This response to the consultation is entirely informed by nearly two decades of involvement with NHS Highland, including two terms as a member of the Caithness and Sutherland Community Health Partnership.

The headline in the Press and Journal, Highlands and Islands Edition, on 7th November 2014 was “MSPs Told To Back Off Over NHS Secrecy Row”. In the light of this article, personal direct experience of past and current NHS Highland practice, and lack of opportunities for meaningful participation available to its community, the existing shortcomings require explanation, closer scrutiny and consideration for reform. The issues of leadership, effectiveness, accountability, relations with stakeholders, overall openness and transparency demand and require closer scrutiny. The following discussion will be within this context.

It should be acknowledged that there are examples elsewhere in Scotland where engagement, involvement and participation may be considered to be exceptional in comparison.

Health and social care services were integrated using the lead agency model in Highland in April 2012, prior to the Public Bodies (Joint Working) (Scotland) Act 2014 being enacted and becoming legislation. It is understood that Highland Council and NHS Highland are unique in adopting this model and questions may be asked as to how it is wholly compliant with current legislation. Prior to integration each of the four Community Health Partnerships had provision for up to two “patient” representatives and two representatives from the voluntary sector. No formal structure existed for selection of representatives, but there was an opportunity for a total of 16 people from the community to participate in the governance process. This provision was removed following “integration”.

As a consequence of the integration of health and social care the four CHPs were abolished and replaced by nine “District Partnerships”, which introduced the principle of “meetings held in public, not public meetings” and restricted membership to “strategic stakeholders”. Following the Community Empowerment (Scotland) Act 2015 being drafted onto the Statute Book, the District Partnerships were reconstituted as Community Planning Partnerships. The membership and format remained mostly unchanged, where there remains no opportunity for members of the community to participate in any discussion about how services are designed, developed, procured or delivered. Based on experience participation by members of the community is not encouraged at CPP meetings.

It is unclear how the CPPs articulate with the NHS Highland Board. The NHS Highland web pages show that the following agencies each hold the Chair of two CPPs: Highlands and Islands Enterprise, NHS Highland, Police Scotland, Scottish Fire and Rescue Service, with the remaining CPP chaired by Highland Council. All CPPs report to the Highland Community Care Partnership which lists its membership as Highland Council, NHS Highland, Police Scotland, Scottish Fire and Rescue Service, Highlands and Islands Enterprise, Scottish Natural Heritage, Highland Third Sector Interface, University of the Highlands and Islands, Skills Development Scotland, and Highlife Highland. One important point to make is there is not a single community organisation, or a single Disabled Persons Organisation, able to represent members of the community that is recognised as a member of HCCP. However, Community Planning is described by the Scottish Government as: “... about how public bodies work together and with the local community to plan for, resource and provide or secure the provision of services which...
improve local outcomes in a local authority area, with a view to reducing inequalities.” Membership of HCCP is drawn entirely from service providers without any meaningful participation from the very community it is tasked to provide services for. It should be noted that Highland Third Sector Interface represents the interests of third sector service providers in Highland, not the community across Highland. The problem is accentuated by the Community Partnerships also assuming the role of locality groups, again blurring the objectives of recent legislation.

There is no organisational structure diagram to show (i) the decision-making pathways within NHS Highland and (ii) where or how within that structure individuals, communities of interest, or communities of place can inform the decision-making process. From the scant information made available¹ it is reasonable to suggest there is no formal role for HCCP in the NHS Highland structure and it is consequently not able to represent the needs and outcomes of the community. Limited by its membership, HCCP is currently unable to represent the interests of the wider community and act to deliver a consensus. There is ample evidence to demonstrate that under the lead agency model of delivering health and social care services, no pathway is open for service providers to work with service users to ensure the best possible use is made of scarce resources. The reporting structure to the NHS Highland Board adopted on 25th July 2017 does not include the HCCP or any organisation acting on behalf of the wider community or, more importantly, disabled people. Further there is no indication of any form of public participation, scrutiny or accountability in that structure or in any recent documents relating to the NHS Highland Board.

