NHS Education for Scotland NES/18/58

AGENDA FOR THE ONE HUNDRED AND FORTY-SECOND BOARD MEETING

Date: Thursday 26th July 2018
Time: 10.15 a.m.
Venue: Meeting Rooms 3 & 4, Westport 102, Edinburgh

1. Chair's introductory remarks

2. Apologies for absence

3. Declarations of interest

4. Minutes of the One Hundred and Forty-First Board Meeting NES/18/56
To approve the minutes of the meeting held on 28th June 2018. (Enclosed)

5. Actions from previous Board Meetings NES/18/57
For review. (Enclosed)

6. Matters arising from the Minutes

7. Chair and Chief Executive Reports

a. Chair's Report — Oral report

b. Chief Executive's Report — NES/18/59 (Enclosed)

8. Governance and Performance Items

a. Risk Register *(C. Lamb)* — NES/18/60 (Enclosed)
For consideration.

b. Finance Report *(A. McColl)* — NES/18/61 (Enclosed)
To receive and endorse.

c. Educational & Research Governance Committee: 28th May *(D. Hutchens)* — NES/18/62 (Enclosed)
To receive and endorse.

d. Remuneration Committee: 31st May *(D. Steele)* — NES/18/63 (Enclosed)
To receive a summary.

e. Remuneration Committee: 5th July *(D. Steele)* — NES/18/64 (Enclosed)
To receive a summary

f. Caldicott Guardian: Annual Report to the Board *S. Irvine* NES/18/65
To receive and endorse. (Enclosed)

9. Strategic Items

a. Progress against Strategic Outcomes for 2014-2019 *D. Cameron* NES/18/66
For consideration. (Enclosed)

b. Medical Recruitment *S. Irvine* NES/18/67
For consideration. (Enclosed)

c. The role of Health & Social Care Partnerships in reducing health inequalities *C. Lamb* NES/18/68 (Enclosed)

10. Items for Noting

a. Feedback, Comments, Concerns and Complaints Annual Report 2017-18 *D. Cameron* (Enclosed)

b. Partnership Forum: 17th May *C. Lamb* NES/18/69
To receive a report and the minutes. (Enclosed)

c. Training and Development Opportunities for Board Members NES/18/70
For information. (Enclosed)

d. The Governance of the NHS in Scotland – ensuring delivery of the best healthcare for Scotland (Scottish Parliament Health and Sport Committee (Enclosed)

11. Any Other Business

12. Date and Time of Next Meeting

Thursday 27th September 2018 at 10.15 a.m.

NHS Education for Scotland
Floor 3, Westport 102
West Port
EDINBURGH EH3 9ND

Tel: 0131 656 3424 (direct dial – David Ferguson)
e-mail: david.ferguson@nes.scot.nhs.uk

July 2018
DJF/cl

IN CONFIDENCE **NES 18 56**

NHS Education for Scotland

MINUTES OF THE ONE HUNDRED AND FORTY-FIRST BOARD MEETING HELD ON THURSDAY 28th JUNE 2018 AT WESTPORT 102, EDINBURGH

Present: Mr David Garbutt (Chair)
Mrs Linda Dunion, Non-executive member
Ms Liz Ford, Employee Director
Professor Stewart Irvine, Director of Medicine
Ms Caroline Lamb, Chief Executive
Mrs Audrey McColl, Director of Finance
Dr Doreen Steele, Non-executive member
Ms Susan Stewart, Non-executive member
Ms Sandra Walker, Non-executive member
Mrs Karen Wilson, Director of NMAHP

In attendance: Mr David Ferguson, Board Services Manager (Board Secretary)
Dr David Felix, Postgraduate Dental Dean
Mr Donald Cameron, Director of Planning and Corporate Resources
Mr Christopher Wroath, Director of Digital
Ms Monica Halcro, Governance & Operational Manager (Finance) (primarily for agenda item 7c)
Ms Jo Brown, Engagement Leader, Grant Thornton (External Auditors) (primarily for agenda item 7c)
Ms Alison Shiell, Manager, Executive Office

ADDITIONAL ITEM: RESIGNATION OF BOARD MEMBER

Susan Stewart informed the Board that she had decided to resign as a non-executive member of the NES Board, with effect from the end of June 2018, in view of her close relationship with Jeane Freeman, the new Cabinet Secretary for Health and Sport. Susan explained that this decision had been taken, with some regret, in order to avoid any perception of a conflict of interest. She added that she had enjoyed her period of office on the NES Board and had learned a lot from the experience.

On behalf of the Board, the Chair indicated that he understood Susan's decision, accepted her resignation, thanked her for her excellent contribution to the work of the Board and its committees since her appointment in March 2015 and wished her all the best for the future.

In terms of appointing a new member to replace Susan Stewart on the Board, the Chair reported that Scottish Government had indicated that it may be possible to Identify a suitable appointee from among the unsuccessful candidates in the most recent round of Board appointments.

1. CHAIR'S INTRODUCTORY REMARKS

The Chair welcomed everyone to the meeting, including Linda Dunion and Sandra Walker, who were attending their first Board meeting since taking up appointment as non-executive members on 1st June 2018, and Jo Brown from Grant Thornton (NES's external auditors).

It was noted that Monica Halcro, Governance & Operational Manager (Finance), would be joining the meeting for agenda item 8c (Annual Accounts 2017-18).

2. APOLOGIES FOR ABSENCE

Apologies were received from Douglas Hutchens, Andrew Tannahill and Dorothy Wright.

3. DECLARATIONS OF INTEREST

There were no declarations of interest in relation to the items on the agenda.

4. MINUTES OF THE ONE HUNDRED AND FORTIETH BOARD MEETING (NES 18 48)

The minutes of the Board meeting held on 28th May 2018 were approved.

Action: DJF

5. ACTIONS FROM PREVIOUS BOARD MEETINGS (NES 18 49)

The Board noted that these actions had been completed or were in hand.

The Chief Executive advised that a strategic review workshop will take place as part of the Board development session on 30th August 2018.

It was noted that the corporate position regarding NES's communication with the IJBs and community planning partnerships might usefully be considered in the contexts of NES's strategic review and the new arrangements for regional planning.

6. MATTERS ARISING FROM THE MINUTES

a. Item 9a: Digital Development Entity (DDE) **(NES 18 49(a))**

The Chief Executive introduced a paper providing an update on the matters which the Board requested to be followed up with Scottish Government after its last meeting on 28th May 2018. At that meeting, the Board had approved a request from Scottish Government that NES should host a new entity (Digital Development Entity (DDE)) to be established to take forward work to implement the Digital Health and Care Strategy and had requested that further information should be sought from Scottish Government in relation to:

- those staff who have been working on the development of the proposals who will come to NES with the work;
- the progress and approach to securing accommodation for the DDE; and
- how relations with the academic community have been developed.

It was noted that the above matters had been clarified by means of an exchange of letters with the Scottish Government Director of Health Finance, who had advised that:

- Geoff Huggins, Liz Elliot and Alistair Hann have undertaken the initial development of the DDE and will accompany the work as it transfers to NES and the expectation is that all future appointmentts will be in accordance with NES recruitment processes.
- The work to identify and secure property for the DDE is being taken forward by the initial DDE team, working with Scottish Government property advisers. Proposals will require the agreement of the NES Board and Scottish Government.
- The academic community in Scotland will be a key partner in the development of the DDE. Health Data Research UK (HDR UK) has created and funded a network of inter-disciplinary research expertise across six collaborative sites in the UK and the UK Director of HDR UK, Professor Andrew Morris, has agreed to chair the DDE sub-committee.

It was also noted, from the cover paper, that discussions had progressed with Scottish Government regarding the governance of the DDE work within NES, with particular reference to the establishment of a DDE sub-committee, which will report to the NES Board.

The following further updates were provided by the Chief Executive:

- Discussions have taken place with Scottish Government regarding the need to increase the number of non-executives on the NES Board, with particular reference to a member with digital expertise.
- The Digital Health and Care Strategy makes reference to a Scottish Government Digital Leadership Board and the membership and remit of this board will be pivotal to the arrangements for establishing the NES Board's DDE sub-committee.

The Board noted the update paper and was satisfied with the Scottish Government's responses to the requests for further information requested at the last Board meeting.

7. GOVERNANCE AND PERFORMANCE ITEMS

a. Audit Committee: 14th June 2018 **(NES 18 51)**

The Board received and noted the minutes and a summary, which were introduced by Doreen Steele.

The Audit Committee's recommendations from this meeting would be considered at agenda item 7c below.

b. Annual Report of the Board **(NES 18 52)**

The Chief Executive introduced a paper presenting the Annual Report of the Board for 2017-18 to the Board for approval. An earlier draft of this report had been circulated to members for review and the comments received had been incorporated in the latest version.

In discussion, it was agreed that it would be useful to include a horizon-scanning exercise at one of the forthcoming Board development sessions. **Action: DJF**

The Board approved its Annual Report for 2017-18.

c. Annual Accounts 2017-18

(i) External Audit Report on 2017-18 Accounts and Letter of Representation **(NES 18 56)**

The Board received the external auditors' final report to the Board and the Auditor General for Scotland on the 2017-18 external audit, which was introduced by Jo Brown, Engagement Leader, Grant Thornton. The following points were highlighted:

- An unmodified audit opinion has been issued.
- No significant or material adjustments to the financial statements were necessary.
- Audrey McColl and her team were thanked for their support and assistance throughout the audit process.

The Board was pleased to note this clean external audit report and congratulated the Finance team on this excellent outcome.

As recommended by the Audit Committee at its meeting on 14th June 2018, the Letter of Representation was approved for signature by the Accountable Officer, on behalf of the Board. **Action: AMcC**

(ii) Annual Report from Audit Committee and Governance Statement **(NES 18 53(a))**

Doreen Steele introduced the Audit Committee's Annual Report to the Board for the year ended 31st March 2018 and the recommendations on the Governance Statement. This report had been approved by the Audit Committee on 14th June 2018.

Doreen added her thanks to the former Audit Committee Chair, Carole Wilkinson, for steering the committee through its work schedule for 2017-18.

It was confirmed that the Audit Committee based its assurance to the Board on a range of sources, including information and evidence from the other committees of the Board.

Attention was drawn to the Best Value Characteristics Assessment included at Appendix 3. Doreen Steele was pleased to highlight that NES's approach to Best Value had been commended by the auditors.

The Board noted the Audit Committee's Annual Report for 2017-18.

On the recommendation of the Audit Committee, the Board approved the Governance Statement for signature by the Chief Executive and inclusion in the Annual Accounts for 2017-18. **Action: AMcC**

(iii) Notification from Sponsored Body Audit Committee **(NES 18 53(b))**

Audrey McColl introduced a paper presenting NES's response to the annual request from the Scottish Government Health Finance and Infrastructure Directorate for details of any significant issues of fraud arising during 2017-18.

The Board noted from the NES response that there had been no significant issues of fraud during 2017-18.

(iv) Annual Report and Accounts for year ended 31st March 2018

Audrey McColl introduced the Annual Accounts for the year ended 31st March 2018, which had been scrutinised by the the external auditors and approved by the Audit Committee at its meeting on 14th June 2018.

The draft Annual Accounts had been circulated to Board members for comment and Audrey McColl highlighted the following changes which had been made as a result of comments received:

- Page 17 – Additional narrative has been provided in relation to dental recruitment.
- Page 41 – There has been a change to the ratio in the table relating to fair play disclosure.
- Page 44 – An additional disclosure has been provided in relation to trade union facility time.

The Annual Accounts for 2017-18 were approved by the Board and arrangements would be made for the copies to be signed by the Board's representatives and the external auditors. **Action: AMcC**

The Chair acknowledged the significant amount of work involved in producing the annual accounts and conveyed the Board's thanks to the Audit Committee, Audrey McColl, Janice Sinclair, Monica Halcro and the Finance team.

The Chief Executive commended the work of the Finance team throughout the year in managing a challenging financial position and achieving a very satisfactory outturn at the year-end. The Chief Executive also acknowledged the extra work involved in complying with the new requirements for presenting the Annual Accounts.

d. Finance and Performance Management Committee: 23rd May 2018 **(NES 18 54)**

The Board received and noted the minutes and a summary, which were introduced by David Garbutt.

As notified to the committee, David Garbutt drew the Board's attention to forthcoming work by the NHSScotland Chairs Group to review the approach to Board governance, with a view to developing a Once for Scotland way forward.

e. Organisational Performance Report **(NES 18 55)**

Donald Cameron introduced a paper providing an overview of NES's performance for the final quarter of 2017-18. The following points were highlighted:

- The report includes a focus on all targets not achieved (Red) or partially achieved (Amber).
- For 2018-19, 70 top priority targets have been identified, which will be reported separately to the Finance & Performance Management Committee and the Board.
- A review of the performance management process is underway, with a view to creating a new integrated digital dashboard for performance, risk and workforce. Live links to this dashboard will be a feature moving forward.

The following points arose in discussion:

- There appear to be some formatting/presentation issues with the spreadsheet, which will be addressed moving forward. **Acton: DC**
- It was acknowledged that more needs to be done to encourage and support some staff to complete their essential learning.
- Consideration will be given to featuring the new digital dashboard, once completed, in a future Board development session. **Action: DC**

Following discussion, the Board noted and was satisfied with the current performance of NES.

8. ITEMS FOR NOTING

There were no items for noting.

9. AN OTHER BUSINESS

There was no other business.

10. DATE AND TIME OF NE T MEETING

The next Board meeting will take place on Thursday 26th July 2018 at 10.15 a.m.

NES
June 2018
DJF/cl

Actions arising from Board meetings: Rolling list

Minute	Title	Action	Responsibility	Date required	Status and date of completion
Actions agreed at Board meeting on 28th June 2018					
7b	Annual Report of the Board 2017-18	Schedule a horizon-scanning exercise in a future Board development session.	David Ferguson	Ongoing	A horizon-scan will take place at the Board development session on 30th August 2018, as part of the strategic review item.
7c	Annual Accounts 2017-18	A range of actions arising from approval of the Annual Accounts and related matters.	Audrey McColl	28th June 2018	All actions completed on 28th June 2018.
7e	Organisational Performance Report	(i) Address formatting/presentation issues with the report spreadsheet.	Donald Cameron	Ongoing	Ongoing
		(ii) Consider featuring the new digital dashboard, once completed, in a future Board development session.	Donald Cameron	Ongoing	Ongoing
Actions agreed at Board meeting on 28th May 2018					
9b	Strategic Review 2019-24	Proceed with the approach to the review set out in the discussion paper.	Donald Cameron	Ongoing	A strategic review item has been included in the programme for the Board development session on 30th August 2018.
Actions agreed at Board meeting on 19th April 2018					
8c	E&RGC minutes: 22nd February 2018	Arrange for the Board to receive, at an appropriate time, an update on the corporate position regarding NES's communication with the IJBs and the community planning partnerships.	Stewart Irvine	Ongoing	This will be considered in the contexts of the strategic review 2019-24 and regional planning developments.

Minute	Title	Action	Responsibility	Date required	Status and date of completion
Actions agreed at Board meeting on 8th March 2018					
10d	Medical Revalidation	(i) Raise the possibility of diverting funding from HIS for the purposes of producing the Scottish annual overview report in future.	Stewart Irvine	Ongoing	The issue of resources for the production of the Scottish annual overview report has been referred to the next meeting of the Scottish Government-led Responsible Officer Network.
		(ii) Consider the suggestion that it may be useful for the Board to consider, at some point, the suggested questions for boards and other governing bodies set out on pages 46-47 of the Pearson review report.	Stewart Irvine	Ongoing	The GMC has advised that, following the Pearson Review, and in relation to the questions of governance, they are amending and updating the Governance Handbook and expecting to re-issue this in the Autumn.
Actions agreed at Board meeting on 24th January 2018					
8ci	Revised Risk Management Strategy	Take account of the discussion points in finalising the revised strategy	Audrey McColl	Ongoing	The revised Risk Management Strategy has been scheduled for submission to the Audit Committee for consideration.
8d	Revised Audit Committee Remit	Take account of the discussion points when the Audit Committee next reviews its remit.	Audrey McColl	January 2019	Ongoing

CHIEF E ECUTIVE S REPORT

Caroline Lamb, Chief Executive

July 2018

1 INTRODUCTION

The agenda for our Board meeting today contains substantive items on progress towards meeting our 2014-19 strategic outcomes, postgraduate medical training and recruitment and how Health and Social Care Partnerships can reduce health inequalities across Scotland.

