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The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland

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To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.

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Introduction

1. The NHS in Scotland marks its seventieth anniversary this year. The NHS was founded on the principle of providing comprehensive health services, free at the point of use and based on need. This principle remains primarily unchanged in today's NHS. However, the demands on the NHS, the services it provides and its administration are almost unrecognisable from those of seventy years ago.

2. As 2018 is a landmark year for NHSScotland it provides an appropriate juncture to not only reflect on the changes it has faced but also ensure it is equipped to adapt and respond to future changes. The Health and Sport Committee has been considering these issues within the context of the governance of the NHS.

3. At the heart of the NHS is the patients it serves and we have sought to reflect this in the approach taken to our inquiry. The Committee has focused on looking at the culture of the NHS and the way this impacts on patients. We have received written evidence and hosted both informal meetings and formal committee evidence sessions with NHS patients to further understand their experiences and views of the NHS and to shape our approach and focus to the inquiry. These sessions have been invaluable and we wish to express special thanks for the willingness of individual patients to share information on often very difficult and emotive personal experiences.

4. Governance has many facets and we have considered the issue of NHS Governance under three broad areas – staff, clinical and corporate governance. The Committee's inquiry into NHS Governance has been its longest running inquiry to date. The Committee's evidence gathering has included receipt of over one hundred written submissions and ten formal evidence sessions.

5. The first main strand of our inquiry looked at how NHS staff are managed in a fair and effective way. We took evidence from front-line staff, trade union representatives, senior NHS managers and the Scottish Government.

6. During our evidence gathering on the second strand to our work on clinical governance we considered the process and procedures through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services, and ensuring they safeguard high standards. We received evidence from patients about their experiences of care, staff representative organisations, a range of patients and third sector organisations and organisations responsible for ensuring and overseeing good clinical governance.

7. The third and final strand to our work considered the structures and processes for decision making, accountability, control and behaviour at the upper levels of the NHS. It included a survey issued to all NHS board members exploring areas considered key to good governance. Following receipt of the results of the survey the Committee took oral evidence from a range of stakeholders external to NHS boards but affected by the decisions they take. The Committee also took evidence from individual NHS board members and concluded its inquiry with an evidence session with the Cabinet Secretary for Health and Sport.

8. Health boards are all accountable directly to the Scottish Parliament and this report considers the issues of staff, clinical and corporate governance in turn. It looks at

the specific areas under each of these strands of governance which we consider need to be addressed to ensure NHS Governance is flexible and sufficiently responsive and robust to ensure delivery of the best healthcare for the people of Scotland.

9. Before going on to discuss each of these specific areas, we would like to highlight one over-arching theme which emerged during the inquiry, which is the importance of ensuring that the NHS in Scotland is adequately funded and resourced.

10. During each strand we heard about funding impacts from a wide variety of witnesses covering:

- Staff governance, including challenges around recruitment and retention
- Clinical governance issues on clinical care; and
- Corporate governance challenges in meeting targets.

11. While the question of the resourcing of the NHS in Scotland is clearly a very important one, the focus of this particular report has been the governance of the NHS, rather than the question of the resourcing of health services. This inquiry has sought to examine the scope for improvements which can be made to the governance arrangements of the NHS in Scotland. Nevertheless, we acknowledge the importance of NHS budgets and resources as a subject, and we will make reference to them at points in this report. However, we commit to return to this subject in more detail during our ongoing scrutiny of the Scottish Government budget.

Staff Governance

12. Staff governance can be considered as a system of corporate accountability for the fair and effective management of all staff.

13. The most valuable resource the NHS in Scotland has is undeniably its staff. There are over 162,000 NHS employees who work tirelessly to deliver health care for the people of Scotland.

14. It is essential that every NHS employee feels valued, listened to and appreciated. They have an important role in developing and improving health services.

15. We looked at the governance arrangements for staff in the NHS. It is important that these work effectively, ensuring staff are supported and motivated to do the best job that they can.

Staff Governance Standard

16. A national Staff Governance Standard was introduced by the NHS Reform (Scotland) Act 2004, placing a duty on NHS boards to monitor their management of staff governance.

17. The duty requires all boards to achieve five standards, demonstrating that staff are:

    - Well informed
    - Appropriately trained and developed
    - Involved in decisions
    - Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
    - Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

18. The Staff Governance Standard was widely welcomed in evidence to the Committee. It was described as a positive set of principles designed to ensure there is genuine staff and trade union involvement and engagement in decisions affecting the operation of NHS boards. [1]

19. Unison Scotland considered the Staff Governance Standard to be an ‘exemplar model’ and noted that NHSScotland “has enjoyed an unprecedented period of industrial harmony”. [2]

20. The Scottish Government was asked what progress had been made in relation to the Staff Governance Standard since monitoring had begun. Shirley Rogers of the Scottish Government stated “We have worked closely with the staff side to make sure that the five standards of staff governance are achieved as frequently as possible, and the survey results and staff governance audit results have shown

considerable improvement in the 10 or 15 years since their introduction. There is, however, more to be done." [3]

Monitoring views of NHS Scotland staff

21. The Staff Governance Standard sets out high level principles which clearly have been broadly welcomed. However, the Committee was keen to explore how these principles have been applied in practice. In particular we wanted to understand how NHS workers themselves feel about their working life.

22. Given the number of staff in the NHS in Scotland and their diverse range of working experiences, it can be challenging to capture their views.

23. However, national staff surveys of NHS workers have attempted to gather information about how employees feel about their place of work. These opinion gathering exercises can help us get a sense of how well the NHS is meeting the Staff Governance Standard.

24. From 2006 until 2015, the annual NHS staff survey was the main mechanism used to gather the views of NHS staff. In 2015, the NHS staff survey was replaced by the iMatter questionnaire which was rolled out over a three year period.

25. iMatter is described as a Continuous Improvement Model and involves more localised monitoring of staff experiences, as well as the opportunity for more local feedback on what can be done differently.

26. In addition, a Dignity at Work Survey was issued in November 2017. The Survey addressed areas not currently covered by iMatter including bullying and harassment, discrimination, abuse and violence from patients and the public, resourcing and whistleblowing.

27. Together, iMatter and the Dignity at Work Survey aim to provide a rounded overview of the national NHS staff experience. Their findings were summarised in the Health and Social Care Staff Experience Report 2017 [4] which was published in March 2018.

Staff Governance - themes raised in evidence

28. The Committee took wide ranging evidence on the subject of staff governance.

29. Many people we spoke to took the opportunity to comment on the wider challenges and pressures facing the NHS. Others commented on how management policies and decisions were impacting on their ability to work effectively. We also looked at the information contained in the Staff Experience Report to obtain insights into the views of staff across the NHS in Scotland.

30. The Committee would wish to highlight some of the main insights it received.

Pressure on staff - what witnesses told us

31. The pressures being faced by the NHS workforce was a recurring theme during our consideration of staff governance. Staff resourcing was mentioned by many witnesses.

32. The 2017 Staff Experience Report recorded that 34% answered positively to the question 'there are enough staff for me to do my job'. This was a 1% increase from the 2015 survey. The question 'I can meet all the conflicting demands on my time at work' was answered positively by 46% of respondents (no change from 2015).

33. Clearly there is scope for these figures to improve.

34. It is worth noting, however, that overall staff levels in the NHS are at the highest level ever with 140,261.9 whole-time equivalent staff employed as at December 2017. The most recent Information Service Division figures show that the number of staff employed by NHSScotland increased by 0.7% over the last year. However, these figures do not tell us whether the level of staff is enough to fulfil the NHS' requirements.

35. We heard that vacancy levels are high in certain areas with a rise in the number of vacant posts being unfilled for six months or more. A number of witnesses felt that increasing demands were being placed on staff, creating stress. For example, Ros Shaw of RCN described nursing staff as being under "immense pressure" due to "huge vacancy levels" in the community and hospital setting. [5]

36. BMA Scotland stated in relation to primary care "the clinical workload is becoming unmanageable". They pointed to the difficulty in the recruitment and retention of doctors as both a cause and an effect of what they described as "stressful working conditions for doctors".

37. We heard similar views from NHS frontline staff at our informal evidence sessions.

38. The issue of low pay was raised by some witnesses such as the RCN.

39. Other witnesses commented that there was pressure to meet targets. This was a point raised by middle managers in our informal evidence sessions. Some suggested that operating in a target-driven culture resulted in innovative suggestions or concerns raised by staff being set aside as this was not the focus of their work.

40. Some witnesses also suggested that time pressures were making it difficult for staff to access continuing professional development. [6]

41. We explored some of these issues with the Cabinet Secretary for Health and Sport. The Cabinet Secretary made reference to the Scottish Government's forthcoming legislation on safe staffing.[i] She stated "We want to put the workload tools on a statutory footing and to make sure that we can use them to good effect.[…] 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." [7]

42. In addition, the Cabinet Secretary made reference to the Scottish Government's approach to workforce planning which has involved the publication of a workforce plan in three stages. The first publication covered the NHS workforce and was published in June 2017. The second publication covered the social care workforce and was published in December 2017. The third publication covered the primary care setting and was published in April 2018.

43. We recognise that NHS staff are working within resourcing and financial pressures against a backdrop of high public expectations, changing demographics and new approaches to service provision. Improving workforce planning is a key component to addressing these issues.

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

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

46. Since the Committee began its NHS governance inquiry the Scottish Government has introduced the Health and Care (Staffing) (Scotland) Bill. As a Committee we will scrutinise this Bill to determine if it will deliver its aim of ensuring appropriate staffing to provide safe and high quality care.

Consultation and staff relations

47. Another recurring theme was staff engagement in organisational decisions and the relationships between senior management and front-line staff. One issue that arose in particular was the question of trust in senior management.

48. In the 2017 Staff Experience Report one of the questions that had the lowest average score was 'I have confidence and trust in senior managers responsible for the wider organisation'.

49. During our informal evidence sessions with NHS frontline staff, some attendees spoke positively about their colleagues but said they rarely felt thanked with any

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i This legislation has since been introduced: 23 May 2018 Health and Care (Staffing) (Scotland) Bill

sincerity by management. Many felt senior management did not understand the pressures frontline staff were facing and communicated poorly.

50. This view tallies with the 2017 Staff Experience Report on the iMatter question 'I feel involved in decisions relating to my organisation'. This question had the lowest average score.

51. We explored frontline staff's apparent disconnect with management with witnesses.

52. BMA Scotland suggested that engagement could be tokenistic: “There is an element of rubber stamping in that fully formed ideas are brought to be validated rather than staff being involved from the bottom up.” [8]

53. Unison Scotland spoke of the pressures on local managers to implement savings plans. It suggested that it was easier to work in partnership with staff during times of growth, because there was a positive message to deliver, whilst it was more difficult during periods of retraction and change. [9]

54. Managers in Partnership also raised concerns about the pressures being faced by management. They spoke about a lack of appreciation of managers and blame apportioned to them. This was resulting in managers suffering ill health and individuals requiring mental health support. [10]

55. Barriers to engagement were also raised. The BMA said there were difficulties for staff to engage in the decision making process due to restraints on time and resources. The BMA also highlighted that the influence and activity of existing mechanisms for influencing health board decisions (e.g. area medical committees, consultant subcommittees and specialty subcommittees) were patchy and varied greatly between NHS boards. These views were support by the RCN and the Allied Health Professions Federation (AHPF), although the AHPF highlighted their lack of access to decision making mechanisms.

56. We heard of work undertaken by some NHS boards to address concerns regarding management visibility. Elaine Mead of NHS Highland told the Committee how her board had encouraged and supported managers – particularly middle managers – to see the work of teams and managers were buddied with wards in some areas. [11]

Discrimination, bullying and harassment

57. Another aspect of staff relationships explored by the Committee was around issues of discrimination, bullying and harassment.

58. The Dignity at Work Survey highlighted that the majority of NHS staff members had not experienced these issues. However, of those who had, only a minority had reported them. Reasons for not reporting unacceptable behaviour included a belief that nothing would happen as a result, concern with what would happen if it was reported, and concerns about confidentiality.

59. Managers in Partnership stated in its written submission that its members reported that “the NHS is blame oriented with a culture of formal grievances to resolve matters that should be discussed informally first. We need to develop a culture of talking about difficulties without blaming with a focus on finding a mutually agreeable solution for all.” [12]

60. Managers in Partnership also expressed frustration that, where staff have raised grievances, managers are often unaware that problems had escalated to that extent. They considered there to be a lack of opportunity for managers to use the informal stages of the Partnership Information Network (PIN) guideline on bullying and harassment which encourages issues to be talked through first. [13]

61. It is clear from the evidence we heard that it is important to ensure good communication between all staff levels within an organisation. We believe it is even more vital when there are staff pressures and changes to service provision. To deliver changes effectively staff must be involved in shaping and influencing decisions as well as implementing them.

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

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

Whistleblowing

64. Whistleblowing and the systems in place for staff to raise concerns are a key aspect of staff governance. We think it is essential that individuals feel confident to speak out when they feel they need to raise concerns.

65. Robin Creelman of NHS Highland used the metaphor of the whistleblowing system as a lifeboat "To me, a whistleblowing system is basically a lifeboat for the culture of the NHS. If the rest of the culture is in place, we should seldom require the lifeboat, but we must have the lifeboat." [14]

Confidence to speak out

66. The Dignity at Work Survey 2017 found that 65% of respondents believed it was safe to speak up and challenge the way things are done if they have concerns about quality, negligence or wrong doing by staff. This is a marked increase of 9% from the 2015 survey. However, the findings show that over a third of staff felt it was unsafe to speak up.

67. Sir Robert Francis QC, who conducted the Freedom to Speak Up review into whistleblowing in the NHS in England, stated in his review "there are disturbing

reports of what happens to those who do raise concerns. Yet failure to speak up can cost lives." [15]

68. He told the Committee "In an ideal world everyone should be able to speak up, be listened to and see action being taken, but unfortunately that is, as we know not the position." [16]

69. Claire Pullar of Managers in Partnership told us "senior managers think that there is still blame attached when someone has the temerity to raise concerns through whistleblowing. The attitude is "How dare they?"" [17]

70. Dr Gordon McDavid of The Medical Protection Society Scotland spoke of concerns raised by its Members "They are scared of what will happen if they speak up or are honest when something goes wrong. Will they be sued?" [18] The Medical Protection Society in its written submission called for a culture of improved openness "…We need an environment where staff are trained and supported to be open about mistakes and to learn from them, and where senior clinicians lead by example." [19]

71. Many witnesses mentioned the importance of having a culture where individuals felt confident and supported to speak out.

72. Ros Shaw of RCN suggested that there needed to be a culture which was both supportive and enabling of staff who raised concerns. [20]

How concerns are raised and dealt with

73. It is important that where NHS staff have concerns, there are systems in place to allow these concerns to be reported and acted upon.

74. We looked into the question of how NHS staff members can report concern about activities in the workplace.

75. We heard during our inquiry that NHS boards are expected to have local policies for staff raising concerns. They are also expected to adhere to the Staff Governance Standard, which involves implementing Partnership Information Network (PIN) policies such as 'Implementing and Reviewing Whistleblowing Arrangements in NHSScotland'.

76. We also explored with witnesses whether more could be done at an earlier stage to prevent staff from feeling they had to whistleblow because their concerns were not being taken seriously. For example, the Datix computer software system seeks to promote a culture of learning by recording, investigating and analysing incidents and near misses. Matt McLaughlin of Unison Scotland told us that Datix offered a route to raising an issue at a local level but noted that it did not provide feedback to people when they made a referral or a report at a local level. [21]

Duty of candour

77. The Committee also noted that the new legal duty of candour, which came into force in April 2018, might help create within the provision of clinical care a culture of openness, thereby negating the need for some whistleblowing.

78. In Scotland the duty is being implemented via the enactment of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016. The duty of candour provisions require health and social care organisations to inform people of any unintended or unexpected incidents which result in death or harm.

79. The Cabinet Secretary explained that the duty of candour would be a legal requirement and aims to drive cultural change and lead to more transparency and openness in how the NHS operates. [22]

National Confidential Alert Line

80. One specific mechanism for staff to raise concerns which we examined was the National Confidential Alert Line (NCAL). It is run by Public Concern at Work which is an independent whistleblowing charity.

81. The NCAL aims to complement existing whistleblowing policies by providing a safe space for staff to raise concerns about patient safety and malpractice. The NCAL does not investigate concerns but legally trained staff offer support and advice.

82. Where appropriate, concerns can be passed to the appropriate regulatory body or NHS boards.

83. Since its launch in 2013 the hotline has received 309 calls from staff. [23]

84. Some of the written submissions we received criticised the fact that callers to the alert line were often referred back to their employer. [24] The BMA Scotland representative noted “the flaw in the helpline that always refers people back to the internal arrangements, so there is no escape from the inward-looking way of addressing things". [25]

Independent National Whistleblower Hotline

85. During this inquiry we also considered Petition PE1605 which is calling for an independent national whistleblowing hotline to replace NCAL.

86. The Petitioner would like the new hotline to have the power to investigate individual reports about mismanagement and malpractice without recourse to NHS managers. This would avoid the current situation where calls to the alert line are referred back to the caller's employer.

