September 2018

Dear Lewis,

HEALTH AND SPORT COMMITTEE: THE GOVERNANCE OF THE NHS IN SCOTLAND - ENSURING DELIVERY OF THE BEST HEALTHCARE FOR SCOTLAND

I am writing to provide a Scottish Government response to the Health and Sport Committee’s report “The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland” which was published on 2 July.

The Scottish Government welcomes this wide ranging report and its overarching theme around the need for a more open and transparent culture in the NHS, both in respect of staff and patients, particularly where things have gone wrong. I agree that staff should be encouraged and enabled to speak up and the public should be confident that issues and concerns will be investigated, improvements made and lessons learnt.

As our detailed response sets out, we already have a programme of work underway to support a culture within health and social care in Scotland that is open and transparent; one that learns both when things go well and when they go wrong. This includes implementation of our statutory organisational duty of candour and measures to support staff to feel empowered to raise issues and concerns. The Committee’s report highlights the shared political commitment to openness and transparency in Scotland and I am confident that this report will help add pace to this important area of work.

The 3 annexes to this letter set out the detailed response to the recommendations and key points in the Committee’s report under the three main subject areas covered:

- Staff governance - Annex A
- Clinical governance - Annex B
- Corporate governance - Annex C

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew’s House, Regent Road, Edinburgh EH1 3DG
www.gov.scot
I would very much welcome the opportunity to discuss the report and our programme of work with the Committee along with Paul Gray, Director General of Health and Social Care and Chief Executive of the NHS in Scotland and Professor Jason Leitch, the National Clinical Director. My office will be happy to work with the clerks to identify a suitable date.

Best wishes,

JEANE FREEMAN

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot
Committee Recommendation

44. We note the work the Scottish Government is currently undertaking regarding production of a workforce plan. The Scottish Government's plans should enable better local and national workforce planning to support improvements in service delivery and redesign. However, the workforce plans should be more than a broad framework within which to consider future workforce planning issues. We recommend that the Scottish Government ensure its workforce plan assesses the current capacity issues around long-term vacancies and proposes specific steps which can be taken to address them. We recognise that the answer to addressing staff pressures is not always to grow the workforce but further recognition needs to be given to the current staff pressures and steps taken to improve the situation.

45. We also believe that it would be helpful if assessment moved away from determining whether the workforce was growing towards consideration of what size the staff establishment should be to meet demand in different areas and how this compares against current staff levels.

Response to the Committee's Recommendations

Improvements in workforce planning will help bring about better alignment between supply and demand, and develop robust scenario planning models using improved data tools (the NES data platform) to inform more evidence-based workforce planning.

Alongside increasing the workforce, it is also necessary to consider skill mix and the role of multidisciplinary teams.

The National Workforce plan contains a range of recommendations that will improve workforce planning in the short, medium and long term and the actions we are taking include:

- £4 million on recruitment campaigns focusing on GP's, social care, nurses and midwives.
- Building a workforce data platform with NES which will enable datasets to be combined in modelling intelligent workforce planning solutions
- Strengthened guidance for workforce planners - setting out improvements to workforce planning guidance practice we need to make - to be published in December.

To address long term vacancies, we scrapped the pay cap and awarded a new pay deal for non-medical staff of 9% over 3 years, helping our efforts to attract and retain staff.

The £4 million recruitment campaign is one strand of campaign activity, containing three distinct campaigns, with the aim of addressing changes in care from acute to the community and responding to known rising demand in care services. The campaigns aim to increase the attractiveness of roles in nursing and social care, widening access across the nursing profession and assisting with fill rates for pre-
registration nursing courses, while also promoting return to practice. The recruitment activity will also support delivery of the investment to recruit 800 more GP’s over the next decade.

The other strand of recruitment activity will be targeting medical specialities that are under particular pressures, and will have an international focus.

In social care, we are working with COSLA to develop a comprehensive workforce planning approach. This work includes enhancing career pathways within social care and across health and social care, recognising the context of the developing multidisciplinary, integrated workforce environment. Career pathways between social care and qualified social work, nursing and advances health practitioner professions are being developed, which will target young people and labour market returners. We are also developing hybrid health and social care roles at para-professional level. One output from this work is an online resource to highlight possible career pathways and training opportunities in the sector, which will provide information to underpin the marketing campaign activity.

Additionally we are working the COSLA on labour market analysis to inform approaches on targeting potential workforce, taking account or rural and urban needs.

The workforce planning guidance that we will publish in December will encourage all health and social care providers to adopt a comprehensive approach to workforce planning in order to ensure that workforce resources are deployed as efficiently as possible. This will involve staff working at the optimum level to which their qualifications allow, and consequently, the development of a mix of skills levels which promotes maximum workforce utilisation.

We will work closely in 2018/19 with NHS Boards, Integration Joint Boards and Primary and Independent Care providers to develop increased workforce planning capability which will support the aims of the revised guidance.

The introduction of the Health and Care (Staffing) Bill to Parliament will also help to support workforce planning and to address current capacity issues. The Bill’s aim is to help ensure improved outcomes for service users by putting in place a framework to support appropriate staffing for high quality care. The Bill will support the wider adoption of professionally led evidence-based approaches to workload planning that have been successful for nursing and midwifery across health and social care. Staffing tools and methodologies developed in this way will support local decision-making, flexibility and the ability to redesign and innovate in other health and care settings.

### Committee Recommendation

62. We heard of good practice examples of management being encouraged to engage with frontline staff in NHS boards. It is important this is encouraged and the time and opportunity provided to facilitate this. We ask the Scottish Government what barriers it believes prevent this approach from being adopted across all NHS boards and what steps are being taken by NHS boards to address this.

### Response to the Committee’s Recommendation
Barriers to effective engagement with staff can include the complexity and pace of change and the capacity for staff to be involved. It is imperative though to involve staff early in any issues that may affect them and throughout the decision-making process. Local Board staffside and management partnership forums have a key role in representing staff views and ensuring staff voices are heard and local communication processes are effective.