The Board are also asked to note a number of key reports including the annual Caldicott Guardian report, the annual Feedback, Comments, Concerns & Complaints report and a report on NHSS Board Governance.

2 ANNOUNCEMENTS

NHSScotland 70th Anniversary Celebrations

All NES regional sites participated in the NHSScotland 70th Anniversary celebrations during the week of 2 – 6 July via the hosting of office tea parties to celebrate 70 years of achievement in Scotland, the difference the NHS has made to people's lives, and the contributions that staff in NES have made. These events were very well attended and photos were shared via our organisational Yammer site. Myself, David Garbutt and Doreen Steele attended the Edinburgh event and Sandra Walker attended the tea party held in Aberdeen. I am grateful to staff involved in the organisation of these events and to everyone who contributed any home baking.

David Garbutt and I also attended a formal Scottish Government celebration event held at the National Museum of Scotland, Edinburgh, along with a group of NES staff who had been nominated from across the directorates in recognition of their contributions. The Earl of Strathearn/HRH Duke of Cambridge was in attendance at this event, which was a wonderful opportunity to celebrate the work of NHSS staff across all levels of the service.

Changes to membership of the NES Board

Linda Dunion and Sandra Walker formally joined the Board as our new Non-Executive members from 1 June.

Susan Stewart resigned from the Board with effect from 30 June and Scottish Government agreed that we could return to the most recent Non-Executive appointment round with a view to possibly appointing a new member from this group of candidates. This process has led to recent the appointment of Anne Currie, who will formally join the Board from 1 September 2018.

Scottish Government have also approved our request to appoint an additional Non-Executive member to our Board, particularly given our recent agreement to host the new NES Digital Service (NDS), previously known as the Digital Development Entity (DDE).

Retiral - Dr Ann Shearer

Board members will wish to note that Ann Shearer will be retiring in August 2018, following seven years in post as Associate Postgraduate Dental Dean. During Ann's time as Associate Postgraduate Dental Dean, she has made an outstanding

contribution to dental education and training, not only though her work within the Dental directorate but also with her involvement in cross-directorate projects. Ann has been responsible for significant changes which have improved the quality of dental core and specialty training in Scotland as well as for other UK-wide initiatives. We wish Ann well for the future.

Retiral - Chief Dental Officer
Margie Taylor, Chief Dental Officer announced in June that she will be retiring from the post in December. Margie has been the Chief Dental Officer for 11 years and has made a significant contribution to reforming dental services in Scotland. In her announcement she highlighted that it has been an enormous privilege to have held the post and to have worked with so many dedicated people.

Retiral - Professor Bill Reid
Board members will want to note that Professor Bill Reid, Postgraduate Dean based in our Edinburgh office will be retiring from NES at the end of August 2018. Bill is a graduate of the University of Glasgow and was a Consultant Physician in Geriatric Medicine in the Department of Medicine for the Elderly at the Southern General Hospital, Glasgow, with a major interest in orthogeriatric rehabilitation and falls. His interests in medical education have been very longstanding. Having been a postgraduate tutor since 1999 – he joined NES as an Associate Postgraduate Dean in 2006, before being appointed to his current role in 2008. He was elected Chair of COPMED UK in 2014, and was awarded the degree of Doctor, Honoris Causa in 2017, by the University of Edinburgh.

NHS Scotland Boards – Publication of Financial Performance
The Scottish Parliament carried a motion on 2 May which called for the immediate publication of the current financial position for all NHS bodies. This information is available on the Scottish Government website and will be updated on a monthly basis going forward. The report reflects the year-to-date position and the forecast outturn, along with an indicative brokerage requirement for each NHS Board.

3 STRATEGIC UPDATE

National and Regional Boards Collaborative Discussion Documents
The new Cabinet Secretary for Health and Sport is keen to ensure that she is fully up to speed on the work which has been on-going to deliver the National and Regional Discussion Documents, this has led to what we hope will be a small delay in the timetable for putting these into the public domain.

NHSScotland Business Systems
I chaired the first meeting of the NHSS Business Systems Programme Board on 15 June. This group provides oversight to all the Business Systems workstreams and the membership comprises of regional representatives from across the NHSS workforce including Chief Executives, eHealth Leads, Directors of Finance, Directors of HR and Staff-Side.

NES Digital Service (NDS)
Work to setup the NDS continues at pace. A more detailed update is provided within this Chief Executive's report and regular updates will be given going forward.

4 MEDIA INTEREST, COMMUNICATIONS AND EVENTS

June saw NES heavily involved in supporting the Scottish Government and other NHS Boards to communicate the 70th Anniversary of NHSScotland. The NES contribution to this included creating:

- The national NHS70 branding (including rebrands for partner organisations, such as the NHS70 rainbow logo)
- Digital Assets (banners, slides, mini animations)
- Historical Fact slides (content and design)
- Careers animations (6) and supporting tweets (both the content and design).
- Updating of SHOW and NHS Careers websites and drafting an article for the national Scottish promotional site: https://www.scotland.org/news

Developing these resources in-house for our Scottish Government and NHS partners is a good example of delivering a once-for-Scotland approach to digital design, saving time and money for our colleagues.

In terms of internal activity, our staff also held tea parties in many of our main sites, which were well attended.

Elsewhere, we were busy promoting NES at the annual two-day NHSScotland staff conference, where we showcased programmes as varied as Duty of Candour and Turas Appraisal. The work that NES does with partners on 'Youth Employment and Developing the Young Workforce' was recognised, with this workstream being selected to lead a spotlight lecture session. We were also delighted that our new oral health qualification for nursery practitioners was recognised with the “People’s Choice” award at the conference.

Looking at the effectiveness of our social media activity around the conference, we were one of the highest profile organisations in terms of views, likes, retweets and mentions.

In terms of proactive media activity over the month, we publicised the Scottish Government investment in trauma training, new educational resources for children's speech and language, and celebrated the fact that more than 160,000 infection control learning modules have been completed in the 12 months since the Scottish Infection Prevention and Control Education Pathway (SIPCEP) foundation layer was launched.

5 NES DIGITAL SERVICE

Following the request by the Scottish Government and with the agreement of the NES Board, the NES Digital Service (NDS) was established on 4 June 2018. NDS will take forward the commitment in the Digital Health and Social Care Strategy to establish a single data platform for health and social care services in Scotland.

Secondment agreements are close to conclusion for Geoff Huggins (as Director) and Liz Elliot (as Chief Operating Officer/COO) and both are already active as part

of the team. Alistair Hann joined NES on 4 June as Chief Technology Officer/CTO. Advertisements are being placed to recruit further members of the team. The team are currently hosted in Westport with work underway to identify appropriate accommodation.

In addition to the work to establish the organisation and create capability, the team is focused on work in respect of CHI (Community Health Index), as agreed with the Scottish Government and the NHS Chief Executives, with a commitment to report in September 2018. NDS will also bring forward a budget, initial work programme and recruitment strategy by the end of the Summer.

The Director for NDS will also be working (with eHealth leads, NSS and ourselves) to develop a financial plan and transition plan to support the broader work of the Strategy, with that work reporting back to the Scottish Government and the new Governance arrangements being put in place under the Strategy.

The NDS will report to the NES Board, the Scottish Government, and to the new Governance arrangements as mentioned above.

Geoff and his team will be happy to meet with any Board members who would find that helpful.

6 DIGITAL

NES Digital – NHSScotland developments
NES continues to provide development to the Turas People product. This has faced a series of challenges around business preparedness and changing stakeholder criteria. Some Occupational Health (OH) colleagues had expressed concern regarding Turas People holding patient data (trainee OH information) which is being worked through by Information Governance and NES Digital colleagues to provide the requested assurances. The product is still on target for delivery in August 2018.

A Microsoft enterprise agreement has now been signed across NHSScotland. All Health Boards can now take Office 365 licences when they are able to. NES will be taking a leading role in the definition and development of a NHS Scotland, single tenancy support team.

The Knowledge Services tender is currently in circulation for application.

NES Digital – internal NES developments
A Microsoft Power BI user group has been established with the first meeting having taken place with representatives from across NES in attendance, with aim of improving corporate/directorate reporting. A training day is in development for mid-August with a follow up meeting planned for September.

The Board will be aware that the 31 May EU General Data Protection Regulation (GDPR) deadline was met with support from the Information Governance (IG) team. IG and Design colleagues produced posters and flyers to raise NES staff awareness and engagement and ensure compliance with the changes in legislation.

The new, ServiceNow-based meeting room booking system has now been released at Edinburgh Dental Education Centre (EDEC) and the Centre for Health Science (CfHS). The CfHS release has resulted in combining separate Medical and Dental meeting rooms so they can now be booked as part of a single NES site. Sites currently using the FMEasy Room Booking System (Westport, 2 Central Quay, Forest Grove House and Aberdeen Dental Education Centre (ADEC) will transfer to ServiceNOW at a later date.

Internal procedures to ensure the robustness and security of our systems continues. This includes the implementation of new firewalls during July.

7 DENTAL (including Healthcare Science)

Dental

Minamata Convention – SDCEP resources
To fulfil the requirements of the global Minamata Convention, which aims to reduce environmental mercury pollution, an EU regulation that restricts use of dental amalgam in certain patient groups came into effect on 1 July 2018. At the request of the four UK Chief Dental Officers the Dental Directorate's Scottish Dental Clinical Effectiveness Programme (SDCEP) has developed professional advice and associated patient information to support implementation of the new restrictions. Use of the implementation advice has government support in each UK country and formal endorsement by several Royal Colleges. Following its publication online in June, hits on the SDCEP website increased by approximately 70%, with the dental amalgam advice page viewed over 4000 times within the first week, the majority of users being outside Scotland. The SDCEP implementation advice and patient information can be viewed at www.sdcep.org.uk/published-guidance/dental-amalgam/.

NHSScotland Event June 2018 – Oral Health poster wins People's Choice Award
Winning the People's Choice poster award at the NHSScotland event highlights the work done to establish cohesive partnerships between Health Boards, Scotland's Colleges and nurseries. The SCQF level 6 Award on 'Supervised Toothbrushing' contributes the health and wellbeing element of the Curriculum for Excellence, it teaches children an important life skill and informs the workforce on the importance of establishing good oral health habits from an early age. Delivery of the qualification is now planned throughout 2018 and into 2019. A national perspective has been developed across Scotland's Colleges, NHS Boards and Nurseries throughout Scotland.

Healthcare Science

Historically, the annual intake to Clinical Scientist Training has been in the 18-25 entrants per annum range. However, this included recurringly-funded training posts supported by non-recurring savings. The existing volume of trainees from previous intake years meant that the recurring budget could only support an intake of 10 entrants in 2018. Expressions of interest from the Service were at the level of 25 entrants.

Entrants with a lower pre-existing qualification level progress through the Scientist Training Programme (STP) route. This incurs higher course fees and travel & subsistence costs than for those of a higher level of pre-existing qualification. The additional cost is approximately £10k per trainee per annum.

Reshaping the training process with more emphasis on local development rather than the STP route enables the proportion of trainees not requiring higher STP costs to be reduced: This revised approach has enabled the 2018 intake level, affordable from the existing recurring budget, to be increased from 10 to 17 trainees; these numbers will increase as current STP completers wash through the scheme.

8 MEDICINE

GMC National Training Surveys
On Monday 9 July, the GMC launched the results of their 2018 surveys of doctors in training and trainers in their online reporting tool, alongside annual data on postgraduate exam pass rates and recruitment information for doctors in training. They also published a short summary report of initial trends from the surveys; and an analysis of how and why doctors are moving in and out of training. In 2018 over 70,000 trainees and trainers across the UK took part in the national training surveys, giving their views on training posts, programmes and environments in England, Northern Ireland, Scotland and Wales. This year, GMC also added new questions to the surveys to help better understand the extent of burnout amongst doctors in training and trainers.

In presenting these findings, the GMC observed that *Together, these findings present a worrying picture. Highly pressurised environments struggle to prioritise training in the face of an increasing population with more complex health needs, constrained budgets, and a medical profession at a crunch point where the supply of new doctors has failed to keep pace with changes in demand.*

However, although there are clear challenges in this year's survey results, it is important that we also recognise that the majority of trainees remain satisfied with their overall educational experience. This is testament to the dedication and hard work of trainers and our teams working across Scotland.

Tier 2 Visa Restrictions
On 15 June, the Home Office laid changes to the UK Immigration Rules before parliament, the effect of which is to exempt all doctors and nurses from the annual Tier2 (General) Limit. This is in response to the particular shortages and pressures facing the NHS at the current time, and the fact that the limit has been oversubscribed in each month since December 2017. The changes will mean that health sector employers will be able to sponsor doctors and nurses without requiring restricted Tier 2 certificates of sponsorship or putting pressure on the limit. This will free up places within the limit for other key roles which contribute to the UK economy and other public services. The changes will be kept under review.

9 NMAHP

Speech, language and communication resource for Health Visitors and Family Nurses
This tool was discussed and highlighted in a debate in Westminster last week. It was announced that:

NHS Education for Scotland has recently announced a new educational resource to help meet speech, language and communication needs. It is an interactive, portable tool that people such as health visitors can take into family homes to pick up on language difficulties early on. It helps them to signpost parents to where they can get more help and support for their children, in order to prevent the gap and language delay before children start school or nursery.

The tool is interactive and versatile and can be accessed on a computer, tablet and smart phone and has the flexibility to be used to support decision-making and practice regarding speech language and communication in the client's home or in the clinic as, and when, needed. The tool also signposts practitioners to suitable resources to help empower parents to promote speech, language and communication in their children, and give them the best possible start in life.

The 'Speech, language and communication: Giving children the best possible start in life' resource is accessible from the following link http://slctoolforhv.nes.digital/.

10 PHARMAC

Teach Treat – Common Acute Clinical Conditions
NES Pharmacy has commissioned clinical assessment skills training for pharmacist Independent Prescribers (IP) from a collaborative of 3 Medical Schools and 1 Nursing School across Scotland for the past 3 years. This has been a requirement to facilitate effective person-centred practice since pharmacists have very limited clinical assessment skills training within their undergraduate course. The expectation is that all pharmacist IPs will complete a basic clinical assessment skills training course (2 days) which covers vital signs and general patient assessment and patient-centred consultation skills training (1 day) including recording and peer review of recorded patient consultations.

One of the advanced courses developed and targeted at community pharmacist IPs focuses on the assessment and management of common acute clinical conditions e.g. chest infection, cellulitis. This training is delivered via an extensive e-learning programme with follow up face to face training at the Clinical Skills Unit in the University of Dundee. To support community pharmacist IPs to implement this into routine clinical practice NES Pharmacy has commissioned 3 experienced community pharmacist IPs to develop and implement a 'Teach & Treat' (T&T) for common acute clinical conditions. The T&T lead pharmacists have been delivering patient services for many years as IPs and have more recently targeted their service delivery for patients with walk in acute common clinical conditions in community pharmacy in partnership with local GP colleagues.

Teach & Treat allows less experienced pharmacist IPs to practice their skills and develop confidence under the clinical supervision of the lead T&T pharmacists with real patients presenting within the community pharmacy. In addition, the pharmacist IPs will be provided with formative feedback on performance from the leads.

It is hoped that these developments will support community pharmacists across Scotland to further extend Pharmacy First services supporting care for patients close to home both in and out of hours.

11 PS□CHOLOG□

Trauma
NES Psychology have been awarded £1.35m to support the implementation of the NES (2017) *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish □ orkforce*. This workforce wide project will include elements to support the development of staff skills and confidence across all tiers of practice, from trauma informed to trauma specialist and be delivered through a range of partnerships including health boards/ IJBs and Third Sector organisations. The 'Opening Doors' animation to support the development of a trauma informed workforce was launched alongside the announcement and can be accessed here.

Psychological Interventions and Therapies for Adult Mental Health
NES has worked in partnership with the Lead Psychologists in Addiction Services Scotland and the Scottish Government to publish 'The Delivery of Psychological Interventions in Substance Misuse Services in Scotland Report' which is available here. This guidance has been introduced as a framework to help local areas assess their own training needs and plan for the development of this workforce. A series of events are planned to look at how to maximise the use of current education and training resources offered by NES to support workforce development.

