FORUM [paper SG/23/24 refers]

13.1 The Director of HR briefly updated the Committee on the progress of this work. Members discussed the level of uptake in signing up to the programme and were advised that, anecdotally, numbers were good and there was enthusiasm. The Director of HR agreed to circulate specific numbers outwith the meeting. Members sought and received clarification about the approach being taken, which was to strongly encourage the relevant staff to sign up and then take a coaching approach with those who did not take it up.

Decision: To note the Senior Leadership Forum Update.

Action: To circulate confirmed uptake numbers for the Leadership Programme and reflect on uptake in future reporting – Director of HR

14. Remuneration Succession Planning Committee (RSPC) ANNUAL REPORT [paper SG/23/25 refers]

14.1 Members considered the Report being presented for information. Members highlighted that there was a mention of the Committee Chair changing in March 2023 rather than March 2022.

Decision: To note the RSPC Annual Report, subject to a date correction.

Action: To correct the reference to March 2023 to March 2022 – Board Services

DRAFT

15. STAFF GOVERNANCE MONITORING RETURN [paper SG/23/26 refers]

15.1 The Staff Governance Monitoring Return was welcomed by Members. Members wished to feedback to Scottish Government their frustrations about the timescales for providing their feedback and were advised that HR Directors have also raised this. Members also discussed the Reasonable Adjustment Passport, clarifying the ownership and development route. Overall, Members were pleased to see NSS's positive position, and how seriously it took its approach to staff governance.

Decision: To note the Staff Governance Monitoring Return.

Action: To pass on feedback to Scottish Government regarding response timescales – Chief Executive and Director of HR

16. FORWARD PROGRAMME [paper SG/23/27 refers]

16.1 Members were presented with the schedule of meetings.

Decision: To note the Staff Governance Committee Forward Programme.

17. ANY OTHER BUSINESS

17.1 Members were advised that a consultation on pension contributions had recently opened and were provided with an overview of the potential impact.

17.2 As this was the last meeting J Jones would be attending as NSS's Director of HR, the Committee thanked her for all her work.

Meeting closed at 1104hrs.

DRAFT

NSS BOARD

	9.3.23			30.6.23		
	Paper (with Number allocated - receipt confirmed if in **Bold**	**Exec Lead**	**Author**	**Paper (with Number allocated -** receipt confirmed if in **Bold**	**Exec Lead**	**Author**
Standing Items	Agenda **[B/23/01]**	Keith Redpath	Board Services	Agenda **B/23/11**	Keith Redpath	Board Services
	Minutes **[B/23/02]**	Keith Redpath	Board Services	Minutes **B/23/12**	Keith Redpath	Board Services
	Action List [**B/23/03]**	Keith Redpath	Board Services	Action List **B/23/13**	Keith Redpath	Board Services
	Chair's Update	Keith Redpath	Keith Redpath	Chair's Update - verbal	Keith Redpath	Keith Redpath
	Chief Executive's Report	Mary Morgan	Mary Morgan	Chief Executive's Report - verbal	Mary Morgan	Mary Morgan
Strategic and Key Items				Annual Report and Accounts (In Private session) IBP/23/01	Mary Morgan	Carolyn Low
				Audit Scotland NSS Annual Audit Report 2021/22 (In Private Session) [I	Mary Morgan	Carolyn Low
	NSS Budget 2023-24 (Presentation)	Carolyn Low				
				NSS ADP and MTP (needs to be in private session)	Lee Neary	Matthew Neilson
				NSS Quality Strategy/Framework B/23/	Lee Neary	?
				NSS SG Framework - **moved to September meeting**	Lee Neary	Caroline McDermott
				NSS Committees Annual Reports 2022-23 **B/23/17**	Keith Redpath	Various
Additional Requests	NSS Corporate Governance Framework **[B/23/04]**	Lee Neary	Hayley Barnett			
Items Deferred						
Performance (items for Scrutiny	Integrated Performance Report **[B/23/05]**	Lee Neary	Matthew Neilson/Caroline McDermott	Integrated Performance Report B/23/16	Lee Neary	Matthew Neilson/Caroline McDermott
	Finance Report see **[B/23/05]**		Carolyn Low	Finance Report see IPR		Carolyn Low
	Service Excellence Report see **[B/23/05]**		Lee Neary	Service Excellence Report see IPR		Lee Neary
	People Report see **[B/23/05]**		Jacqui Jones	People Report see IPR		Jacqui Jones
	Sustainability Report see **[B/23/05]**		Julie Critchley	Sustainability Report see IPR		Julie Critchley
	ADP Q5 Report **[B/23/10]**	Lee Neary	Matthew Neilson/Caroline McDermott			
	Risks and Issues Report **[B/23/06]**	Lee Neary	Matthew Neilson/Caroline McDermott			
Additional Requests	Public Inquiries Update **[B/23/**	Lee Neary	Marie Brown			
Items Deferred				Public Inquiries Update **B/23/18**	Lee Neary	Marie Brown
Board Papers	Governance Committee Minutes (Draft and Approved) B/23/		Board Services	Governance Committee Minutes (Draft and Approved) **B/23/19**		Board Services
For Info	Forward Programme **[B/23/08]**		Board Services	Forward Programme **B/23/20**		Board Services

