OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 27 February 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 27 February 2018

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HEALTH AND SPORT COMMITTEE
7th 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:

Dr Catherine Calderwood (Scottish Government)
Linda Dunion (NHS Tayside)
Dr Graham Foster (NHS Forth Valley)
Christine Lester (NHS Grampian)
Christine McLaughlin (Scottish Government)
Shona Robison (Cabinet Secretary for Health and Sport)
Shirley Rogers (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 27 February 2018

[The Convener opened the meeting at 10:02]

Subordinate Legislation

Community Care (Provision of Residential Accommodation Outwith Scotland) (Scotland) Amendment Regulations 2018 (SSI 2018/16)

Community Care (Provision of Residential Accommodation Outwith Scotland) (Scotland) Amendment (No 2) Regulations 2018 (SSI 2018/42)

The Convener (Lewis Macdonald): Welcome to the seventh meeting of the Health and Sport Committee in 2018. I ask everyone to ensure that mobile phones are on silent, and not to record or photograph proceedings; we will record them for you.

Agenda item 1 is subordinate legislation. We have three instruments that are subject to negative procedure to consider. The first instrument is the Community Care (Provision of Residential Accommodation Outwith Scotland) (Scotland) Amendment Regulations 2018 (SSI 2018/16), and the second is the Community Care (Provision of Residential Accommodation Outwith Scotland) (Scotland) Amendment (No 2) Regulations 2018 (SSI 2018/42). It is no coincidence that they have similar names. No motion has been lodged to annul either of the instruments.

The Delegated Powers and Law Reform Committee commented on the first instrument because of a drafting error. The regulations are being introduced because of a change in legislation elsewhere; unfortunately, the date in the first instrument is 24 hours too late, so there would be a gap in provision. The DPLR Committee pointed that out to the Scottish Government, which has laid the second instrument in order to correct the error. This is the second time in a very few weeks that we have had a drafting error of that kind in an instrument. I am sure that the point will be well understood by those who are responsible for drafting such instruments.

As members do not have comments on either instrument, does the committee agree to make no recommendations on them?

Members *indicated agreement.*

Functions of Health Boards and Special Health Boards (Scotland) (Miscellaneous Amendments) Order 2018 (SSI 2018/27)

The Convener: There has been no motion to annul the instrument, and the Delegated Powers and Law Reform Committee has made no comments on it.

As members have no comments, does the committee agree to make no recommendations?

Members *indicated agreement.*

NHS Governance (Corporate)

10:04

The Convener: Agenda item 2 is two evidence-taking sessions on national health service corporate governance. In the first session, we will hear from members of health boards. I welcome to the meeting Linda Dunion, who is a non-executive board member at NHS Tayside; Christine Lester, who is a non-executive board member at NHS Grampian; and Dr Graham Foster, who is the director of public health and strategic planning at NHS Forth Valley.

I say, by way of introduction, that I am very grateful not only to our three witnesses but to other NHS board members who very helpfully responded to our recent survey. It is because of that that we are very interested to hear directly from board members about their differing perspectives.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I want to begin by looking at diversity on NHS boards, which we also considered in last week's evidence session. Of the board members who responded to our survey, 64 per cent are 55 or over. However, there is no one in the 18 to 24 age bracket, as I highlighted last week, in the context of this year's being the year of young people in Scotland.

It was not only age that was highlighted as a factor. Bill Scott from Inclusion Scotland said:

"There is also desperate underrepresentation of disabled people on all public boards, including NHS boards."—[*Official Report, Health and Sport Committee,* 20 February 2018; c 6.]

Is there an issue with representation?

Secondly, can you talk us through how positions are advertised in your local contexts? Do any issues with regard to advertising positions need to be considered in greater detail?

Christine Lester (NHS Grampian): I will start, if that is okay.

I was appointed as part of the alternative pilot, in which people were either elected to a board or chosen as lay members of the public. I came into the role after answering an advert in the *The Press and Journal*. I am now coming to the end of the second of my two four-year terms, but it is only in the past three or four years that I have felt myself to be as well informed as I need to be. I point out that the board is all that I have been doing I was widowed shortly before I joined and was a carer for my husband, and it has taken over my life. There is so much for a layperson to learn.

From an age perspective, the remuneration does not allow people to play a full-time or even a part-time role, and the role is just not versatile enough to allow a person to hold down another job at the same time. I also suspect that the small salary involved would have a massive impact on people who are on welfare benefits. I say, therefore, that NHS Grampian is well represented from the disability perspective, but not from the age perspective.

Linda Dunion (NHS Tayside): We need to be clear about why we want diverse boards, so I will take things back a step.

When I read the *Official Report* of last week's evidence, I was quite concerned by some of it. I might be misinterpreting it, but it seemed to me at points that diversity is perhaps seen if not as a substitute, then as a way of ensuring that certain voices are heard at the board table in a representative fashion. That is counter to the code of conduct: we cannot "represent" people. I have had to deal with this issue in the Perth and Kinross integration joint board, which I chair, and it is a source of confusion that needs to be addressed. We need to distinguish between having diverse boards, which I am not arguing against, and putting in place effective mechanisms by which the huge variety of different perspectives can be brought to bear on decision making, strategy and implementation of strategic direction by boards.

There are two different things to take into account. As far as how board positions are advertised is concerned, it is very misleading to suggest that it is possible to be an effective non-executive member—I, too, am a lay member; I have come through the public appointments process—in eight hours a week. About three years ago, NHS Tayside went through a recruitment process and recruited a much-needed female member to the board. She did not last because she had expected to commit eight hours a week to the role. When she could not do it, she was very unhappy for quite a long time and felt that she was failing. She was not—she was trying to do something that simply was not doable. There is an issue in that respect.

There is also an issue with the process by which people come to the board. Christine Lester talked about how long it takes to get to grips with a health board. When I joined NHS Tayside, the chair of another board told me to expect not to know what I was talking about until I had been on the board for two years. That was extremely helpful advice, which made me feel a lot better. The issue is one that everybody talks about.

I think that there is a place for nurturing people and for being more creative about how we attract people to boards, but we have a responsibility to ensure that, below the board, there are

mechanisms in place whereby there is genuine engagement and participation and people can make meaningful contributions to the business of the board.

Dr Graham Foster (NHS Forth Valley): It is important to think about form following function and about what are the functions of the various members of boards: they are made up of a variety of individuals who perform different roles. I am an executive director of a board; that is a professional role, and I and the other executive directors trained for a long time to enable us to carry out the role. It took probably 20 years of training to get me to the stage at which I was appointed as a board member and could take on that very important responsibility.

When non-executive directors come on to boards, it is important that we think about what we are asking them to do. I have the hugest respect for the non-execs on our board; I see them working incredibly hard to get to grips with extremely complex and difficult challenges, often in situations that they are not used to.

Traditionally, the role of a non-executive board member was very much about holding people to account. If that is the role, there is huge potential to have very diverse boards, because that role is about asking difficult questions. It might, for example, involve asking why we are not doing something for young people. One of Forth Valley's local authorities uses a young persons' panel, which I know from experience is hugely valuable, because such questions are asked. Boards need to be asked whether they are representing the interests of various groups in their communities. Having people with the expertise and willingness to ask those questions is extremely important to us—it is hugely valuable.

In recent years, expectations about board members—non-executive board members, in particular—have increased and changed. I agree absolutely with what Linda Dunion said. Anyone who thinks that they can be a non-executive board member part time is probably kidding themselves.

Greater emphasis has been put on community planning. For example, Forth Valley NHS's board has non-executive directors who participate in community planning, which is a significant role. It is also expected that we will field non-executive board members to take part in integration joint boards. Those roles are quite different from the holding-to-account role that we have traditionally asked our non-exec members to perform. I am not sure that sufficient thought has been given to the training and support that they need to fulfil those roles.

The work on integration joint boards, in particular, is challenging, because it is a very different environment. On IJBs, there is a balance of non-executive board members and local authority councillors. As the committee will be aware, councillors come from a different background and have different experience, and they will have very different expectations of structure and process from those of a non-executive board member, who might be a young person who signed up to do eight hours a week to provide some scrutiny of the board and to ask difficult questions.

To answer Jenny Gilruth's original question, I think diversity would be an extremely good thing, but if we are to achieve that and make it possible for non-executive board members to deliver what we are looking for, we need to stop and reflect on what we are asking of our non-executive board members.

Perhaps there are alternative ways in which to achieve diversity. Panels, advisory boards and so on might be a different way to make it more possible for such individuals to step forward. If we want individuals from all sorts of different backgrounds to participate, we need to make it possible for them to participate. At the moment, being a non-executive board member is pretty scary and is a difficult role to take on.

10:15

Jenny Gilruth: I appreciate what you are saying, Dr Foster. I imagine that becoming a non-executive board member would be "pretty scary" if you did not have a board background, and in particular in the medical sector. However, one could apply the same logic to becoming a politician. The Scottish Parliament has legislated for gender representation on public boards. In the past, people may have argued that becoming a politician might be too scary for women. We have moved the argument on.

Linda Dunion said that no one can do the work of a non-executive member in eight hours a week, Christine Lester said that she had got to grips with the process only in the last three or four years and Dr Foster said that having to get to grips with such a complex role could put people off. Rather than giving adequate training, perhaps we need to consider the current system and how we can make it more accessible to everyone. We could look at using plain English in board meetings and consider how to make the language that is used by the NHS much more accessible for all groups in society. Regardless of gender and disability, we can use language to engage more people in the process so that it does not take more than eight hours a week to do the job and so that the system is more accessible. Is there something we could consider in that respect to make board membership more accessible?

Linda Dunion: That is a really good point and one that I agree with. We have talked a lot about that in NHS Tayside and have made a lot of changes since our newish chair, John Connell, came into post. The density of the language and the number of technical terms that are used pose a real barrier. Traditionally, the NHS has been very poor at talking in plain English and there has not been a culture of transparency. That creates a vicious circle that excludes people—although not always deliberately. It is an important issue.

The way in which we carry out our business is also not helpful. For example, last week I was in a meeting for five hours. Who can you ask to do that, during the week, during the day, as a formal board member? There needs to be a high degree of formality around many of the issues that we discuss—we are receiving reports on clinical care and governance, finance and so on, which need a formal structure to deal with them effectively. That said, if we think about people's different circumstances, it is no surprise that it is people who are retired, who are semi-retired or who have very flexible employers who are able to sit on a board and fulfil all the functions that are expected of a non-executive member, because it is not all about board and committee meetings.

Christine Lester: I went through the process of appointment after answering an advert in *The Press and Journal*. If you go on the public appointments website for board members in Scotland, you will see that it is all competency based, which is a very technical way to apply for a role. I would struggle with that—I know that because I have looked at the adverts recently as I am coming to end of my term as a non-executive board member. If boards want ordinary young people on them, they are looking for really extraordinary young people just to get through that part of the process.

Graham Foster: I absolutely agree with Jenny Gilruth that we need to change. If we want diversity we will have to move with the times. I would be up for that. We must ensure that our boards speak in plain English. My role as a board member is often to say, "Hang on a minute—can we just explain what that means?" to ensure that we are using language that is entirely intelligible and that we have not descended into professional gobbledegook. That is really important.

Our meetings tend to be very formal, which inhibits the structure and limits people to asking only the questions that they really want to ask. We can be much more flexible about meetings, which can be less formal and in different settings—for example, board seminars between board meetings are not in public, so people can be more comfortable about asking questions. Meeting lengths need to be sensible, with regular breaks, as it is no longer acceptable to expect people to sit for three hours just because "That's how it's always been done." Boards can do all sorts of things to be more accommodating.

We need to think about what we ask people to do. Jenny Gilruth's analogy is absolutely right: we can elect politicians at any adult age, but we do not ask them to be the First Minister straight away. People should be used for what they have been asked to do, which is to hold us to account. The bigger and wider the range of people who do that, the better. The more we can encourage people to ask questions, the better the system will be.

Sandra White (Glasgow Kelvin) (SNP): The panel seems to have explained that a number of the population would be put off and be frightened of becoming a board member.