Psychology of Parenting
Since starting in 2013, the Psychology of Parenting Project (PoPP) has now trained over 700 practitioners in either Level 4 Group Triple P, or the Incredible Years Preschool programmes. These practitioners, who are drawn from the wider Children's Services workforce within the NHS, Education, Social Care and the Third Sector, across 22 Community Planning Partnerships in Scotland, have delivered, or are currently delivering over 700 groups to 4,400 families of young children (aged between 3-6 years) with elevated levels of behaviour problems.

Psychology of Dementia
The 'Cognitive Rehabilitation in Dementia: A Learning Resource for Staff' mobile application was nominated for Best Mobile Project of the Year at the recent Digital Technology Leaders Awards 2018 and though unsuccessful, the team were delighted to have been shortlisted against a strong field of nominees.

12 WORKFORCE

The Cabinet Secretary has now announced the implementation of the Lead Employer arrangements across NHS Scotland which will come into effect from the

1st of August 2018. On this date, NHS Scotland will move from potentially 22 Health Board employers to 4 Lead Employers for trainee doctors. The purpose of this model is to deliver an improved recruitment and employment experience for doctors and dentists in training, and enhanced effectiveness and efficiencies in practice – one employer for the duration of a training programme. From August, NES will become the sole employer for all GP, Public Health and Occupational Medicine Specialty Trainees.

An Employment Responsibilities Agreement (ERA) sets out how the model will work, and Turas People has been developed to facilitate the sharing of information between Boards across NHS Scotland to enable trainees to be paid correctly and on time. Information Governance agreements have been put in place to facilitate the sharing of employee information together with single national policies to ensure consistent treatment and common procedures across all Boards.

It is hoped these new arrangements make a substantive contribution to the wider ambition of *Improving Junior Doctors □ orking □ives*.

CALENDAR

21 May

Scottish Government Sustainability □ Value (S□V) Programme Board
I attended this meeting and gave an update on the NHSS Workforce workstream, which relates mainly to agency staffing and related expenditure. I also gave an update on the NES Lead Employer arrangements as part of an HR Shared Services update and presented an overall work programme for 2018/19. Other substantive agenda items included updates on National Facilities & Procurement, Clinical Transformation and Effective Prescribing and a discussion on the future delivery of the S&V workstreams in 2018/19 and beyond.

Scottish Government Safe Staffing Bill Strategic Programme Board
I attended my first meeting of this Programme Board as a representative of the NHSS Chief Executives. Karen Wilson is also a member of this group. Agenda items included a paper on refreshed proposals for the Safe Staffing Bill, and the programme board's future role in the Parliamentary process.

Professor Andrew Morris
I had a telephone call with Andrew Morris to discuss the NES Digital Service and related governance arrangements.

22 May: NES Executive Team

The Executive Team discussed future Board meeting agendas and development sessions, directorate risk management and the annual Feedback, Comments, Concerns and Complaints report which is included in this Board agenda for noting.

23 May

Li Ford
I met with Liz Ford to discuss the NES Digital Service, with particular reference to any Staff-Side developments.

Ameet Bellad
I met with Ameet Bellad (Senior Specialist Lead, Workforce) to discuss future Executive Team corporate and workforce reporting requirements.

Sharon Millar
I met with Sharon Millar (Principal Lead, Organisational Development, Leadership & Learning) to discuss an upcoming Workforce Scotland steering group meeting that she attended on my behalf. NES, Healthcare Improvement Scotland and Health Scotland are due to receive a joint commission to develop a leadership programme for the Public Health workforce.

25 May: Scottish Centre for Simulation and Clinical Factors (SCSCHF) 20th Anniversary celebrations

Myself and David Garbutt attended an event at the SCSCHF Centre in Larbert to mark the SCSCHF's 20th Anniversary. Lindsay Burley (previous NES Board Chair) and Malcolm Wright (previous NES Chief Executive) attended the formal opening of the Larbert centre in 2013. The Chair and Chief Executive of NHS Forth Valley, along with the Director of the SCSCHF, gave us a tour of the centre and we had the opportunity to view a demonstration of the High Fidelity trauma training scenario.

30 May

NHSS Implementation Leads
The Implementation Leads met via teleconference to discuss the presentation of the National/Regional plans at the National H&SCDP Programme Board meeting on 7 June.

Pro ect Lift Transforming Care. Starting With ou Leadership Event.
Myself and Audrey McColl attended this event, which was led by Shirley Rogers and Paul Gray and included contributions from Dr Dave Caesar (Project Lift Chair/ Clinical Advisor to the Chief Medical Officer) and Professor Michael West (King's Fund). The event explored how the Project Lift approach is underpinned by human, economic and performance benefits of compassionate leadership and set out the project's leadership development offer and the way in which NHSS talent will be managed in the future.

31 May

Sir Lewis Ritchie
I met with Lewis Ritchie to discuss the next NHS Tayside progress report which is due to be submitted on 15 October 2018.

NHSS Management Steering Group
I attended this meeting via teleconference where we discussed national pay negotiations and received Medical and Agenda for Change workforce updates.

Scott-Moncrieff
I met with Matt Swann from our internal auditors, Scott-Moncrieff, to discuss the scope of an internal audit focusing on NES's role in health and social care integration.

11 June: National Performance Framework Conference

I attended this conference which celebrated 10 years of Scottish Government's National Performance Framework which measures national wellbeing across a range of economic, health, social and environmental indicators and targets.

12 June

National Boards Collaborative Programme Board
I attended this meeting where substantive agenda items included papers on the National Boards collaborative plan investment proposal, stakeholder engagement, and strategic communications. Donald Cameron provided an update on the joint National/Regional summary discussion document which he is co-ordinating with Phil Raines (Scottish Government).

NHSS Chief Executives - Private Meeting
The Chief Executives received a paper on eHealth cyber security compliance, a service proposal for the HR Recruitment Shared Services workstream and progress updates on NHSS finances, performance, pay negotiations. The Chief Executives also received a briefing on Scotland Deanery Quality Management visit reports which had been prepared by colleagues in the Medical Directorate.

13 June

NHSS Chief Executives - Strategy Meeting
Myself and the other Implementation Leads contributed to an item which focused on the implementation of the National/Regional Board delivery plans. Other substantive items included a presentation on the Human Trafficking Oversight Group, updates on the NHSS Procurement Transformation and National Radiology programme and a paper on potential integration the three NHSS Health and Social Care workforce plans.

NHSS Chief Executives - Business Meeting
The main items of discussion at this meeting were updates on the UK's withdrawal from the EU and Project Lift.

NHSS Chief Executives Private Meeting with Paul Gray
I attended the monthly private meeting with Paul Gray.

14 June: Christine McLaughlin

I met with Christine McLaughlin (Director of Health Finance) to discuss the NES Digital Service and the wider NHSS Business Systems programme of work.

15 June

NHSS Implementation Leads
I chaired this meeting where we discussed the financial chapters of the National and Regional discussion documents. Phil Raines (Scottish Government) led a discussion of the overall 'Scotland Narrative' and the future release of this document and the National/Regional discussion documents into the public domain.

NHSS Business Systems Programme Board
As mentioned in the Strategic Update, I chaired the inaugural meeting of this programme board which will provide oversight to the Business Systems programme of work. Agenda items included a discussion on programme board governance arrangements, membership and terms of reference and how the Scottish Government's Digital Health & Care Strategy is directly linked to this work. Members also received updates on individual business systems workstreams including: Payroll, HR/recruitment, Finance, eRostering and Workforce Planning.

18 19 June: NHSScotland Event 2018

Colleagues and I attended the NHSScotland event; this year the event had four keynote plenary sessions, a number of topical Parallel and Spotlight Sessions and a fantastic range of posters. NHS Education for Scotland: Youth Employment and Developing the Young Workforce featured in the spotlight session and presented on the current youth development and employment activities across NHSScotland that NHS Education for Scotland and partners are working on. The presentation provided evidence to inform future national approaches to youth engagement and employment in NHSScotland and social care partners.

20 June: National IT Contract Management Board

At this meeting a presentation and update was provided by Atos. Other agenda items that were discussed were the Funding options for Applications Compliance Phase, VME Modernisation and a paper on ePayslips saving application was received.

21 June: SSSC NES Partnership Group
The agenda items discussed at this meeting were the NES/SSSC partnership update, the national workforce plan, living well in the communities' and the future work of this group.

22 June: Public Health Scotland

I met with Professor Marion Bain to discuss the development of the new public health organisation.

26 June: Ruth Thompson

Ruth Thompson (Chief Nursing Office, Scottish Government) and I discussed the work that has being undertaken on behalf of SEND in relation to best practice for rostering. We discussed the Transformation Fund around rostering/eRostering, and the opportunities within that to access some resources.

27 June: Senior Women in the Scottish Public Sector – KPMG Event
This event was their first event and it explored how Artificial Intelligence (AI), Intelligent Automation (IA), Blockchain and other emerging tech trends could radically change Scotland's public sector.

29 June

NHS Tayside AAG (Assurance Advisory Group) Progress Report
Sir Lewis Ritchie and I discussed the process to gather evidence for the progress report. The report is due to be submitted to Paul Gray on 15 October 2018.

Implementation Leads Meeting
I chaired this meeting where we received a presentation from Peter Lock, Director and Rebecca Squirrell, Management Consultant, Deloitte. At the meeting an update from Phil Raines relating to business within the Scottish Government was provided. We also discussed the final draft of the Transformation Fund proposal. Other items covered on the agenda were the action tracker, communication update and the evaluation framework.

National Board Chief Executives Meeting
I participated in the monthly catch-up meeting with the National Boards Chief Executives.

2 July

Laura Allison
I met with Laura Allison, Head of Quality Improvement, NES. Laura and I discussed the Non-Exec Board development work that has been recently transferred from Health Improvement Scotland.

Geoff Huggins, Li Elliot and Dorothy Wright
The developments within the NES Digital Service (NDS) were discussed.

3 July

NES Executive Team
The main agenda item for this meeting was the July Board papers. The Executive team noted the Progress against Strategic Outcomes paper and NES Workforce Plan for 2018/19. Kristi Long joined the meeting for this item and provided an overview of the plan.

Workforce Data Intelligence Meeting with ISD and SG
Christopher and I met witch colleagues from ISD and the Scottish Government to discuss the future state for workforce data and intelligence.

5 July

Scottish Access Collaborative - National Boards Collaborative Plan
Myself and Angiolina Foster (Chief Executive, NHS24) met with colleagues at Scottish Government to discuss how the work of Scottish Access Collaborative can link with the National Boards Collaborative Plan.

NHSS 70th Anniversary Tea Party
As noted in my introduction NES offices held tea parties which celebrated the 70th Anniversary of the NHSS. David Garbutt and I had the pleasure of attending the tea party held in Westport.

NHSS 70th Anniversary Celebrations
David Garbutt and I had the pleasure of attending this event held at the National Museum of Scotland, Edinburgh, along with a group of NES staff who had been nominated from across the directorates in recognition of their contributions.

9 July: Christine McLaughlin
I met with Christine McLaughlin (Director of Health Finance) to discuss the NES Digital Service and the wider NHSS Business Systems programme of work. David Garbutt joined us for part of the meeting to discuss the governance points that were raised at the 28 May Board meeting.

10 – 11 July: The Kings Fund Digital Health Care Congress
Christopher Wroath and I attended this event; this two-day congress provided a forum for health and care professionals to come together and learn from successful adoptions and practical implementations of digital health and care.

NES **NES 18 60**
Item 8a **(Enclosure)**
July 2018

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

NES Risk Register – for submission to July 2018 Board meeting.

2. Author(s) of Paper

Caroline Lamb, Chief Executive

3. Purpose of Paper

The purpose of this paper is to present the NES Risk Register as at 12 July 2018. The Risk Register will be submitted as an individual governance item going forward.

As per the update submitted to the May 2018 Board meeting, the wording of the risks and associated control measures have been updated. Board members will note the updated register is similar to the format of previous risk registers, however it now also includes explicit reference to each risk's control measures and highlights the risk owner/lead Director.

4. Key Issues

The rating associated with Risk 2 has been adjusted to move the likelihood of this risk occurring from a 4 to a 3. This moves the overall rating to Priority 2. This adjustment reflects the fact that although NES received no overall budget uplift, we have now successfully negotiated with Scottish Government to receive an uplift on our Training Grade salaries budget.

The rating associated with Risk 7 has been increased to reflect an increased likelihood. This is based on the number of retirals from senior posts being experienced not just in NES but across NHSScotland.

5. Recommendation(s) for Decision

The Board is invited to note the information contained in this report.

NES Corporate Risk Register

Risk No.	Description	Risk Owner (Lead Director)	I x L	Current Period: Inherent Risk	I x L	Residual Risk	Control measures	Appetite	Last Period (July 18): I x L	Last Period (July 18): Residual Risk
	Strategic Policy Risks									
1	Pressures on the system result in education and training being considered as less important	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**4 x 4**	**Primary 1**	1. NES Board to advocate and promote the importance of education and training		**4 x 4**	**Primary 1**
2	Scottish Government budgetary decision results in an uplift for NES that is less than cost pressures which in turn could mean NES Board are unable to balance expenditure	NES Executive Team (Audrey McColl)	5 x 5	**Primary 1**	**4 x 3**	**Primary 2**	1. Monthly management accounts show actual performance against budget projections ahead of year-end 2. Monthly management accounts are reviewed by Directors and the Director of Finance allowing mitigating action to be taken to manage any overspend/ underspend	**Open**	**4 x 4**	**Primary 1**
3	Policy development, UK-wide and within Scotland, may have negative impact on NES's capacity to support attraction, recruitment and retention of the workforce	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 3**	**Contingency**	1. NES Directors maintain strong engagement with relevant leads at Scottish Government 2. NES to maintain an evidence bank to support ability to influence policy decisions 3. Chief Executive and NES Directors to maintain links with other UK organisations		**3 x 3**	**Contingency**
4	Challenges that Boards and other organisations have in meeting demand for staffing result in a negative perception of NES's involvement in the attraction, recruitment and retention of the workforce	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**	1. Maintain clarity in relation to NES's role and influence 2. Work with Boards to ensure optimal deployment of staff		**3 x 4**	**Primary 2**
5	Changes in the landscape of health and social care and pressures in the system result in a risk that NES is unable to manage constructive relationships with key partners	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**	1. Chief Executive and/or NES Directors maintain open and collaborative relationships/arrangements with counterparts in partner organisations 2. Ensure Chair is well briefed to management relationships with other Board/organisational Chairs		**3 x 4**	**Primary 2**
	Operational Service Delivery Risks									
6	In the face of new and existing demands, NES is unable to allocate resources to support priority activities in an agile and responsive manner	NES Executive Team (Caroline Lamb)	5 x 5	**Primary 1**	**3 x 4**	**Primary 2**	1. Resource allocation process to be driven by a prioritisation framework 2. Continued focus on improving processes to release capacity		**3 x 4**	**Primary 2**
7	Turnover in key roles leads to loss of expertise/corporate knowledge resulting in negative impact on performance	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**	1. Succession planning in place for key individuals 2. Talent management	**Open**	**3 x 3**	**Contingency**
8	Organisational or other changes lead to dissatisfaction and disengagement of staff	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 3**	**Contingency**	1. Strong partnership working arrangements in place and maintained through regular contact		**3 x 2**	**Contingency**
9	Major adverse incident impacting on business continuity	NES Executive Team (Christopher Wroath)	4 x 4	**Primary 1**	**2 x 4**	**Housekeeping**	1. Disaster Recovery Plan in place 2. Business Continuity Plans in place (Board and directorate level)		**2 x 4**	**Housekeeping**

