OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 20 February 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 20 February 2018

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HEALTH AND SPORT COMMITTEE
6th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
David Stewart (Highlands and Islands) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rachel Cackett (Royal College of Nursing)
Kenryck Lloyd-Jones (Allied Health Professions Federation Scotland)
Dr Brian Montgomery
Bill Scott (Inclusion Scotland)
Ruchir Shah (Scottish Council for Voluntary Organisations)
Claire Sweeney (Audit Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 20 February 2018

[The Convener opened the meeting at 10:33]

NHS Governance

The Convener (Lewis Macdonald): Good morning and welcome to the sixth meeting in 2018 of the Health and Sport Committee. I ask everyone to ensure that their mobile phones are switched to silent and point out that proceedings are being recorded and filmed, so there is no need for anyone else to do likewise. We have received apologies from David Stewart.

Agenda item 1 of our formal proceedings is a round-table evidence-taking session on national health service corporate governance. I welcome everyone who has joined us for this session, and I would like to highlight the responses that we received to our survey and our call for evidence.

I think that the best way to start is to introduce myself and then to get everyone round the table to introduce themselves, too. I am the convener of the committee and a North East Scotland MSP.

Ash Denham (Edinburgh Eastern) (SNP): I am the deputy convener and the MSP for Edinburgh Eastern.

Kenryck Lloyd-Jones (Allied Health Professions Federation Scotland): I am representing the Allied Health Professions Federation Scotland this morning, but I am also employed by the Chartered Society of Physiotherapy in Scotland.

Miles Briggs (Lothian) (Con): I am a Conservative MSP for the Lothian region and Conservative spokesman for health and sport.

Bill Scott (Inclusion Scotland): Good morning. I am director of policy for Inclusion Scotland, which is a disabled people's organisation.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, everyone. I am the Liberal Democrat MSP for Edinburgh Western and my party's health spokesperson.

Dr Brian Montgomery: I am currently an independent healthcare consultant, but I am here by dint of a number of previous roles, including general practitioner, trust and divisional medical director at NHS Lothian and board medical director—and latterly interim chief executive—at NHS Fife.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Good morning. I am the MSP for Mid Fife and Glenrothes.

Emma Harper (South Scotland) (SNP): Good morning. I am a South Scotland MSP.

Rachel Cackett (Royal College of Nursing): I am a policy adviser for the Royal College of Nursing in Scotland.

Alison Johnstone (Lothian) (Green): I am a Lothian MSP.

Ivan McKee (Glasgow Provan) (SNP): Good morning. I am the MSP for Glasgow Provan.

Claire Sweeney (Audit Scotland): Good morning. I am an associate director at Audit Scotland.

Brian Whittle (South Scotland) (Con): Good morning. I am a South Scotland MSP.

Sandra White (Glasgow Kelvin) (SNP): Good morning. I am the MSP for Glasgow Kelvin.

Ruchir Shah (Scottish Council for Voluntary Organisations): I head up the policy and research department at the Scottish Council for Voluntary Organisations.

The Convener: Thank you very much. I should say that, when we put out our call for evidence in January, we also issued a survey to members of NHS boards. We will hear more from some of those board members at a future meeting, but I want to thank the 47 per cent of board members who responded. That is a very good response rate, and we really appreciate it.

There are a number of issues on which our witnesses have a high level of expertise. I ask Brian Whittle to begin the questioning.

Brian Whittle: Is there a need for patients, the public and the third sector to have a bigger role in NHS governance? Is there distance between the boards and the general public that needs to be closed?

Claire Sweeney: Perhaps I can kick off. Every year, we produce an overview report of the NHS in Scotland. In the most recent, which was produced last October, we mentioned the need for a very different conversation with the public about operation of the health system and some of the difficult decisions that now have to be made because of financial pressures and integration of health and social care. Given that very changed landscape, we say that there is a need for a more open and honest conversation with the public about the direction of travel for health and social care services.

Bill Scott: Inclusion Scotland agrees. We firmly believe in the findings and recommendations of

the Christie commission, which made it clear that service users must be involved in management and governance of the services that they receive. After all, that is the only way of transforming those services and ensuring that they meet the needs of the people who use them day to day. Brian Whittle mentioned patients, but people with long-term health conditions, disabilities and so on who rely on health services more frequently than other members of the population generally do must be very involved in service planning and commissioning, as well as in other aspects of NHS governance.

Dr Montgomery: I would extend that and make a distinction between active service users, if you like, and the wider population. That brings us back to Claire Sweeney's point about the need to look forward: we are in an environment where the number of options and opportunities that are open to us is far greater than what we can currently afford. Some very difficult choices and discussions lie ahead and it is not for the professions or, indeed, the boards to make those decisions by themselves: they have to be made collaboratively with the wider public.

Rachel Cackett: I will pick up on Brian Montgomery's point. Some of you might remember work that was done by the Royal College of Nursing a couple of years ago on performance management and measuring success in the health service. In that work, we made a point—which Claire Sweeney and Brian Montgomery have just made—about the need to make some difficult decisions and to reach those decisions in partnership with the people who use the services, those who might need them in the future and those who deliver them, including members of the Royal College of Nursing. I therefore underline the comments that have been made.

At the heart of our written response is the point that we now have a number of different systems at play, which also comes across when we talk about how we engage third sector organisations and the public. Looking across the integration landscape and at the legislation on integration, colleagues in the third sector will be able to say better than I can whether it is working well: there are legislative frameworks around engagement in integration for functions that have been delegated to the local level.

We have a different system in NHS boards, and we have emerging regional agendas in which some of the engagement is perhaps less clear because we are at such an early stage in understanding what the regional system might look like.

We therefore have what we might call quite a mixed market in how people can engage, which does not always make it the easiest thing to do. On governance, how we do it well and how we engage people, the key things that we need to look at come down to transparency and clarity. On decision making and accountability for it, we have to be absolutely clear from the very beginning—especially when we deal with, for example, clinical safety or quality of care—where such decisions sit and who is responsible for them.

Kenryck Lloyd-Jones: When we talk about including the public, a distinction possibly needs to be made between service-user organisations, service users and members of the general public who are potential service users. How we engage and involve them might depend on the kinds of decision making that we are looking for. For example, there might be a public consultation on particular proposals, whereas in looking at design and delivery of services we might involve service-user organisations that have the expertise that is required for them to speak on behalf of service users.

Ruchir Shah: We are picking up on a lot of frustration in the third sector and among the people whom it supports about their bringing issues to the attention of NHS governance that are not followed up or treated with equity or the level of respect that other decision makers might be afforded.

To pick up on Kenryck Lloyd-Jones's point, the overall context is that Scotland now has an ambition to have a much more open Government culture. The Scottish Government has made commitments through the Open Government Partnership, so at the moment the international spotlight is on Scotland as a pioneer in open government in respect of issues such as participation, accountability and transparency.

In participatory budgeting, things have been working quite well: the general public, including service users and organisations, are given a genuine say and can see how that influences decisions and how they are made. We have picked up that even if people who put in their views and perspectives do not get the outcomes that they want, they are happy with that process. With a very stark decision—such as whether to shut a hospital—that is politically very difficult, if people can see how it was made and what the trade-offs were, and if they genuinely feel that their views—not just individually, but through discussions with each other—have been heard publicly, they are much happier. We have evidence of that happening in participatory budgeting around the United Kingdom: it is certainly something that could apply here.