We agree that direct engagement with staff is critical and we need to adopt good practice where we find it. We have transformed our approach to staff experience through iMatter, which has become the most engaging and inclusive staff experience measurement ever run across NHS Scotland, with 108,230 respondents from 22 Health Boards and 23 HSCPs and a response rate of 63%. Our current staff experience and staff governance monitoring processes allow us to assess local and national progress on staff engagement and staff governance and identify good practice nationally – but we need to be assured they are delivering consistent and sustained improvement across NHS Scotland. That is why we are actively reviewing our approaches to ensure we are achieving the best outcomes local and nationally.

We are evaluating our approach to staff experience (Strathclyde University Academic evaluation – report due June 2019, staff governance monitoring (new approach being developed and is expected to be agreed in partnership by end November 2018), partnership working, including reviewing local arrangements (Strathclyde University Research – report due October 2018). We would be happy to keep the Committee updated on these important pieces of work.

**Committee Recommendation**

63. Bullying, discrimination and harassment in the workplace are unacceptable. NHS staff must feel confident to raise concerns regarding colleagues’ behaviour and treatment towards them. It is concerning that of those who experience these issues only a minority feel confident to raise them. We believe further steps need to be taken to increase confidence in the response individuals expect to receive when raising concerns. We ask the Scottish Government what steps it is taking alongside NHS boards to increase staff confidence to report bullying, discrimination and harassment.

**Response to the Committee Recommendation**

The Dignity at Work Survey (March 2018) clearly showed this was a cultural issue. For example while 85% of staff reported they did not experience bullying and harassment from colleagues it must be recognised that 15% of staff highlighted they have experienced this, and more needs to be done.

Each year the Scottish Government undertakes a Staff Governance Monitoring exercise where we seek assurance from Boards that they are complying with the Staff Governance Standard. In this exercise Boards are asked to provide evidence on a range of subjects, including for example whistleblowing levels and support, and actions taken to promote and support equality and diversity. When the information is provided to the Scottish Government it is assessed and Boards are then asked for follow up information if this is felt necessary. This year we will ask Boards in our feedback letters to follow up on the Committee’s recommendation by asking what mechanisms are in place to support the reporting of bullying and harassment, and these letters will be issued to Boards by the end of September. On receipt of the responses we will consider how we can best support Boards to, if necessary, strengthen their current arrangements.
At a national level our focus is on introducing legislation in the autumn to establish an Independent National Whistleblowing Officer for NHS Scotland to go live by end September 2019. This will provide an external review where a member of staff feels they have been bullied or harassed after raising whistleblowing concerns. We are clear that the INWO will have the ability to provide independent challenge and oversight with the statutory powers it needs to make a real difference and the power to access any relevant information needed to reach a view on a case and lay reports in parliament. The role includes reviewing the application of local process, decision making, and the outcome. This also includes whether the whistleblower has been treated in line with whistleblowing standards the SPSO intends to set and the organisational culture.

The INWO will also have a national leadership role, providing direction, support and guidance to the relevant bodies with the focus on continuous improvement, early resolution, recording and reporting.

We have also committed to reviewing the bullying and harassment workforce policy, and this has been prioritised in the first tranche of policies to be reviewed on a ‘Once for Scotland’ basis, by the end of February 2019.

Committee Recommendation

117. Whilst there has been an increase in NHS staff feeling confident to speak up, there is still over a third of staff who feel unwilling to do so. We believe this issue must be addressed. Ultimately there needs to be a culture of openness and transparency. There must also be mechanisms in place for staff to raise concerns in an environment where the support and guidance offered to NHS staff is both valued and trusted.

Response to the Committee Recommendation

We agree more needs to be done to promote an open and transparent culture.

Significant progress has been made but we agree that more should be done to encourage staff to speak up and reassure staff that concerns will be listened to and acted upon. Evidence shows the majority of staff feel it is safe to speak up and raise concerns. The latest (November 2017) Dignity at Work Survey show 65 per cent of staff feel it is safe to speak up and raise concerns up by almost 10 percentage points on the last survey in 2015. Only 19% of staff disagreed (less than 1/5th) of respondents.

We are leading this at national level in conjunction with the SPSO, by introducing whistleblowing standards, including challenging timeframes which the new independent whistleblowing Officer will use to hold Boards to account as the final, external stage scrutiny of whistleblowing concerns.

This will provide an external review where a member of staff feels they have been bullied or harassed after raising whistleblowing concerns. We are clear that the INWO will have the ability to provide independent challenge and oversight with the statutory powers it needs to make a real difference and the power to access any relevant information needed to reach a view on a case and lay reports in parliament. The role includes reviewing the application of local process, decision making, and the outcome. This also includes whether the whistleblower has
been treated in line with whistleblowing standards the SPSO intends to set and the organisational culture.

The INWO will also have a national leadership role, providing direction, support and guidance to the relevant bodies with the focus on continuous improvement, early resolution, recording and reporting.

Legislation is being introduced in the autumn alongside a consultation on the new whistleblowing standards – with this work being led by the SPSO to ensure independence and impartiality. This builds on our earlier stakeholder events and will provide space for the Committee to input into the proposed approach. The INWO will be operational from September 2019.

Our policies are already clear that the unfair treatment of staff is a disciplinary matter. We have also committed to reviewing the whistleblowing workforce policy, and this has been prioritised in the first tranche of policies to be reviewed on a ‘Once for Scotland’ basis, by the end of February 2019.

Committee Recommendation
118. We welcome the acknowledgement by the Scottish Government that changes need to be made to support individuals to feel more confident to raise concerns. We welcome the recent introduction of the Duty of Candour and the forthcoming creation of the post of Independent National Whistleblowing Officer (INWO). We believe these measures have the potential to make valuable contributions to achieving a cultural change in how the NHS in Scotland treats whistleblowing. We ask the Scottish Government to provide further information on how it will monitor and assess the implementation and impact of these new policies and what difference it expects them to deliver. In particular we expect to see a significant improvement in the percentage of staff feeling ‘confident to speak out’ and ask the Scottish Government what level it expects to see in the 2018 Staff Experience Report as a result of these changes.