Risk No.	Description	Risk Owner (Lead Director)	I x L	Current Period: Inherent Risk	I x L	Residual Risk	Control measures	Appetite	Last Period (July 18): I x L	Last Period (July 18): Residual Risk
	Finance Risks									
10	The complexity of the NES budget results in year-end underspend giving the impression that NES Is overfunded	NES Executive Team (Audrey McColl)	4 x 5	**Primary 1**	**3 x 3**	**Contingency**	1. Early engagement with Finance & Performance Management Committee and NES Board to give indication of likely financial position 2. Directorates given indicative budgets to plan own activities and expenditure 3. Ongoing programme of identifying efficiency savings 4. Final budget approved by NES Board by end of March each year	**Averse**	**3 x 3**	**Contingency**
11	NES is unable to identify in year savings required to balance budget and therefore has year-end overspend	NES Executive Team (Audrey McColl)	4 x 5	**Primary 1**	**3 x 4**	**Primary 2**	1. Early engagement with Finance & Performance Management Committee and NES Board to give indication of likely financial position 2. Directorates given indicative budgets to plan own activities and expenditure 3. Ongoing programme of identifying efficiency savings 4. Final budget approved by NES Board by end of March each year		**3 x 4**	**Primary 2**
	Reputational Credibility Risks									
12	NES is not able to demonstrate the impact from the interventions that it has developed and delivered	NES Executive Team (Caroline Lamb)	4 x 5	**Primary 1**	**3 x 4**	**Primary 2**	1. Planning systems require all activities to include anticipated desired outcome 2. Desired outcome measured 3. Readiness to 'fail fast' rather than pursue initiatives that aren't working	**Cautious**	**3 x 4**	**Primary 2**
13	NES does not deliver leading to a loss of reputation and confidence from stakeholders	NES Executive Team (Caroline Lamb)	4 x 5	**Primary 1**	**3 x 2**	**Contingency**	1. Ensure targets set are SMART and also have resources allocated to them to support delivery 2. Ensure Chief Executive, NES Directors, Board and standing committees have access to regular management reporting		**3 x 2**	**Contingency**
	Accountability Governance Risks									
14	Failures in Board processes lead to corporate governance non-compliance and loss of credibility with Scottish Government e.g. failure to comply with statutory and/or other requirements, failures in financial/audit/staff governance/educational quality procedures	NES Executive Team (Donald Cameron)	5 x 5	**Primary 1**	**2 x 2**	**Housekeeping**	1. Standing committees responsible for each governance domain 2. Each committee provides annual report to Audit Committee 3. Comprehensive programme of internal audit	**Averse**	**2 x 2**	**Housekeeping**
15	NES has a breach of Information Governance requirements resulting in loss of data and/or negative publicity	NES Executive Team (Christopher Wroath)	4 x 5	**Primary 1**	**3 x 2**	**Contingency**	1. Statutory and relevant data security processes in place, with specific reference to the new General Data Protection Regulation which becomes law on 25 May 2018		**2 x 2**	**Contingency**

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Finance Report to 30th June 2018.

2. Author(s) of Paper

Keith Douglas, Interim Head of Finance Business Partnering.
Audrey McColl, Director of Finance.

3. Purpose of Paper

The purpose of this paper is to present the financial results for the first three months of the year to 30th June 2018 and to indicate the current anticipated forecast outturn as at 31st March 2019.

4. Key Items

The consolidated financial position by directorate is detailed in section 2.

Overall there is a year to date underspend of £0.5m as at 30th June. This is primarily the net impact of an underspend on training grades and Fellows costs within the Medical directorate and timing differences in Psychology, offset by an overspend in Digital and the phasing of the provisions budget. The overspend in Digital arises from expenditure being incurred, in order to meet delivery schedules, on Programmes where it is anticipated that funding will be provided from the Scottish Government Transformational Fund but where formal confirmation has not yet been received.

The current forecast outturn is a £6k underspend, with underspends on Medical Fellows being offset by projected overspends in the Workforce directorate. It is expected that the consolidated forecast will change once the impact of the August rotation of Medical Training Grades, from both new recruitment and the transition of trainees between the different stages of training, is included. The impact on the financial forecast of this rotation will be included in the Finance report which reflects data as at the end of September 2018.

At this stage in the financial year, there are a significant number of in-year allocations from the Scottish Government, still outstanding. As in previous years, we will work closely with SG colleagues to enable receipt of this funding as soon as possible.

As part of the new National Digital Health and Care Strategy, Scottish Government has asked NES to host the Digital Development Entity (DDE). For financial reporting purposes this will be shown as a separate NES Directorate for the July reporting cycle.

5. Recommendations

The Board is invited to note the information contained in this report.

Finance Report to 30th June 2018

1 Overview

1.1 Background

NES' baseline budget for 2018/19 was £423.4m. We have also received a further £5.4m of recurrent baseline funding which relates to the estimated cost of pay increases for trainees.

We have received confirmation of additional earmarked allocations totalling £13.3m. In addition, we have budgeted for additional in-year allocations of £12.6m, of which we have received £0.3m to date. We have also included an anticipated allocation of £0.6m from the SG Transformation fund, which represents NES' committed expenditure to date on relevant programmes. We are working with colleagues at Scottish Government to enable receipt of these outstanding allocations as soon as possible. The current budget for 2018/19 is therefore £455.3m.

Although the 2018/19 budget submitted to SGHD was balanced, this included a requirement for savings of £1.7m which it was expected would be realised from the time lag on staff recruitment and from employer pension contributions not required for those staff who choose to opt out of the pension scheme. At the end of June, £179k has been realised and reported within the year to date numbers, whilst £200k has been identified as anticipated savings, and forms part of the forecast outturn.

1.2 Summary Financial Position

As the detailed Financial position (s.2 below) shows, the YTD variance represents an underspend of £0.5m. This is primarily due to:

- Medical (£647k underspend) - training grades (£296k) due to lower volumes of Foundation year 1 and 2 trainees; Underspend in medical fellows due to vacancies (5.7 wte)(£108k), income received through Quality Improvement ahead of budget (£73k), Pharmacy underspend (£50k) mainly from timing of training courses.
- Psychology (£289k underspend) –primarily timing issues, as the budget for some activity areas (Therapies, Psychology workforce, Parent Training and CAMHS) has been spread across the year whilst the activity is expected to be more focused on the latter part of the year.
- Digital (£338k overspend) of which £258k relates to programmes where funding is expected to be received from the SG Transformation Fund. The remaining overspend is due to the timing of receipt of e-portfolio income compared to budget.
- Net provisions (£186k overspend) – largely due to less than profiled savings realised to date from superannuation opt-outs and vacancies.

These are offset by the net impact of several small overspends/underspends spread across all other budget areas.

The forecast outturn as at 31st March 2019 (see table below) is an underspend of £6k made up primarily of forecast overspends in Digital (£58k), Workforce (£176k) and Finance (£50k) offset by underspends in Medical (£192k) with smaller underspends reported through Dental, and Provisions.

2.0 Directorate Variance Analysis

An analysis of individual Directorate variances for both the year to date and forecast, is provided, and material forecast variances are examined below.

MONTHLY REPORTING FOR JUNE P03	Period 3					
Directorate	Year to Date			Full Year		
	Current Budget	Outturn	Variance	Current Budget	Outturn	Variance
Quality Management	18,551	18,543	8	78,691	78,676	15
Strategic Planning and Directorate Support	1,745	1,683	63	6,637	6,667	-30
Training Programme Management	63,787	63,345	442	259,255	259,049	206
Professional Development	1,255	1,120	135	5,898	5,897	1
Medical Total	**85,338**	**84,691**	**647**	**350,480**	**350,288**	**192**
Dental	11,206	11,154	51	44,737	44,698	39
NMAHP	1,192	1,240	-48	9,047	9,031	16
Psychology	4,511	4,222	289	18,149	18,152	-3
Healthcare Sciences	645	646	-1	2,455	2,432	23
Optometry	234	228	6	938	940	-2
Digital	2,206	2,544	-338	9,565	9,623	-58
Workforce	1,015	984	31	4,481	4,657	-176
Finance	510	486	25	2,042	2,092	-50
Properties	951	903	47	3,805	3,805	0
Facilities Management	170	158	12	641	641	-0
Planning (incl OPIP)	277	278	-1	1,135	1,135	-0
Net Provisions (excluding AME & Depreciation)	154	341	-186	7,860	7,835	25
NES Total (revenue)	**108,409**	**107,875**	**533**	**455,335**	**455,329**	**6**

All figures in £'000s

2.1 Medical

Medical are reporting a £647k YTD underspend. The largest single element of this is an underspend within Training Programme Management (TPM) on Training Grades (£296k) in relation to FY1 and FY2 vacancies for the first 3 months of the year. The initial Foundation recruitment figures for August 18 suggest that these posts will be filled at the start of the new training year. There has also been a smaller underspend on GP trainees of £33k.

Other areas of underspend YTD within the Medical Directorate are £108k relating to Fellows vacancies , £73k additional income in Quality Improvement on training courses where the income was received in 2017/18 but deferred to 2018/19 as that is when the courses will take place, Pharmacy underspends of £50k due to timing of training spend, and a number of smaller value underspends in study leave, recruitment, and general management largely related to timing issues.

The forecast outturn is a £192k underspend primarily due to a reduction in the forecast costs for Fellows as there are vacancies in Rural, SCREDS, GP Health Inequality and Forensic Fellow posts.

It should be noted that further movement is expected in this forecast once the impact of the August rotation has been costed, particularly in training grades and training grants.

2.2 Dental

The year to date underspend of £51k relates to Dental VTs but is a timing difference as it has been identified that there are some outstanding accruals which missed the cut-off date.

Dental are currently forecasting a year-end outturn of a £39k underspend due to an anticipated future month vacancy.

2.3 NMAHP

Year to date, the NMAHP Directorate is reporting a £48k overspend, which is generally timing related however, £24k relates to 17/18 spend which had not been accrued at year end. The Directorate are confident they will be able to manage remaining activities within their existing budget.

The full year forecast is currently an underspend of £16k which relates to vacancies to be clawed back.

2.4 Psychology

The YTD underspend of £289k is primarily timing as the budget for some activity areas (Therapies, Parent Training, Workforce Intelligence and CAMHS) has been spread across the year whilst the activity is expected to be more focused on the latter part of the year. A review of budget phasing will be carried out in July. There have also been invoicing delays for University fees (£46k).

The current forecast is to break even.

2.5 Digital

The Digital directorate is reporting an overspend in the 3 months to the end of June, of £338k.

Of this, £258k relates to programmes where, in order to meet required delivery schedules, expenditure has taken place in advance of formal confirmation that anticipated Transformation Funding from SG will be received. The programmes are; Appraisal (£70k), Single Employer (£130k), and Turas Learn (£58k).

A timing overspend has also arisen on ePortfolio (£135k net of corporate contribution) due to budget phasing ahead of current anticipated income, offset by a £45k underspend in KSG subscriptions (due to timing of invoicing).

The full year forecast is an overspend of £58k, due to VAT reclaim issues on Azure Hosting and Alma Primo licences. This issue will be raised with our VAT Advisors.

The full year forecast assumes that all anticipated allocations from the Transformation Fund will be received.

2.6 Workforce

The Directorate is reporting a small underspend in the 3 months to June of £31k. Underspends on O&LD training of £144k are offset by additional costs of £104k relating to the full year staff costs for PVG and Tier 2 visas. NES manages these processes for all medical trainees on a once for Scotland Basis. Although all direct costs eg the cost of the visa, are recharged to Boards, the staff costs have been absorbed by NES.

The full year forecast is an overspend of £176k of which £104k relates to the PVG and Tier 2 visa staffing costs and £66k relates to additional resources being made available to HR Central for 18/19 to support identified capacity issues.

2.7 Finance

The year to date position is an underspend of £25k due to the phasing of the external audit fee budget and an over accrual for Internal Audit fees reversing in the period.

Finance is reporting a forecast overspend for the full year of £50k, due to pay pressures from utilising agency cover for essential vacant posts (£90k) offset by underspends generated by one post on a career break (£29k) and an appointment below budget (£12k).

2.8 Net Provisions

Provisions reflects a £186k overspend for the period to date, due to vacancy savings reported being below budget by £246k offset by lower than anticipated spends in the apprenticeship levy and depreciation. Additional costs have also been incurred for redundancy payments (£17k) and e-Rostering works (£41k.)

The full year budget for net provisions is £7.9m. This is made up of 2018/19 budgeted pay award, charges for depreciation, savings targets to be clawed back from Directorates, the Apprenticeship Levy, top-slicing of external income to cover overheads, and other provisions (such as those for redeployment and potential claims and unidentified savings targets).

The current forecast is that Provisions is showing a £24k underspend for 2018/19. In the creation of the 2018/19 budget it was assumed that NES would have to fund pay increases for NES employed trainees as they were not part of the funding arrangements for Agenda for Change staff. It has been confirmed that these additional costs will be covered by SG and the net impact of these adjustments is that the Unidentified Savings Target for the year has been reduced to £300k.

3.0 Key risks to achievement of financial targets

In order to deliver outturn in line with budget, the key risks below will need to be managed across NES:

- Although a proportion of the required £1.7m of savings from the vacancy lag has already been realised, there remains £1.5m yet to be recognised. The remaining balance is dependent on estimated vacancies occurring and existing for the length of time expected;

- Any variance against our budgeted position on training grades and grants as a result of the August rotations, from both new recruitment and transition of trainees between stages of training will result in movement in the outturn position. This can be as a result of hospital vacancies now paid at a lower rate by NES, vacancies in GP trainees on NES payroll, less than full time appointments, remedials or double running. Finance are working with colleagues across Directorates to ensure that any such variances are identified and quantified.
- We have a further £12.3m of non-recurrent allocations due from SGHD. We continue to work with SGHD to ensure that all agreed allocations are received in full.
- We are also working proactively to obtain confirmation of the funding which will be allocated to NES as part of the implementation of the National Board collaborative plan.
- The necessary arrangements are being put in place to ensure appropriate financial management is in place to support the hosting of the Digital Development Entity.

4.0 <u>Recommendations</u>

The Board is invited to note the information contained in this report.

KD
AMcC
July 2018

NES **NES 18 62**
Item 8c **(Enclosure)**

July 2018

NHS Education for Scotland

Board Paper Summary: Educational Research Governance Committee (E RGC) Minutes

1. Title of Paper

Minutes of the Educational & Research Governance Committee (E&RGC) meeting held on 28 May 2018: copy attached.

(N.B. Although these minutes have been reviewed and approved by the committee's executive secretary and executive lead, there has not yet been an opportunity for the committee chair to review them)

2. Author(s) of Paper

David Ferguson, Board Services Manager

3. Purpose of Paper

To receive the unconfirmed minutes of the E&RGC meeting held on 28 May 2018.

4. Items for Noting

Item 8 – Summary Educational Governance monitoring report: GP Pharmacist programme

The committee received this report and noted the substantial assurance provided by the Pharmacy team in relation to the management of programme quality.

Item 9 – GMC National Review of Medical Education and Training in Scotland

The committee received reports from the General Medical Council and was pleased to note the excellent outcomes.

Item 10 – E&RGC Annual Report 2017-2018

Subject to amendments, the E&RGC Annual Report for 2017-2018 was approved for submission to the Audit Committee.

Item 11 – Feedback, Comments, Concerns and Complaints annual report 2017-2018

Subject to suggested amendments, the report was approved.

Item 12 – Equality & Diversity annual report 2017-2018

The committee received and noted this report and indicated that the paper reflected ongoing development and improvement.

Item 13 – NES risk registers

In receiving a report from NES's local risk registers detailing all risks relating to education quality with an inherent priority rating of Primary 1 or Primary 2, the committee agreed that the issue of inconsistency in the identification and scoring of risks between directorates and programme teams should be addressed by a cross-directorate short-life working group.

Item 18 – Any other business: Mental Health postgraduate medical training programme at NHS Tayside

The committee received an update on the Mental Health postgraduate medical training programme at NHS Tayside, which has been placed in GMC enhanced monitoring status.

5. Recommendations

The Board is asked to note the unconfirmed E&RGC minutes and invited to ask questions.

NES
July 2018
DJF

Unconfirmed

NHS Education for Scotland

EDUCATIONAL RESEARCH GOVERNANCE COMMITTEE

Minutes of the thirty-second meeting of the Educational Research Governance Committee held on Monday 28 May 2018 at Westport 102, Edinburgh

Present: Mr Douglas Hutchens (Chair)
Dr Doreen Steele
Ms Carole Wilkinson
Dr Andrew Tannahill

In attendance: Mr David Garbutt, NES Chair
Ms Caroline Lamb, Chief Executive
Professor Stewart Irvine, Director of Medicine/Executive Lead
Mr Rob Coward, Educational Projects Manager/Executive Secretary
Professor Alastair McLellan, Postgraduate Dean (Quality) (Item 9)
Mrs Karen Wilson, Director of NMAHP

1. Welcome and introductions

The Chair welcomed everyone to the meeting. It was noted that Karen Wilson and David Garbutt were attending their first E&RGC meeting. Carole Wilkinson was attending her final meeting before completing her term as a NES Board member. She was thanked by all members for her contributions to the work of the Committee.