Brian Whittle: I have a quick follow-up question. As Ruchir Shah mentioned, we have an ambition to be more open and transparent, and to allow more people into the decision-making

process. However, do we have a practical system in place that will allow that to happen? If not, where do we have to change?

Ruchir Shah: We have a practical system in place. It is the Open Government Partnership national action plan, which is a mechanism that has to be designed jointly by citizens, civil society and the Government in the participating country. At the moment, Scotland is coming to the end of a pioneering action plan in which it made five commitments, including on financial transparency, participation and opening up how the national performance framework is developed. The action plan is very much a first step, but there is a mechanism for moving on to a two-year plan from August onwards. The opportunity that we have is in having a clear mechanism with international guidelines that can improve participation, transparency and accountability in how decisions that affect people are made.

There are many tools, techniques and resources available internationally. The Scottish Council for Voluntary Organisations supports that and is helping to mobilise citizens and civil society around it.

10:45

Claire Sweeney: There is a potential disconnect between the overall policy ambition and how it is realised on the ground. Audit Scotland looks across all of the public sector, so we see differences in how some policies are applied. Interesting challenges are thrown up through things such as participatory budgeting and self-directed support and what that looks like in the health context. One could argue that there is an easier fit for local authorities in the context of integration joint boards, but there are still questions about how integration is being applied in the health context. Audit Scotland will certainly pay attention to that over the next little while. In the past we have published reports on self-directed support that have highlighted some of the tensions. We need to keep looking at that.

We are doing a little bit of work around community empowerment with other scrutiny partners, which has revealed to us that the authorities that do it very well have spent a lot of time on and have investment in developing a really good relationship with communities, so that when times are hard and difficult decisions need to be made, there is—although it is not easy—an environment in which engagement is expected, people are willing to participate in the discussion and trust has been built up. That is not the case in all areas.

Jenny Gilruth: Claire Sweeney just spoke about the disconnect between policy ambition and what happens in reality, and Bill Scott made the point about the need for service users to be involved in service delivery from the very beginning. If we drill down into the statistics and consider the demographics of current NHS board membership we see that the majority of respondents to our survey—64 per cent—are aged 55 or over, a third are aged between 35 and 54, one is aged between 25 and 34 and there is no one in the 18 to 24 category. How can we reach out to other age groups and get greater diversity on our boards to ensure that all the public are involved in the process, rather than just a small section of society, who are probably involved in other things, too?

Bill Scott: There is also desperate underrepresentation of disabled people on all public boards, including NHS boards. We need to do far more. When the chairs and conveners of boards were asked whether diversity and equality are primary considerations when recruiting new board members, it was clear that those are not uppermost in their minds. We need to have boards that represent everyone in society.

There will always be difficulty in finding people to come forward from some groups. When we talk about community empowerment, we should think about developing the potential of individuals to represent groups on boards, and so on. Lived experience can take a person so far because the person knows how provision affects them, but they also need to know how it affects the group that they are there to represent. Things can affect people—for example, people in various impairment groups—in different ways.

Young people, in particular, are underrepresented. That is not because young people do not care about the health service, but because they are likely to use it less frequently than older people and are more likely to think that someone else will do the job for them. However, when we take issues to young people, they often become very politically engaged and are willing to serve and do their bit.

We need to ask how much we do as a society to reach out to young people, and how we can get them interested in being involved with health boards. I am sure that the issue is not just about who is recruited, but about who applies. If there are public places available on boards and you want to broaden out the applications for those places, you will have to target specific groups in society that are underrepresented, and ensure that they feel that their service will be valued and their voices heard in the process. If you do not do that, the young person, for example, will walk into a room of people whom they have never seen before and will have no idea what their roles are—they will just know that they are older. It can be

very difficult to be the sole young person in the room.

Dr Montgomery: There is an important distinction to be made between being on boards and being actively and meaningfully involved in board-led mechanisms. One of the dangers in trying to make boards as representative as possible is that we run the risk of ending up with cumbersome bodies on which many of the people round the table are interested in only a fraction of the agenda. In my experience, that has certainly been a problem on boards over a number of years. The real challenge is less about who is round the board table, important though that is in terms of general representation—certainly for a territorial board—and more about what sits underneath that board and how the board then empowers and responds to those substructures. That is where we need specific, focused and knowledgeable input from a wide variety of stakeholders.

The Convener: Are you saying that it is essentially a question of finding a balance between diverse representation and skills and experience?

Dr Montgomery: Although a board needs to have good cross-representation, it would be unreasonable and unrealistic to expect every interest to be represented around the board table. What is more important is what happens beyond the board table, and how those at the board table then respond to that.

Rachel Cackett: The people who responded to the survey and those who currently take on the role of non-executive directors are doing an enormous public service. It is an enormous job. We have been looking recently at the papers that go out to NHS boards and to IJBs—let us remember that many of the non-execs have a dual role on two different governance functions—and those papers can run to hundreds and hundreds of pages, so it is an enormous task that we ask of people when they are doing that public service. It is important to acknowledge that, whether or not there is the right mix at the moment.

For the work that we did on measuring success, which I mentioned before, we commissioned a number of fairly eminent people in Scotland to write some articles for us. One of them looked at major service failures, and one of the issues that was brought up for us there was the importance of diversity on boards, to ensure that decisions are challenged sufficiently. Too much of the same tends to result in decisions not being challenged well enough.

Bill Scott said something that reminded me of conversations that we had many years ago in the Parliament about how NHS boards should be configured. It is important to ensure, on the one hand, that there are lots of opportunities for people to have genuine participation and engagement in decision making, which may not mean a board seat, and that we also develop the grass roots, so that there are people who can move into those roles at other points and so that diversity will come through. However, we have to acknowledge the task that we set people who take on non-exec roles, and we do not even know yet where that will sit with the regional planning agenda as it emerges.

Claire Sweeney: I echo Rachel Cackett's points. It is important to note that the size of the ask is significant, but we have a job to do to make that seem doable for people, so that it is possible for younger folk to be involved and so that groups that are not involved in the way that we would like them to be see it as something that they can do. Sometimes, the pressures around the health system can put people off, because the task can seem impossible. The auditors of every public body in Scotland have a particularly important role in supporting non-execs, so that if they have questions about finance we can offer training and support their development in the areas in which they feel a little weaker. It is a huge public service, so it needs to be made as easy as possible for people.

Kenryck Lloyd-Jones: I fully recognise some of the limitations around a representative model—I am here today representing the Allied Health Professions Federation Scotland, which brings together 13 different professions in health and social care—but I think that there is a way in which the various interests can be included to ensure that good decisions are being made. For the past decade, we have said that there ought to be allied health professional representation and inclusiveness in decision making, because AHPs cover every aspect of care from intensive care and accident and emergency through to primary care and social care. They also bring a fresh perspective, particularly around integration and the biopsychosocial model of care.

