Agenda Item 8

External Review: Culture and Governance – Emergency Department, Forth Valley Royal Hospital

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Falkirk Integration Joint Board

3 September 2021

External Review: Culture and Governance – Emergency Department, Forth Valley Royal Hospital

For Decision

1. Executive Summary

1.1 The Integration Joint Board (IJB) has responsibility for the Strategic Planning and Commissioning of the Emergency Department (ED) as part of set aside arrangements in relation to Large Hospital services. The IJB issues directions to NHS Forth Valley for the delivery of ED services and receives regular updates as part of the performance reports submitted to the Board.

1.2 The paper provides information to the members of the Board on a recent External Review of ED commissioned by the NHS Chief Executive in response to a formal complaint from the Royal College of Nursing (RCN) and Unison about staff experience in ED.

1.3 The review was originally intended to examine the prevailing culture within the ED, however this was subsequently expanded to also include wider clinical, staff and corporate governance arrangements.

1.4 The published review report highlights a number of recommendations regarding the overall governance and culture in NHS Forth Valley in addition to specific improvements to support staff in ED.

2. Recommendations

The Integration Joint Board is asked to:

2.1 note the external review report and actions undertaken by the Health Board.

2.2 delegate the IJB Clinical and Care Governance Committee to oversee implementation of the action plan from the Culture and Governance ED review report in order to provide assurance to the IJB regarding patients safety.

3. Background

3.1 The NHS Chief Executive, in response to serious concerns raised by the RCN and Unison, commissioned an independent external review of the Emergency Department in Forth Valley Royal Hospital. The review took place in three phases between December 2020 and May 2021.

3.2 During the initial phase of the review the external team proposed to extend the scope of the review to include both culture and governance in recognition of the important contribution of effective Corporate, Clinical and Staff governance performance on the culture of all or part of any NHS organisation.

3.3 This approach was supported by the Health Board. The External Review report has been shared with ED staff, staff side representatives and those directly involved in the review process. The report and the NHS Board response was also published as part of the NHS Board papers on 6 August (see appendix 1).

3.4 The External Review team identified 45 recommendations covering ED itself but also a series of recommendations about wider culture and governance (including staff governance, clinical governance and corporate governance). The Health Board have accepted all the recommendations set out in the External Review report attached at appendix 1 and approved the action plan (attached within the same appendix) at their meeting on 6 August 2021.

3.5 In addition, a new sub-committee of the Health Board has been set up, led by NHS Forth Valley's Chair Janie McCusker, to oversee the implementation of the Review recommendations as part of a wider program of ED improvements which is already underway. The Health Board have also invested in a 'Speak Up' initiative that will be rolled out in support of the new National Whistleblowing Standards.

4. Report Findings

4.1 The report to the NHS Board on 6 August attached at appendix 1 details work undertaken as part of the Health Board response to the external report including a series of meetings between the NHS Board Chair and Chief Executive and ED staff which generated some additional recommendations listed in the CEO's cover report within the appendix.

4.2 The External Review describes its findings and associated recommendations in the areas below:

4.3 ### Corporate Governance

The external work with SLT has not yet started, the plan indicates that SLT will be involved in designing OD work which does not fully reflect the recommendation for an external expert assessment of relationships and behaviours between members of SLT.

4.4 ### Clinical Governance

It is recommended that the Board review its entire clinical governance arrangements. While the review and the Board response do not refer to the IJB Clinical and Care governance arrangements, it will be critical that there is alignment between IJB and NHS processes to provide assurance to the NHS Board and IJB in respect of clinical care and patient safety.

4.5 The IJB CCG should be tasked to review this the action plan to provide this assurance for the IJB.

4.6 Staff Governance

The review highlights a number of recommendations which are addressed in the NHS Board response. The IJB may wish to consider the appropriateness of current staff governance arrangements. Senior HSCP managers have recently been given access to NHS IT systems. HSCP staff reports have now been developed for staff absence, training etc as well as new health and safety reports.

4.7 Nursing workforce

A number of improvement actions are currently underway to support the ED nursing workforce. The IJB may wish to request assurance for nursing within the community hospitals and community nursing teams.

4.1 The IJB may wish to delegate the IJB Clinical and Care Governance Committee to oversee the progress with the NHS action plan and if required, request action on areas related to governance and patient safety impacting on IJB functions.

5. Conclusions

5.1 It is essential that colleagues work together to find optimal solutions for improvement in leadership, delivery of safe and high quality care, improvement of staff experience and in governance systems providing overall assurance of performance.

Resource Implications

There are financial implications arising from the outcome of the Culture and Governance ED review, primarily in relation to the additional staffing commitments that are associated with several of the review recommendations and the associated action plan developed and agreed by the NHS Board. Potential costs have not been fully quantified at this stage and there is an expectation that the newly formed NHS Board sub-committee will advise on all resource implications (including identification of a recurring funding source) in due course.

Impact on IJB Outcomes and Priorities

The whole health and care system is experiencing significant demand and staffing pressures. The performance of ED is a critical element of the Unscheduled Care pathway and the performance impacts on patient experience and the delivery of the IJB remobilisation and delivery plan.

Directions

No new Direction or amendment to an existing Direction is required as a result of the recommendations of this report.

Legal & Risk Implications

The impact of the issues raised re patient safety in the external report and the mitigation in the action plan for IJB functions will be reviewed by the IJB CCG and incorporated into the IJB risk register.

Consultation

Consultation was not required for this report.

Equalities Assessment

The IJB will be a public body, for the purposes of the Equality Act 2010. Officers must ensure that equalities implications have been considered and that an equalities impact assessment is completed, where appropriate. A combined NHS/Council tool is being developed for this purpose.

6. Report Author

Patricia Cassidy, Chief Officer

7. List of Background Papers

n/a

8. Appendices

Appendix 1:	External Review Report and Action Plan

Appendix 1

External Review

Culture and Governance – Emergency Department, Forth Valley Royal Hospital

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Report Submitted - 9 June 2021

Commissioned By: Cathie Cowan, Chief Executive, NHS Forth Valley

Contents

1. Introduction

1.1 On 19th November 2020 an email was received by the Chief Executive, NHS Forth Valley from the Regional Officer of the Royal College of Nursing (on behalf of both the RCN and Unison). The email raised very serious concerns about the alleged existing culture within the nursing team of the Emergency Department – hereafter referred to as ED), Forth Valley Royal Hospital (the Emergency Department team - hereafter referred to as ED team).

1.2 The concerns suggested that over a prolonged period of time, management within NHS Forth Valley have ignored inappropriate behaviours within the ED team and as a consequence have colluded with and condoned such behaviour.

1.3 The concerns included:

- Staff perceptions and experience of management of the ED team.
- Concerns in relation to the delivery of safe patient care.
- Numerous staff resignations from employment in the ED team due to inappropriate leadership, management behaviour and professional concerns about safe staffing and patient care.
- Staff perception that workforce policies are not consistently or properly interpreted and applied.
- High levels of tension between staff and senior staff in the workplace in contradiction of NHS Forth Valley's Organisational Values and resulting in the irretrievable breakdown of necessary working relationships.
- Recognition of the likely impact of the above concerns on the quality of patient care, members of staff within the ED and the reputation and performance of NHS Forth Valley generally.

1.4 The Chief Executive determined that the serious nature of the concerns raised by the ED team warranted commissioning of a review of the prevailing culture within the ED. In order to establish objectivity in completion of the review and reassurance for staff through a safe and confidential process the Chief Executive took the decision to establish an external, independent Review Team (the Review Team).

The Chief Executive co-created a review Scoping Document with the Interim Associate Director of Human Resources (Titled: Culture Review – ED Team) and following representation from the Review Team agreed that the Review needed to include examination of Governance frameworks in the cycle from Ward to Board. The Scoping Document is attached at Appendix 10.1.

1.5 Members of the Review Team were appointed in early December 2020 and were selected to bring an important balance of experience from Director and Executive Director roles in Nursing, General Management and Human Resource Management across NHS Scotland. The members of the Review Team are detailed in Appendix 10.2. (The Chief Executive appointed Kenneth Small to accept responsibility as Lead of the Review Team.)

1.6 At an early stage in discussions to establish the focus, work and outcomes, the Review Team agreed that their approach would be styled on that of 'critical friends' and that findings, conclusions and recommendations from the final Review Report would be improvement focused.

- In accordance with the principles of good Governance for project management, the Chief Executive also appointed a Non-Executive Director, NHS Forth Valley to act in an oversight and governance assurance role for the Board and a Senior Responsible Officer to provide support, resources and local guidance in completion of the Review.

2. Structure of the Review Process

2.1 In recognition of the significant scope of the concerns raised and the scale of the anticipated staff numbers involved an early decision was made to conduct the Review through a programme of Phases. Over the Phases meetings were conducted with the Chair and Chief Executive, Non-Executive Directors, Chairs of Governance Committees, Executive Directors, System Leadership Team, staff and managers within the ED with some of these individuals being seen twice.

Phase 1: (December 2020 – January 2021)

2.2 Establish a comprehensive knowledge and understanding of the history behind the RCN and Unison decision to formally raise concerns about the alleged existing culture within the nursing team in the ED. This was achieved through a lengthy meeting of relevant RCN and Unison Representatives, NHS Forth Valley Employee Director and members of the Review Team on 6th January 2021.

2.3 Scope out and submit a comprehensive request for copies of relevant, important, historical and contemporary documentation from NHS Forth Valley to guide and inform the focus of the work of the Review Team. A request for remote access to a list of Corporate, Clinical and Staff Governance performance documents relevant to the Review was submitted by the Review Team to NHS Forth Valley on 18th December 2020. Regrettably response, availability and access to the request for documents was patchy. This was a frustrating experience for the Review Team and for Administrative support colleagues in NHS Forth Valley as valuable reading time was lost over the Christmas / New Year holiday period. The importance, nature and anticipated organisational ease of access to the documents requested was such that the Review Team had expected to be quickly 'bombarded' with information – and were surprised when this was not the case.

2.4 Establish early contact with the appointed Non-Executive Director (on 22nd December 2020) and Senior Responsible Officer (on 5th January 2021).

2.5 Reach agreement with the Chief Executive on an important amendment to the scope and title of the Review. The Review Team proposed the tile "Culture and Governance Review" recognising the important contribution of effective Corporate, Clinical and Staff Governance performance on the culture of all or part of any NHS organisation. The Review Team therefore undertook a broad assessment of key factors underpinning the ED culture; staff psychological safety and how this linked to the Boards Leadership and governance systems. For this reason and in light of the findings set out in the Boards recent internal audit reports relating to Corporate, Staff and Clinical Governance, this report focuses on these areas alongside key Nursing workforce issues. The Review Team felt it was necessary to structure this report using these headings to assist the Board in their quest for Systematic Quality Improvement systems delivered through a culture of strong leadership, openness and inclusivity.

Phase 2: (Late January – February 2021)

2.6 Establish arrangements for an initial meeting of the Review Team with individual members of the NHS Forth Valley System Leadership Team (hereafter referred to as SLT) to:

- Facilitate introductions (as necessary).
- Understand any previous or current Senior Manager knowledge, awareness or involvement in the concerns raised by the RCN and Unison.
- Provide clarity on the scope and approach to be taken in conducting the Review.
- Develop insight and understanding by the Review Team of the current Corporate, Clinical and Staff Governance arrangements in NHS Forth Valley.

2.7 An initial individual interview was held with some members of the SLT between 26th January – 10th February 2021. Subsequent (sometimes multiple) meetings were held throughout the period of the review.

2.8 Communicate with all medical and nursing staff employed within the ED team to inform them of the decision to establish the independent Review of Culture and Governance, introduce members of the Review Team and confirm that the opportunity for a personal, confidential interview would be provided for all medical and nursing staff within the ED. Communication with the staff was achieved through delivery to home addresses of an individual letter jointly signed by the Chief Executive and Employee Director. A bespoke, anonymous Psychological Safety Questionnaire was enclosed with each letter and staff were invited to complete and return the Questionnaires to an 'independent' address. The Psychological Safety Questionnaire was designed to begin the process of staff engagement and involvement sharing thoughts and experiences within the ED and also to inform the focus and content of the Phase 3 interviews with staff.

2.9 Establish arrangements for individual meetings with Managers, Professional Nurse leaders and Clinical leaders with responsibilities covering the ED at Forth Valley Royal Hospital. (Completed in mid-February 2021)

Phase 3: (Late February – March 2021)

2.10 Reflect on and assess the feedback and information gathered in Phases 1 and 2 and use this to design the approach to inclusive engagement with the medical and nursing staff in the ED team.

2.11 Preparatory staff communication, engagement and assurance arranged and delivered through local RCN and Unison Representatives.

2.12 Design of a consistent (and flexible) Staff Interview Framework for use in conducting informative, searching, objective, focused and constructive interviews.

2.13 Invitations issued to all nursing (79) and medical staff (26) in the ED team.

(Reflection and Report Completion Early April – May 2021)

3. Principles Adopted in the Conduct of the Review

3.1 Be fair and objective treating all concerned with dignity and respect.

3.2 Avoid pre-judgement. Wait until all concerned have been interviewed and information has been examined before reaching determinations, conclusions and recommendations.

3.3 Avoid bias or the appearance of bias through maintenance of independence and equality of opportunity and treatment.

3.4 Plan and share the process to be followed conducting the Review in advance with all concerned.

3.5 This to include the stages of the Review, information requirements, planned interviews and the broad timeframe for completion, if possible.

3.6 Investigate promptly and communicate progress regularly. Escalate any areas of immediate concern on patient/staff safety to the Executive Medical Director and Executive Director of Nursing, Midwifery and Allied Health Professionals (hereafter referred to as Executive Director NMAHPs).

3.7 Maintain an appropriate independence from stakeholders to avoid `inappropriate influence and promote integrity of the process and outcomes.

3.8 Protect the confidentiality of information and statements made throughout the Review.

3.9 Proactively promote engagement and participation of all concerned seeking balanced, 360 degree contributions to the Review process.

3.10 Reach and deliver fair and objective determinations based on the credibility and thorough evaluation of information presented.

4. Organisational Culture: Psychological Safety Questionnaire and Interview Themes

4.1 The psychological survey used was a survey adapted by NHS Lanarkshire and is based upon the IHI climate survey. It was used initially as part of the Health foundations developing safety work in Mental Health programme.

4.2 The questionnaire has four domains; these are:

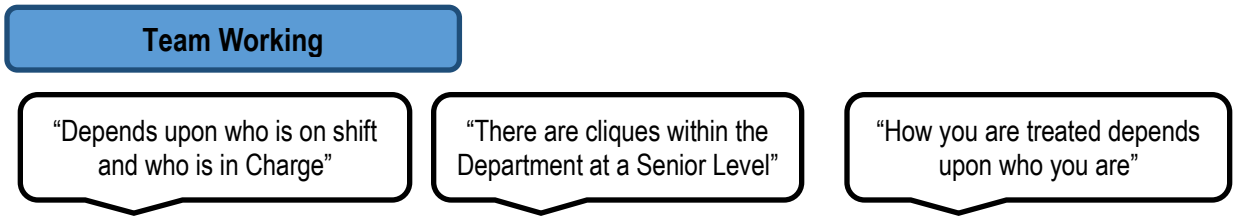
- Teamwork
- Leadership
- Learning Environment
- Quality

4.3 Staff were asked to respond anonymously and confirm response options using Strongly Disagree, Slightly Disagree, Strongly Agree, Slightly Agree.

4.4 105 surveys were administered. 61 responses were returned, giving a response rate of 58%. Of note, 43 staff members also took the time to append additional information for the Review Team to consider.

4.5 Staff were invited to meet with the members of the Review Team and a total of 43 individuals took up this opportunity. (35 Nursing, 2 Medical, 6 leavers - 4 Nursing and 2 Medical). During these discussions, staff were invited to share their experiences of working within ED on a confidential basis. Review Team members used structured themes noted within the Psychological Survey to support further discussion.

4.6 The frontline staff who came forward portrayed tremendous compassion and professionalism and expressed a high level of loyalty not only to the ED but also to NHS Forth Valley as a Board. Many of the staff interviewed described themselves as "battle weary" and at times traumatised by their experiences over a number of years in this department. Of the 43 individuals seen only 1 member of staff described a wholly positive experience.



4.7 This section of the survey covers the areas of feeling able to speak up; multi-disciplinary team working and challenge; communications and disagreement resolution at team level.

- 36% of staff do not feel free to speak up
- 29% say it is not easy to ask questions
- 29% say MDT doesn't work very well
- 70% say communications break down regularly
- 63% say disagreements in the workplace are not appropriately managed

4.8 This area was explored as part of the staff interviews with the Review Team.

4.9 In general staff told us that "on the floor front line staff" got on reasonably well. However, teamwork and the feeling of a positive and supportive working environment and culture was person dependent resulting in no consistency of behaviours or values from shift to shift. At times staff reported being anxious about going on duty, dependent on who was Nurse in Charge and described Nursing cliques. Team meetings were infrequent and there was little opportunity for attendance or shared learning between Medical and Nursing staff.

Leadership

"Managers only come into the department to check on meeting targets – they don't introduce themselves "

"You only get feedback to tell you that you have done something wrong"

"You just feel lucky that you have not been taken into the cupboard to get a row and that it is happening to someone else "

4.10 In this section staff are asked about the visibility and availability of leaders; communication; individual and team feedback and their value as individuals.

- 48% say leadership not available at predictable times
- 48% say don't get communication on performance feedback
- 76% say don't make time to reflect with me on performance
- 73% say don't provide meaningful feedback to the wider team
- 76% don't provide feedback and make me feel valued

4.11 This area was also explored as part of the staff interviews with the Review Team. Staff told us leadership was not visible unless to scrutinise flow performance. Nursing staff were unable to describe Professional Nursing governance arrangements or arrangements for professional stewardship, such as safeguarding practice; competency, appraisal conduct issues. Concern was raised that senior staff at band 6 and 7 are not fulfilling the role of Clinical Leaders/Experts through support and supervision. Rather their role has become one of a co-ordinator of department flow and attending hospital safety Huddles or two hourly department flow meetings with Duty Managers.

4.12 Medical and Nursing staff told us that they feel that there is a lack of respect for senior medical opinion and that there was a culture in place that made staff fearful of being publicly humiliated by managers and that this could be career limiting. It is important to note some did describe not feeling able to come forward regarding "near misses" or submitting IR1's or that when they did they were made to feel uncomfortable about doing so which obviously has implications for patient safety if these types of incidents are not reported. This is discussed further in Sections 3 and 4 below.

4.13 Descriptions were also given of staff feeling that they have been publicly berated, subjected to disciplinary procedures and being "brought to tears".

Learning Environment

"There are competency books but they are never used "

"When am I going to stop having to babysit you" mentor to mentee

"You just pray that you are not going to be asked to undertake a procedure that you have not been trained in"

4.14 In this section staff were asked about the learning culture within the department and how this integrates and encourages improvement. Particularly how staff are encouraged to report near misses or incidents and how learning from adverse events is feedback.

- 49% say the learning environment does not utilise feedback from people that work there

- 48% say the learning environment does not integrate lessons learned from work settings
- 60% say they do not get time to pause and gain insight into what they do well
- 43% say they are not empowered to report errors
- 44% say not easy to discuss errors
- 57% say they don't get feedback on incidents raised and learning applied
- 60% say culture does not make it easy to learn from others

4.15 This area was also explored as part of the staff interviews. Nursing and Medical staff told us that nurse staffing levels were insufficient; this was particularly exacerbated when RESUS was open. Particular concern was raised regarding the high turnover of staff within the department and the impact this had on more Junior staff and their ability to speak up. In addition, they cited major concerns about poor induction of staff at department level and their feelings of anxiety on a daily basis about competence levels particularly at Junior band 5 and 6 level. They described students as being unsupported and a general lack of mentorship. This was also reflected in poor use of eKSF/TURAS and appraisal, which in turn resulted in poor training and development. Medical staff were able to describe departmental learning opportunities through protected training and Morbidity and Mortality reviews. Nursing staff whilst invited to attend these sessions were frequently unable to attend due to service demands within the Department or having to attend within their own personal time.

Quality

"We get the email to tell us to complete iMatter and we do – never been involved in an Action Planning discussion after that"

"I have never heard of Duty of Candour"

"If you raise an IR1 or speak up about any issue it will be held against you"

4.16 In this section staff are asked about their ability to influence improvements in the department and how their expertise to drive improvements and safety.

- 62% say the learning environment does not effectively identify opportunities for improvement
- 61% say suggestions for improvement would not be acted upon
- 32 % say they don't feel the team has the necessary skills to drive improvement and safety in the department

4.17 This area was also explored as part of the staff interviews. Staff were largely familiar with iMatter surveys but they told us that it feels like it is a "tick box" exercise. They told us there was no formal feedback given and there was local evidence of "action planning" meetings or the development of action plans which is the key element of iMatter in terms of being able to effect change within the local working environment.

4.18 As stated above the Review team were given examples of reluctance to report incidents or near misses as a consequence of a culture of poor follow up and lack of corrective action. Staff felt it was both futile to report any issues as a result of perceived lack of action and also that to do so may be held against them with fear of retribution if they did so. This results in their feeling that even if they did raise issues that it would do little to delivery any improvements. Nursing staff were familiar with some Audit activity but unaware of the modified Nursing Care Assurance dashboard in the department. Nursing

staff were not familiar with Duty of Candour and their responsibilities arising from this and were also unable to give examples of learning from complaints. Most staff were unfamiliar with Board and Acute Governance systems and how this related to front line staff and patient care.

4.19 The Review Team understand that to see the direct quotes above and below and staff feedback will be difficult especially for those who are leaders within the ED and also the Executive and Senior Teams. As the Board are very clear on the values and working environment that they wish to see embedded within their organization this honest and direct feedback clearly demonstrates that this is not how things "feel on the ground" for the workforce. It is hoped that the Leaders of the organization will welcome the fact that the staff have felt able to share their views as a result of this process and act upon this in partnership with their workforce and the Trade Unions and Professional Associations to work to improve the staff experience which is inevitably linked to a more positive staff experience.

4.20 The Review Team were able during the discussions held with individual staff to create a "safe environment" where staff felt able to share their experiences and feelings regarding working within the ED. The Review Team have used direct quotes within this report and have detailed below others which were captured during these discussions which it is hoped will help Senior Leaders and the Board appreciate the feelings of their workforce which are articulated in their own words:

"*Got to stage I didn't want to go to work"*

"NHS FV cannot be trusted to implement their own policies"

"I have worked in different organisations in Scotland and can confidently say that FVRH is by far the most unsupportive to nursing staff. In other words, not pro nursing, personally I do not feel backed by this organisation"

"The immediate shop floor culture of openness and patient centred is as good as any unit I have worked in however, there is an inability to address wider factors especially safe sustainable Medical out of hours staffing and nurses have not been supported with career progression. These factors have led to loss of many excellent colleagues"

"Don't upset the hierarchy...some people get away with murder others would get their faces torn off"

"The culture needs to change and be more supportive"

"ED needs to be a safer space"

"Apart from sending a couple of e mails management in NHS Forth Valley Royal have made no effort to acknowledge the everyday challenges in the dept"

"No clear communication, particular in quality improvement"

"I can honestly say something changes every day and we are not informed"

"I feel dept. understaffed, undervalued, contributing to staff wellbeing and safety"

"Left dept. in tears multiple times .no chance to speak up"

"So upset at the tone and the way the manager conducted the meeting, I had to excuse myself and regain my composure before I could re-join the meeting"

"Fantastic nurses and doctors they provide excellent care, felt guilty when I left but had to for my mental health"

"Find it difficult to work with management their attitude can be unforgiving, abrupt and can exacerbate already tense situations"

"No formal teaching anymore"

5. Corporate Governance

5.1 In the context of the concerns raised by staff the Review Team felt it was important to undertake a desktop review of a range of NHS Board and Board Sub-Committees and to establish if there was a "golden thread" approach to how governance committees report to and feed into the Board. The Review Team focused particularly on the Boards approach to Culture, staff wellbeing; safety and quality.

5.2 The Review Team also considered it essential to speak to Executive and non-executive Directors (specifically Staff Governance and Clinical Governance) in order to better understand how this translated into the leadership and governance systems in place to support front line staff through the effective performance and management of healthcare in NHS Forth Valley.

5.3 The board sets out their approach to Corporate Governance systems in three elements:

- Fiduciary governance- providing good stewardship of assets
- Strategic governance- formulating strategy and setting future direction
- Generative governance – influencing culture through leadership and sense making role

This fits with the NHS Corporate Governance Blueprint for good governance, which defines governance as the systems by which organisations are directed and controlled.