Response to the Committee Recommendation
We welcome the Committee’s constructive comments on the Duty of Candour and the INWO.

Organisations must now publish annual reports on containing incidents that have activated the Duty of Candour procedure. This further layer of transparency will help inform understanding and assess the impact of this new policy.

We expect the creation of the INWO role and standards to drive improvements. The intention is for the INWO to support and improve the response of the relevant body when handling concerns raised by staff, including a duty to record and report all whistleblowing cases in a standardised way. The new Whistleblowing Procedure currently being developed for this purpose will provide a simple, time bound and streamlined process for resolving whistleblowing concerns early and locally by capable, well-trained staff.

Work is also underway to create a single standardised whistleblowing policy that is user friendly and puts staff and managers at the centre. This will result in a more consistent approach from Health Boards than under the current arrangements.
We anticipate that the INWO will also have a duty to report on its investigations and share a copy of the report with the Scottish Ministers and Parliament. This will allow us to assess the impact of this new role.

We have transformed our approach to staff experience through iMatter, which has become the most engaging and inclusive staff experience measurement ever run across NHS Scotland, with 108,230 respondents from 22 Health Boards and 23 HSCPs and a response rate of 63%.

In contrast to iMatter, the response rate to Dignity at Work (DaW) Survey remained stubbornly low (36%) and similar to previous national staff surveys. This suggests that staff are not engaging with this approach and we need to find a better way to engage with staff on the issues covered. We have recently commissioned Strathclyde University to evaluate our approach to measuring staff experience with a final report in June 2019, this will give us expert advice on how we can improve our levels of engagement on these issues. Whilst the DaW survey will not run in 2018, we expect Boards to use the time to take action on the results of the previous survey and for the evaluation to give us recommendations on how we can better monitor and take action on these important issues.

**Committee Recommendation**

119. We recommend that the Scottish Government introduce an investigative line for whistleblowing. We believe that an investigative line would work well in conjunction with the new role of Independent National Whistleblowing Officer in providing external oversight and support to the whistleblowing system.

**Response to the Committee Recommendation**

Working with the Scottish Public Services Ombudsman we are already introducing whistleblowing standards set independently that will be used to hold Health Boards to account.

An investigative line may be the correct solution for other employers where it is the main form of external scrutiny. However for NHS Scotland, Whistleblowers will have the opportunity to raise their concerns externally through the Independent National Whistleblowing Officer (INWO) with this function held by the Scottish Public Services Ombudsman. The potential exclusion of Health Boards from whistleblowing investigations at the first stage could complicate and extend any investigative process.

It is right that Boards, as employers have the responsibility to initially respond to a concern and this is key in improving local culture but where a whistleblower remains concerned they will be able to raise the issue with the INWO. This process is also supported by advice from the independent Whistleblowing Alert and Advice line service funded by the Scottish Government.

In our view external scrutiny is more appropriate at this second stage than at stage one through an investigative line, this helps promote a culture where the majority of concerns can be raised and resolved locally, promoting continuous improvement.
120. We recommend that the Scottish Government allow NHS boards to appoint individuals other than non-executive board directors to the role of Whistleblowing Champion. We also recommend there is staff involvement in the appointment process. A mixture of non-executive board members and non-board members which staff have been involved in appointing may assist in instilling confidence in the system. It will also enable a comparison to be made between the two different types of Whistleblowing Champion to determine if there is any difference in outcome depending on who is in the role.

Response to the Committee Recommendation

We support the Committee’s view that the role of Non-Executive whistleblowing champion has added value in improving oversight and governance. Staff need to have the confidence to raise concerns locally and Health Boards need to ensure the right people are in place to respond to concerns with the right skills and training, recognising that the non-executive role is around governance rather than a contact point for staff in live whistleblowing cases.

We are leading on improving culture and processes at a national level in conjunction with the SPSO, by introducing whistleblowing standards, including challenging timeframes which the new independent whistleblowing Officer will use to hold Boards to account as the final, external stage scrutiny of whistleblowing concerns.

This will provide an external review where a member of staff feels they have been bullied or harassed after raising whistleblowing concerns. We are clear that the INWO will have the ability to provide independent challenge and oversight with the statutory powers it needs to make a real difference and the power to access any relevant information needed to reach a view on a case and lay reports in parliament. The role includes reviewing the application of local process, decision making, and the outcome. This also includes whether the whistleblower has been treated in line with whistleblowing standards the SPSO intends to set and the organisational culture.

The INWO will also have a national leadership role, providing direction, support and guidance to the relevant bodies with the focus on continuous improvement, early resolution, recording and reporting.

Legislation is being introduced in the autumn alongside a consultation on the new whistleblowing standards – with this work being led by the SPSO to ensure independence and impartiality. This builds on our earlier stakeholder events and will provide space for the Committee to input into the proposed approach. The INWO will be operational from September 2019.

We will be writing to Boards to ask them to prioritise preparedness for the new whistleblowing policy, standards, and the introduction of the Independent National Whistleblowing Officer.

We will ask them to consider the Committee’s comments recognising this will be a decision for Boards to make within the context of their review of local policy support, training and governance arrangements.

Committee Recommendation

121. We believe the new INWO will have a key role to play in ensuring whistleblowers are treated fairly. We ask the Scottish Government
what avenues for redress will be open to the INWO if they establish that an individual has been treated unfairly as a result of raising concerns. We also ask the Scottish Government what sanctions it believes would be appropriate to impose on individual NHS employees who mistreat whistleblowers. We are keen to ensure that the NHS in Scotland encourages and supports whistleblowers and when faced with unfair treatment there should be a clear line of recourse and redress.

**Response to the Committee Recommendation**

Employment tribunals already provide redress where a whistleblower has suffered detriment as a result of whistleblowing. This is a reserved function, and the Scottish Parliament does not have legislative competence in this area.