87. The Petitioner suggested the NHS should adopt a reporting line similar to that operated by the City of Edinburgh Council. The Edinburgh hotline is operated by an external provider, although it is managed internally by senior staff. It is the hotline staff who interview whistleblowers and categorise their concerns as major or minor.

A course of action is then agreed in consultation with senior staff. In cases of major issues, this involves an investigation led by the provider of the hotline service.

88. We note that the NCAL is predominantly an advice line for staff while the City of Edinburgh Council hotline is a reporting line with a role in investigating a concern.

89. Sir Robert Francis told the Committee that having both models [a reporting line and an investigative line] was a good idea. [26]

90. Cathy James of NCAL Public Concern at Work, who gave evidence to the Committee, commented in a BBC article that "an investigatory service aimed at whistleblowing cases across the NHS could make a real difference to the experience of those raising concerns in the health sector, but this is not the service we provide to NHS Scotland". [27]

91. The contract for the NCAL was re-tendered in June 2017 and it has remained predominantly an advice line for staff. The Cabinet Secretary stated that this fulfilled the Freedom to Speak Up review's recommendation that an external support service is available to staff.

Whistleblowing Champions and the Independent National Whistleblowing Officer

92. The Committee also took evidence about the idea of whistleblowing champions.

93. Following the recommendation of the Freedom to Speak Up review, whistleblowing champions were appointed in each health board in Scotland. The purpose of the Champion is to provide an oversight and assurance role on whistleblowing.

94. The review considered that the whistleblowing champion should be someone "who is recognised as independent and impartial, has the authority to speak to anyone within or outside the trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed, and has dedicated time to perform this role".

95. The Scottish Government's view is that champions "provide independent assurance at a local level" and the role does "not form any part of whistleblowing policy". [28]

96. The Scottish Government also intends to establish an Independent National Whistleblowing Officer (INWO) to review independently the handling of whistleblowing cases in NHSScotland and "provide independent challenge and oversight". [29] The Cabinet Secretary detailed that legislation would be introduced in 2018 to allow the INWO role to be hosted within the Scottish Public Services Ombudsman office (SPSO). It was expected that the post would be established in late 2018. [30]

97. The Committee heard some concerns about the independence of the whistleblowing champions.

98. One concern was that health boards had been instructed in a Chief Executive Letter to appoint a non-executive director to the role.

99. Rab Wilson (who identified himself as an NHS Whistleblower) indicated his view was that this meant the appointments were neither independent, fair or impartial.

100. Sir Robert Francis also noted the risk that a non-executive director taking the role could be perceived as leading to a conflict of interest. He noted that "a non-executive director has a corporate responsibility to the running of the organisation that to some might be seen as conflicting with their role of helping to oil the wheels of the system for challenging the organisation." [31]

101. On the other hand, some of the current whistleblowing champions provided examples of when their role had operated effectively, for example by upgrading the level of an investigation resulting from whistleblowing. Morag Brown, non-executive director and whistleblowing champion at NHS Greater Glasgow and Clyde, discussed being able to "speak up and challenge" in her role. She acknowledged, however, that there was potential for public concern about the independence of the role. [32]

102. She suggested that the new Independent National Whistleblowing Officer could play a role in monitoring boards' performance in relation to whistleblowing and producing national materials and training for whistleblowers. [33]

103. The Cabinet Secretary was asked about the potential conflict of interest of non-executive directors being whistleblowing champions. She stated that the role of whistleblowing champions "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". She also provided a specific example of where the role had operated effectively to improve the information that was gathered and recorded about the nature and number of whistleblowing cases. [34]

Treatment of Whistleblowers

104. One of the keys to encouraging staff to speak out is for individuals to have confidence in how they will be treated.

105. Some of the case studies referred to in the Freedom to Speak Up review, and in the evidence we received, highlighted cases of bullying, harassment and threats against whistleblowers.

106. In the Freedom to Speak Up review, Sir Robert Francis wrote: "Whistleblowers have provided convincing evidence that they raised serious concerns which were not only rejected but were met with a response which focused on disciplinary action against them rather than any effective attempt to address the issue they raised." [35]

107. Some of the written evidence received by the Committee also detailed examples of alleged mistreatment of staff who had raised concerns. [36]

Blacklisting

108. One concern raised in written evidence by Dr Sukhomoy Das and Dr Jane Hamilton following their experiences of whistleblowing, was the subsequent difficulties they faced when applying for other jobs in the NHS.

109. There was a suggestion made by some witnesses that the NHS in effect operates a 'blacklist' and that whistleblowers are discriminated against when seeking employment in another board.

110. This allegation was strongly refuted by NHS board representatives. Kenneth Small of NHS Lanarkshire stated "There is no such thing as a blacklist. I would play no part in that, personally or professionally." [37]

111. The Employment Rights Act 1996 protects people from "suffering a detriment" from their employer as a result of making a public interest disclosure, however, it does not give them legal protection from the actions of a potential future employer.

112. Sir Robert Francis reiterated in evidence to the Committee the recommendation in his review that legal protections should be extended outside the particular organisation in which an individual is working, so that people who are applying for jobs elsewhere in the NHS would be protected. [38]

113. The law in this area is largely reserved. The UK Government consulted on the draft Employment Rights Act 1996 (NHS Recruitment – Protect Disclosure) Regulations 2018. These regulations will allow a whistleblower to take a potential NHS employer to a tribunal and potentially receive compensation if they feel they have been discriminated against. The UK Government responded to the consultation in March. The UK Government stated it would implement the regulations at the earliest opportunity. [39]

Junior Doctors

114. We also received specific concerns about the whistleblowing protections being afforded to junior doctors. BMA Scotland told the Committee in March 2017 that the current legal position meant that if a junior doctor suffered detrimental treatment from NHS Education Scotland (NES) as a result of whistleblowing, they would not receive the equivalent legal protection they would have obtained had they been mistreated by the territorial health board which employed them. BMA Scotland stated that this was "one area where the NHS is falling short of what is expected" in relation to whistleblowing and the Staff Governance Standard. [40]

115. Following BMA Scotland's evidence session with the Committee the Scottish Junior Doctors Committee met with NHS Education Scotland to work together to achieve a solution to the issue. On 1 March 2018 the Scottish Government announced that legal protections were now in place for junior doctors and other postgraduate trainees if they are subjected to detrimental treatment by NES for raising any concerns. [41]

116. One of the witnesses described whistleblowing as a lifeboat, which should seldom be required if an open and transparent culture is in place. If we apply this metaphor to our assessment of whistleblowing our conclusion is that at present the lifeboat is not viewed as a safe haven as many staff are not willing to enter into it and those who do can find it is to their detriment.

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

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

119. Whilst welcoming these new policies we do believe there are still further steps which need to be made to the current whistleblowing system to ensure it is as robust and fit for purpose as possible. We support the work of the National Confidential Alert Line and believe it provides a useful function for staff wishing to raise concerns. However, it is predominantly an advice line for staff and not an investigative line. We note the comments made by Sir Robert Francis that having both a reporting line and an investigative line is a good idea. We also received evidence on how an investigative line can operate effectively at a local authority level. We believe the introduction of a reporting line for NHS whistleblowers would further enhance the external support services available to NHS staff. We recommend that the Scottish Government introduce an investigative line for whistleblowing. We believe that an investigative line would work well in conjunction with the new role of Independent National Whistleblowing Officer in providing external oversight and support to the whistleblowing system.

120. Looking at the systems currently in place we recognise the merits of non-executive board directors operating as Whistleblowing Champions. They are well placed to understand NHS structures and board processes and have the authority to speak out and challenge poor practice. However, we recognise there is a potential conflict of interest in a non-executive director taking on the role whilst also having a corporate responsibility to run the NHS board. Whilst the issue may be one of perception if this is a barrier to staff feeling confident about speaking out, steps need to be taken to try to change that perception. We therefore recommend that the Scottish Government allow NHS boards to appoint individuals other than non-executive board directors to the role of Whistleblowing

Champion. We also recommend there is staff involvement in the appointment process. A mixture of non-executive board members and non-board members which staff have been involved in appointing may assist in instilling confidence in the system. It will also enable a comparison to be made between the two different types of Whistleblowing Champion to determine if there is any difference in outcome depending on who is in the role.

121. Staff must have confidence in how they will be treated if they speak up. We were concerned to hear of cases of alleged mistreatment of staff when they had raised concerns. NHS employees are meant to be protected from detrimental treatment when raising concerns. We believe the new INWO will have a key role to play in ensuring whistleblowers are treated fairly. We ask the Scottish Government what avenues for redress will be open to the INWO if they establish that an individual has been treated unfairly as a result of raising concerns. We also ask the Scottish Government what sanctions it believes would be appropriate to impose on individual NHS employees who mistreat whistleblowers. We are keen to ensure that the NHS in Scotland encourages and supports whistleblowers and when faced with unfair treatment there should be a clear line of recourse and redress.

122. We were concerned by accounts from some individuals alleging that they had faced discrimination when seeking employment in another board as a result of having whistle-blown. We must ensure that legal protections are extended to protect those in that situation. We therefore welcome the commitment made by the UK Government to extending protection in relation to recruitment.

123. In relation to protections provided to junior doctors, we are pleased that since BMA Scotland first raised its concerns with the Committee legal protections have now been put in place for junior doctors if they suffer detrimental treatment from NES as a result of whistleblowing. It is vitally important that all NHS staff at all stages of their careers are offered the same legal protection if they are treated unfairly within any areas of the NHS.

Regulation of Managers

124. Another issue explored during the course of consideration of staff governance was the regulation of professions. There is currently statutory regulation of 32 healthcare professions across nine professional regulatory bodies in the NHS.

125. The Committee received some calls for NHS managers to be regulated in the same way that other health professionals are. This stemmed from the Sir Robert Francis Review which recommended the following principle:

> "An enhancement of the requirement that directors of healthcare providers be fit and proper persons and are disqualified from being such if, among other things, they have committed serious mismanagement or misconduct in office."

126. The difference in regulation between health professionals and NHS management was raised in the written submissions to the Committee. Dr Hamilton in her written submission stated "Front line staff are now additionally obliged by a 'duty of

candour' to raise concerns where they become apparent, with legal consequences (such as being 'struck off' or prosecuted) if they do not. Curiously and discrepantly, no such legal 'duty' applies to senior management nor are they ever held legally accountable for wrong-doing or incompetence, as would occur in the private sector for example." [42]

127. A poll in the British Medical Journal found that 91% of doctors who responded believed that healthcare managers should be regulated in the same way as doctors.

128. The poll was accompanied by an editorial that quoted Sir Robert Francis "When we look at what really goes on in a hospital, in the engine room, we've got consultants and, alongside them, managers. Together they are meant to manage a service and yet one side is subject to a regulator, and could be in jeopardy for any decision that they make, whereas the other side is not." [43]

129. We raised with NHS managers the prospect of regulation. Elaine Mead of NHS Highland said she would welcome external validation. She felt that a lot of managers would be happy to be subject to the same scrutiny faced by their clinical colleagues. [44]

130. While the regulation of health professions that were regulated prior to devolution is a reserved matter, the regulation of new professions would be devolved to Scotland.

131. Paul Gray, Chief Executive of NHS Scotland said that he would "welcome proposals for the regulation of managers and leaders in the NHS because it would bring parity" with other health professionals in the NHS. He added that thought would have to be given to the "risks and opportunities" regulation would present. [45]

132. The issue of regulation of management has been raised during the course of our inquiry. NHS managers are not currently regulated in the same way that other health professionals are. This creates an imbalance between clinical and managerial staff. We note the Chief Executive of NHS Scotland's comments that he would welcome proposal for the regulation of managers and leaders in the NHS and that thought would have to be given to the risks and opportunities this presented. We believe the time is right for this issue to be given further detailed consideration by the Scottish Government. For such a change in approach to the regulation of NHS management to be delivered successfully it will require the support and involvement in development by NHS managers. They will need to recognise the benefits it could bring to them in their role and the wider NHS service and its patients. We recommend the Scottish Government undertake a review of the case for regulation of NHS management to determine the merits, steps and requirements that would be needed to deliver this change.

Integration Authorities

133. Another issue we wish to raise on the subject of staff governance is the impact the establishment of integration authorities is having on the delivery of the Staff Governance Standard.

134. Integration Authorities do not currently operate under the same partnership working model set out in the Staff Governance Standard. Unison Scotland described local authorities as “another big complex beast” which “does not necessarily have at its heart that commitment to staff governance". [46]

135. We heard of the practical impact of some health services and their staff now being managed on a daily and strategic basis by non-health professionals. [47] Some examples were provided of where concerns had arisen with proposed changes to service provision and staff terms and conditions. Unison Scotland suggested that the nature and construction of Integrated Joint Boards created the potential for there to be “a culture clash”. It called for further guidance from the Scottish Government to address these issues. [48]

136. We asked the Cabinet Secretary if there were any plans to have a single governance standard for health and social care staff. In response she detailed there had initially been some sensitivities regarding one system being seen to impose its approach on another. However, the merits of the staff governance principles had been recognised by Integration Authorities with a gradual adoption of staff governance principles across a number of Integration Authorities. She stated that the expectation was that more would follow. [49]

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

Staff Survey and iMatter

138. Our consideration of the issues around staff governance has been informed by the Health and Social Care Staff Experience Report 2017. We wish to make some comments on staff engagement in this process, the presentation of the information and the action taken as a result of the survey findings.

Response rates

139. It is clear to us that opinion gathering exercises are most valuable when there is a good participation rate by NHS staff.

140. The response rate for the iMatter survey (63% across NHSScotland and 23 integration authorities) has been higher than that for the Dignity at Work Survey (36% across NHS Scotland and 12 integration authorities).

141. We heard from witnesses this was because the iMatter survey was much more meaningful for staff as it related to their experience of the day-to-day workplace and their team. [50]

142. We also heard that for both surveys there were both regional variations in response rates between NHS territorial boards and also variations between NHS territorial boards and special health boards. The response rate for iMatter ranged from 52% (NHS Western Isles) to 85% (NHS Health Scotland). The response rate for the Dignity and Work Survey ranged from 30% (NHS Greater Glasgow and Clyde) to 84% (NHS Health Scotland).

143. We believe that it is essential that the NHS listens to the views of its staff - its most valuable resource. There should be effective mechanisms in place to gather these views, with the objective being to encourage a high response rate.

144. We welcome the introduction of iMatter as it has led to an increase in staff participation in the monitoring of NHS staff governance. The more staff who engage with iMatter the more accurate the picture of staff experiences across the NHS.

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

146. The 2017 Dignity at Work Survey only achieved a 36% response rate in comparison to a 63% response rate for iMatter. The issues covered by the Dignity at Work Survey, including bullying and harassment, discrimination, abuse and violence from patients and the public, resourcing and whistleblowing are central to staff governance and it is important as complete a picture as possible is obtained of these issues. Given the increased engagement achieved through the iMatter approach, the Committee recommends that the Scottish Government examines whether these issues should be included within the scope of the iMatter questionnaire. There should be a high level of engagement by staff across all issues relevant to staff governance.

Employee Engagement Index Score

147. One aspect of the Staff Experience Report we raised with the Scottish Government was about how the scores for the iMatter questionnaire are calculated and presented.

148. The Staff Experience Report uses an Employee Engagement Index (EEI) Score as a key indicator of performance against various iMatter questions. The questions invite respondents to pick a number on a scale from 6 (strongly agree) to 1 (strongly disagree).

149. The Staff Experience Report explains that the EEI score is shown as a percentage of the total score available. The EEI score is the number of responses for each point in the scale multiplied by its numerical value (6 to 1) added together, then divided by the overall number of responses.

150. As we understand it, the scale used for responding to each question starts at 1 rather than 0, which means the lowest possible EEI score is 16.6% rather than zero.

151. We were concerned that, as presented, the EEI score is potentially inflated and that is was not clear from the report whether this had been adjusted for.

152. We wrote to the Cabinet Secretary for Health and Sport [51] to seek further clarification on this issue and assurance that the EEI could not inadvertently give a misleading impression. We wanted to be clear that the way the EEI was calculated creates an accurate picture of performance against the staff governance standard.

153. The Cabinet Secretary's response stated that a "mistake was made" in the weighting of the scores. Her response detailed "For a 1-6 weighting to be applied a different formula would be required to transfer the EEI into a percentage. This has led to the iMatter results with the Health and Social Care Staff Experience Report unintentionally referring to the index scores in percentage terms when they were not." [52]

154. Her letter detailed that this issue would be taken into account when considering recommendations for the intended approach for the iMatter model in 2018. A review of the measurement of the EEI will also be built into the scope of the work for an external evaluation of the Scottish Government approach to staff experience through the iMatter and Dignity at work surveys.

155. It is important that the way the EEI is calculated creates an accurate impression of staff experience. We therefore welcome the Scottish Government's acknowledgement that it will review the measurement of the EEI going forward.

Acting on the survey results

156. Several witnesses made the point that it was important that the results of the survey were acted upon.

157. Individual teams within each part of NHS Scotland are expected to complete and agree action plans based on the findings of their responses to iMatter. However, the Staff Experience Report shows that there is a huge variation between NHS boards in the share of teams completing the required action plans, ranging from 12% (NHS Western Isles) to 97% (NHS Health Scotland).