5.4 Of particular reference for the Review Team was the Board's March 2019 self - assessment response and Improvement Plan to NHS Scotland DL (2019), 2 - "Blue print for Good Governance"

5.5 The Review Team noted the Boards intention at that time to support a "systemic quality improvement system" within Forth Valley aligned to Health Board governance and their internal governance arrangements. The Review Team noted the Boards Improvement plan, in particular recognition of the need to:

- Create psychological safety for people, teams and Health board members to speak up
- Model Board values and behaviours and call out bad behaviours
- Reinforce a culture of accountability and continuous focus on performance and celebrating success

5.6 The Review Team were also sighted on the follow up Board paper in August 2020. The paper reflects the Cabinet Secretary's wish to see all NHS boards develop a model of Active Governance. The paper sets out the Boards intention to implement "Active Governance and a Board Assurance Framework" aimed at both reinforcing strategic focus and better management of risks by providing the necessary information to assist the Board to obtain the assurance that they require.

5.7 The Review Team were advised that under the auspices of the Board Chair work was planned to review Board governance and better links to risk management. The Review Team were not able to review any information on progress to date with this work. It was also unclear how the Board has communicated its approach to "Systemic Quality Improvement" to date and intends to communicate any changes going forward to provide clarity of direction.

5.8 During discussions with members of the Executive and system leadership team the Review Team sought clarity on how this approach to governance was being taking forward and embedded within Forth Valley. The Review Team heard there was a need to secure better connection at this level to mitigate the real risk of lack of focus and engagement; drive and effort in order to overcome the substantial challenges that face the board. The Review Team were unclear how the Board undertakes regular reviews of Board effectiveness and how Executive leaders were actively involved in shaping corporate objectives and governance systems currently and going forward.

5.9 The Review Team noted a range of reports were regularly presented to the Board and Governance committees on service delivery, areas of risk, finance and workforce. It was not always obvious to the Review Team how these measures reflected continuous Improvement, are embedded across all aspects of services and how they are explicitly demonstrated within Board and committee discussions and reporting arrangements. In particular, it was not clear how information flows and timely data is used to relevant board committees to provide assurance and improvement.

5.10 The Review Team were also unable to assess how the Board actively engages with staff and any structured programmes in place to enhance Board visibility and engagement with front line staff and the boards desire to model Board values and behaviours; focus on reinforcing a culture of improvement and celebrating success and creating psychological safety for people and teams.

5.11 The Review Team took account of the unprecedented challenge of managing the response to the Coronavirus pandemic from March 2020 and the guidance provided to NHS board Chairs and Chief Executives from the Scottish Government throughout 2020 with regard to the management of governance arrangements during this period. The team noted that during phase one of the pandemic NHS Forth Valley (particularly acute services) was moderately impacted in comparison to other Boards in the central belt, however with a more severe impact during the second wave of the pandemic.

5.12 The Review Team noted the Boards approach to effective governance during this period. This included the need to ensure that all efforts were invested in supporting the immediate response to the Pandemic and that the System Leadership Team were not unnecessarily diverted from these efforts if they continued to service existing Governance arrangements and the full range of Governance committees.

5.13 The Review Team noted the Board papers setting out revised governance arrangements during this time but was unable to clarify how detailed discussions took place with Executive Directors regarding the implementation of the need to "stand down" extant governance processes and also discussions on how these would be reinstated. The Review Team were also unable to determine in detail how the "stand down" arrangements provided the scrutiny, assurance and mitigation of risks particularly in relation to Staffing matters including health and wellbeing; clinical governance and patient safety issues during this period.

5.14 The Review Team were surprised that despite long standing concerns about culture within the ED high rates of staff turnover, previous iMatter results in that area and previous external reviews that Board members and particularly System Leadership members were not aware of the cultural issues in terms of behaviours which were present within the area and also underlying allegations of bullying and harassment and the impact on nursing staff.

5.15 The Review Team were made aware of organisational structure changes that had taken place within NHS Forth Valley Acute Division during 2019 and early 2020. The Review Team were provided with information on the revised leadership structures and governance arrangements within the Acute Division. It was noted that the implementation of the revised leadership structure evolved over a nine-month period but were unable to review any transition, communication or organisational development plans to support the organisational change.

5.16 The Review Team noted that the Board had driven significant improvements in Unscheduled Care waiting time performance, however the Review Team heard that the new structures lacked focus and were not widely understood by front line staff. As a consequence, clarity about accountability lines and decision making responsibilities were unclear. Of particular concern was the lack of clarity around Nursing leadership and the confusion with Operational management roles and responsibilities. The new leadership team were variable in terms of experience and skills, including the roles and responsibilities of management and clinical leads. This was evident in both nursing and medical leadership and may have contributed to a lack of consistency in leadership roles. Clinical leadership, particularly nursing, did not come across as strong or fully empowered. Staff told us that the focus on waiting times could often be at the expense of safety and quality within the ED. The team recognised the impact of Covid on current working arrangements, the absolute need to reduce overcrowding in ED and the impact on the leadership team, however there was limited tangible evidence of an on-going focus on patient and staff safety during this period.

5.17 The Review Team were given access to a range of Information from Acute Hospital meetings to discuss operational and governance arrangements. It was not possible to determine the effectiveness of these committees, however, what was noted was the lack of clarity in relation to the functions of groups and committees, the variable membership and commitment to attendant meetings and the lack of alignment with the overall approach to improving efficiency, effectiveness and the safety of acute patients in NHS Forth Valley and alignment with the Boards aspiration of “Systemic Quality Improvement”. The Review Team believe there needs to be a better connect between the Acute Hospital Management and the Board Governance ambitions.

5.18 Recommendations

1) That there is an external expert assessment of relationships and behaviours between members of the SLT, clarity on roles and contributions; what is expected of them collectively and individually and in particular ability to challenge peers

2) That there is an external assessment of relationships and behaviours between Systems Leadership Team and Non-Executive Board members with a particular focus on how they engage, scrutinise and utilise the information presented to them and use this to make an informed assessment for assurance purposes.

3) **The Board should revisit the results of the 2019 self-assessment on the Blue print for Good Governance taking account of the findings of this review and expedite the plans to introduce "Active Governance".**

4) **The Board should consider any recommendations arising from the national work to improve assurance systems and develop a local assurance framework that embeds and refreshes relevant information flows and timely data to support scrutiny and assurance Board /Committees. (consider qualitative as well as quantative data and benchmarking)**

5) **The Board should consider developing a more proactive simplified communication plan to help paint a clear picture of how the organisation is governed, how priorities are developed and well communicated and to raise awareness and understanding by all stakeholders**

6) **The board should develop a structured programme of visibility and engagement with staff in order to demonstrate Board values; encourage staff to speak up and be heard and reinforce a culture of continuous improvement. (This could be through Patient Safety leadership walk rounds, meet the Board sessions or a range of other engagement initiatives)**

7) **NHS Forth Valley should urgently review the current Acute Division management arrangements to ensure there is sufficient Senior Clinical leadership to provide oversight of whole hospital issues. This needs to provide clarity on lines of accountability for operational and professional governance, so that staff understand the routes of escalation if they have any issues or concerns. In doing this ensure that robust operational management systems are in place to drive continuous improvement involving staff at grass roots level.**

8) **That this review of management arrangements needs to be complemented by a thorough review of Hospital governance arrangements that compliments the Board assurance framework and promotes and assures Safe, Effective and Person Centred Care from ward to Board.**

6. Clinical Governance

6.1 This section of the Review Team Report focuses on NHSFV approach to Clinical Governance and is integrally linked with the findings set out within the section relating to Corporate Governance and in particular the Boards desire to create a 'systemic quality improvement systems'.

6.2 The Health Act of 1999, introduced Clinical Governance into the NHS in Scotland. At that time it was described as:

"The vital ingredient which will enable us to achieve a Health Service in which the quality of health care is paramount". Clinical Governance simply means "Corporate Accountability" for clinical performance.

6.3 To address the patient safety issues identified by staff, the Review Team considered it necessary to understand NHSFVs Clinical Governance arrangements specifically linked

to the adequacy of their ability to provide scrutiny and assurance at all levels of the organisation of Safe Effective and Person Centred Care.

6.4 The Review Team started this process by considering the "Sharing Intelligence Report" produced by the Boards Medical Director, Director of NMAHPs and Director of Acute Services. This report described their findings using the Vincent Framework which the Review Team noted was first introduced to the Clinical Governance Working Group at its July 2020 meeting. The Framework is discussed in more detail later.

6.5 The information contained within this report gave the team a limited snapshot of safety and governance within the ED. The Review Team considered however that the level of SAERs was lower than anticipated in a department of its size and complexity; the level of complaints higher than expected and although there was a limited amount of data relating to Care Assurance, the information presented demonstrated clearly that staff experience and staff turnover were showing as a red flag. The report also contained a very optimistic appraisal of Education and training within the Department – which was at odds with the feedback from staff. (This is discussed in more detail in the nursing workforce section.)

6.6 The Review Team sought clarity on the effectiveness of the existing Governance and Quality systems and how this linked and supported the ED safety and quality of care. In particular, the Review Team were keen to understand how aware the Executive team were of issues facing staff within the ED and how Executive and Clinical leaders influenced and directed a culture of embedding continuous quality improvements at grass roots level. Specifically, the Review Team sought clarity to the following questions.

1. Can the Board articulate its governance processes for assuring the quality of treatment and patient care.
2. Can staff at all levels of the organisation describe the key elements of quality and governance processes?
3. Are leadership roles clear in terms of accountability for safety and quality?
4. Are risks to the delivery of safe care escalated and managed.
5. Does the Board have an appetite of encouraging reporting of near misses?
6. How are IR1s and SAERs and complaints analysed and lessons learned and disseminated?

6.7 Our findings are explained below - the first of which relates to questions 1, 2 and 3.

6.8 The Review Team were not able to get a clear and accurate picture of the Boards approach to clinical governance and quality assurance and how this linked from board to point of care and point of care to Board.

6.9 The Review Team felt this was exacerbated by the impact of the changes to the organizational arrangements in the Acute Directorate and the Boards approach to effective governance during the Coronavirus Pandemic.

6.10 There was very limited information available describing how the Board was being kept informed and this was further evidenced by the Review Team being informed that the Acute Directorates clinical governance arrangements were "just," being embedded into the system.

6.11 The Review Team further noted the first meeting of the Acute Services Governance, Quality & Risk Meeting was held on 16/11/20, at which the groups draft terms of reference were discussed and what the clinical governance arrangements below that group might look like, confirming that the new clinical governance arrangements were at an early stage

resulting in a challenge for the Board to have a direct line of scrutiny and assurance. The Review Team were unable to confirm what transitional arrangements had been in place during this period.

6.12 The Review Team were advised that work was underway to map clinical governance arrangements below the Clinical Governance Working Group, (this group reports to the Clinical Governance Committee,) this was intended to demonstrate how issues below the Clinical Governance Working Group were prioritised and escalated.

6.13 At our discussion with the Lead for Clinical Governance in the ED the Review Team were advised of Clinical Governance meetings attended outwith the ED the last of which was at the end of 2019.

6.14 The Review Team noted from reviewing minutes of various Clinical Governance Working Groups very little evidence of robust scrutiny by Non-Executives Directors. Items tended to be "noted" rather than given a level of discussion to confirm scrutiny and assurance. To that end we were unable to ascertain how this supported the Boards aspiration to "Reinforce a culture of accountability and a continuous focus on performances".

6.15 Also it was not always possible to see how actions were followed up between meetings, an example of this relates to "Adverse Events Management NHS self -evaluation "which was published in April 2019 and how the information from this review has been used to improve practice locally. This is discussed in more detail below.

6.16 The Review Team were advised that the Boards Quality Strategy went out of date in 2019 and Covid pressures had delayed production of an updated strategy. The Review Team were pleased to learn however that a new Quality and Improvement Strategy is currently being developed involving a wide range of staff from across the Board and a draft has already been shared with the SLT. The Review Team recognised that this draft document was work in progress and commended the work undertaken to date particularly the intention to "involve staff and give staff safety, more opportunities to learn from others and support to have the energy to continue to change". The Review Team were unclear how the board intended to drive this forward, get true staff engagement and also the associated timescale and resources required to bring this ambition to life.

6.17 The Review Team are aware that Health Improvement Scotland (HIS) paused all support for the Patient Safety Programmes in March 2020 and between June and December 2020 have been collaborating with Health and Social Care in Scotland to develop a package of essential safe care. The Review Team were unable to reference any discussion about this during the review period.

6.18 The Executive Medical Director explained that NHS Forth Valley were on an Improvement journey. The Review Team were advised that at the Clinical Governance Working Group meeting held in July 2020, the Executive Medical Director introduced the "Vincent Framework," the intention being that the Framework would be rolled out Across the Board. The Framework is a practical guide for measuring and monitoring safety in the NHS, it was described to the group "as a method of providing assurance to the Board that safe effective systems of care were in place." It was not clear to the Review Team how this was being implemented, what training was being put in place to support this ambitious change and how this was being communicated to front line staff.

6.19 The Review Team are aware that Other health care systems have embedded this structured approach to Clinical Governance and they have seen benefits but this was only achieved in organisations where there was strong focused visible and committed leadership at all levels and robust and clear communication channels enabling all staff to

understand the framework what the benefits were, and what was expected of them. It was reported to us that the framework was only received in early March this year (by email) to a clinician who is the ED Lead for Clinical Governance strongly suggesting that there is further work to be done to fully implement and embed the framework, and therefore demonstrate the ambition of providing the Board with assurance that safe systems are in place.

The Vincent Frameworks Asks:

6.20 Disappointingly nursing staff within the ED had a very limited understanding of Clinical Governance. Some senior nurses said they had heard of Care Assurance but they had no access to it. Staff reported completing audits but there was no meaningful feedback or learning.

6.21 The Review Team were also surprised to learn that senior and junior nurses did not understand the Duty of Candour which became a legal requirement for Boards in 2018, and is a regulatory requirement of the Nursing and Midwifery Council.

6.22 Across all NHS Boards ultimate responsibility for Clinical Governance sits with the Chief Executive, and like many other Health Boards NHSFV has adopted the triumvirate approach to Clinical Governance, where the Manager, Doctor and Nurse collaboratively lead and drive this agenda.

6.23 It was not obvious to the Review Team how well this triumvirate model works at Board level within Forth Valley. Indeed, the Review Team heard that there were often tensions within the team and that clarity of objectives was not always clear. It was unclear how much this model is actually embedded. The Acute triumvirate described close working being at a very embryonic stage and below that whilst the triumvirate model was in place it was very difficult to ascertain how well it is working in practice.

6.24 In the ED, the sense was Doctors and Nurses worked quite separately on clinical governance issues. Doctors were afforded protected time for learning from Morbidity and

mortality meetings, but the majority of times nurses were not able to participate. This was evident also in relation to learning from adverse events and this is described more fully below.

6.25 The Review Team found staff confusion with the Professional Nursing leadership arrangements and general management structures and indeed most nurses in the ED could not identify who their professional leaders were. As these roles are responsible for quality safety of patient care and safe staffing this caused concern.

6.26 Given the above we could only conclude professional nursing leadership roles were not clear in terms of accountability for safety and quality and we shared our concerns with the Executive Director NMAHPs.

6.27 The Review Team observed a leadership team and an approach to safety and quality where there was, at times a disconnect between what they thought was happening and what was actually happening.

6.28 A key focus for the Review Team was to explore the consistency of approach of the management of and learning from adverse events. The Review Team recognised that NHS Forth Valley is a complex system and adverse events can and do occur with significant effect on the people involved. The Review Team recognise that staff who are involved in adverse events may be psychologically and emotionally affected and that it is incumbent upon leaders to have processes in place to check in with staff. The Review Team were therefore keen to understand how transparent and prompt remedial action processes were and how learning for quality and safety and staff support was enacted and incorporated to minimise recurrence.

6.29 This section focuses our findings on the questions below:

1. Are risks to the delivery of safe care escalated and managed
2. Does the Board have an appetite of encouraging reporting of near misses
3. How are adverse events (IR1's, SAERS) analysed, lessons learned and disseminated

6.30 Over the period of the review the Review Team explored this with front line and senior staff to gauge how this was perceived and or worked in practice at Emergency Dept. level in Forth Valley.

6.31 The Review Team also reviewed the extant NHS Forth Valley policy (Due for review December 2020). The Review Team noted this document is 63 pages long and would perhaps be difficult for staff to read in full. However, the policy sets out a clear ambition to learn from adverse events. The document makes clear it is the responsibility of all staff to report adverse incidents and near misses and to be actively involved in review and learning relative to their role. It also makes clear that feedback will be given and a just culture will underpin this

6.32 The Review Team were provided information at the outset of the review by members of the executive team, setting out summary information relating to IR1s and SAERs within the ED.

6.33 The information provided concluded there were no red flags relating to adverse event management within the department and noted that management were of the opinion that they were very reassured by the low number reported, in the absence of any benchmarking data. The Review Team were of the view however that the level of IR1s/

SAERs could be considered low given the patient acuity and volume of activity within this department.

6.34 Whilst not specific to the ED this seems to be borne out by the data summarised within the - HIS Adverse Events Management: NHS Board self-evaluation, published in April 2019 which provides summary information relating to Adverse events, Category 1AE and Level 1 with level 1 review (SAER). The Review Team felt it necessary early in the review to share our concerns about SAER reporting and initial findings of the psychological survey. These concerns were reported to the Medical and Nursing Executive Directors.

6.35 The Review Team noted that the HIS Adverse events report was discussed at the Boards Clinical Governance Committee in February 2020 but were unable to reference follow up action at the December 2020 Clinical governance committee. The Review Team did note the Clinical Governance Committee requested further clarity on "the assurance process for learning and involving families". The Review Team were not able to clarify if an SAER tracking system was in place and how this was monitored at Board level. The Review Team have subsequently been made aware that the Executive Medical Director has planned an event for April 2021. The Review Team welcome this intervention and note it is intended for senior staff and would recommend that further work is done to support staff at grass roots level.

6.36 A significant theme emerging from discussion with staff and feedback from the psychological survey questionnaires was staff's reluctance to record incidents and safety concerns. Indeed 48% of staff who completed the survey said they were not empowered to report errors and a similar number of staff said it was not easy to discuss errors. Disappointingly almost 60% of staff reported that they do not get any feedback on incidents raised and therefore no learning applied.

6.37 As part of our discussions with staff the Review Team were told that this was due to fear of repercussion and fear of speaking up. It was also suggested that "what happens on shift stays on shift" again a reference to poor reporting and lack of learning for the department. Staff described it being a futile process as there was lack of feedback.

6.38 The only exception the Review Team were given was in relation to violence and aggression, reporting of this was encouraged to enable security presence within the department. Conversely however, staff reported that issues such as safe staffing, department crowding were actively discouraged.

6.39 The Review Team were surprised that almost without exception nursing staff within the department could not describe the Adverse events management policy and the Review Team escalated this promptly to the Executive Medical and Nursing Directors, Nursing staff described being unaware of what happens after IR1s were submitted. It was not evident to the Review Team how aware staff were in relation the Boards policy or how awareness of what constitutes an adverse event or near miss; how adverse events are graded; what systems were in place and how these were analysed at department level. Of concern also was staffs lack of awareness of Duty of Candour legislation.

6.40 It was suggested to the Review Team that local leaders did not understand the impact of SAERs on staff and how this impacted them psychologically. As a consequence, when SAERs did occur there was a perception by some staff that a blame culture prevailed and as a consequence limited support for staff.

6.41 Recommendations

1) **The Board should immediately review its entire Clinical Governance arrangements to ensure a clear line of responsibility and accountability from the Board to the point of care and from the point of care to the Board. This should include reviewing all work streams and groups to ensure adequate depth and breadth of assurance. This will enable the committee to provide the Board with the assurance of safe effective person centred care.**

2) **All members of the Clinical Governance Committee should be given support to discharge their responsibilities by identifying any training and education requirements.**

3) **The Clinical Governance Committee should consider developing a communication strategy which clearly raises the profile and awareness of the Committees Role purpose and work plan to provide front line staff with a better understanding.**

4) **The Clinical Governance Committee minutes should provide evidence of the level of the committee's discussion and scrutiny to demonstrate assurance of safe and effective person centred care.**

5) **The Executive Director NMAHPs must clarify the lines of professional nurse leadership, governance and accountability in the Acute Division and ensure staff in these roles are supported to effectively discharge their responsibilities.**

6) **The Executive Medical Director must immediately develop an implementation plan for the Role out of the Vincent Framework ensuring there is strong visible committed clinical leadership at every level of the organisation this will help staff understand the benefits of the Framework and the expectations of them.**

7) **The Board should prioritise the progression of the Quality Strategy ensuring that the workforce is consulted and engaged in its development and implementation**

8) **NHS Forth Valley Adverse events policy was due for revision in December 2020. The Board needs to review how this policy is made easy for frontline staff to understand then subsequently implemented and monitored to be able to demonstrate the Boards commitment to promoting an open and honest culture that is based on supporting staff within a culture of continuous improvement**

9) **The Review Team were unable to establish the existence of a robust SAER tracking system. The Board are encouraged to confirm or develop such a system ensuring that the workforce is aware of this and how to use this effectively.**

10) **The Board should ensure that reports on adverse events with links to improvement plans are prepared; disseminated and analysed in a timely manner. That analysis is shared at department/ operational level and through quality and safety fora at Divisional and board level.**

11) **The Board should ensure arrangements are in place to support staff involved in adverse events**

12) The Board should urgently review ED staff awareness of Duty of Candour

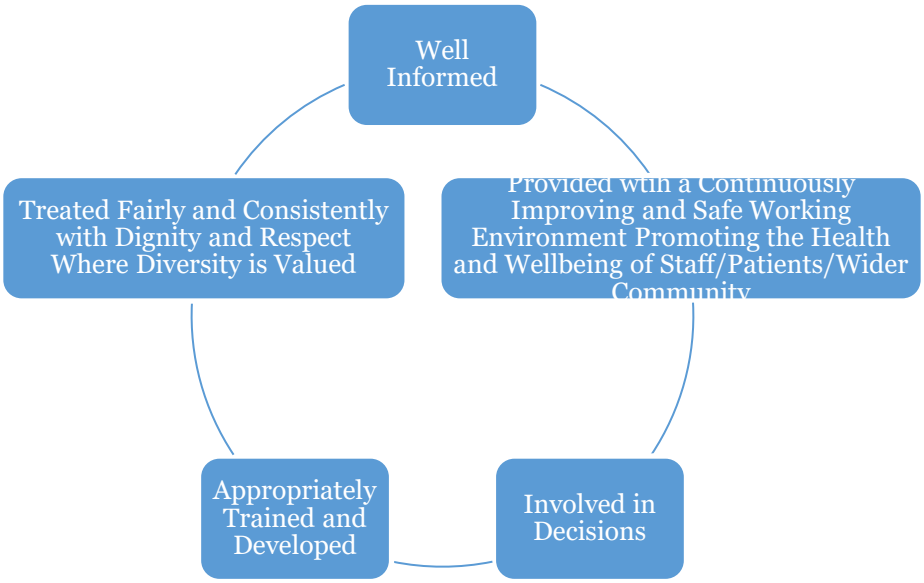
13) The Systems Leadership Team should consider how all members of the team are cited on emerging clinical and patient safety / patient facing priority issues and consider creating an action group that supports a nimbler approach to considering emerging issues.

7. Staff Governance

7.1 Staff Governance is firmly established as one of the strands of the NHS Scotland governance framework for which all Boards are held accountable. Staff Governance is underpinned by a strategic legislative framework introduced by the NHS Reform (Scotland) Act 2004. The aim of Staff Governance and the 2020 Vision Strategy is to ensure the modernisation of the workforce through pay, partnership and good employment practices and supports a culture of continuous improvement.

7.2 It is defined as "a system of corporate accountability for the fair and effective management of all staff". The Staff Governance Standard Framework is the key policy document to support the legislation described above and includes the following standards and strands against which Boards are required to measure their performance. It also promotes Partnership working with Trade Unions and Professional Organisations and the link between a positive staff experience and a positive experience for patients and service users.

7.3 The Standard requires all NHS Boards to demonstrate that staff are:



7.4 In order to effectively embed Staff Governance and achieve the aims described above there is a need for ownership of, and accountability to, the Staff Governance Standard at all levels and across all staff groups, from individual staff and their representatives, managers at all levels and Board members. This crucial element formed an integral element of the Review Team's assessment of the commitment within the Board to all of the Staff Governance strands.