Allied health professionals have something to contribute, and we would like that to be included. We think that the best way of enabling that to happen is through better guidance on including those people. However, that requires investment in leadership. No single person can know everything about every profession, so there must be investment so that whoever is in the representative role has a degree of accountability and can engage with the people whom they are there to support.

Jenny Gilruth: I appreciate what Dr Montgomery said, but I find it startling that there is no board member in the country who is in the 18

to 24 age bracket. Particularly given that this is the year of Scotland's young people, we need young people's voices around the table, including at board level. Currently, board membership is not representative of the country and there is an emphasis on retired people, which I think could be detrimental to service delivery, because, as Bill Scott said, if people are not at the table they cannot have an impact on the decisions that are made.

Only 10 per cent of respondents to our survey said that the recruitment process always led to the right people being appointed to the board. Some respondents called for a national approach to induction and training, for consistency. That relates to what Claire Sweeney said about the complexities of the process, which might put younger people off—I do not necessarily accept that; I think that getting to grips with the technicalities of the role can be a struggle for people of any age. Do we need a national training programme?

Ruchir Shah: Right now in the charity sector we are thinking about governance quite closely, as you can imagine—there is a huge amount of scrutiny of governance. With that comes training and awareness of not just people's backgrounds but the skill sets that they bring and what they do as part of the governance of an organisation.

As we talk about the need for balance on boards, we also need to ensure that people know the weight of responsibility that will fall on them when they are on a board. I do not think that we do enough to support people to understand their governance role and its implications, including for themselves. The issue goes way beyond the problem of people being given 100-page reports the day before meetings, as happens in some sectors. People need support and they need to be aware of what they are getting into.

Rather than putting all the weight of governance on to NHS boards, the trick here might be somehow to open up the governance of health services and NHS bodies, through wider mechanisms that involve the public, so that, in the context of decisions, less emphasis is on solely who is around the table on the board. That might make for a more balanced system in general, and it would make things like training a lot easier.

Claire Sweeney: It is absolutely true that more needs to be done to support all age groups. It is clear from the survey responses that there is a demand for support. We would focus on financial skills, as we find that people often worry about their financial skills when they join boards. Some courses are available to help to support people in that regard.

Another thing that we look for is the respectful challenge that non-execs need to give, on quite complex issues. Again, when people are new to a board they need support so that they can be confident about taking on that role. Sometimes we get feedback from new non-execs that the ability to ask what might seem a silly or basic question, which has not been asked before, can be valuable; it is good to give people the confidence to be able to challenge in that way. People need support with not just a whole set of technical skills but softer skills. There is more to be done to support people, for sure.

Dr Montgomery: I echo what everyone has said. It is important to have a breadth and variety of perspectives around the table, but my sense is that non-exec colleagues, in particular, also need and value the ability to see and understand the bigger picture. There is potentially a huge induction process that people need to go through to enable them to get a degree of confidence in that regard.

A few years ago, I had experience in Fife on one of the two boards that had elected boards for a while. That was a fascinating process, not least because it almost felt as though the pause button had been pressed, in that a significant number of non-executive directors who had built up comfort, confidence and experience over the years disappeared and were replaced by individuals who were voted on to the board by the local public. By their own admission, although they understood their particular interests and perspectives, those individuals found it difficult to slot into the picture and offer the challenges to areas that they were not comfortable with. The elected boards have been paused and we have moved on without them, but there is a lot more to do around training and induction for board members.

It is also important to remember that the issue is not just the board that people are appointed to. Board members need to understand the NHS in Scotland, particularly as we are starting to look much more closely at regional issues. The induction and training have to cover more than just the local geography.

11:00

Bill Scott: The Scottish Government funded us to establish a Highland localisation and employment project to do the very things that we are talking about: to work with local disabled people and the groups that represent them—whether they are organisations of or for disabled people—to develop the potential for disabled people to participate in decision making in community partnerships and in health governance. The idea is there. Even before the training, we have to start to build confidence in people so that

they think that they are capable of doing it. That might mean starting well before the board stage and getting people involved in other decision-making activities.

We did a mapping exercise in Highland where the hierarchy goes through the NHS board, the integration joint monitoring committee, the health and social care partnership as it was, the adult strategic commissioning groups, and then the improvement groups. Disabled people were represented only on the improvement groups, and they have all been halted and become task-focused groups; that means that no new disabled people are being recruited to those groups so there are very few opportunities for people to develop and to move on. It does not seem that people are moving into any of the other governance groups, and that limits their ability to see the bigger picture and build up the knowledge that they need.

We agree that people should not just be on a board to represent an interest group; they should be there to represent everyone while bringing the specific knowledge of an interest group to the table and showing how what the board plans to do will not work for the group, or part of the group, that they represent. The lived experience is part of what they bring to the table and it is an asset that can be used, rather than a limitation on their ability to make decisions.

I agree that a lot of development work is needed, but we need to prise open some of the other decision-making bodies in NHS boards so that we can promote people and allow them a larger role as non-executive directors.

Ivan McKee: I want to follow up in more detail on some of the issues that Jenny Gilruth raised around training. In my experience of dealing with health boards, I know that the executive members have the whip-hand and the non-executive members are not challenging to anything like the extent that they should be. Other members have probably had the same experience in their relationships with health boards.

We also see that in the private sector, where there are lots of examples in which the failure of non-executive members to hold executives to account has led to disasters occurring. I want to drill down into that a bit more. To what extent do non-executive board members understand the job that they are doing—being a non-executive director is a job in itself—and to what extent do the executives understand that the non-executive members' job is to hold them to account? What induction and training are in place to facilitate that? Are we just throwing people in and seeing whether they sink or swim?

Claire Sweeney: There is an induction programme for new non-executive directors. We contribute to that by talking about the financial position across Scotland. That induction is for all public board members, not just those in the health system.

It worries us when we go to boards and audit committees and find that there is not sufficient challenge. The position is not as healthy as we would like it to be in all areas, and some areas need to work a bit harder to make sure that their non-executive directors are challenging and are given the right information. That relates to Rachel Cackett's point about the sheer volume of information that people are expected to absorb so that they can fulfil their role on the board.

The local audit teams challenge around that and report on it through the local audit reports. In all our work, and particularly in certain pieces of work such as our report on the role of boards, we are keen to emphasise the importance of the scrutiny role. It needs to be respectful, but it needs to be challenging.

We have commented before that, where there have been major failings in the public sector, governance tends to be at their heart. One of the healthy signs is a respectful but challenging relationship, particularly between the chief executive and the chair. The auditors look at that in detail. We see it in places, but it is by no means the whole picture.

Rachel Cackett: The changing landscape of health and social care that everyone finds themselves in is also a challenge for the directors generally. One of the pieces of work that the RCN has been involved in for a number of years is supporting those nurses who have been appointed to integration joint boards in a governance role. That is a brand new role, and we have to be aware that, while we may be used to the traditional NHS board governance processes, the integration joint boards are quite a different thing.

We are bringing together two different cultures on how decisions are made. To support nursing leaders, we have worked with nurses who have been appointed to seats on the joint boards to help them to work through what the difference is. Going into that new environment is a real learning curve. For example, on an NHS board an executive nurse director has a voting seat, whereas on an integration joint board they do not. The way in which decisions are made and the expectations of clinical expertise are quite different.