I want to pick up on the fact that being on a board affects people's benefits. People who work are on benefits, not just people who are not working. Near enough half the population could be being stopped from becoming a board member, and this committee needs to look at that. I thank Christine Lester for raising the point, which I had not realised. My big worry is that half the population is being excluded because they are on benefits or are being frightened off because boards seem so formal.

Christine Lester: I was on benefits when I came to this role, which is why I am aware of the issue. My jobseekers allowance was stopped. Luckily, I had a small widow's pension, which enabled me to continue. Other people would not have been so lucky.

Ivan McKee (Glasgow Provan) (SNP): Thank you for coming along to talk to us this morning. It has been very illuminating so far. I was particularly taken by what Dr Foster said about form following function. It is important to understand the purpose of a non-executive board member.

I get all the points about the job being difficult and scary. However, people are being asked to hold to account an organisation that spends £13 billion of taxpayers' money and is responsible for the lives and wellbeing of hundreds of thousands of people. If it was not a big scary job, there would be something wrong.

I want to drill down into clarity about the role. Is the job description written down? If so, is it written as it should be?

Linda Dunion: When people apply for a public appointment, the job description—or role description—is set out, but a person who has not spoken to a non-exec would not really know what it means. I was previously on the board of what was the care commission, for which there was probably closer fit between the description and the

expectation. I have never met a non-exec on the territorial boards who would not have said the same as we have said today. The expectation is the issue.

The description of the board member role concentrates strictly on the governance role. In some respects, that is the most important part of the role. I have had to work hard with IJB members so that they appreciate that an IJB is a board and that certain responsibilities go with that—they sign a code of conduct, for example, and a lot flows from that. That is true for anybody who comes on to a board.

However, information is lacking on the additional expectations for the board member role. The role is an opportunity to do other things—I am a member of the community planning partnership board in Perth and Kinross, and I have done other things as a board member on the IJB. However, those things do not fit into the expected time.

A practical suggestion that I have made in our board in the past is that we should look to create opportunities for people to buddy or shadow existing non-executive board members, particularly when we know that vacancies are going to come up. Likewise, when new people are appointed, it would be good if there could be a system whereby their remuneration kicks in before they join the board, so that they can come in for a sort of pre-induction, as it were. That would enable them to marry up with not just non-executive board members but some of the executive board members in order to get a sense of the language, the culture and the issues before they sit down at the board table. That would help everybody, not only people who are currently underrepresented.

Christine Lester: You mentioned language and the accessibility of language, and one of the other big issues around that is the amount of reading that people have to do. I usually have a big pile of stuff to read, which I can do sitting at the kitchen table at home. However, I live in rural Moray and, if I have a meeting in Edinburgh, I have to come down the day before, bringing with me a thick pile of papers that I have to read. For example, there was a master class for board members in Edinburgh yesterday, so I came down on Sunday with a thick pile of papers that arrived at my house on Friday.

You get better at managing that, but there is no question but that those papers could be presented in a much more concise form. For example, Audit Scotland reports are extremely clear and concise pieces of paperwork. It can be done. If you challenge it, the situation gets a bit better for a while, but then the volume creeps back up again. That part of the process is a nightmare, and it could be much better.

Ivan McKee: If the job is to hold the executive board members to account, how effective are non-executive board members at that? Is it possible that the papers are so big and complicated and the language is so difficult deliberately, in order to make it more difficult for the non-executive board members to hold the executive board members to account?

Christine Lester: I would not say that it is done deliberately. I think that the landscape is so complicated that each issue has a lot of background to it, which means that a lot of information is contained in appendices. For the executive board members, that information is their bread and butter; it is what they live and breathe. In my experience, the documents are that size because there is an attempt to put all the information on the table. That said, there is no doubt about the fact that the information can be presented in a clearer form. For example, it could come in bits before the meeting; it does not all have to come the week before.

In NHS Grampian, we have quite a good way of doing things that involves seminars. Those are informal briefings that give people an opportunity to work together. When I started in the role seven years ago, they were a good thing. However, with the integration landscape and all the associated changes, including regional development issues, the seminars are now taken up with a lot of issues that are separate from the board business, which means that it is difficult to deal with everything in the time that is available.

Ivan McKee: How effective are non-executive board members at holding executive board members to account?

Christine Lester: I personally hold the chief executive to account. I think that we are quite good at doing that.

Linda Dunion: In Tayside, we have done a lot of work on the volume of papers over the past few years. We have vastly reduced the number of papers that people receive, because we were getting hundreds and hundreds of pages all the time, and we could not possibly read them. A lot of work was done to revise the committee structure and delegate responsibility to the committees. However, at each board meeting, we receive a chair's assurance report from each of the standing committees, which brings out any issues that need to come to the attention of the board. That gives the board an opportunity to request other information before it makes a decision.

We have also streamlined the reporting around performance. A lot of work is being done to change the systems in order to reduce that side of the workload for the non-executive board

members, which enables them to be more effective.

Moreover, a lot of work has been done on listening to non-execs about what we need to fulfil our role more effectively. That includes issues such as the use of plain English, which we spoke about.

Ivan McKee: That is good to hear. Thank you.

10:30

Dr Foster: I confess that, as an executive director, I dread those piles of papers as much as my colleagues do. I find them equally daunting and equally difficult to get through, and it is often the wee small hours before you have read through all the papers for the next meeting—and we have a lot of meetings.

The difficulty is that there is a culture in the NHS in which it is felt that all those papers need to be produced and entered into the public record in order to deliver governance, accountability and openness. It would therefore be refreshing and helpful if we could get some guidance on that and if someone could say, "Actually, you don't need to produce that many papers for every meeting for a board to be held to account as a public body." Our board has reduced the number of papers quite considerably in recent times, largely because of expediency more than anything else; we simply do not have enough people to produce that amount of paper any more, and we have a smaller exec team, which means that we cannot manage it anyway.

It is important that we reduce the number of papers. After all, it is absolutely right to say that, if you produce a very thick pile of papers, you are just burying the facts in a mountain of paper. If you could make the key points on a couple of A4 pages, that would be absolutely fine. That said, as officials in the NHS, we would need to be clear that that was good enough and that we were not failing the public by not being sufficiently open and not producing sufficient information. If we could strike that balance, we could have a revolution with regard to board papers.

I want to check that everyone is familiar with the structure of NHS boards, because it is different from the way in which other public organisations are structured. The chief executive is the chief accountable officer and is appointed directly by the cabinet secretary, who also appoints executive directors like me; non-execs are also appointed. As a result, the board comprises a group of individuals who share responsibility for running that large public organisation. We are in control of a huge amount of public money—in our case, it is £550 million. That is quite a lot for me to take on, and I feel personally accountable for that spend and for not overspending the money.

That is our model, and it is different from that of the other agencies that we deal with. In local authorities, for example, the councillors are effectively in control and the staff work for them; that differs from how the NHS is currently run, and other public bodies are run in various different ways. It is therefore important to be familiar with the structure of boards, how that works and how that function is delivered.

The Convener: That is excellent. Thank you very much.

We now move on to questions about involving staff and the public, and I will start with Alison Johnstone.

Alison Johnstone (Lothian) (Green): Your evidence so far has helped us to understand the challenging nature of your role and your responsibility just to get your head round the facts and figures. You certainly have to scrutinise a lot of information. However, I note that last week some witnesses felt that the lack of public trust in boards might have come about because of a tendency to inform and perhaps consult in what sometimes appears to be a less than meaningful way. Are the correct mechanisms in place to enable the public, the staff and the third sector to get involved in NHS decision making on an on-going basis, and has public engagement been hardwired into the process in the way that we probably all think that it should be?

The Convener: Who would like to start off on that very large question?

Dr Foster: Public engagement is really important, and we take it very seriously and work hard at it in a range of ways. In our communications work, we try to keep the public informed through our relationship with the media and the information that we send out. We also have our meetings in public, publish all our minutes and so on, and we have active involvement with members of the public through patient representatives on various groups. In most of our planning groups—our clinical governance committee, for example—you will find a member of the public watching what we are doing and asking challenging questions, and that really helps us to focus on the fact that we are serving our public and to remember that that is what we are all about. We also have a number of public panels that we ask questions of, which helps to keep us informed.

I have forgotten its name, but we have a public website where individuals can ask the NHS questions. We are very energetic in following that and in responding very quickly, and if you post a

question or a concern about the care that you have received in our health board—

Christine Lester: It is the Care Opinion website.

Dr Foster: That is the one—thank you very much. We use that website a lot; indeed, I would be surprised if someone who posted on it did not receive a response within 48 hours, or even a lot quicker. In fact, you will often get a response the same day, with someone saying, "Really sorry you've had that challenge. Can we direct you to how you can access that service?" That technological approach has been very successful for us and has helped enormously.

That said, we need to make sure that we respond to public opinion in a realistic way. We get the people whom we get; for example, we will get as members of committees people who have a particular specialist interest. Those individuals are very hard-working and committed, but they tend to stay with us for quite a long time, which means that we do not have a lot of turnover. Moreover, they probably do not reflect a real cross-section of our local society, and it would be better if that we had that. Obviously the panels are much better at that sort of thing, but again, you do not necessarily get that. Nevertheless, we are really committed to getting public engagement, because it is important to us.

Christine Lester: It is important, and I would note that we are embracing new ways of doing things, including the use of social media such as Facebook and Twitter. Over the winter, NHS Grampian has been very successful in tweeting about the number of people who have fallen over, the fact that the pavements are slippy, the need for people to go to pharmacists and so on, and those tweets were shared again and again and the posts on Facebook got loads of likes. It is a really good approach.

That said, we should not forget the need to have an honest conversation with the public. It is not just something that we do during the winter or when we have good news to share; the changing landscape means that we should be engaging with the public all the time. Part of the issue is that we are driven by media interest, which makes us almost a bit fearful about having an honest conversation and saying what we can and cannot do and why we can or cannot do it. It is a real challenge for us, but we need to have it.

Linda Dunion: I would draw a distinction in this regard. As far as the information that is communicated is concerned, the NHS does quite a good job, with some of the techniques that we have heard about being used effectively. It is certainly easier than it used to be for members of the public to tell the NHS what it thinks.

However, if we are talking about genuine engagement, we need to look further down at the localities within the IJB structure and, for example, the local action partnerships that we in Perth and Kinross have under the community planning partnership and which are working very closely with those IJB localities. I would also highlight the strategic commissioning plan for Perth and Kinross IJB, which involved a huge public engagement exercise that was run by the local third sector interface with public sector funding. I see that kind of engagement as starting with individuals, neighbourhoods and communities, not just with those who are explicitly involved in health but community development trusts or, say, walking groups or whatever that might be involved in things that might lead to social prescribing. We need to look at what is happening at community level and feed that up through the system to ensure that NHS boards have a very robust—I hate that word, but everyone uses it—sounding board that really tells them what is happening on the ground.

We had a model in Aberfeldy that demonstrates something that is, to me, absolutely key to sharing the difficult information that we have just been talking about, which is giving communities ownership of the data and the complexity of the issues. If people are trusted with the information that we have at our disposal, they can really help and it can be a joint effort to arrive at solutions that people will support because they understand them. I remember sitting in a public meeting in Aberfeldy and the woman next to me, whom I did not know, turned round and said, "You get awful wedded to bricks and mortar, don't you? My daughter was born in the hospital and I was born in the hospital but, actually, it has to go." She concluded that because she had been part of the process, and we need to see more of that happening.

The Convener: The next question is from Ash Denham.

Ash Denham (Edinburgh Eastern) (SNP): I think that my question has been covered by the answer to Alison Johnson's question.

Miles Briggs (Lothian) (Con): Good morning, panel. I want to develop Alison Johnstone's point and refer to the results of a piece of research that the Scottish Parliament information centre provided us with. I think that it surprised us all. It suggested that the majority of members of NHS health boards believe that the boards are not always honest with the public about their decisions.