7.5 Staff Governance themes formed part of the discussions held with both the senior leaders, non-executive Chairs and staff seen as part of this review process. This supported an

assessment and comparison between relevant Board and Staff Governance Committee papers and how things feel for staff within the ED on a day to day basis "on the ground"

7.6 Taking each of the Staff Governance standards in turn the assessment made as part of this review for each of these is detailed below given the scope of this review it is inevitable that there are certain of the standards which feature more significantly than others and also that there is an inextricable link between Staff Governance, Clinical Governance and Corporate Governance and Organisational Culture hence some recommendations are appropriate in more than one section of the report.

iMatter is described as a process in a dedicated section at 7.25 below with reference to the 2019 Board Report and also a small number of the ED reports. iMatter provides an overarching Board report including an Employee Engagement Index Score (EEI) and also local team reports using the same structure. The score quoted at each of the heading sections below relate to the overarching Board Report score which can, understandably, vary from the results seen at team levels within the Board.

WELL INFORMED (Board Report 2019 = score 79)

7.7 An analysis of the Board papers during 2019 – 2021 demonstrated that the Head of Communications provided reports to the Board (papers considered on 28/5/19;26/11/19; 28/1/20:28/7/20:15/12/20; outlining the communications framework which includes both "out-facing" communications for the public and users of the service and also some workforce related areas e.g. Health and Wellbeing, Excel communications and promotions of Staff Governance strands such as iMatter etc. In common with other Boards NHS Forth Valley also has an intranet and external facing website within which information can be shared with the workforce.

7.8 However, the significant gap in terms of communication and awareness that has been identified as described within the individual staff interviews held relates to being well informed at a local ED level with regard to issues already referred to within other Sections of this report (Corporate and Clinical Governance and Themes from the interviews held). More specifically this relates to understanding the new Acute Services structural arrangements, the professional and operational management reporting relationships and professional issues such as Duty of Candour as some examples. This Staff Governance strand also cross-references to paragraph 7.13 below regarding being involved in decisions that affect them. It also has in integral link to effective Partnership working with Trade Unions and Professional Associations which provides another rich and effective channel of communication with the workforce.

7.9 The Communications strategy for the Board should include not only "best practice" in terms of external communication for patients, service users and key partners but also as part of the Staff Governance action plan must include developing effective communication channels with the workforce. This should look at both formal and informal mechanisms for this type of communication.

PROVIDED WITH A CONTINUOUSLY IMPROVING AND SAFE WORKING ENVIRONMENT PROMOTING THE HEALTH AND WELLBEING OF STAFF/PATIENTS/WIDER COMMUNITY (Board Report 2019 = score 76)

7.10 An analysis of Board papers during 2019 – 2021 demonstrated that Quarterly Health and Safety reports were provided to the Board via the Staff Governance Committee (papers

considered on 14/12/18; 28/05/19;18/8/20;27/10/20; providing general updates on H&S and H&WB reports and activity within the Board

7.11 The Review Team were advised that there has been a recent review of the Health and Safety Governance arrangements within the Board.

7.12 The Review Team were provided with the Draft document entitled "Health and Safety Strategy and Governance Framework 2021-24" which outlines the intended arrangements for the Board going forward. This document is comprehensive in nature and provides an assurance structure which is seen as being critical to provide assurance to the Board that Health and Safety accountability and responsibilities are clear from workforce "on the ground" to Board assurance level. It is crucial that this is finalised and approved by the Board as a matter of urgency and communicated clearly to all staff.

APPROPRIATELY TRAINED AND DEVELOPED (Board Report 2019 = score 72)

7.13 An analysis of Board papers during 2019 – 2021 demonstrated that the Head of Organisational Development, Learning and Education provided reports to the Board (papers considered on 28/5/19;26/11/19;27/10/20;15/12/20: providing general updates on OD and Learning and Education and iMatter activity within the Board.

7.14 As described above the gap that has been identified as described in the individual staff interviews relates to the induction, training and development that is undertaken within the ED. Specific examples were provided of competency booklets for all staff Bands which had previously been used as part of induction to the Department and ongoing training but which are not used on a regular basis currently and a specific Education post which had been in-situ but which is now vacant. It was also felt that whilst staff were allocated a "Mentor" upon commencing in the Department that this did not always feel supportive e.g. comments allegedly made such as "when am I going to stop babysitting you".

7.15 More concerning from both a Staff Governance, Clinical Governance and Patient Safety perspective were the comments and direct quotes received from staff where they at times felt anxious in carrying out their clinical role as they did not feel that they had received the appropriate level of Induction training when they joined the department. This was especially prevalent when staff were asked to cover Resuscitation either because they did not feel adequately trained or because the more experienced staff had to move to cover Resuscitation then they do not feel as well supported clinically "on the floor".

7.16 It also appears to be the case that eKsf/TURAS completion becomes a focus mainly at the time of revalidation for staff and is not seen as an important interaction between the individual and their manager to consider and develop a Personal Development Plan (PDP). The Review Team heard that in some cases it happens but was described as a "tick box exercise" or for some individuals has not happened regularly. In addition, it may be the case that a PDP is discussed and agreed, however, due to service demands on the floor the ability to be released to attend can be an issue.

7.17 Another underpinning element in respect of this strand is Workforce Planning. The need for effective workforce planning is listed within the Strategic Corporate Risk Register from the perspective of the implementation of the Primary Care Improvement Plan and also the need to ensure that the transition into the delivery of integrated services is achieved.

7.18 There are internal arrangements in place to undertake workforce planning in order to support the overarching Workforce Strategy and People Strategy and is it recommended

that these are also reviewed to ensure that these remain "fit for purpose" and include Partnership involvement. This recommendation is also linked to the narrative within the Nursing Workforce and Clinical Governance sections relating to workforce related issues and recommendations

INVOLVED IN DECISIONS (Board Report 2019 = score 70)

7.19 As stated in paragraph 8.9 above areas were described by the workforce where they did not feel well Informed and this has an element of cross over to this Staff Governance strand.

7.20 Examples were provided during the staff interviews of instances where they did not feel that they had been involved in decisions or had any explanations or discussions regarding changes in working practices within the ED which did have a direct impact upon their working environment.

7.21 Examples provided included, the new Acute Services Management structure and lack of clarity on the roles and responsibilities within it including the different arrangements for operational and professional accountability. Also the introduction of the new working arrangements within ED which included the "streaming" of patients was cited as being difficult for staff as they felt that there had been no full discussion with them on this and how it would affect them in their professional role. An example was provided to the Review Team where an individual described only being aware of the change to their role upon commencement of their shift.

7.22 This also cross-references to the lack of Partnership involvement at a local level within the Directorate as this is another channel which ensures that the voice of the workforce is heard and involved in any organisational change or significant changes in working practices. This relationship also acts as two-way channel of communication which can provide positive benefits for all parties involved.

TREATED FAIRLY AND CONSISTENTLY, WITH DIGNITY AND RESPECT, IN AN ENVIRONMENT WHERE DIVERSITY IS VALUED (Board Report 2019 = score 76)

7.23 As can be seen from the responses from the Psychological Safety Questionnaire and the themes drawn from this and the individual interviews there is a significant strength of feeling that staff within the ED do not feel that they are treated "fairly and consistently, with dignity and respect, in an environment where diversity is valued. The main thrust of the themes relates to the values and behaviours displayed not only as peers, colleagues and managers within the Directorate but also from the Executive and Senior Management towards those within the Directorate.

7.24 As a Review Team we have drawn our conclusions from both the Questionnaire responses and the interviews and that these will be difficult for senior colleagues to see and receive feedback upon and there may even be a view that these have no validity because they are, and we accept, only one side of the story of the ED. However, what cannot be ignored is the high level of response from the Psychological Safety Questionnaire (105 issued and 61 returned) and the common thread of perceptions and feelings that staff have taken the time to share with us and that whatever the Senior view may be in challenging these what has to be accepted is that this is the reality for the staff within the Directorate. It also has to be recognised that the staff spoken to still had an extremely high level of loyalty to not only their patients and the Department but also NHS Forth Valley as a Board and this is very positive for the Board and were more than willing

to provide their own suggestions as to how things could be improved within the Department.

7.25 In common with all NHS Boards in Scotland, following the Sturrock Review in NHS Highland, NHS Forth Valley had to undertake a self-assessment based upon the requirements of the letter received from the Cabinet Secretary post the publication of Sturrock. This was completed and considered by the Board at its meeting on the 6th August 2019.

7.26 The Review Team were advised that a Working Group involving Partnership has been established to progress the work required post-Sturrock. However, this group has not as yet fully met and whilst some impact on progression would have been as a result of Covid19 it is considered by the Review Team that some work could have been progressed in terms of establishing relevant groups or fora to commence focused work between August 2019 when the relevant Cabinet Secretary letter was received and the beginning of the impact of Covid in 2020. It is important given what has been assessed during this review regarding values and behaviours that this work is progressed as a matter of urgency with clear action plans, accountable leads, critical timescales and KPI's/benefits realisation.

7.27 The Review Team were also provided with the Staff Governance papers for its meeting in March 2021 which included an OD paper describing the steps being taken regarding the "Speak Up" initiative linked to the introduction of the new National Standards on Whistleblowing and the establishment of a Short Life Working Group to progress this work. This is welcomed by the Review Team and it is to be hoped that the culture of "Speaking Up" will be developed not only in relation to the normal categories defined within this but also in respect to the completion of IR1s and SAER's and the creation of a learning organisation culture.

iMatter

7.28 This is an important staff engagement tool which asks the workforce to respond based upon the underpinning Staff Governance strands as well as responses regarding how they feel about their "team" and "line manager" and the "organisation" as a whole.

7.29 Responses from the workforce within the ED would appear to indicate a disconnect between their experience of feedback and involvement described with regard to iMatter and Action Planning and the responses which make up Board reports on iMatter. For example, figures reported in 2018 showed an increase in the completion of Action plans from 25% in 2017 to 80% in 2018 with the ambition to reach 80%+ in 2019. The actual KPI report for iMatter for the Board in 2019 shows that 74% of iMatter reports were achieved and 72% of Action Plans achieved. From the direct staff experience it may be the case that the ED is an area which does not have a high completion rate of Action Plans or inclusive Action Planning discussions and this should be examined further by the Board.

7.30 It has been possible to examine 3 Team reports from 2019 and also the Pulse Survey in 2020 for the Emergency Directorate and it is the case that in respect of iMatter there were response rates ranging from 67% to 86% with EEI scores ranging from 68 to 83 and an overall assessment score of 5.16 to 8.17. Within the Team reports examined there were no red responses although there were some yellow and amber responses (relating to involved in decisions; performance being managed well; being trained and developed; time to support learning growth; helpful feedback; feeling appreciated)

7.31 The overarching 2019 Board Report was also reviewed demonstrating a 68% response rate and an EEI of 75 this showed all Staff Governance strands as being in Green; Yellow areas included – Board member's visibility; trust and confidence in Board members; involved in decisions; performance being managed well). It is normal in iMatter for the overarching Board report to have more improvement areas and these tend to fall into the areas listed.

7.32 The Review Team were also provided with the Staff Governance papers for its meeting in March 2021 which included an OD paper on the iMatter action plan for 2021 which is seeking to further embed iMatter also linked to the themes arising from the 2020 Pulse Survey results. It is timely, given the responses received from the workforce, that this is also going to seek to refresh iMatter and the crucial part that it plays in a continuous improvement journey.

Partnership Working

7.33 Since the publication of MEL 1999 (59) "Towards a New Way of Working" partnership working with Trade Union and Professional Association colleagues is a well-established way of working at both a National and Local Board level within NHS Scotland. ACAS note that employees will only be able to perform at their best if they know their duties, obligations and rights and have an opportunity of making their views known to management on issues that affect them.

7.34 The commitment to Partnership working is demonstrated by the establishment of the role of Employee Director as a non-Executive member of the Board, and in most Boards in Scotland, also by their involvement in the senior management groups including those Chaired by Chief Executives with their Executive and Senior Leaders. It is based upon the values of trust, integrity and openness across all Board activities and also embraces the core values of fairness and consistency. There are many examples of Partnership working delivering very positive outcomes in terms of the delivery of organisational change and service redesign for the delivery of improved services to patients.

7.35 It is extremely disappointing that within NHS Forth Valley that Partnership working has not been embraced in the same way as in other Boards and this is demonstrated by the Employee Director not being a member of the Executive or System Leadership team. This is viewed as a serious missed opportunity to embrace and demonstrate a true commitment to partnership working that can only add value to the Board's consideration and delivery of high quality and inclusive workforce related decisions.

7.36 It was also demonstrated that there was not a consistent commitment or support from management within the Acute Division to the local Partnership Forum. This is viewed by the Review Team as another opportunity missed in relation to effective Partnership working at a local level. The Partnership Forum provides not only another channel for valuable communication in respect of any issues affecting the workforce but also enables effective and credible working relationships to be established between representatives and managers which can prevent issues being escalated or becoming more significant in nature.

7.36 Recommendations

1) Urgent review of the arrangements for the implementation of iMatter within the ED specifically but also for the Board as a whole in terms of ensuring that there is oversight of performance at a Board and Staff Governance

Committee level to ensure that there is a more proactive approach taken to both identify and support "red/amber areas".

2) **Increase the Staff Governance content for Board performance monitoring and "Balanced Scorecard" to include performance on statutory and mandatory training, eKsf/TURAS compliance, iMatter and relevant H&S KPIs (the introduction of Pentana should support this) to be better able to triangulate meaningful workforce related KPIs to identify any "hot spots" in a more effective manner**

3) **Urgent review all of the Staff Governance standards in terms of an internal self-assessment to review any areas for improvement and develop appropriate actions plans, key milestones and leads as appropriate**

4) **Urgent review of Partnership arrangements at both a Board and local level to ensure that these are as inclusive as possible to reap the benefits of positive partnership working and also that appropriate senior commitment is given to Partnership Fora at both a Board and local level**

5) **Provision of support/training to both the Employee Director and Partnership representatives to ensure that they understand the roles and responsibilities that come with operating in a committed partnership environment and that they are able to fulfil these in a meaningful and effective way.**

6) **Ensure that Partnership working is embedded as the "business as usual model" within NHS Forth Valley and work is done to raise awareness of this with line managers and HR staff who should also be encouraged to act as ambassadors for partnership working with managers in the day to day operation of the Board**

7) **In line with the issues also raised within other sections of this report to review the induction, training and development and TURAS arrangements and compliance by both managers and staff to ensure that these are fit for purpose throughout the Board**

8) **Urgent review of Induction, skills assessment and the learning and development plan within the ED to ensure that staff are competent to carry out their role safely as this has a direct bearing in terms of patient safety and also as individual's their professional registration requirements**

9) **Review of workforce planning arrangements in partnership to ensure that these are "fit for purpose" in order to support the overarching Workforce Strategy and People Strategy and Integration plans.**

10) **Urgent implementation of the post-Sturrock governance and action plan to be able to assess the overall organisational culture and develop an improvement plan to ensure that staff feel safe and able to speak up and also work within a positive environment**

11) **Ensure that the Health and Safety governance structures and responsibilities are approved as a matter of urgency and disseminated throughout the Board.**

12) **It is recognised that the Staff Governance standards must be owned at a local level and committed to by managers in order to make them meaningful**

for staff, however, it is important that the HR Director in Partnership with the Employee Director takes a robust monitoring and performance management role in order to be assured and to be able to provide assurance to the Board and Staff Governance Committee of overall performance in all of the strands.

8. Nursing Workforce and Professional Oversight of Safe Staffing

8.1 The Review Team had the pleasure of meeting a large number of ED nursing staff across a range of grades. Without exception the Review Team were impressed by their candour and levels of professionalism.

8.2 Throughout the review period, members of the nursing and medical workforce raised concerns about levels of safe nursing staffing within the ED department. They were clear that this was exacerbated by but not as a consequence of COVID. However, they described a culture within the department that did not welcome raising concerns of this kind. The Review Team were advised that these concerns had been raised by the RCN through the professional nursing structure and an email dated 19th October 2020 informed senior members of the acute management team. It is understood that this was then escalated within the organisation to Director level through receipt of an email dated 18th December 2020.

8.3 These concerns were raised in terms of numbers of staff, skill mix and grade mix and also clinical leadership, support and supervision. Staff cited major concerns about poor induction of staff at department level and their feelings of anxiety due to perceived or real lack of competency levels particular at junior band 5 and newly appointed band 6 level. Staff told us that access to structured training and development was limited, that the competency framework was there on paper but not in practice and that there was no meaningful career structure. This also included lack of appraisal and links to EKSF. They described the brief introduction of the Education role as a welcome development, however the post holder left after a very short time in post.

8.4 The role of the Team leaders at band 6 and 7 were raised by a number of the staff. They described this role as more managerial than clinical on a day to day basis “off the floor”. There is a perception that the key function of this role on a day to day basis is the Coordination of flow and link directly with the Hospital Duty Management system. Staff also highlighted issues about rostering practices within the department and inconsistencies arising from this in terms of both grade and skill mix.

8.5 Staff raised concerns about lack of involvement in changes in the department and specific reference was made to the introduction of a “Streaming Nurse” without any consultation, training or discussion. Staff described this role as being mainly a means of redirecting patients to minor injuries (often out-with the main department) without any clinical assessment. The review team escalated this concern to the Executive Medical Director and Executive Director of NMAHPs and we were subsequently advised that this is under review. Concerns were also raised about the creation of the Urgent Care area and changes for the Emergency Nurse Practitioner cohort without engagement or consultation or cognisance of their personal safety.

8.6 Staffing of the RESUS area was raised without exception. The Review Team were able to review activity for this area over a period of time. Data provided would suggest that there are on average eight patients treated through this area on a daily basis. The Review Team were therefore surprised that staff reported that staffing of this area was not consistently factored into daily staffing levels. As a consequence, staff described real safety concerns

when senior members of nursing staff were deployed to this area leaving more junior staff short in numbers and skills to deal with the remaining ED activity.

8.7 Disappointingly the majority of junior and senior members of the nursing staff could not describe the nursing professional governance arrangements that were in place for them to raise these concerns out-with their direct line management arrangements. Indeed, they were not aware of key professional nursing roles.

8.8 The Review Team met with Executive and Senior nursing staff and reviewed a large amount of information. The Review Team observed a Professional leadership group where there was, at times, significant disconnect between what they thought was happening and what was actually happening “on the ground” in terms of staff’s feelings and perceptions.

8.9 The Review Team noted several issues arising from the Psychological Safety responses and staff feedback where there was lack of awareness about issues that senior professional nurses might reasonably have been sighted on, if robust assurance frameworks were in place, due to the impact to the risks associated with practice

8.10 The Review Team were made aware that Nursing and Midwifery safe staffing and workforce/workload monitoring and delivery is discharged through the “Excellence in Care/ Safe staffing Programme Board”. This sits under the Safe Care and Staffing Council. A Safe and Efficient Nursing and Midwifery staffing group is chaired by the Chief Nurse. This group compromising Heads of Nursing, Finance, Workforce and recruitment leads and usually meets 4-6 weekly. The Review Team were surprised that Staff side colleagues were not involved in this important professional governance group.

8.11 The Review Team were surprised to learn that this group was stood down during Covid. It is not clear what formal professional governance arrangements were put in place however the Review Team were advised that Monthly reporting on spend etc. was monitored through local operational managers at Directorate level.

8.12 The Review Team were advised that in line with other NHS Boards and safe staffing legislation, NHS Forth Valley regularly apply workforce tools. The Board acted as a pilot site for the ED toolkit (EDEM) in 2017. More recently the N&M workforce tool, which includes triangulation against professional judgment was run in January 2020. The local calculation includes a predicted absence allowance of 21.5% (National recommendation 22.5 %)

8.13 The current Funded establishment within ED is 71.5 wte, this compares to a predicted requirement of 67.00wte using EDEM tool and 75.5 wte using professional judgment. The Review Team were provided with further workforce information that demonstrated that average absences over the year were in excess of 28% and around 11wte staff were used to backfill. Staff turnover during the period was in the region of 10%.

8.14 In addition, the board provided benchmarking information from another NHS board, which seem to suggest that Forth Valley staffing is considerably richer in both numbers and skill mix. The Review Team were not aware of activity figures for this board and therefore sought to also benchmark with a similar sized Health Board and this yielded a different set of results suggesting that Forth Valley staffing was less favourable in terms of number of staff but richer grade mix.

8.15 The Review Team concluded that a number of actions need to be taken to ensure that ED nursing workforce planning is prioritised to ensure patient safety is managed effectively including skill mix and that ED nursing staff have the skills and knowledge to deliver safe

and effective patient care across the spectrum of ED services. Nursing professional leadership structures are not well understood and there is confusion with operational management functions. As a result, staff were unaware or unable to confidentially raise concerns and seek decisions when needed.

8.16 Recommendations

1) **The Board should consider creating a Clinical Nurse manager post to support services across ED and Minor injuries units. The post holder should fulfil the role of Senior Nurse, be an expert ED nurse who has completed as a minimum, level 2 competencies (as set out by RCN or equivalent) and has responsibility for overall clinical support and supervision overseeing quality improvement and assurance, workforce management etc. The post holder should fulfil a supervisory role and have on average two fixed clinical sessions per week**

2) **The Board should review the Professional nursing structure and implement a more fit for purpose leadership structure. Core to this should be enhancing visibility and engagement with front line staff and patients to improve trust and confidence; create a culture of openness where staff feel listened to and supported.**

3) **The Board should revisit the ED staffing taking account of information provided within this report, consideration should be given to applying the key Nursing workforce standards set out by RCEM and RCN in October 2020 particularly as it applies to:**

   - **Further review of workforce numbers and comparable benchmarks**
   - **Appropriate skill mix at Charge Nurse (Team leader); Staff Nurse; Foundation Staff Nurse and Clinical support worker level, with an overall 80-20 skill mix.**
   - **Explicit attention should be given to safe and consistent staffing of the RESUS area and the concerns raised by staff**
   - **Clarity on the "streaming role" in particular staffs concerns about patient safety and clinical competency to undertake this role**
   - **Review of departmental induction for staff at all grades and consideration of a period of supernumerary status for nurses new to the department and nurses at Foundation level.**
   - **Development of an ED career framework linked to recognised emergency nursing clinical competencies supported by an ED training plan**.
   - **Development of the Team leader role as a clinical expert providing on the job clinical support and supervision and expert across a range of areas included within the Emergency nursing competency frameworks and clear links with departmental quality outcome monitoring**
   - **Improved scrutiny around Rostering practices with a particular focus on staff competency levels alongside variation in clinical demand**

- **The Nursing workforce governance group should consider the existing terms of reference and membership and whether they are sufficiently sighted on the short and long term staffing challenges, links to quality outcomes and should consider reviewing membership and inclusion of staff side input and reporting arrangements**

9. Conclusions and Final Remarks

a. The Review Team are grateful to everyone who contributed and helped in completion of this challenging review.

b. In particular, the Review Team commend the staff of the ED for their honest, personal and professional descriptions of experience working in the Department and for their contributions to help inform and enhance a journey of improvement.

c. The Review Team are also grateful to Carol-Anne Cook and Denise Davidson for their excellent administrative help and support throughout the review.

d. The Review Team commend the content and recommendations contained within this Report to the Board of NHS Forth Valley. The Report is worthy of serious reflection, consideration and action helping to deliver on the Board's commitment to continuous improvement and the principles of the People Strategy which include: fit for future leadership; effective recruitment and retention; health and wellbeing of the workforce; a positive and values based culture; transforming our workforce; working with our partners.

e. The Board and the Executive / SLT are clearly well intentioned in their endeavours – but the findings from the Review suggest that there are important improvements needed both to systems and the follow through and performance monitoring of any implementation plans.

f. The Report contains challenging messages and feedback from staff – much of which was difficult for the Review Team to hear and we recognise will also be difficult for the Board and senior leadership to hear.

g. It is important is to recognise that these statements reflect the reality of the current feelings and experience of a group of staff providing care and service within the Board – and must be accepted as such.

h. An open, inclusive, transparent, genuine partnership approach by the Board to the sharing and response to this Report will undoubtedly be recognised by the staff as a positive start on the journey of response and improvement.

i. It is recognised that implementation of the Recommendations in the Report will be challenging. It will need all of the stakeholders to engage constructively in discussions and reach conclusions in partnership. Whether the stakeholders are internal or external to NHS Forth Valley it is essential that colleagues work together to find the optimal solutions for improvement in leadership, delivery of safe and high quality of care, improvement of staff experience and in governance systems providing overall assurance of performance.

j. It is important to emphasise that across all levels of the organisation the Review Team found dedicated and hardworking staff committed to delivering the highest standard of healthcare to the people of Forth Valley who also hold a high degree of loyalty and commitment to the Board

k. The Review Team expects that the Recommendations made in the Report will be used in a truly holistic and integrated way in partnership to provide help, guidance and support to staff working in NHS Forth Valley to deliver the necessary improvements.