We are clear that the INWO should have the ability to provide independent challenge and oversight with the statutory powers it needs to make a real difference. The intended powers which will be subject to parliamentary scrutiny through the legislative process - will give the INWO the power to access any relevant information needed to reach a view on a case, make recommendations and lay reports in parliament.

The INWO will provide an effective mechanism for external review where individual staff members have a concern about how a health body providing services on behalf of the NHS has handled their case. This includes the application of local process, decision making, and the outcome to provide closure for the individual. This also includes whether the whistleblower has been treated in line with whistleblowing standards and the organisational culture. The INWO will also have a national leadership role in setting standards, providing direction, support and guidance to Health Boards/relevant bodies with a focus on continuous improvement, early resolution, and good practice and reporting.

The intention is to bring whistleblowing cases to a clear, fair and final conclusion in a reasonable timeframe. Our policies are already clear that the unfair treatment of staff is a disciplinary matter.

**Committee Recommendations**

132. We recommend the Scottish Government undertake a review of the case for regulation of NHS management to determine the merits, steps and requirements that would be needed to deliver this change.

**Response to the Committee Recommendation**

NHS managers are required to make decisions which often have far-reaching and occasionally tragic consequences. We agree that they should be subject to professional accountability for their decisions and actions, and work is underway to identify suitable and proportionate mechanisms through which this might be best achieved.

**Committee Recommendation**

137. We are pleased to learn that the NHS staff governance principles are gradually being adopted across a number of Integration Authorities. Integration Authorities are now into their third year of operation and we believe there is merit in ensuring these principles are embedded across all Integration Authorities. If the integration of services across health and social care is to be achieved there must be
consistency in the values and treatment of staff across both the health and social care sectors to ensure there is a collegiate and united approach. We expect parity of treatment for all staff and that creating a single Staff Governance Standard across health and social care would greatly assist in meeting this objective. We ask the Scottish Government to work with local authorities, NHS boards, trade unions and Integration Authorities to establish such a standard and to focus on how its delivery would assist in meeting the wider aim of integration of health and social care services.

**Response to the Committee Recommendation**

We welcome the positive comments from the Committee regarding the NHS Scotland approach to staff governance, and agree there is a need for fair and consistent treatment, though recognise that integration brings together different cultures, systems and approaches that have developed locally. Integration authorities are not employers and local authorities and the NHS have very different approaches to staff governance and how it is monitored. A single approach is not an end in itself and the focus should be on improved outcomes regardless of the system that provides them.

I share concerns expressed by COSLA on the apparent lack of engagement from the Committee with local government and the third and independent sectors in forming this recommendation.

I have asked my officials to engage with stakeholders to gather views on the Committee’s recommendation, including any opportunities and challenges. This will provide a basis for a fuller consideration of any work required at local or national levels.

**Committee Recommendations**

145. The response rates for both the iMatter questionnaire and the Dignity at Work Survey vary significantly between different boards and NHS organisations. We therefore question how accurate a picture the Staff Experience Report is able to provide of the staff experience across the whole of the NHS in Scotland. We ask the Scottish Government to detail its explanation for this variation in response rates and the steps it proposes to take, alongside health boards, to improve participation where engagement is currently low. We also ask the Scottish Government to detail what response rate it hopes to achieve in the next annual report of iMatter.

146. Given the increased engagement achieved through the iMatter approach, the Committee recommends that the Scottish Government examines whether these Dignity at Work issues should be included within the scope of the iMatter questionnaire. There should be a high level of engagement by staff across all issues relevant to staff governance.

164. The Staff Experience Report provides a useful tool for measuring performance against the staff governance standard. We also believe that it should be used as a tool to drive improvements in performance. To facilitate this approach we recommend that within three months of the publication of the annual Staff Experience Report, the Scottish Government should publish an action plan for areas for improvement. This should detail the steps the Scottish Government proposes to take, and which it expects specific NHS boards to take, to deliver improvements. We also recommend that the Scottish Government should make it clear what level of improvement in performance against the staff governance standard it expects in each individual board with minimum levels for improvement set and explanations provided for variance with high performing areas.

165. There is currently a huge variation across NHS boards in the extent to which iMatter action plans are being completed. We ask the
Scottish Government to explain the reasons for this variation and detail what steps it is taking to increase the usage of action plans by NHS boards who are currently performing poorly. We also ask the Scottish Government to detail what percentage share of action plans completed it would expect each NHS board to achieve in 2018.

166. iMatter assessment is conducted at a team level. This provides an opportunity to drill down to a departmental and clinical specialist level to identify areas of good practice and areas for improvement. We believe that this information should be used to assess whether there are any common trends being experienced by the same types of NHS staff or in the same clinical areas across NHS boards. We ask the Scottish Government in the next Staff Experience Report to provide an analysis which looks at trends across staff groups or clinical specialisms as well as by NHS board.

Response to the Committee Recommendations

Response rates for iMatter varied between 52% to 85%, with a national average of 63%. Even the lowest level of participation in that range still represents the majority of staff within that Board. A national average of 63% provides a very good picture of staff experience and is nearly double the level of response from earlier national surveys. There are a number of reasons why response rates may vary, including potential for survey fatigue (when combined with other local or national surveys), local approaches to disseminating and promoting surveys and also, most importantly, staff perceptions on how feedback in earlier surveys have been taken account of, and actioned.

Response rates for the Dignity at Work Survey varied between 21% and 73%, with a national average of 36%. The average percentage demonstrates that staff are not engaged with the survey and we need to find a better way to engage with staff on the issues that it covered.

In light of the stubbornly low levels of participation in the DaW survey the Scottish Government agreed with the recommendation of the Scottish Workforce and Staff Governance Committee to not run the survey in 2018 (iMatter will report in early 2019) and in the meantime the iMatter model, which has been hugely successful, will continue to provide our core measure of staff experience. We have commissioned an external evaluation of our approach to measuring staff experience by Strathclyde University that will report in June 2019. This will allow us to consider any required changes to our future approach.
### Committee Recommendations - CPD Allowances

210. - We recommend the Scottish Government conduct a review of NHS board performance on the implementation of the allowance for CPD as set out in the Scottish Government's workforce planning tools. It is important that NHS boards are ensuring that nursing and midwifery staff are able to access the time they are entitled to for CPD.