The survey received responses from about half of all board members, and a total of 59 per cent of those said that the board was "mostly", "sometimes" or "hardly ever" transparent about its

decision making. How can that be improved? As we have just heard, there is sometimes a disconnect between decisions that are taken by the boards and the public, who do not feel that they are part of the decision making process.

Linda Dunion: That is about culture change. I can give you another example, of which you may well be aware, from the redesign of in-patient adult mental health and learning disability services in NHS Tayside. About two and a half years ago, there had been the beginnings of a consultation process, but then the board was asked to take a decision. A councillor member of the board and I were very unhappy at being asked to do that, because we felt that the consultation process had been inadequate.

There was pressure on us, and we knew that our not taking the decision would cause a delay, but we felt that the public had not had a chance to be involved meaningfully in the process, and that the people who used those services, their carers and the staff had not had the opportunity to be properly engaged in informing the decision or, as it turned out, in helping with option appraisals and arriving at a preferred option.

The process was pushed back. That was not a universally popular decision, but it was the right one. That is an example of where non-execs need to be quite firm and draw on their own lived and professional experiences to change a decision that would otherwise be made. If we are serious about being honest with the public, we need to recognise that that takes a certain skill set, investment and a certain amount of time—but it does not need to be an inordinate amount of time.

Christine Lester: I think that the honest conversation just needs to start. We are quite good at the good news, or at saying something in so many words that nobody else understands it. We need to use clear, concise language, tell it like it is and do that all the time, because life is like that. The NHS is no different from anywhere else; things are challenging sometimes—quite a lot of the time.

We should talk about money and about how much it costs if people do not turn up to their general practice surgery or out-patient appointments. That is really important and we do not do that. We do the good news but not all of the news, so it is a big deal when a bit of bad news or not-so-good news comes out. However, life is like that and we should be doing the whole thing around language and telling it like it is in board meetings, including through the papers.

10:45

Dr Foster: I think that we are really talking about public confidence in the system. That is at the heart of it. In the world in which we live, it is very challenging to maintain public confidence in the service, because it is the nature of that world that people challenge everything that goes wrong. They challenge targets and things that they see are not right, and we are not very good at celebrating success.

This year is the 70th anniversary of the national health service, which was started in 1948, and it has never been better. There is absolutely no doubt about that and I challenge anyone to prove otherwise. It has never been better and it does spectacular things. Every day, we are doing new interventions that were not possible before, and we are saving lives. The NHS is free to everyone at the point of delivery, and it is the envy of the world. Nowhere else could do what we in Scotland do with the NHS, and we should be proud of it.

It belongs to us, and we want it to be great. Yet we spend an awful lot of time trying to solve little problems around the edges, so that it sounds as though the service is constantly in crisis. There are challenges there. We are partly guilty of believing our own hype, in that even our non-executive board members believe that we are constantly rolling from one crisis to the next. We should stop and think objectively about the quality of the service that we deliver and about the fact that we have continued to sustain that delivery despite all the financial pressures and austerity that we have faced in recent years and all the other things that we have had to do.

We should compare that with the past when, every year, we used to have NHS financial uplifts of 7, 8 or 9 per cent. For the past decade, we have run at almost flat cash or with 1 per cent increases, because that is the way that public finances are now. It is the same for everyone in the public service and for the Government. Yet we have continued to sustain an NHS that is free for everyone. We are not turning people away. We are delivering fantastic new services. I was watching television this morning, and they were talking about the fact that, every year, 6,000 premature babies are alive who would not be if it were not for the NHS. We could not do any of that before we started out in 1948.

However, we really struggle. Last year, when I did a presentation at a conference, I went back to look at the original launch documents for the NHS. Within a few months of its launch in 1948, the Minister of Health was already saying that the country would struggle with the service because expectations were rising, technology was moving ahead and the population was getting bigger. Here we are, 70 years later, and we are still facing the same challenges. However, we have done it: we continue to deliver our fantastic NHS. Sometimes,

we forget to celebrate that and to remember that it is a very good thing.

Yes, there are challenges all around the edges, and we need to get better and to work on those. It is tough, and money is tight. However, sometimes we get wrapped up in the idea that the NHS is constantly in crisis. If we say that, the public believes it and loses confidence in the service. That is the challenge. There is a big question about how we maintain public confidence. When we say that we are not being honest with the public, that is part of the root of the problem. We are dealing with all those challenges and battling against the idea that it is all in crisis. We are saying, "No, no, it's all right," but we actually know that it is very difficult. That is where we get tension between being really honest with our public and telling them about what the challenges are.

Miles Briggs: I have a brief supplementary question. Part of the research pointed towards your decision making possibly not feeding into what the Scottish or the United Kingdom Government wants to see. I was interested to find that out. Is there political interference from central Government in your decision-making processes? Do you have examples of that in which you have felt that you could not take a decision and take the public with you because central Government made it known that it would not like to see that happen?

Dr Foster: This is the "no comment" moment.

Linda Dunion: I am not aware of any such decisions. I know that, in the survey results, there were quite a lot of comments about the fact that health boards have to meet targets that the Scottish Government sets and be accountable to it. In my time on the board, I have not been aware of a specific instance in which the Government has leant on NHS Tayside to make a decision that we did not want to make.

Christine Lester: I wish that I could say the same. The timing of elections quite often stymies discussion in the period that is called purdah. We might have a momentum going and then it all has to stop and start again. It is like a giant tanker. If we are trying to turn it around, do things differently and change, that whole cycle of local and national elections—and, boy, we have had a few of those recently—does not stop discussion, but it definitely holds things back. We might have a trajectory and have the public and local and national politicians engaged, and then we have to stop. It takes time to get going again, which has been a real issue in fostering change—certainly in rural communities, in which we want to do things differently.

Alex Cole-Hamilton (Edinburgh Western) (LD): I will pick up on the public confidence issue that Graham Foster just described. When building public confidence, we need to manage expectations of service adequately. As an Edinburgh MSP, I can speak only about NHS Lothian, but I have lost count of the number of constituents who have come to see me because of protracted waiting-time delays. They were led to believe that they were in a certain waiting-time bracket, whether the 12-week guarantee or any other notional expectation, but that was blown out of the water by an indication that they would have to wait months longer than that. I ask the witnesses to give us an idea of how each of their boards deals with expectations on waiting times, particularly when there are statutory targets to meet.

Dr Foster: As you said, it is about public confidence. Waiting times are one of the areas in which we face challenges. Expectations are high and we generate many of them ourselves, perhaps because we are not realistic about what we can do. That is related to the previous question, which I did not answer but which was about the challenges that we face and times when are we are not able to make our own decisions.

Ultimately, the boards are accountable for their own decisions and free to make them, but we face continual pressure to do ever more every year. New technologies and new drugs are an example of that. It is very difficult to explain to the public that the latest new cancer treatment that perhaps cost hundreds of thousands of pounds is not as important as ensuring that we clear a waiting list or give everyone the core, life-saving treatment that they need. We find it very difficult when we are challenged by someone who asks why, in Scotland, we cannot use a new technology that is being used in America or England and says that we must do it now. Such things are expensive and difficult. It is hard to set our priorities locally because all those things come in from left field.

A lot of discussion is going on, particularly between the medical directors in Scotland, to try to bring some order to that and try to reduce those new expectations so that we can stop and think about the cost of the new things that are constantly being added to the expectations. I could probably talk for a whole hour about different examples of decisions that are made outwith the control of boards that suddenly increase our costs. They are quite challenging and we have to manage them.

Recently, following an inspection, an infection control nurse in a national agency asked us to use a certain infection control measure. For us, that would collectively cost between £60,000 and £100,000 to implement. I could find no evidence base for it whatsoever and could see no benefit to patients from it but a national expert thought that it would be a good idea if we changed the way that we clean.

Such changes do not get any governance checks and there is no cost impact assessment of them. Someone in a national agency tells us to change the guidance, add a new level and raise the bar and we just have to dig into our coffers and find the costs for that, which is really challenging. Those are the realities that the health board faces every day, so there are questions to be asked about all the different agencies that produce rules, some of which are entirely valid and some of which are less so. Do those agencies stop and think about the cost to the public purse of the impact of the decisions that they take?

To come back to your question, which was about waiting times, it is really important that we not lead patients into believing that they will get something and then not deliver. We need to be realistic about what we can deliver. We are very guilty of putting people into pathways that drive them down a line that tells them that they need an operation, that it will be done in 12 weeks and that there is no alternative. However, those individuals often have a lot of alternatives and we know that, if we asked doctors, the individual would not have that operation in the first place or it would certainly be delayed because they would follow another pathway.

Before we came in, we were talking about knee operations. Let us take the example of someone who goes to see their GP with a painful knee and the GP says that they will send them to an orthopaedic surgeon. The minute that they see the orthopaedic surgeon and the surgeon says that they could have a knee replacement, the clock starts ticking and, because they are on the clock, they have to get their knee replacement. We do not tell them that they would benefit from a knee replacement but might also benefit from physiotherapy—which could keep them without a knee replacement for another four or five years or possibly a decade—that they might benefit from a certain drug or that they might choose to keep doing what they are doing and change their behaviour. We do not stop and ask the patient what is important to them. We are really bad at doing that.

Because we have all these waiting times targets and other things, we slavishly follow the pathway and as soon as you are a potential candidate for a knee replacement, the clock is ticking and we shove you through that tube, give you a knee replacement and you go home. We sometimes hear people saying, "Well I went to the doctor with a sore knee and I had my knee replaced. How did that happen?" It is because we are so obsessed with waiting times and so on. We need to be much more honest with the public about what we can do and what the alternatives are. If we are going to tell someone that they need a replacement, we should do it in good time, but we need to be a bit more sensible about when we put people on those pathways. We should give them the alternatives and make sure that they are doing what is right for them at the time. I am quite convinced that we are doing a lot of things that are not in the best interests of the patients; we are doing them because we think that we ought to.

Christine Lester: It is funny that Dr Foster mentioned knee replacements. We have been talking about obesity strategies and I recently learned that losing 1kg means a loss of 8kg for the knee because of the way in which a knee's mechanism works. That is fantastic. Losing 1kg is achievable, so someone who has got a sore knee should go home and lose a kilo first. That is infinitely preferable to waiting for weeks and weeks before going into hospital. I just thought I would throw that in because it is fascinating that losing 1kg to benefit by 8kg is achievable. I would be quite happy to go for that.

To go back to the question, waiting times are a real challenge. NHS Grampian has chosen to clinically prioritise people, so those people who need treatment will be seen first, and quickly. The waiting times are published on our website but only cover those who are on that pathway. A member of the general public would not be able to find that information on our website. That goes back to the honest conversation that I have been talking about and the expectations that people have of the NHS and what it can provide for them when their knee gets sore, for example.

We are also talking about realistic medicine. We have all read about it and talked about it on boards, but we are still shying away from having a public conversation about what realistic medicine means for people and their expectations before they go to their GP.

The Convener: We have touched on IJBs from a couple of different directions in our discussions about seminars and external advice. Before I ask colleagues to ask their questions about IJBs, can I ask whether there is a sense that the development of IJBs and a regional level provision has reduced boards' strategic role? Do board members feel that their strategic grip is less than it was a couple of years ago?

Linda Dunion: I would not say so. This is very front of mind at the moment. NHS Tayside has been developing a number of strategies in surgical services, primary care and what have you, all under the umbrella of our integrated clinical strategy. That is an important part of the landscape for IJBs and community planning partnerships.

It is about the organisations finding their place in the new environment. However, given our responsibilities—I can speak only for NHS Tayside

in this regard—it is really important that health boards know what their own strategy is about and how it sits alongside regional strategies.

I refer back to what I said earlier about ensuring that there is also a bottom-up approach and that the strategy is informed by what is happening across the piece. If integration does not work, if communities and individuals are not more knowledgeable—if they do not have the information and do not own the data on what is happening locally—and if individuals do not have ownership of their individual health, that will be to the detriment of the health board in determining its own strategies.

We are talking about a new modus vivendi, but I do not see any diminution of the role of the health board in setting strategy.