Kenneth Small Rosslyn Crocket Rosemary Lyness Barbara Anne Nelson

9 June 2021

SECTION 5: CORPORATE GOVERNANCE	RECOMMENDATIONS
1) That there is an external expert assessment of relationships and behaviours between members of the SLT, clarity on roles and contributions; what is expected of them collectively and individually and in particular ability to challenge peers 2) That there is an external assessment of relationships and behaviours between Systems Leadership Team and Non-Executive Board members with a particular focus on how they engage, scrutinise and utilise the information presented to them and use this to make an informed assessment for assurance purposes. 3) The Board should revisit the results of the 2019 self-assessment on the Blue print for Good Governance taking account of the findings of this review and expedite the plans to introduce "Active Governance". 4) The Board should consider any recommendations arising from the national work to improve assurance systems and develop a local assurance framework that embeds and refreshes relevant information flows and timely data to support scrutiny and assurance Board /Committees. (consider qualitative as well as quantative data and benchmarking) 5) The Board should consider developing a more proactive simplified communication plan to help paint a clear picture of how the organisation is governed, how priorities are developed and well communicated and to raise awareness and understanding by all stakeholders	6) The board should develop a structured programme of visibility and engagement with staff in order to demonstrate Board values; encourage staff to speak up and be heard and reinforce a culture of continuous improvement. (This could be through Patient Safety leadership walkrounds, meet the Board sessions or a range of other engagement initiatives) 7) NHS Forth Valley should urgently review the current Acute Division management arrangements to ensure there is sufficient Senior Clinical leadership to provide oversight of whole hospital issues. This needs to provide clarity on lines of accountability for operational and professional governance, so that staff understand the routes of escalation if they have any issues or concerns. In doing this ensure that robust operational management systems are in place to drive continuous improvement involving staff at grass roots level. 8) That this review of management arrangements needs to be complemented by a thorough review of Hospital governance arrangements that compliments the Board assurance framework and promotes and assures Safe, effective and person centered care from ward to Board.

SECTION 6: CLINICAL GOVERNANCE	RECOMMENDATIONS

1) The Board should immediately review its entire Clinical Governance arrangements to ensure a clear line of responsibility and accountability from the Board to the point of care and from the point of care to the Board. This should include reviewing all workstreams and groups to ensure adequate depth and breadth of assurance. This will enable the committee to provide the Board with the assurance of safe effective person centered care. **2) All members of the Clinical Governance Committee should be given support to discharge their responsibilities by identifying any training and education requirements.** **3) The Clinical Governance Committee should consider developing a communication strategy which clearly raises the profile and awareness of the Committees Role purpose and work plan to provide front line staff with a better understanding.** **4) The Clinical Governance Committee minutes should provide evidence of the level of the committee's discussion and scrutiny to demonstrate assurance of safe and effective person centered care** **5) The Executive Director NMAHPs must clarify the lines of professional nurse leadership, governance and accountability in the Acute Division and ensure staff in these roles are supported to effectively discharge their responsibilities.** **6) The Executive Medical Director must immediately develop an implementation plan for the Role out of the Vincent Framework ensuring there is strong visible committed clinical leadership at every level of the organisation this will help staff understand the benefits of the Framework and the expectations of them.**	**7) The Board should prioritise the progression of the Quality Strategy ensuring that the workforce is consulted and engaged in its development and implementation** **8) NHS Forth Valley Adverse events policy was due for revision in December 2020. The Board needs to review how this policy is made easy for frontline staff to understand then subsequently implemented and monitored to be able to demonstrate the Boards commitment to promoting an open and honest culture that is based on supporting staff within a culture of continuous improvement** **9) The Review Team were unable to establish the existence of a robust SAER tracking system. The Board are encouraged to confirm or develop such a system ensuring that the workforce is aware of this and how to use this effectively.** **10) The Board should ensure that reports on adverse events with links to improvement plans are prepared; disseminated and analysed in a timely manner. That analysis is shared at department/ operational level and through quality and safety fora at Divisional and board level.** **11) The Board should ensure arrangements are in place to support staff involved in adverse events** **12) The Board should urgently review ED staff awareness of Duty of Candour** **13) The Systems Leadership Team should consider how all members of the team are cited on emerging clinical and patient safety / patient facing priority issues and consider creating an action group that supports a nimbler approach to considering emerging issues.**

SECTION 7: STAFF GOVERNANCE	RECOMMENDATIONS
1) Urgent review of the arrangements for the implementation of iMatter within the ED specifically but also for the Board as a whole in terms of ensuring that there is oversight of performance at a Board and Staff Governance Committee level to ensure that there is a more proactive approach taken to both identify and support "red/amber areas". 2) Increase the Staff Governance content for Board performance monitoring and "Balanced Scorecard" to include performance on statutory and mandatory training, eKsf/TURAS compliance, iMatter and relevant H&S KPIs (the introduction of Pentana should support this) to be better able to triangulate meaningful workforce related KPIs to identify any "hot spots" in a more effective manner. 3) Review all of the Staff Governance standards in terms of an internal self-assessment to review any areas for improvement and develop appropriate actions plans, key milestones and leads as appropriate 4) Urgent review of Partnership arrangements at both a Board and local level to ensure that these are as inclusive as possible to reap the benefits of positive partnership working and also that appropriate senior commitment is given to Partnership Fora at both a Board and local level 5) Provision of support/training to both the Employee Director and Partnership representatives to ensure that they understand the roles and responsibilities that come with operating in a committed partnership environment and that they are able to fulfil these in a meaningful and effective way. 6) Ensure that Partnership working is embedded as the "business as usual model" within NHS Forth Valley and work is done to raise awareness of this with line managers and HR staff who should also be encouraged to act as ambassadors for partnership working with managers in the day to day operation of the Board.	7) In line with the issues also raised within other sections of this report to review the induction, training and development and TURAS arrangements and compliance by both managers and staff to ensure that these are fit for purpose throughout the Board 8) Review of Induction, skills assessment and the learning and development plan within the ED to ensure that staff are competent to carry out their role safely as this has a direct bearing in terms of patient safety and also as individual's their professional registration requirements 9) Review of workforce planning arrangements in partnership to ensure that these are "fit for purpose" in order to support the overarching Workforce Strategy and People Strategy and Integration plans. 10) Implementation of the post-Sturrock governance and action plan to be able to assess the overall organisational culture and develop an improvement plan to ensure that staff feel safe and able to speak up and also work within a positive environment 11) Ensure that the Health and Safety governance structures and responsibilities are approved as a matter of urgency and disseminated throughout the Board. 12) It is recognised that the Staff Governance standards must be owned at a local level and committed to by managers in order to make them meaningful for staff, however, it is important that the HR Director in Partnership with the Employee Director takes a robust monitoring and performance management role in order to be assured and to be able to provide assurance to the Board and Staff Governance Committee of overall performance in all of the strands.

SECTION 8: NURSING WORKFORCE	RECOMMENDATIONS

1) The Board should consider creating a Clinical Nurse manager post to support services across ED and Minor injuries units. The post holder should fulfil the role of Senior Nurse, be an expert ED nurse who has completed as a minimum, level 2 competencies (as set out by RCN or equivalent) and has responsibility for overall clinical support and supervision overseeing quality improvement and assurance, workforce management etc. The post holder should fulfil a supervisory role and have on average two fixed clinical sessions per week **2) The Board should review the Professional nursing structure and implement a more fit for purpose leadership structure. Core to this should be enhancing visibility and engagement with front line staff and patients to improve trust and confidence; create a culture of openness where staff feel listened to and supported.** **3) The Board should revisit the ED staffing taking account of information provided within this report, consideration should be given to applying the key Nursing workforce standards set out by RCEM and RCN in October 2020 particularly as it applies to:** - **Further review of workforce numbers and comparable benchmarks** - **Appropriate skill mix at Charge Nurse (Team leader); Staff Nurse; Foundation Staff Nurse and Clinical support worker level, with an overall 80-20 skill mix.** - **Explicit attention should be given to safe and consistent staffing of the RESUS area and the concerns raised by staff** - **Clarity on the "streaming role" in particular staffs concerns about patient safety and clinical competency to undertake this role**	- **Review of departmental induction for staff at all grades and consideration of a period of supernumerary status for nurses new to the department and nurses at Foundation level.** - **Development of an ED career framework linked to recognised emergency nursing clinical competencies supported by an ED training plan.** - **Development of the Team leader role as a clinical expert providing on the job clinical support and supervision and expert across a range of areas included within the Emergency nursing competency frameworks and clear links with departmental quality outcome monitoring** - **Improved scrutiny around Rostering practices with a particular focus on staff competency levels alongside variation in clinical demand** - **The Nursing workforce governance group should consider the existing terms of reference and membership and whether they are sufficiently sighted on the short and long term staffing challenges, links to quality outcomes and should Consider reviewing membership and inclusion of staff side input and reporting arrangements**

Culture and Governance Review

Background

Having been approached by Staff Side the Chief Executive has commissioned an external review to consider both the culture and governance notably; corporate, clinical and staff governance arrangements affecting Nursing Staff working within the Emergency Department. The External Review Team will include:

Rosslyn Crocket, Formerly Executive Nurse Director, NHS Greater Glasgow & Clyde

Rosemary Lyness, Formerly Executive Nurse Director and Director of Acute Services, NHS Lanarkshire

Barbara Anne Nelson, Formerly Director of Human Resources, NHS Fife

Kenny Small, Formerly Director of Human Resources, NHS Lanarkshire

The Review will include 3 phases:

Phase 1

The External Review Team will reach out to Staff Side members to make arrangements to meet with them. The purpose of this meeting is for the External Review Team and Partnership Representatives to introduce themselves and for the members of the External Review Team to explore the nature and detail of the concerns raised by the Partnership Representatives on behalf of staff. The External Review Team will take the opportunity to inform Partnership Representatives of the Chief Executive's intention to present a letter to all nursing staff working within the Emergency Department informing them of the launch of the Culture and Governance Review, introducing the External Review Team, informing staff of the opportunity to personally participate in the Review and enclosing a Psychological Safety questionnaire with an invitation for staff to complete this and submit the questionnaire as an initial contribution to the Review.

Phase 2

Directors (Clinical Directors, Director of Human Resources and Director of Acute Services) and the Chief Nurse, Acute Services; ED Clinical Director and Clinical Lead will be invited to meet with the Review Team. The purpose of this meeting is again to facilitate introductions, to establish clarity of the scope and approach to be taken in conducting the Review, to develop understanding and insight into the approach and arrangements in NHS Forth Valley in delivery of Corporate, Clinical and Staff Governance and for the Review Team to better understand any knowledge, awareness and involvement raised by Partnership Representatives.

Phase 3

The External Review Team will give due consideration to information gleaned from these meetings (phases 1 and 2) to inform the decision on the approach to a wider ED Nursing staff engagement, design of a standardised approach to staff interviews, staff communication and launch of individual staff interviews, week commencing 8 February 2021.

Cathie Cowan
Chief Executive

Elaine Bell
Associate Director of HR

January 2021

External Review Team – Biographies

Kenneth Small: Retired in July 2018 following 10 years as Director of Human Resources, NHS Lanarkshire. Enjoyed a career of 42 years in a number of NHS Human Resources and Organisational Development roles in Scotland and England. Project work successfully completed for Scottish Government, NHS Fife, NHS Ayrshire and Arran, NHS State Hospital and NHS Greater Glasgow & Clyde in retirement.

Roslynn Crocket (MBE): Retired in September 2015, after serving as a Board Member firstly in Ayrshire and Arran for 4 years as Director of Nursing and Community Services. Followed by 17 years as Executive Nurse Director and Allied Health Professionals, in Greater Glasgow and Clyde where for a period of time held executive lead for Mental Health Services and Women and Children Services. This was following a career of 38 years in Nursing and Senior Management in Glasgow, Ayrshire and Arran and Argyll and Clyde. Prior to and in retirement Served as a Trustee on 2 Charitable organisations, chairing one of their Clinical and Care Governance Committees, Chaired an independent review of NHS Lanarkshire's palliative care services.

Rosemary Lyness (MBE): Retired in 2015 after serving as a Board member in NHS Lanarkshire for 11 years as Director of Acute Services and Executive Director of Nurses, Midwives and Allied Health Professionals. This was following a career of 37 years in Nursing and Senior Management in Glasgow, the Channel Islands, Edinburgh and Lanarkshire. Following retirement provided support to NHS Grampian as Interim Executive Nurse Director and Executive support role in NHS Lothian (post Academy of Physicians Whistleblowing report). Also serving member of Erskine Caring for Veterans Charity as a Trustee and Chair of the Boards Care and Clinical Governance Committee.

Barbara Anne Nelson: Retired in December 2019 following 5 years in a Director role within The State Hospitals Board for Scotland and NHS Fife. This was following a career of 40 years within Human Resources and Organisational Development roles within the NHS and Local Government. Following retirement projects have included the co-production and implementation of the Healing Process within NHS Highland (post Sturrock), supporting the establishment of NHS Louisa Jordan and also work within NSS, NHS Golden Jubilee, and other work within NHS Forth Valley.

The Review Team reviewed and considered Board Papers and Assurance Committee Papers covering the period 2019-2021 and also the following specific documentation:

1. Policies; NHS FV Whistleblowing Arrangement, Management of Adverse and Significant Adverse Events policy, NHSS Grievance Policy, Bullying & Harassment policy
2. Acute Services Partnership Forum Agenda 01/10/19 & 17/12/19
3. Area Partnership Forum meetings 21/02/20; 06/11/20
4. Emergency & Inpatient Care Clinical Governance Group notes 03/09/20; 23/09/20; 02/11/20; 11/11/20; 3/12/20 and 22/01/21; Action log 3.1 & 3.2; Exception reports WARDS
5. Acute Services Governance, Quality and Risk meetings 16/11/21; 17/12/20
6. ED Structure; Overall Senior Reporting Structure, Acute Services Structure, Ambulatory Diagnostics Theatre Structure; Emergency Care and Inpatients Structure; Job Descriptions and Objectives (Service Manager, Operational Manager, Chief Nurse, Head of Acute Services and Director of Acute Services); Final Organisational Chart; Acute Services Review
7. Strategic Risk Register Q4 2020-21
8. Bar Charts ED Adverts Events July – December 2020
9. ED Monthly Reports from July to December 2020
10. ED Risk on Corporate Risk Register Jan 21; ED Risk Register Jan 21
11. Senior Charge Nurse Meeting notes from June to Dec 20
12. Capacity and Demand Escalation Plan; Unscheduled Care Programme; Draft Escalation ED 1HR Target Guidance
13. Forth Valley Whole System Demand and Capacity Barometer, including Breach Report, Capacity and Flow Dashboard, Compliance Report, Daily Safety Report, Attendance and Redirection, Attendances and Breaches reports. RED Resus Adult setup and Resus Paed Setup; Steam Guide v5
14. ED Complaints and Feedback, Care Opinion Stories summary
15. Examples of Business Cases, Change Proposals and Projects
16. Pathways and Processes for ED; Front Door Streaming, Triage and Redirection; MIU Redirection (All local protocols based on RCEM Standards)
17. Handover guidance for 08:00 hrs and 22:00 hrs, Huddles and NIC daily review information
18. Minutes of ED Department meetings from August 20 to January 21
19. ED Training records, Induction for Staff Nurses, Nurses Handbook, ED Consultant Charge Duties, Nurse in Charge Duties, PDP progress ED nursing staff; iMatter Team reports
20. Staff Governance Terms of Reference and Minutes; 20/09/19; 13/12/19; 18/08/20; 11/12/20; Sturrock Review Group meeting 09/02/21; Governance Update: “Incident Reporting, SAERs and Duty of Candour: What you need to know – and do” Apr 21
21. Exit interview themes from ED Staff
22. Sharing Intelligence ED NHS FV Dec 20
23. Clinical Governance meetings 13/11/20; 25/11/20
24. ED Positives in past 18 months Aug 19 – Feb 21
25. Executive Safety Visit reports
26. FV Quality Organisation Structure; Draft Quality Strategy and Communication and Engagement Plan; FV Quality Improvement Strategy “Better Every Day”
27. Our People Strategy 2018-2021; Workforce Plan 2019-2020; Clacks and Stirling Health Structure, Falkirk Structure, Staff Transition Support Requirements
28. NHS Forth Valley Board meeting May 20
29. ED Bank and Agency Financial Year 2019-20
30. Rotas; ED Consultant 2019, ED Junior Dr from Jul 19 up to Mar 20; ED Nursing Jan 19 – Dec 19

31. Hospital Management Board (HMT) Terms of Reference and Notes from Jan 19 –Mar 20; changed to Acute Services Management Group (ASD) notes from 02/11/20 and 03/12/20
32. Ambulatory Care, Diagnostics & Theatres Management Team meeting 04/02/20, Emergency, Urgent Care and Inpatients Management Team meeting 01/12/20
33. Scheduled Care Deliver Group (SCDG) Terms of Reference and Meetings from Jun 20 to Dec 20

Appendix 10.4

NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone:
Fax:

Date
Your Ref
Our Ref

Enquiries to
Extensions
Direct Line

Dear Colleague

Firstly, I would like to thank you for your ongoing support at this challenging time as you and the team continue to deal with the ongoing Covid-19 pandemic. Some of you may be aware that a number of concerns were recently brought to my attention relating to the culture and working relationships within the Emergency Department at Forth Valley Royal Hospital and the impact of these on staff, particularly nursing staff.

Following detailed discussions with staff side representatives, senior management and senior clinical staff and in line, with our commitment to openness and transparency, I have asked an external team of experienced healthcare professionals to carry out an independent review of the culture and governance arrangements within the Emergency Department. The External Review Team membership is as follows:

- Rosslyn Crocket: Formerly Executive Nurse Director, NHS Greater Glasgow and Clyde.
- Rosemary Lyness: Formerly Executive Nurse Director and Director of Acute Services, NHS Lanarkshire. Since retirement Rosemary has provided Executive level support and professional advice in NHS Grampian and NHS Lothian with a particular focus on nursing, leadership and management, patient safety, quality, and service improvement.
- Barbara Anne Nelson: Formerly Director of Human Resources, NHS Fife. Since retirement Barbara Anne has provided Executive level support and professional advice to The Golden Jubilee National Hospital, NHS Forth Valley and NHS Highland with a particular focus on partnership working, dispute resolution, effective leadership and management of dignity at work.
- Kenny Small: Formerly Director of Human Resources, NHS Lanarkshire. Since retirement Kenny has provided Executive level advice and support to NHSScotland, NHS Fife, NHS Ayrshire and Arran and NHS Greater Glasgow and Clyde with a particular focus on organisational development, dispute resolution, whistleblowing, and investigation of complex dignity at work issues.
- The Review Team has already commenced preparatory assessment work and plan to conduct a series of individual, confidential meetings with nursing staff who work in the Emergency Department over the next few weeks. A further letter providing more information about the arrangements for these meetings will follow soon.
- In the meantime, the Review Team is keen to receive early, anonymised feedback from nursing staff who work in the Emergency Department through the completion and return of the enclosed Psychological Safety Questionnaire. We ask that you please take time to complete and return the questionnaire to help inform the Review Team's understanding of the working environment in the Emergency Department and the experiences of local nursing staff. It would be helpful if you could complete and return the questionnaire to the Review Team using the enclosed pre-paid envelope by **Friday 5th February 2021**.

- Robert Clark, NHS Forth Valley's Employee Director, and I want staff to speak up and feel confident to share their personal experience and feedback. We would therefore encourage you to engage and contribute to this Review process as openly and honestly as possible. The findings from the Review will be used to identify any key themes, issues or concerns along with recommendations on how these can be addressed.

Staff side representatives are available to provide advice and support and a confidential HR email address, fv.hrreview@nhs.scot, has also been established to help respond to any questions you may have during the review process. You can also find details of local services and support on our Staff Support and Wellbeing webpage www.nhsforthvalley.com/staffsupport and the National Wellbeing website www.promis.scot.

Kind Regards

Cathie Cowan
Chief Executive
NHS Forth Valley

Robert Clark
Employee Director
NHS Forth Valley

Appendix 10.5

NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone:
Fax:

Date
Your Ref
Our Ref

Enquiries to
Extensions
Direct Line

Dear Colleague

We wrote to you recently to inform you that we had commissioned an External Review Team to undertake a Culture and Governance Review within the Emergency Department and we would like to update you on the progress of this work. Over the last few weeks, the External Review Team has been gathering key information and is currently analysing the anonymised psychological safety questionnaires which have recently been completed and returned. Robert Clark, NHS Forth Valley's Employee Director and I would like to take this opportunity to thank you for your contribution this far.

As outlined in our previous letter, the External Review Team would now like to invite you to an individual, confidential meeting with them.

Due to COVID-19 restrictions all meetings will be held virtually and can be facilitated using MS Teams or by telephone, depending on your preference. During office hours we have arranged for an office in the Learning Centre at Forth Valley Royal Hospital to be made available for you should you wish to use this for your meeting. There will be a laptop available in this room which you can use for an MS Teams call. There will also be a landline telephone available in this room is this is your preference.

The External Review Team will work together in a team of two and have allocated one-hour meeting slots from Tuesday to Friday from 10am to 8pm commencing Tuesday 23rd February 2021. If you would like to meet the team to talk with them in confidence, then please call Denise Davidson between the hours of 9am and 4pm on 07771977665 to arrange a suitable date and time.

We would like to provide further reassurance that any information you provide to the External Review Team is given in confidence and will only be used to identify key themes, issues, concerns and will not be attributed to any individual member of staff.

As previously mentioned, we want to support staff to speak up and feel confident to share their personal experience and feedback. We would therefore encourage you to engage in these confidential meetings as openly and honestly as possible. We would anticipate this next stage of the review will take approximately 4 – 6 weeks, depending on the number of staff who wish to meet.

We have asked the External Review Team to prepare a report with their findings and recommendations. We will then be able to share these with you.

As before staff side representatives are available to provide advice and support and a confidential HR email address, fv.hrreview@nhs.scot, is also available to help respond to any questions you may have during the review process. You can also find details of local services and support on our Staff Support and Wellbeing webpage www.nhsforthvalley.com/staffsupport and the National Wellbeing website www.promis.scot.

Kind Regards

Yours sincerely

Cathie Cowan
Chief Executive
NHS Forth Valley

Robert Clark
Employee Director
NHS Forth Valley

FTF Internal Audit Service

Appendix 3

Annual Internal Audit Report 2020/21

Report No. A06/22

Issued To: C Cowan, Chief Executive
J McCusker, Chair

S Urquhart, Director of Finance
NHS Forth Valley Directors / System Leadership Team

G Bowden, Audit Follow Up Co-ordinator
A Gibson, Corporate Risk Manager

Audit & Risk Committee
External Audit

Contents

Draft Report Issued	30 June 2021
Management Responses Received	9 July 2021
Target Audit & Risk Committee Date	15 July 2021
Final Report Issued	9 July 2021
Final Report Re-issued	**28 July 2021**

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit & Risk Committee provides details on the outcomes of the 2020/21 internal audit and my opinion on the Board's internal control framework for the financial year 2020/21.

2. Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place.
- The 2020/21 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

3. In addition, we have not advised management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work.
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected.
- The format and content of the Governance Statement in relation to the relevant guidance.
- The disclosure of all relevant issues.

ACTION

4. The Audit & Risk Committee is asked to **note** this report in evaluating the internal control environment and **report** accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2020/21 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the Director of Finance. The resultant audits range from risk based reviews of individual systems and controls through to the strategic governance and control environment.

6. The authority, role and objectives for Internal Audit are set out in Section 15.3 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

7. Internal Audit is also required to provide the Audit & Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit & Risk Committee should support the Accountable Officer and the Board by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of the financial statements and the annual report. The scope of the Committee's work should encompass all the assurance needs of the Accountable Officer and the Board. Within this the Committee should have particular engagement with the work of Internal Audit, risk management, the External Auditor, and financial management and reporting issues.

