

Public Service Reform Committee

Dear Convenor,

I am writing to follow up on my participation in the evidence session held on 17 September. For convenience, the official report for the session can be found at <https://www.parliament.scot/api/sitecore/CustomMedia/OfficialReport?meetingId=20243>.

In response to your question on the institutional and cultural barriers to effective public service reform, I indicated that the Scottish Health Equity Research Unit (SHERU) would write to the committee to provide further evidence.

It is widely recognised that siloed working is a key institutional barrier, both to effective public service delivery and to effective public service reform. In research we have undertaken with public service practitioners, participants repeatedly described problems flowing across organisational boundaries more easily than the resources, authority or accountability needed to respond to them – even when there was universal agreement that collaboration was needed. Housing, health, employability, justice and community organisations often worked with the same people through different eligibility rules, funding arrangements and performance frameworks. Effective collaboration was common, but too often depended on personal relationships and people working around organisational structures.

With respect to cultural barriers, our research indicates that such barriers often operate at a high level. It is not simply that staff working within siloes are too narrowly focused on their own areas, protective of their own resources, or resistant to change. On the contrary, staff often express frustration over the siloed structures within which they are obliged to operate, pointing to the challenges of solving cross-cutting problems while funding, accountability, information and performance are organised through individual organisations and services. Research participants do however mention cultural barriers on behalf of decisionmakers with sufficient oversight to change these structures. This is an example of the disconnect that I mentioned in my opening statement, whereby the ‘implementation intelligence’ of on-the-ground practitioners is not being adequately incorporated into higher-level strategies, policies, and decisions.

In terms of examples of how public service reform could address the sorts of problems that I mentioned in the session, frontline practitioners have indicated that the following actions would have the most impact:

- Develop policy and implementation together. Bring local practitioners, managers, third-sector partners and communities into decisions before commitments, budgets and targets are fixed. Continue that dialogue as delivery exposes problems.
- Provide longer-term, more flexible funding. Give local services enough stability to retain staff, sustain trusted relationships and adapt support to local needs.
- Allow innovation time to develop and learn, rather than relying on successive short pilots. Change what services are rewarded for. Replace multiple siloed targets and excessive reporting with fewer shared outcomes. In employability, recognise progress in health, confidence and stability, alongside sustained work, so providers are not incentivised to favour people closest to employment.
- Make responsibility across services explicit. Strengthen national leadership for prevention across housing, health, employability and justice. Ensure clearer ownership at transitions such as hospital discharge and prison release, where responsibility can otherwise fall between organisations.
- Match expectations with delivery capacity. Assess the cumulative demands of new policies against staffing, resources and existing duties. Support workforce wellbeing, supervision and protected time for coordination and reflection. In housing, address the supply constraints that limit what prevention can achieve & adjust expectations of what is feasible in meantime.
- Make appropriate information sharing easier. Provide practical national guidance, training and leadership on information governance, alongside investment in compatible systems. Staff need confidence about what they can share and less time spent duplicating records.
- Understand people's trajectories and the costs of delayed help. Improve evidence on repeat homelessness, programme re-entry, disengagement and movement across services. Examine cumulative harms and costs across budgets, rather than judging each service through isolated contacts.
- Make young adult men at heightened risk of deaths from alcohol, suicide and drugs a visible prevention priority. Recognise their overlapping housing, health, employment and justice needs; review how policies interact for them; and identify opportunities to intervene before crisis.
- Connect local innovation to national learning. Create sustained opportunities for areas to learn from one another, evaluate promising approaches and feed that learning into national decisions.

- Support the public case for prevention. National leaders should explain its purpose and timescales, and respond when stigma or misinformation obstructs support for vulnerable groups.

I hope that this additional information is useful to the committee.

Sincerely,

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