Brian Whittle (South Scotland) (Con): With the movement of IJBs towards regional planning, you must be having to adapt to take on the role of the IJBs. Are you getting room to breathe in that environment? Are you getting the room to adapt? Do you have the tools for adapting the boards into that role?

11:00

Dr Foster: You are right that it is a very busy world just now—it is a congested playing field, if we can use that analogy. There are a lot of things going on, which is making life very difficult. Boards are probably smaller now than they have been. They have fewer staff and less resource, and we are trying to set up a bigger and more complicated structure and make it work.

On strategy, I agree with the previous answer. Boards have strong responsibility for strategic direction making and they are continuing to do that. In my own board we have very clear healthcare and health improvement strategies and we want to deliver those things. We understand the principles behind why regional planning is important but, at the moment, it is very much about establishing structures and processes, needs assessments, planning and so on, and not about doing the critical work that we need to do of joining up regional services. We have probably got a bit distracted from that because we are trying to set up the new structure.

As a board, we are absolutely committed to integration. We want to deliver the original integration principles that are set out in the Public Bodies (Joint Working) (Scotland) Act 2014, but again we are finding that very challenging. We have got sidetracked into a discussion about structures and processes, who works for the IJB and who does not, what their roles and responsibilities are, who line manages who, operational delivery issues and so on. Actually, we just want to get on with doing something at the front line for patients, but that is really tricky because we have got sidetracked into all the different organisation and governance arrangements and, until those settle down, it is a struggle to make other things land.

The core of the question was about strategic planning. I go back to the fact that my role is strategic planning and that integration and the IJBs are meant to be about strategic planning. We are almost wondering when we are going to start doing strategic planning in the IJBs, because we have spent so much time on governance and structures that we have never got round to it. At the moment, the boards are still doing the strategic planning, and we are waiting.

Christine Lester: I am the chair of Moray IJB, where I think that we have a very different scenario. Do not forget that integration is quite new—it is not even two years old and we have been given a lot to do. From the Moray perspective, some of the things that we have been given to deal with are ones that neither the health board nor the local authority has wanted to do up. Therefore, it does not come with any good news on the horizon—for want of a better word—but the opportunity is great. Moray was one of the first places to have a community health and social care partnership before it had an IJB, so we had people working together in the same building. They were all sitting in different offices, but now they are all in the same office. We have health people who are managed by local authority employees and vice versa.

Moray is a small place and I think that that has probably made it easier, because it is all the same people at the end of the day; it is quite a small-structured environment. We have been able to do the strategic planning side. We are between Highland and Grampian—we are part of Grampian but we are in the A96 corridor—so strategically Moray is in a good place to be doing that planning and we are doing it. The regional side is definitely not being driven locally at the moment; it is being driven nationally and through the health board structure, and there is less input from the IJB and the local authority.

Brian Whittle: Is there a danger of duplication of work by the IJB and the board and, if so, how do we avoid that?

Christine Lester: Not from my perspective, but I do not know about anybody else.

Linda Dunion: I do not recognise that. There might be a danger of duplication, but I do not see it in practice. I was up at Pitlochry on Friday with members of the IJB and we were extremely encouraged. There is a layer at which we might say that integration is struggling, which is the layer

of getting that kind of management structure in place, but what is happening on the ground is that people are just rolling up their sleeves, getting on with it and doing some fabulous work. We on the board of the IJB can get so bound up in thinking always about the finance and the heavy papers that we have in front of us that it is good sometimes to be reminded that people have embraced integration, and they are getting on and making it happen. We were sitting with people from health, the council and third sector community organisations, so I am very encouraged by what is happening on the ground. We just need to crack the structures and get to integrated budgets, because that is key to making it happen properly.

Dr Foster: I agree with a lot of that. My initial answer to the question whether there is a danger of duplication would be that there absolutely is not, because the same people as before are doing the work. The IJB is a new planning committee in effect—it is not a huge new organisation that is going to take over a lot of the work—so it is always the same people doing the work and there should not be a danger of duplication.

However, I am reminded that the topic of conversation this morning is corporate governance. We were talking earlier about those piles of papers and big meetings and all that administrative burden, and there is definitely duplication of that now because we have a lot more meetings. We will not see board meetings decreasing by an amount corresponding to the number of new papers that there are at IJB meetings. For a small board such as NHS Forth Valley it is certainly a struggle for our non-execs and execs to support the sheer number of meetings that we have. We have to support a number of IJBs and community planning partnerships as well as the board, where previously we just had the one structure. There is a lot of duplication of the administration and governance but not of the actual work.

Sandra White: In its report in 2015, Audit Scotland talked about governance accountability. I am pleased to hear you say that you feel that, basically, integrated joint boards and so on are moving in the right direction. Do you think that the governance has improved since the IJBs were introduced? As you say, there are lots of layers with councillors and others and regional boards as well. Some people seem to think that the accountability is a bit blurred between local and regional boards. What do you feel about that? Is it easier now? Possibly it is not, but will it become much easier? Is there a timescale for that?

Christine Lester: If we look at what the legislation says about the role of an integration joint board and that of an NHS board, it is very clear what the governance and accountability structure is. There is quite a lot of talk about it being unclear, but my personal view is that a lot of people do not like it and it is easier for them to say, "It is not very clear to me," than it is to say, "I do not like it." That applies to both the local authority and the NHS boards, and it is because there is a loss of control—it is human nature. People throw those things in, but they are red herrings.

These are legislated bodies, with structure and accountability pathways, and they have professional people who do a really good job—the chief officers are fantastic at what they do. We have three very good chief officers under NHS Grampian within the integration joint boards. In fact, one of them is leaving Aberdeen to come to Edinburgh shortly. I think that a lot of the talk is just in the wind. Integration is not liked, so people throw in the point about governance—that is my personal view.

Sandra White: Do you think that cultural change is needed?

Christine Lester: There is a definite need for cultural change. That issue of kind of power and control goes across the regional planning environment as well—health would like it done this way and local authorities would like it done that. Actually, we want that done in the IJBs, because where people want to go for their healthcare is down to the communities.

Dr Foster: As witnesses we have not met beforehand and we do not know each other, so I had no idea that Christine Lester was going to say that, but I absolutely agree. If we go back to the original legislation and integration principles, it is clear what we are trying to achieve and how we are meant to go about that. There is a complex environment in Scotland with 32 local authorities, 31 IJBs and 14 territorial health boards, and everyone is trying to twist integration to be the way they want it to be.

That has caused a lot of difficulty, because people are looking for local solutions and some people have one vision while others have another. If one is to be critical, I do not think that the guidance has been all that clear in terms of sticking to the original 2014 act and saying what is expected. That is to allow people a bit of room to move, develop and have different solutions to the same problems, but if we just got on with doing what the 2014 act told us to do in the first place, we would see that what we are meant to be doing is very clear—I think that Christine Lester is right about that.

Emma Harper (South Scotland) (SNP): I have a similar question to the one that Sandra White asked. I am encouraged to hear what you are

saying about targets and timeframes. Sir Harry Burns mentioned them and how we should not just be looking at 12 weeks or 16 weeks or whatever. It is about what matters to the person and realistic medicine. Someone might need pulmonary rehab before they go for a knee replacement, or they should be given a weight loss package for losing the 1kg that they need to lose. I am encouraged to hear about that, and about the IJBs integrating in the communities.

Are there difficulties in scrutinising when regional boards might deliver cancer care? For instance, NHS Dumfries and Galloway sends patients to NHS Greater Glasgow and Clyde, NHS Lothian and NHS Ayrshire and Arran for urology and cancer services. Is it therefore difficult to scrutinise when things are measured that go region-wide rather than simply being board-wide?

Dr Foster: I am not sure that it is difficult to scrutinise that, although it introduces challenges. In Scotland, we are guilty of trying to compare 14 health boards and assuming that all are exactly the same. We could compare them by creating a league table and just showing which is best and which is worst, but the boards are all different. The challenges facing NHS Highland and the pathway that it has into care is different from the pathway that NHS Orkney has, which is different from that of NHS Dumfries and Galloway, which is different from NHS Greater Glasgow and Clyde. That leads to challenges.

In some ways, the regions will help with that. As an executive director, I often get involved with addressing delays in people's treatment, or I am approached by other boards that are looking after our patients with a list of all the patients that we have sent them in the past six months and asked to review them and make sure that we still need them to be seen. I end up thinking that they have been on a waiting list for six months; we cannot stop now and send them somewhere else. The other board just has to see them.

We move people around between boards and do things that are not helpful, so the regions should get us away from that. We will move more towards the idea that we are looking after our patients and it does not matter whether they are on a waiting list in Glasgow or Forth Valley or Lanarkshire. It is not a competition. It is about making sure that the patient is getting the service that they need as quickly as they can. There is no gain to Glasgow in treating my patients quickly because the waiting list is mine and not Glasgow's. Such competition is unhealthy and regions might help us to do better by the patients. That is the big hope in doing things in a more joined-up way.

The Convener: That leads us into our final area of questioning, which is from David Stewart.

David Stewart (Highlands and Islands) (Lab): I am interested in getting your views on sharing and learning from other boards. As you might know, we had some interesting feedback on that in our survey results. Can you give the committee some good examples of where you have learned from other boards either adjacent to yours or in other parts of Scotland?

Dr Foster: That will require a bit of thought. While my colleagues are thinking, I will give one example. Two of the three of us were at a collective event yesterday. All the board executives and non-executives were together at a Health Improvement Scotland quality improvement event at which we shared good practice. The event then finished with individual sessions in boards at which we set action plans for what we do locally. However, three quarters of the day was collective and we networked, talked and listened to experts, and we thought about how we could do things and looked at what other boards had done. We had presentations from boards such as NHS Lothian, which talked about what it has done on quality improvement at its quality improvement academy. We drew lessons from that that we will take back for our boards to think about. That was a good example of what you are asking and it took place just yesterday.

Christine Lester: The sharing of learning is something that executive colleagues do more than non-executives. It is not that non-executives cannot learn and share among themselves—they certainly can—but we would have a different conversation around challenges, scrutiny, supporting each other, especially when someone first starts in the role. I know of sharing and learning taking place on our board, but it has come through executive colleagues such as medical directors and nursing directors who are all working together nationally and coming back to the board in that way.

11:15

Linda Dunion: I agree with Christine Lester that the sharing of learning is more ad hoc for non-executives.

Christine Lester and Graham Foster also mentioned national events and opportunities for networking. For me, that is just a step too far. If you are already spending some time each day on board business, whether it be the IJB or NHS Tayside, taking a whole day out to do a national event is difficult. When I have been at them, I have found them valuable, but I just cannot prioritise them. There is merit there, but it is difficult.

David Stewart: As I hinted there, our survey responses contained some expressions of concern that the NHS is quite poor at sharing

knowledge and learning. This might be a question for Graham Foster. Are there any particular barriers to sharing and learning from other boards in your professional experience?

Dr Foster: I think that there is a will to do it and people would like to do it. There are challenges around time, however. By our very nature, we are internally focused. As board members, we are trying to deliver to our own targets and performance. My priority will always be to make sure that I am at the board meeting in Forth Valley and not in Glasgow helping to improve performance there.

That said, there is no lack of will. We get great help when we ask for it. For example, our local accident and emergency department has faced challenges in meeting the four-hour targets. The Academy of Medical Royal Colleges has been in to help us. We have had visitors from other boards. We have looked around and taken lots of advice on whether we can do anything different, whether we are getting anything wrong, and whether there is another model that we can use. People have been very willing to give up time to help us but, at the end of the day, we tend to focus on 14 separate health boards. That is traditionally how our service has been run and it is natural to worry about our own challenges and budgets, and not necessarily to spend a lot of time reaching out to others. That is probably the impression that leads to the answer that you are describing.

Given time, I think that we could come up with lots of great examples of how boards learn from one another and share learning, and how staff move between boards and so on. It is not that we have 14 boards that do not speak to one another but we do have a system that is focused on 14 separate boards rather than one collective whole.