INTERNAL CONTROL

8. The Internal Control Evaluation (ICE), issued January 2020, was informed by detailed review of formal evidence sources including Board, Standing Committees, System Leadership Team (SLT), and other papers. The ICE noted many actions to enhance governance and achieve transformation and concluded that NHS Forth Valley's assurance structures were adequate and effective but did make 6 recommendations for improvement by year end. The status of previous recommendations is summarised in table 1 below.

9. During the year we worked with management to review and update outstanding internal audit recommendations to take account of Covid19, including those arising from previous ICE report.

10. Throughout the year, our audits have provided assurance and made recommendations for improvements. Of these, the ICE was the most significant. We have undertaken detailed follow up of the agreed actions arising from that report as well as testing to identify any material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the impact of Covid19 and the governance arrangements in place during the year. Some areas for further development were identified and will be followed up in the 2021/22 ICE and, where applicable, our detailed findings have been included in the NHS Forth Valley 2020/21 Governance Statement.

11. Our assessment of the progress taken to address ICE recommendations is detailed in table 1 on page 11. NHS Forth Valley has demonstrated good progress with only minor slippage on some actions. Several of the more strategic actions are not yet due for completion but are progressing well. We will comment on the effectiveness of the action taken in the 2021/22 ICE.

12. For 2020/21, the Governance Statement format and guidance were included within the NHSScotland Annual Accounts Manual. Whilst Health and Social Care Integration is not specifically referenced, the guidance does make it clear that the Governance Statement applies to the consolidated financial statements as whole, which would therefore include activities under the direction of IJBs.

13. The Board has produced a Governance Statement which states that:

    'During the previous financial year, no significant control weaknesses or issues have arisen, and no significant failures have arisen in the expected standards for good governance, risk management and control. Attention is, however, drawn to the key risks reported to Forth Valley NHS Board during 2020/21 and in particular to the treatment time guarantees underpinned by statute'.

14. Our audit work has provided evidence of compliance with the requirements of the Accountable Officer Memorandum and this, combined with a sound corporate governance framework in place within the Board throughout 2020/21, provides assurance for the Chief Executive as Accountable Officer.

15. Therefore, **it is my opinion** that:

    - The Board has adequate and effective internal controls in place.
    - The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

16. All Executive Directors and Senior Managers were required to provide a statement confirming that adequate and effective internal controls and risk management arrangements were in place throughout the year across all areas of responsibility and, in an enhancement to previous years, to consider five specific themes in their responses. These assurances have been reviewed and no control issues, breaches of Standing Orders / Standing Financial Instructions were identified.

17. The Governance Statement reflects the necessary changes to Board governance and operating arrangements due to Covid19 and the work to remobilise. The Governance Statement includes details of the Boards performance and risk profile and future changes to organisational and supporting strategies. The risk assessment and management section of the Governance Statement is particularly helpful in describing the risk profile of the organisation, including the impact of and response to the Covid19 pandemic. All elements of the Governance Statement have been considered by Internal Audit in previous Annual Internal Audit Reports and the ICE and have been followed up in detail in this report.

Key Themes

18. As noted in the ICE, during the first part of the year the Board maintained and improved its governance arrangements and has performed well in exceptionally difficult circumstances, facing the unprecedented challenges created by Covid19. We welcome significant improvements in governance since the ICE report was issued, including the development of a Healthcare Strategy risk, the ongoing refresh of the Healthcare Strategy and Board approval of the Governance Improvement Plan.

19. This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. There are opportunities now to enhance governance further through the application of assurance mapping principles and our report contains recommendations aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance. The allocation of risk to Standing Committees is very welcome and our report highlights areas where this can be developed further to allow more focused consideration of these risks, and in particular how to provide assurances over risks whose component parts include the loci of many Standing Committees.

20. Whilst there have been positive improvements in many areas, we would highlight known issues in Information Security and Information Governance, where the Board's own systems have identified that improvements are necessary to achieve minimum standards which will require additional resources.

Key developments since the issue of the ICE included:

- The third iteration of the Remobilisation Plan covering the period April 2021 – March 2022 was presented to the Board in May, as soon as possible after the Scottish Elections. The initial Mobilisation Plan and subsequent System-Wide Remobilisation Plans were developed in partnership and adopted a whole system approach to support the initial response to Covid19 and the ensuing recovery. The plan set out a summary of actions being taken to build on the work currently underway to resume services, informed by Service/Partnership Remobilisation Plans appended to the Remobilisation Plan. It articulates outcomes and associated risk and mitigations and summarises the organisation's priorities for 2021/22 and beyond.
- Overall, there has been good progress on recommendations from the ICE. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.

- There has been a continuing focus on Good Governance including development of a Governance Improvement Plan and a Board development session on assurance, with a Board Assurance Framework and risk appetite development event planned.
- A Healthcare Strategy risk has been agreed.
- Development of a revised Healthcare Strategy and supporting strategies, including a Quality Strategy is ongoing.
- Improvements in staff governance arrangements have been evidenced through enhanced assurance arrangements for the Staff Governance Committee, and development of the interim Workforce Plan.

21. During 2020/21 we delivered 18 audit products, including 1 from 2019/20. These audits reviewed the systems of financial and management control operating within the Board and provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit & Risk Committee throughout the year.

22. A number of our reports, including the ICE and Sustainability work, have been wide ranging and complex audits which have relevance to a wide range of areas within Forth Valley. These should provide the basis for discussion around how NHS Forth Valley can best build on the very good work already being done to improve and sustain service provision.

23. Board management continue to respond positively to our findings and action plans have been agreed to improve the systems of control. Board staff have maintained a system for the follow-up of audit recommendations and reporting of results to the Audit & Risk Committee. In January 2021, Internal Audit assisted the Board by carrying out a Red, Amber, Green (RAG) status assessment of outstanding recommendations and removing from the Audit Follow Up system actions which had been completed or were consolidated and superseded by recommendations in the 2020/21 ICE report. As reported to the 12 March 2021 Audit & Risk Committee, 63% of audit actions due were complete, 37% of audit actions were not yet due for responses and no audit actions were overdue.

ADDED VALUE

24. The Internal Audit Service has been responsive to the needs of the Board and has assisted the Board and added value by:

    - Examining a wide range of controls in place across the organisation.
    - In conjunction with Local Authority Internal Auditors, undertaking IJB internal audits and providing a Chief Internal Auditor Service.
    - For Clackmannanshire & Stirling Integrated Joint Board (IJB), updating and enhancing the IJB Governance Statement self assessment checklist and providing support with regard to Audit & Risk Committee arrangements.
    - Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive Internal Control Evaluation which permitted remedial action to be taken in-year. This review made recommendations focused on enhancements to ensure NHS Forth Valley has in place appropriate and proportionate governance, which supports and monitors the delivery of objectives and is commensurate with the challenging environment within which it is operating.

- Continuing to liaise with management and providing ad-hoc advice on a wide-range of governance and control issues.
- Provision of Committee Assurance principles and risk guidance, suggested for adoption by Standing Committees.
- The Chief Internal Auditor provided a 'How do we Know' assurance presentation to the January 2021 Board development session.
- Providing best practice examples of assurance and risk reporting for Standing and other committees, with a particular focus on the Staff Governance Committee.
- Progressing the ongoing assurance mapping exercise to identify, assess, structure and develop assurances relating to key risks as well as those required from Directors. Internal Audit facilitated a joint approach across its four mainland clients as well as linking with national developments. In NHS Forth Valley the risk chosen as a pilot was Strategic Risk 002 - Unscheduled Care. Work will continue as part of the 2021/22 Annual Internal Audit Plan.
- Providing advice to inform the development of the Strategic Risk Register.
- Internal audit A17A/21 considered governance arrangements and the embedding of risk management processes within the Acute Services Directorate. We provided advice and examples of best practice to inform the operation of the Acute Services Directorate Governance and Risk Management Group.
- Internal audit A20/21 provided advice on the governance and operation of the Medical Devices Group.
- Continuing to contribute to the development of IJB risk management and clinical and care governance arrangements.
- Providing the Fraud Liaison Officer function for NHS Forth Valley, including provision of advice, support on referrals from Counter Fraud Services and on internal investigations, quarterly reporting to the Audit & Risk Committee, provision of the Fraud Policy and inclusion of fraud in relevant HR Policies.
- Assisting and working jointly with Board staff and Counter Fraud Services to further develop the Board's counter fraud arrangements and liaising with Counter Fraud Services and the Board to disseminate Intelligence Alerts to key officers.

25. Internal Audit have also used any time made available by necessary senior management prioritisation of Covid19 duties to reflect on our working practices, both to build on action taken in response to previous External Quality Reviews and to adapt to a post Covid19 environment. This has included:

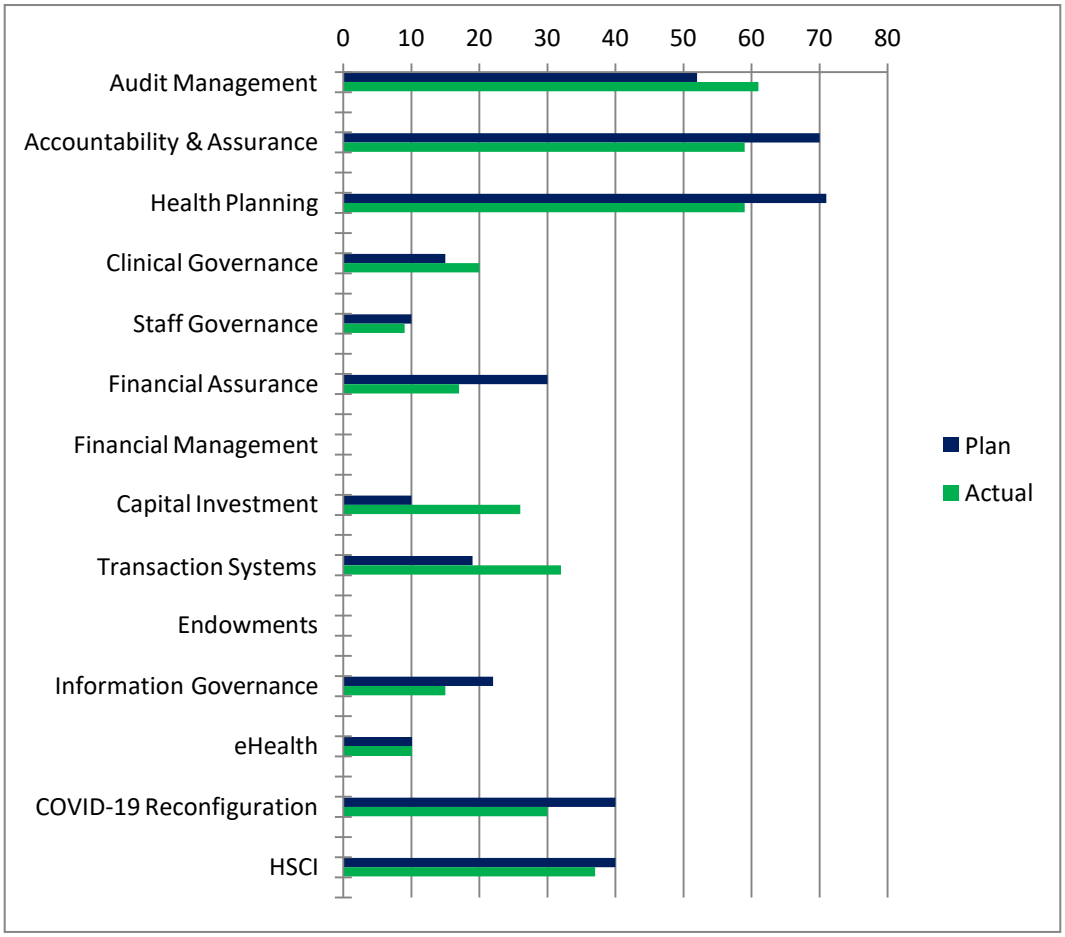
- Attendance at Board and Standing Committee meetings to inform our opinion on the organisation's governance arrangements and the control environment.
- Revision of the internal audit reporting protocol and flowchart.
- Development of a revised client quality questionnaire.
- Update and enhancement of the FTF Intelligence Library.
- Review of internal documentation and processes including analytical review and performance review, again to ensure we add value wherever possible.
- Review and update of our risk assessment categorisation.
- Ongoing development of the FTF website.

- Review and update of the FTF self assessment against the Public Sector Internal Audit Standards.

26. The 2020/21 Annual Internal Audit Plan included provision for delivering audit services, together with council colleagues, and providing the Chief Internal Auditor function to Clackmannanshire & Stirling Integrated Joint Boards as well as contributing to the audit plan of Falkirk IJB. Internal Audit Plans were agreed for each IJB. Internal Audit has continued to highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk as well as the requirement for revised Strategic Commissioning Plans and working with partners.

INTERNAL AUDIT COVER

27. **Figure 1: Internal Audit Cover 2020/21**



28. Figure 1 summarises the 2020/21 outturn position against the planned internal audit cover. The initial Annual Internal Audit Plan was approved by the Audit Committee at its meeting on 16 June 2020. It was agreed at that time that the plan would be revised as changes to the risk profile and other factors became better known, and the Audit Committee approved amendments in March 2021. We have delivered 375 days against the planned 389 days.

29. Following a recommendation from the External Quality Assessment (EQA) carried out on Internal Audit in 2018/19, we continue with the agreed process of risk assessing outstanding 2020/21 audits for inclusion in the 2021/22 plan.

30. A summary of 2020/21 performance is shown in Section 3.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

31. Due to prioritisation of Covid19 duties, the FTF Partnership Board met only once in 2020/21. The Partnership Board is chaired by the NHS Tayside Director of Finance and the FTF client Directors of Finance are members. The FTF Management Team attends all meetings. During the year the Partnership Board reviewed the Internal Audit Shared Service Agreement 2018-2023 and the Internal Audit Service Specification, as well as approving the 2020/21 budget. The Partnership Board also approved revised risk assessment definitions for internal audit reporting.

32. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the specification and the Public Sector Internal Audit Standards (PSIAS).

33. Internal Audit is compliant with PSIAS, and has organisational independence as defined by PSIAS, except that, in common with many NHSScotland bodies, the Chief Internal Auditor reports through the Director of Finance rather than the Accountable Officer. There are no impairments to independence or objectivity.

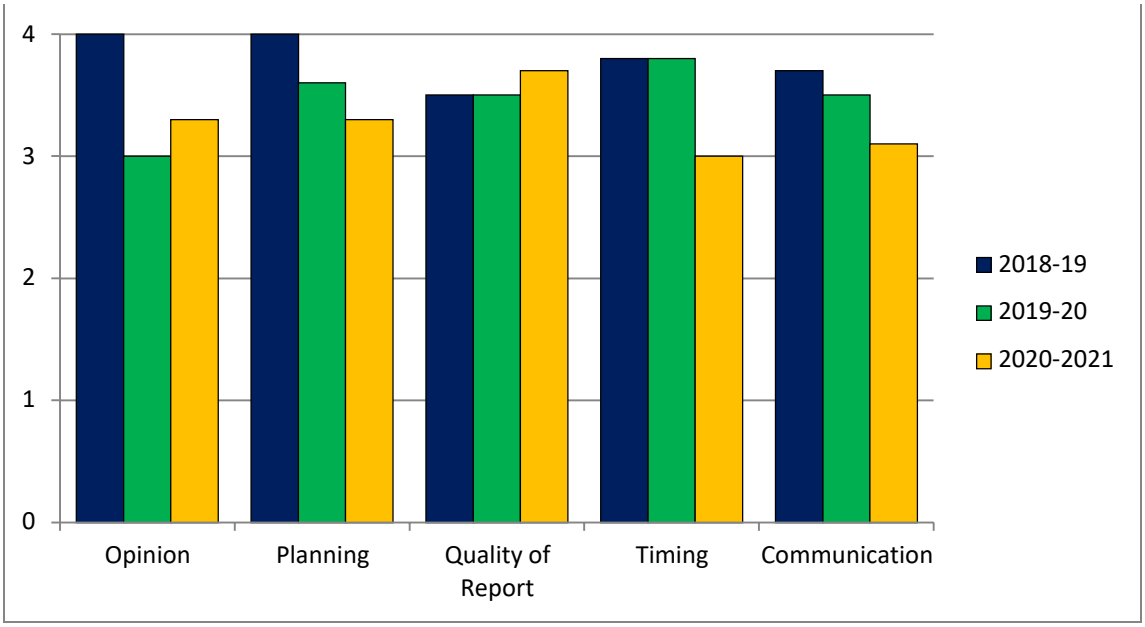
34. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

35. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent External Quality Assessment (EQA) of the NHS Forth Valley Internal Audit Service in 2018/19, concluded that *'it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* FTF has updated its self assessment and this will be reported to the NHS Forth Valley Audit and Risk Committee in early 2021/22.

36. A key measure of the quality and effectiveness of the audits is the Board responses to our client satisfaction surveys, which are sent to line managers following the issue of each audit report. Figure 2 shows that, overall, our audits have been perceived as good or very good by the report recipients.

37. Figure 2: Summary of Client Satisfaction Surveys

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



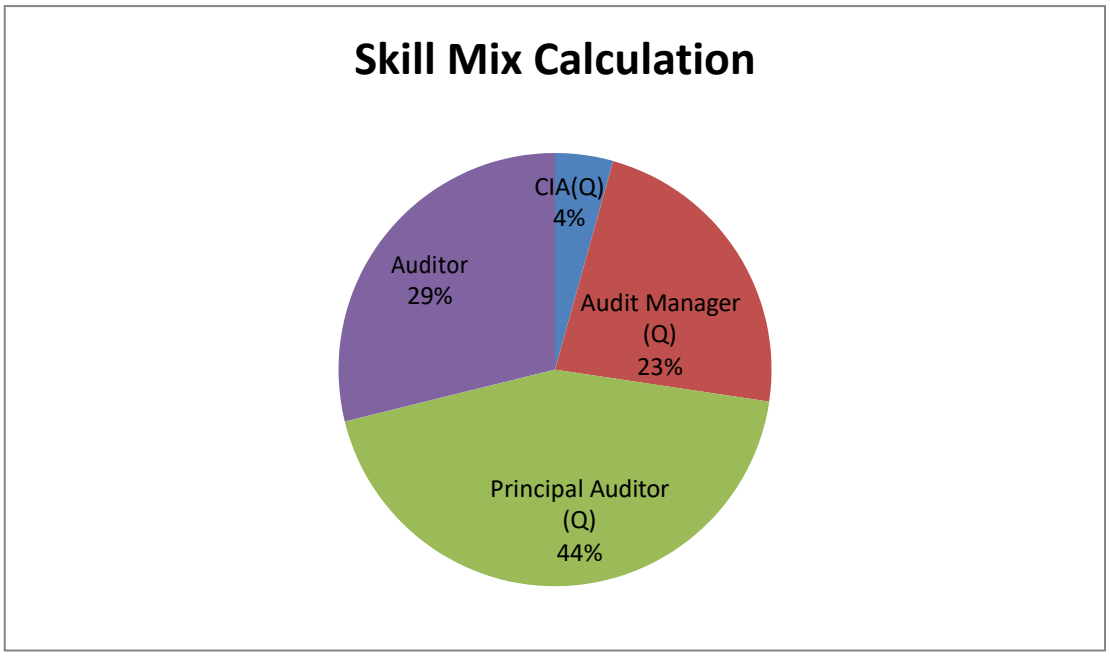
38. Other detailed performance statistics are shown in Section 3.

STAFFING AND SKILL MIX

39. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2020/21 the audit was delivered with a skill mix of 71%, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

40. Figure 3: Audit Staff Skill Mix 2020/21

Audit Staff Inputs in 2020/21 [days] Q= qualified input.

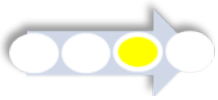


ACKNOWLEDGEMENT

41. On behalf of the Internal Audit Service, I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit.

42. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance, the Audit Follow Up Co-ordinator and the Audit & Risk Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

TABLE 1 - ICE 2020/21 (A08/21) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Agreed Management Actions with Dates**	**Assurance Against Progress**
1. Sustainability & Transformation • Timetable to support the development of Healthcare Strategy - **March 2021** • Stock take of extant Healthcare strategy with stakeholder engagement - **May / July 2021** • Healthcare Strategy consultation - **August 2021** • Healthcare Strategy to be presented for NHS Board for approval - **September 2021** *Action Owner: Chief Executive*	• Timetable reported to Board on 25 May 2021 • Review of existing strategy and stakeholder engagement planned for July / August 2021 • Consultation planned for July / August 2021 • Healthcare Strategy scheduled for Board approval November 2021	 **On track**
2. Strategy Risk • Strategy/Transformation Corporate Risk to be developed and agreed by SLT and presented to the Board for approval - May 2021 • Next Strategic Risk Register review to consider COVID-19 factors how these relate to the Board's strategic/corporate risks - May 2021. *Action Owners: Chief Executive, supported by the Head of Policy & Performance and the Corporate Risk Manager*	• 'SRR014: Healthcare Strategy' was added during the Q1 2021/22 risk review presented to the SLT on 17 May 2021. This risk is still pending Board approval • Although consideration has been made towards the impact of Covid19 to the new Healthcare Strategy risk, this consideration is not evident across all strategic risks in the Q1 2021/22 risk review report. SRR012 Covid19 Remobilisation Plans remains a separate risk	 **Minor slippage on agreed timelines**
3. Governance and Year End Assurances • Implementation of Board and Assurance Committee template - April 2021	• Per the Governance Improvement Plan presented to the Board on 30 March 2021, the Board template will be adopted by the Board, Assurance Committees and Board operational and advisory fora by June 2021	 **On track**

• Governance update to NHS Board will seek endorsement of 'principles' - March 2021 • If adopted each Assurance Committee will be asked to conduct a review of their short and longer term governance arrangements - August 2021 *Action Owner: Chief Executive*	• NHS Forth Valley's Governance Improvement Plan focuses on the agreed governance model, notably fiduciary, strategic, and generative actions to underpin the Board's commitment to being an effective high performing NHS Board. The Governance Improvement Plan was presented and endorsed by the Board on 30 March 2021 • Assurance Committee terms of reference, membership including Non-Executive Chair and Corporate Director leads and support to be reviewed by June 2021 • Development of an Assurance Strategy which will set out a Board-wide Assurance System linking risk and performance is due by October 2021	
4. Risk Management • The Corporate Risk Manager to prepare a progress report setting out a response to each of the Internal Audit points raised against risk management with a timescale for completion and this report will be presented to SLT for approval and subsequently to the Audit Committee on a regular basis – **June 2021** *Action Owners: Chief Executive, supported by the Head of Policy and Performance and the Corporate Risk Manager*	• This progress report will now be included in the Risk Management annual report to the July 2021 Audit & Risk Committee. The annual report will include an update on the key areas, an update to the overall workplan and timeline	 On track
5. Clinical Governance • Revision to the Clinical Governance Strategy which will sit within the Quality Strategy, which is whole system, encompassing HSCPs and Clinical & Care Governance – **December 2021** • Continue to refine the clinical risk management aspects within	• Quality Strategy is being developed as per presentation to 1 March 2021 System Leadership Team and due December 2021 • Quarterly reporting of strategic risks aligned to Clinical Governance Committee started in June 2021. More detailed scrutiny of strategic	 **On track**

the Strategic Risk process – **December 2021** *Action Owners: Medical Director, supported by the Head of Clinical Governance and the Head of Efficiency, Improvement and Innovation.*	risks and mitigating strategies to be developed as reporting becomes embedded	
6. Staff Governance Committee and Workforce • Refresh of Workforce Strategy and Plan - December 2021 • Develop an Staff Governance Annual Workforce Plan - June 2021 • Undertake a Covid19 workforce related risk review - May 2021 • Introduce a Staff Governance 'Assurance Report' - June 2021 • HR Dashboard to be operational - May 2021 *Action Owner: HR Director*	**6. Staff Governance Committee and Workforce** • Draft Interim workforce plan, aligned to remobilisation plan, submitted to Scottish Government • Work on 'Our People Strategy 2018 – 2021' underway and expected to be completed by December 2021 • Annual Staff Governance Committee (SGC) Assurance Plan and Work Plan 2021/22 presented to the SGC in May 2021 • Covid19 workforce related risk review to be presented to the Staff Governance Committee in September 2021 • Staff Governance Committee Annual Report was presented to the Board on 25 May 2021 in private session • Development of suite of workforce dashboards within the Pentana Person-Centred Portal with presentation to SLT on 31 May 2021 and presented for approval to the SGC due 17 September 2021	 **Minor slippage on agreed timelines**

Corporate Governance

Strategic risks:

- **SRR012 COVID-19 Remobilisation - If NHS FV does not deliver an effective remobilisation plan in response to COVID-19 there is a risk we fail to manage demand on services and miss opportunities for long term change / improvement.**
- **SRR013 Brexit. f there is a continued lack of clarity around the terms and conditions of the UK's exit from the European Union, there is a risk there may be negative and / or unforeseen impacts on healthcare, impeding NHS Forth Valley's ability to prepare and contingency plan for a smooth transition.**
- ***New risk* - SRR014 Healthcare Strategy. If the planned review of the NHS Forth Valley Healthcare Strategy (2016-2021) does not incorporate learning from the COVID-19 pandemic and does not align with government policy and / or Integration Authorities Strategic Commissioning Plans there is a risk the Board's vision, corporate objectives and key priorities will be incorrect, resulting in services that are not sustainable in the long term and an inability to delivery transformation.**

Remobilisation

A Forth Valley System-Wide Remobilisation Planning Session on 22 February 2021 focused on a step change towards recovery and renewal, and on development of the Remobilisation Plan. Following submission of the draft NHS Forth Valley System-Wide Remobilisation Plan April 2021 to March 2022 (RMPv3) to Scottish Government (SG) on 2 March 2021 and SG feedback on 4 March 2021, the RMPv3 was approved by the Forth Valley NHS Board on 25 May 2021, at the earliest opportunity following the Scottish elections.