211.- We recommend the Scottish Government place statutory requirements on boards to ensure delivery of appropriate CPD time for all NHS staff.

### Response to the Committee’s Recommendations

Nursing and midwifery absence allowance is being reviewed as part of the Health and Care (Staffing) (Scotland) Bill.

The 2% predictable absence allowance for CPD equates to 33 hours per whole time equivalent member of staff. Application of this allocation is not currently monitored. A review of this allowance, will report in December 2018, and includes consideration of requirements for registered and non-registered staff and the impact of full and part time working on allowance required for CPD. As part of the legislation, Boards will be required to apply the CPD allowance, this will be fully described in the Ministerial Guidance that will support the application of the legislative requirements. The implementation will be complete with the commencement of the bill by the end of 2019.

Excellence in Care, will also include measures relating to workforce, one of which will be monitoring of predictable absence allowance, including CPD. This will be monitored at ward/team, hospital/locality and NHS Board level across NHS Scotland. Where improvement support is required this will be provided by Excellence in Care leads and by Nursing and Midwifery Workload Workforce Planning Programme advisors. Testing of data collection is currently ongoing and expected to be completed by November 2018. The measures will then be available on the EIC Care Assurance Information Resource (CAIR) by end December 2018. Excellence in Care workforce measures are expected to be on CAIR dashboard by March 2019 which will provide baseline information and improvement support provided to work towards CPD allocation by commencement of the bill.

### Committee Recommendations - The Role of HIS

214. - We seek assurances the inspection regime for the new standards will include ensuring the views of service users are sought. We also believe inspections must assess not only where issues lie with regards to performance against standards but also seek to identify the reasons for poor performance and assess whether there are systematic issues faced across NHS boards which need to be addressed.

216. - We recommend the Scottish Government should undertake a fundamental review of HIS’s function with a view to implementing a more systematic and coherent approach to its work. We believe there is merit in consideration being given to HIS having a broader look at how standards and guidelines are delivered and how well they are designed for the purposes they are seeking to address. We believe this would also assist in enhancing its roles as an improvement body. Its reporting on standards and guidelines would provide a benchmark for performance and encourage adequate implementation. We also believe consideration should be given to HIS being given greater enforcement powers in this role.
We consider this enhanced role for HIS would also allow it to assist in streamlining guidance and standards where required and help with dissemination. This might address concerns regarding the wide range of standards and guidelines which currently exist and the concerns which have been raised regarding variation in care provided.

(NB - recommendations 298 to 300 are also relevant here)

298. - In relation to SAEs HIS becomes involved at the request of the Scottish Government. We consider HIS’s role should be more proactive including a greater surveillance function to help identify and preferably prevent systemic failures at an earlier stage.

299. - There should therefore be a review of the role of HIS with the principal aim of ensuring its scrutiny function is as effective as possible. We recommend a review should include the areas we have highlighted earlier including consideration of a greater role for HIS in relation to the monitoring and delivery of clinical standards and guidelines. We also recommend HIS be tasked to make further improvements to the current operation of the SAEs national framework.

300. - A central part of this review should therefore be to give consideration to the advantages and disadvantages of making the scrutiny and assurance directorate of HIS a separate entity.

Response to the Committee’s Recommendations

The Scottish Government does not view a fundamental review as necessary, however we agree with the thrust of recommendation 298 and will work with HIS to strengthen their role.

HIS was established by the Public Service Reform Scotland Act 2010 as a health body. It is not a special health board. The deliberate policy decision to put evidence, improvement, scrutiny and public participation in the same organisation was taken to promote the use of improvement and evidence to support the scrutiny process and to identify, develop and implement continuous quality improvement rather than focus solely on compliance against minimum standards.

Furthermore we have encouraged HIS to work closely with health boards to develop a supportive environment for scrutiny. This approach has been endorsed by the Kings Fund.

‘Closer to home, the NHS in Scotland is pursuing a health care quality strategy supported by Healthcare Improvement Scotland. It seeks to do so through various means including inspection but also by developing evidence-based guidelines and standards, working with frontline clinical staff, empowering patients and the public, and developing and sustaining networks that facilitate the sharing of improvement expertise. An early priority should be for leaders in England to study work going on in Scotland and to learn from it’.

We continue to believe this is the right strategic approach to scrutiny and improvement. However we recognise the concerns set out in the committee report about a potential blurring of roles and a perception of “marking their own homework”. We can confirm that HIS have the same legal status and largely the same range of scrutiny and inspection powers as the Care Quality Commission (CQC) (and Welsh and Northern Irish counterparts).

The HIS Quality of Care Approach and Quality Framework will be used to assess care provision and specifically includes seeking the views of service users and their families, amongst others. The Quality of Care Framework approach is based on regular open and honest organisational
self-evaluation combined with other data and intelligence to form the basis of improvement-focused scrutiny, including inspections when required. As part of the approach, external scrutiny will consider relevant service-specific standards or indicators as well as aligning with the Health and Social Care Standards. The report of the pilot Quality of Care review in NHS Orkney was published on 23 August. During 2018-19 HIS will undertake 4 board-level Quality of Care reviews. This will be supported by an awareness-raising programme for service stakeholders.

To increase the understanding and clarity of HIS’ operational independence in relation to scrutiny and inspection clear we will develop a formal statement of the principles by which HIS should operate, underpinned by a revised operating framework to be agreed by December 2018.

We also propose, by December 2018 to:
- agree a new unified escalation procedure for HIS which is clear about sanctions that are available
- review legislation to establish areas where additional powers could be helpful. This would include wider powers relating to access to information and the introduction of improvement notices as an additional step in the escalation process
- seek advice from SGLD as to whether the broad powers that HIS already have are sufficient for what is proposed in terms of escalation and enforcement or whether more are needed.