We keep coming back to the same point. Bill Scott talked about ensuring that the expertise of people who experience a disability is heard on a board, and we want to ensure that nurses' expertise in clinical quality and assurance is heard

and taken on board in the right way. We are all finding our feet slightly differently. Non-executive directors are a particular case, but the issue is not limited to the non-executive directors on boards.

Dr Montgomery: As an executive director, I expected and welcomed challenge and found it useful. Most of that challenge took place long before the issue got to the board table, despite it coming from non-executive directors and others. That echoes my earlier point about the success of a board relating to its committee structure and the various activities that feed into and inform that board.

As an executive director, I would expect challenge to be taking place through the committee structure and through development sessions. The advantage of development sessions is that they tend to be on one subject. Stakeholders can then be engaged more widely, for example by getting clinicians to meet board non-executive directors and others and, if it was helpful to the non-executives, bringing in local politicians.

Part of the discussion would take place before the issue got to the board table. The challenge would be there and would be responded to. The quality of discussion would be better than it would be possible to achieve round a board table, because of the flexibility to augment the participants.

Sandra White: I spent time on the Public Audit Committee when it looked at various boards, particularly in the college sector. A lot of issues arose that were of concern. I want to drill down a bit. People have accused boards of moving insiders from one board to another. From my committee experience, I know that the same people tend to be involved and that they know one another. Is that a problem, particularly in rural areas?

Another issue that I want to pick up on is the number of members on each board, as that is not representative of the population of each area. Up in the islands, for instance, there are 41 members on the boards; there are 14 members on each board in Orkney and Shetland, and 13 in the Western Isles. Those are quite small areas and I assume that people know each other, but there are 14 members on the board down in NHS Lanarkshire, yet there is a population of 652,000 people. What are panel members' thoughts on that? Is a small pocket of people being used for health boards in certain areas, and should the number of members be representative of the population of the areas that the boards cover?

Claire Sweeney: In the recent induction process for all non-execs in Scotland, the last session was quite interesting and felt a little bit different, because there were more representatives from rural areas and, in particular, from the islands. We are really interested in the extent to which some issues are not NHS or urban issues, and are about connections to and understanding of the needs of the local population. That is a small anecdotal example, but I can definitely see more of that coming through, particularly in some of the more rural areas. The Islands (Scotland) Bill will have an impact on that, too, and we are watching that quite carefully. The sense of needing to be close to and having a connection with the population is starting to come through. I cannot speak about the NHS context, but we see that in the induction sessions.

Emma Harper: I am interested in the board membership of and engagement with allied health professionals. It looks as though only nine out of 32 of the integration joint boards have an AHP director at the table—the numbers remain quite barren, so AHPs are underrepresented. Does that impact on the ability to take forward the national chronic obstructive pulmonary disease guidance for implementing pulmonary rehab, for example, if ideas are not put forward to or shared between boards? How would you move forward with the number of AHPs on boards?

Kenryck Lloyd-Jones: You phrased that perfectly well. The allied health professions recognise that a wide range of services can be improved through their involvement, whether through falls prevention measures, COPD and respiratory care, keeping people out of hospital or getting people out of hospital more quickly. With all the major problems that the NHS faces, people do not know what they do not know, so there is potential, but that potential is not recognised. That is where the allied health professions feel frustrated, because they know that they have potential solutions in relation to many aspects of care. We are talking about 13 different professions, so there is a whole range of areas in which they are involved in assessment, diagnosis and treatment, but they come at it from a perspective that is non-medical and, therefore, they bring something different to the table when it comes to improving services. They believe that the message about their potential is not well understood by people who are outside their professions.

Emma Harper: I should mention that I am the convener of the cross-party group on lung health, so I am interested in physiotherapy and other allied health professions. The Government wants AHPs to be central to change, but is that made more difficult if there are 13 allied health professions with everybody doing something quite different?

Kenryck Lloyd-Jones: It will always be a challenge for one individual to represent everyone because there is no such thing as an allied health professional. Each of the professions is educated separately, but the professions are grouped together as the allied health professions—often, the term "allied health professionals" is used to mean that they are not doctors or nurses but have some clinical role. In that context, it is a challenge for anyone to know the potential of each allied health profession.

The important point is that the onus is on anybody who takes on any kind of representative role—anyone who is a mouthpiece or who sits at the table when services are being designed—to ask their colleagues what their role might be, whether that is in respiratory care, getting people out of hospital, preventative care or whatever it happens to be. The important thing is to go back to, facilitate and invest in the networks to create that collaborative culture. The allied health professions are very good at that, but a great deal more investment is needed to get the right leadership to shift services forward.

11:15

Dr Montgomery: Kenryck Lloyd-Jones has more or less made the point that I was about to make. I accept the added value of having someone with a broad understanding of AHPs at the board table, but that is of little consequence if we do not have the right mechanisms in the groups that really make the decisions and recommendations on making things happen. As I said earlier, a lot of this is about what happens beyond the board and how the board responds to that. As a medical director, I had exactly the same issue in that, as one doctor, I could not hope to represent the entire breadth of the medical profession. However, I took advice from an assortment of "ologists" and ensured that I had my arguments sorted out by the time that I got to the board. Indeed, I took advice from not just the doctors but the whole clinical community. The important thing is that, by the time that the board gets involved in the discussion, that breadth and quality need to be there.

Rachel Cackett: It comes back to the point that we make in our written submission, which is that we need to ensure that all parts of corporate governance are on the table equally. The clinical governance part is absolutely key. From looking at papers in different governance groups, I would say that, in the current climate, there is a tendency to focus on financial governance and the extraordinary pressure that boards, IJBs and others are under to make ends meet in the face of current demand. If we do not ensure that the clinical governance elements are up there alongside that, that the clinicians' views are clearly heard and that that advice then influences the financial decisions, that is when things get out of kilter. It is about how we ensure that those voices are heard.

That goes back to the earlier points about the involvement of service users or their representatives. We have to ensure that those mechanisms are really strong. To respond to Brian Montgomery's point, the clinical governance committee is a really important part of any governance group, whether at integration joint board level, NHS board level or, in future, regional level. We have to ensure that the diversity of voices is heard, no matter what the governance structure and ultimate accountability are. That is the area where we could probably do more.

In our submission, we ask for a review of the clinical guidance for integration joint boards. We are now two or three years in and we can see what it looks like on the ground. We have moved from theory into practice, and there are things that we need to learn.

Those are the areas where we could make things much stronger to ensure that our entire corporate governance system works well.

Bill Scott: A report last year by the Health and Sport Committee pointed out that we need to invest in the people whom we want to be involved. If we expect people to represent a wide group, such as allied health professionals or disabled people, some investment is needed in those people so that they can do that job properly. That applies at any level of governance but particularly at corporate governance and board level. Some people face barriers to taking the first steps. Disabled people and carers face barriers to being involved, and there might be physical barriers, sensory barriers or confidence barriers based on mental health issues that have to be overcome before someone can take the first steps. People need support. In some instances, they will need advocacy support to be able to take part in decision making that affects their lives. Others will need developmental support to take that first step with confidence that they will be supported to take part in decision making, and then to move on.