The same Board meeting committed to refreshing the Healthcare Strategy and approved an associated timetable. The NHS Board vision, values and corporate objectives will also be refreshed following a period of engagement from July to August 2021. Updates on development of the Healthcare Strategy 2021/2026 will be reported to the NHS Board, the Board Committees and Advisory Forums, with the final Strategy presented to the NHS Board for approval in November 2021.

The ICE report 2020/21 report recommended establishing greater formality of governance and reporting of remobilisation progress to the SLT. The 16 June 2021 SLT approved Terms of Reference for a Corporate Management Team (CMT) which will provide system wide governance and oversight of the Remobilisation Plan and contribute to the strategic long term direction of the NHS Board. The CMT had its first meeting on 5 July 2021.

Healthcare Strategy

As recommended in the 2020/21 ICE report, a Healthcare Strategy risk was agreed by SLT in May and will be presented to Audit & Risk Committee Board in July 2021. Given its strategic importance, this risk should be monitored by the Performance & Resources Committee (P&RC).

The new risk identified future actions including the stock take of the 2016-21 strategy, the need for a forward plan and timeline and the requirement to work with the IJBs and other stakeholders to inform and influence strategy.

The Governance Improvement Plan approved by Board on 25 May 2021 includes actions for the Board to develop and agree strategic priorities and direction, monitor implementation of strategic direction and develop and monitor supporting strategies.

Risk Management

The quarter 4 Strategic Risk Register (SRR) update presented to the 30 March 2021 Board captured 10 strategic risks, 7 of which were described as 'very high' and 3 of which were 'high'. The Covid19 risk score remains Red, with a risk score of 20 and a target risk score of 6. The March 2021 Board approved a full review of the SRR, reflecting a number of comments made in the ICE.

The risk profile remained largely static throughout the year as noted within the ICE. However, towards the end of the year three risks were closed and the May SLT approved the new Healthcare Strategy risk and reduction of the Brexit risk score, for approval at the July Board.

Implementation of our recommendation to ensure that the impact of Covid19 is fully reflected in all strategic risks is not yet fully apparent, although we do note that some excellent work in the Scheduled Care and Finance risk for example. There has been considerable improvement in risk management arrangements since our ICE report. In particular:

- Strategic risks have been aligned to Standing Committees and assurance reporting commenced in February 2021.
- Standing Committee risk deep dives have been introduced.
- The SLT now regularly reviews the full SRR.
- A Board Development Session covering the Board Assurance Framework and risk appetite was scheduled for 8 June 2021, albeit this was postponed due to operational exigencies.
- The Corporate Risk Manager has commenced a review of the existing strategic and operational risk registers, including assessing the functionality of the Safeguard and Pentana systems as a risk management database.
- Recruitment of 3 Risk Management Officers, aligned to Directorates/Partnerships has commenced.
- The NHS Forth Valley Corporate Risk Manager is working with colleagues from the IJBs and Local Authorities to develop a Forth Valley wide Risk Management Strategy which will set out responsibilities and provision of assurances for risks related to health services managed by the Chief Officers/Directors of Health & Social Care and reporting to the Chief Executive. Internal Audit has provided a good practice example to assist with this development.

The following recommendations from the 2020/21 ICE are ongoing and an update will be provided in the Risk Management annual report to the July 2021 Audit & Risk Committee:

- Board input to horizon scanning to identify emerging risks.
- Incorporation of assurance mapping principles and, in particular, ensuring that Standing Committees provide robust scrutiny of risks, controls and assurances under their purview.
- Completion of review and refresh of operational risks, to be further progressed when all Risk Management Officers are in post.

Good Governance

The Chief Executive provided a Governance Review report to the 30 March 2021 Board meeting and a Governance Improvement Plan has been developed with SMART actions,

outcomes and timescales. The Improvement Plan includes review of the Corporate Governance framework and, importantly, includes development of an Assurance Strategy which will set out a Board-wide Assurance System linking risk and performance, as well as further development of assurance mapping.

We are pleased to note the following developments since publication of the ICE report in January 2021:

- Development of the Head of Policy & Performance role
- Appointment of a Board Secretary to support good governance
- Introduction of the Staff Governance Committee assurance plan in May 2021
- Expansion of the previous Audit Committee role to that of an Audit & Risk Committee with strategic risk updates presented to each meeting
- All NHS Forth Valley Standing Committees were able to deliver year end assurances through their annual reports despite the challenging circumstances

Performance

A Recovery Scorecard reporting on the System-Wide Remobilisation Plan is presented to each Board and Performance & Resources Committee (P&RC) meeting. While it was agreed by the May 2021 Board that there should be no or limited changes to the scorecard for a period of approximately 6 months to ensure work is embedded, the Recovery Scorecard remains fluid and a review was planned for June 2021.

The performance management process needs to be appropriately supported with the right level of infrastructure and resources, in particular digital. We were therefore pleased to note that, in supporting the organisational development of Pentana and the wider performance agenda, the February 2021 P&RC approved funding for 2 Senior Information Analysts and recruitment is underway. In addition, the new Corporate Performance Manager will commence at end of July 2021. These appointments will provide the technical information management support required to enable, for example, automation of scorecards and development and preparation of data to enable linkage to Pentana. The Corporate Performance Manager will manage the project and an update on progress will be presented to the August P&RC.

The Scheduled Care risk, aligned to the Clinical Governance Committee, reflects work carried out to articulate the pressure on scheduled care as a result of long-standing imbalance in demand and capacity, additional pressures due to Covid19 and possible pent up demand due to reduction in referral rates. A presentation to the April P&RC on 'Sustainable Delivery of Waiting Times Standards and Quality Care' explored this risk in detail and described how sustainability would be created through transformational change, maximising elective care and use of the national treatment centre. A Sustainability update presentation is scheduled for the 29 June 2021 P&RC.

The fluctuating position for 4 hour target compliance remains a focus for the Board; overall compliance with the 4 hour target in April 2021 was 84.1%, against a target of 95%. The 26 April 2021 SLT received a presentation on the challenges associated with Unscheduled Care Delivery and achievement of the 4 hour Access Performance and it was agreed that the delivery plan would be updated by end of June 2021. Internal Audit provided comments on this risk as part of A11/21 – Assurance Framework to inform its update.

Other areas

At their 25 May 2021 meeting, the Board noted the steps being taken to enhance Covid19 surveillance and response, and the ongoing roll out of the Covid19 vaccination programme. The Board also approved value added recurring investments in several initiatives including business cases for the Falkirk Community Hospital site and primary care premises; an updated response to the GMS Contract; proposals to invest in care at home and stroke services; the proposal previously presented to P&RC to remobilise, recover and redesign elective care services and a proposal to use eRostering to improve job planning.

A12/21 – Policies & Procedures provided moderate assurance and concluded that the Policy, Procedure and Guideline Development Framework was well designed and that for the sample of policies and procedures tested, procedures for developing policies were being followed, with appropriate approval. Management have agreed action by the end of September 2021 to clarify responsibilities for oversight, approval and monitoring of the Policy Management Framework, covering both clinical and non-clinical policies and ensuring changes in working practices as a result of Covid19 are reflected in policies.

Emergency Department (ED) review

In response to concerns raised by staff side, the Chief Executive commissioned an independent external review to consider both the culture and governance notably: corporate, clinical and staff governance arrangements and how these affected nursing staff working within ED. The final report received on 9 June has been shared with staff and staff side representatives. In December 2020 a retrospective review of the safety and assurance measures within the Emergency Department was completed and as reported to the February 2021 Clinical Governance Committee (CGC), provided assurance regarding safety system measures. In addition, a Significant Adverse Event Review has been commissioned to provide further assurance.

The Chief Executive's ED Review commissioning paper and retrospective review of safety and assurance measures report were presented to the February CGC in private session but due to an oversight, did not feature in the CGC annual report 2020/21. The Medical Director has advised that this had been picked up and an addendum to the CGC annual report will be issued. A special Staff Governance Committee (SGC) meeting on 5 March 2021 also received an update on the commissioning of this review, as did the 23 February 2021 Performance & Resources Committee (P&RC), albeit the SGC and P&RC annual reports which included the matter were taken in private session. The Board has also been updated on this matter in closed session to ensure it complies with a duty of care to all its employees. The Board intends to present this report to an open Board having now issued the report to all staff and staff side representatives.

Action Point Reference 1 – Governance improvements & annual assurances	
Finding:	
While the Board is currently held in public, some items, such as the Staff Governance Committee and Performance & Resources Committee annual reports were considered in closed session, as permitted under the Board's Standing Orders.	
Audit Recommendation:	
To ensure transparency and to demonstrate good governance we recommend that Standing Orders be amended so that Board and Standing Committees items considered under Reserved Business or in a closed session are shown on the agenda and minutes, and the applicable Freedom of Information provision clearly stated. The 15 July 2021 Audit & Risk Committee should be provided with a paper setting out the key issues and risks identified from the Standing Committee annual reports, and confirming consistency with Directors' assurances and the Governance Statement.	
Assessment of Risk:	
Merits attention	 There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
Standing Orders will be amended to ensure all closed sessions are shown on the agenda and minutes with applicable FOI exemptions referenced.	
Action by:	**Date of expected completion:**
Board Secretary	**September 2021**

Action Point Reference 2 - Good Governance & Risk Management

Finding:

This report demonstrates that governance and risk management arrangements have improved considerably, despite challenging circumstances. Some enhancements will be implemented in 2021/22.

Audit Recommendation:

Further suggested enhancements include:

I. **Standing Committee annual reports:**

- Annual reports should be structured along the main areas of business as defined in the Committee's Terms of Reference and / or Assurance Plan so that assurances / updates against each area are easily identifiable allowing definite conclusions to be made.
- Performance information should be enhanced, highlighting areas of poor performance and assessing whether actions being taken are effective (also see below re overt linkages to risk).
- References should be made to the annual report(s) of sub-committees, including an overt opinion on the performance / assurance provided from the report(s).
- An evaluation of the movement in strategic risks aligned to the Standing Committee and areas where actions were not effective should be included.
- Annual reports should reflect consideration of key risks and concerns and how these will be reflected in the workplan for the year ahead.

II. Forward planners should be introduced for the Audit & Risk Committee and P&RC. In time, these forward planners should incorporate an assurance plan, linking to key risks and responsibilities of the committees as set out in their Terms of Reference to help ensure that all necessary assurances are received during the year.

III. Performance and assurance reports should clearly state which risks they are providing assurance on. In the longer term, officers could work towards quantifying the level of assurance provided by assurance and performance reports.

IV. Internal Audit reports, and in particular the ICE, should be routinely considered by the relevant Standing Committee.

Risk Management:

- Risk reporting to Standing Committees and routine risk deep dives should allow more detailed scrutiny of strategic risk reports. Appendix A of the Committee Assurance Principles documents (shared by internal audit) provides suggested questions for risk owners and questions for committees which may be useful in shaping discussion.
- As risk reporting matures, consideration will need to be given to assurances around risks with elements that fall under the remit of more than one committee. For example, the Scheduled Care risk is aligned to the Clinical Governance Committee but contains workforce elements, and the Primary Care risk is aligned to the Staff Governance Committee, but contains Infrastructure and digital elements.

Assessment of Risk:	
Merits attention	 There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:
• **Standing Committee Annual Reports will adopt the enhancements as recommended by Internal Audit.** • **Forward Planners will be introduced for the Audit & Risk Committee and Policy & Resources Committee.** • **Performance and assurance reports will reference the risk that assurance is being provided on.** • **Internal Audit reports including the ICE report will routinely be considered by relevant Standing Committees.**

Action by:	Date of expected completion:
Chief Executive and Head of Policy and Performance	**September 2021**

Action Point Reference 3 – Performance Management

Finding:

Scottish Government guidance was that the RMPv3 would be the Annual Operational Plan (AOP) for 2021/22. However, the national format for these remobilisation plans will not easily translate into SMART performance measures which will allow monitoring of achievement of key objectives.

The Recovery Scorecard is manually updated on a weekly basis and is not automatically generated by the Pentana system. A quality, timely and effective performance management process will only be sustainable in the longer term if consideration is given to appropriate investment in resources and infrastructure to support this critical function.

Audit Recommendation:

In the short term, consideration should be given as to how the RMPv3 will generate holistic and/or local SMART targets which can be monitored by the P&RC and how assurance can be provided that Forth Valley is on track to achieve the outcomes within the RMPv3.

In the longer term, performance management systems to monitor achievement of outcomes set out in the revised Healthcare Strategy should be reviewed and consideration given to how this can be measured.

The Terms of Reference of the Performance & Resources Committee include the requirement to 'To oversee the ongoing development of a performance management culture'. As previously recommended in internal audit report A14/19 - Operational Performance Reporting, consideration should be given to the reinstatement of a system of Directorate Performance Reviews, which are already in place for finance considerations.

The Recovery Scorecard is continuously evolving to ensure relevant performance measures are adequately captured. Our high level review of the Recovery Scorecard identified some potential enhancements which have been shared with the Recovery Scorecard Short Life Working Group.

Assessment of Risk:

Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**

Management Response/Action:

Directorate and Partnership Performance Reviews will be reinstated, a Review is planned for Mental Health Services and this will inform our approach going forward

KPIs aligned to the RMP 3 will be considered as part of the review of the Recovery Scorecard.

Action by:	Date of expected completion:
Chief Executive & Head of Policy & Performance	**September 2021**

Clinical Governance

Strategic risks:

- **SRR002 Unscheduled Care - If NHS FV fails to deliver on the 6 Essential Actions Improvement Programme there is a risk we will be unable to deliver and maintain appropriate levels of unscheduled care, resulting in service sustainability issues and poor patient experience (including the 4 hour access standard).**
- **SRR004 Scheduled Care - If there are delays in delivery of scheduled care there is a risk that NHS FV will be unable to meet its obligations to deliver the National Waiting Times Plan targets for 2020-21, resulting in poor patient experience and outcomes.**

The March 2021 SLT received a briefing paper and presentation on development of the new Quality Strategy (2021 – 2026), which will encompass the Clinical Governance Strategy and is scheduled for issue by December 2021.

Our high level review of the draft Quality Strategy welcomed the intention to include HSCP activity and highlighted the opportunity to incorporate committee assurance principles, most notably a focus on risk both in terms of the items to be considered and the way that assurances are provided. It has been recognised that further work is required to ensure that that there are no gaps in assurances across the system and no unnecessary duplication. This intention is also reflected in February 2021 Clinical Governance Committee (CGC) minutes in relation to the annual report as well as in papers to the March 2021 Clinical Governance Working Group (CGWG) and the June 2021 CGC.

Management have confirmed that integrated Clinical & Care Governance structures will be described within the new Quality Strategy, to ensure there is a mechanism to allow a holistic review of risk and issues across Forth Valley and to identify interface risks. The Medical Director has confirmed that work continues to explore assurance mechanisms with the IJBs, pending clarification of implementation of the Feeley report.

Clackmannanshire & Stirling IJB internal audit - CS07-21 reviewed the adequacy of revised Clinical and Care Governance arrangements, with a focus on the nature and source of assurance to the IJB on the quality of all services it commissions and made a number of recommendations to enhance the quality of assurances to the IJB.

We would expect the strategy to fully reflect clinical governance arrangements with due prominence given to the provision of effective, as well as safe, services throughout. We would also expect realistic medicine to be included. There would be benefit in incorporating any recommendations arising from the recent Emergency Department review, when available.

Quarterly reporting to CGC and CGWG on the strategic risks for Scheduled Care and Unscheduled Care started in June 2021. Both risks are scored at 20 – High, with target scores of 9. The Corporate Risk Manager attends CGWG and CGC meetings and following a verbal update to the 9 February 2021 CGC, a full risk report was presented to the June 2021 meeting. The CGC noted that as organisational and directorate level risk profiles develop, the CGC will receive expanded reporting on a larger range of risks.

During the first wave of Covid19, the SGHSCD instructed Health Boards to cease some treatments and diagnoses. This was accompanied by changes in patient self-referral, and we know that these two factors will inevitably result in patient harm. However, the Scheduled Care risk (SRR004) still focuses on Waiting Times targets, which are no longer a key issue and does not fully capture the impact of cessation of treatment/diagnosis on patients. There

is a risk to the Board that failure to prioritise effectively and plan for the impending changes to case-mix and population need could cause additional, preventable, death and harm. We have been informed that the Medical Director and Associate Medical Directors have undertaken work to quantify potential harm, which will form the basis of a presentation to the CGC and will inform an update of the Unscheduled Care risk.

The Unscheduled Care risk has a number of workforce elements which are not fully articulated in the workforce planning risk. While the alignment of the risk to the CGC is appropriate, assurances on the management of this risk should address workforce issues.

The Clinical Governance Committee (CGC) met three times during the year. The restricted February 2021 CGC agenda still included the four key reports - Safety & Assurance, Standards & Reviews, Healthcare Associated Infections and Person Centeredness as well as review of Terms of Reference and draft CGC annual report, as well as considering the draft Clinical Governance Working Group (CGWG) annual report. The CGC annual report concluded that *'the integrated approach, the frequency of meetings, the breadth of the business undertaken, and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in Standing Orders. As a result of the work undertaken during the year, I can confirm that adequate scrutiny of Clinical Governance arrangements were in place throughout NHS Forth Valley during the year'.*

Enhancements to Clinical Governance arrangements have continued in year including:

- Update of CGC Terms of Reference to more clearly link to Public Health.
- Further refinement of the CGC and CGWG Forward Planners which reflect the 'Vincent Framework' for Measuring and Monitoring Safety in the NHS.
- Development of the Safety and Assurance report which includes the Scottish Patient Safety Programme work streams. The report currently includes directorate assurances from Acute, Mental Health, Pharmacy and Woman & Children with Health & Social Care Partnership assurance reports planned next.
- Refinement of the Standards & Reviews report on external clinical standards and guidance and inspections, reviews and accreditation visits including Covid19 related standards and guidance, to ensure appropriate dissemination and actions are in place.
- A new streamlined process for undertaking Significant Adverse Event Reviews (SAERs) is being tested and will be documented in a refreshed, re-launched Adverse Events Management Policy. Implementation and effectiveness of the new policy will need to be closely monitored.

A development session on Incident Reporting, Significant Adverse Event Reviews and Duty of Candour took place on 21 April 2021 with a focus on ensuring staff awareness of roles and responsibilities in reporting, signing off incidents and the organisational duty of candour process. The Duty of Candour annual report was scheduled to be presented to the June 2021 CGC. However, due to staffing changes within the Clinical Governance department the report will now be presented to the August meeting.

HIS carried out an Acute Hospital Covid19 focused inspection at Forth Valley Royal Hospital on 2 February 2021 which identified four areas of good practice as well as two recommendations which were implemented by 31 March 2021.

The need to suppress the transmission of Covid19 and prevent/control nosocomial related infections and care home outbreaks features in the Remobilisation Plan April 2021 – March 2022. Data and accompanying narrative for both patient and staff infection was provided in the Healthcare Acquired Infection Annual report, presented to the June 2021 CGC.

Action Point Reference 4 - Clinical Governance arrangements	
Finding:	
The CGC and CGWG both have extensive remits and lengthy agendas. Our review of minutes and papers identified duplication of reporting. For example, the Safety and Assurance report, Standards & Reviews report, Complaints and Feedback Performance Report and Significant Adverse Events Reports are presented to both the CGC and CGWG.	
Audit Recommendation:	
We recommend a review of reporting to the CGC and CGWG to ensure there are no gaps in reporting, to eliminate duplication and to ensure that there is a focus on key risks and priorities. The Committee Assurance principles may well be helpful in this review.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The above comments are accepted and will form the basis of actions, presented to the Clinical Governance Working Group and Clinical Governance Committee. **There may be some misalignment though of internal audit expectations of a Quality Strategy and the organisation's. A direction for the Clinical Governance Strategy will emerge from the Quality Strategy and will be clearly featured within but may require further development. Similarly, the discussion of risk is unlikely to be detailed within this Quality Strategy.**	
Action by:	**Date of expected completion:**
Medical Director and Heads of Quality and Clinical Governance	**November 2021**

Staff Governance

Strategic risks:

- **SRR001: Primary Care - If there is insufficient funding and recruitment there is a risk that NHS FV will not implement the Primary Care Improvement Plan, resulting in an inability to fulfil the Scottish Government Memorandum of Understanding as part of the GP contract, jeopardising GP practice sustainability.**
- **SRR009: Workforce Plans - If NHS FV does not implement effective strategic workforce planning (including aligning funding requirements) there is a risk that we will not have a workforce in future that is the right size, with the right skills and competencies, organised appropriately within a budge we can afford, resulting in sub-optimal service delivery to the public.**

Our ICE report provided a summary of staff governance activity to the end of December 2020 and a number of enhancements to improve assurances to the Staff Governance Committee (SGC) were agreed with the Director of HR for completion by end of 2021. Since the ICE report was issued in January 2021, an assurance workplan, structured around the Staff Governance Standard was introduced in May 2021. We will continue to provide advice and comment as the system matures, particularly in relation to assurances around risk and compliance with the Staff Governance Standard. Strategic risk assurance reporting started in March 2021 and, as with other risks, will develop further throughout the year.

SGC quarterly meetings paused in early 2020 under Covid19 governance and were re-started remotely in August 2020.

Internal Audit has previously highlighted the need for robust workforce planning, noting that monitoring of workforce planning has not yet been included within the controls relating to the Workforce Plan strategic risk. A draft Interim Workforce Plan was submitted by the deadline of 30 April 2021 to the Scottish Government and was approved by the SGC on 14 May 2021 but has not yet been presented to the Board for approval.

Internal audit review of the draft Interim Workforce Plan confirmed compliance with Scottish Governance guidance including use of the template issued and reflection of workforce elements of the Covid19 remobilisation plan. It will be a priority to ensure that the Interim Workforce Plan is translated into SMART targets and that progress against these is reported to the SGC to allow effective monitoring; the format of these reports should be considered carefully to ensure that assurances are relevant, reliable, and sufficient and that they clearly link to risks and controls.

The Integrated Workforce Plan 2022-2025 is now due to be submitted in March 2022. It would be preferable to have revised reporting and assurance arrangements in place before that time, so that the full plan can be prepared with these requirements in mind.

The SGC has received regular updates on measures put in place to secure the health and well-being of staff during the Covid19 pandemic including:

- Quarterly Health and Safety reports and minutes of the H&S Board, including updates on infection control.
- A Covid19 Health & Safety & Occupational Health Report covering social distancing, testing, vaccinations and Covid19 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
- The Covid19 RIDDOR reporting process was further developed and implemented during Quarter 4 and assurances on the revised process were provided to the SCG. The revised

process more effectively identifies Covid19 positive staff who contracted the virus whilst at work, along with the total incidents reported to the Health & Safety Executive.

- A report on Covid-related Health and Safety developments.
- A section on health and wellbeing within each HR Director's report to the SGC.

The pandemic has exacerbated many existing workforce risks and Management have recently completed a review of all Covid19 workforce related issues with an associated impact / likelihood for each which will be presented to the September 2021SG. It is recommended that SR0009 Workforce Plan risk is redefined into a wider Workforce Sustainability risk, which includes Covid19 and non Covid19 elements.