Response to the Committee’s Recommendation – Feedback Mechanisms

238.- We recommend that the Scottish Government asks the national Datix user group to determine if the concerns expressed to the Committee [lack of a function to provide feedback to staff on what action has been taken with regard to the incidents recorded] are widespread and, if so, what further steps need be taken to improve the provision of feedback through the Datix system.

Response to the Committee’s Recommendation

We agree that the Datix user group should examine these concerns. With regard to the Committee’s specific comments regarding the feedback facility on Datix which is not currently used by all Boards, we will instruct Boards that they should all use the feedback facility and that this information should be made available to HIS and Scottish Government for national analysis and learning.

It is worth noting that any work on openness and learning has to look beyond specific formal systems to how these are used by people to learn and improve services, experiences and outcomes (including for staff). The first step is to identify how systems such as Datix, duty of candour, adverse events or complaints etc. are currently supporting the overall aim of openness and learning; how their effectiveness could be further enhanced; and what else needs to change to deliver the vision of a culture of openness and learning. This work is being taken forward by the Scottish Government in conjunction with stakeholders.
Committee Recommendation – Complaints Management

241. - We recommend that at an NHS board level an individual within its complaints management team is tasked to lead on driving these improvements [disconnect between patient making the complaint and the clinician; complaints dealt with promptly and effectively and where appropriate resolved at a local level] learning from complaints.]

Response to the Committee’s Recommendation

We are supportive of the Committee’s view that learning from mistakes and near misses are key to creating a culture of improvement and are taking action to foster that culture.

The first annual reports under the new standardised NHS Complaints Handling Process, which was introduced in April 2017 have now been submitted. The new process was designed to address many of the issues which were also identified by the Committee. An initial analysis of the first reports shows that around 45% of complaints are resolved satisfactorily at the early resolution stage – within 5 days of a complaint being made as opposed to 28% before the new procedure was introduced. A thorough analysis of the complaints reports will be undertaken in the autumn and any learning from that will be shared. Priorities for continuous improvement in complaint handling will be identified.

The Duty of Candour Regulations, which came into force on 1 April 2018, with a focus on personal contact with those affected, support, a process of review and action that is meaningful and informed by the principles of learning and continuous improvement. The first duty of candour reports will be published as soon as practicable after the end of the financial year 2018-19.

We agree that the Clinical Governance Committees of the Boards should consider not only complaints, but also other reporting systems such as Serious Adverse Events and Duty of Candour to identify improvement priorities with open and learning approach which looks beyond specific formal systems to people’s experiences and outcomes (including for staff).

Committee Recommendations - Adverse Events

278. - Steps must be taken to ensure that the procedures for recording SAEs are working as effectively and consistently as they can.
279. - We believe this [establishment of common procedures for investigating SAEs] will help promote consistency and transparency in the system for dealing with SAEs. We recommend that Healthcare Improvement Scotland should be tasked with bringing forward these changes in order to improve the operation of the current system.
280. - We also believe that centralised reporting of SAEs should be introduced.
282. - We therefore recommend that consideration is given to moving to a quarterly reporting requirement for the duty of candour, including SAEs.
We believe this increased level of reporting would assist in identifying any common issues across NHS boards and help facilitate a timely response which addresses these issues.

Response to the Committee’s Recommendations

The Scottish Government is aware that at this time there are different approaches to adverse events. At one extreme all SAER are reviewed locally with no central reporting, and at the other there is mandatory national reporting. We believe that neither works effectively and that there needs to be a balanced approach that seeks to empower staff to learn when things go wrong, whilst still allowing for learning and accountability at national level. There must be consistency of approach across NHS Boards as regards to category one adverse events and Boards in different parts of the country should not be ‘doing their own thing’.

We have been successful in reducing Clostridium difficile Infection (CDI) in Scotland by adopting this approach. The surveillance of CDI in Scotland is set up to obtain accurate baseline infection data, monitor trends and identify new emerging strains in the healthcare setting. Since the beginning of 2007 there has been a 95 per cent reduction in cases of MRSA and a 87 per cent reduction in cases of CDI in patients over 65 years. The Adverse Events Framework seeks to achieve similar outcomes through adverse event reporting, but it is recognised that in order to do so there is still a need for HIS to be able to assure and demonstrate national consistency. The Scottish Government believes that HIS needs to become more proactive in its surveillance to help identify and preferably prevent systemic failures at an earlier stage. There is a need to harness best practice in collecting meaningful data and to identify and share learning from governance structures that have a proven track record in harm prevention through early intervention.

We are considering the introduction of a standardised national Adverse Event reporting process, covering a small number of specific “harms” (including maternity; mental health; social care - integration; and primary care) and linked to Duty of Candour Procedure reporting. This would be used to provide a national picture on a number of identified harms. The list could change periodically based on intelligence that identify trends and national learning. This will preserve the important local ownership of reporting and review while providing an explicit national transparent oversight of a common set of information. We propose that the Hospital Standardised Mortality Ratios committee in HIS should extend their remit to cover this process and reporting should be shared with the Sharing Intelligence group that HIS co-chairs. The reporting will also be integral to Quality of Care Reviews and to the Annual Review process for NHS Boards.

HIS has agreed to carry out a 90 day review of its role in the Adverse Events process as soon as possible. However for this to be effective, the review needs to establish a reporting baseline and look further than the National Adverse Events Framework, which was recently updated to reflect the Duty of Candour Procedure, and must consider past failings and where a more hands-on approach by HIS, as set out above, could prevent AEs and strengthen the AE reporting system, both locally and nationally. We expect the review to be completed and its findings to be implemented by HIS by 31 March 2019.
### Committee Recommendations - Accountability

330. While we understand the constraints boards now face in setting the strategic direction - particularly since the creation of IJBs - we feel that this is as intended and therefore not a matter of concern in and of itself. However, we do have sympathy that there has not been the commensurate shift in accountability and NHS boards are still being held to account for strategy set by others. The Committee would like to see a strengthening of the accountability mechanisms for IJBs and regional planning boards.