158. When asked about the staff survey, a witness from Unison Scotland stated "If people act on what they are told, it will be a raging success; if they do what they did with the existing staff survey, which was to completely ignore it, it will just be the same again." [53]

159. This view was echoed by Gary Wilson who was a Non-Executive member of the Board of NHS Health Scotland until 2013. He was supportive of the aims of the Staff Governance Standard, but stated "the problem is with the lack of any action when these standards are not being implemented". [54]

160. RCN was critical of the annual assessment of performance against the Staff Governance Standard which was conducted between an Area Partnership Forum and the Scottish Government. Meetings tended to focus on the positive examples rather than the points of concern raised by the staff survey. [55]

161. Other views were more positive. Kenneth Small of NHS Lanarkshire told the Committee that he did not agree that the staff survey results were ignored. He explained the former annual staff survey results had been used to inform priorities for action and improvement by the Board's staff governance committee. [56]

162. We also heard from some witnesses who commented that the move to the iMatter questionnaire had been helpful. BMA Scotland noted that iMatter had the potential to deliver improvements in staff governance as it could help generate local solutions to issues. [57]

163. Kenneth Small of NHS Lanarkshire considered that another advantage of iMatter was that, as well as enabling an assessment of performance at an NHS corporate and individual board level, in time it could also assess performance within specific department and clinical areas in boards. [58]

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

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

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

Clinical Governance

167. The second strand of our inquiry considered clinical governance. Clinical governance has been defined as:

> "A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." [59]

168. Patients are entitled to expect the care they receive to be safe, effective and tailored to their needs. They also expect services will treat them with dignity and respect.

169. During this phase of the inquiry we looked at the systems which are in place to maintain and improve patient care and the systems to address failings if things go wrong.

170. In this section we explore some of the themes and issues that arose during our consideration of clinical governance.

Standards and guidelines of care

171. A key part of clinical governance is the setting and meeting of standards for good quality care. NHS boards are expected to abide by national service standards and guidelines. This includes meeting Local Delivery Plan (LDP) standards which are one of the key mechanisms for performance managing health boards. Most of the standards are former 'HEAT' targets, with HEAT being an acronym relating to four key objectives:

- Health Improvement
- Efficiency and Governance Improvements
- Access to Services
- Treatment Appropriate to Individuals. [60]

172. In addition to LDP standards there is a range of other standards and guidelines produced by the Scottish Government, its arms-length bodies and other professional bodies, which NHS boards are expected to pay due regard to.

173. Sources of guidance include:

- The Scottish Government – for example Chief Executive Letters
- NHS Healthcare Improvement Scotland – produces standards for care. NHS Healthcare Improvement Scotland also incorporates organisations such as the Scottish Intercollegiate Guidelines Network (SIGN) (which produces guidelines on clinical practice) and the Scottish Medicines Consortium (which advises boards on the clinical and cost-effectiveness of newly licensed medicines)

- Health Protection Scotland – issues guidance on the management of infectious and environmental hazards
- National Institute for Health and Care Excellence (NICE) – although the guidance it provides is officially for England, some is applicable and relevant in Scotland
- Professional bodies – including the Royal Colleges. [61]

174. Healthcare Improvement Scotland (HIS) is tasked with improving the quality of care in the NHS and has a key role in setting standards for care and treatment. HIS describes itself as an improvement body rather than a regulator and it has few legal powers to enforce sanctions against NHS boards. Instead it works with boards to bring about improvements. As a result, NHS boards still have a large degree of autonomy over what health services they deliver to the population and how they do so.

175. HIS also incorporates the Scottish Health Council (SHC) which is tasked with overseeing how well NHS boards consult with the public and how boards support the public to get involved.

176. We explored with HIS its role in the development, implementation and monitoring of the standards and guidelines detailed above. In evidence to the Committee Robbie Pearson, Chief Executive of Healthcare Improvement Scotland stated that HIS "has a pivotal role in supporting the production of the guidelines and standards." [62] and has a key role in their dissemination too.

177. We examined how care and treatment standards and guidelines are developed, implemented and monitored and the extent to which this ensures the consistent delivery of effective care for patients.

178. The general opinion expressed by witnesses was that in the areas standards or guidelines exist, they are good. However, some witnesses expressed concern that awareness of existing standards and guidelines was not high amongst practitioners and service users.

179. For example Clare Ogden of Action for ME discussed the usage of the Scottish Good Practice Statement on ME-CFS published in 2010. A survey issued to GPs four years after publication found two-thirds of GPs were unaware of the statement. Clare Ogden felt this was reflected in the patient experience, with many patients believing their GP had a lack of understanding of the condition which led to poor advice being provided. [63]

180. Some written evidence we received highlighted there are some conditions which have no standards or guidelines for diagnosis and treatment. In such instances it is a matter for professionals to ensure quality. [64]

181. Some questions were also raised about the suitability of clinical guidelines. Dr Peter Bennie of the BMA suggested that clinical guidelines may have "limited or no relevance" because they do not take account of co-morbidity, something which is fairly typical of many patients today. [65]

Implementation

182. In evidence we heard there can be variations in how standards and guidelines are implemented. This can affect the experience of patients and the services provided to them. [66]

183. Down's Syndrome Scotland reported that the quality of care for patients with Down's Syndrome often varied depending on where they lived and who was supporting them. [67] The Royal College of Pathologists also highlighted a wide variation in practice regarding the use of laboratory requests for specific tests. According to its evidence, the under and over requesting of particular tests raised patient safety issues as a result of under-diagnosis and over-treatment. [68]

184. The Health and Social Care Standards published in June 2017 set out what service users should expect when using health, social care or social work services in Scotland. These standards are underpinned by five key principles which include dignity and respect. [69]

185. Whilst several NHS boards emphasised that dignity and respect were core values of NHSScotland, we received evidence which suggested this was not always reflected in patients' experiences.

186. Carolyn Lochhead of SAMH highlighted its survey of people who had used NHS mental health services in the last year, which found that 40 per cent of respondents said they had been treated disrespectfully. [70] Derek Young of Age Scotland stated that for patients, being treated with dignity and respect was as important as the quality of care delivered. He highlighted that whilst dignity and respect are included within standards these aspects of care do not yet form the basis of enough inspections. [71]

187. We explored with staff representatives why patients may not always be treated with dignity and respect. Dr Peter Bennie of the BMA emphasised that "No one receives poor treatment deliberately, and very few receive poor treatment because of thoughtlessness". [72] Dr Lorna Greene of the Royal College of Nursing summed up the view expressed by several witnesses that whilst there was a requirement to deliver care in a dignified and respectful way, "resources, pressures on time and staffing will all impact on the quality of care that is delivered". [73]

Volume

188. In the course of our consideration of clinical governance, we heard a number of suggestions as to why there might be variation in the implementation of standards and guidelines.

189. The volume of standards or guidelines was raised as an issue. Reference was made to there being a "plethora of guidance". [74]

190. Dr Peter Bennie of the BMA said that whilst new guidelines were well publicised "it was difficult to keep up to date with everything that comes through". [75]

191. Jason Leitch, National Clinical Director, Scottish Government raised a similar point stating “it is almost impossible for people to keep up with the guidelines in their own specialties, never mind the generic guidelines". He placed emphasis on ensuring implementation by making sure that guidelines can be applied to the clinical environment. [76]

192. One specific issue which the Committee explored with witnesses was whether staff had the time to undertake Continuing Professional Development (CPD), to keep up to date with new standards and guidelines. We received suggestions that a lack of resources meant staff did not have time to take stock and undertake CPD.

193. In its written submission RCN mentioned day-to-day service pressures as a barrier to accessing CPD, as well as nursing staff having a lack of protected study time. [77]

194. We also heard that there appears to be a variation between professions as to whether staff are able to access time for CPD.

195. Dr David Chung of the Royal College of Emergency Medicine Scotland told us that whilst he had protected time, nurses did not “As a doctor with protected CPD and so on, I find it incredibly incongruous to have to watch my nurses come in on their days off to do courses because they cannot do them as part of their normal work. That is completely unfair." [78]

196. We raised the issue of staff accessing CPD with Professor Jason Leitch, National Clinical Director, Scottish Government. In a letter to the Committee he stated “For nurses and midwives there is a 2% predictable absence allowance for CPD which is built in to the workforce planning tools.” [79]

Inspection and Monitoring

197. We heard about the importance of monitoring the implementation of guidelines and standards. The Scottish Public Service Ombudsman told the Committee “Putting standards in place and disseminating them are important but, once they are in place, we must continually monitor their implementation and, if they do not deliver the outcomes that we expect learn from that.” [80]

198. The role of Healthcare Improvement Scotland (HIS) was raised within this context.

199. We received some examples of HIS assessing how standards were being implemented through its inspection activity, including Healthcare Environment Inspections and Older People in Acute Hospitals inspections. Robbie Pearson, the Chief Executive of HIS, highlighted that the Healthcare Environment Inspectorate had produced around 270 reports and the number of ‘requirements and recommendations’ had fallen consistently year on year and there had also been a reduction in infection, with MRSA rates falling by 90%. [81]

200. However, the implementation of other standards does not appear to be routinely monitored by HIS.

201. For example, Rachel Le Noan of Down's Syndrome Scotland explained that her organisation had been invited by HIS to be a member of a group creating the national screening standards for Down's Syndrome. However, she noted that HIS had no role in implementing and monitoring the standards which she considered to be "quite troubling". [82]

202. We also heard concerns expressed about the role of HIS as both a scrutiny body and an improvement body, and the potential conflict of interest this could present (this issue is explored further in this report under consideration of 'regulatory regime').

Consistency in Outcomes

203. Another issue which was raised during discussions about the guidelines and standards of care was consistency in the standard of care delivered. We received calls for improvements to be made in collecting patient outcome data and for there to be better use of routinely collected data to inform good practice.

204. Dr Calderwood, the Chief Medical Officer, discussed variations in care and explained that an Atlas of Variation was being developed which will look at unnecessary variations in practice across Scotland. She told the Committee this was due to be published in April and would cover three operative procedures - hip replacement, knee replacement and cataract surgery. It would provide data at both population level and by health board. [83]

205. The Cabinet Secretary added "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 there is a lot of scope, particularly in elective care, to make big inroads into variation." [84]

206. Clinical standards and guidelines have a key role to play in ensuring patients receive high quality, safe care and are treated with dignity and respect.

207. Where standards and guidelines exist they have been generally welcomed. However, we believe that they are not being used as effectively or consistently as they should be, which is resulting in current variations in patient experience and outcomes. There are also occasions where guidelines do not take account of issues such as co-morbidity.

208. Staff awareness, knowledge and understanding of standards and guidelines is critical to ensuring effective use. We note the challenges faced by staff in keeping up to date with the frequently wide-ranging standards and guidelines relevant to their work. Having the time to undertake Continuing Professional Development is very important if this objective is to be met.

209. We were concerned to learn that, whilst the Scottish Government highlighted that time to access CPD was built into workforce planning tools for nurses and midwives, there were examples of staff in these roles who reported not being

able to access CPD during their normal working day. We do not consider this to be acceptable.

210. We do not consider having a predicted absence allowance for CPD built into workforce planning tools is enough. We recommend the Scottish Government conduct a review of NHS board performance on the implementation of the allowance for CPD as set out in the Scottish Government's workforce planning tools. It is important that NHS boards are ensuring that nursing and midwifery staff are able to access the time they are entitled to for CPD.

211. We also believe there must be parity between all NHS staff in being given access to their allocated time to conduct CPD. We recommend the Scottish Government place statutory requirements on boards to ensure delivery of appropriate CPD time for all NHS staff.

212. Treating patients with dignity and respect is arguably as important as the quality of the care they receive. We were concerned to learn of instances where patients felt they had not been treated with dignity and respect. These are core values of NHSScotland and should be as central to good clinical governance as the quality and safety of the care that is provided.

213. We believe there must be a focus on the patient's whole experience of their health care. Ultimately treating individuals with dignity and respect will result in a more positive experience which in turn can assist in ensuring a positive outcome for the patient.

214. We therefore welcome the inclusion of dignity and respect as principles underpinning the new Health and Social Care Standards. We heard from some staff representatives that there can be instances where the quality of care they provide can be affected by resources, pressures on time and staffing. We seek assurances the inspection regime for the new standards will include ensuring the views of service users are sought. We also believe inspections must assess not only where issues lie with regards to performance against standards but also seek to identify the reasons for poor performance and assess whether there are systematic issues faced across NHS boards which need to be addressed.

215. There appears to be variations in the current dissemination, implementation, inspection and monitoring of standards and guidelines. We heard of the key role Healthcare Improvement Scotland can play in monitoring and inspecting certain standards and guidance.

216. However, HIS only undertakes this role for some standards and guidelines. We believe the rationale for what is inspected and monitored and what is not is unclear. We recommend the Scottish Government should undertake a fundamental review of HIS's function with a view to implementing a more systematic and coherent approach to its work. We believe there is merit in consideration being given to HIS having a broader look at how standards and guidelines are delivered and how well they are designed for the purposes they are seeking to address. We believe this would also assist in enhancing its roles as an improvement body. Its reporting on standards and guidelines would provide a benchmark for performance and encourage adequate implementation. We also

believe consideration should be given to HIS being given greater enforcement powers in this role. We consider this enhanced role for HIS would also allow it to assist in streamlining guidance and standards where required and help with dissemination. This might address concerns regarding the wide range of standards and guidelines which currently exist and the concerns which have been raised regarding variation in care provided.

Learning and improvement when things go wrong

217. Learning from mistakes or near misses in the provision of healthcare and services is key to creating a culture of improvement.

218. The issue of this culture of improvement was first raised in our discussions regarding whistleblowing. It was raised again during our consideration of the complaints system and the framework for managing serious adverse events (SAEs). We heard that it was important that these systems and frameworks operated in a culture of openness, transparency and learning.

219. Some witnesses suggested that changes need to be made to the current culture of how the NHS responds to mistakes. Dr Bennie of BMA told the Committee "In much of the health service, there is a culture of learned helplessness – a sense that passing on bad news will have no effect and, therefore, there is no point in doing it." [85]

220. Witnesses including HIS and SPSO emphasised the importance of learning from near misses and mistakes and ensuring that changes were made to clinical practice as a result. Professor Fluck, Medical Director of NHS Grampian summarised the view expressed by several witnesses when he argued that the focus on complaints should be on the "culture processes and behaviours around how we use the information to learn from it." [86]

Datix system

221. During our consideration of whistleblowing some concerns were raised that the Datix computer software system which records incidents and near misses lacked a system for providing feedback. This meant the Datix system did not provide the opportunity for lessons to be learnt from incidents.

222. Dr Chung of the Royal College of Emergency Medicine said that "feedback is crucial for quality improvements of any kind" but the Datix system was "cumbersome". Dr Chung described it as a "not very slick system and it is a barrier to getting proper feedback and learning." [87]

223. Other witnesses including Lorna Greene of the Royal College of Nursing echoed this view. She said that having a system where people can log their concerns is a vital part of an improvement culture. She emphasised the importance of receiving

feedback on what data recorded in the Datix system had been used for and its role in delivering improvements. [88]

224. In response to Dr Chung's concerns, Professor Leitch, National Clinical Director, Scottish Government stated that Datix was used well in health boards and that there was a national Datix user group where users come together to share best practice. [89]

Complaints

225. Complaints about NHS services are an important mechanism for gathering feedback and a route to improving services.

226. The new NHS complaints procedure came into effect in April 2017. Under the procedure complaints should be made directly to an NHS board. This can be a two stage process. Under stage one the NHS board should seek to resolve the complaint within five working days. If the complaint is more complex or requires more detailed investigation it proceeds to stage two. Under normal circumstances the NHS board then has up to 20 working days to provide a decision on the complaint. If an individual is unhappy with the NHS board's final decision they can ask for it to be considered by the Scottish Public Services Ombudsman or seek a judicial review.