The Strategic Risk relating to Primary Care (SRR001), which is aligned to the SGC, will be reviewed by Internal Audit during the scheduled audit of the Primary Care Improvement Plan in 2021/22. This audit will assist the SGC by reviewing the controls in detail and providing an opinion on whether the controls are operating as intended.

Sickness absence for the year (excluding Covid19 related absences which are recorded as Special Leave) for 2020/21 was reported at 5.67% which is lower than last year (5.91%) but remains higher than the Scottish average.

Management informed us that 22% of staff had completed appraisals on TURAS as of 31 March 2021, against the National Standard of 80% and acknowledged a lack of reporting to the SGC on training and development and stated that the SGC will receive an update on steps being taken to improve this.

A 'Person Centred Portal' is at an advanced stage and HR have developed a suite of workforce dashboards within the portal, which are due to be presented for approval to the SGC on 17 September 2021. Directorates/HSCP HR Workforce Performance Groups were established in April 2021 and review their workforce information monthly.

A Whistleblowing Oversight Core Group (WBOG) was established in February 2021 to plan for the implementation of the National Whistleblowing Standards, which came into effect on 1 April 2021. A Whistleblowing Implementation Group (WIG) will deliver key elements and actions within the implementation plan and report on them to the WBOG, with the SGC receiving reports on progress and impact. The SGC Annual Report 20/21 provided an update on the implementation of the extant 'Once for Scotland' Whistleblowing Policy. However, the SGC did not receive an annual Whistleblowing report nor any data on Whistleblowing cases during 2020/21.

The SGC Annual Report 2020/2021 was approved, subject to the agreed changes by the SGC in March 2021 and was presented to the Board on 25 May 2021 in closed session. The SGC Annual Report includes a positive statement of assurance from the Chair of the SGC for financial year 2020/21.

On 25 May 2021 the Board approved the Remuneration Committee, as per The Staff Governance Framework (4th Edition), as a committee of the NHS Board, with membership extended to the Chairs of Board Committees. The Remuneration Committee shall produce an Annual Report to the NHS Board, and it is proposed the first meeting of the newly constituted committee will be in mid July following an induction led by the Director of HR for new members.

Action Point Reference 5: Workforce Planning	
Finding:	
The interim workforce plan contains narrative covering key themes across the Board, but not measurable key workforce targets against which performance can be measured.	
Audit Recommendation:	
It will be a priority to ensure that the interim workforce plan is translated into SMART targets and that progress against these is reported to the SGC to allow effective monitoring; the format of these reports should be considered carefully to ensure that assurances are relevant, reliable and sufficient and that they clearly link to risks and controls. The Integrated Workforce Plan 2022-2025 is now due to be submitted in March 2022, it would be preferable to have revised reporting and assurance arrangements in place before that time, so that the full plan can be prepared with these requirements in mind.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
The format and content of reporting arrangements will be considered for implementation prior to completion of the Integrated Workforce Plan 2022-2025, in order to provide relevant assurances.	
Action by:	**Date of expected completion:**
Director of Human Resources	**November 2021**

Financial Governance

Strategic Risks:

- **SRR005 Financial Break Even - If NHS FV financial plans are not aligned to strategic plans and external drivers of change, there is a risk that our cost base for our services over the medium to long term could exceed our future funding allocation, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision.**
- **SRR010 Estates and Supporting Infrastructure - If there is insufficient Capital funding to develop and improve the property portfolio there is a risk the Estate and supporting infrastructure will not be maintained in line with national and local requirements.**

As reported to the 25 May 2021 Board, the draft financial outturn position to 31 March 2021, subject to external audit review, receipt of final Scottish Government budget allocations, and on final outturn positions for Integration Authorities was:

- A surplus of £0.244m against a Revenue Resource Limit of £757.423m.
- A break-even position against Capital Resources of £15.129m.
- Cash target achieved with a closing bank balance of £0.035m at 31st March 2021, and,
- 2020/21 savings delivered of £20.7m, of which £14.0m (68%) are non recurring which included £5.2m support from Scottish Government in relation to Covid19 savings delays.

At its meeting on 31 March 2020 the Board approved a 5 Year Financial Plan and 5 Year Capital Plan 2021/22 – 2025/26, noting that plans will be subject to constant review. The 2021/22 financial plan was based on NHS Forth Valley's continuing response to the pandemic and on delivering recovery / remobilisation priorities whilst incorporating a baseline uplift of 1.5% (following an announcement from the Scottish Government in January 2021).

Initial savings targets were set out in the 2020/21 financial plan against a number of themes, supported by a new Cost Improvement Board that has been established to work with the Corporate Project Management Office (CPMO) team to support the management and delivery of savings requirements in the new financial year. Savings in 2020/21 have come largely from unsustainable non-recurring sources which will increase the financial gap in future based on current resource and expenditure assumptions, £32.4m of savings will be required to deliver financial balance in 2021/22 which will be extremely difficult. In the longer term, financial sustainability will only be achieved through the redesign of services and very clear priorities. Finance performance review meetings will be held every two months to increase focus around savings and cost improvements.

Financial reporting throughout the year to the P&RC and Board remained consistent and the position was clearly presented despite the challenges imposed by the pandemic. Operational risks, including the impact of Covid19, were highlighted within the finance report to the February 2021 P&RC and March 2021 Board, although these were not clearly linked to Strategic risks, particularly SRR005.

Financial governance arrangements have been enhanced by reporting on waivers of Standing Orders to the Audit & Risk Committee. The P&RC receive regular updates on current major capital projects and property transactions including the impact of Covid19. A draft Property Capital Plan 2021 was presented to the SLT on 12 April 2021 and provides the detailed property priorities for the organisation for 2021/22. It was noted that the plan was

developed following the review of achievements and slippage in 2020/21, including the impact of the pandemic and against the backdrop of the years 2021/22 to 2024/25 and the national position in relation to capital funding. It will be important to ensure that plans for the revision of the Property and Asset Management Strategy and the plans for the individual categories of assets therein are reviewed in alignment with the scheduled review of the Healthcare Strategy in 2021/22 to ensure clear linkages. A detailed review of property strategy including the impact of Covid19 on current and future property requirements will be included within the scope of the Primary Care Improvement audit and the Capital Planning audit, both scheduled for 2021/22.

A Best Value update annual report is scheduled for presentation to the Audit & Risk Committee on 15 July 2021. Discussions are currently on-going around enhancements to the content of previous Best Value annual reports to ensure that the process is providing meaningful insights along with the necessary assurances to NHS Forth Valley's internal Governance arrangements.

Overall, the economic impact of Covid19 will continue to have a significant impact on the financial environment in both the short and medium to longer term. Both UK and Scottish Government Budgets currently only set out one-year spending plans with longer term, post Covid19 economic strategies emerging later. Given this uncertainty, there will be a need to continually review and adapt NHS Forth Valley financial plans over coming months and years as resource availability and projected costs become clearer.

Internal audit report A26/21, Ordering, Requisitioning and Receipt provided recommendations to improve the financial delegation process for Pecos approvals. Action to ensure consistent use of the authorised signatory form to record Pecos approvals was agreed, along with maintenance of a single system that retains all financial delegations across the Board, whether Pecos or non Pecos related.

Internal audit A23/21 – Payroll, provided moderate assurance. Management agreed recommendations relating to: assessing and mitigating any risks associated with a change in controls over permanent amendments associated with the eESS interface; review of the Finance Department risk register to ensure that the controls in place adequately mitigate against the implications of Covid19; re-establishment of Key Performance Indicators.

Information Governance

Strategic Risks:

- **SRR003 Information Governance - If NHS Forth Valley fails to implement effective Information Governance arrangements there is a risk we will not comply with a range of requirements relating to GDPR and the Network and Information System Regulation (NIS), resulting in reputational damage and potential legal breaches leading to financial penalties.**
- **SRR011 IT Infrastructure - If there are significant technical and cyber vulnerabilities there is a risk the NHS FV IT Infrastructure could fail, resulting in potential major incidents or impact to service delivery.**

Digital

The mid-term review of the NHS Forth Valley's Digital and eHealth Strategy 2018-22, presented to the March 2021 Digital and eHealth Programme Board (DEHPB) noted that the Strategy may finish early in light of planned National Digital Strategy refresh, which will include learning from the Covid19 response. The Digital and eHealth Strategy would, in any event, have required revision to take account of the Board's new Healthcare Strategy.

It was reported to the March 2021 DEHPB that 16 of the 28 original projects/programmes of work, were scheduled to be delivered by the end of March 2021, of which 2 projects would now not be delivered within the timeframe due to delays in national projects and the need to prioritise additional programmes and accelerate others in order to respond to Covid19 and deliver remobilisation plans. An update on Digital and eHealth Delivery Plan projects was also presented to the February 2021 P&RC.

The Digital & eHealth Delivery Plan 2021/2022 was formally approved by the DEHPB at its meeting on 11 March 2021 and noted that considerable work is still required on Network Information Systems Regulation (NISR) and Cyber Security.

Following a recommendation in A29/21 - eHealth Strategic Planning and Governance, the March 2021 DEHPB approved amendments to the eHealth Programme Board Terms of Reference to include reference to the regular reporting of the implementation of the Digital and eHealth Delivery Plan to the P&RC.

Risk and assurance reporting

Risk 'deep dive' reports on the Information Governance (IG) and the IT Infrastructure strategic risks have not yet been reported to the P&RC, and although a verbal update was provided to the IGC in January 2021, there is no periodic assurance reporting to the Information Governance Committee (IGC). We do however note that the quarterly digital report to the P&RC includes infrastructure issues. In Quarter 3 2020/21 May 2021, the strategic IG risk score increased from 16 to 20. Internal audit report A29/20 – Information Assurance & Information Security follow up, recommended a refresh of the Information Governance Corporate risk and the addition of 'Information Governance and Security' assessment to Board and Committee templates. Neither has yet been addressed.

The Information Governance annual report 2020/21 highlighted the need for resources to address key items. The additional resource required over the next 2 years has been included in the approved financial plan and the Director of Finance has advised that the recurring commitments will be revisited as they become clearer over that period, and will be addressed in future plans. In addition, a phased investment plan is in place to resource the

priority developments around GDPR / information asset register. Appropriate resourcing is key to mitigating the IG risk and we would expect that this control would feature within the IG strategic risk, with monitoring in place.

An updated Covid19 Risk Assessment presented to the IGC in September 2020 downgraded the risk relating to Covid19 working practices to major from extreme. However, there was no evaluation of the mitigation strategies in place that supported the lowering of the risk. There have been no subsequent updates made to this assessment despite the continuously evolving environment. This Covid19 risk assessment should be updated and incorporated within the relevant Strategic risk(s).

The Cyber Security Awareness Strategy has recently been updated taking into consideration feedback from the 2021 NIS audit. We have been informed that a strategic risk for Cyber resilience will be introduced from quarter 2 of 2021/22 and the status of the existing strategic IT infrastructure will be reviewed.

SRR.011 IT Infrastructure Risk states; *"If there are significant technical and cyber vulnerabilities there is a risk the NHS FV IT Infrastructure could fail, resulting in potential major incidents or impact to service delivery"* with a current risk score of 16 and target of 6. Covid19 has increased the risk to information security, with a number of cyber-attacks being attempted recently but this has not resulted in a change to the risk score. This may be because the overall risk score reflects improvements in the other aspects e.g. focus on NIS, CISCO monitoring tool, and increased staff resource. Therefore, we welcome the development of a specific Cyber risk and the planned review of SRR.011.

Other current controls in place to support and manage cyber security are noted in the Strategic Risk Register (SRR) with an update on some aspects presented through the Capital Projects, Equipment & eHealth Projects report. There was also a presentation on Cyber Security to the P&RC in February 2021. An action is noted on the SRR against the Associate Director of Digital & eHealth to re-establish the Cyber Security Group by 30-June 2021 which should help enhance the assurance process further. As with other risks, we would expect assurance reporting on SRR003 and SRR011 to the P&RC develop further over the coming year with a particular focus on the areas of concern noted in this section.

External reviews

The Network and Information Systems Regulations (NISR) audit report was issued in October 2020. The June IGC was informed that actions are largely on-track to complete Critical and Urgent recommendations either before or shortly after the next regulatory audit, which took place at the end of June 2021. The Information and Cyber Security team have now been assigned dedicated time to focus on NIS compliance matters which was reported to have improved the implementation of NIS controls.

The NIS highlights report to the IGC on 10 June 2021 showed that:

- Of 4 Critical (Black) Audit Recommendations, 3 were complete and 1 was in progress (due to be completed by June 2021)
- Of 15 Urgent (Red) recommendations, 4 were complete and 11 were in progress (3 of which were due to be completed in June 2021)
- Of 104 actions overall, 18% were complete, 23% were in progress and 59% not started. Of those in progress or not started, 29% of those were expected to be completed by June 2021 for audit, which would represent a rapid acceleration if achieved.

Progress on NIS recommendations was reported to the P&RC in February 2021 through the Capital Projects, Equipment & eHealth Projects update and an update was also included with the Information Governance Annual Report 2020/21, presented to the P&RC in April 2021,

which highlighted progress against recommendations, categorised by importance. A post-audit meeting with the Scottish Government took place on 15 December 2020 to review the recommendations and ensure planned work would appropriately satisfy the requirements as set down by the Competent Authority and since then, progress has been made in some key areas. Internal audit A14&A28/21 – Organisational Response to External Reports recommended that the P&RC should receive a regular Highlight Report on NISR, to include a risk assessment of black (critical) and red (urgent) recommendations, and clearly stating any risks to achievement of actions steps being taken to ensure overall compliance with NIS regulations.

Whilst we note that that the Cyber Security / Resilience Group, to be reinstated by 30 June 2021, should provide better tracking of progress on NIS, to help coordinate efforts of the new tools, staff and resources, this should be accompanied by specific assurances to the P&RC on the effectiveness of these arrangements and the subsequent impact on related risks.

Information Governance

The Information Governance Annual report 2020/21 was presented to the IGC in April 2021 and approved by the P&RC in May 2021. It concluded that appropriate governance arrangements were in place throughout the year and that assurances had been provided to the P&RC on the work undertaken and progressed during the year. Internal audit A30/21 provided moderate assurance on the security of e-Health related mobile devices such as laptops and tablets, including the arrangements for the requisitioning, receipt, labelling, storage and disposal of such equipment.

Action Point Reference 6 - Risk & Assurance reporting	
Finding:	
Currently, risk reporting to Standing Committees covers only those risks where the risk score has changed and, as a result, detailed risk reports on the IG and the IT Infrastructure strategic risks have not yet been reported to the P&RC. A programme of 'deep dive' risk reporting has commenced and will include all strategic risks. We have been informed that a strategic risk for Cyber resilience will be introduced from quarter 2 of 2021/22 and the status of the existing strategic IT infrastructure will be reviewed.	
Audit Recommendation:	
As a number of strategic risks are aligned to the P&RC, a programme of prioritised reporting should be agreed to ensure adequate and prioritised reporting on all risks aligned to the committee, including IG and cyber security.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
A forward look programme of prioritised reporting on strategic risks aligned to the Performance & Resources Committee will be agreed.	
Action by:	**Date of expected completion:**
Performance Manager with support from Corporate Risk Manager and relevant risk leads	**November 2021**

Key Performance Indicators – Performance against Service Specification

	Planning	Target	2019/20	2020/21
1	Strategic/Annual Plan presented to Audit & Risk Committee by April 30th		Draft presented 16 June 2020	Draft circulated 9 June 2021
2	Annual Internal Audit Report presented to Audit & Risk Committee by June		Yes	Yes
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	100%	100%
4	Draft reports issued by target date	75%	81%	53%
5	Responses received from client within timescale defined in reporting protocol	75%	81%	80%
6	Final reports presented to target Audit & Risk Committee	75%	84%	78%
7	Number of days delivered against plan	100% at year-end	91%	93%
8	Number of audits delivered to planned number of days (within 10%)	75%	74%	71%
9	Skill mix	50%	72%	71%
10	Staff provision by category	As per SSA/Spec	Pie chart	
	Effectiveness			
11	Client satisfaction surveys	Average score of 3	Bar chart	

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	None
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	Two
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Four

Foreword

The Chair and Chief Executive are grateful to the External Review Team for undertaking an independent Culture and Governance Review of NHS Forth Valley's Emergency Department (ED) at the request of the Health Board's Chief Executive.

We would also want to express our sincere thanks and gratitude to everyone who engaged in the Review process by providing feedback and sharing their personal experiences, including the staff-side (RCN and Unison) colleagues who raised concerns directly with the Chief Executive.

The Review has identified significant issues and behaviours that do not align with NHS Forth Valley's core values. We believe it is therefore important that, in responding to this report, we live up to our organisation's values of being person centred, respectful, ambitious, and supportive, with a commitment to working together as a team and always acting with integrity.

Having shared the External Review Report (attached at Appendix 2) with all ED staff, we then offered ED staff an opportunity to meet with us to discuss the review process, the review report and its recommendations and any other improvements that staff would like to see to respond to the issues raised. At these staff meetings we were both encouraged and impressed by the staff's ambition to use this report to *''pave the way''* for improvement. The staff we met spoke about the Review as a *''positive and inclusive process''* and *''being the start of a process''* and *''a chance to own our improvement journey''.*

In addition to the External Review report recommendations, staff were keen to suggest a number of actions which they felt would improve their day-to-day work and experiences.

To demonstrate that we have placed ED staff at the heart of our response we have separated our response to the External Review recommendations, set out at Appendix 1, from those additional recommendations, ideas, and suggestions we heard from frontline staff, staff-side representatives, and managers.

It is also important to note that many of the wider governance-related issues highlighted in the review report are already being addressed and several others are being implemented as part of local remobilisation plans. NHS Forth Valley's governance arrangements are also subject to annual review by its independent auditors and their findings are set out in Appendix 3. These conclude, based on work undertaken throughout the year, that the 'Board has adequate and effective internal controls in place.'

NHS Forth Valley has a duty to ensure the health and wellbeing of local staff as well as the patients they look after, and we want to encourage an open, honest culture where staff have the confidence to speak up about any issues which concern them. The Health Board has

invested in a 'Speak Up' initiative that will be rolled out in support of the new National Whistleblowing Standards.

A new sub-committee of the Health Board, led by NHS Forth Valley's Chair Janie McCusker, has been set up to oversee the implementation of the Review recommendations as part of a wider plan of ED improvements which is already underway.

Janie McCusker
Chair
NHS Forth Valley

Cathie Cowan
Chief Executive
NHS Forth Valley

1. Background

On the 19th of November 2020 the Regional Officer of the Royal College of Nursing (RCN) approached the Health Board's Chief Executive. The Chief Executive then received an email setting out these concerns on behalf of the RCN and Unison. The email raised serious concerns regarding the alleged culture within the Emergency Department, particularly in relation to nursing.

The Chief Executive determined that the serious nature of these concerns warranted the commissioning of an external review led by an independent team. Members of the Review Team were appointed in December 2020.

The review process involved a number of phases. In Phase 1 ED staff were invited by the Chief Executive and Employee Director to complete a confidential psychological safety questionnaire which covered teamwork, leadership, learning environment and quality. Of the 105 questionnaires issued, 61 responses were received and were reviewed by the External Review team to establish any recurring themes. In Phase 2 NHS Forth Valley's Chief Executive and Employee Director wrote to ED staff to invite them to meet with members of the External Review team. Forty-three individuals took up this opportunity (39 nurses, including 4 leavers) and 4 doctors (including 2 leavers).

The External Review team identified 45 recommendations. The Health Board accepted all the recommendations set out in the External Review report, many of which are already in place and/or in progress with a final date of completion by the end of 2021.

NHS Forth Valley's Chair and Chief Executive, through their meetings with frontline ED staff (nurses, doctors, and managers) identified a number of further actions and recommendations in addition to the External Review recommendations which are set out below along with the Health Board's response.

The response adopts the Psychological Safety Questionnaire (based on the Institute for Healthcare Improvement (IHI) Climate Survey) four key themes: teamwork, leadership, learning environment and quality.

2. Feedback from Frontline Staff and Additional Actions

The Chair and Chief Executive, having shared the External Review report with everyone involved in the review, met with ED staff week beginning 5th of July 2021. Feedback from staff about the review was overwhelmingly positive as they felt they had been listened to and were confident that things would change. Staff showed great professionalism and courage

throughout the review process and are keen to be involved in the improvement work which has now started to address the issues raised.

In addition to these meetings, a workshop took place on 30th of June 2021 where 25 staff came together to develop their vision for the 'Redesign of Urgent and Emergency Care'. The output from this event (art capturing conversation set out below) is supporting teamwork to redesign how future services are developed and delivered. This builds on a number of recent service developments e.g., the creation of a new Urgent Care Centre at Forth Valley Royal Hospital and the ongoing development of Same Day Emergency Care. The integration of ED, Urgent Care, and Same Day Emergency Care will be a key focus as staff come together as one overarching team to respond to increasing demand and meeting the needs of patients.

Further to the Review report recommendations a number of additional recommendations put forward by frontline staff (nurses, doctors, and managers) are set out below. These additional recommendations have been shared with and are supported by Senior Clinical Decision Makers in ED and staff side representatives. The recommendations are being presented by the Chief Executive to the NHS Board to endorse.

- Teamwork

'In general staff told us that "'on the floor front line staff" got on reasonably well. However, teamwork and the feeling of a positive and supportive working environment and culture was person dependent resulting in no consistency of behaviours or values from shift to shift. ……. Team meetings were infrequent and there was little opportunity for attendance or shared learning between Medical and Nursing staff.' (Culture and Governance Review – ED, Page 6)

- Response and Additional Actions

NHS Forth Valley will ensure all ED nursing staff have **access to 2 hours protected learning time** per week or 1 day per month. This commitment will require additional staffing to ensure nursing staff have similar learning opportunities as students/trainees and medical staff. **Two Education Facilitators reporting to the Head of Learning and Organisational Development (OD) will be appointed** to provide on-site (AAU and ED) e.g., training, quality improvement, education, and teaching. In addition, there will be a range of Organisational Development initiatives to support multidisciplinary team working.

- Leadership

'Staff told us leadership was not visible unless to scrutinise flow performance. ….. Concern was raised that senior staff at band 6 and 7 are not fulfilling the role of Clinical Leaders/Experts through support and supervision. …. Rather their role has become one of a co-ordinator of department flow and attending safety Huddles or two hourly department flow meetings with Duty Managers.'. (Culture and Governance Review – ED, Page 7)

- Response and Additional Actions

The **4-hour access standard is a whole system measure**. A review of how we collect and report on performance data to stimulate improvement is a key feature in our recently approved Quality Strategy. **Nurse Clinical Leaders (Band 6 and Band 7) will be freed up to fulfil their expert mentoring and supervision role by leading specific ED service areas** e.g., triage, treatments etc 24/7.

- Learning Environment

'Nursing and Medical staff told us that nurse staffing levels were insufficient; this was particularly exacerbated when RESUS was open. …. In addition, they cited major concerns about poor induction of staff at department level and their feelings of anxiety on a daily basis about competency levels particularly at Junior band 5 and 6 level'. (Culture and Governance Review – ED, Page 8)

- Response and Additional Actions

NHS Forth Valley has recently recruited to several medical posts, including 2 ED Consultants (to fill existing vacancies), 4 ED Development Fellows and 3 ED Specialty Doctor posts. Staff are due to take up post from early August 2021 onwards. In addition, NHS Forth Valley has

agreed to work alongside senior ED clinical staff (nurses and doctors) to review staffing levels and cover 24/7. It is intended that a review of staffing will respond to middle grade rota fragility and the change in demand on all grades and professions. A commitment to **invest in the Healthcare Support Workers role and development** to support Band 2 and Band 3 roles within ED and the wider organisation has been made.

The Chair and Chief Executive in their meetings with staff heard nursing staff say that they wanted to **develop a programme of induction** based on their needs following appointment. **A short life working group will be established to support this work beginning in late-August 2021.** The Head of Learning and OD will support this work as part of the Health Board's investment in organisation wide induction for all new starts.

- Quality

'61% (of staff) say suggestions for improvement would not be acted upon …. 32% say they don't feel the team has the necessary skills to drive improvement and safety in the department.'…. The Review Team were given examples of reluctance to report incidents or near misses as a consequence of a culture of poor follow up and lack of corrective action'. (Culture and Governance Review – ED, Page 8)

- Response and Additional Actions

The **Front Door Workshop on 30 June 2021 where 25 staff came together to develop** their vision to 'Redesign of Urgent and Emergency Care' centred around three key programmes that align with our overarching **vision of 'Transforming our Care'**.