427. The lines of accountability for IJBs and regional boards are not always clear. For example, there is confusion regarding where responsibility as well as accountability for delivery of some services lies. We recommend immediate attention is given to Audit Scotland’s call for the Health and Social Care Delivery Plan to simplify and make clear the lines of accountability and decision-making between the Health and Social Care Delivery Plan Programme Board and major work programme delivery oversight groups, regional boards, NHS boards and Integration Authorities.

### Response to the Committee’s Recommendations

Our review of progress with integration will consider good practice and any challenges with governance and accountability arrangements and will report in the new year.

### Committee Recommendation - Targets and Indicators

333. We received evidence which described NHS boards as balancing the triangle of quality of care, performance targets and resources. We believe the approach by NHS boards does not need to be a triangle if targets are aligned with quality of care and outcomes. We request an update from the Scottish Government on the actions it is taking following the Targets and Indicators in Health and Social Care in Scotland review by Sir Harry Burns.

### Response to the Committee Recommendation

It is important that NHS Boards balance, and optimise, quality, performance and resource use. Sir Harry’s review provides us with a useful starting point for a longer-term conversation about delivering improvement through changes in behaviours and services, and balancing the opportunities of local empowerment with consistent adoption of good practice.
Committee Recommendations - Non-Executive Directors

364. We ask the Scottish Government what steps it will take to ensure executive directors understand and respect the key role of non-executive members in delivering a challenge function.
365. We believe the complexity of the non-executive board member post, the time commitment and the volume of paperwork all suggest that some board members may not be able to focus primarily on their strategic overview role. We are concerned that board members' involvement in operational issues may be at the cost of providing these core strategic functions. In our ongoing work with Health Boards we will pursue this issue but also look to the Scottish Government to advise what steps it will take to support non-executive directors.

Response to the Committee’s Recommendations

Non-Executive Directors are essential to the effective operation of all our health boards. They bring a huge range of skills and experience to their role and are responsible for not only the strategic vision for their board but also the delivery of the vital challenge function around the board table. It is essential, therefore, that all Board members should be clear about their roles, responsibilities and accountabilities – whether they be executives, non-executives or stakeholder members. Health Boards are unique in bringing together these cohorts together around the table, with each individual having an equal input to discussions and all, no matter their background, being accountable for the work of the Board. The roles of Board members are clearly outlined in ‘On Board’ which is given to all newly appointed members. We also work very closely with Boards and the Commissioner for Ethical Standards in Public Life Scotland to ensure that when non-executive positions are advertised, applicants are made fully aware of the role within the Board.

We are committed to ensuring that non-executive members are supported to be effective in their roles. We already have developed a wide range of learning and development resources, from helpful booklets on key board issues through to national workshops and mentoring and coaching. We will continue to build on these resources but we also recognize the need to respect that non-executive members are not full time and so training and development opportunities need to be flexible to suit their needs. The work on reviewing NHS corporate governance that has been carried out by John Brown and Susan Walsh will also enable us to pursue the adoption of good practice in corporate governance across all boards, further supporting non-executives in their key role.

Committee Recommendations - Membership of Health Boards

363. We welcome the comments from the Cabinet Secretary for Health and Sport regarding moving beyond a traditional competency-based approach to recruitment. We ask what assessment the Scottish Government will conduct to determine if this change in approach is leading to more diversity in board appointments.
364. While we agree that it would be impossible to represent every interest around the board table, the current way in which boards recruit, operate and remunerate non-executive members, limits opportunities for certain demographic groups to get involved. The Committee strongly recommends that the Scottish Government's review of corporate governance looks for ways to modernise the foundations of boards and how they operate in order to better reflect the populations that they serve while taking advantage of the knowledge and skills of a broader range of people.
One other aspect of board diversity that was raised was the call made for the lack of representation of allied health professional directors on territorial or special health boards to be addressed. Given the key role that AHPs increasingly play in integrating health and social care, we are surprised at this lack of overall representation and mechanisms for their involvement and ask the Scottish Government how this can be addressed.

Response to the Committee’s Recommendations

We are committed to ensuring that our Boards are representative of the communities they serve. We are proud of the progress made on gender balance but we are not complacent and continue to look at what more can be done.

We continue to work closely with the Commissioner for Ethical Standards in Public Life to develop new and alternative methods for attracting a diverse range of applicants for non-executive appointments and will put measures in place to evaluate the impact of the change to a values based approach to appointments. We also continue to support the Commissioner in developing work around the impact that diversity has on the effectiveness of boards of public bodies. In taking forward the work to increase diversity, we will link this closely to the review of NHS corporate governance carried out by John Brown and Susan Walsh.

There is a need for NHS Boards to be agile and responsive to change and their ‘make-up’ should also be under continuous review. There are absolutely no plans to merge our current health boards but we recognize that the environment in which health and care services are delivered in has changed significantly over the last few years with the introduction of integration and new ways of delivering services being developed. We are, however, mindful that representation on Boards doesn’t always have to be through Board Membership, but through increased representation on committees of Boards and improvements in stakeholder engagement.

Committee Recommendation – Public Involvement

396. We recognise there is a role to be undertaken in overseeing how well NHS boards consult with the public and how boards support the public to get involved in their work. Equally the role should encompass the work of the integrated boards and regionalisation proposals where these are distinct. This role is currently allocated to the Scottish Health Council (itself part of a Board) in whom we have no confidence and we recommend this function is reallocated to a fully independent body.

Response to the Committee Recommendation

We agree with the Committee that public and staff confidence in NHS Boards is critical, and that Boards must move to a relationship with those who use their services and the wider public that goes beyond informing and consulting to encompass genuine collaboration and coproduction in service delivery, particularly where there are proposals for service change.