We have to think about the barriers to people being involved. I worked for several years in an area of multiple deprivation where there were many strong activists who could have played a role in decision making in the health board—not always at board level but in the locality—but who needed to be developed to have the confidence to do that.

There is something about our recruitment processes for public bodies that is a barrier. We expect certain levels of experience in running a

business and so on. People might not have that experience, but they might have run a local charity. Is that any less valuable than running a business? People who have that experience can bring it to the table. We need to think through how we recruit to public bodies so that we fully represent all of society, and that includes a lot of people who live in deprived areas and who have little or no opportunity to participate in governance.

The Convener: Thanks. A number of witnesses have commented on levels or areas of representation or activity other than at board level. For example, there are public partnership forums, and equivalent forums for staff and service users. How effective and useful are those forums in providing a means for people to engage further at a later step? Indeed, do they perform the function that they are there to perform?

Ruchir Shah: We are still in a consultation-focused model. NHS boards and other major public sector institutions issue consultations to individuals, who are asked to fill in their responses. Those then go back into a black box and decisions are made, and people may or may not feel that they have been heard. We absolutely need to change the model. It needs to be less about many-to-one consultations and much more about deliberative decisions and discussions. That is why participation is key.

Some really good ideas have come out, such as the social security panels, but such things need to be developed to a point where they genuinely involve conversations between people. I raised the point about participatory budgeting because practice in that area is being piloted right now, and we can apply the same principles whereby people do not just speak to, fill in forms for and respond directly to an institution but actually speak to one another, deliberate, share and build their confidence. As a result of that, many of them will be inspired to participate in more formal structures. However, the listening needs to happen not just in the formal structures but in the forums that are set up for people to engage in.

Claire Sweeney: It is probably not surprising, but one of the starkest comments in the survey responses was about boards feeling that they are powerless to make the decisions that need to be made.

Everything that we have heard is about the need for a more open and honest conversation and more engagement. In the structures and systems that we have in place, we see the clinical governance committees and audit committees as key committees, but something is still getting in the way of organisations feeling that they are then able to take on some of the really tricky stuff. We have talked about some of the reasons for that, including the challenging new environment that everyone is operating in and the integration of health and social care, which brings together two cultures with different skills and experience. There is definitely a period of working through some of those challenges.

I was struck that some of the respondents mentioned that they still find it difficult to get over the line and make challenging decisions. We need to consider what they need to help them do that. We have talked about some of that today.

Dr Montgomery: There have been some examples of very good patient and public engagement, but in the main it has tended to be focused on specific conditions or diseases. One thinks of some of the work that has gone on in the wider cancer field and in diabetes, and with some of the heart disease issues. Each local board will have its own specific examples. However, part of the difficulty is that it is all very ad hoc and reactive. There is no standard methodology. That may not necessarily be all bad, but it is then difficult to evaluate it later in the process. It certainly makes it difficult to compare and contrast what happens in one board area with what happens in another.

The other thing that I highlight from my experience of those disease areas is that many important decisions are made without input from the board. For example, many of the decisions that are made, with patient and public input, by a diabetes managed clinical network will be reported to the board, but the board's permission will not be sought—the board will not be a major part of the decision-making process. Boards tend to get involved in the more difficult and contentious areas, but for the vast majority of clinical processes and services the decisions are made without ever getting to the board. However, as we get increasingly into health and social care integration, that is changing. The IJBs clearly want to have much more of a hands-on role, which I think is only right and proper, given the complexity. Yet again, I think that we are in danger of investing more in the boards than they actually deliver or need to deliver.

Alex Cole-Hamilton: Good morning. Before I get to my question, I put down a marker in support of what Emma Harper said about allied health professionals. The committee hears a lot about the recruitment and retention crisis, particularly in the GP and nursing professions. We do not pay as much attention to what is going on in the AHP sector. When the committee looks at things such as the safe staffing bill, it will be important that we reflect those considerations.

My question is about failure in meeting demand and how boards respond to that. We have heard a great deal about missed targets and the response—or lack thereof—by individual boards

across the country. I am repeatedly struck by the fact that there a silo approach to that; there is no sense of learning. When one health board adopts a successful approach to a missed target, the approach does not seem to be repeated in other health boards. Why is that? What is the problem with sharing best practice across the health boards, and how do we get better at that kind of cross fertilisation?

Kenryck Lloyd-Jones: Thank you for that question. Particularly when we look at improving systems, we make gestures towards taking a collaborative approach. That seems to be delivering results. For example, in accident and emergency services, we are not hitting the target of people being seen within four hours. We could have an investigation into everything that is going on behind the hospital door—in other words, how many staff are on in the evenings and at weekends and whether the hospital is responding to demand at the right time. However, what is really required is a whole-service approach.

We discussed COPD earlier. Respiratory problems can be one of the main reasons why people are blue-lighted to A and E. A respiratory flare-up can happen over a weekend, but if we can just get somebody the antibiotics on the Friday they will not be blue-lighted to A and E on the Sunday. A whole-service approach is very much what the allied health professions are talking about. There is still too much temptation to use a model that looks at where the symptom of the problem lies—which is in A and E, where we do not have enough staff to hit the four-hour target—rather than taking whole-system approach, which looks at why people are coming into A and E and whether there is anything that we can do to prevent that. Does that help?

Alex Cole-Hamilton: Yes.

Dr Montgomery: Picking up the specific details of the question, and also Kenryck Lloyd-Jones's use of the key word "collaboration", I suggest that the current board-level governance arrangements militate against collaboration. Boards are held to account in terms of both performance—performance management and targets—and resource allocation. Collaboration is driven by crisis; it is not driven by people saying, "Let's realise some opportunities here". There is actually a disincentive for boards to collaborate meaningfully and to be on the front foot. Collaboration usually happens too late in the day, because much of the performance management is about the delivery of short-term targets rather than consolidating services and developing robustness and sustainability.

The Convener: Is your point that a different governance approach might produce a more collaborative culture between boards? Is that what you are saying?

11:30

Dr Montgomery: Indeed. Let me highlight some examples from my recent experience. Board A might find itself struggling to deliver a service and will say to board B, "If we pooled resources, could we do this differently together?" In such circumstances, board B's reaction tends to be, "That's all very interesting, but doing that might compromise our own performance." As I have said, the structure militates against constructive collaboration, because boards are held to account for what happens in the short term on their own patch.

Claire Sweeney: Something interesting is happening with regard to the systemic issues that the health system in Scotland faces, which we highlighted in our overview report last October. Boards are, I think, more inclined to look to each other, because of the difficulties with coming in on balance financially while, at the same time, trying to hit targets.

We have had quite a lot to say about the ways in which targets influence how health boards, in particular, operate. I know that a review of that is under way, but integration coupled with some of the current pressures on the system mean that the time for this is right, and the environment for sharing things and learning from each other seems a little bit more fertile. The question of what needs to be delivered differently in different parts of Scotland versus what can be done on a once-for-Scotland basis must be thought through more clearly, but it is starting to become a bit clearer—or it certainly will become clearer over the next wee while. Attention certainly needs to be paid to that issue.

Dr Montgomery: The move towards regional planning and delivery is absolutely the right thing to do, but we still have no framework for holding regions to account. The framework still holds individual boards to account as regions, which are virtual constructs.