Barriers to making complaints

227. We explored with witnesses the current operation of the complaints procedure. Several witnesses suggested there were barriers to patients providing feedback on their experiences and making a complaint about their treatment. Carolyn Lochhead of SAMH stated there was a lack of awareness about complaint procedures. [90] This was a view supported by Parkinson's UK in Scotland who said in its written submission that whilst there were positive opportunities for patients to provide feedback on services anonymously through Care Opinion, they were little known by the public. [91]

228. Another potential barrier to making complaints, which was highlighted by Derek Young of Age Scotland, was that each NHS board has its own complaints process. He explained that this meant a patient who wished to raise concerns regarding a range of NHS services across NHS boards would have to raise numerous complaints, which he felt was an onerous task. [92]

229. We heard in our informal evidence sessions with NHS patients that patients often feared recriminations if they raised concerns especially when they or family members were still receiving treatment. Some felt the complaints process should be external to the NHS board in order to give patients the same protection as staff and bring greater objectivity to the procedure. Sue Lavery, who provided insights into her experience raising concerns about her late mother's NHS care, stated "No matter how serious the complaint, complaints automatically supported NHS staff as if mum and I wrote fictional complaints!". [93]

230. Derek Young of Age Scotland emphasised the importance of ensuring that patients felt the complaints service was consistent and could be trusted to "be on their side". He considered that the complaints system would be supported by patients where they felt that it would ultimately result in changes either for them or for other individuals facing similar clinical issues. [94]

Ensuring positive outcomes from complaints

231. We also heard concerns that the procedure for handling complaints can sometimes result in a disconnect between the patient and the clinician. Professor Fluck of NHS Grampian told the Committee it would be helpful if there was an increase in the involvement of patients at an early phase of a complaint investigation. [95] Sue Lavery said in her written submission that after she raised a complaint no one came to speak to her or her mother to discuss it. [96]

232. This concern was also acknowledged by clinicians. The British Dental Association said in its written submission "Responses to patient complaints can be delayed and non-specific. Clinicians' feedback is often ignored and a vague (diplomatic) version of the truth is sent back to patients. BDA Scotland is concerned that generic responses are issued with no intention of dealing with the root of the problem". [97]

233. Ella Brown, whose father died following a fall at Victoria Hospital in Fife, also suggested that initially she had felt "abandoned" by the NHS board having raised her concerns about the care her father had received. However, the experience she relayed to the Committee about the handling of her complaint had ultimately been a positive one as it had resulted in service changes. She told the Committee that the NHS board had contacted her and she had been able to play a key role in helping to shape services and bring about changes aimed at reducing hospital falls. [98]

234. Some NHS board representatives including Dr Gillies of NHS Lothian suggested that an advantage of the complaint system being managed within individual NHS boards is that boards can take ownership of driving the change that is required as a result of the complaint and ensuring changes are embedded in everyday practice. [99]

235. The SPSO stated that learning from complaints was the most important performance indicator of the new complaints procedure. The SPSO highlighted several areas where she felt improvements could be made in the operation of the current system. This included improvements to how the NHS learns from complaints and changes that were made to the system as a result. She also believed improvements could be made to the consistency of complaint handling by NHS boards. There were examples where a corporate explanation for a response to a complaint had been given which had not had the right level of clinical input. [100]

236. Finally the SPSO emphasised that the new system needed an opportunity to become embedded to deliver a shift in culture. [101]

237. Learning from mistakes or near misses in the provision of healthcare and services is key to creating a culture of improvement. We were concerned to hear suggestions that there is currently a culture of "learned helplessness". Steps must be taken to challenge and address this.

238. The Datix computer software system has an important role to play in recording incidents and near misses. We were therefore concerned to hear suggestion, from staff using Datix that it lacked a function for providing feedback to staff on what action has been taken as a result. Professor Leitch, National Clinical Director, Scottish Government highlighted the work of the national Datix user group. We recommend that the Scottish Government asks the national Datix user group to determine if the concerns expressed to the Committee are widespread and, if so, what further steps need be taken to improve the provision of feedback through the Datix system. We believe it is important that routine feedback on Datix entries is provided as this will assist in reassuring staff that something is done with the issues that they raise.

239. We were also concerned to learn that NHS patients can face barriers to making complaints. We heard for some patients there was a lack of awareness and understanding of complaints procedures. We also heard concerns about the complexities caused by each NHS board having its own procedure for complaints. The need for trust in the system was also emphasised with some witnesses questioning the objectivity of the complaints procedure, which led to concerns that raising a complaint would have a detrimental impact on the care they receive. There was also a lack of confidence that raising a complaint would result in changes to their or others care and treatment.

240. We believe that some of these concerns have arisen because the current complaints system can often be too process driven. There can be a disconnect between the patient and the clinician. Complaints are dealt with at a corporate level with limited input from clinical staff directly involved in providing the care and treatment. This results in little liaison taking place with the patients and families involved in raising the complaint. We believe changes need to be made to this approach.

241. Complaints should be dealt with promptly and effectively and, where appropriate, resolved at a local level. We believe improving the approach taken to handling complaints will also empower staff to learn and deliver changes in practice and procedure as a result of their involvement in complaint handling. We recommend that at an NHS board level an individual within its complaints management team is tasked to lead on driving these improvements in complaint handling.

242. We heard good practice examples of where NHS boards had engaged with patients and family members who had made complaints and this had resulted in positive changes to clinical practice. We need to ensure that this positive experience is one experienced by more patients who raise a concern.

Serious Adverse Events

243. One of the key areas we examined in the clinical governance strand of the inquiry was the investigation of serious adverse events (SAEs).

244. An adverse event can be defined as an event that could have caused, or did result in, harm to people or groups of people.

245. HIS first published a national framework for managing SAEs in September 2013, and this was refreshed in 2015. The framework aims to support NHS boards to standardise processes. It includes a national definition of an adverse event, and guidance on reporting, accountability, responsibilities and learning. [102]

246. The framework aims include to provide:

- a consistent national approach to the identification, reporting and review of adverse events, and allow best practice to be actively promoted across Scotland.

- national resources to develop the skills, culture and systems required to effectively learn from adverse events to improve services across Scotland.

Concerns with the operation of SAEs monitoring and reporting

247. Fraser Morton's baby son, Lucas, was stillborn at Crosshouse Hospital in Kilmarnock in November 2015.

248. In response to his death, NHS Ayrshire & Arran apologised over failures during the later stages of pregnancy to identify complications which contributed to the infant's "very tragic and unnecessary death". Mr Morton and a number of families called for a public inquiry into infant deaths at the maternity unit. The Cabinet Secretary subsequently instructed an investigation by HIS into the management of adverse events in the maternity unit. The report from that investigation was published in 2016 and made a number of recommendations for both NHS Ayrshire & Arran and for the whole of the NHS in Scotland.

249. Fraser Morton's written and oral evidence to the Committee provided valuable insights into the current monitoring and reporting of SAEs. We wish to thank Mr Morton for sharing his very difficult personal experience with the Committee and for his powerful evidence.

250. Fraser Morton questioned how effectively the current national framework identified concerns and problems with the quality and safety of the care and services provided.

251. In particular he expressed concern that health boards were able to determine for themselves what events require to be categorised as 'adverse events' within the general framework. He suggested this leads to inconsistencies across health boards in the numbers of such events recorded and the investigations that take place. Mr Morton called for standardisation of what constitutes a SAE to help identify their occurrence and also to determine whether there were recurring themes in events across health boards. [103]

252. Fraser Morton also raised concerns that there was no central monitoring of SAEs. This was a concern also raised in the Organisation for Economic Co-operation and Development (OECD) report 'Reviews of Health Care Quality: United Kingdom 2016'. The report's chapter on Health care quality in Scotland discusses adverse event reporting in Scotland being done locally, not nationally. The report states "The lack of a national system for reporting/counting adverse events is another weakness, despite other innovations in promoting patient safety." [104]

253. Fraser Morton suggested the Cabinet Secretary's intervention in relation to the situation in Ayrshire and Arran had followed 'adverse national publicity', rather than due to monitoring by the NHS board or the Scottish Government. He believed there had been missed opportunities to identify concerns earlier as there was no central gathering or analysis of SAEs. [105]

254. Fraser Morton also told the Committee that when he had raised concerns regarding his son's death he had been told to pursue the individual doctors/midwives involved. "We were challenged to sue-that is the best way that I can describe it. We were actually challenged: Why don't you just sue us? That was in response to difficult questions that we were asking about the failings surrounding our son's death." [106] He told the Committee that he did not think it was appropriate that individuals should be held personally responsible for what he deemed to be a service failure.

255. This issue was also raised by some witnesses in relation to the Dr Bawa-Garba case.[ii]

256. The suggestion was made that this case was an example of where an individual had been held to account but there was no equivalent system for picking up service failures.

HIS and Scottish Government response to concerns regarding SAEs monitoring and reporting

257. We explored with Robbie Pearson, the Chief Executive of HIS and Professor Jason Leitch, National Clinical Director, Scottish Government whether improvements could be made to the monitoring and reporting of SAEs.

258. HIS stated that it was in the process of revising the national framework to improve current approaches to the management of adverse events. [107]

259. Both the Scottish Government and HIS acknowledged there were concerns with the current operation of the SAEs system. Dr Calderwood, Chief Medical Officer, told the Committee in relation to SAEs "We have had inconsistency in what is reported and in our responses". [108]

[ii] Dr Bawa-Garba was a specialist trainee in England who was found guilty of manslaughter by gross negligence and struck off the medical register. This was following mistakes in her care of a 6 year old boy who subsequently died. Many in the medical profession feel that a number of systemic failures were significant factors in the boy's death but that Dr Bawa-Garba was the only one held to account.

260. Robbie Pearson, the Chief Executive of HIS, made a similar point “there is an issue with the consistency and quality of reporting and with the quality of investigations”. [109]

261. However, when asked about the possible merits of creating a national reporting system for SAEs, Robbie Pearson stated “I would caution against creating an accounting system alone” stating that “the numbers are only part of the system”. [110] He stated that the priority should be to work to create a culture of openness, transparency and learning. [111]

262. When asked about central reporting of SAEs, Professor Leitch stated the Scottish Government is aware of developments in NHS boards via a ‘performance management infrastructure’. [112] He believed that a significant change in the number of adverse events would be picked up nationally.

263. Professor Leitch confirmed that there was no central monitoring of the number of SAEs and questioned the usefulness of such an approach: "The addition of adverse events into a table would not help us, because the definitions are so broad and varied. Individual clinicians make the judgements". [113]

264. He said that in countries that had a national reporting system for adverse events, most have abandoned it.

265. In Professor Leitch’s letter to the Committee on 5 February 2018 he referred to the quarterly Hospital Standardised Mortality Ratios forming the basis of a HIS investigation into mortality in Lanarkshire hospitals. Whilst this example highlights routinely collected data being instrumental in the identification of possible systematic problems in other areas and acting as a catalyst for further investigation Professor Leitch remained clear that the Scottish Government was “unconvinced that holding numbers of adverse events centrally would service a meaningful purpose.” [114]

266. We returned to the issue of SAEs in the Committee's final evidence session with the Cabinet Secretary for Health and Sport in February 2018.

267. The Cabinet Secretary highlighted that the Chief Medical Officer had written to all boards with a reminder of the need for consistency on what constitutes a SAE review and how reviews should be handled. The Cabinet Secretary stated: "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". [115]

Duty of candour

268. As part of its consideration of SAEs, the Committee considered the implications of the introduction of the duty of candour.

269. Robbie Pearson, the Chief Executive of HIS, stated in written correspondence that the duty of candour may impact on the monitoring and reporting of adverse events: "It would be a legal requirement for NHS boards to publicly report on adverse events where the duty of candour has been applied and on the learning and improvement actions resulting from the review of these adverse events." [116]

270. The introduction of the duty of candour is considered an important tool in ensuring a cultural shift to a system of openness and learning. Professor Jason Leitch explained: "It is well established that being candid promotes accountability for safer systems, better engages staff in improvement efforts, and engenders greater trust in patients and service users." [117]

271. He emphasised that the "duty of candour is not about apportioning blame." He explained that most instances of failures in the provision of treatment or care related to a need to focus attention on "quality improvements through the range of improvements and change mechanisms available, supported by strong leadership in a culture of openness and continuous learning." [118]

272. The Cabinet Secretary expressed similar sentiments. She emphasised that the duty of candour "provides another level of reassurance and an extra level of transparency." She detailed that it places a legal duty on organisations and the individuals within them to publish annual reports on all incidents that have instigated the duty of candour procedures. [119]

273. In response to concerns that there was no central record of adverse event she stated "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." [120]

274. The Cabinet Secretary also made reference to the case of Dr Bawa-Garba in England within the context of ensuring there is openness when issues arise. [121]

275. Learning lessons from Serious Adverse Events (SAEs) can help the NHS in Scotland manage adverse events in the future, and support preventative measures so as to reduce the risk of serious harm to patients.

276. However we believe there is a need for greater consistency in how SAEs are dealt with.

277. There is currently a national framework setting out how to deal with SAEs. Healthcare Improvement Scotland supports a consistent national approach to identification, reviewing, reporting and learning from adverse events. However, as has been acknowledged by the Chief Medical Officer, there are concerns with how the arrangements for recording SAEs are working in practice. For example there appear to have been inconsistencies in what incidents are being reported as adverse events.

278. The arrangements for recording SAEs represent a key tool for managing risk. Ultimately if these arrangements are not operating effectively, this could put lives at risk. Steps must be taken to ensure that the procedures for recording SAEs are working as effectively and consistently as they can.

279. At present NHS boards are given discretion regarding how they translate the national framework for dealing with adverse events into their day to day operations. However we think there is little justification as to why NHS boards are afforded this discretion and it should be revisited. For example, there may be merit in a standardised definition for SAEs being established across all NHS boards to set out what constitutes a SAE. There may also be advantages in common procedures for investigating SAEs being established so best practice can be shared and promoted. We believe this will help promote consistency and transparency in the system for dealing with SAEs. We recommend that Healthcare Improvement Scotland should be tasked with bringing forward these changes in order to improve the operation of the current system.

280. We also believe that centralised reporting of SAEs should be introduced. To date the Scottish Government has not been convinced of the need for a national reporting of SAEs. However, we do not share this view and, while we accept it would not be a magic bullet, we believe that encouraging a national overview to be taken of SAEs would enable wider systemic issues to be identified more swiftly and then acted upon. As noted by Professor Leitch in his letter to the Committee, routinely collected data has been instrumental in the past in picking up on possible systemic problems in other areas and acting as a catalyst for further investigation and we believe adopting this systematic approach for SAEs will be beneficial.

281. Emphasis is placed on ensuring there is a culture of openness and learning and we believe this could be enhanced by regular monitoring to identify systemic issues as it will give staff the reassurance that they are not the only ones who are accountable. The approach to centralised reporting of SAEs could follow a similar model to that which has already been established for the duty of candour, where there is a requirement to report annually.

282. It is important to be able to identify in a timely manner similar SAEs which have occurred across boards, and to avoid the build-up of systematic issues which affect the provision of safe and appropriate care. We therefore recommend that consideration is given to moving to a quarterly reporting requirement for the duty of candour, including SAEs. We believe this increased level of reporting would assist in identifying any common issues across NHS boards and help facilitate a timely response which addresses these issues.

Regulatory regime

Independent regulator

283. HIS overarching purpose is “better quality health and social care for everyone in Scotland.” [122]

284. HIS is an organisation which is at the centre of ensuring delivery of good clinical governance in NHS Scotland. It has a key role in relation to the standards that

underpin clinical care and in setting the frameworks for what happens when things go wrong.

285. The suitability of the role and remit of HIS was a recurring theme throughout the course of the Committee's governance inquiry.

286. We received some suggestions that there was a need for an independent regulator of the NHS to be established. These submissions were generally critical of HIS being a special health board of the NHS, with a limited role in the investigation of complaints and service failures. We also heard views suggesting that there was a conflict of interest inherent within the constitution of HIS, as it combines scrutiny with improving service delivery.

287. The Royal Society of Edinburgh suggested there may be merit in expanding the role of HIS. The Royal Society noted there is not an equivalent body in Scotland to the one that operates in England to independently investigate system failure. The Royal Society of Edinburgh suggested that HIS, along with other organisations who carry out investigation into health service in Scotland, should be "empowered to expand their remit to support more robust investigations." [123]

288. Fraser Morton called for an independent investigatory body to be established with expanded powers, compared to HIS. Fraser Morton told the Committee that HIS "is an organisation which has suffered from mission creep since its inception […] HIS is effectively hamstrung in its efforts due to the fact that it is not a regulator, has no powers, and is not entirely independent of the NHS." [124]

289. Fraser Morton also suggested that HIS should have greater powers to enforce sanctions on NHS boards. He told the Committee "we cannot continue to expect HIS to continue with their flawed ideological hands off holistic approach to the clinical governance of healthcare in Scotland. Speaking softly and not being armed with a big stick is clearly not working." [125]

290. In contrast, Dr Bennie of BMA Scotland told the Committee there may be limited merit in having an independent regulator. Dr Bennie was critical of the role of the Care Quality Commission as the independent regulator of health and social care in England. He suggested that there had been instances where the Commission had not identified systematic problems with care provision. He stated "An external regulator will often miss what is really going on. Ownership by managers and clinicians on the ground is what will change what is really going on." [126]

291. The OECD report which reviewed healthcare quality in the UK was critical of the dual role of HIS as a scrutiny and improvement body: "Although the strengthening of HIS' competence is welcome, Scotland should reconsider whether the mixing of scrutiny and quality improvement activity within [HIS] represents a conflict of interest. The mix of these roles means that the system's inspector risks "marking its own homework." [127]

292. While the report goes on to note the efforts HIS makes to ensure the functions of assessment and improvement are kept separate, it also explains that OECD countries are increasingly placing the scrutiny function at arms length from service delivery. It recommends that Scotland should make the Scrutiny and Assurance

directorate of HIS a separate entity and that it should consider publishing a comprehensive assessment of the quality of care in Scotland. [128]

293. We explored with the Cabinet Secretary for Health and Sport these calls for an independent regulator to be established and the suggestion that the Scrutiny and Assurance Directorate should be separated from the rest of HIS.