David Stewart: If we look at the wider view on this, Healthcare Improvement Scotland has an excellent website, as you know. I looked at the ihub recently. I am interested in diabetes, for example, and it has some good examples of best practice. From your professional point of view, is that a good development? That information is obviously centrally held and it gives best practice to all boards. Is that useful and could it be developed?

Dr Foster: Yes, it is helpful. We have diabetes networks and they are also useful. That is a good way of sharing best practice and learning and developing.

I am slightly wary of your question because we in Scotland are guilty of having spent the last decade moving our expertise from front-line boards and into national agencies. We have lots of experts and inspectors. We have an inspection-focused environment and lots of national agencies, and we have created a system in which the natural career progression of someone who is successful in their specialism is to leave their territorial board and the front line and become a national expert running some sort of national advice service. That is great for an academic but it is a bit like the story that we had in education a few years ago. I would quite like to see a system in which we reverse that trend and where there are greater rewards for staying in a board and supporting front-line services and less of a focus on lots of national agencies. If I say that what you asked about is a great idea, I fear that we will lose more of our skilled staff who will go and sit in Edinburgh and Glasgow and give us advice.

David Stewart: I do not want to stymie your career progression.

Dr Foster: I am absolutely committed to Forth Valley and I am staying there. It is the place for me to make a difference as a director of public health.

David Stewart: Your basic message is for us to look at best practice but to decentralise as much as possible.

Dr Foster: Yes. We need staff in the boards. The one thing that boards are struggling for at the moment is staff. We do not have the expert staff to deliver on the demands that the service is facing.

The Convener: I thank all our witnesses for the evidence that they have given this morning. It is extremely helpful to us. We will hear next from the cabinet secretary and we will put to her some of the points that have been raised today as well as evidence from previous sessions.

11:19

Meeting suspended.

11:22

On resuming—

The Convener: I thank our second panel of witnesses on NHS governance for their patience. I welcome to the committee Shona Robison, the Cabinet Secretary for Health and Sport, and, from the Scottish Government, Dr Catherine Calderwood, the chief medical officer, Christine McLaughlin, the director of health finance, and Shirley Rogers, the director of health workforce and strategic change.

I invite the cabinet secretary to make an opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): Thank you, convener. I am grateful to the committee for the invitation to appear today and I welcome the work on governance that you are undertaking.

Our NHS boards are responsible for providing the vision and the strategic direction through which they deliver high-quality, safe and effective care to our communities. Effective governance is essential in ensuring that our health and care system functions efficiently and effectively.

The corporate governance of our NHS is underpinned by legislation and a range of guidance, but we do not simply rely on those documents to ensure that governance is in place. The governance of NHS Scotland is delivered by all those who serve on our health boards. Our boards comprise a unique mix of non-executives, drawn through an appointments system regulated by the office of the Commissioner for Ethical Standards in Public Life in Scotland; executive directors, who bring a range of skills and experience; and stakeholder members, who represent our partnership with local authorities, workforce and the clinical community. I recognise that unique mix of members and the strengths that it brings to the governance and the assurance arrangements of our health and care system; I also recognise that we must continue to keep the make-up of the boards under review to ensure that we are diverse—as Scotland is diverse—but also capable of delivering the vital governance functions that the NHS and our communities rely on.

With that in mind, I restate my commitment to delivering diversity to our boards. We are committed to the Scottish Government's gender balance 50:50 by 2020 pledge. More than that, we are committed to moving away from the traditional competency-based approach to making public appointments, which can act as a barrier to people applying. Working with the Commissioner for Ethical Standards in Public Life in Scotland, we have begun to appoint non-executive members not just on their skills and experience, but on how their values match with those of the NHS. Paul Gray recently chaired an appointment panel to deliver four new chairs for our health boards. At the heart of that process were our values of care and compassion; dignity and respect; openness, honesty and responsibility; and quality and teamwork. Over the coming months, we will begin work with all our health boards to ensure a similar values-based approach to the selection of their senior executive directors.

Similarly, in an evolving health and care system, the processes and the machinery of governance must continue to evolve. Traditionally, corporate governance has focused on direction, control and the establishment of rules and procedures. In our NHS, we recognise that that is not enough and that we must respond quickly and robustly to emerging issues and, importantly, ensure that open and constructive engagement exists. For NHS Scotland that involves an open and transparent approach to governance, including annual reviews that are held in public, board papers and minutes that are published, internal and external audits, certificates of assurance submitted from boards to the director general of health and social care, and the ladder of escalation providing a framework for intervention where there are concerns.

That approach is underpinned by regular dialogue between the Scottish Government and NHS boards on developing strategy and emergent issues. The regular dialogue includes meetings between the chairs of NHS boards and me, as well as regular meetings between chief executives and Paul Gray and his directors. Similarly, senior officials remain in close contact with the range of professional groups such as the Scottish partnership forum, medical directors and finance directors.

The mix of legislation and guidance that is in place, along with the regular open and constructive dialogue that we have with senior executive and non-executive board members, gives me sufficient assurance about the performance of NHS Scotland, but I am certainly not complacent.

As we seek to improve services and drive up quality, we must also develop and improve our corporate governance arrangements. The introduction in 2015 of the integration of health and social care changed our landscape forever. In 2016, the publication of the "Health and Social Care Delivery Plan" set out a vision for Government and local health and care services to deliver better patient care and better population health, including greater regional co-operation.

We continue to seek new ways to improve and strengthen our governance of the NHS, which we do with our partners and in the light of best practice. We are building from a strong existing foundation of corporate governance in the NHS, and our intention is to continue to develop our approach in recognition of the vital role played by good governance.

I welcome the work that the committee has undertaken on corporate governance and the survey of health board members that was commissioned, which provides a level of assurance about how board members perceive themselves and their role. Importantly, it provides further confirmation that the developments on corporate governance that are under way are the right things to do.

The Convener: Thank you very much, cabinet secretary; that is very helpful.

We have a wide-ranging inquiry, so there are a number of areas that we want to raise questions on. I will start with staff governance. The former

NHS staff survey has been replaced with iMatter, which was expected to be fully implemented by the end of 2017. I think that you previously informed us that you expected to publish this month a health and social care staff experience report on the basis of that. Will you tell us about the publication of the report? What action do you anticipate being taken as a result of its findings?

Shona Robison: The health and social care staff experience report, which covers the full results of iMatter and the dignity at work survey, will be published on Friday 2 March.

It is fair to say that the timescales for producing the report have been challenging, given that this is the first report of its type and the complexities of the data gathering and the analysis. The independent company that was contracted to undertake the work has been working closely with officials to ensure the robustness and the accuracy of the data that the report will present. It is right that the report be got right, if you like, before publication, so a little more time has been taken to make sure that that is the case.

The iMatter staff experience continuous improvement model has been developed and provides a new mechanism for measuring employee engagement levels across all 22 health boards, so we are keen to make sure that there is a growing participation in it.

Shirley Rogers will provide a bit more detail.

11:30

Shirley Rogers (Scottish Government): The committee will be aware that iMatter is a very different tool from the staff survey, which was a paper-based set of correspondence with boxes that people ticked to show how they were feeling. The iMatter system sits more closely alongside some of our organisational development initiatives and allows teams and individuals to talk about the individual sets of circumstances that they see in their part of the organisation, and to develop their own plans for how they want to tackle those initiatives.

The iMatter system has given us a significantly larger return. In 2017, the questionnaire achieved a 63 per cent response rate, with 108,000 respondents out of 172,000 staff, or thereabouts, including nearly 24,000 staff from 23 health and social care partnerships, so it is not something that is only to be used within the NHS. It has a wider reach into IJBs. That compares with previous staff survey completion rates, which varied from 28 to 38 per cent over the preceding three attempts, so that much larger sample size is giving us something quite different. Alongside that, we ran the complementary dignity at work survey in November last year and achieved a response rate of 36 per cent, which was 63,000 respondents. We anticipate having a good platform from which to draw conclusions about how it feels to work in health and social care across the piece, and to be able to encourage and support boards in doing whatever needs to be done locally to improve those levels of engagement.

The Convener: The publication date of 2 March is close to your initial intention to publish in February. You will not want to pre-empt the publication, but can you tell us a little bit about what responses iMatter reflects? You have talked about the level of participation, which is clearly welcome. What does it tell us about the standards of staff governance in individual boards and across the country?

Shirley Rogers: The first thing it tells us, which is important, is that staff governance is taken seriously. The particular pleasure that I have had is in seeing how the staff side has contributed to that, and the importance that the staff side has placed on iMatter and the analysis from the boards. It tells us an awful lot about the pride and engagement that people working in health and social care feel. It also tells us a little bit about some of the challenges that may arise from the experience of working in health and social care, so it gives us that richness.

I would like to quote a representative of the Royal College of Nursing, who said:

> "Health trade unions, as well as employers and the Scottish Government are committed to implementing the new approach from 2017, ensuring that staff concerns are better recorded and listened to. It is simply not the case that NHS staff are being silenced. Rather, staff representatives have worked in partnership with employers and the Scottish Government to strengthen the process by which staff can have their say."

Shona Robison: It emerged from the Scottish workforce and staff governance committee as a concept in the first place, so it was very much driven by the staff side, which is positive.

The Convener: Yes, indeed. The next question is from Emma Harper.

Emma Harper: I am interested in whistleblowing. When the committee took evidence previously about whistleblowing, some concerns were expressed about the independence of whistleblowing investigations, allegations of mistreatment of whistleblowers, and the independence of whistleblowing champions as non-executive directors of a board. I would like the cabinet secretary and the panel to tell us a little bit more about the role of whistleblowing investigations. How will the Scottish Government assess the effectiveness of the new role, and what changes do you expect to see?

Shona Robison: Because of the non-executive whistleblowing champions?

Emma Harper: Yes.

Shona Robison: The non-exec whistleblowing champions have been in place in each board since 2015, and boards have allocated the role to existing non-executive directors. It was intended to provide a level of local scrutiny and assurance, independent of the direct management or handling of whistleblowing concerns, so that there would be a go-to person who would be separate from someone's line manager. That go-to person was also seen as someone who could promote and champion whistleblowing as a concept in its own right.

As is outlined in our whistleblowing policy, each board also has a designated and trained named contact whom staff may contact directly for advice and to raise concerns outwith line management. The whistleblowing champions are also there to ensure that internal mechanisms in boards are working effectively, in line with whistleblowing policy, and to support staff in raising concerns. Training is being provided and guidance is being developed to support the champions in their role. For some, their interest in the role may have come from their having been whistleblowers themselves previously.

The benefits of the role are emerging. In one board, the whistleblowing champion challenged the way in which the board had gathered information about the number and nature of whistleblowing cases, which led to a piece of work being undertaken across the whole of the NHS to ensure that information was gathered and recorded consistently. The templates were then piloted in four boards and will be rolled out following partnership agreement later in the year. There are other examples of benefits flowing from the role. We can furnish the committee with details of those if it would find that helpful.

Emma Harper: I assume that there will be a continuous review of the process and that there will be updates as the role evolves and items are exposed.

Shona Robison: Yes, absolutely. There have been stakeholder events, which are important as far as getting feedback is concerned. Those have raised important issues around training, implementation and communication, on which we will reflect as the policy develops further. We also need to look at the role of whistleblowing champions, the relationship that they will have with the independent national whistleblowing officer and the support that is available for whistleblowers at local and national levels. As the landscape with the national officer develops, it will be important to look at the development of relationships with local champions. The process will be an evolutionary one but it is important and, so far, it has demonstrated its worth.

Sandra White: I have a brief supplementary question regarding the INWO role, which will be introduced sometime this year under the auspices of the Scottish Public Services Ombudsman. Do we have a date for that? Cabinet secretary, you said previously that we still have whistleblowers to whom people can go and they will then go to the new independent officer, so there seem to be three steps. Is that correct?

Shona Robison: Let me answer the first question. Legislation will be introduced in the first part of this year to allow the INWO role to be hosted within the SPSO's office, with a view to the INWO being introduced in late 2018.

The Convener: Do you anticipate that that will be secondary legislation?