The Convener: That is a very important point.

Rachel Cackett: Given the great state of flux that we are in with regard to the delivery and governance of services, we need absolute clarity of accountability. After all, we are talking about high-risk clinical interventions, so we must be really clear about where decisions on resources and what services look like are being made and who will be held accountable for them.

Some of the boundaries that we have been used to are now getting blurred. That is not necessarily a bad thing, but we need frameworks

to go alongside that. For example, a health board might have a number of integration authorities beneath it but only one of those authorities is hosting services for the rest of them. In those circumstances, there are questions about how those decisions are being made for the entire population.

If we look at the issue from the other side, at the regional planning issues that are beginning to emerge, we see similar questions arising. Who is held accountable for decisions about those regional services within our current structures, and what might we need to change in order to make those structures transparent and robust for the future?

Alex Cole-Hamilton: I am fascinated by the point that the way in which things are constructed is counterproductive to any effort to collaborate—

Dr Montgomery: I would not say "any effort".

Alex Cole-Hamilton: I was talking about your point about boards thinking, "If we help this board in this way, we might impede ourselves in another."

I always come back to this particular example. The health board that is doing best on cancer waiting time targets is systematically logging all the reasons for missed appointments or delays in waiting times. It then mitigates the situation and builds in a strategy to ensure that such things do not happen again. That seems such a simple approach, but it is working, so why is it not being picked up by other health boards? I accept the point you make about the structural problems and the potential for collaboration to impede another board or authority, but, as far as the sharing of simple advice or good ideas is concerned, are we really that far behind?

Dr Montgomery: We do not have the correct impetus—the correct framework, if you like—that lets people say, "Let's all pursue the best of everything." It is part of a much bigger picture that has to be taken into account at a local level.

I find it quite interesting that, as more and more services are being deemed appropriate for a regional approach, bits of services are potentially being taken out of an individual board's control and are having to be dealt with at a different level.

Whereas previously we have tended to have what are like 14 independent fiefdoms in the territorial boards, the collaboration on certain issues is creating significant challenges. Nevertheless, I think that it is the way forward—it has to be, because we are increasingly lacking critical mass, particularly in some hospital services, and that will continue with the 14-board model. However, we have not yet got clever enough to develop the framework that promotes that collaboration—the framework for governance, performance management and resource allocation.

Ash Denham: During the course of this inquiry, we have received a number of submissions that have pointed to concerns that stakeholders have about the level of openness and transparency of boards. Does the panel think that those concerns are justifiable? Is there a problem with boards' openness and transparency?

Ruchir Shah: We have a network of around 300 people who have an active interest in openness and open approaches to governance in Scotland, and we put the committee's call for evidence into the forum for that network. We got a lot of comments back, and I have to say that all the comments on the transparency and openness of NHS boards were negative.

The research in the survey analysis report by the Scottish Parliament information centre suggests that board members feel that they operate fairly openly but they perceive that the wider public does not think that. There is a recognition and an understanding even within NHS boards that there is concern among the wider public about how open and transparent the boards are.

Given that everybody recognises that concern, there is clearly an opportunity to do something about it. I am not sure how much more research we need to do before we should just crack on and tackle the issues of openness and transparency.

Claire Sweeney: In our recent report "NHS in Scotland 2017", we have signalled the need to be more open and transparent and to have better levels of engagement with the public.

Integration is starting to shine a different light on some of those issues. The very way in which integration joint boards were established, through the Public Bodies (Joint Working) (Scotland) Act 2014, means that they have a duty to be more open and transparent. That is having an effect on the NHS boards, for sure, although there is more to be done.

Ash Denham: In that recent overview report, Audit Scotland recommended a number of things that boards could do, including the publication of all board and committee papers and minutes, public attendance at meetings and the filling of gaps in data in key areas of the NHS. In addition, SCVO is currently working on the Open Government Partnership action plan.

At this point, where do you feel that boards are with regard to those recommendations? How far on are they with the action plan, and where do you see that going in the short term?

Ruchir Shah: The pilot action plan, which has just come to an end, did not drill down to that level of detail. However, there is the two-year action plan, which I understand the Government has committed to and which there is now a process behind. A number of individuals and networks—certainly on the civil society side—have a specific interest in tackling the issue of openness and transparency around health in general, in relation to not just NHS boards but all the decisions that affect health and care, as part of the openness and transparency agenda and the action plan's agenda for Scotland.

There is a willingness and an interest on the part of many people on the civil society side, and I sense that there is potentially an interest on the Government's side as well. Over the next two to three months, those actions will be put together, and I hope that that action will come through as part of that process.

Claire Sweeney: We will follow up on the recommendations that we made in the report. Our local auditors in all the NHS boards and integration joint boards across Scotland will also pay attention to reporting on those recommendations through their annual audit reports.

We are just kicking off the second of three pieces of work to look at integration in Scotland. We will look at it in more detail in that piece of work, in which we will drill down into certain areas in Scotland to understand how partnerships are working in terms of their openness and whether there are lessons to be learned for elsewhere. We hope to see some really good examples and to be able to highlight some things that are not working so well.

Bill Scott: Transparency and accountability go pretty much hand in hand. You will find that, where there is not the ability to be represented at any level or at very few levels in a board, the public feel that the board is not being open and accountable, because the only people who sit around the table are board representatives or the usual suspects, which we have heard about. The same public appointees are quite often on different boards and public bodies. It is, therefore, a closed club rather than an open one.

I have been quite critical of what has happened in Highland, but an innovative community learning and development peer opportunity for disabled people to participate in has been set up in the mid-Ross community partnership area. A local Highland NHS Board member, the community planning partnership and so on have co-produced with disabled people and their groups an opportunity for somebody to join the local community partnership and be supported in that. They want that approach to be broadened out to all the community partnerships throughout the Highland area.

That goes back to the investment that is needed. If we identify groups that are underrepresented, we will need to actively do something to ensure that they are represented in the future. We cannot just hope that somebody will come forward; people have to go out and work with those groups to find out what their interests are and what they think is not being represented in local decision making, ensuring that those issues are properly represented at the local level first before building up. It is about looking to transform things from the grass roots to the top rather than from the top down.

Emma Harper: I am interested in transparency and communication to members of the public. I know that the IJBs are pretty new—they have been around for about two years—but, when I visited Stranraer with the Cabinet Secretary for Health and Sport yesterday, I found that the people at Galloway community hospital feel that the services are deteriorating or reducing although they are being expanded locally to mirror what is happening in Dumfries and Galloway royal infirmary. I am interested in how information should be disseminated. Is it the board's or the IJB's job to do that? How can we ensure that people understand what models of care are, what new care is and all the language that is being used? I am interested in how we can support that.

Rachel Cackett: That reminds me of a piece of work that we did a few years ago on the role of the advanced nurse practitioner. We undertook a number of case studies, which I would be happy to share with the committee, that looked at how communities had taken on advanced nurse practitioners in their areas.