No aspect of the lack of participation can be better demonstrated than the complete absence of recognition and opportunity for disabled people or their representatives in Highland to inform NHS Highland of services to achieve agreed outcomes. The Scottish National Census 2011 shows that nearly 20% of the population in Highland self-identify as having a disability that affects their lives. Under the lead agency model NHS Highland is tasked to provide health and social care services for adults, yet there is not a single Disabled Persons Organisation that it works with in the design, procurement, delivery, and evaluation of those services. There is a need to question whether NHS Highland simply refuses to recognise the social model of service delivery and the life experience of disabled people.

Reporting to the NHS Highland Board there are 17 “Board” Committees, of which only two have the word “Governance” in the title, and 10 “Professional” Committees². The Health and Social Care Governance Committee is listed in the document as a NHS Highland Board Committee and is understood to have no connection whatsoever with the HCCP. The membership of the “Governance” committees is unclear although a number of the committees have a structure similar to that set out in a report to the Board in March 2012³, which makes provision for “Public/Patient Member Representative X 3”. In practice the representatives are appointed by NHS Highland, in some instances as representatives of Third Sector organisations rather than of either the public or patients. Not all the 17 “Board” committees include Public / Patient Representatives as part of the membership. The role of such representatives is opaque as there is no appropriate public or patient organisation or body to represent or report back to.

As an aside, it should be noted there is a Psychology Advisory Committee. Given the increasing problems and concerns around mental health it is surprising there is no Professional Committee to oversee Mental Health provision and Psychiatry within NHS Highland.

Between September 2015 and January 2016 a review of the governance arrangements of the NHS Highland Board was carried out by Jan Polley, Polley Solutions Ltd. The main findings

¹ NHS Highland Board, 25 July 2017, Item 4.2
² Highland NHS Board 26 September 2017 Item 4.10
³ Highland NHS Board, 21March 2012, Item 3.2
were produced in February 2016 and copies were circulated to Board members but not placed in the public domain. The main findings summarised in a report to the Board were identified as leadership, performance scrutiny role of the board, development of a performance framework, respective roles of non-executive board members and executive board members, remits of the governance committees, and strengthening of the corporate governance support given to the board. Completely missing was any mention of the role the NHS Highland Board has in providing public accountability or providing opportunities for public / patient participation. Further there was no indication of how the NHS Highland Board should articulate with CCPs, HCCP or, through the Integration Joint Management Committee, with Highland Council.

It remains that there is no pathway for a member of the public or a patient to engage with NHS Highland at any level. The committee structure requires clarification and simplification with a pathway that provides for patients and members of the public to engage with NHS Highland in a meaningful way together with appropriate support. Currently the CCPs and HCCP are in existence, without any funding stream from the Scottish Government, Highland Council or NHS Highland. It is uncertain what role the Partnerships have in designing and delivering services in Highland or what influence can be exerted on Highland Council or NHS Highland, despite the two pieces of legislation intended to improve local services and make local democracy more inclusive. The Integrated Joint Management Committee reports to both Highland Council and NHS Highland, without providing a pathway for communities of interest to participate in the way decisions that affect them are made. Agendas and minutes are available on NHS Highland web pages, which is no substitute for direct representation and / or participation.

A number of NHS Scotland trusts set up active public / patient participation forums, of which there are a number of outstanding examples; NHS Highland, however, only established an email address list under the title Highland Health Voices Network. The interaction with NHS Highland was unidirectional, where subscribers were solely intended to be recipients of information released by NHS Highland. At no time was there any engagement, participation or involvement of subscribers in the provision of services. The initiative was not a success, attracting at its peak no more than about 300 subscribers, and was abandoned after less than five years. Locality groups, required by the Public Bodies (Joint Working) (Scotland) Act, which include public representation, have not been established in Highland.

The last remaining opportunity for community engagement with NHS Highland was the existence of eight "improvement groups", each, in theory, intended to improve services for specific sectors. The membership and structure of each group was different, depending on the preferences of the respective Chair. For example, meetings of the Carers' Improvement Group were open to anyone who wished to attend. This was the exception as the usual practice was for meetings to be closed and membership confined to representatives of groups and organisations. Again there was no pathway for service users to either participate or be represented. In a number of instances NHS Highland itself helped to fund organisations represented at meetings. The past tense is used simply because a member of senior management has recently confirmed that "Improvement Groups no longer formally exist" and "task and finish groups are more appropriate to take forward areas of work".