2. Apologies for absence

There were no apologies for absence.

3. Notification of any other business

It was agreed that an item on the Mental Health postgraduate medical training programme at NHS Tayside would be considered under ‘Any other business’.

4. Declaration of interests

There were no declarations of interest in relation to the items on the agenda.

5. Minutes of the Educational Research Governance Committee
(NES/E&RGC/18/07)

The minutes of the E&RGC meeting held on 22 February were agreed as an accurate record.

6. Action status report and other matters arising (NES E RGC 18 09)

Members received the report on the status of actions agreed at previous E&RGC meetings. Several action items were discussed as follows:

Minute 6, 22 February 2018 – It was noted that that the Executive Team had received an outcomes-focussed style of remit for the E&RGC and indicated that this approach would be considered as part of a planned review of all Board committee remits.

Minute 6, 22 February 2018 – Members requested that a consolidated progress report on recommendations made by Directorate Review panels be circulated outwith the meeting. **Action: RC**

Minute 10, 22 February 2018 – It was agreed that the Finance and Performance Management Committee paper on the implementation of the GDPR would be circulated to E&RGC members immediately. **Action: RC**

Minute 8.2, 14 December 2017 – Members requested further information on the reasons why Scottish Postgraduate Career Fellowship Scheme would not be linked with the Quality Improvement programme. This information should address the issue of value for money highlighted in the summary monitoring report.
Action: RC

Minute 11, 14 December 2017 – Alastair McLellan advised that the suggested amendments of the Medical Deanery Quality Management Framework would be addressed prior to the next E&RGC meeting. **Action AMcL**

Members emphasised the need to progress actions more quickly to reduce the length of future Action Status Reports.

7. Minutes of the Educational Research Governance Executive Group
(NES/E&RGC/1810)

Stewart Irvine presented the minutes of the Educational & Research Governance Executive Group meeting on 30 April 2018. Members noted the minute relating to ethical review of NES projects and asked if related training would be provided for the staff involved. It was agreed that this point would be checked and confirmed by correspondence. **Action: RC**

8. Summary Educational Governance monitoring report – GP Pharmacist programme (NES/E&RGC/18/11)

Stewart Irvine presented the summary Educational Governance monitoring report on the GP Pharmacist programme. He explained that it was a relatively new initiative, supporting a strategically significant Scottish Government initiative in primary care. Members welcomed the rapid progress achieved by the Pharmacy team, but noted the issues relating to supervisory infrastructure for this group. This was being addressed through multi-disciplinary approaches within GP practices.

The Committee noted the substantial assurance provided by the Pharmacy team in relation to the management of programme quality.

9. GMC National Review of Medical Education and Training in Scotland (NES/E&RGC/1812)

The Committee received reports from the General Medical Council following its review of Scotland in 2017. Alastair McLellan presented the National Overview and Postgraduate Deanery reports, which included the GMC's action plan for NES and described NES's role in coordinating and monitoring responses to Health Board action plans. Alastair drew members' attention to the conclusions of the visit, which indicated that '*The standard of medical education and training in Scotland is very high* □ ' and that '*The Scotland Deanery and NES deserve great credit for the support they provide to the boards and medical schools*.' The report identified several 'Areas of Good Practice', 'Areas of Working Well', and made two 'Requirements' and one Recommendation. Stewart Irvine confirmed that he would be responsible for signing-off the responses to requirements and the recommendation before they are sent to the GMC

Alastair explained that one of the Requirements, relating to the use of the obsolete 'Senior House Officer' title, was being addressed by the GMC at a UK level and by NES in Scotland. NES is leading several remedial actions including a communications programme, and promoting the use of different coloured name badges.

On behalf of the NES Board, Committee members thanked Alastair, Stewart and Medicine colleagues for their hard work on the GMC visit and congratulated them on the excellent outcomes.

10. E□RGC annual report 2017-2018 (NES/E&RGC/18/13)

The Committee received the draft E&RGC annual report to the Audit Committee for comment and approval. The report, covering the 2017-2018 financial year, was intended to provide evidence and assurances as to the extent to which the Committee has discharged its remit. Presenting the report, Rob Coward highlighted changes, including a new commentary on themes emerging from monitoring reports considered during the year.

Members thanked Rob for the report and suggested several amendments to enhance its accuracy, clarity and completeness. It was agreed that future draft E&RGC annual reports would be approved by the Chair prior to distribution with meeting papers. **Action: RC□DH**

Members commented on the length of the report and it was agreed that a much shorter version, detailing compliance with remit, should be submitted to the Audit Committee. A more detailed version would be considered by the E&RGC for the purposes of self-reflection. **Action: RC**

The report was approved subject to amendments and signing-off by the Chair. **Action: RC□DH**

11. Feedback, Comments, Concerns and Complaints annual report 2017-2018 (NES/E&RGC/18/14)

Rob Coward presented the draft Feedback, Comments, Concerns and Complaints report for 2017-2018. He explained that that the report is a statutory requirement in accordance with the Patient Rights (Scotland) Directions Act 2017 and Scottish Government complaints guidance. The report detailed the complaints received by NES, which were handled through formal investigation processes. The report also included detailed information on how NES gathers and uses feedback from our service-users and how they are involved in projects and programmes.

Members noted the few complaints handled by NES during the year and suggested that the report should provide a comparison with the numbers of complaints received in previous years. The Committee agreed that it was important to further emphasise how NES has learned from the complaints received.

The draft report was approved subject to suggested amendments. **Action: RC**

12. Equality and Diversity annual report 2017-2018 (NES/E&RGC/18/15)

Members received the year-end Equality and Diversity report for 2017-2018 summarising performance against Operational Plan equality targets, equality impact assessments (EQIAs) and statutory reporting requirements. Presenting the report, Kristi Long explained that it was largely based on data extracted from NES's performance management database, MiTracker. This indicated that all targets had a green status at the year-end. Delivery of EQIAs also improved during the year.

Members noted the possible effects of the National Boards Collaborative Plan on compliance with statutory equality duties, for which the Boards are individually responsible. This issue was being discussed with the Scottish Government. It was noted that high level EQIAs would help with more detailed implementation of policies and services.

The E&RGC thanked Kristi for her paper which reflected ongoing development and improvement.

13. NES risk registers (NES/E&RGC/18/16)

The Committee received a report from NES's local risk registers detailing all risks relating to education quality with an inherent priority rating of Primary 1 or Primary 2. This report was in line with the NES Risk Management Strategy and recommendations from the internal auditors. The purpose of the report was to enable the Committee to check that risks were being managed effectively.

Rob Coward reported that there was some inconsistency in the identification and scoring of risks between directorates and programme teams. It had been agreed that this issue would be addressed by a cross-directorate short-life working group.

The risk report was noted.

14. Educational Governance case study (NES/E&RGC/18/17)

Members considered a case study based on NES's GP Pharmacist's programme. This illustrated the application of the Pharmacy team's expertise and experience in managing workplace learning to undergraduate pharmacy education.

Members welcomed the case study and noted the reference to funding of placement learning in undergraduate pharmacy training. In response to a question, it was agreed that this would be raised with appropriate stakeholders.

Action: RC SI

15. Identification of risks

There were no risks identified requiring further assurance.

16. Items for inclusion in the E□RGC annual report

It was agreed that the following item should be included in the Committee's annual report:

GMC National Review of Scotland

17. Scheduled E□RGC workplan items not covered on the meeting agenda

Members noted that the scheduled Educational Governance monitoring report on the Clinical Skills programme had been deferred.

18. Any other business

Mental Health postgraduate medical training programme at NHS Tayside
Stewart Irvine provided the Committee with an update on the Mental Health training programme at NHS Tayside, which had been placed in Enhanced Monitoring status.

19. Date and time of next meeting

The next E&RGC meeting would be held on Thursday 20 September 2018 at 10.15 a.m.

RC/SI
June 2018

NES **NES 18 63**
Item 8d **(Enclosure)**
July 2018

NHS Education for Scotland

Board Paper Summary: Remuneration Committee Meeting

1. Title of Paper

Summary of the Remuneration Committee meeting held on 31 May 2018.

2. Author(s) of Paper

Alison Shiell, Senior Officer (Planning & Corporate Governance)

3. Purpose of Paper

To receive a summary of the Remuneration Committee meeting held on 31 May 2018.

4. Items for Noting

a) Item 7 – Executive Objectives for 2018/19

The Committee reviewed the 2018/19 objectives and weightings for the NES Executive Team. The objectives will be submitted for formal approval at the July meeting.

b) Item 8 – Digital Development Entity

The Committee endorsed a job evaluation process for one of the leadership roles within the Scottish Government Digital Development Entity.

c) Item 9 – Remuneration Committee Annual Report to the Audit Committee

The Committee approved the annual report of the Staff Governance Committee (including the Remuneration Committee) for 2017-18, subject to minor amendments.

5. Recommendations

None.

NES
June 2018
AS/djf

NES **NES 18 64**
Item 8(e) **(Enclosure)**
July 2018

NHS Education for Scotland

Board Paper Summary: Remuneration Committee Meeting

1. Title of Paper

Summary of the Remuneration Committee meeting held on 5 July 2018.

2. Author(s) of Paper

Alison Shiell, Senior Officer (Planning & Corporate Governance)

3. Purpose of Paper

To receive a summary of the Remuneration Committee meeting held on 5 July 2018.

4. Items for Noting

a) Item 7 – Executive Objectives for 2018/19

The Committee approved the 2018/19 objectives for the Executive Team.

b) Item 8 - Executive Cohort Performance Management Reviews 2017/18

The Committee approved the outcomes of the 2017/18 Performance Management Reviews for staff in the Executive Cohort and direct reports to the Chief Executive.

c) Item 9 – NES Digital Service (NDS)

The Committee received a verbal progress update on the formation of the NDS (previously known as the Digital Development Entity/DDE).

5. Recommendations

None.

NES
July 2018
AS/

NES **NES 18 65**
Item 8f **(Enclosure)**
July 2018

NHS Education for Scotland Board Paper

Caldicott Guardian Report 2017-2018

1. Title of Paper

NES Review of Compliance with Caldicott Requirements 2017-2018

2. Author(s) of Paper

Stewart Irvine, Caldicott Guardian.

Tracey Gill, Senior Specialist Information Analyst – Information Governance & Security

3. Purpose of Paper

To provide the Board with assurance around NES compliance with the Caldicott Principles.

4 Key Issues

In general, the risks of inappropriate disclosure of PII in all the workstreams within NES are considered to be low and the level of attention to the Caldicott principles is generally high. There remains a risk in Dentistry, Medicine and Pharmacy around the use of e-portfolios and video consultations. Postgraduate Deans, tutors and advisers continue to maintain high awareness of the risk, ensure "at risk" groups are kept aware of their obligations, and employ new technology wherever possible to minimize the risk.

We are aware that the proposed developments in NES Digital Services will result in NES routinely holding significant quantities of patient identifiable information and we are engaging at an early stage to understand the considerable implications for Caldicott responsibilities.

5. Recommendation(s) for Decision

The Board is invited to note the content of the report.

NES Review of Compliance with Caldicott Requirements 2017-2018

Summary

"*The Caldicott Guardian plays a key operational role in ensuring that NHSS and partner organisations satisfy the highest practical standards for handling patient identifiable information.*

NHSScotland Caldicott Guardian"s Principles into Practice

Caldicott Guardians are responsible for agreeing and reviewing the governance and use of (Patient Identifiable Information) PII by the staff of their organisation or those shared with other NHS Scotland organisations.

Access to PII is not required for core NES business and our standard strategy is to avoid PII being received, accessed or processed by NES staff or contractors in their NES capacities.

There are some areas where there is a risk of inadvertent inclusion of PII on NES systems and the risk has to be mitigated, or where there is an exceptional business requirement where some processing of PII by NES is necessary and this must be managed appropriately.

This report provides an overview of mitigation and controls in these cases, key areas being:

- The risk of accidental inclusion of PII in ePortfolio, SEA, practice logs or similar documents.
- The management of video or audio recordings of patient consultations in General Medical Practice, Pharmacy and Psychology.
- The visibility of PII to the Family Nursing Partnership in their capacity of providing national support

Conclusion

In general, the risks of inappropriate disclosure of PII in all the workstreams within NES are considered to be low and the level of attention to the Caldicott principles is generally high. There remains a risk in Dentistry, Medicine and Pharmacy around the use of e-portfolios and video consultations. Postgraduate Deans, tutors and advisers continue to maintain high awareness of the risk, ensure "at risk" groups are kept aware of their obligations, and employ new technology wherever possible to minimise the risk.

There is an emerging risk with the development of the new data system to support the Family Nurse Partnership (FNP) programme in Scotland. This will replicate the functions of the existing FNP system and will be hosted on the NES Turas Platform. NES will not host any PII until the appropriate governance procedures are in place.

Function/activity	NES use of, or exposure to, patient data	Controls	Planned actions 2018-2019
All disciplines – ePortfolios and Significant Event Analyses	Risk of inadvertent inclusion of PII within ePortfolio content, SEAs, placement logs, case studies or similar.	Trainees and practitioners made aware of the requirement to exclude PII in ePortfolio content, SEAs, placement logs, case studies or similar products for reflective practice. Trainers/mentors raise incidents of inappropriate PII use with trainee.	Conduct audit of sample ePortfolio content for incidents of PII inclusion.
All disciplines – Sessional and seconded clinical staff in NES	Risk of inadvertent inclusion of patient records/data on NES systems.	Management and use of patient data is governed by the Caldicott and Information Governance controls of the relevant Health Board or Practice. Clinicians are subject to professional ethical codes including relevant patient confidentiality.	
All disciplines – Trainees in clinical environments	None.	Management and use of patient data is governed by the Caldicott and Information Governance controls of the relevant Health Board or Practice. Trainees in all disciplines are required to complete appropriate IG training by employing/hosting Board. (Dental) A written MoU between NES and dental trainees (VDP and VDHT) explicitly covers Caldicott guidelines and is signed by all trainees. The VT Trainer-trainee contract covers the trainee's responsibility under Caldicott and is signed by both trainer and trainee. (Psychology) Trainees are given guidance centrally by the Programme before moving to the clinical environment including confidentiality, data protection, record keeping etc. Further guidance given within Board mandatory induction training. Governance is delivered through Board IG systems, further enhanced through regular checks by the Programme with clinical supervisors on trainee adherence (recording of notes etc).	

Function/activity	NES use of, or exposure to, patient data	Controls	Planned actions 2018-2019
		Trainees engaging in evaluation/research will seek advice directly from Board Caldicott for advice/direction on use of information. Some medical trainees (GPSTs, public health and occupational health), will have an employment contract with NES which sets out information governance requirements and mandatory training. Other medical trainees have a training agreement which includes reference to adherence to GMP and GMC professional requirements and DPIA 2018. This document is currently being updated to ensure compliance with new legislation.	