294. The Cabinet Secretary told the Committee that the strength of HIS was that it had been developed to have a dual function of delivering improvement through its inspections. She gave the example of the Healthcare Environment Inspectorate (HEI) within HIS. She explained that not only was the HEI able to identify issues that need to be resolved by an organisation but it also had the ability to work with them to deliver these improvements. “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.” [129]

295. She said that the inspection reports produced by HIS were robust and that as an organisation it did not “pull its punches” in terms of exposing areas of concerns. Indeed, she noted that it often called on external expertise to conduct its work. The Cabinet Secretary believed that HIS had worked effectively to improve patient safety. [130]

296. We recognise the central role HIS plays in ensuring delivery of good quality care and clinical best practice.

297. However, HIS’s scrutiny function and its approach to delivery of improvements to the performance of NHS boards is not systematic. As highlighted earlier in the report HIS's role in relation to implementation, inspection and monitoring of standards and guidelines is not consistent and there does not appear to be a clear rationale for its areas of focus.

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

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

300. We are concerned a special health board is not perceived by the public as being sufficiently independent to enforce sanctions. Nor do we consider they currently have adequate powers. A central part of this review should therefore be to give consideration to the advantage and disadvantages of making the scrutiny and assurance directorate of HIS a separate entity. We acknowledge the merits in one body being well placed to identify problems and offer solutions through undertaking both scrutiny and improvement functions. The key concern is to

operate with a greater degree of objectivity and independence while also having sufficient powers to bring about necessary change.

301. We recognise the value from being able to maintain the dialogue HIS has between and within its separate areas and would expect this to be replicated in the event that the functions of HIS are separated while at the same time improving the public's perception of independence.

Corporate Governance

302. The third and final strand of our inquiry considered corporate governance.

Overview, background and purpose

303. It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. The main purpose of boards is to provide effective leadership, direction, support and guidance to organisations and ensure that the policies and priorities of Scottish ministers (and the Scottish Government) are implemented. In most cases, the board is the most senior group in the organisation and provides important oversight of how public money is spent. [131]

304. Central to the NHS delivering the best healthcare for Scotland is ensuring appropriate structures and processes for decision making, accountability, control and behaviour at the upper levels of the organisation are in place.

305. NHS boards are required to have a code of corporate governance in place and good governance is ensured through a Committee structure within each NHS board. The membership of NHS boards comprises, Executive Members, Non-Executive Lay Members and Non-Executive Stakeholder Members. Executive Members hold a place by virtue of their employed position within the Board (e.g. Chief Executive or Medical Director). Non-Executive Lay Members are appointed by Ministers after open competition and Non-Executive Stakeholder Members are appointed and paid in the same way as lay members but are representatives of specific interests that must be represented on the Board (e.g. chair of the area clinical forum).

306. In considering this area we do not set out to examine the detail of all aspects of governance; there are numerous guides and reports on this available. Rather we seek to consider the overarching principles we expect NHS boards to operate against and in particular consider their core strategic purposes as stewards of public resources. We looked at how NHS leadership was providing the vision and the strategic direction to deliver the transformational change required in health and social care. As well as considering the functions boards should perform, we also considered whether the approach and behaviours adopted at the senior levels of the NHS were fostering a culture of openness and improvement.

307. In 2010 Audit Scotland reported on The role of boards which examined the role and work of boards in the public sector. That report remains relevant, although we understand some updating is imminent. In its report Audit Scotland state: “Most public bodies are governed by a board which provides oversight of how they are performing, how they spend their money and a link through the Scottish Parliament to the electorate. Boards are in place to ensure the good corporate governance of public bodies, defined by the Scottish Government as ‘the structures and processes for decision-making and accountability, controls and behaviour at the top of organisations' ". [132]

308. Scottish Government guidance for board members defines the role of the board as:-

- "giving leadership and strategic direction
- defining control mechanisms to safeguard public resources
- supervising the overall management of the body's activities
- reporting on stewardship and performance." [133]

309. In March 2017 the Scottish Government published On Board guidance for Board members. The guidance covers the roles and responsibilities of Boards including their decision-making responsibilities and the operational and statutory accountability responsibilities of the Chief Executive. [134]

310. The guidance details the four main functions of a board as being:

- to ensure the body delivers its functions in accordance with Ministers' policies and priorities;
- to provide strategic leadership;
- to ensure financial leadership;
- and to hold the Chief Executive and senior management team to account.

311. We used the above functions in the Scottish Government's good practice guidance for boards and the roles set out by Audit Scotland as the framework by which to consider the performance of NHS boards.

Evidence gathering

312. Our evidence gathering on corporate governance included undertaking a survey of NHS territorial board members. The survey covered a number of areas which are considered key to good governance, including board members' challenge and scrutiny function and their confidence in decision making and achieving strategic aims. The Committee received responses from 126 NHS board members. This equates to 47% of all NHS board members in Scotland. A SPICe research analysis of the survey results was produced. [135]

313. We wish to take this opportunity to thank all those board members who took the time to respond to the Committee's survey. Board members' responses provided valuable insights into how they perceived themselves and their role.

314. In addition to the survey we also issued a general call for views seeking opinions on how well NHS boards adhere to the key principles of good corporate governance as outlined by the UK Code of Corporate Governance (leadership, effectiveness, accountability, relations with stakeholders).

315. We held an oral evidence session with a range of stakeholders who are external to NHS boards but are familiar with how they function. We also took formal evidence from a selection of NHS board members and held a final evidence session on the governance inquiry with the Cabinet Secretary for Health and Sport.

316. This part of our report is divided into three sections:

- the board, membership and role;
- board engagement with stakeholders; and
- the impact on the role of the board from IJBs and regionalisation.

The role of the NHS board member

317. NHS board members' primary role is in ensuring the delivery of good corporate governance.

318. The Scottish Government ‘On Board’ guidance for board members emphasises that they must adhere to collective corporate responsibility, confidentiality and the highest standards of conduct. The guidance also states that individual board members should contribute fully to board deliberations and exercise a healthy challenge function.

319. During the course of our consideration of corporate governance a range of issues were raised in relation to the work of NHS board members. They included how board members are equipped for their role, how effective they are in carrying it out and the diversity of board membership.

Role of NHS boards in setting strategic direction and financial planning

320. The On Board guidance details that two of the main functions of a board are to ensure strategic leadership and financial stewardship. The guidance details this should include developing and agreeing the organisation's strategy and ensuring financial information is accurate and financial controls and systems of risk management are robust and defensible.

321. The Cabinet Secretary for Health and Sport told us “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.” [136]

322. However, some responses to the NHS board survey suggested that boards faced challenges in delivering this strategic leadership. There was a perception from some board members that NHS boards were powerless to set strategy and affect the change they want. They attributed this largely to the delegation of board functions to IJBs, the greater regional planning of services, and their assertion that much of the strategic direction is set centrally by the Scottish Government.

323. This lack of freedom was also felt by some to be compounded by other factors outwith the board's control such as financial and work constraints.

324. In addition, some respondents to the survey of board members also expressed frustration about the ability of boards to plan for the longer term. Witnesses also

highlighted difficulties in boards being able to provide long-term strategic direction due to the focus on the delivery of short-term targets. Dr Brian Montgomery highlighted that boards are held to account on their performance management, targets and resource allocation. He suggested that not only did this create difficulties in focusing on long-term planning but there was little to encourage collaboration across boards, as boards were only accountable for what happened to patients and services in their own board area. [137]

325. Dr Montgomery also spoke about NHS boards balancing the triangle of quality of care, performance targets and resources. He explained that when there are pressures on resources, in order to maintain quality of care, targets are "what is most likely to suffer, in an attempt to maintain and enhance the quality of care with a finite budget". [138]

326. Rachel Cackett of RCN was critical that the focus on targets made it more challenging to have conversations about long-term transformation of services. [139]

327. Financial resourcing was also discussed. Some evidence we heard was critical that financial sustainability had been allowed to dominate decision making in governance bodies. RCN suggested there was not enough focus on the clinical implications or potential consequences on the outcomes of decisions. [140]

328. Claire Sweeney of Audit Scotland welcomed the development of a financial framework to underpin the Scottish Government's 2020 strategic vision for achieving sustainable quality in the delivery of healthcare services across Scotland. She believed it should set out the steps that need to be taken to realise the vision that has been set out and assist with long-term planning. "The connection between the policy aspiration and what it means for local areas has been missing; everyone understands and signs up to the overall visions, but it has been very difficult to realise it in practical terms." [141]

329. The Cabinet Secretary was clear NHS boards are responsible for providing strategic direction. However, we received evidence which suggested that NHS boards consider they face challenges in delivering this strategic leadership.

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

331. In relation to strategy set by the Scottish Government, again we understand the frustration felt by boards although it is appropriate the Scottish Government retains such a role. However, we would like to see more constructive challenge by NHS boards relating to the relative prioritisation of the ways in which strategic direction impacts locally. Our perception is that board Chairs and Chief Executives are reluctant to speak up or criticise in a public forum. However, board members have a duty to act in the best interests of the organisation and should

be pursuing and pushing the appropriate strategic approach which best meets the needs of the Board. We feel that this external challenge function is lacking at present.[iii]

332. Equally we do not accept an inability to undertake financial planning exists. Boards have historically received annual settlements at or above health inflation levels and there is no suggestion this is likely to change in the near future. Boards are in a more advantageous position to plan financially than most other public bodies or indeed private bodies.

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

Effectiveness of Board members – Board performance

334. As noted earlier, the Scottish Government 'On Board' guidance for board members states that board members should contribute fully to board deliberations and exercise a healthy 'challenge function'. It details it is important that no individual board member (or Chair) should dominate debates held by the board or should have an excessive influence on board decision–making. The guidance also states that board members should not hesitate to challenge the Chair if they believe that a decision is wrong.

335. Some responses to the NHS board survey commented on the relationship between the executive and non-executive members. Some of these respondents felt that challenge by non-executive members was not welcomed by the chief executive and/or the executive members and could lead to defensiveness. Some also thought that there could be a lack of appreciation of the challenge function of non-executive members.

336. There was some discussion in evidence about the effectiveness of boards in undertaking this 'challenge function'.

337. Claire Sweeney of Audit Scotland emphasised the importance of non-executive board members being confident enough to provide a 'challenge function'. In relation to board performance she stated that "one of the healthy signs is a respectful but challenging relationship, particularly between the chief executive and the chair". [142]

338. Claire Sweeney suggested there was scope for improvements in how board members undertake the challenge function. She told the Committee "It worries us when we go to boards and audit committees and find that there is not sufficient challenge. The position is not as healthy as we would like it to be in all areas, and some areas need to work a bit harder to make sure that their non-executive directors are challenging and are given the right information." [143]

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iii Ash Denham, Kate Forbes, Emma Harper and Ivan McKee dissented from this paragraph.

Undertaking the role

339. A number of responses to the board survey also raised the difficulty in recruiting people to boards and highlighted the complexity of the job and the need for skills and experience.

340. Many witnesses spoke of the level of responsibility that came with the post and the high workload. Ruchir Shah of SCVO said “we need to ensure that people know the weight of responsibility that will fall on them when they are on a board, I do not think that we do enough to support people to understand their governance role and its implications, including for themselves.” [144]

341. Dr Graham Foster, Director of Public Health and Strategic Planning at NHS Forth Valley told the Committee: “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.”He told the Committee that in recent years the expectations of the role had increased and changed. [145]

342. In relation to workload, the high volume of paperwork that board members dealt with was discussed. Christine Lester non-executive board member of NHS Grampian suggested that board papers could be presented in a more concise and accessible form. Linda Dunion non-executive board member at NHS Tayside highlighted that work had been undertaken in her board to reduce the workload of non-executive board members. This had included reductions in the volume of papers and increasing the delegated responsibilities to committees and streamlining reporting around performance. [146]

343. Christine Lester of NHS Grampian told the Committee that the low salary for a non-executive board member meant the post could not be considered either a full or part time job, however the role's commitments prevented an individual from having another job at the same time. She also highlighted that the remuneration for the post could affect people's ability to claim welfare benefits. [147]

344. Christine Lester was also critical of the exclusively competency based approach to public appointments and considered this to be a barrier to potential recruits. [148]

345. Linda Dunion of NHS Tayside, also suggested the way posts were advertised was misleading as the time commitment for the role was far greater than the eight hours a week that was advertised. [149]

Equipped for the role

346. Another area considered in relation to board membership was whether the induction and training that new board members received equipped them for the role.

347. NHS board members who responded to the Committee's survey were generally positive about the adequacy of the induction, training and assessment that is provided. However, training was the aspect which received the most comments. Many responses called for better training, particularly for non-executive members.

Respondents felt this was required due to the complexity of the NHS, the language that is used and the challenges facing the NHS. Some responses called for a national programme of induction and training in order to ensure greater consistency.

348. Claire Sweeney of Audit Scotland told the Committee that auditors of public bodies had a particularly important role to play in providing non-executive board members with training and support in their development. She stated that developing financial skills was an area new board members often highlighted that they required to develop. [150]

349. We received some suggestions that time is required for board members to build up the expertise and the understanding that is required. Christine Lester, Non-executive board Member of NHS Grampian said "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." [151]

350. Linda Dunion of NHS Tayside suggested that to support new non-executive board members there should be an opportunity for a pre-induction programme. Individuals could learn about the language, culture and the issues facing the board through buddying or shadowing existing non-executive board members before they officially began their post. [152]

Board diversity

351. Several witnesses emphasised the importance of delivering diversity in board membership. They considered that board diversity is a route to ensuring decisions would be sufficiently challenged at a board level. [153]

352. In the Committee's survey of NHS board members and in oral evidence some concerns were raised regarding the current diversity and representativeness of NHS board members. These concerns centred on the relative lack of representation of people with disabilities, people from minority ethnic groups, young age groups and people from a range of social backgrounds.

353. Bill Scott of Inclusion Scotland discussed a concern raised by a number of witnesses, namely that the same type of people were being appointed as board members. In some cases the same public appointees were on a number of different public bodies. He suggested that board membership was not very inclusive and described it as "a closed club rather than an open one." [154]

354. To increase applications from more diverse groups, Bill Scott said "you will have to target specific groups in society that are underrepresented, and ensure that they feel that their service will be valued and their voices heard in the process." He highlighted the work being undertaken by the Highland localisation and employment project to address the lack of representation of people with disabilities in decision making in community partnerships and in health governance. [155]

355. We also heard suggestions that the time commitment, level of remuneration and recruitment methods for board posts created barriers to achieving diversity in representation.

356. Some respondents to the board survey suggested the focus should be on the ability of members rather than membership diversity. They stressed the difficulty in getting people of a high enough 'calibre' to apply for board posts.

357. Other witnesses in oral evidence also suggested board diversity should not be seen as the only focus in order to ensure a range of perspectives were taken into account at a board level.

358. Dr Montgomery, former Interim Chief Executive at NHS Fife, suggested it was "unreasonable and unrealistic to expect every interest to be represented around the board table" and that it could result in "cumbersome bodies on which many of the people round the table are interested in only a fraction of the agenda." Instead he suggested it was more important to ensure the committees and bodies that sit below the board structure included involvement from a wide range of stakeholders and that board members responded well to this input. [156]

359. The views we heard about diversity in board membership primarily focused on non-executive board members. However, there were calls from Allied Health Professions Federation Scotland that the diversity of Executive Board Membership should also be considered. They were critical of the lack of representation of allied health professionals (AHP) in decision making in the NHS. They noted that there were no AHP Directors on any territorial or special health boards. [157]

360. The Cabinet Secretary for Health and Sport responded to the evidence we received on board diversity. She stated that the Scottish Government was committed to providing gender balance 50:50 by 2020. In addition, the Scottish Government was moving away from a traditional competency-based approach to recruitment. As well as considering individuals' skills and experience, it was focusing more on ensuring individuals values matched those of the NHS. [158]

361. The issue of NHS board governance was raised at the Conveners Group evidence session with the First Minister on 18 April 2018. The First Minister told the Conveners Group that at the end of 2017 the Scottish Government commissioned a pilot review of corporate governance in NHS boards which was being led by John Brown in NHS Greater Glasgow and Clyde. The First Minister told the Conveners Group that a report of findings would be published before the summer recess. [159]

362. NHS board members have an essential role to play in the delivery of good corporate governance. It is important to ensure that the right people are appointed to the posts and those board members are provided with appropriate training and support to enable them to carry out their role effectively.

363. We welcome the comments from the Cabinet Secretary for Health and Sport regarding moving beyond a traditional competency-based approach to recruitment. We ask what assessment the Scottish Government will conduct to determine if this change in approach is leading to more diversity in board appointments.

364. As the Scottish Government On Board guidance details a key function of the board and its members is to provide strategic leadership and to hold the Chief Executive and senior management team to account. We are concerned by Audit

Scotland's assessment that boards' 'challenge function' is not operating as effectively in some areas as it could, in particular we expect there to be a respectful but challenging relationship between the Directors (of all types) to the chief executive and the chair. We received evidence of occasions where there could be a lack of appreciation by executive members of the challenge function of non-executive members. We ask the Scottish Government what steps it will take to ensure executive directors understand and respect the key role of non-executive members in delivering a challenge function.

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

366. While we agree that it would be impossible to represent every interest around the board table, the current way in which boards recruit, operate and remunerate non-executive members, limits opportunities for certain demographic groups to get involved. The Committee strongly recommends that the Scottish Government's review of corporate governance looks for ways to modernise the foundations of boards and how they operate in order to better reflect the populations that they serve while taking advantage of the knowledge and skills of a broader range of people.