The central functions of the SHC as set out in legislation are to support, ensure and monitor NHS Boards in the discharge of their duty to encourage public involvement in decisions relating to the planning, development and delivery of healthcare services. We recognise that this needs to include an increased focus on building capacity within NHS Boards to elicit, hear and respond to feedback. Other organisations such as the Health and Social Care Alliance Scotland (who are partners in the delivery of Our Voice) are funded to support people and groups to engage with health and care.
Rather than set up a separate organisation our preference is to build capability and capacity within SHC, drawing on the wider resources of HIS (including improvement support), to deliver this role. As part of this HIS are in the process of appointing a new Director of Community Engagement, who will also be the Chief Officer for the Scottish Health Council. The Director of Community Engagement will be responsible for marshalling all of the resources of HIS related to the engagement of people and communities, and will have a more visible role in issuing quality assurance reports on major change process directly and publicly to NHS Board Chief Executives and Chairs. HIS has recognised that the existing staffing structure and skills mix within the SHC needs to be strengthened to deliver this role. Implementation of this programme of change is underway and will be progressed as a priority by HIS in 2018-19. Strengthening the leadership and staffing of the SHC in this way will enable the reformed SHC to engage at a more strategic level with NHS Boards, supporting NHS Boards at a local and regional level to use the Our Voice principles of openness, flexibility and inclusion to improve their engagement with communities.

The Chief Executive of NHS Scotland, Paul Gray, advised the Petitions Committee in March 2017 that Chief Executive’s letters including CEL 4 (2010): Informing, Engaging and Consulting People in Developing Health and Community Care Services, provide guidance and direction to NHS Boards but not to Integration Authorities. Integration Authorities have a range of duties conferred upon them through the Public Bodies (Joint Working) (Scotland) Act 2014, which requires a comprehensive approach to engagement and participation with a range of key stakeholders. The 2014 Act provides Ministers with powers to direct Health Boards, Local Authorities and Integration Authorities on any matter relating to integration as defined under that Act.

**Committee Recommendations – Annual Reviews**

434. There are a range of mechanisms used by the Scottish Government to ensure the provision of support and monitoring of performance of NHS boards. The annual review of each NHS board is a central component of this model. We note that there have been changes in approach to these annual reviews in recent years with Ministerial attendance no longer being required at all reviews. We ask the Scottish Government for further information on the reasons for this change and assurances this does not signify a change in the value and importance of these reviews.

435. We expect these reviews to properly hold NHS boards to account for their performance. During the course of our inquiry we heard little reference to the function the reviews perform. Whilst we note action points flow from these reviews, there appears to be no transparent and clear course of action taken when boards fail to deliver the recommendations made. Combined with inconsistent scrutiny by HIS and important matters such as serious adverse events being dealt with internally by boards, we feel the oversight of NHS boards is inadequate. We ask the Scottish Government to review these annual reviews and bring forward proposals to demonstrate the annual reviews are a core component of its accountability mechanism.

**Response to the Committee’s Recommendations**

Annual Reviews are a key part of the yearly performance management cycle which also includes the submission of Operational Plans and at least one Balanced Performance and Finance meeting in year as well as Annual Reviews. The overall objective of the cycle is to hold boards to account for their delivery of good quality healthcare services for their communities and for the expenditure of significant sums of public money. For the forthcoming annual reviews, Ministers will Chair these in each of the territorial Boards, the Golden Jubilee Foundation, SAS and NHS 24.
Each board is required to publish self-assessment and ‘at a glance’ material for each Review year which include a clear update on progress with the previous year’s Annual Review action points. We will also expect boards to hold an event where the public can engage with them on their work.

I will continue to revisit the Annual Review process, in conjunction with our key partners.

**Committee Recommendation – Endowment Funds**

440. One concern raised by the situation in NHS Tayside is whether there are any conflicts of interest in NHS board members also being charity trustees. Given the statutory duties of a director and the close connection between endowment boards and NHS Boards we do not see how it can be possible for persons to be members of both boards simultaneously and give the perception of independence in each role. Accordingly we recommend that no member of an NHS Board should be permitted to be a member of an endowment board.

**Response to the Committee Recommendation**

Senior officials are working with OSCR to identify ways to further strengthen the governance of NHS Endowment Funds, including possible legislative options and various degrees of separation from NHS Boards.

The Chief Executive of OSCR wrote to NHS Endowment Fund Chairs on 15 June to ask them to consider a range of short term actions to increase transparency and increase public confidence.

OSCR is continuing with its review of the Tayside situation and I will give serious consideration to any recommendations arising from the final report in terms of the implications for the wider governance of health boards.

A Finance Development Group, chaired by the Scottish Government’s Director of Health Finance and attended by representatives from the NHS, Local Government, Integration Authorities, Audit Scotland and COSLA, is considering immediate financial issues and developing proposals for longer-term financial planning across the system.

Development work is also underway with Chairs, Vice Chairs, Chief Officers and Chief Finance Officers of IJBs to ensure they are fully supported in their roles and that integration is effectively embedding and delivering better and more sustainable outcomes. In addition the improvement service is producing guidance for elected members to assist them with their roles on IJBs and will be undertaking training once these are published.
Committee Recommendation – Conflict of Interest

441. Given the above and the issues we have heard about the difficulties directors have had in being members of both health boards and IJBs we also have concerns around how a member of both boards can simultaneously act in the best interests of bodies who may have competing priorities for finance. Equally this gives rise to similar perception issues as above and we recommend the government review examining governance consider the board membership of IJBs and how members who are also members of other bodies, particularly local health boards and local authorities can avoid similar conflicts.

Response to the Committee Recommendation

A Finance Development Group, chaired by the Scottish Government’s Director of Health Finance and attended by representatives from the NHS, Local Government, Integration Authorities, Audit Scotland and COSLA, is considering immediate financial issues and developing proposals for longer-term financial planning across the system.

Development work is also underway with Chairs, Vice Chairs, Chief Officers and Chief Finance Officers of IJBs to ensure they are fully supported in their roles and that integration is effectively embedding and delivering better and more sustainable outcomes. In addition the improvement service is producing guidance for elected members to assist them with their roles on JBIs and will be undertaking training once these are published.