The **roll out of the clinical governance 'Vincent Framework'** to provide visible clinical leadership at all levels of the organisation. How we collect, analyse and report on performance data (incident reporting including significant adverse events and complaints etc.,) to **stimulate improvement** is a key focus of our **recently approved Quality Strategy**. This Strategy sets out the Board's unwavering commitment to improving quality and promoting a culture of excellence, learning and improvement. The Health Board has already agreed to **invest in proven quality improvement skills and approaches for our staff**.

3. Conclusion

The Chief Executive, in response to serious concerns raised by the RCN and Unison, commissioned an independent external review of the Emergency Department in Forth Valley Royal Hospital. This approach was supported by the Health Board and the External Review report has been shared with ED staff, staff side representatives and those directly involved in the review process.

The External Review report and its findings are clearly distressing, and the Health Board has accepted all 45 recommendations and will now oversee the implementation of an Improvement Plan to ensure that all the issues and concerns raised are addressed. Staff and staff side representatives will play a key part in assuring the Health Board that the changes implemented are addressing the issues and improving the experience of frontline staff.

The Health Board's sub-committee, established on the 18 June 2021 to oversee the implementation of the Improvement Plan, which includes additional recommendations informed by frontline ED staff (set out in appendix 1 of this covering report), will continue to meet regularly to monitor and assess progress.

Key improvement measures developed by staff and staff side representatives will be reported to the Health Board from September 2021 onwards.

Recommendations

The Forth Valley NHS Board is asked to:

- **endorse** the additional staff recommendations set out in Appendix 1
- **approve** the Draft Improvement Implementation Plan set out in Appendix 1
- **note** the External Review report: 'Culture and Governance - Emergency Department, Forth Valley Royal Hospital' attached at Appendix 2
- **note** the Annual Internal Audit Report 2020/2021 attached at Appendix 3

Cathie Cowan
Chief Executive

3 August 2021

Appendix 1

Additional Recommendations

- **Teamwork**

NHS Forth Valley will ensure all Emergency Department (ED) nursing staff have **access to 2 hours protected learning time** per week or 1 day per month. This commitment will require additional staffing to ensure nursing staff have similar learning opportunities as students/trainees and medical staff. **Two Education Facilitators reporting to the Head of Learning and Organisational Development (OD) will be appointed** to provide on-site (AAU and ED) e.g., training, quality improvement, education, and teaching. In addition, there will be a range of Organisational Development initiatives to support multidisciplinary team working.

- **Leadership**

The **4-hour access standard is a whole system measure**. A review of how we collect and report on performance data to stimulate improvement is a key feature in our recently approved Quality Strategy. **Nurse Clinical Leaders (Band 6 and Band 7) will be freed up to fulfil their expert mentoring and supervision role by leading specific ED service areas** e.g., triage, treatments etc 24/7.

- **Learning Environment**

NHS Forth Valley has recently recruited to several medical posts, including 2 ED Consultants (to fill existing vacancies), 4 ED Development Fellows and 3 ED Specialty Doctor posts. Staff are due to take up post from early August 2021 onwards. In addition, NHS Forth Valley has **agreed to work alongside senior ED clinical staff (nurses and doctors) to review staffing levels and cover 24/7**. It is intended that a review of staffing will respond to middle grade rota fragility and the change in demand on all grades and professions. A commitment to **invest in the Healthcare Support Workers role and development** to support Band 2 and Band 3 roles within ED and the wider organisation has been made.

The Chair and Chief Executive in their meetings with staff heard nursing staff say that they wanted to **develop a programme of induction** based on their needs following appointment. **A short life working group will be established to support this work beginning in late-August 2021.** The Head of Learning and OD will support this work as part of the Health Board's investment in organisation wide induction for all new starts.

- **Quality**

The **Front Door Workshop on 30 June 2021 where 25 staff came together to develop** their vision to 'Redesign of Urgent and Emergency Care' centred around three key programmes that align with our overarching **vision of 'Transforming our Care'**.

The **roll out of the clinical governance 'Vincent Framework'** will provide visible clinical leadership at all levels of the organisation. How we collect, analyse and report on performance data (incident reporting including significant adverse events and complaints etc.,) to **stimulate improvement** is a key focus of our **recently approved Quality Strategy**. This Strategy sets out the Board's unwavering commitment to improving quality and promoting a culture of excellence, learning and improvement. The Health Board has already agreed to **invest in proven quality improvement skills and approaches for our staff**.

Nursing Workforce and Professional Oversight of Safe Staffing - led by Professor A Wallace, Nurse Director

	Recommendations	Response/Action(s)	Timescale	RAG
1.	The Board should consider creating a Clinical Nurse Manager post to support services across ED and Minor Injuries units. The postholder should fulfil the role of Senior Nurse, be an expert ED nurse who has completed a minimum, level 2 competencies (as set out by RCN or equivalent) and has responsibility for overall clinical support and supervision overseeing quality improvement and assurance, workforce management etc. The postholder should fulfil a supervisory role and have an average two fixed clinical sessions per week.	• In progress. The Acute Services Directorate has a Chief Nurse supported by 2 Heads of Nursing. A senior clinical nurse manager will be appointed to the Emergency Department to support the current Band 7 SCN roles. A Job Description is currently being developed and once evaluated the post will be then advertised in early September 2021.	Sept - Nov 2021	
2.	The Board should review the Professional nursing structure and implement a more fit for purpose leadership structure. Core to this should be enhancing visibility and engagement with front line staff and patients to improve trust and confidence; create a culture of openness where staff feel listened to and supported.	• In progress. A review of professional nursing on the Forth Valley Royal Hospital site will be undertaken. Currently nurse staffing and structures are benchmarked and comparable with NHS Scotland Territorial Health Boards.	September 2021	
3.	The Board should take into account of information provided within this report, consideration should be given to applying the key Nursing Workforce standards set out by RCEM and RCN in October 2020 particularly as it applies to:	• In place. NHS Scotland has a national workforce and workload planning tool in place in line with CEL 32/2011. NHS Forth Valley was a test site for the development of the ED staffing tool for both nursing and medical staff and this has been used consistently since 2014.	In place	
a.	Further review of workforce numbers and comparable benchmarks	• In progress. A review of nurse staffing/skill mix will be undertaken in line with increased demand. The most recent review took place in January 2020 – the findings reported a staffing compliment of 65.48 WTE – the establishment at this time is 70 WTE.	September 2021	
b.	Appropriate skill mix at Charge Nurse (Team Leader); Staff Nurse; Foundational Staff Nurse and Clinical support worker level, with an overall 80-20 skill mix	• In progress. Criteria are in place for ensuring nursing staff rostering is developed to include a minimum level of Senior Nurses for each shift. Overall skill mix in the ED is 81.5 qualified to 18.5 unqualified. This will be reviewed as part of skill mix review described above.	September 2021	
c.	Explicit attention should be given to safe and consistent staffing of the RESUS area and the concerns raised by staff	• In progress. Work is underway to review ED nurse staffing to be aligned with the new models of care and investment in a new Urgent Care Centre and Flow Navigation Centre.	September 2021	
d.	Clarity on the “streaming role” in particular staff concerns about patient safety and clinical competency to undertake this role.	• In progress. This was implemented at the height of the pandemic. Triage has been re-established and nurse induction will include triage competencies.	September 2021	
e.	Review of departmental induction for staff at all grades and consideration of a period of supernumerary status for nurses new to the department and nurses at Foundation level	• In progress. See Staff Governance Action 8 - period of supernumerary time to support review of induction involving staff and staff-side in ED Working Group.	October 2021	
f.	Development of a ED career linked to recognised emergency planning nursing, clinical competencies supported by an ED training plan	• In progress. Band 5 and Band 6 competency frameworks are currently under review and being reviewed in line with level 1&2 RCN guidelines. Further work will be carried out in support of all grades.	September 2021	
g.	Development of the Team leader role as a clinical expert providing on the job clinical support and supervision and	• In progress. Team Leader role to take account of role as a clinical expert will be defined.	Sept - November 2021	

	expert across a range of areas included within the Emergency nursing competency frameworks and clear links with departmental quality outcome monitoring.			
h.	Improved scrutiny around Rostering practices with a particularly focus on staff competency levels alongside variation in clinical demand.	• In progress. Rostering pilot work underway to inform roll out of eRostering.	September 2021	
i.	The Nursing workforce governance group should consider the existing terms of reference and membership and whether they are sufficiently sighted on the short and long term staffing challenges, links to quality outcomes and should consider reviewing membership and inclusion of staff side input and reporting arrangements.	• In place. The Nursing Workforce overarching governance group already established includes staff-side representation from Unison and RCN.	In place	

Clinical Governance - led by A Murray, Medical Director

	Recommendations	Response/Action(s)	Timescale	RAG Status
1.	The Board should immediately review its entire Clinical Governance arrangements to ensure a clear line of responsibility and accountability from the Board to point of care and from point of care to the Board. This should include reviewing all work streams and groups to ensure adequate depth and breadth of assurance. This will enable the committee to provide the Board with assurance of safe effective person centred care.	• In progress. The Clinical Governance Committee at its meeting in June 2021 considered work underway to set out an 'overview of clinical governance arrangements' within NHS Forth Valley. The Clinical Governance Committee will receive an update on this work at its August 2021 meeting.	October 2021	
2.	All members of the Clinical Governance Committee should be given support to discharge their responsibilities by identifying training and education requirements.	• In progress. As part of the Board's self assessment process facilitated by NHS Education for Scotland a Training Needs Analysis will be compiled for all Health Board Non-Executives to support Non-Executive members discharge their scrutiny and assurance roles.	October 2021	
3.	The Clinical Governance Committee should consider developing a communication strategy which clearly raises the profile and awareness of the Committees Role purpose and work plan to provide front line staff with a better understanding.	• In progress. The Code of Corporate Governance will be presented to the Health Board in November 2021 and as part of this process a communication piece will set out the Governance arrangements including all Board Assurance Committees.	November 2021	
4.	The Clinical Governance minutes should provide evidence of the level of the committee's discussion and scrutiny to demonstrate assurance of safe and effective person centred care.	• In place. Minutes will include Committee member's discussion to demonstrate active scrutiny and assurance actions.	In place	
5.	The Executive Director of NMAHPs must clarify the lines of professional nurse leadership, governance and accountability in the Acute Division and ensure staff in these roles are supported to effectively discharge their responsibilities.	• In place. The Executive Nurse Director has provided the necessary clarity and in going forward Heads of Nursing will report directly to the Chief Nurse.	In place	
6.	The Executive Medical Director must immediately develop an implementation plan for the Role out of the Vincent Framework ensuring there is strong visible committed clinical leadership at every level of the organisation this will help staff understand the benefits of the Framework and the expectations of them.	• In place. The Executive Medical Director introduced the Vincent Framework to both measure and monitor patient safety in July 2020. This new approach is intended to provide enhanced assurance; Committee members have welcomed the Framework. The roll out of this approach is underway and will be adopted by Directorates and Partnerships.	December 2021	
7.	The Board should prioritise the progression of the Quality Strategy ensuring that the workforce is consulted and engaged in its development and implementation.	• Completed. The development of a new Quality Strategy was paused during the pandemic and picked up again in early 2021. Following an extensive engagement process the new Strategy was presented to the Board for approval in July 2021.	Complete	
8.	NHS Forth Valley Adverse events policy was due for revision in December 2020. The Board needs to review how this policy is made easy for frontline staff to understand then subsequently implemented and monitored to be able to demonstrate the Boards commitment to promoting an open and honest culture that is based on supporting staff within a culture of continuous improvement.	• In progress. The SAER policy was refreshed in early 2021 and feedback from staff was gathered in April 2021 this will inform the in-depth review planned for later in 2021. The output from this review will inform the Policy update. This will be presented to the Clinical Governance Committee for approval in November 2021.	November 2021	
9.	The Review Team were unable to establish the existence of a robust SAER tracking system. The Board are encouraged	• In place. The SAER tracking process has been in place for a number of years and is presented regularly to both the Clinical Governance Working Group and Clinical	August 2021	

	to confirm or develop such a system ensuring that the workforce is aware of this and how to use this effectively.	Governance Committee. This recommendation will be discussed at the Clinical Governance Committee and assurance provided to members regarding the established tracking system in place.		
10.	The Board should ensure that reports on adverse events with links to improvement plans are prepared; disseminated and analysed in a timely manner. That analysis is shared at department / operational level and through quality and safety fora at Divisional and Board level.	• In progress. The Health Board's approach to adverse events learning is through Learning Summaries which are presented and discussed at Departmental and Clinical Governance Working Group meetings. It is intended that these will be presented to future Clinical Governance Committee (CGC) meetings. The Clinical Governance Team will be expanded to ensure this work is progressed.	Reporting will be expanded to include the CGC from November 2021	
11.	The Board should ensure arrangements are in place to support staff involved in adverse events.	• In place. Every SAER has a staff support member on the review group in keeping with National Policy.	In place	
12.	The Board should urgently review ED staff awareness of Duty of Candour	• In place. Registered clinicians should be aware of their own professional Duty of Candour; Organisational Duty of Candour was featured in the Governance event held in April 2021. Duty of Candour will be included in Corporate Induction.	In place	
13.	The System Leadership Team should consider how all members of the team are cited on emerging clinical and patient safety/patient facing priority issues and consider creating an action group that supports a nimbler approach to considering emerging issues.	• In progress. The System Leadership Team (SLT) members are currently updated at every meeting on emerging key issues through a dedicated check in process on the agenda. This will be strengthened to explicitly request clinical and patient safety emergent issues. A prompt and agile response to issues raised will be commissioned, and evidenced in the SLT minutes. • Directorate and Partnership Performance meetings will be re-established from September 2021 onwards, these meetings will focus on services including patient safety issues/priorities, workforce and budget performance.	In place	

Staff Governance - led by L Donaldson, Director of Human Resources

	Recommendations	Response/Action(s)	Timescales	RAG
1.	Urgent review of the arrangements for the implementation of iMatter within the ED specifically but also for the Board as a whole in terms of ensuring that there is oversight of performance at a Board and Staff Governance Committee level to ensure that there is a more proactive approach taken to both identify and support "red / amber areas".	• In progress. Previous Board wide iMatter surveys have had no 'red' ratings. The iMatter plan for 2021 with corresponding timetable was presented and approved by the Staff Governance Committee on May 2021. Organisational wide preparation (including the Emergency Department) to inform the iMatter 2021 Survey has begun in readiness including internal communication for the Survey Go-Live date of 23rd August 2021. Training via MS Teams is in place to support Managers implement the iMatter process. This includes responsibilities in relation to the iMatter continuous improvement process. • iMatter assurance process to measure participation levels and action planning activities geared to support learning and improvement at team and Directorate/Partnership levels are being developed to coincide with publication of survey results. iMatter compliance reporting e.g. action planning will be discussed at Directorate/Partnership performance meetings and organisational assurance reporting will be presented to all Staff Governance Committee meetings.	August - October 2021	
2.	Increase the Staff Governance content for Board performance monitoring and "Balanced Scorecard" to include performance on statutory and mandatory training, eKSF / TURAS compliance, iMatter and relevant H&S KPI's (the introduction of Pentana should support this) to be better able to triangulate meaningful workforce related KPI's to identify "hot spots" in a more effective manner.	• In place. The HR Dashboard developed during 2020/2021 was presented to the System Leadership Team (SLT) in May 2021. Workforce Performance Groups (WPG) established in April 2021 are now meeting monthly linked with Directorate/Partnership Management Teams. • Enhanced Partnership Chair and HRD meetings involving senior staff side representatives commenced in June 2021. These meetings provide an opportunity to triangulate data/information to then report on to the SLT, Area Partnership Forum (APF) and thereafter quarterly to the Staff Governance Committee.	In place	
3.	Review all of the Staff Governance Standards in terms of an internal self-assessment to review any areas for improvement and develop appropriate action plans, key milestones and leads as appropriate.	• In place. Plan to report on the 5 strands of the Staff Governance Standard was presented and approved at the Staff Governance Committee in May 2021. • The Employee Director and Director of Human Resources will jointly sign off and present this report to the Staff Governance Committee having been approved by the APF.	In place	
4.	Urgent review of Partnership arrangements at a Board and local level to ensure that these are as inclusive as possible to reap the benefits of positive partnership working and also that appropriate senior commitment is given to Partnership Fora at both a Board and local level.	• In progress. Joint working and enhanced partnership arrangements highlighted and have been agreed and a review of the Acute Partnership Forum working arrangements is underway.	September 2021	
5.	Provision of Support / Training to both the Employee Director and Partnership Representatives to ensure that they understand the roles and responsibilities that come with operating in a committed partnership environment and that they are able to fulfil these in a meaningful and effective way.	• In progress. The Employee Director, Director of Human Resources and Chief Executive with the full involvement of staff-side representatives will determine enhanced ways of working to support ongoing effective partnership working.	September 2021	
6.	Ensure that Partnership working is embedded as the "business as usual model" within NHS Forth Valley and work is done to raise awareness of this with line managers and HR staff who should also be encouraged to act as ambassadors for partnership working with managers in the day-to-day operation of the Board	• In progress. The ED External Review has highlighted that our escalation process is working. However, as highlighted by the External Review Team the response to issues highlighted at appropriate levels had not been acted on. Action 5 (above) will explore this recommendation to consider any change in reporting arrangements.	September 2021	

7.	In line with the issues also raised within other sections of this report to review the induction, training and development and TURAS arrangements and compliance by both managers and staff to ensure that these are fit for purpose throughout the Board.	• In place. Revised corporate induction arrangements paused during the pandemic - refreshed and launched in June 2021. Work is underway to refresh Directorates/Partnerships induction. • TURAS appraisal updated and system re-launched.	In place	
8.	Review of Induction, skills assessment and learning and development plan within ED to ensure that staff are competent to carry out their role safely as this has a direct bearing in terms of patient safety and also as individual's their professional registration requirements.	• In progress. ED Working Group with staff representatives will be established to oversee ED induction programme specifically for nursing (medical and student nurse induction in place). Education Facilitators will be appointed to support ED and Acute Assessment areas to provide structured education and training. Posts will report directly to Head of Learning and OD. • Implementation of Essential Training passport is in development and will provide all staff with at least 2 days each year to complete mandatory training.	October 2021	
9.	Review of workforce planning arrangements in partnership to ensure that these are "fit for purpose in order to support the overarching Workforce Strategy and People Strategy and Integration Plans.	• In place. As per the Annual Internal Audit Report 2020/2021 (attached at Appendix 3) 'Our People Strategy' (i.e., Workforce and People Strategy) will be reviewed by December 2021. • Interim Workforce Plan in line with national guidance was presented and approved at the APF and Staff Governance Committee in May/June 2021.	In place	
10.	Implementation of the post-Sturrock governance and action plan to be able to assess the overall organisational culture and develop an improvement plan to ensure that staff feel safe and able to speak up and also work within a positive environment.	• In progress. The Health Board has a Sturrock Review Group in place. The Group has developed and approved an Action Plan. The actions are reported to the Staff Governance Committee. • The Health Board has approved a new Speak Up initiative; this initiative supports the implementation of the Whistleblowing legislation and has been developed in partnership with staff and staff-side representatives.	August 2021	
11.	Ensure that the Health and Safety governance Structures and responsibilities are approved as a matter of urgency and disseminated throughout the Board.	• In progress. The Health Board has an established Health and Safety Committee Structure in place including a revised policy. The development of a Health & Safety Strategy, in addition to the policy was paused during the pandemic; this will be presented to the Health Board's for approval in September 2021.	September 2021	
12.	It is recognised that the Staff Governance Standards must be owned at a local level and committed to by managers in order to make them meaningful for staff, however, it is important that the HR Director in Partnership with the Employee Director takes a robust monitoring and performance management role in order to be assured and to be able to provide assurance to the Board and Staff Governance Committee of overall performance in all of the strands.	• In place. See Staff Governance Action 3 above.	In place	

Corporate Governance - led by C Cowan, Chief Executive

	Recommendations	Response/Action(s)	Timescale	RAG Status
1.	That there is an external expert assessment of relationships and behaviours between members of the SLT, clarity on roles and contributions; what is expected of them collectively and individually and in particular ability to challenge peers.	• In progress. The current OD Programme involving the Board's Executive Directors continues and SLT members will be invited to participate in shaping an OD programme. The programme will focus on team working, authorising environment and provide clarity on individual and collective roles and responsibilities.	October 2021	
2.	That there is an external assessment of relationships and behaviours between the System Leadership Team and Non-Executive Board members with a particular focus on how they engage, scrutinise and utilise the information presented to them and use this to make an informed assessment for assurance purposes.	• In progress. The Health Board in June 2020 approved an extension of Board membership to include all SLT members. The Health Board in line with the NHS Corporate Governance systems is committed to ongoing regular self assessments in response to the NHS Scotland DL (2019) – Blueprint for Good Governance. A Health Board self-assessment workshop was due to take place in 2021 and due to the pandemic was paused. A workshop to explore and provide clarity on relationships and behaviours between SLT and Non-Executive members is being progressed with NHS Education for Scotland. • Health Board Development sessions, pre Covid-19 focused on governance related topics and took place bimonthly. These sessions were paused during the pandemic and Board meetings were increased to monthly as part of revised governance arrangements. Health Board Seminars recommenced in January 2021; the January session led by the Health Board Chair focused on 'Active Governance'.	October 2021	
3.	The Board should revisit the results of the 2019 self-assessment on the Blueprint for Good Governance taking account of the findings of this review and expedite the plans to introduce "Active Governance".	• In progress. The update to the Blueprint for Good Governance - Improvement Plan was presented and approved by the Health Board in March 2021. This Plan will be further updated following the Health Board's self-assessment workshop and as in previous years will be facilitated by NHS Education for Scotland.	October 2021	
4.	The Board should consider any recommendations arising from the national work to improve assurance systems and develop a local assurance framework that embeds and refreshes relevant information flows and timely data to support scrutiny and assurance Board /Committees. (consider qualitative as well as quantitative data and benchmarking)	• In progress. The national work to inform 'active governance' will be adopted by the Health Board and will contribute to the Board's Assurance Framework – a Health Board Seminar is being rescheduled to further enhance our approach risk management and Health Board assurance. • The Staff Governance Committee considered and approved the Staff Governance Assurance Framework and Plan at its meeting in May 2021. This work will be undertaken for all Health Board Assurance Committees.	October 2021	
5.	The Board should consider developing a more proactive simplified communication plan to help paint a clear picture of how the organisation is governed, how priorities are developed and well communicated and to raise awareness and understanding by all stakeholders.	• In progress. The Health Board has appointed a Board Secretary and a refresh of the Health Board's Code of Corporate Governance is underway. This will be presented to the Health Board for approval in November 2021.	November 2021	
6.	The Board should develop a structured programme of visibility and engagement with staff in order to demonstrate Board values; encourage staff to speak up and be heard and reinforce a culture of continuous improvement. (This could be through Patient Safety leadership walk rounds, meet the Board sessions or a range of other engagement initiatives)	• In progress. The Health Board had approved a revised visibility and engagement approach to support Leadership (Patient Safety) Walkrounds – this programme in response to Covid-19 restrictions was paused. Feedback from these initial walkrounds from staff had been very positive. Leadership walkrounds will be discussed and agreed following the Health Board Seminar in August 2021.	September 2021	

7.	NHS Forth Valley should urgently review the current Acute Division management arrangements to ensure there is sufficient Senior Clinical leadership to provide oversight of whole hospital issues. This needs to provide clarity on lines of accountability for operational and professional governance, so that staff understand the routes of escalation if they have any issues or concerns. In doing this ensure that robust operational management systems are in place to drive continuous improvement involving staff at grass roots level.	• In progress. The Chief Executive is working with Acute Service Leads to address the recommendations that refer to the findings in paragraph 5.16, 5.17 and 5.18 in relation to the Acute Management structures, governance, professional leadership and staff empowerment. The outcome of this review will be reported to the Sub Committee and thereafter via the Health Board Assurance – Staff Governance and Clinical Governance Committees.	September 2021	
8.	That this review of management arrangements needs to be complemented by a thorough review of Hospital governance arrangements that compliments the Board assurance framework and promotes and assures Safe, Effective and Person Centred Care from ward to Board	• In progress. This will be factored into the review of the Acute Division management arrangements. The Executive Nurse Director is leading a review of 24/7 clinical nurse leadership as part of our ongoing response to Safe Staffing legislation.	October 2021	

N.B.

RAG Status

Green: currently on target to be achieved within the timescales set out in the Improvement Plan

Blue: in place/complete