Shona Robison: Yes. The committee will be pleased to hear that it will be secondary legislation.

The Convener: I am just checking.

Shona Robison: As regards the relationship and roles, it is important that we are clear and that there are opportunities for further training and development of guidance around how the INWO role relates to the local champions. We need to develop that work, which Shirley Rogers might want to talk about.

Shirley Rogers: The decision to site the INWO within the SPSO—there are far too many initials in all these sentences—was taken after a fairly substantial bit of consultation. A proposal was developed, which we are in the process of implementing. The arrangements by which people can raise whistleblowing concerns are many, and are designed to be so. They can use the independent helpline or whatever.

The other important point about the INWO is that gathering information in an appropriately anonymised way will help the system to learn. Above everything else in our approach to whistleblowing, it is important that we try to get the system to learn as a result of concerns being raised. I can supplement the cabinet secretary's examples if the committee would find that helpful. We are already getting examples in which practice and relationships have been changed as a result.

The Convener: We move on to the wider issues of workload and human resourcing, which Alison Johnstone will ask about.

Alison Johnstone: Good morning. During the staff governance strand of our inquiry, we heard about the stress that some NHS employees are under as a result of underresourcing. There was a

feeling that staff often work above and beyond their contracted hours out of good will, but that can lead to burnout, which in turn leads to sick leave and puts pressure on colleagues.

A key tenet of the GP contract and the vision for primary care is that GPs will be freed up to focus on certain tasks and other health professionals will perform some of the tasks that they are already performing. What work has been done with the other professions to realise that vision for primary care?

Shona Robison: We recognise that our NHS staff work extremely hard, whichever role they perform, and that, on many occasions, they go beyond the call of duty. This winter has demonstrated that staff go the extra mile to keep patients safe, and I pay tribute to each and every one of them.

That is why we are looking at the development of safe staffing. We want to put the workload tools on a statutory footing and to make sure that we can use them to good effect. Where those tools have been tested—for example, in NHS Forth Valley—a reduction in sickness absence has been shown. It is about having the right staff at the right time in the right place and being able to flex the rotas to take account of patients with a high level of acuity, such as patients with dementia. That is an important general point to make.

As far as the GP contract and the new model are concerned, the negotiation was a bilateral one between the Scottish Government and the British Medical Association, but in building a multidisciplinary team, what is important is the engagement of those other staff. That process, which involves organisations that represent other staff, has picked up pace. We want to make sure not only that the multidisciplinary model has the support of those other groups, but that the way in which it will work in practice is worked through. A lot of work has been done following the agreement of the contract to expedite that process in anticipation of the changes that are to take place.

As you will appreciate, when there is a bilateral agreement and a vote is held on a new contract, people have to vote on what is in the contract. That has been quite tricky, because the delivery of the model will require the engagement of other staff groups. It has been a complex thing to progress, but a lot of effort has been put into engagement with those other staff groups.

Alison Johnstone: Are we confident that phase 3 of the workforce plan will look at the issue and that those other groups have the capacity to be as fully involved as we would want them to be?

Shona Robison: Part 3 of the workforce plan, which is due to published imminently, is not just about increasing the number of GPs, albeit that we made an important commitment to do that; it is also about growing the other elements of the workforce.

We have made some substantial announcements in that direction. For example, we have committed to providing 2,600 additional nursing and midwifery training posts by the end of the parliamentary session. That big commitment, which will result in a big uplift in that core workforce, was made with a view to many of those staff working in the community as we shift the balance of care. Community and practice nurses are a hugely important part of the multidisciplinary model, as are allied health professionals and mental health workers. We made a commitment to provide 800 additional mental health workers as part of our financial commitment in the programme for government. It is a question of bringing together all that work and shifting the resources.

The resources that are going into primary care and delivering the GP contract in 2018-19 are substantial: £110 million of additional investment is a game changer. The commitment to continuing to invest in primary care will help deliver the workforce that we need to build, but it will take time. I cannot say that two weeks on Tuesday we will have all those people in place; we recognise that it will take time to build the workforce. The GP contract is a build-up, if you like, of that model—it will not happen overnight, but we have embarked on that direction of travel, which will deliver better patient care.

11:45

Shirley Rogers: Alison Johnstone's first question was about how people are supported. A battery of resources are available to the NHS workforce, of which I am a proud member, which involve occupational health support, staff support generally, welfare support and so on. We are working closely with the royal colleges on supporting people in roles that the committee will understand are quite pressurised. We work closely with the RCN. We have a programme of work looking at staff wellbeing. The NHS and health and social care employ a lot of people, so if we can improve the wellbeing of our staff we will do quite a lot to improve the wellbeing of the population. A battery of things are available to help and support NHS and other staff.

I want to pick up the point that the cabinet secretary just made. The need to ensure the sustainability of the health service requires us to think ever harder about multidisciplinary and multiprofessional teams. The importance that is placed in part 3 of the workforce plan on things such as pharmacy services, the support that is required for paramedicine and the AHPs generally has allowed us to engage quite heavily in that

space. As the cabinet secretary said, part 3 will talk quite a lot about what we have found from the GP contract, but it will not speak only about that; it will talk about what the primary care team looks like and what it will continue to look more like.

Dr Catherine Calderwood (Scottish Government): I want to pick up Alison Johnstone's point about stress and burnout in staff. My next chief medical officer's annual report, which will be published in mid-April, has a chapter on valuing our NHS healthcare staff. It will be distributed to all doctors, nurses and AHPs in Scotland, so it will raise awareness of some of the support that Shirley Rogers alluded to. It also contains a lot of information about research that is being done about the impact not only on the staff but on the care that they provide. We know, for example, that staff who are under pressure might become very risk averse; they do not make good decisions regarding risk, which probably leads to overtreatment and overinvestigation, so the staff's stress has an impact on patient care. I explore that in the report in order to raise awareness among those staff groups that they need to look after themselves and that we have a duty to look after them.

The Convener: Thank you. That is very helpful. We move on to clinical governance.

Brian Whittle: I am interested in how we measure adverse events. The committee has explored that issue and has heard quite a lot of conflicting evidence from a number of people. I am interested in what constitutes an adverse event, what guidance is given, who monitors that and who responds to changes within that in the health board.

Shona Robison: As you know, HIS is the lead organisation for adverse events. Back in 2012, we instructed HIS to develop a national framework and a programme of reviews for adverse events. That national framework was published in September 2013 following extensive consultation. It was then refreshed in April 2015 to reflect changes in best practice and to ensure consistency of approach. When changes in patterns of incidents or concerns occur in an individual board, the national adverse events framework is clear that boards should undertake trend analysis of adverse events data.

You will be aware of concerns about inconsistency at NHS Ayrshire and Arran in the application of the significant adverse event review process. HIS was involved in addressing that issue, which it is monitoring quarterly. Catherine Calderwood, as the CMO, wrote to the boards with a reminder of the important need for consistency on what constitutes a significant adverse event review and how reviews should be handled.

Dr Calderwood: Brian Whittle's point is well made—we have had inconsistency in what is reported and in our responses. Mr Whittle is very interested in the involvement of people who have been harmed or have had adverse events, and of their families. For the first time, we are attempting to bring the processes to much more standardised forms of reporting and report reactions. Mr Whittle knows about the national work in maternity services, where inconsistencies have been found not only across Scotland but across the UK. We are not alone in having had a problem in the past, but we know that the standardised report involves feedback for families as well as patients.

Brian Whittle: Do the boards have the responsibility of reviewing adverse events or is there a level above the boards, in which the Government has an overview? It is not the measurement of adverse events against others that is important; we are not trying to penalise everybody but to create an environment in which we can learn. Significant adverse events give the opportunity to look at the system rather than individual healthcare professionals. Where does the Government sit in that process?

Shona Robison: The boards look at their adverse events and trend analysis to see whether trends are emerging, and HIS has an overview. If HIS identifies a serious concern with a board, because something has emerged from trend analysis or HIS scrutiny work, it can escalate the matter to the board's accountable officer, the chief executive, the chair and the Scottish Government.

In an example in August 2013, the previous cabinet secretary commissioned HIS to undertake a rapid review of the safety and quality of care for adult patients in NHS Lanarkshire; that was prompted by a higher than predicted level of mortality in the first quarter of 2013. The measurement of the hospital standardised mortality ratio gave that ability. The review report made recommendations, which included the need for a stronger focus on leadership in implementing robust safety measures. The recommendations were aimed at senior managers to make improvements and services were redesigned; Brian Whittle alluded to that. That example shows that NHS Lanarkshire, initially, and HIS identified a trend that something was not right; that the matter was escalated to the Scottish Government; and that the cabinet secretary intervened. It also shows what flowed from the process.

The duty of candour, which will come into force from 1 April, provides another level of reassurance and an extra layer of transparency. It reminds everyone—and, by statute, places a legal duty on organisations and the individuals within them who provide health and care services—to publish annual reports on all incidents that have instigated

a duty of candour procedure, what actions were taken and the learning from them.

I am confident that the system is robust enough to pick up anything that needs to be picked up. The committee might have seen the reporting on the fact that the patient safety programme has delivered in cutting hospital mortality rates by more than 10 per cent during the period, which meets a key aim 15 months early. The Scottish patient safety programme sits behind all this as a way of ensuring that learning is not just learning for its own sake, but that it improves patient safety. There is evidence that the programme, over the 10 years of its operation, has led to a safer system. Things still happen and go wrong, but overall the system is safer than it was 10 years ago.

The Convener: The evidence that we have received from HIS suggests that there is not really a central record of adverse events, and that it does not really have access to all that information. Do you recognise that view?

Shona Robison: The duty of candour requires those reports to be published, and it requires learning and changes to be made on the back of a report. The fact that those reports are published brings transparency and scrutiny not just to the health service but to the public. That is an important development on the back of the duty of candour. We always keep those things under review. For me, the most important thing is that there is openness when something happens. Obviously, there are concerns with the Dr Bawa-Garba case—although that was an English case, we need to ensure that the message goes out.

When the duty of candour comes into force from 1 April, we want to re-emphasise that the most important things are openness and transparency around what has occurred. That is really important because, if we do not have that openness, people will retreat and not be open and transparent, so the opportunity to learn about and improve patient safety will be lost. Therefore, the most important things are openness and transparency, and learning from incidents. The duty of candour will help to make the reporting of those incidents clear and bring transparency, and I hope that it will address some of the criticisms about whether health boards are open and transparent enough with the information flow. Obviously, patient confidentiality needs to be protected, but a lot of information can be placed in the public domain.

The role and involvement of HIS provide the scrutiny that is required; they also ensure a clear escalation process to the Scottish Government so that a trend or systemic issue within a board can be picked up and acted upon. I gave an example of a rapid review in NHS Lanarkshire, but we have also been quite quick to make improvements after adverse event reporting in NHS Ayrshire and Arran. We always keep things under review and there might be other things that we can do, but there have been a lot a developments in this space—not least the duty of candour, which will add real value.

The Convener: I want to ask more generally about standards and variation in care. The chief medical officer made some comments in public recently on the issue. I am talking about not just adverse events, but standards of care generally. Do health professionals need more guidance or support in delivering a consistent standard of care?

Dr Calderwood: We are beginning to understand the amount of variation that there is not only in practice, but in the outcomes of that practice. My first annual report pointed out variations across Scotland. I spoke not only to doctors but to mixed health professionals and those who work in social care, and I really challenged them to say whether they knew how their practice compared with the next unit, the next care home or the next health board.

12:00

People are not aware that there is variation in practice and procedures. There is such awareness in England, where an atlas of variation has been published for some years. This year, we will publish an atlas of variation in Scotland for the first time. We hope to have it by the end of April and it will cover hip replacement, knee replacement and cataract surgery. It will be done by population level and by health board. At the moment, we probably flag up more questions than answers. I do not know what the rate of hip replacements is, but I know that it should not vary in a country such as Scotland, with one rate in one part of the country and three or four times that rate in a different part of the country.