Function/activity	NES use of, or exposure to, patient data	Controls	Planned actions 2018-2019
Medicine - General Practice Training - Consultation peer review	Consultation peer review, with the educational emphasis on patient centered consulting, is an important part of teaching both for doctors in training and established doctors returning to NHS practice. It has been incorporated into both Scottish Prospective Educational Supervisor Course (SPESC) and is a component of the NES Returners to General Practice Scheme. Consultations are viewed in the surgery, but occasionally these files are taken to district training sessions or calibration meetings elsewhere. GP returners are required to submit 4 consultations to the National GP Peer Review process.	Following GMC guidance all patients who have their consultations recorded are informed and sign a consent form both pre and post consultation. They can ask the GP/GPST to delete their consultation at any time thereafter. The data files are encrypted and delivered for peer review by a trusted hand or sent by registered post. GPs use standard digital video recorders and transfer the information to their secure NHS computers for this purpose. The digital recording is then transferred to an encrypted memory stick. All GPs and GPSTs making digital files of their consultations are made aware that they are responsible for the security of these files. GP returners follow the same processes.	
NMAHP - Family Nurse Partnership (FNP) – *legacy data system*	Three staff occupying specialist analytic roles in the FNP National Unit (FNP NU) have access to PII. This information is accessed via the FNP Scottish Information System (FNP SIS). FNP SIS is a specific instance of the MiDIS platform which is hosted by NHS Tayside. The system is accessed through a secure web-based portal on the SWAN network. Three NES staff build and edit data reports, while also undertaking	FNP NU has an Information Sharing Protocol in place with Boards who are implementing FNP: Boards approve FNP NU staff to view PII relating to their clients. FNP data reports are accessed through a secure web portal. The system itself, housed at NHS Tayside, as the facility to store specific reports online without the need to download data to NES. During report development, it is often necessary to download Excel versions of reports to undertake analysis that cannot be performed using the portal's own software client. Such files are stored in secure folders within NES Sharepoint which can only be accessed by aforementioned members of staff. Files are deleted when no longer	Continue to explore opportunities to reduce exposure to PII Explore potential for MIDIS to undertake regular random review of audit trail in FNP SIS to check staff have not opened client records

Function/activity	NES use of, or exposure to, patient data	Controls	Planned actions 2018-2019
	system administration of the data entry side of the system: • Report build & edit: Staff have access to a range of PII as FNP SIS pulls demographic data from the national CHI registry. The purpose of receiving PII is to monitor fidelity with the FNP licence agreement which exists between the Scottish Government and University of Colorado in Denver. Health Board reports are required by staff at the implementation sites to monitor the clinical implementation of the programme and it is necessary to include several patient identifiable fields on some reports (eg. Infant name, infant date of birth, client and infant CHI number). • System administrators: Staff have theoretical access to edit a range of client-level records but never do so and this is confirmed by an audit trail within FNP SIS itself.	required by the FNP NU. Once deleted, files remain available in the recycle bin for 90 days then become unrecoverable. PII is shared only with the relevant health board with local teams viewing reports with data pertaining to their own Board only. Aggregated (non PII), national-level data is shared with the Scottish Government (and other bodies, e.g. the University of Colorado) on request. All requests for information (PII and non PII) are logged and subject to systematic review against governance parameters before responding. As part of the overarching governance for FNP NU this log is reviewed monthly to identify emerging trends/issues and risks. Most requests come from NHS Boards for information on their own data – asking for it to be provided in a more readable format. Transmission of PII is via email to either NHS domain email addresses or .gsx domain addresses (where FNP teams are embedded within local councils rather than Boards). All FNP NU staff undertake standard mandatory Information Governance training and this is captured in Essential Learning. Furthermore, FNP NU analytical staff who can access PII attend bespoke workshops with the Information Governance & Security (IG&S) Lead. Where issues arise that are not covered by the protocols in place, there is direct contact with the IG&S Lead to seek advice in the first instance.	

Function/activity	NES use of, or exposure to, patient data	Controls	Planned actions 2018-2019

Function/activity	NES use of, or exposure to, patient data	Controls	Planned actions 2018-2019
NES Digital – Turas FNP	NES Digital are currently developing a new data system to support the Family Nurse Partnership (FNP) programme in Scotland. This will replicate the functions of the existing FNP system and is required as the current provider, MiDIS, has indicated that support will be withdrawn in late 2018. At present the system is still in development but when complete, the full range of FNP data will be held within Turas FNP. This includes a number of identifiable fields relating to FNP clients and their infants such as: CHI Number Date of Birth Name Address Postcode A variety of clinical data per the programme's data capture requirements. Analytical staff will have the same level of exposure to data as with the legacy system but in addition, certain staff members within the digital directorate will have exposure to PII as they migrate data from the legacy system and as they maintain the system going forward.	NES Digital will act as Data Processors under instruction from the Data Controllers who are the Scottish Government and the territorial boards where FNP is delivered. The Scottish Government are currently preparing a data sharing agreement which will outline NES Digital's exact requirements and responsibilities. In anticipation of this NES have prepared the following documents: • Data Protection Impact Assessment (DPIA) • Specific Information Risk Assessment (IRA) • General Information Risk Assessment for Microsoft Azure Web Services • NHS NES User Information Security Policy • Azure – Intro to Security • Azure – Advanced Threat Detection • Azure - Logging and Auditing • Azure - Operational Security • Azure - Network Security	Advanced Safe Information Handling Training for all staff members who will be exposed to or handling PII will be undertaken prior to go-live. NES will not host any PII until Information Sharing Agreements from Government have been received and scrutinized.

Function/activity	NES use of, or exposure to, patient data	Controls	Planned actions 2018-2019
Pharmacy - Pharmacist consultations with patients	Patient consultations are video recorded for review by pharmacist Independent Prescribers following training. This is an important part of teaching for pharmacists who are qualified prescribers with the educational emphasis on patient centered consulting. The number of submitted consultations is approximately 20-30 per annum. Caldicott requirements and Code of Conduct on Confidentiality are elements of the Pre-Registration Pharmacist Scheme (PRPS) Programme. In relation to the Hospital Vocational Training Scheme, students and tutors are advised that any submissions, paper or electronic, do not include PII. Caldicott requirements and Code of Conduct on Confidentiality will be formally covered in trainee and tutor training.	Recordings stored on an encrypted memory tablet, which is sent to any pharmacist wishing to submit. Tablet data then downloaded by NES staff to encrypted sticks. Encrypted sticks sent by registered post to Peer Reviewers. Patients sign a consent form (based on GMC guidance) pre and post consultation and are free to ask the pharmacist to delete their consultation at any time thereafter. NES Pharmacy has 3 members of staff who have responsibility within their job description for managing this service. All are very aware of Caldicott confidentiality and security. System for logging incidents of non-compliance to the encrypted procedure. No such incidents have been recorded. PRPS and VT Foundation trainees are made aware of the requirement to exclude PII in ePortfolio content, SEAs, placement logs, case studies or similar products for reflective practice. They are also continually reminded that any material used in tutorials must have PII removed.	Continue to explore opportunities to reduce exposure to PII Continue to log any incidents of non-compliance to the consultation encrypted procedure. VT Foundation induction is moving from National to Regional Induction (due to increased numbers). Pharmacy will ensure PII is covered in all regional induction programmes.
Psychology - Psychology of Parenting Project (PoPP).	PII held on the PoPP database includes data on the children and families enrolled in the national programme. These data are required to assess impact and reach. Arrangements are in place between the Public Health and Intelligence business unit of NHS National Services Scotland (the former Information Services Division), and	Direct access to the PII is via password protected role-based user accounts. Relevant staff are aware of their responsibilities to maintain confidentiality and have completed appropriate training.	Continue to explore opportunities to reduce exposure to PII, including regular audits of staff with access to the database to ensure that it is still appropriate for them to retain access. Undertake a review of the

Function/activity	NES use of, or exposure to, patient data	Controls	Planned actions 2018-2019
	NES regarding storage and use of PoPP data held in the newly developed PoPP Database. The data are owned by NES, and the database has been built at NSS.		current PII captured on the database to explore options to reduce the amount of PII collected

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Update on progress against the nine Strategic Outcomes in the NES Strategic Framework for 2014-2019

2. Author(s) of Paper

Caroline Lamb (Chief Executive)
Donald Cameron (Director of Planning and Corporate Resources)
Directorate contributions and editing by Planning and Corporate Governance staff (Simon Williams, Rob Coward and Helen Allbutt)

3. Purpose of Paper

To update on progress against our nine key strategic outcomes for 2014-2019.

4. Key Issues

The Board and the Finance and Performance Management Committee receive regular reports on progress against our annual Local Delivery Plans (LDP) and Operational Plans which are designed to deliver against our five strategic themes. Each year we set detailed targets and deliverables against these themes which are reported to our Board on a quarterly basis, with the annual summary of performance being set out in our Annual Report and Accounts.

Our Strategic Framework for 2014-2019 also identified nine key strategic outcomes and we report on our progress against these priorities on an annual basis. This document represents our fourth annual update.

In this report, we provide detail about each of the nine outcomes and a narrative summary of progress highlighting specific areas of our work. The report also outlines key challenges (with mitigating actions) and presents concise case studies to illustrate development of a project, programme or other aspect of our business.

The Board is aware of some of the developments and challenges in these areas from a range of reports and updates received over the last year.

5. Educational Implications

This report includes the educational activity undertaken by NES over the period 1st April 2014 to 31st July 2018 in support of our nine strategic outcomes.

6. Financial Implications

These activities are delivered within the financial plan agreed by the Board.

7. Which of the 9 Strategic Outcome(s) does this align to

These activities specifically support the nine strategic outcomes within the Strategic Framework 2014 - 2019.

8. Relevance to Better Health, Better Care

These activities support the current Scottish health and care policy context allied to feedback from our stakeholders.

9. Key Risks and Proposals to Mitigate the Risks

Some of the strategic challenges facing these activities are as follows:

- financial resourcing
- changing policy and political environment

10. Equality and Diversity

The NES response to the equality and diversity agenda is set out in our Operational Plan.

11. Communications Plan

A Communications Plan has been produced and a copy sent to the Head of Communications for information and retention:

Yes		No	X

A Communications Plan format template is available in the 'Meetings' and 'Communications' sections of the NES Intranet.

12. Recommendation(s) for Decision

Board members are invited to consider and comment on the progress information presented in the report.

NES
July 2018
DC

Update on progress against the nine Strategic Outcomes in the NES Strategic Framework 2014 - 2019

July 2018

Introduction

The NES Strategic Framework 2014-2019 focusses on five strategic themes:

- an excellent workforce;
- improved quality;
- new models of care;
- enhanced educational infrastructure and
- an improved organisation.

Each year we set detailed targets and deliverables against these themes. Progress against these is reported to the NES Board on a quarterly basis. An annual summary of our performance is then published in our Annual Report and Accounts.

The Strategic Framework 2014-2019 also identifies nine key outcomes focussing on excellence in key areas of our business. Those key outcomes are:

- A demonstrable impact of our work on healthcare services
- An excellent learning environment where there is better access to education for all healthcare staff
- Flexible access to a broad range of quality improvement education in the workplace
- Leadership and management development that enables positive change, values and behaviours
- A key role in analysis, intelligence and modelling for the NHSScotland workforce to strengthen workforce planning
- A range of development opportunities for support workers and new and extended roles to support integration
- Improved and consistent use of technology with measurable benefits for user satisfaction, accessibility and impact
- Consistently well-developed educational support roles and networks to enable education across the workplace
- An effective organisation where staff are enabled to give their best and our values are evident in everyday work.

This fourth annual report on our strategic outcomes gives a summary of our progress thus far. It includes information about data sources, key challenges and actions taken to mitigate these challenges. Case studies are provided for each outcome to give a flavour of what we do.

This report affirms our continuing progress against the key strategic outcomes and shows how our close partnership with all our stakeholders - learners, health boards, regulators and others - allows us both to manage and enhance the quality of learning in a growing range of settings.

We remain on target to deliver positively against our planned outcomes by the conclusion of this Strategic Framework in 2019 whilst also being aware that the nature of many of these outcomes is that they will never be completely achieved, and that continual attention will be needed in the light of future developments and challenges. We also recognise the evolving context by reassessing our priorities to align with new strategies such as the Health and Social Care Delivery Plan, the three parts of the National Health and Social Care Workforce Plan, the Digital Health and

Care Strategy and the emerging National Board and Regional Plans to support these.

As this Framework was designed to set our ambitions for 2014-19, during 2018-19 we will be engaging widely as we develop our Strategic Framework for future years. Over the rest of this year, we will be consulting with colleagues and stakeholders across the sector on the major themes which will come to the fore over the next five years as the landscape evolves and national strategies are embedded.

Outcome 1: A demonstrable impact of our work on healthcare services.

What the outcome means
This outcome reflects our priority of being able to identify and demonstrate the value that our work is adding to NHSScotland and beyond, assisting us in our understanding of what works, and enabling us to identify areas for improvement.

Where do we want to be by 2019 and how will this be measured
The challenges faced by NES and other organisations in isolating the impact of education and training from other contributory factors are well documented. We have, however, made progress in moving the focus of organisational accountability away from outputs (courses, participation in training etc.) towards identifying and evaluating the impact or outcomes of our activities (improved professional practice, skills acquisition etc.).

By 2019 we want to ensure that we have arrangements in place to set out the planned impact of educational activities in all programmes that lend themselves to this type of analysis, and to evaluate the achievement of these impacts. We anticipate that this will enable us to demonstrate a positive service impact across a range of projects. It will also assist us in identifying interventions that have not achieved the planned impact.

The principal method of measuring progress has been through our MiTracker system, which records the planned outcomes for each activity in the Operational Plan and a RAG indicator of progress in the Performance Dashboard

Progress so far
During 2017-2018 we have continued to make steady progress in demonstrating the impact of our work on health and care services. The new management information system, MiTracker, has further clarified the outcomes desired from our numerous activities, which are linked to performance targets. A large majority of these are appropriately focused on one of the four types of impact set out in the NES impact framework (engagement, education/learning, performance and service). Of the targets relating to health and care service improvements (excluding internally focused targets relating to the 'Improved Organisation' strategic theme), over 91% are linked to an impact related outcome. A high proportion of these (61.1%) relate to some form of service impact (improved clinical outcomes, better quality, improved productivity, cost savings etc.) with educational impact (22.4%) and performance impact (16.3%) also providing a focus for educational and other activities.

A review of all performance targets identified a number where the expected outcome is very specific and measurable (for example, the Psychology team set the target of supporting *18 MSc trainees in applied psychology for children and young people APC P to complete training by January February 2018*). In other areas, the target

specified in the performance dashboard relates to the production of deliverables (e.g. launch of e-learning modules) or project milestones (such as updating a curriculum framework) which relate to longer-term impact.

We have continued to support NES staff in planning and measuring impact through developmental workshops and provision of consultancy advice. Through this support and the commitment of NES staff, there is a growing number of examples illustrating how NES has added value in areas such as improving staff competence, enhancing performance, supporting service change and improving the patient experience.

Progress in implementing the impact framework

Throughout the year, the implementation of our impact planning and measurement framework has been a focus for Educational Governance reporting by various programme teams. These reports indicate that programme teams have actively sought evidence of impact, although some aspects of impact measurement remain challenging (as detailed in the '*Challenges necessary improvements* section below).

The review of the Psychology Directorate in November 2017 identified several areas of activity where we have tracked the impact of our educational support on practice. The Psychology Team indicated that an implementation tracker process had been instituted for several programmes, including the Behavioural Activation (BA) Trainers initiative. In these cases, data was captured on post-training activity to look at the effects on the quality of service delivery. Tracking the Behavioural Activation trainers has improved the quality of the training, performance assessment and coaching of the trainers. Clinical outcome monitoring for people attending BA Groups in Lanarkshire has demonstrated significant outcomes for people with depression. The Psychology of Parenting Programme (PoPP) looked at the effects of the education on professional practice and on outcomes for families. The PoPP data has demonstrated that 4233 families have taken part in a PoPP group. 61% of children who were rated by their parents on the Strengths and Difficulties Questionnaire to be in the clinical range at the start of groups had moved out of this high-risk range when their parents finished attending a group, with 44% of these children's behaviour being rated by their parents as falling within the normal range. Other programmes gathered data on the pre- and post-training skills and confidence of participants.