367. We also believe that further steps should be taken to ensure board members are equipped with the skills, knowledge, expertise and confidence to fulfil their role.

368. We heard calls for better training to be given to non-executive board members. Concerns were raised about the length of time non-executive board members take to feel well placed to carry out their role. Financial skills were highlighted as an area that often required development.

369. The above are all matters that should be investigated in the review of corporate governance commissioned by the Scottish Government. We expect this review to make recommendations about changes that can be made to improve the delivery of the core functions of boards.

370. We believe there is merit in the idea of offering all new non-executive board members the opportunity to shadow or buddy an existing member before they begin in post. We understand this may already be happening informally in some board areas. There may be merit in this becoming the standard practice for all new members as this would assist in building the confidence and expertise of non-executive board members before they formally take up post.

371. We believe it is important that diversity in board membership is achieved. Board diversity is a key route to ensuring there is a range of skills, experience and perspectives represented. We welcome the Scottish Government commitment to provide gender balance on boards by 2020. However this is not the only aspect of diversity on boards which needs to be taken into account. We are concerned

that currently there is an under representation of people with disabilities, people from minority ethnic groups and people from different social groups. We expect the Scottish Government to take steps to increase the extent to which under-represented groups are represented on boards.

372. One other aspect of board diversity that was raised was the call made for the lack of representation of allied health professional directors on territorial or special health boards to be addressed. Given the key role that AHP increasingly plays in integrating health and social care, we are surprised at this lack of overall representation and mechanisms for their involvement and ask the Scottish Government how this can be addressed.

NHS board relationships with stakeholders

373. The Scottish Government “On Board” guidance emphasises the importance of a board managing its relationship with stakeholders to ensure their concerns and needs are taken into account.

374. The guidance states that board stakeholders and the general public “should have access to full and accurate information on the decision-making processes and activities of each public body and have the opportunity to influence decisions and actions.”

375. The guidance also details the expectation that “public bodies should communicate clearly with their stakeholders, make information widely available, consult thoroughly and imaginatively and seek feedback on the public body's performance, acting on it as appropriate.”

376. NHS boards’ performance against this criteria is looked at in this part of our report using the evidence collected during the course of the Committee's inquiry and our other recent work including our ongoing scrutiny of individual Health Boards.

Consultation

377. Witnesses expressed a general perception that boards had a tendency to consult and inform rather than involve or in any way allow stakeholders and the general public to influence decision-making on an ongoing basis. There was a call made for greater use of vehicles like Public Partnership Forums to bring patients, carers and the third sector together. [160] Several witnesses expressed the view that public consultation on service change was tokenistic and that boards viewed this as an inconvenience.

378. Derek Young of Age Scotland told the Committee “It is not about just people’s ability to put their views across, or their confidence in feeling that they have an opportunity to do that; it is about what is done with those views once they are received.” [161] As a result some witnesses felt it became a tick box exercise with a pre-determined outcome .

Openness and transparency

379. Concerns about the openness and transparency of communications between the board, its stakeholders and the general public were also raised. Respondents to the Committee's survey were largely confident about the openness and transparency of their own board, with ratings for their openness and transparency with staff being slightly higher than with the public. However, some responses acknowledged that this perception of openness and transparency is not shared by the public. Some of the survey responses attributed these attitudes to negative publicity arising from scrutiny by the press and politicians, as well as a general opposition to changes being proposed by boards.

380. Issues around openness and transparency were raised by staff bodies. The BMA in its written submission was critical of decisions regarding service prioritisation and resourcing being taken below board level. It considered the decision making process at this level was often less clear. The BMA commented that "It is not open and transparent to simply put a decision into the public domain and communicate it to staff. Instead, the reasoning and evidence for such decisions should be clear and easily available." [162]

381. Several witnesses emphasised the importance of ensuring openness and transparency not only with regard to the decision taken but also the reason behind the decision making. Some witnesses noted that, whilst some board decisions may have been the result of constrained finances, there was a lack of openness in sharing this reason with the public. The National Pharmacy Association provided the example of patient safety reasons often being cited by NHS boards as the explanation for a change in its preferred product decision, when financial reasons may have been the actual reason due to the cost of a product increasing. [163]

Changing the conversation

382. We heard that ensuring public awareness of the challenges faced by health boards was of key importance. Dr Montgomery told the Committee "Some very difficult choices and discussions lie ahead and it is not for the professions or, indeed, the boards to make those decisions by themselves: they have to be made collaboratively with the wider public." [164]

383. There was a call made for the nature of the relationship between NHS boards, stakeholders and the public to change. Claire Sweeney of Audit Scotland described this as a "need for a very different conversation with the public" which was "more open and honest" and considered the "difficult decisions" that now had to be made due to financial pressures and the integration of health and social care. [165]

384. We heard some suggestions as to how NHS boards can improve their approach to openness and transparency.

385. For example, Chest Heart and Stroke Scotland noted that service users and carers were members on integrated joint boards. In its view, this raised questions about the current composition of NHS boards "why if this public involvement approach is

fit for new health and social care governance arrangements, is it not fit for existing structures also?". [166]

386. Claire Sweeney of Audit Scotland suggested that integration of health and social care was having an impact on health boards as the way IJBs are constituted places a duty on them to be more open and transparent. [167]

387. Audit Scotland in its most recent NHS Overview report had suggested practical steps health boards should take to improve their openness and transparency. This included the publication of all board and committee papers and minutes, public attendance at meetings and the filling of gaps in data in key areas of the NHS (especially primary care). [168]

388. We also heard that the Open Government Partnership had the potential to deliver improvements in the relationship between boards and the public. The Open Government Partnership is an international programme aimed at improving government's openness, accountability and responsiveness to citizens. The SCVO is involved in the Scottish Government's work in taking this forward through the Open Government Partnership Scottish Action Plan. [169]

389. Ruchir Shah of SCVO highlighted work being undertaken on participatory budgeting in which the general public are given a "genuine say" and a clearer sense of how decisions are reached. He felt that the same principles could be applied to engaging with the public on politically contentious issues such as hospital closures. [170]

390. During the course of this session we have twice taken evidence from the Scottish Health Council, initially on its role and latterly on the progress of the long running review it has been conducting into its own functions. The Scottish Health Council monitors how NHS boards carry out their statutory duty to involve patients and the public in the planning and delivery of NHS services. On 24 January 2017 and in subsequent correspondence we criticised the transparency and approach of the Scottish Health Council initial review which led to further work being undertaken. Some 15 months later, on 1 May 2018, we were disappointed to hear the review was still incomplete and proposals for a change of approach and emphasis unavailable. Work was still ongoing in "defining, very clearly, the role and contribution of the Scottish Health Council ……." [171]

391. Public and staff confidence in NHS boards is critical to ensuring they retain the support of the people who work for them and those they serve.

392. The delivery of transformational change in the provision of health and social care can only be achieved with the support of stakeholders and the general public. These changes are not something that should be done to them but done with them. This requires a fundamental change in the relationship between NHS boards, their stakeholders and the public.

393. Boards must move to a relationship that goes beyond consulting and informing, to focus on collaboration and coproduction. Boards must become more open and honest about the pressures and challenges they face which will ultimately help stakeholders understand and have confidence in the decisions being taken.

394. Integration has the potential to encourage NHS boards to improve their openness and transparency given that IJBs have this focus. We also note the potential of the Open Government Partnership Scottish Action Plan to deliver improvements in the relationship between boards and the public.

395. However the drive for this change must come from NHS boards. They must be equipped with the necessary skills and resources to involve the public and staff in decisions in a meaningful way.

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

397. We ask the Scottish Government what changes to national and board-level resourcing and best practice will be needed to enable the public, staff and the third sector to become involved in NHS decision making on an ongoing basis.

Integration Joint Boards and Regional Planning

398. In the last few years the health and social care landscape has changed with initially the creation of 31 Integrated Joint Boards and latterly three regional boards. This part looks at the consequential implications for governance structures.

399. The framework to implement health and social care integration came into force in April 2016. As a result, 31 IJBs are now in operation and managing over £8 billion of health and social care funding.

400. The National Health and Social Care Delivery Plan committed to putting in place new arrangements for the regional planning of some services. In 2017, an existing NHS Chief Executive was appointed to each of the three regional boards:

- John Burns (NHS Ayrshire & Arran) in the West
- Tim Davison (NHS Lothian) in the East and
- Malcolm Wright (NHS Grampian) in the North.

401. Each of the three regions were asked to gather expertise and write a regional delivery plan for submission to the Delivery Board in 2017.

402. A recurring theme throughout our consideration of corporate governance was how the IJBs and regional planning were affecting governance and accountability.

Integration Joint Boards

403. The board survey and the written and oral evidence we received suggested specifically in relation to IJBs that there was some confusion among board members about roles and responsibility in the new structure, with a feeling that some administrative work was being duplicated.

404. Dr Foster of NHS Forth Valley highlighted that, for a small board like his, it was a challenge for non-executives and executive members to support the volume of meetings associated with the new structures. He told the Committee that IJBs had resulted in an increased administrative burden for board members "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." [172] We are unclear why the Health Board feel they are "supporting" an independent body.

405. We were also interested in the implications of the comment by Dr Foster who described working with IJBs as being challenging because IJBs operated in a very different environment to NHS boards. He highlighted that non-executive board members were now sitting alongside local authority councillors and they had different backgrounds, experience and expectations of structure and process. [173] In some respects this is a heartening comment as a purpose of the IJBs was to bring together the different experiences and cultures of the previous bodies involved in delivering these services. Yet we have concerns to learn that to deliver similar services as previously delivered is considered "challenging". In many respects these two comments encapsulate the problems of integration which require to be resolved if governance is to become fit for purpose.

406. Cultural differences were also highlighted by Rachel Cackett of RCN who spoke of the learning curve being experienced by nursing leaders on integration joint boards. She highlighted that on an NHS board an executive nurse director has a voting role, whereas on an IJB they do not. She felt it was important to consider how they could ensure their expertise in clinical quality and assurance was taken into account in both structures. [174]

407. We also learned of concerns from service users that under IJBs there was a lack of transparency regarding where responsibility lay for service delivery. Parkinson's UK in Scotland, in its written submission, gave the example that in one NHS board area there was ambiguity regarding where accountability for decision making on Parkinson's service rested "the buck is being passed between the board and the IJB with nobody taking responsibility for decision making." [175]

408. These concerns reiterated the point made by Audit Scotland in its report of 2015 on integration which stated "The proposed governance arrangements are complex, with some uncertainty about how they will work in practice. This will make it difficult for staff and the public to understand who is responsible for the care they receive." [176]

409. Audit Scotland in its NHS in Scotland overview report called for the Scottish Government to develop a robust governance framework for the delivery of the Health and Social Care Delivery Plan which should "… simplify and make clear the lines of accountability and decision making authority between the Health and Social

Care Delivery Plan Programme Board and major work programme delivery oversight groups, regional boards, NHS boards and Integration Authorities." [177]

410. Whilst we heard much evidence about ensuring the appropriate structures and procedures were in place for delivering changes through IJBs and regionalisation, other witnesses suggested the focus should be on the actual changes to services the new governance structures were set up to deliver. [178]

411. Christine Lester of NHS Grampian said that her personal view was that concerns about the new governance and accountability structures were a "red herring". Ultimately it was not that the changes were unclear but people did not like them because there was a loss of control for the local authority and the NHS board. [179]

412. However NHS Lothian on 24 April when asked about accountability for delayed discharges advised: "Who is accountable? The trite answer is that we all are. The chief executive of NHS Lothian, as the accountable officer, is accountable; the chief officer of the IJB is accountable and the chief executive of the City of Edinburgh Council is accountable. That is the model that we have set up so it is a shared accountability. At the end of the day, accountability still rests primarily with the chief executive of the health board as accountable officer." [180]

413. We asked the Scottish Government whether further changes needed to be made to the current governance structures.

414. In response Christine McLaughlin of the Scottish Government pointed to Audit Scotland's forthcoming report on IJBs as providing an independent assessment of what progress had been made.

415. Christine McLaughlin stated that "The purpose of IJBs is to bring parties together in joint working and that purpose has certainly been achieved. […] 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 we can see signs of progress there." [181]

416. We also explored with the Scottish Government whether there is a framework for governance at a regional level or if the role of the regional planning boards is more to act as a co-ordinating structure.

Regionalisation

417. The potential merits of regionalisation were highlighted by some witnesses. Dr Foster believed there could be benefits for the patient in a more joined up approach to service delivery. There would be less focus on NHS boards' individual performance on waiting lists and more focus on ensuring all patients across the country achieved access to services as quickly as possible. [182]

418. Dr Montgomery also recognised the potential benefits of regionalisation, however like many witnesses he highlighted that there was no formal framework for holding regional structures to account.

419. Rachel Cackett of Royal College of Nursing described the current delivery and governance of services as in a "great state of flux". She emphasised that it was important to ensure there was "transparency and clarity" on decision making and lines of accountability on issues such as clinical safety and quality of care. She called for frameworks to be developed to support this. She asked "Who is held accountable for decisions about those regional services within our current structures, and what might we need to change in order to make those structures transparent and robust for the future?"

420. One example given in the survey illustrating how accountability may be blurred was that NHS boards are held responsible for performance against the cancer waiting time targets, despite cancer services increasingly being planned and delivered on a regional basis.

421. Christine McLaughlin of the Scottish Government told the Committee "The introduction of the regional collaborative planning and delivery has not taken away the governance structures in place […]"

422. She went on to explain "The regional structures plan those services that can best co-operate with one another to deliver a better service for patients regionally. 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." [183]

423. She confirmed the expectation that regional and national plans would be submitted at the end of March 2018. [184]

424. The issue of regionalisation was also raised by the Committee Convener Lewis Macdonald in questions to the First Minister's during her evidence session with the Conveners Group.

425. The First Minister described individual health boards as "the building block of regionalisation". [185]

426. In relation to accountability structures she stated that "increasingly we are thinking about whether there are changes required". "My view and it's not a view that everybody agrees with I think we need to allow regionalisation to evolve in the way that it is; […] I tend not to be of the view that we should go for hardwired structural changes to embed that in a firmer way that means the health board continues to be the building block. The link of accountability that we have just now continues to be the appropriate one." [186]

427. The lines of accountability for IJBs and regional boards are not always clear. For example, there is confusion regarding where responsibility as well as accountability for delivery of some services lies. We recommend immediate

attention is given to Audit Scotland's call for the Health and Social Care Delivery Plan to simplify and make clear the lines of accountability and decision-making between the Health and Social Care Delivery Plan Programme Board and major work programme delivery oversight groups, regional boards, NHS boards and Integration Authorities.

Role of the Scottish Government

428. The Audit Scotland Role of Boards report details that the Scottish Government Health Directorates have a well-established framework of support and monitoring for NHS bodies. The Finance and Delivery Directorates provide ongoing support for health boards to help them meet their performance and financial targets.

429. The Cabinet Secretary told the Committee that there is “regular dialogue between the Scottish Government and NHS boards on developing strategy and emergent issues”. Monthly meetings are held between the chairs of NHS bodies and the Cabinet Secretary for Health and Sport to discuss strategic issues, while the Director-General for Health meets the chief executives of each NHS board monthly to discuss operational issues. [187]

430. Every year there is a public review of each NHS board. The 2010 Role of Boards report suggested these sessions were chaired annually by a member of the Ministerial team. The Cabinet Secretary detailed that these are now chaired by Ministers biennially and officials from the Scottish Government chair them in alternate years. She told the Committee that the board review provides an opportunity to look back over the board's performance in the last year and to look forward to the board's plans for the following year. Board reviews also involve the Scottish Government meeting with representatives from the Area Partnership Forum, staff, clinical community and patients. [188]

431. At the annual review the Cabinet Secretary detailed that following the public session along with Scottish Government officials they will consider in private with the board more of the detail, including the financial plans. The Cabinet Secretary summed up the role of the reviews “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.” [189]

432. The Cabinet Secretary explained “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.” She referenced the changed landscape as a result of the introduction of health and social care integration and more regional co-operation. She added “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.” [190]

433. Yet in our scrutiny of individual boards we have frequently encountered recommendations continuing year on year without any discernible improvement occurring nor could we identify any sanctions applying when actions are not met.

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

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

Director Conflicts of Interest

436. The Committee's inquiry has highlighted the important role governance at an individual health board plays in ensuring delivery of the best healthcare for Scotland. Our inquiry has not sought to evaluate individual NHS boards' performance in delivering this function but to provide commentary on how boards' performance can be improved and enhanced. However, following the conclusion of our oral evidence sessions on our inquiry allegations were made regarding NHS Tayside's misuse of the Tayside NHS Board Endowment Fund monies.

437. On 16 April 2018, David Robb, Chief Executive of the Office of the Scottish Charity Regulator wrote to the Committee attaching a letter to Paul Gray. The letter details: “it is the responsibility of the charity trustees to comply with their legal duties in managing the charity – as regulator we will intervene where we judge it to be in the public interest to investigate possible misconduct [..]. In particular, trustees must ensure that they act in the best interests of the charity at all times, that all expenditure is in line with the charity's purposes and that any grants or donations are used for the purposes for which the charity accepted them, and in line with any conditions imposed. This is what we are investigating with the Tayside Endowment Funds and, in light of the strong public interest in this case, we are pursuing it as a top priority.” [191]

438. The Public Audit and Post-Legislative Scrutiny Committee has taken evidence on the 2016/17 audit of NHS Tayside.

439. The Committee notes the series of reviews and investigations that have been initiated as a result of the recent revelations in respect of NHS Tayside. We

welcome the work being undertaken by our colleagues in the Public Audit and Post-legislative Scrutiny Committee to consider the specifics regarding the situation in NHS Tayside. Given the focus of our work on NHS Governance we are interested in the wider implications this has for broader governance and structural issues.