The next step is about how to interrogate that data and examine whether too few procedures are being done in some parts of the country and too many are being done in other parts of the country. We will start with the three operative procedures that I indicated. They were chosen because they are very common and are done in all areas across Scotland. We will build on that data year on year, and we plan to add data on public health measures. For example, it might surprise the committee to hear that rates of childhood obesity vary across Scotland, going from less than 20 per cent in some parts of Scotland to over a third in other parts. The parts of Scotland with the highest rates might not be where we would expect; it is not inner-city Glasgow but Dumfries and Galloway and NHS Shetland.

Again, we need to understand that first of all. I can give the committee the data concerned, but we need to explore it with those areas. That brings us back to the importance of local data for local interpretation. The Government's top-down approach will sometimes not help, because local areas know their own issues and have the right people to solve them. However, we are determined to tackle variation, because I cannot tolerate there being differing patient outcomes across a small country with a population of 5.4 million.

The Convener: That is clearly a very important step. You have identified the three disciplines that will be examined first. How will the evidence from that feed into priority setting by HIS or by the Government directly in relation to boards?

Shona Robison: It fits very well with the elective collaborative that is being led by Professor Derek Bell, because that is very much about identifying best practice and wicked problems, if you like, and being able to work on those issues with the best brains and expertise and then roll out best practice. Some of the work done around orthopaedics in Glasgow is an example of that, particularly the work in Glasgow royal infirmary with the virtual clinics. That is an example of groundbreaking work in a particular specialty. That type of work will help to address variation and create the most effective and efficient use of resources.

We are using the twin track of investment and reform because if we can get the reform bit right, we can ensure that every pound is spent in the most efficient way and delivers the best outcomes. We are trying to tackle unwarranted variation. Some variation will be acceptable—for example, variation in remote and rural Scotland might be warranted—but we are concerned about unwarranted variation, where there is no reason, other than people continuing to do things in the same way, for having different outputs and outcomes. We think that there is a lot of scope, particularly in elective care, to make big inroads into variation.

We can also do that type of work on the public health side. In this afternoon's debate in the chamber, members will have an opportunity to explore the development of public health policy in the area of diet and obesity. Some exciting preventative work is going on with type 2 diabetes, for example, with some exciting results from a pilot that shows patients managing to avoid type 2 diabetes. We could share that information with the committee. I saw a presentation at the chairs' meeting about some of the early results, and the percentage of patients with type 2 diabetes whose condition was being turned around—that is not a technical term, but you know what I mean—through exercise and diet was very exciting. Those are the types of ideas that we want to roll out.

The Convener: Thank you. A number of colleagues want to ask about scrutiny of NHS boards.

David Stewart: The panel will know that the committee has received a number of written submissions suggesting that an independent regulator of the NHS in Scotland should be created. Do the cabinet secretary and her colleagues agree with that suggestion?

Shona Robison: We have had that debate on a number of occasions. I ask myself what it is that we are looking for in terms of the performance, scrutiny and safety of our services. Healthcare Improvement Scotland was developed to have a dual function. We could have set up an inspecting body that sat separately, but if it did not have an improvement arm we would have been left with inspected organisations with a set of problems but no solutions to go with them.

The clue is in the title: the reason why Healthcare Improvement Scotland has a focus on improvement is to achieve improvement through its inspections. Anybody who has read any of the HIS reports would find it hard to argue that the organisation pulls its punches in any way. I have had to go in front of the cameras a number of times to talk about HIS reports on particular services, and I know that it does not pull its punches and that the reports are very robust.

The Healthcare Environment Inspectorate, which sits within HIS, focuses on cleanliness and infection control. It identifies from its inspections the issues to be resolved and works with the inspected organisation on its improvement plan. For me, that dual approach is a better way to proceed from a patient safety point of view, because—and this is the critical point—it helps the board do something about the issues that have been identified.

HIS also does work with others. For example, it has a memorandum of understanding with the Health and Safety Executive. There is a clear relationship between the two organisations, and if there are issues with health and safety, the committee can be assured that the right issues will be dealt with by the right organisation.

I believe very strongly that HIS has worked well in improving patient safety. We are 10 years down the line with the patient safety programme and we have a safer system. I think that HIS's dual role, in inspection but also in improvement, has helped to deliver that.

David Stewart: I certainly agree that Healthcare Improvement Scotland has done an excellent job in terms of sharing best practice. The ihub, which

was referred to a few minutes ago, and the work around diabetes are really first class.

However, I refer the cabinet secretary to a recent report from the Organisation for Economic Co-operation and Development, which says, about the mix of roles between scrutiny and quality improvement, that

"The mix of these roles means that the system's inspector risks 'marking its own homework'."

What is the cabinet secretary's view on that report?

Shona Robison: I understand the OECD's report and I have read that bit of it. My answer relates to the nature of HIS reports. If there was an idea that things were all cosy and that HIS was producing rosy reports on the services that it inspects that said that everything was fine, there might be a concern, but that is not the case. As I said, HIS does not pull its punches. Its reports are very robust and have exposed some difficult issues. They provide scrutiny, they are in the public domain and I read them. HIS takes action with organisations to address issues and it goes back to check that the board has done what it said that it would do about a particular service.

The Government engages with boards, too. There have been a number of times when I have had a phone call with the chair of a board to ask what they are going to do about a report, and I follow that up. You can be assured that there is no softly, softly approach around the reports. They are robust in nature, but they have an important improvement element so that, when HIS goes back to the board, there is assurance that the shortcomings that needed to be addressed have been addressed.

David Stewart: As I stressed, HIS does an excellent job, particularly on quality improvement. Has the Government looked at responding to the OECD report by separating out the functions and, on the basis of, "If it ain't broke, why fix it?", keeping quality improvement but perhaps having an independent scrutiny function?

Shona Robison: That would be really difficult to do with HIS because if you separated out those functions, you would not have the strength that HIS has from identifying the problem and supporting the organisation to address it. If you did that, those two functions would not sit together, and HIS's strength comes from that.

HIS also brings in external people. HIS is not a group of people who decide which of them will pick up each report; it brings in people with external expertise—quite often from outwith Scotland—to take part in particular reports. The idea that there is no external scrutiny is wrong. For the individuals who come to do work on behalf of HIS, it is not worth compromising their professional reputation, and you can see from the reports that that does not happen, because they do not pull their punches. That external expertise is brought to bear in the full light of public reports. The important bit that happens after the report is the improvement work that takes place and the checking by HIS that improvements have been made.

We have a system that works to constantly improve the service in Scotland and, from a patient safety perspective, that is extremely important.

Ivan McKee: I thank the cabinet secretary and her officials for coming along to talk to us this afternoon. I want to talk about board scrutiny but, before I go into the review process, I will comment on the conversation about HIS.

I am glad to hear that there is a grown-up approach to continuous improvement processes. In my experience, it is important to combine the roles of not only understanding what the problem is but going on to fix it. The organisation would be much less effective if the two roles were split up. It is important to drive the solution and improvement processes using the same methodology.

On board reviews, I want to drill down into how those happen, how often they take place, how effective they are in holding boards to account for their performance, and whether the process has been set up to be as effective as it can be.

Shona Robison: Boards have annual reviews, which are open to the public. Ministers are involved biennially, so I chair numerous board reviews every two years, and officials from the Scottish Government chair them the following year. A board review provides us with an opportunity to look back at what the board did during the previous year and to ask questions about that in the public domain; it also provides us with an opportunity to look forward to the board's plan for the following year.

The board reviews also give me and other ministers an opportunity to drill down and to meet people. For example, as part of a board review, I meet representatives from the area partnership forum and the staff side and have a full and frank discussion with them. I also meet with the clinical community and the patients who receive the services. Again, that is an opportunity to hear what they think, and they do not pull their punches. There are some positive responses, but some can be challenging.

After the public session, we drill down further in private session with the board around some of the detail. Christine McLaughlin and others will look at financial aspects, for example—she gets in and about some of the financial plans. It is an

opportunity for the board to showcase some of the work that it is doing, but it is also an opportunity for us to hold it to account.

12:15

Ivan McKee: There is obviously quite a long time between reviews. What review process goes on on a weekly, monthly or quarterly basis?

Shona Robison: The senior management team and Christine McLaughlin can say a little about that. There is on-going work with boards. Every week there will be some contact with boards; if there are issues and concerns, contact will be frequent. I meet the chairs on a monthly basis to discuss particular issues: I make them aware of things that are coming up, they raise strategic issues with me, and we have a good discussion. Paul Gray meets the chief executives every month to discuss more operational issues.

It is fair to say that the engagement between the Scottish Government and the boards—particularly their senior management teams—is regular and close. That is as it should be, because it is important that we know whether there are issues within boards and, likewise, that they alert us if there are any issues.

Christine McLaughlin (Scottish Government): A number of recent conversations have been about individual components of the wider system of assurance that we operate. All those things—an HIS report, for example, or a particular incident—will be part of a wider assurance system, and we try to join up all those components when we look at a board's overall performance and its management of risks.

As well as the planned meetings, there are mid-year reviews, which involve Scottish Government officials and all NHS boards. If particular boards are deemed to have a higher level of risk, we may have more frequent formal meetings—quarterly or bi-monthly, or whatever is needed—with a specific set of actions to take forward.

There are also governance statements that come through from boards as part of the audit process, with external audit, scrutiny and assurance as part of that, and we take all those components into consideration. If there are particular levels of risk, we take a case management approach, where we look at staffing and clinical issues along with issues of performance and finance, and we bring that all together to take a more rounded view of the board's performance The annual review is a much more public part of that overall approach to performance and assurance, but it is only one component and its success is based on the success of everything that is done on a daily, weekly or monthly basis in the system.

Miles Briggs: I want to look at the culture of governance, because that is something that keeps coming up in all the work that we have been doing and in the evidence that people have given. I do not know whether the panel members have had a chance to look at the research that was conducted for the committee by SPICe with more than half the health board members on the governance role in health boards. One respondent said that the level of political interference in NHS health boards was "excessive and negative", while others said that they spent too long "fire-fighting" rather than planning ahead. Some board members also complained that they had little control over the strategic direction, as the Scottish Government

"is so dominant in the delivery of health care".

How would you respond to those points, which were put to the committee? Do you recognise those concerns about planning and governance?

Shona Robison: You have highlighted a few issues. We should always take such issues seriously but, overall, I thought that the feedback from the survey was very positive.

It is about the balance between local and national—if I had a pound for every time an MSP has asked me to intervene to knock heads together or to tell a chair to get a particular board issue sorted, I would be a very rich woman indeed. Sometimes people say, "You should do this, you should intervene and you should get a grip," and at other times people say, "It's political interference." There is a balance to be struck and I am sure that members around the table and in Parliament more widely would not expect the cabinet secretary for health to sit back and say to health boards, "Do whatever you want."

There is a strategic direction for the health service; patients should be able to expect a consistent level of care. We talked about the issue of variation across boards earlier. If we did not have a national strategic direction, we would be failing in our duty to deliver that consistent level of care. However, the flipside of that is that we expect boards—with their partners, through the IJBs—to be interrogating their own data and coming up with local solutions. It is about getting the right balance.

The charge of political interference could be levied at Opposition politicians in a local setting as much as it could be at Government ministers. A number of non-execs in particular have said to me that, when it comes to making service changes, the political resistance to that from local members can sometimes be very difficult. Therefore, I am not sure that the survey respondent necessarily had Government ministers in mind when they made their remark about political interference.

For us as politicians, it is about getting the balance right. On the one hand, we need to make sure that there is accountability—as the cabinet secretary for health, I am ultimately accountable and I take that very seriously. Therefore, I need to assure myself that the boards are carrying out their duties in a way that is consistent with our expectations. On the other hand, we need to allow boards to make decisions in a way that there is clear guidance around. That is a difficult balance to strike—it always will be. Sometimes we get it right and sometimes we do not.