Development Session Dates:	
	20.4.23
	23.8.23
	12-13.10.23
	24.11.23
	20.2.24

27.9.23		
Paper (with Number allocated - receipt confirmed if in Bold)	**Exec Lead**	**Author**
Agenda B/23/	Keith Redpath	Board Services
Minutes B/23/	Keith Redpath	Board Services
Action List B/23/	Keith Redpath	Board Services
Chair's Update	Keith Redpath	Keith Redpath
Chief Executive's Report	Mary Morgan	Mary Morgan
Annual Feedback and Complaints Report 2022-23 (Final)	Lee Neary	Louise Maclennan
NSS SG Framework	Lee Neary	Caroline McDermott
Integrated Performance Report [B/23/]	Lee Neary	Matthew Neilson/Caroline McDermott
Finance Report see **[B/23/05]**		Carolyn Low
Service Excellence Report see **[B/23/05]**		Lee Neary
People Report see **[B/23/05]**		Jacqui Jones
Sustainability Report see **[B/23/05]**		Julie Critchley
Public Inquiries Update **[B/23/**		
Governance Committee Minutes (Draft and Approved) B/23/		Board Services
Forward Programme [B/23/]		Board Services

15.12.23		
Paper (with Number allocated - receipt confirmed if in Bold	**Exec Lead**	**Author**
Agenda B/23/	Keith Redpath	Board Services
Minutes B/23/	Keith Redpath	Board Services
Action List B/23/	Keith Redpath	Board Services
Chair's Update	Keith Redpath	Keith Redpath
Chief Executive's Report	Mary Morgan	Mary Morgan
Integrated Performance Report [B/23/]	Lee Neary	Matthew Neilson/Caroline McDermott
Finance Report see **[B/23/05]**		Carolyn Low
Service Excellence Report see **[B/23/05]**		Lee Neary
People Report see **[B/23/05]**		Jacqui Jones
Sustainability Report see **[B/23/05]**		Julie Critchley
Public Inquiries Update **[B/23/**		
Governance Committee Minutes (Draft and Approved) B/23/		Board Services
Forward Programme [B/23/]		Board Services

28.3.24		
Paper (with Number allocated - receipt confirmed if in **Bold**	**Exec Lead**	**Author**
Agenda B/24/	Keith Redpath	Board Services
Minutes B/24/	Keith Redpath	Board Services
Action List B/24/	Keith Redpath	Board Services
Chair's Update	Keith Redpath	Keith Redpath
Chief Executive's Report	Mary Morgan	Mary Morgan
Integrated Performance Report [B/23/]	Lee Neary	Matthew Neilson/Caroline McDermott
Finance Report see **[B/23/05]**		Carolyn Low
Service Excellence Report see **[B/23/05]**		Lee Neary
People Report see **[B/23/05]**		Jacqui Jones
Sustainability Report see **[B/23/05]**		Julie Critchley
Public Inquiries Update **[B/23/**		
Governance Committee Minutes (Draft and Approved) B/23/		Board Services
Forward Programme [B/23/]		Board Services