As you were talking, I had in my mind one of our island communities in which the advanced nurse practitioner service was going to take over out-of-hours care. There was a great deal of opposition to that at the start, and the health board did a huge amount of work. It took people off to another health board whose similar service model on an island had had a really good impact on the local community—that addresses the point about learning. Community leaders were taken to meet people who talked them through what the redesign of the service could look like for them and what it would mean. Then, when we interviewed community leaders a couple of years down the line from that change, they were incredibly supportive of it. However, that required the effort to go and talk about why the change could be an improvement to, rather than a reduction in, the service.

I do not think that we are always as good as we could be at talking about how changing services

can potentially improve things for communities as opposed to people feeling that they are losing something that they may have valued for some time. There is probably more that we could do. Alex Cole-Hamilton spoke about the idea of learning from other areas, and there is much more that we could do in that respect. That is a helpful example, which I am happy to share further.

Ruchir Shah: One issue that we have picked up is the importance of being proactive rather than waiting for people to make freedom of information requests about decisions and information that has been made available. There is a very strong feeling about that now, which we are picking up.

11:45

The work that the Scottish Government is doing around identity assurance is a really good example of that. The Government is making use of various structures, including the new website for blogging about the discussions that take place on the various programme boards and stakeholder groups. However, it is not just blogging about what they are doing, because it is open for comments so that people can post questions that everyone can see. It is all moderated, but it means that people can see what other people are asking. In relation to transparency, being able to see what people are asking about, so that others are not afraid to ask a similar question, is really important. That encourages openness and transparency and ensures that it is not just a one-way process.

Dr Montgomery: There are two important strands to the question of communication. First—as Emma Harper mentioned in speaking about Dumfries and Galloway—there is the question of how to keep the local population informed about what is going on and why. As we have sought to bring together resources around integration, I have been struck by how little the average health board invests in communications—the boards' communications departments are rudimentary even in comparison to those of local authorities.

The answer is not necessarily to create a communications industry in each health board but perhaps links to the second strand, which is the need for communication at a supra-board level—possibly even at a national level—about where health and social care is going and the benefits of that particular direction.

As you know, there is huge suspicion that any changes are being driven by financial reasons—they are synonymous with cuts—rather than because they represent a more effective, sustainable and better model of care. When it is left to a health board to lead the discussion at the point of implementing local change, it is too late in the day. We need to have a much earlier conversation about what we want from our health and social care service over the coming years.

Claire Sweeney: That takes us back to the earlier conversation about skills and experience. We expect a very different skill set from that which we would traditionally have expected in many of the professions that we are talking about. We expect openness and a willingness to be challenged, to be more transparent and to get things wrong sometimes and for that to be okay. We expect a different tone of engagement from our professions now, and perhaps we have not done enough to support people with that or even talk about it. That can work very well, but it is quite tricky to do that, particularly around some of the really difficult decisions that need to be made. When we talk about the skills on boards and in the various organisations, it is worth recognising that some of this approach is fairly new territory for some people.

Rachel Cackett: We must also remember the pressure that boards are under. On the one hand, we are asking boards to be at the heart of an enormous transformational agenda, which will result in services looking radically different over a number of years if they are to pick up the gauntlets that have been thrown down by the Scottish Government and the Parliament to allow our services to change to meet demand. On the other, we are talking about targets, lack of resource—in other committee discussions we have talked about annual budgeting and the need to break even every year—and the huge political pressure to meet targets.

We must bear it in mind that we are asking our board governors to do two things at once, which are not always easily compatible, and that does not leave them in an easy position when it comes to having an open and honest conversation. If we do not acknowledge that here, in Parliament, the culture that sets around the sorts of decision that boards are asked to make and the way in which they are asked to make them will put them between a rock and a hard place.

Bill Scott: Brian Montgomery talked about the need to keep people informed, but I think that that is not enough. That is how consultation has largely taken place up to now: boards have informed people about what is happening and have asked them to understand why it is happening. We need to involve people from the outset by asking them what they want from the health service and how we can collectively deliver what they want. We must limit their expectations and tell them what the situation is—what we currently have to deliver, what the resources are and so on.

It is a big question, but, if we do not co-produce by trusting people with the information and having faith that they will make meaningful choices from

the options that are presented to them, we will not develop a health service that properly meets the needs of a modern, 21st century society.

We must trust that people who are informed will begin to own the choices that are made, rather than have a situation in which people are told about choices that have been made for them. If people own the choices, they will understand the limitations. They may see a local hospital close or services that they have relied on move 20 miles away, and they may just be told that the choice is good for them, but they need to believe that the choice is right. For that to happen, they and their representatives must be involved from the outset in arriving at the choices that are offered, not be told, "It is this or nothing."

The Convener: We are moving towards the end of the session, but first we have this question from Alison Johnstone.

Alison Johnstone: Rachel Cackett pointed out that boards are under pressure to meet clinical targets on reduced budgets, which written submissions have suggested can often feel unrealistic and demoralise staff. Some submissions expressed a lack of trust that boards make decisions in the best interests of the public—one submission said that there was real frustration about that. There was recognition that decisions are constrained by finances. In relation to openness and transparency, one respondent wrote:

> "We are terrible at admitting that we are financially constrained and pretend that decisions are based on clinical grounds when in most cases they are based on clinical, staffing and financial elements. The debate with the public is therefore fundamentally dishonest (and the public are not stupid)."

Openness and transparency are very much part of the issue and it would help if people understood why a decision had been reached.

How can the competing pressures—scarce resources and the wishes of the public—be balanced to result in decisions that are acceptable to all? Is that simply too big an ask?

Dr Montgomery: I will further complicate your description by saying that it feels more like a triangle. At the three corners are quality of care, which is paramount; performance, which is basically about targets; and resources, which are money, people, buildings and the rest. The current challenge is how to keep the triangle level, balanced across those three corners. A fair degree of compromise goes on.

The reality of the financial situation has a degree of naked emperor about it, but we increasingly see that what is most likely to suffer, in an attempt to maintain and enhance the quality of care within a finite budget, is the delivery of current targets. To deliver those targets—as we have said throughout this morning's session—we needs to have a conversation about whether, in the new world that we are in, there are different ways to challenge the problem.

A lot of it comes back to the point that I made earlier, which is that we are in the fortunate position of having so much to offer in health and social care that it exceeds the budget that is available to deliver it. That is where the difficult choices start to come in.

Rachel Cackett: The question touches on a number of things that we have discussed this morning. It is important that we ensure that the arms of governance have equal weighting. If the discussion becomes heavily weighted towards the financial savings targets that boards and IJBs have to make, it ends up skewed, and quality of care can easily get lost. We cannot allow that to happen—I agree with Brian Montgomery that the issue of quality of care has to be up there in the services that we are talking about. We have to make sure that boards give equal weight across the system to both discussions.

We need to come back to targets and what we describe as "good performance", because the pressure relating to those things means that it is not easy to have conversations about long-term transformation, which is the ball game that we have to be in. What does long-term transformation mean?

You asked whether we will satisfy everyone. We will almost certainly not satisfy everyone, but that is where openness and transparency and the discussions that Ruchir Shah has been having about how to involve people come in. Everyone will not necessarily agree, but at least there will be a sense of proper participation. That is important for staff as well as for the public. Participation of the people who receive services and those who deliver them is key. That is the only way in which we will be able to move forward.