Miles Briggs: To go back to the CMO's point about the need for an atlas of variation, I think that everybody knows that there is a postcode lottery across Scotland. How can we look at how best practice is shared? Our inquiry has shown that it is often the case that, when health boards get things right, they do not necessarily share that best practice across the country. We can really make an impact in terms of governance if we try to put the sharing of best practice at the heart of our health service. As the CMO said, in a country of 5.4 million people, surely we can get that best practice shared across the health boards. Political leadership is at the heart of that. How do you see that developing? How will you make sure that best practice is shared? That has not happened to date and it is quite clear that the current approach has not worked.

Shona Robison: I think that it has worked in some ways. The patient safety programme is now 10 years old and when I go around speaking to clinicians, as I did last week, I hear about how that programme has developed over those 10 years. You would not go into a health setting now without the patient safety programme and best practice having been implemented. We have a safer service because people have taken the evidence from the patient safety programme and applied it.

I have seen some of the work that the Western general hospital has done to develop that programme in order to reduce harm and save lives; the programme has really engaged the clinical community, because it sees the benefits of it. That is a good example of something that happens everywhere, but there is more work to be done to address variation.

I think that we have moved away from the "not invented here" syndrome, as there is a lot more regional working going on. We have seen the emerging priorities of the north, the east and the west on what they will do collectively to share not just best practice but services, and they are looking at doing things differently in order to be more efficient and deliver better patient care.

The pace of that work is picking up, which is important. The work that Catherine Calderwood is doing on producing an atlas of variation will bring a rigour and scrutiny to the data that we expect boards and their partners not only to scrutinise but to do something about. Over the next few years, you will see far less unwarranted variation and far more efficiency in the way that things are done. Technological advances will help with that. There would need to be a pretty good excuse not to do something if it is evidentially proven to work.

Alex Cole-Hamilton: Good morning. Thank you for coming to see us.

My line of questioning is about public confidence. In particular, it is about expectation management, which I asked the previous panel of witnesses about. We can do something about that at a national level through Government policy, but it is also the preserve of implementation by NHS boards.

That speaks to Dr Calderwood's thesis on realistic medicine and everything that you have told us about that approach this morning, such as that, when credited with the facts about their situation, the public will be far more understanding than clinicians might expect and will make more mature decisions and decisions that might not be expected of them in the first place.

I have lost count of the number of times that I have been visited in my surgeries by constituents who have had already long waits for treatment extended further significantly beyond what they were told to expect. That happens a great deal; I am sure that the situation varies from board to board. How can we do better at expectation management on waiting times? In many such cases, had my constituents been told how long they would have to be prepared to wait, they would have accepted it. It would have been uncomfortable, but it would not have been as demoralising as being told halfway through that wait that they would have to wait the same again and still further.

Shona Robison: Improving access in all its dimensions is important. I will come back to waiting times in a second.

In primary care, the reason for developing the multidisciplinary team is to improve patient access and care. That is about expectation management to the extent that the flipside of that is that patients might not always see a doctor, but they will see the right health professional or care professional to meet their needs. That means that they will get quicker access to the team.

That is a good example of the discussion with the public. The Health and Social Care Alliance Scotland is doing a lot of work on engaging with the public on what that approach means for them. I sat in on a session of that work and it is interesting that people are open to that. They do not care what label the health professional or care

professional has, as long as they can deal with the problem speedily and in a manner that is easy to access.

I absolutely accept that we have a challenge with waiting times. We are doing a lot of work through not just investment but reform. The work that Professor Derek Bell is carrying out on reform of elective procedures is about improving and reducing the time that people have to wait by making better use of the resources that we have. The investment that is going in is helping to transform the way that we deliver care so that people are able to get quicker access to the treatment that they need.

Within that, there will always be a level of clinical prioritisation for urgent cases. We have a big focus on cancer pathways at the moment to ensure that people get more rapid access through diagnostics into treatment. That will take time, given the demands on a service. Over the past 10 years, there has been huge growth in demand for out-patient appointments, treatment and procedures. We have an ageing population, so that is no surprise.

On building capacity, work is progressing on the five elective centres to ensure that we have the capacity for the growing demand for knee replacements, hip replacements and ophthalmology. That is like chasing an ever-moving target, to be blunt, because although we are increasing capacity, demand is also increasing and it is difficult to achieve the right balance.

There is a discussion to be had with the public about what they can expect. For example, the work on the modern out-patient programme aims to avoid the default being a GP just referring everybody to an out-patient appointment when other outcomes might be better for that patient. That is very much the realistic medicine territory that Catherine Calderwood spoke about earlier.

12:30

Jenny Gilruth: On board diversity, you will have heard from the earlier evidence session that the responses to our survey show that board membership tends to be comprised of those who are over 55. The boards that responded to our survey do not have anyone on them who is in the 18 to 24 age bracket. Last week, Inclusion Scotland flagged up the issue of disability and how we get those who have disabilities on to boards and enable them to make a meaningful contribution to the process. Do you have any views on how we can get more people involved in the board process? Do you recognise that there are problems?

The cabinet secretary mentioned the gender representation on public boards legislation in her opening remarks. Has the Government considered using an advertising campaign that targets certain groups and makes board membership more accessible to them than it is currently?

Shona Robison: Yes. A lot of work has been done to recruit a more diverse group of people. We can talk about some of the examples of that, but we should recognise that progress has been made. If we look back over the past few years, we see that 48.8 per cent of all appointees are now women, which is a big increase from where we were. However, Jenny Gilruth is right to point out that there is still underrepresentation of younger people, people from an ethnic minority background, people who have disabilities, and so on.

As I mentioned in my opening remarks, we have to broaden out how positions are advertised, and the skills and experience that are required. Skills and experience are important and people have to be able to do the job—that is a given—but we also need to look at the wider range of experience that someone might bring to a board. There have been many attempts to do that, and work is on-going to make sure that we are not missing the opportunity to recruit.

Shirley Rogers: I would like to respond with a few examples, and I might touch on Mr Briggs's questions about the culture of boards and how we share experience.

Jenny Gilruth is right that a board will be more effective if it represents the demographic of the people it serves. There are some challenges around that and the construct of part-time non-executive positions. It is quite a challenging role to hold boards to account for complex systems of governance and procedure. However, that should not prevent us from making some significant efforts.

The kind of effort that I mean involves things such as the use of social media campaigns rather than traditional print media, and working closely with the Commissioner for Ethical Standards in Public Life in Scotland to revise the application form process and make sure that it is right. It needs to be less onerous and less experientially based if it is to attract younger people. We have examples of a number of boards reconfiguring the interview process to make it less formal and to use people's judgment and values rather than necessarily looking for a long track record of experience, which obviously plays to a different market.

There are two other things that might be useful and important to the specifics of diversity on a board. One has been to look to have open sessions. For example, we had an outreach session in Maryhill community halls, as a result of

which we attracted approximately 190 applications from a variety of different people. It was not just a case of putting a standard small advert in the back of a paper somewhere.

The other important thing that we have been doing is that, when we have had the opportunity to recruit a number of board members at the same time, we have pre-designated some of those posts as development posts so that we can take into account the need to bring in people who might not have had experience in that space.

I will link together Ms Gilruth's and Mr Briggs's questions. It is important that we understand the breadth and the importance of the role of non-executives. That role is not necessarily fully evident when someone says that that is what they are. We have produced in easy-to-read terms a series of support materials entitled "What Non-Executive Directors Need to Know" so that there is no great confusion about the language or whatever.

There are eight booklets, and I want to pay particular attention to five of them, which help to answer the question about the sharing of best practice. Those booklets are on quality efficiency and value, quality improvement and measurement, innovation, person-centred care and improvement-focused governance. For completeness, I add that the other booklets cover health inequalities, induction—so that people really understand the basics of governance—and personal effectiveness.

In addition to the board development, induction and training programmes that take place, a battery of materials is now available, which are written as simply as it is possible for them to be. Without spoiling the story, they talk about the role of a non-executive in holding the system to account and sharing that practice.

The Convener: I am conscious of time, and we have two other areas that we need to cover quickly.

Sandra White: I wanted to raise aspects of that topic, too. In particular, I wanted to ask how taking on a non-executive role would impact someone on welfare benefits, which was an issue that was mentioned by the previous panel in response to a question from Jenny Gilruth. There are a number of issues to raise in that regard, so perhaps we could write to you about those, if that would be all right with you, cabinet secretary.

Shona Robison: Yes.

Sandra White: Thank you very much.

I want to ask about the governance of the IJBs—I will be as quick as I can. We heard from the previous panel that a bottom-up approach is the proper way to go; Dr Calderwood has said that, too. However, there are cultural difficulties. In 2015, Audit Scotland produced its report "Health and social care integration". Can you provide an update? Are IJBs working better? The issue of a potential conflict of interests has been raised, because the same members can sit on both boards and the chief officers are employed either by the board or by the local authority. One respondent called for a review of IJB governance arrangements.

I have two quick questions. Have things improved since Audit Scotland's 2015 report? Should we be looking to have a different approach for the IJBs?

Shona Robison: In the interests of saving time, I will simply say that a lot of work has gone on since the Audit Scotland report and will ask Christine McLaughlin to give a brief response.

Christine McLaughlin: The most important thing to note—I hope that you are aware of this—is that Audit Scotland is doing a second report on IJBs, which is due to come out in November this year. That will give you a more independent assessment. Everyone is very aware of the report and they see it as a bit of a milestone in looking at the progress of IJBs.

The purpose of IJBs is to bring parties together in joint working and that purpose has certainly been achieved. The current set of governance arrangements is different from the governance that we have had previously. If we look at how partnerships worked over the Christmas period, it has been shown that the governance arrangements did not hinder their ability to work well. There were lots of good examples of partnerships working well with the acute service and the Scottish Ambulance Service. Those anecdotes provide evidence on the ground that the partnerships are working and that the different governance arrangements did not stop any of that happening.

A lot of the governance is about looking at having a three-year commissioning plan as much as it is about day-to-day operations. There is a lot for us to build on. Governance is operating in a different way and we need to make sure that people understand and are comfortable with those differences and that, where there is a sense of conflict, we take action to ensure that that is not the case.

I am relatively confident that we can see signs of progress there, but we will look to the Audit Scotland report to give us all clarity through its independent assessment.

Ash Denham: I will touch briefly on the governance of regional planning boards, which, as you will know, is an issue that has come up in our inquiry. Is there a framework for governance at a

regional level, or is the role of the regional planning boards more to act as a co-ordinating structure?

Shona Robison: Again, in the interests of saving time, I will let Shirley Rogers respond, because she has been most involved in the regional planning boards.

Shirley Rogers: The introduction of regional collaborative planning and delivery has not taken away the governance structures in place, so the board in Tayside is still responsible for Tayside and the board in Highland is still responsible for Highland.

The regional structures plan those services that can best co-operate with one another to deliver a better service for patients regionally. There are a number of tiers. The national delivery plan, which you will be aware of, has the national boards providing solutions. The national boards focus on things such as digital platforms. There is a regional tier, which at the moment is in the process of planning the production of a series of proposals that we will consider in due course on things that could be delivered in a slightly different way. Some of that harks back to Mr Briggs's point about variation and trying to establish best practice that is delivered across a region rather than board by board. However, as I say, the existing governance structures have not been taken away and the board remains accountable for the services that are delivered in its patch.

We will see what comes forward as part of the delivery plan. The expectation is that regional and national plans will be submitted for our consideration towards the end of March. It will take some time to look at those. If the plans include proposals that would require the service to go into consultation about future arrangements, I emphasise that the consultation arrangements for those changes to service have not changed either.

The Convener: I thank the cabinet secretary and her colleagues for a helpful session. Governance of the NHS is clearly a topic on which committee members would cheerfully interrogate you all day, but it has been very helpful to have had such well-focused responses.

The cabinet secretary has offered to provide us with further information, particularly on prevention measures related to diabetes interventions, and Shirley Rogers mentioned examples of the impact of whistleblowers. It would also be useful to have your views on Sandra White's point about the evidence from the previous panel on the impact of the appointment to a health board of somebody on benefits and how that might act as a disincentive.

Shona Robison: We will write to you on those points.

The Convener: Thank you very much—that is much appreciated.

12:42

Meeting continued in private until 12:58.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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