The abandonment of Improvement Groups removes the last vestige of public and / or patient participation within the NHS Highland structure. It is reasonable to suggest that third sector and voluntary organisations do not have any means of engagement, involvement or participation structure for service users or communities of interest. A report to the NHS Highland Board in July 2017 provides a diagram in Appendix 3 showing the reporting structure, from the Improvement Groups at the lowest level through to Highland Council and NHS Highland Board. There is no indication of (i) where the remit for service improvement or for evaluating service

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4 Highland NHS Board, 31 May 2016, Item 4.2
5 NHS Highland Board, 25 July 2017, Item 4.2
provision is located, (ii) where communities of interest, such as disabled people or difficulty-specific groups, are included in the design, development, procurement, delivery and evaluation of service provision. The importance of this cannot be underestimated as NHS Highland is the lead agency for the provision of adult health and social care.

Do you trust NHS Boards to make decisions that are in the best interests of the public?

During the past two decades NHS Highland has slowly removed opportunities for interaction with both patients and the wider public. The current structure and function of the NHS Highland Board, as can be seen from minutes of meetings, is to receive reports from Board Committees and Area Professional Committees. There is no opportunity for public scrutiny or accountability of its actions. When the Chief Executive refuses to meet with a MSP on matters affecting a significant number of constituents there are concerns that decisions are being made that might not be in the best interests of the public. Any input to the NHS Highland Board has to be made through a number of intermediate bodies, any one of which can modulate the original recommendation or block it in its entirety. If the NHS Highland Board is to make decisions that are in the best interests of the public, it has to be, and be seen to be, accountable to the public. At present there is absolutely no mechanism in place to allow this to happen.

Are NHS board decisions open and transparent?

Throughout my two terms as a member of Caithness and Sutherland Community Health Partnership the management held briefing meetings for “lay members” on agenda items prior to the actual meeting, at which time questions were actively discouraged. For decisions of NHS Highland Board to be open and transparent, there has to be a mechanism in place for the public to (i) have an input into the decision-making process, and (ii) to access a pathway to the Board for it to provide substantive reasons for decisions made. There is no mechanism in place at any level for either of these outcomes to be achieved.

How accountable do you feel NHS boards are?

When a publicly funded organisation declines to provide substantive answers to an elected representative and has the audacity to publicly reprimand those representatives by telling them to “back off”, there are problems relating to accountability. In particular NHS Highland has a history of being “economical with the truth” and declining to answer legitimate FoI questions. Current examples can be offered of where senior management have declined to engage with members of the public concerning aspects of service provision and the welfare of vulnerable people. Trust is a two way street car, but currently NHS Highland is demanding the trust of the people it provides services for without any attempt to make provision for being accountable for decisions it makes.

How effective are NHS boards at delivering health services and improving the health of their population?

As set out in the above paragraphs it is not the health services that NHS Highland provides which require consideration, as these will usually be scrutinised by professional bodies. It is the “care at home” and social care services that are of greater concern in maintaining the health of the population. Access to services in remote and rural areas is a problem further potentiated by the increasing lack of appropriate public and patient transport. It appears that NHS Highland is moving slowly towards providing health services in fewer places leading to the concern that the health of its population will not improve, perhaps deteriorate, as access to services becomes increasingly difficult. This is aggravated by the lack of input disabled people have in changes to service provision and the attempts by NHS Highland to restrict the use of SDS packages to
outcomes defined by its management rather than outcomes based on the lived experience of service users.

Recommendations

The prime concern is that the NHS Highland Board is making decisions that affect the health, welfare and day-to-day lives of disabled people without an understanding of the individual impact these decisions may have. The complete lack of any form of public/patient participation structure and demonstrable unwillingness to engage with both public and patients accentuates problems that might arise.

1. The Scottish Parliament is invited to consider establishing the elected post of Health Commissioner for each NHS Board

2. The Scottish Parliament is invited to consider establishing an independent Public/Patient Participation Forum associated with each NHS Board, which has access to NHS Boards and senior management. Whilst funding may come through the respective NHS Board the management of the Forum should be through a management group that is independent of other elected bodies, locality groups and community planning partnerships.

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