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

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

Annex A - Minutes of Meeting

4th Meeting, 2017 (Session 5) Tuesday 7 February 2017

1. NHS Governance (in private): The Committee considered and agreed its approach to the inquiry.

8th Meeting, 2017 (Session 5) Tuesday 21 March 2017

3. NHS Governance: The Committee discussed this morning's informal evidence session with NHS Scotland patients.

9th Meeting, 2017 (Session 5) Tuesday 28 March 2017

3. NHS Governance: The Committee discussed this morning's informal evidence session with NHS frontline staff.

11th Meeting, 2017 (Session 5) Tuesday 25 April 2017

3. NHS Governance: The Committee discussed last week's informal evidence session with NHS senior managers.

12th Meeting, 2017 (Session 5) Tuesday 9 May 2017

10. NHS Governance (in private): The Committee considered and agreed its approach to the inquiry.

15th Meeting, 2017 (Session 5) Tuesday 30 May 2017

2. NHS Governance: The Committee took evidence from—

- Donald Harley, Deputy Scottish Secretary, British Medical Association;
- Ros Shaw, Senior Officer, Royal College of Nursing Scotland;
- Kenryck Lloyd-Jones, Public Affairs and Policy Manager for Scotland, Chartered Society of Physiotherapy Scotland, representative of the Allied Health Professions Federation Scotland;
- Matt McLaughlin, Secretary to the Health Committee, UNISON Scotland;
- Claire Pullar, National Officer, Managers in Partnership.

5. NHS Governance (in private): The Committee considered the evidence heard earlier in the meeting.

16th Meeting, 2017 (Session 5) Tuesday 13 June 2017

13. NHS Governance: The Committee took evidence from—

- Sir Robert Francis QC;
- Cathy James, Chief Executive, Public Concern at Work;

- Kirsty-Louise Campbell, Senior Manager of Strategy and Insight, and Laura Callender, Governance Compliance Manager, City of Edinburgh Council;
- Robin Creelman, Non-Executive Director and Whistleblowing Champion, NHS Highland;
- Morag Brown, Non-Executive Director, Co-chair of the Staff Governance Committee and Whistleblowing Champion, NHS Greater Glasgow and Clyde.

15. NHS Governance (in private): The Committee considered the evidence heard earlier in the meeting.

17th Meeting, 2017 (Session 5) Tuesday 20 June 2017

6. NHS Governance (in private): The Committee considered its approach to phase two of its inquiry - Clinical Governance and agreed to issue a call for views over the summer recess.

20th Meeting, 2017 (Session 5) Tuesday 19 September 2017

2. NHS Governance: The Committee took evidence on staff governance from—

- George Doherty, Director of Human Resources, NHS Tayside;
- Jennifer Porteous, Director of Human Resources and Workforce Development, NHS Western Isles;
- Elaine Mead, Chief Executive, NHS Highland;
- Kenneth Small, Director of Human Resources, NHS Lanarkshire.

4. NHS Governance (in private): The Committee considered the evidence heard earlier in the meeting.

21st Meeting, 2017 (Session 5) Tuesday 26 September 2017

3. NHS Governance: The Committee took evidence on staff governance from—

- Shona Robison, Cabinet Secretary for Health and Sport;
- Paul Gray, Director General Health & Social Care and Chief Executive NHSScotland, and
- Shirley Rogers, Director of Health Workforce and Strategic Change, all Scottish Government.

5. NHS Governance (in private): The Committee considered the evidence heard earlier in the session and agreed to issue a letter to the Scottish Government at this interim stage.

22nd Meeting, 2017 (Session 5) Tuesday 3 October 2017

6. NHS Governance (in private): The Committee considered a summary of written evidence and agreed its approach to Clinical Governance.

25th Meeting, 2017 (Session 5) Tuesday 7 November 2017

2. NHS Governance: The Committee discussed this morning's informal evidence session with NHS patients.

26th Meeting, 2017 (Session 5) Tuesday 14 November 2017

1. NHS Governance: The Committee took evidence on clinical governance from—

- Rachel Le Noan, Policy Officer, Down's Syndrome Scotland;
- Clare Ogden, Head of Communications and Policy, Action for M.E.;
- Carolyn Lochhead, Public Affairs Manager, SAMH;
- Derek Young, Senior Policy Officer, Age Scotland.

2. NHS Governance (in private): The Committee considered the NHS clinical governance evidence heard earlier in the session.

27th Meeting, 2017 (Session 5) Tuesday 21 November 2017

3. NHS Governance: The Committee took evidence on clinical governance from—

- Dr David Chung, Vice President, Royal College of Emergency Medicine Scotland;
- Dr Peter Bennie, Chair, BMA Scotland;
- Sara Conroy, Professional Adviser, Chartered Society of Physiotherapy representing the Allied Health Professions Federation Scotland;
- Lorna Greene, Policy Officer, Royal College of Nursing (Scotland);
- Dr Gordon McDavid, Medicolegal Adviser, The Medical Protection Society.

4. NHS Governance (in private): The Committee considered the evidence heard earlier in the session.

28th Meeting, 2017 (Session 5) Tuesday 28 November 2017

2. NHS Governance: The Committee took evidence, in a round table format, on clinical governance from—

- Robbie Pearson, Chief Executive, Healthcare Improvement Scotland;
- Dr Tracey Gillies, Medical Director, NHS Lothian;
- Professor Nick Fluck, Medical Director/Responsible Officer/Caldicott Guardian, NHS Grampian;
- Dr Christopher Mackintosh, Medical Director, South Lanarkshire Health and Social Care Partnership;
- Sheena Morrison, Head of Public Protection and Quality Assurance, Glasgow City Health and Social Care Partnership;
- Professor Jason Leitch, National Clinical Director, Scottish Government;

- Rosemary Agnew, Ombudsman, Scottish Public Services Ombudsman.

6. NHS Governance (in private): The Committee considered the evidence heard earlier in the session.

30th Meeting, 2017 (Session 5) Tuesday 12 December 2017

2. NHS Governance: The Committee took evidence on clinical governance from—

- Fraser Morton; and
- Ella Brown.

4. NHS Governance (in private): The Committee considered the evidence heard earlier in the session.

5. NHS Governance: The Committee considered and agreed its approach to the next phase of its inquiry work on corporate governance.

31st Meeting, 2017 (Session 5) Tuesday 19 December 2017

4. NHS Governance (in private): The Committee considered and agreed a further approach to its inquiry work on corporate governance.

3rd Meeting, 2018 (Session 5) Tuesday 23 January 2018

6. NHS Governance (in private): The Committee considered and agreed follow up correspondence.

4th Meeting, 2018 (Session 5) Tuesday 30 January 2018

7. NHS Governance (in private): The Committee considered and agreed a draft paper on witness selection for Corporate Governance.

6th Meeting, 2018 (Session 5) Tuesday 20 February 2018

1. NHS Governance (Corporate): The Committee took evidence on corporate governance, in a round table format, from—

- Dr Brian Montgomery, Independent Healthcare Consultant, (former Medical Director and Interim Chief Executive, NHS Fife);
- Ruchir Shah, Policy Manager, Scottish Council for Voluntary Organisations;
- Bill Scott, Director of Policy, Inclusion Scotland;
- Rachel Cackett, Policy Adviser, RCN Scotland;
- Kenryck Lloyd-Jones, Public Affairs and Policy Manager, Chartered Society of Physiotherapy, representative of the Allied Health Professions Federation Scotland;
- Claire Sweeney, Associate Director, Audit Scotland.

2. NHS Governance (Corporate) (in private): The Committee considered the evidence heard earlier in the meeting.

7th Meeting, 2018 (Session 5) Tuesday 27 February 2018

2. NHS Governance (Corporate): The Committee took evidence on corporate governance from—

- Linda Dunion, Non-Executive Board Member, NHS Tayside;
- Christine Lester, Non-Executive Board Member, NHS Grampian;
- Dr Graham Foster, Director of Public Health and Strategic Planning, NHS Forth Valley;

and then from—

- Shona Robison, Cabinet Secretary for Health and Sport;
- Christine McLaughlin, Director of Health Finance;
- Dr Catherine Calderwood, Chief Medical Officer, and
- Shirley Rogers, Director of Health Workforce and Strategic Change, all Scottish Government.

3. NHS Governance (Corporate) (in private): The Committee considered the evidence heard earlier in the session. The Committee agreed to produce a report on NHS Governance for consideration at a future meeting.

11th Meeting, 2018 (Session 5) Tuesday 27 March 2018

6. NHS Governance (in private): The Committee considered a paper from the Clerk and agreed to seek clarification from the Scottish Government in relation to the NHS Staff Experience Report.

18th Meeting, 2018 (Session 5) Tuesday 5 June 2018

1. NHS Governance (in private): The Committee considered a draft report .

12. NHS Governance (in private): The Committee continued its consideration of a draft report and agreed to continue consideration at its next meeting.

19th Meeting, 2018 (Session 5) Tuesday 12 June 2018

3. NHS Governance (in private): The Committee continued its consideration of a draft report and agreed to continue consideration at its next meeting.

20th Meeting, 2018 (Session 5) Tuesday 26 June 2018

3. NHS Governance (in private): The Committee considered and agreed a revised draft report.

Annexe B - Evidence

Written evidence - staff governance

- NHSG001 Anonymous 1
- NHSG002 BMA
- NHSG003 Dr Peter Gordon
- NHSG004 Mr Gary Wilson
- NHSG005 NHS National Services Scotland
- NHSG006 RCN Scotland
- NHSG007 Royal College of Physicians of Edinburgh
- NHSG008 UNISON Scotland
- NHSG009 Sukhomoy Das
- NHSG010 Joan Fraser
- NHSG011 Allied Health Profressions Federation (AHPF) Scotland
- NHSG012 Coalition for Racial Equality and Rights
- NHSG013 Dorothy S McHaffie
- NHSG014 Dr Ian Kerr
- NHSG015 Rab Wilson
- NHSG016 GMC
- NHSG017 Dr Jane Hamilton
- NHSG018 Managers in Partnership (MiP)

Additional written evidence - staff governance

- BMA Scotland follow-up submission
- Sir Robert Francis QC

Written evidence - clinical governance

- CGOV001 Alec Scott
- CGOV002 NHS Fife

- CGOV003 Healthcare Improvement Scotland
- CGOV004 Down's Syndrome Scotland
- CGOV005 NHS24
- CGOV006 Royal College of Physicians of Edinburgh
- CGOV007 Scottish Disability Equality Forum
- CGOV008 The Royal College of Psychiatrists in Scotland (with specific input from the Child and Adolescent Faculty)
- CGOV009 National Pharmacy Association
- CGOV010 Action for M.E
- CGOV011 Community Pharmacy Scotland
- CGOV012 NHS Education for Scotland
- CGOV013 Dorothy-Grace Elder
- CGOV014 Royal College of Emergency Medicine Scotland
- CGOV015 NHS Lothian
- CGOV016 Scottish Women's Convention
- CGOV017 Royal College of Pathologists
- CGOV018 NHS Orkney
- CGOV019 SPSO
- CGOV020 Kathleen Powderly
- CGOV021 RCN Scotland
- CGOV022 Macmillan Cancer Support in Scotland
- CGOV023 SAMH
- CGOV024 The Royal College of Paediatrics & Child Health
- CGOV025 NHS National Services Scotland
- CGOV026 BMA Scotland
- CGOV027 Allied Health Professions Federation Scotland
- CGOV028 Royal College of Speech and Language Therapists
- CGOV029 HIV Scotland
- CGOV030 Health and Social Care Alliance Scotland (the ALLIANCE)

- CGOV031 Royal Pharmaceutical Society
- CGOV032 The Medical Protection Society
- CGOV033 Fraser Morton
- CGOV034 BDA Scotland
- CGOV035 Glasgow City HSCP
- CGOV036 NHS Forth Valley
- CGOV037 Scottish Independent Advocacy Alliance
- CGOV038 NHS Centre for Integrative Care Campaign Team
- CGOV039 Age Scotland
- CGOV040 Anonymous 1
- CGOV041 NHS Ayrshire and Arran
- CGOV042 General Medical Council
- CGOV043 RCGP Scotland
- CGOV044 NHS Grampian
- CGOV045 North Ayrshire HSCP
- CGOV046 Parkinson's UK in Scotland
- CGOV047 Sue Lavery
- CGOV048 The Royal Society of Edinburgh
- CGOV049 South Lanarkshire Health and Social Care Partnership
- CGOV050 Dorothy Gibson

Additional written evidence - clinical governance

- Letter from Dr Peter J Gordon
- Letter from Dr Peter Bennie, Chair, BMA Scotland
- Royal College of Surgeons of Edinburgh
- Anonymous Carer submission re NHS Adverse Incident Review
- NHS Grampian response to CPD question
- NHS Grampian response to Dignity and Respect question
- NHS Lothian response to CPD question and Dignity and Respect question

- Letter to Professor Jason Leitch, National Clinical Director, Scottish Government from David Cullum, Clerk to the Health and Sport Committee - 7 December 2017
- Letter to Robbie Pearson, Chief Executive, Healthcare Improvement Scotland from David Cullum, Clerk to the Health and Sport Committee - 7 December 2017
- Letter to Rosemary Agnew, Ombudsman, Scottish Public Services Ombudsman from David Cullum, Clerk to the Health and Sport Committee - 7 December 2017
- Letter from Robbie Pearson, Chief Executive, Healthcare Improvement Scotland to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017
- Letter from Professor Jason Leitch, National Clinical Director, Scottish Government to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017
- Letter from Rosemary Agnew, Ombudsman, Scottish Public Services Ombudsman to Neil Findlay MSP, Convener of the Health and Sport Committee - 18 December 2017
- Letter to Professor Jason Leitch, National Clinical Director, Scottish Government from Lewis Macdonald MSP, Convener of the Health and Sport Committee - 24 January 2018
- Letter from Professor Jason Leitch, National Clinical Director, Scottish Government to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 5 February 2018

Written evidence - corporate governance

- CORP001 Rab Wilson
- CORP002 Sandesh Gulhane, Scottish Lead for BMA GP trainees Subcommittee
- CORP003 Andrew Muir
- CORP004 W. Hunter Watson
- CORP005 David Byrne, Emeritus Professor of Applied Social Sciences, Durham University
- CORP006 Ms R J Pengelly - ScotSectorLink
- CORP007 Professor Catriona Paisey, University of Glasgow
- CORP008 NHS National Services Scotland
- CORP009 Chris Bridgeford, Founder, affasair
- CORP010 The Royal College of Psychiatrists in Scotland
- CORP011 British Standards Institution
- CORP012 RCN Scotland

- CORP013 National Pharmacy Association
- CORP014 Dorothy-Grace Elder
- CORP015 British Homeopathic Association
- CORP016 Community Pharmacy Scotland
- CORP017 Chest Heart and Stroke Scotland
- CORP018 Scottish Health Campaigns Network (SHCN)
- CORP019 Parkinson's UK in Scotland
- CORP020 Dorothy Gibson
- CORP021 Kenneth Barr
- CORP022 NHS Orkney
- CORP023 BMA Scotland
- CORP024 Scottish Independent Advocacy Alliance (SIAA)
- CORP025 Allied Health Professions Federation Scotland
- CORP026 RCGP Scotland
- CORP027 BDA Scotland
- CORP028 Dr Minh Alexander
- CORP029 Inclusion Scotland
- CORP030 Dr Sheena B Pinion
- CORP031 UNISON Scotland
- CORP032 Joyce Harvie
- CORP033 Allan J Tubb
- CORP034 NHS Centre for Integrative Care Campaign Team
- CORP035 Dr George Venters
- CORP036 Catherine Hughes
- CORP037 Evonne McLatchie (previously submitted for SOS Edinburgh Cleft Group)
- CORP038 Royal College of Physicians of Edinburgh

Additional written evidence - corporate governance

- Letter from Shona Robison MSP, Cabinet Secretary for Health and Sport to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 21 March 2018

- Letter to Shona Robison MSP, Cabinet Secretary for Health and Sport from Lewis Macdonald MSP, Convener of the Health and Sport Committee - 28 March 2018
- Letter from Shona Robison MSP, Cabinet Secretary for Health and Sport to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 24 April 2018
- Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee - 23 February 2018 (plus attachments 1 and 2 below)
- Attachment 1 - NHS Tayside Transformation Support Team Second Report - 23 February 2018
- Attachment 2 - Letter to Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland from Lewis D Ritchie, Chairman, NHS Tayside Assurance and Advisory Group - 23 February 2018
- Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee - 7 March 2018
- Letter from Paul Gray, Director-General Heath and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee and Lewis Macdonald MSP, Convener of the Health and Sport Committee - 5 April 2018
- Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee and Lewis Macdonald MSP, Convener of the Health and Sport Committee - 6 April 2018
- Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee and Lewis Macdonald MSP, Convener of the Health and Sport Committee - 12 April 2018
- Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to David Robb, Chief Executive, Office of the Scottish Charity Regulator - 12 April 2018
- Letter from David Robb, Chief Executive, Office of the Scottish Charity Regulator to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee and Lewis Macdonald MSP, Convener of the Health and Sport Committee - 16 April 2018
- Letter from David Robb, Chief Executive, Office of the Scottish Charity Regulator to Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland - 16 April 2018
- Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee - 21 May 2018

- Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee regarding the Grant Thornton Report on financial governance in NHS Tayside - 22 May 2018
- Letter from David Robb, Chief Executive, Office of the Scottish Charity Regulator to Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland re NHS Endowment Funds risk assessment - 30 May 2018
- Letter from David Robb, Chief Executive, Office of the Scottish Charity Regulator to Lewis Macdonald MSP, Convener of the Health and Sport Committee re 2016/17 Audit of NHS Tayside - 31 May 2018
- Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee regarding the 2016/17 Audit of NHS Tayside - 12 June 2018
- Letter from Sharon Fairweather, Director of Internal Audit, Scottish Government to Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland regarding the Internal Audit review of the actions taken by the Scottish Government in response to the Independent Review by Grant Thornton on e-Health Funding - 18 June 2018

Official Reports of Meetings

- Tuesday 21 March 2017 - evidence from stakeholders
- Tuesday 28 March 2017 - evidence from stakeholders
- Tuesday 25 April 2017 - evidence from stakeholders
- Tuesday 30 May 2017 - evidence from stakeholders
- Tuesday 13 June 2017 - evidence from stakeholders
- Tuesday 19 September 2017 - evidence from stakeholders
- Tuesday 26 September 2017 - evidence from the Scottish Government
- Tuesday 7 November 2017 - evidence from stakeholders
- Tuesday 14 November 2017 - evidence from stakeholders
- Tuesday 21 November 2017 - evidence from stakeholders
- Tuesday 28 November 2017 - round table evidence from stakeholders
- Tuesday 12 December 2017 - evidence from stakeholders
- Tuesday 20 February 2018 - round table evidence from stakeholders
- Tuesday 27 February 2018 - evidence from stakeholders and then from the Scottish Government

1 BMA. Written submission and RCN Scotland. Written submission, Staff Governance

2 UNISON Scotland. Written submission, Staff Governance

3 Health and Sport Committee. *Official Report 26 September 2017*, Col 26.

4 Scottish Government (2017). *The Health and Social Care Staff Experience Report 2017*

5 Health and Sport Committee. *Official Report 30 May 2017*, Col 28.

6 Health and Sport Committee. *Official Report 30 May 2017*, Col 28-29.

7 Health and Sport Committee. *Official Report 27 February 2018*, Col 35.

8 Health and Sport Committee. *Official Report 30 May 2017*, Col 26.

9 UNISON Scotland. Written submission, Staff Governance, Health and Sport Committee. *Official Report 30 May 2017*, Col 27.

10 Managers in Partnership. Written submission, Staff Governance

11 Health and Sport Committee. *Official Report 19 September 2017*, Col 4.

12 Managers in Partnership. Written submission, Staff Governance

13 Managers in Partnership. Written submission, Staff Governance

14 Health and Sport Committee. *Official Report 13 June 2017*, Col 45.

15 Sir Robert Francis QC (2015). *Freedom to speak up: An Independent Review into creating an open and honest reporting culture in the NHS*.

16 Health and Sport Committee. *Official Report 13 June 2017*, Col 48.

17 Health and Sport Committee. *Official Report 30 May 2017*, Col 31.

18 Health and Sport Committee. *Official Report 21 November 2017*, Col 16.

19 The Medical Protection Society. Written submission, Staff Governance

20 Health and Sport Committee. *Official Report 30 May 2017*, Col 34.

21 Health and Sport Committee. *Official Report 30 May 2017*, Col 33.

22 Health and Sport Committee. *Official Report 26 September 2017*, Col 34.

23 Health and Sport Committee. *Official Report 26 September 2017*, Col 32.

24 Rab Wilson. Written submission and Dr Jane Hamilton. Written submission Staff Governance

25 Health and Sport Committee. *Official Report 30 May 2017*, Col 35.

26 Health and Sport Committee. *Official Report 13 June 2017*, Col 54.

27 BBC article (14 October 2016). *NHS whistleblowing helpline dubbed 'completely toothless'*.

28 Submission to Public Petitions Committee 14 October 2016.

29 Scottish Government submission to Petition and Health and Sport Committee. *Official Report 26 September 2017*, Col 24.

30 Health and Sport Committee. *Official Report 27 February 2018*, Col 34.

31 Health and Sport Committee. *Official Report 13 June 2017*, Col 60.

32 Health and Sport Committee. *Official Report 13 June 2017*, Col 58.

33 Health and Sport Committee. *Official Report 13 June 2017*, Col 58-59.

34 Health and Sport Committee. *Official Report 27 Feb 2018*, Col 33.

35 Sir Robert Francis QC (2015). *Freedom to speak up: An Independent Review into creating an open and honest reporting culture in the NHS*.

36 e.g. Dr Peter Gordon, Dr Sukhomoy Das, Dorothy McHaffie, Dr Ian Kerr, Rab Wilson, Dr Jane Hamilton. Written submissions, Staff Governance

37 Health and Sport Committee. *Official Report 19 September 2017*, Col 11.

38 2.

39 The Draft Employment Rights Act 1996 (NHS Recruitment - Protected Disclosure) Regulations 2018: Response to the consultation on protecting whistleblowers seeking jobs in the NHS

40 BMA Scotland. Written submission, Staff Governance

41 Scottish Government (2018). *More protection for junior doctors.*

42 Dr Jane Hamilton. Written submission, Staff Governance

43 BMJ (24 April 2017) *NHS Managers should face the same regulations as doctors*

44 Health and Sport Committee. *Official Report 19 September 2017*, Col 26.

45 Health and Sport Committee. *Official Report 26 September 2017*, Col 35.

46 Health and Sport Committee. *Official Report 30 May 2017*, Col 28.

47 RCN Scotland. Written submission, Staff Governance

48 Health and Sport Committee. *Official Report 30 May 2017*, Col 36- 37.

49 Health and Sport Committee. *Official Report 26 September 2017*, Col 37.

50 Health and Sport Committee. *Official Report 19 September 2017*, Col 3, George Doherty, NHS Tayside.

51 Letter from Lewis Macdonald MSP, Convener of the Health and Sport Committee to Shona Robison MSP, Cabinet Secretary for Health and Sport - 28 March 2018

52 Letter from Shona Robison MSP, Cabinet Secretary for Health and Sport to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 24 April 2018

53 Health and Sport Committee. *Official Report 30 May 2017*, Col 43.

54 Gary Wilson. Written submission, Staff Governance

55 RCN Scotland. Written submission, Staff Governance

56 Health and Sport Committee. *Official Report 19 September 2017*, Col 3.

57 BMA Scotland. Written submission, Staff Governance

58 Health and Sport Committee. *Official Report 19 September 2017*, Col 5.

59 Scally G and Donaldson LJ (1998) *Clinical governance and the drive for quality improvement in the new NHS in England*. British Medical Journal 317(7150) 4 July pp.61-65.

60 Scottish Parliament Information Centre. (2016) *The National Health Service in Scotland*. SPICe Briefing SB 16/100.

61 Scottish Parliament Information Centre. (2016) *The National Health Service in Scotland*. SPICe Briefing SB 16/100.

62 Health and Sport Committee. *Official Report 28 November 2017*, Col 3.

63 Health and Sport Committee. *Official Report 14 November 2017*, Col 2.

64 South Lanarkshire Health and Social Care Partnership. Written submission, Clinical Governance

65 Health and Sport Committee. *Official Report 21 November 2017*, Col 6.

66 Health and Sport Committee. *Official Report 14 November 2017*, Col 1-2. SAMH

67 Down's Syndrome Scotland. Written submission, Clinical Governance

68 The Royal College of Pathologists. Written submission, Clinical Governance

69 Scottish Government. (2017) *Health and Social Care Standards: My support, my life.*

70 SAMH. Written submission, Clinical Governance, Health and Sport Committee. *Official Report 14 November 2017*, Col 7.

71 Health and Sport Committee. *Official Report 14 November 2017*, Col 8.

72 Health and Sport Committee. *Official Report 21 November 2017*, Col 26.

73 Health and Sport Committee. *Official Report 21 November 2017*, Col 26.

74 Health and Sport Committee. *Official Report 21 November 2017*, Col 7, Dr McDavid.

75 Health and Sport Committee. *Official Report 21 November 2017*, Col 3.

76 Health and Sport Committee. *Official Report 28 November 2017* , Col 4.

77 RCN Scotland. Written submission, Clinical Governance

78 Health and Sport Committee. *Official Report 21 November 2017*, Col 5.

79 Letter from Professor Jason Leitch, National Clinical Director, Scottish Government to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017.

80 Health and Sport Committee. *Official Report 28 November 2017*, Col 4.

81 Health and Sport Committee. *Official Report 28 November 2017*, Col 8.

82 Health and Sport Committee. *Official Report 14 November 2017*, Col 3 & 5.

83 Health and Sport Committee. *Official Report 27 February 2018*, Col 40.

84 Health and Sport Committee. *Official Report 27 February 2018*, Col 41.

85 Health and Sport Committee. *Official Report 21 November 2017*, Col 8.

86 Health and Sport Committee. *Official Report 28 November 2017*, Col 23.

87 Health and Sport Committee. *Official Report 21 November 2017*, Col 6-7.

88 Health and Sport Committee. *Official Report 21 November 2017*, Col 8.

89 Health and Sport Committee. *Official Report 21 November 2017*, Col 23.

90 Health and Sport Committee. *Official Report 14 November 2017*, Col 9, 11.

91 Parkinson's UK in Scotland. Written submission, Clinical Governance

92 Health and Sport Committee. *Official Report 14 November 2017*, Col 10.

93 Sue Lavery. Written submission, Clinical Governance

94 Health and Sport Committee. *Official Report 14 November 2017*, Col 10.

95 Health and Sport Committee. *Official Report 28 November 2017*, Col 19.

96 Sue Lavery. Written submission, Clinical Governance

97 BDA Scotland. Written submission, Clinical Governance

98 Health and Sport Committee. *Official Report 12 December 2017*, Col 43.

99 Health and Sport Committee. *Official Report 28 November 2017*, Col 16.

100 Health and Sport Committee. *Official Report 28 November 2017*, Col 15-16.

101 Health and Sport Committee. *Official Report 28 November 2017*, Col 16.

102 Healthcare Improvement Scotland: A national approach to learning from adverse events through reporting, review and the sharing of learning.

103 Health and Sport Committee. *Official Report 12 December 2017*, Col 38, 42.

104 OECD (2016) *Reviews of Health Care Quality: United Kingdom* Chapter 2: Health care quality in Scotland.

105 Health and Sport Committee. *Official Report 12 December 2017*, Col 42. Fraser Morton. Written submission, Clinical Governance.

106 Health and Sport Committee. *Official Report 12 December 2017*, Col 47.

107 Letter from Robbie Pearson, Chief Executive, Healthcare Improvement Scotland to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017.

108 Health and Sport Committee. *Official Report 27 February 2018*, Col 38.

109 Health and Sport Committee. *Official Report 28 November 2017*, Col 19.

110 Health and Sport Committee. *Official Report 28 November 2017*, Col 19-20.

111 Letter from Robbie Pearson, Chief Executive, Healthcare Improvement Scotland to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017.

112 Health and Sport Committee. *Official Report 28 November 2017*, Col 20.

113 Health and Sport Committee. *Official Report 28 November 2017*, Col 20.

114 Letter from Professor Jason Leitch, National Clinical Director, Scottish Government to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 5 February 2018.

115 Health and Sport Committee. *Official Report 27 February 2017*, Col 38.

116 Letter from Robbie Pearson, Chief Executive, Healthcare Improvement Scotland to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017.

117 Letter from Professor Jason Leitch, National Clinical Director, Scottish Government to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017.

118 Letter from Professor Jason Leitch, National Clinical Director, Scottish Government to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017.

119 Health and Sport Committee. *Official Report 27 February 2018*, Col 38-39.

120 Health and Sport Committee. *Official Report 27 February 2018*, Col 39.

121 Health and Sport Committee. *Official Report 27 February 2018*, Col 39.

122 Healthcare Improvement Scotland (2011): About Us

123 The Royal Society of Edinburgh. Written submission, Clinical Governance

124 Fraser Morton. Written submission, Clinical Governance

125 Fraser Morton. Written submission Clinical Governance and Health and Sport Committee. *Official report 12 December 2017*, Col 49.

126 Health and Sport Committee. *Official Report 21 November 2017*, Col 23.

127 OECD (2016) *Reviews of Health Care Quality: United Kingdom* .

128 OECD (2016) *Reviews of Health Care Quality: United Kingdom* .

129 Health and Sport Committee. *Official Report 27 February 2018*, Col 42-43.

130 Health and Sport Committee. *Official Report 27 February 2018*, Col 42-43.

131 Audit Scotland. (2010) *The role of Boards*, paragraph 23.

132 Audit Scotland. (2010) *The role of Boards*, paragraph 4.

133 Audit Scotland. (2010) *The role of Boards*, paragraph 4.

134 Scottish Government (2017) *On Board a Guide for Members of Statutory Boards*

135 Scottish Parliament Information Centre (2018) - NHS Corporate Governance - Survey Analysis Report

136 Health and Sport Committee. *Official Report 27 February 2018*, Col 29.

137 Health and Sport Committee. *Official Report 20 February 2018*, Col 19.

138 Health and Sport Committee. *Official Report 20 February 2018*, Col 27-28.

139 Health and Sport Committee. *Official Report 20 February 2018*, Col 26.

140 RCN Scotland. Written submission, Corporate Governance

141 Health and Sport Committee. *Official Report 20 February 2018*, Col 31-32.

142 Health and Sport Committee. *Official Report 20 February 2018*, Col 12.

143 Health and Sport Committee. *Official Report 20 February 2018*, Col 12.

144 Health and Sport Committee. *Official Report 20 February 2018*, Col 9.

145 Health and Sport Committee. *Official Report 27 February 2018*, Col 5.

146 Health and Sport Committee. *Official Report 27 February 2018*, Col 10.

147 Health and Sport Committee. *Official Report 27 February 2018*, Col 4.

148 Health and Sport Committee. *Official Report 27 February 2018*, Col 7.

149 Health and Sport Committee. *Official Report 27 February 2018*, Col 4.

150 Health and Sport Committee. *Official Report 20 February 2018*, Col 8, 9.

151 Health and Sport Committee. *Official Report 27 February 2018*, Col 3.

152 Health and Sport Committee. *Official Report 27 February 2018*, Col 9.

153 Rachel Cackett, RCN Scotland, Health and Sport Committee. *Official Report 20 February 2018*, Col 7.

154 Health and Sport Committee. *Official Report 20 February 2018*, Col 23.

155 Health and Sport Committee. *Official Report 20 February 2018*, Col 6 & 10.

156 Health and Sport Committee. *Official Report 20 February 2018*, Col 7.

157 Allied Health Professions Federation Scotland. Written submission, Staff Governance and Corporate Governance

158 Health and Sport Committee. *Official Report 27 February 2018*, Col 29.

159 The Conveners Group. *18 April 2018*, page 12.

160 Royal College of Psychiatrists of Scotland. Written submission, Corporate governance

161 Health and Sport Committee. *Official Report 14 November 2017*, Col 17.

162 BMA. Written submission, Corporate Governance

163 National Pharmacy Association. Written submission, Corporate Governance

164 Health and Sport Committee. *Official Report, 20 February 2018*, Col 2.

165 Health and Sport Committee. *Official Report, 20 February 2018*, Col 2.

166 Chest, Heart and Stroke Scotland. Written submission, Corporate Governance

167 Health and Sport Committee. *Official Report, 20 February 2018*, Col 2.

168 Audit Scotland. (2017) *NHS in Scotland 2017* .

169 Scottish Government (2016) *Open Government Partnership Scottish Action Plan* .

170 Health and Sport Committee. *Official Report, 20 February 2018*, Col 4.

171 Health and Sport Committee. *Official Report, 1 May 2018*, Col 3.

172 Health and Sport Committee. *Official Report, 27 February 2018*, Col 23.

173 Health and Sport Committee. *Official Report, 27 February 2018*, Col 5, 6.

174 Health and Sport Committee. *Official Report, 20 February 2018*, Col 12.

175 Parkinson's UK in Scotland. Written submission, Corporate Governance

176 Audit Scotland. (2015) *Health and Social Care Integration* .

177 Audit Scotland. (2017) *NHS in Scotland 2017* .

178 Dr Foster, Health and Sport Committee. *Official Report 27 February 2018*, Col 21, 22.

179 Health and Sport Committee. *Official Report 27 February 2018*, Col 24.

180 Health and Sport Committee. *Official Report 24 Apr 2018*, Col 32.

181 Health and Sport Committee. *Official Report 27 February 2018*, Col 52.

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