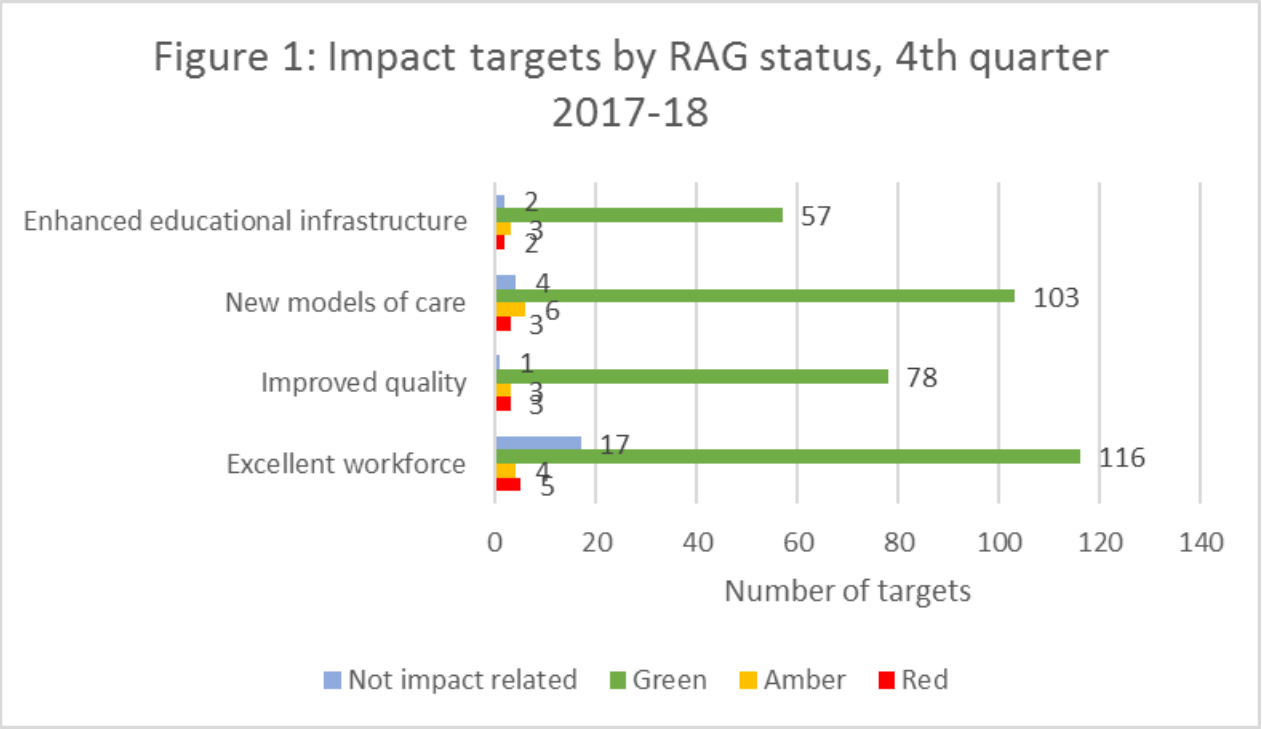
The Educational Governance monitoring report on the Medicine CPD Connect programme described the engagement impact of Practice Based Small Group Learning. This indicated that evidence of participant engagement in this form of learning is the commitment-to-change statement that is sought and recorded towards the end of each session. There is good evidence (including from our own published work) that commitment to change in a peer group setting is more likely to result in actual change in practice.

Our Quality Improvement Team's Educational Governance report detailed the effects of the Scottish Improvement Leader (ScIL) programme on participant confidence (Educational impact) and performance (Performance impact). Evaluation data showed that 88% of participants felt confident in applying improvement thinking and tools, with 71% who reported the use of these skills in their role. One area where ScIL alumni had applied their learning in practice was in training colleagues. The Educational Governance report indicated that one cohort alone has facilitated QI learning with over 500 colleagues.

Our impact logic model is supported by guidance, staff development workshops, consultancy support and a series of three short e-learning bites.

2017-2018 □uarter 4 Performance Report

The 2017-2018 Quarter 4 Performance Report provides RAG status data on the impact targets linked to the strategic themes within our Strategic Framework. Four of these themes (as specified in Figure 1 below) relate to our educational activities with the fifth focusing on NES as an 'Improved organisation'. The following commentary concerns only educational themes given their relevance to Strategic Framework Outcome 1.



A slightly higher proportion of targets (91.6%) in the Performance Dashboard relates to impact, by comparison with the previous year (87.7%). Of these impact targets 87% were successfully met during the year. A small number were not considered to relate to impact because they concerned administrative changes internal to the organisation.

A majority of the performance targets focused on improvements in health and care services (better quality care, better patient satisfaction etc.) with an increasing proportion of targets related to changes in professional practice. Over a fifth addressed educational impact; including attainment of qualifications or successful course and training programme completions. A number of the performance target updates recorded in MiTracker refer to project deliverables rather than impact on services. These are viewed as necessary steps toward impact rather than impact in itself.

Challenges necessary improvements and mitigating actions
Although progress has been achieved toward our commitment to *A measurable impact on health and care services*, several Educational Governance reports document the difficulties associated with collecting credible data on impact. A review of reports processed by the NMAHP Educational and Research Governance Group comments on these difficulties, and the NMAHP Research and Information Officer has been working with each programme during 2017/18 to help identify areas of activity and supporting staff to consider how impact could be measured. Also in NMAHP, a workshop to consider and share examples of impact measurement across the programmes was held in April.

A recurring issue for NES has been the difficulty associated with attributing positive impact to our own work in complex health and social care systems. In areas such as Healthcare Associated Infections, where several initiatives are implemented simultaneously, isolating the contribution of the educational support can be problematic. To help address some of these issues, the Planning and Corporate Resources team has been promoting the use of Contribution Analysis techniques for some NES activities to credibly isolate positive changes relating to our work. These techniques were showcased at the recent NMAHP evaluation seminar and will feature in a Guidance for Educators site on our Turas Learn application.

Case study: Leadership and Management Development alumni survey
A survey of participants in NES Leadership and Management programmes was conducted in summer 2017. The purpose of the survey was to gain insight into the experiences of participants and the impact of the programme on their work and career. This was designed to provide a baseline from which to review leadership and management development programmes and effect quality improvements. The survey covered the programmes, Playing to Your Strengths, Delivering the Future and Leading for the Future. The evaluation of Leadership & Management programmes, conducted by the Organisational Development and Leadership Learning team with support from Planning and Corporate Resources, was based on NES's recommended approach to measuring impact.

The survey elicited responses from 185 alumni from the three programmes, who were invited to provide data about their overall satisfaction and the effects of

programmes on learning (self-assessed impact on confidence and capability across the six NHSScotland Leadership Qualities), work performance (relationships with team members, achievement of personal objectives, leading change etc.) and career progression.

Responses to the survey provided a clear and consistent view of the positive impact experienced by leadership and development alumni across the three programmes. Engagement impact was very positive, and there was clear evidence of increased confidence and development in the six Leadership Qualities. Responses highlighted differences between the three programmes however, and some variation in how alumni viewed the contributions of the programmes in the Leadership Qualities. Although a majority of respondents indicated that the programmes had made a positive contribution in all six areas, they were considered less beneficial in fostering Creativity and Innovation. This finding is being addressed by the OD&LL team. A significant proportion of the alumni responding to the survey reported that they had advanced to a promoted post since completing the programme. Over two-thirds of participants in Delivering the Future (DtF) had achieved a promotion, with a large proportion of these individuals citing the programme as being instrumental in this progression. One DtF participant stated:
It was a course that that kept me growing long after the course had finished. I started thinking that I was going to learn how to do my job better and by the time I had finished I realised that the intention was to get me to do my next job better and to have me make that transition from Clinical Director to Associate Medical Director.

The Leadership and Management Development alumni survey yielded very positive data about the three programmes covered, while highlighting some significant issues for reflection and improvement. An important outcome of the survey was demonstrating a practical and credible way of collecting data on the impact of leadership and management programmes, which will be further developed by the OD&LL team and implemented selectively across its portfolio.

Outcome 2: An excellent learning environment where there is better access to education for all healthcare staff.

What the outcome means

This outcome signalled our intention to improve the quality of the learning environment for all those who are training and developing their practice within NHSScotland and in social care settings. The outcome recognises the amount of learning that takes place within the workplace and addresses several dimensions of educational quality including: supervision, protected time for learning, educational support, learning facilities and inclusivity of learning, together with the accessibility of relevant educational opportunities.

Where do we want to be by 2019 and how will this be measured

By 2019 we want to have access to data that enables us to assess the quality of the learning environment in which placements for all undergraduates and trainees (where we have a locus of responsibility) are delivered. By 2019 we also aspire to be able to increasingly join up this information across professional groups and link this to data from other national organisations to provide an integrated and holistic view of the learning environment.

By 2019 we also want to have measures in place which enable us to demonstrate how our interventions have contributed to an improvement in the quality of the learning environment.

Progress so far

NES continues to invest significant resources in the development and continuous improvement of high quality learning environments across an expanding range of health and care settings and staff groups. Our role in supporting the learning environment extends from the funding of Health Boards to provide undergraduate placement learning, to supporting the quality of placement learning environments by collecting and analysing data, preparing educational supervisors and trainers, providing practice education infrastructure and quality managing training programmes.

Our quality management of medical education and training is the means by which the Deanery improves the quality of training provided by ‘local education providers’ (LEPs). The Deanery’s role in quality managing training is a statutory requirement and forms a key component of the GMC’s Quality Assurance Framework. We work increasingly with Medical Schools, which are required to quality manage undergraduate medical education and training. This is beneficial as undergraduate and postgraduate training are often provided in the same training environments.

NES's quality management processes and practice were a key focus for the General Medical Council's review of the Scotland Deanery and medical education in Scotland during 2017-18. The review was conducted as part of the GMC's 5-year cycle of visits designed to assure the quality of training throughout the UK. This wide-ranging review considered evidence from NES staff, undergraduate schools of medicine, local education providers and others. The GMC's assessment was that the Deanery has a '*consistent approach to quality management*' and that '*the Deanery are aware of what is happening across Scotland and have robust systems in place for identifying and managing concerns over safety of quality*'.

Our Flying Start NHS development programme for nurses, midwives and allied health professionals is a key feature of the learning environment infrastructure for this large staff group. It has been completely revised and was relaunched in 2017 to reflect the changing health and social care landscape. The programme is designed to support learning and development of all newly qualified practitioners working in all sectors and settings across Scotland to help them make the step from student to qualified, confident, and capable practitioner. Hosted on TURAS Learn, NES digital learning management system, access to on-line materials and resources is available anytime from any phone, mobile device or computer enabling learning to be focused in the workplace. The Scottish Government fully endorses the new programme and expects that all newly qualified nurses, midwives and allied health professionals are supported to complete the programme during their first year in practice. A measuring impact plan is in place to capture views and experiences of newly qualified NMAHPs and this will help ensure the development programme remains dynamic and responsive to rapidly changing practice environments. Moving forward, one of the key challenges is how we extend our range in social care, and specifically in care homes.

Challenges, necessary improvements and mitigating actions

Our arrangements for managing and supporting the quality of learning environments have enabled us to develop a clear understanding of the multiple challenges arising from workplace education and training in different settings. These issues include the paucity of robust supervisory arrangements in some environments, the behaviours of a minority of senior staff in supervisory roles, and the time allocated to education and training in work rotas. We have learned that responding to these significant issues requires partnership and collaborative working at all levels.

In Medicine, Scotland's *Taskforce to Improve the Quality of Medical Education and Training* has approached educational quality at a strategic level. This Taskforce works in partnership to share and disseminate good practice across Scotland. Some key achievements include:

- Joint planning for the 2017 GMC National Review of Scotland

- Trainee engagement in improving the quality of medical education & training – showcasing the ‘chief resident model’
- Managing bullying and undermining in the training environment
- Differential attainment in postgraduate medical education and training

Case study: □uality Management of the Practice Learning Environment (□MPLE)

The QMPLE resource was developed by NES in partnership with key stakeholders, as a national data reporting platform, capturing real time information on the quality of pre-registration nursing and midwifery students’ practice learning experiences. This enables student feedback to be aggregated and compared at local, regional and national levels. Key purposes of this feedback are to ensure ongoing improvements in practice learning and to inform the annual pre-registration performance review process. The project, originally funded by Scottish Government, reflects the importance of high quality practice learning to enable safe, effective and person-centred care.

QMPLE is accessible to universities, practice and students and has the following features.

- It allows students to complete their feedback which will be visible to practice staff a short time later. The system provides built in collated reports on student feedback for each area and these can also be collated to provide reports at learning environment, service and organisation level.
- Practice areas update their placement learning opportunities and student information and this is available to students when they log in to the system.
- Nursing and Midwifery Council educational audits are completed on line and are readily available to both the practice area and the university.
- Information on mentors will be available to senior charge nurses / team leaders.
- Up to date information is readily available to students who will use the system to access placement information, mentor details and download any placement induction packs.

Ultimately, insight into the quality of the learning environment will have a positive impact on the student experience as it will inform support, development and educational priorities for practice education support roles in the future. In addition, QMPLE has the potential to enhance the practice learning environment by:

- Ensuring students' learning needs are being met in a safe environment.
- Informing planning of future practice learning experiences.
- Identifying areas for improvements and promoting areas of excellence which can be shared with others.
- Providing evidence of quality learning and mentorship within the Excellence in Care initiative (Scottish Government, 2015).

- Providing valuable feedback to mentors and practice teachers on the work they do with students which can be used as evidence for reflection as part of Nursing & Midwifery Council Revalidation (NMC, 2015).

Reflecting on the work to date, we have reviewed what has worked well and what might have been done differently. One of the key challenges that has impacted on progress, in terms of timescales, has been the data governance process which required development and approval of agreements with each of the 12 universities in turn. Given the impact on timelines, engagement with the Council of Deans could have been undertaken earlier in the development of the QMPLE system.

Outcome 3: Flexible access to a broad range of quality improvement education in the workplace.

What the outcome means
The NHSScotland Quality Strategy is the approach and shared focus for all work to realise the 2020 vision. This outcome reflects our commitment to making quality improvement (QI) education available to all staff groups (clinical and non-clinical) to ensure that the workforce is supported to implement and deliver QI activities on a day to day basis in services.

Where do we want to be by 2019 and how will this be measured
By 2019 we want to have trained a total of 284 people in the Scottish Improvement Leader (ScIL) programme and to have supported a further 60 Fellows through the Scottish Quality Safety Fellowship (SQSF). We also want to ensure that unit specific modules on QI are available to staff across the entire workforce, and we want to be able to quantify how many staff have completed these modules.

We will measure this by tracking participation on the taught programmes and tracking those accessing specific modules through our digital platform.

Progress so far
Good progress has been made against the Strategic Framework commitments. Key developments since 2014 include the following:

- The Scottish Improvement Leader (ScIL) programme set out in 2014 to have 284 Scottish Improvement Leaders operating across the public services by 2019. In 2014, one cohort was funded per year. There are now four cohorts funded each year through the Scottish Government and Healthcare Improvement Scotland, equating to 120 SciLs being trained per year. To date:
    - 268 ScILs have completed training and are working to support change across their home organisations.
    - 92 ScILs are currently in training
    - 32 new ScILs have been recruited to commence training in August 18.
- Since 2014, 142 Scottish Quality and Safety Fellows have been trained across Scotland. Cohort 11 commences in September 2018, which will result in a further 18 Scottish Fellows joining this network. The Cabinet Secretary for Health and Sport funds 2 places on the Fellowship for staff working to achieve recommendations from the Vale of Leven Inquiry. By March 2019, there will be 4 Vale of Leven Fellows.
- The Scottish Coaching and Leading for Improvement programme (SCLIP) was developed in 2017, for individuals working in a team lead role or with a similar level of responsibility, with a focus on quality improvement. The purpose of the programme is to equip these core managers to coach and lead teams, to support achievement of improvement strategies in their organisations. To date:
    - 3 cohorts have completed the programme, with each cohort comprising 30 participants
    - 2 cohorts were commissioned by the Chief Nursing Office Directorate (CNOD), Scottish Government to support Excellence in Care

    - 1 cohort was commissioned by the Children's and Young Persons Improvement Collaborative (CYPIC), Scottish Government
- The Scottish Improvement Foundation Skills (SIFS) programme was developed in 2017. SIFS is a new innovative QI learning programme delivered entirely in a virtual learning environment. The aim is to develop individuals' skills, knowledge and confidence to be active team members contributing to the improvement of local services. To date:
    - 85 people have completed the course
    - 23 people are currently in training
    - 120 will be recruited onto the programme by November 2018
    - 80 further people will be recruited in Autumn 2018 to complete the programme by March 2018
- The QI □one on Turas contains all relevant online resources for anyone wishing to learn about quality improvement. A review of content commenced in 2017, the purpose being to align practical tools and eLearning modules to content taught on programmes. As a result, resources have been reduced to ensure simple, concise, succinct and consistent messaging for users of the website. The most significant aspect is the planned reduction of 16 eLearning modules to just 4. Measurement for Improvement, the first newly developed module of the 4, was completed in May 2017.