We need to set the issue in its political context. The NHS will always be close to many people's hearts, and we must be aware of the political pressures that there will be as regards what the new approach might mean for the future. That is the landscape that we work in, which now includes local government, through integration joint boards. We can do a number of things, but we must make sure that we consider how we talk about performance, that we understand what we mean by success and that there is genuine participation.

Brian Montgomery brought up the issue of managed clinical networks and how they have transformed services without those services having to go through the formal governance processes. When we did our work on how we

might rethink what success looks like for health and social care services, one model that we were interested in was what managed clinical networks have done by collaborating and using participation to come up with ways to improve the services that are delivered for people. There are ideas out there about things that we could do, but we are working within a huge constraint on resources and the political pressure that goes along with the NHS.

Claire Sweeney: If we try to continue to do what we have always done with the current resources and the staff that we can get—we know that some of the posts cannot be filled—that approach will not work, so we need a different model. Health and social care integration must be part of the answer.

An issue that is worth mentioning that we have not talked about is the focus on outcomes and what difference it is making for people. Some healthy open conversations are starting to take place between clinicians and their patients about whether they want to continue a particular treatment and whether it is right for them. That approach brings with it all sorts of tensions to do with hitting waiting times targets and what performance might mean in a context in which the care that works for one individual might be very different from the care that works for other people. It opens up a range of variables that we have not previously had to deal with.

There also needs to be an acknowledgement that some of what we are discussing is not for the health system to fix—some of it is about access to the right housing and education and welfare issues. The discussion needs to be broadened, and integration is starting to open up such conversations. The issue is not just about how the acute hospitals are operating; it is also about whether the shift to prevention is happening quickly enough and how we can create a bit more space for it to happen.

Alison Johnstone: There is an issue that I would like Kenryck Lloyd-Jones to address. In its written submission, the Allied Health Professions Federation Scotland points out that the average cost of an adaptation is £2,800, but that if that adaptation is not made, £7,500 can be spent on dealing with all sorts of other issues. There needs to be a shift to prevention. Where in the governance process are we looking at whether such savings are being made?

Kenryck Lloyd-Jones: I would like to reflect on the fact that we have a system that is under pressure to make short-term decisions, often on declining budgets, whereby a very restricted look is taken at a particular aspect of how the budget is spent with a view to identifying how it can be shaved. What the system needs is long-term future planning to transform services so that we reduce the demand where we can and we support the population to get the right outcomes. If we are to achieve all that, we need whole-system thinking.

We have continually seen examples of cases in which investment in a preventative service would save money but it would save money off somebody else's budget, and for that reason, there is never the incentive to instigate it. As allied health professionals, we have continually said, "If you could just provide us with that budget, we could save all this money," but there is never the incentive to deliver on that. We get pilot schemes that are clinically effective and cost effective, but they are often done with money from the Scottish Government, through a centralised pot to fund initiatives. That means that the minute that an initiative's funding ends, with the expectation that it will become embedded in a service, the initiative is dropped—not because it has not worked or proved clinically effective and cost effective, but because it requires extra money that is no longer in the budget.

12:00

That kind of decision making needs to be challenged and needs to change. Where are the AHPs in all this? What we are seeking is parity of esteem. We want to get the right professionals around the table, to make the right decisions in the interests of the people whom we serve. Instead of thinking in terms of the budget and the short term, it is about considering how we can deliver lasting improvements, sometimes by getting different people to offer a slightly different service, which achieves a better outcome for everyone involved.

Dr Montgomery: We have talked a lot about resources, which is understandable, but I will be bold and say that the long-term answer is not more money. The resource challenges that we currently have are as much to do with people and facilities as they are to do with money. In some instances, we are unable to buy the things that we need or find the people whom we need to employ; we cannot use the money that is there.

The other challenge that we have is that we are spending a lot of money inefficiently and ineffectively. We are not achieving good value for the expenditure. For example, we are keeping people in acute hospital beds who do not need to be there, when we could provide home-care packages or nursing home beds for a fraction of the cost. We are spending money on locum staff to sustain services that are really yesterday's model.

We need the transformational change that Claire Sweeney and others have been talking about all morning. I hope that discussions such as

this one will give us another platform to enable us to get into that territory and discuss the need for a different, sustainable model for health and social care.

Brian Whittle: It seems to me that we are always coming across the issue that Kenryck Lloyd-Jones described. A little pilot scheme comes along and proves that we can spend less money and get better outcomes, in the context of the big budget, but when it comes to the end of the pilot scheme the initiative ends up on a shelf.

I find that massively frustrating. There was a very good initiative at University hospital Crosshouse, whereby stroke rehabilitation was taken into the community after six weeks. The approach was proven to reduce recurrence of stroke and readmission to hospital. However, the initiative ended up back on the shelf, which does not seem logical. How do we get to a point at which initiatives that are proven to work are adopted across the board?

Kenryck Lloyd-Jones: We need a whole-system buy-in to change. Very often, pilot schemes are initiated with a particular service, to look at changing to a better model, and they get investment from a third-party source.

Rehabilitation in the community can save a fortune. If we can rehabilitate someone to a point at which they are able to remain independent in their own home for longer, we can save a fortune in on-going social care. An ageing population that lacks independence is going to be a major drag on resource, and providing people with independence should be the priority. However, to do that, we have to spend money before the person requires social care. How do we get the whole system to recognise the cost saving, when the service that is providing care has to spend more money to save everyone else from intervening later?

The Convener: We have had a good discussion about accountability and scrutiny, and we have acknowledged that although there is an increasing focus on providing services at regional level, there is as yet no mechanism in place for achieving a regional approach.

Is there anything that we should be thinking about or saying to the Government about improving accountability and scrutiny in the existing territorial boards, in a way that will have application at regional level as the approach develops?

Claire Sweeney: The Scottish Government is developing a financial framework to underpin the 2020 vision. We think that that is an important part of the answer. The connection between the policy aspiration and what it means for local areas has been missing; everyone understands and signs up to the overall vision, but it has been very difficult to realise it in practical terms, for all the reasons that we have talked about.

We will be really interested to see what the financial framework looks like, because it should set out the steps that need to be taken to realise the vision that has been set out. It will speak to the issue of long-term financial planning and long-term planning in the round, which you talked about and which we think is part of the missing picture.

Ruchir Shah: I absolutely agree that we need a wider systems-change approach. If we are to take such an approach, we need to change our frame of reference at the highest level.

It is fortunate that there is a new frame of reference that we can use: the sustainable development goals. At the moment, the Scottish Government is working on the national performance framework, which it will shortly lay before the Parliament. As part of that, the Government is integrating the national performance framework with the sustainable development goals.

That approach allows us to start looking at the issue through a more preventative and system-wide lens. How does improving health outcomes relate to tackling poverty, climate change, gender equality, education and a range of other things? By looking at the issue through that lens, we can start not just to talk about systems—that will put a lot of people off—but to use a concrete and internationally recognised frame of reference, to which the Scottish Government has committed and which it has integrated with its national performance framework, to provide a wider context for tackling health.

The Convener: I thank all the witnesses for attending. This has been a useful and wide-ranging discussion, which will inform our on-going inquiry.

12:06

Meeting continued in private until 12:36.

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