Challenges □necessary improvements and mitigating actions
The most significant challenge faced for delivering QI programmes and modules is meeting national demand. The delivery of QI programmes is dependent on 2 factors:

- the availability of long-term funding to support system needs
- securing expert faculty time to support delivery of programmes from staff who are not NES employees

Case study: A Leadership Pro□ect from the ScIL Programme
Julia Mackel, a quality and safety improvement manager from NHS Lothian focussed her project on improving patient outcomes, by ensuring a structured response was taken when patients deteriorate, to reduce instances of cardiac arrest. Working with her team she set a target for 50% of deteriorating patients to have evidence of a structured response. Julia and her team applied QI tools and techniques to help them understand the system and generate change ideas. They found that the time spent in the diagnostic stage, before changes were tested, was invaluable. They gathered data, implemented a weekly data collection tool, and found which change ideas helped improve compliance with the structured response bundle. These included using visual aids and a sticker. Because of this work, structured response rates increased from an average of 38% to 72% and improvement was sustained. The ward experienced no cardiac arrests during the project period.

Julia said:
□Being on Scl□ was an incredible opportunity. By applying the QI learning I gained we saw a significant and sustained improvement in our process for deteriorating patients, reducing cardiac arrests and medical emergencies. Our change ideas are now being spread to other wards. The expertise I developed is being utilised to help increase our organisational QI capacity and capability through the lead role I now have in □othian's QI coaching provision□.

Outcome 4: Leadership and management development that enables positive change, values and behaviours.

What the outcome means
The health and care sector in NHSScotland is undergoing transformational change and the leaders in our health and care system are dealing with complex and demanding issues in the implementation of strategy and policy and in the design and delivery of services. This change requires the right leadership at all levels across the health and care system to achieve the required culture and behaviours to deliver the 2020 Vision and beyond.

Where do we want to be by 2019 and how will this be measured
We wish to be an effective and highly valued partner in the design and delivery of innovative ideas, policies and initiatives that are scalable and deliver the capacity and capability the health and care sector requires to meet their leadership challenges. We will be delivering on a wider platform of organisational and leadership development; and delivering digitally enabled solutions with significant progress made on assessing impact and continually improving our contribution at pace.

We will be delivering on the Once for Scotland ambition. Measurement of progress will be based on feedback, impact assessment and progress against agreed objectives.

Progress so far
During 2017/18 we consolidated the new operating model for Organisational & Leadership Development in NES which has focussed our resources and objectives around the 4 domains of Leadership & Management, Organisational Development, Learning & Development and the measurement of Quality & Impact. This reflects the priority attached to activities by Scottish Government and stakeholders across the health and care system.

2017/18 also saw the design, development and implementation of a new Leadership & Management Development Framework for Health & Care in Scotland. This has come to life via the launch of the Leadership & Management one on Turas Learn, which enables staff from across health and care in Scotland to access high quality resources, programmes, websites and e-modules from any device, anywhere, any time. It also provides the basis for coalescing learning resources on Turas that support leaders and managers at all levels and stages of their career and the future development of a manager's e-Portfolio.

In collaboration with Scottish Government and our national board partners we have continued to develop and implement Project Lift, a new approach to executive level appraisal, leadership development and talent management. The goal of this work is to establish a system-wide approach to identifying, supporting, enhancing and growing leadership talent at all levels to transform NHS Scotland and its services and improve the experience of our people. We have created a new centrally managed, nationally focused and regionally oriented team who will work with external technical partners to develop Project Lift. The team will then support the

delivery of Project Lift across the NHS, and where possible to wider health and care environments.

Referencing Scottish Government and Health Board Chief Executives' priorities for leadership and management development agreed in 2015, we have continued to work on leadership development for the future through continuing to support the Scottish Clinical Leadership Fellows, recruiting further graduates to the NHS General Management Training Scheme and working collaboratively with boards to develop new and innovative placements. We also continue to work collaboratively. An example of this is when O&LD combined with NES Quality Improvement and the Nursing Directorate in Scottish Government to design, develop and deliver 3 pilot programmes of the Scottish Coaching & Leadership for Improvement Programme (SCLIP). The pilot stage worked closely with the Scottish Government Children's and Young People's Improvement Collaborative (CYPIC) to engage a range of professionals from health, education and social care in a shared development experience. We are also working to change the culture to enable cross-sectoral working. We are doing this by delivering in collaboration with the Royal College of General Practitioners and Scottish Social Services Council Leadership for Integration packages of learning and support for those working at the interface of primary care, secondary care and social care, introducing a new online 360 Tool via Turas that explicitly focusses on the 6 Leadership Qualities for Health & Social Care. We continue to deliver Leading for the Future in partnership with other health boards and partners.

Internally, a cross-Directorate group has reviewed the provision of leadership and management development education and training by NES. This has identified potential opportunities for greater consistency and improved sharing of learning resources.

Challenges necessary improvements and mitigating actions
The main challenge is managing expectations from an environment where there is significant, perhaps even unprecedented, interest in leadership development. Because of the multiplicity of theories and approaches available, this could create a tension between NHS and wider public sector offers, and also between uni- and multi-professional commissions within health. It also increases the importance of being able to demonstrate impact. This challenge is being mitigated by close working with colleagues at Scottish Government and in the service.

Evidencing impact is a focus in respect of all our programmes and initiatives. A useful quantitative baseline was provided via a survey of alumni in spring 2017. The development of a Scottish Leadership Community open to all programme alumni and others interested in leadership learning will help in this respect and will assist us in collecting qualitative impact stories that help to understand participants' experience beyond the numbers. We will also be working with members of the Education and Research Governance Committee (ERGC) Executive Group to support improvement in this area.

Case study: The impact of Leadership for Integration – □ACL and CLIP
Leadership for Integration has two parts, aimed at individuals and groups: □*ou as a Collaborative □eader* (YACL) and *Collaborative □eadership in Practice* (CLIP)

- YACL centres around three coaching sessions and two workshops over a period of four months. Each participant has brought their own 'live' issues to the sessions with their coach and this has meant that whatever the immediate focus, the learning has been both personal and applied.
- CLIP is a bespoke package that has offered what those on the ground have felt is needed to support their work. Each CLIP site has focused on developing local responses to integration and addressing their own practical partnership issues. CLIP interventions have at times been small-scale, for example, one-off facilitation of an event or workshop, whilst in other places the CLIP resource has been used to work more intensely with a dedicated group over several months. Some CLIP sites have a strong focus on the improvement of existing services while others have an explicit goal of developing new ways of delivering services.

For both YACL and CLIP participants, the work of developing collaborative leadership for integration is seen as a necessary, if not sufficient focus, which is enabling them to become more effective in their working environment to progress health and social care integration.

There are examples of changes in both thinking and practice that are significant as a demonstration of what is possible now and, in the future, as well as providing much needed momentum and energy for further change.

> □*It was genuinely one of the most useful experiences professionally. I have never had supervision which has allowed me to focus on who I am and what I bring to my role and how I can effect change in such a structured, interesting and challenging way.*□(HSCP manager, YACL)

> "□ *e share more and are more open.* □ *e□re not assuming so much about each other.* □ *e□re not assuming that the other person understands our work.*□(East Kilbride, CLIP)

Integration is everywhere a work in progress. However, □*eadership for Integration* has been able to challenge the dominant narratives at play; such that integration has been turned from something 'imposed' upon people by statute, that may cause fear or anxiety about jobs, professional roles and the future of services, into something for which there is a more positive individual and collective commitment, because of the belief that it will ultimately improve outcomes for people and communities. The new understandings and relationships that exist amongst local professionals, teams and organisations, give them confidence that they are on the right track.

Outcome 5: A key role in analysis, intelligence and modelling for the NHS Scotland workforce to strengthen workforce planning.

What the outcome means
One of the challenges identified in Everyone Matters is "strengthening workforce planning to ensure the right people, in the right numbers, are in the right place, at the right time". We are not responsible for workforce planning, but we do have access to significant, and growing amounts of data about the trainee workforce, and increasingly about the way in which individual cohorts of staff are accessing training and development. This outcome reflects the importance of ensuring that best use is made of this data and the intelligence contributes meaningfully to workforce planning.

Where do we want to be by 2019 and how will this be measured
When this Framework was launched in 2014, our ambition was that by 2019 we would want to be in a position whereby we were making effective use of the data from all the systems which we control and to which we have access; and our analysis intelligence and modelling would be sought out by those responsible for workforce planning. However, following publication of Part 1 of the National Health and Social Care Workforce Plan, we have stretched our ambitions even further.

The National Health and Social Care Workforce Plan Part One, published in June 2017, (http://www.gov.scot/Publications/2017/06/1354) gave NES a key role in analysis, intelligence and modelling for the NHS Scotland workforce to strengthen workforce planning. NES was set several tasks to complete in 2017-19. These include:

- developing a minimum standardised data set with potential to use across different sectors;
- bringing together relevant data sources in a new supply-side platform, and analysing and aligning them to better inform workforce planning;
- determining the data required for effective decisions on workforce and improving analysis of future demand and support;
- determining how NHS Boards might use specialty profiles as part of a suite of effective workforce planning tools;
- designing a pipeline approach demonstrating how supply via training and recruitment numbers will meet estimated demand;
- developing training resources to assist adoption of the workforce planning guidance in NHS Boards, SSSC and IJBs; and
- assessing how the nationally controlled student intake process might extend to professions beyond nursing, medical and dental, linking this to career paths and opportunities across health and social care.

Progress against all these targets is measured regularly and reported to the Scottish Government.

Progress so far
Highlights of progress against these tasks include:

1. delivery of a proof of concept platform that copies, stores, transforms, models and visualises data within a Microsoft Data Lake;
2. delivery of several engagement sessions with key stakeholders; and

3. delivery of a briefing paper on controlling student numbers.

In addition, NES continues to use a data, analysis and reporting approach to support workforce planning in dentistry, nursing and midwifery, optometry, psychology, and medicine. This is done through:

- a data tool that enables data linkage;
- a platform that facilitates data analysis;
- a reporting platform that reports the results of the analysis in an accessible format, and dashboards developed to inform Reference Groups.

NES also supports workforce planning for child and adolescent mental health by providing multidisciplinary workforce data.

Challenges necessary improvements and mitigating actions

There are some challenges to the delivery of these targets:

1. Sufficient and timely access to data, which NES is addressing by developing information governance arrangements to support the transfer and storage of data in the Data Lake;
2. Identifying the nature of workforce planners' requirements, which NES is addressing by planning further engagement sessions with key stakeholders;
3. Ensuring there is sufficient staff and resource to support user requirements, which NES is addressing by acquiring resource from the Scottish Government.

Case study: Workforce data analytics

In April 2017, the Scottish Government asked NES to provide analytical support for the medical profiles, which combine information from several sources on medical training and employment and support workforce planning in each medical specialty.

NES has redesigned, updated and extended these profiles. One of the extensions is the development of consultant projections for each specialty, which have been used by regional and national workforce planners for scenario planning.

Subject to information governance approval these profiles will be one component of the Health and Social Care Workforce Platform.

Outcome 6: A range of development opportunities for support workers and new and extended roles to support integration.

What the outcome means
Support workers represent around 40% of the NHSScotland workforce but have traditionally received very little training and development support. Our ambition in relation to this group of staff is to increase access to, and awareness of, sustainable learning and development opportunities. This outcome also recognises that we need to ensure a national and coherent approach in relation to the development of new and extended roles which are identified by the service as being required as part of an integrated team.

Where do we want to be by 2019 and how will this be measured
By 2019, we aim to support Everyone Matters by embedding and sustaining learning development opportunities and pathways for increased numbers of support staff. We also aim to have been proactive and supportive in providing education resources and opportunities on a consistent and national basis, including the development of education support for staff in new and extended roles. These outcomes will be measured through target setting (e.g. specific numbers of Boards/learner uptake) and using evaluation methods such as questionnaire and interview.

Progress so far
Some examples of work include the following:

Education and career pathways

- To date, NES has established nine Business & Administration Networks and five Estates and Facilities Implementation Teams (with a further seven Boards at development stage) in NHSS Boards to disseminate the Education Pathways for these staff and to promote and support local uptake of learning for support workers.
- Over the course of 3 stakeholder events to discuss career pathways and role development for clinical HCSWs, we worked with 50 delegates from 14 health boards and three education providers and one partnership organisation. One of these events was specifically aimed at the Allied Health Professions and the final event of the financial year included stakeholders from colleges and the Open University. We have also led a successful regional collaborative working event with colleges and Boards and will roll this out to other regions in 2019. We continue to support Boards to increase youth employment and to make NHSScotland the ‘employer of choice’ for young people through youth engagement activities and partnerships with schools/colleges.
- Feedback has demonstrated a high level of satisfaction with the learning, resources, events and support provided at our learning workshops, local and regional roadshows and other national events.
- NMAHP staff were also involved in the Chief Nursing Officers Commission on Widening Participation into Nursing and Midwifery Education and Careers helping to develop and lead the workshop events.

Qualifications and prior learning

- We are following up our development with partners of an HNC by developing an HND in Facilities Services Management to provide articulation into degree level programmes.
- We have begun to work in partnership with stakeholders on a national project for Recognition of Prior Learning to promote equality of access to learning for HCSWs.

Digital skills

- We have carried out research into the development of digital skills for support staff and into the skills and knowledge required for care support staff in the use of Technology Enabled Care. We are now implementing education to support these developments including online training materials.

Consultancy

- We have undertaken 24 consultancy visits across 12 NHS Boards. These visits are requested and aim to support change with a Board. A further 26 visits or conversations were undertaken with eight NHS Boards who have requested information or involvement in an event to support HCSWs.

Challenges necessary improvements and mitigating actions

The diversity of the support workforce across NHSScotland and other sectors means that collaborative working, whilst challenging, provides an opportunity for us to offer expert advice on education for HCSWs. Embedding and sustaining information and support can also be a challenge due to limited infrastructure for this workforce. With health boards increasingly under pressure, they may not be able to release staff to participate in learning. In addition, the learning and development needs of support workers are not always prioritised and supported by relevant communication and IT infrastructure.

We continue to seek more detailed workforce data so that we can carry out meaningful learning needs assessments and identify learning gaps e.g. qualifications required for an integrated workforce.

Case study: Reach of events and projects

Our work and reach are increasing towards 2019. One example of this is the successful National Healthcare Support Workers event led annually by NES. Since 2014, the number of applicants has increased steadily and, in 2018, over 750 applications were received for 200 delegate places. We will consider how to accommodate greater numbers of delegates in 2019. Secondly, our team now supports a wider range of staff within the workforce including care at home support staff and younger staff through our youth engagement and employability programmes, including an increasing number of Apprentices across NHSScotland.

Case study: National Stakeholder Events to Support the Development of Career Pathway

As requested by our stakeholders in March 2017, we have continued to bring together NHS Boards, AHP career fellows and educational partners to consider key issues related to the development of clinical healthcare support workers.

We have held three stakeholder events in September 2017, December 2017 and in February 2018. Delegates have responded well to the different focus on each occasion, including education infrastructure, the Allied Health professions, Chief Nursing Officer's commission on widening participation.

The events have been designed to be participative with delegates working latterly in regional groups. The evaluation has been positive with participants indicating that they felt that it was important for NES to host such a network and many finding discussion of the strategic context useful for local developments.

Case Study: Making the most of Healthcare Support Workers in NHS Grampian
NES and NHS Grampian piloted a Masterclass approach for Senior Charge Nurses (SCNs) to unlock the potential of clinical healthcare support workers (HCSWs) in Royal Aberdeen Children's Hospital (RACH). The feedback showed that with consultancy and support, the SCNs developed their own capacity to maximise the contribution HCSWs can make in their own teams.

A one-day workshop and two half-day follow up sessions were held for SCNs from five wards at RACH between December 2015 and September 2016. Support from NES and NHS Grampian's own educators allowed SCNs to step back and see the bigger picture. They could then create their vision for HCSW roles and an action plan which involved all staff. The change was collaborative and not imposed, and once the SCN team had support to understand and use the HCSW Learning Framework in their context, the outcomes they achieved were simple but had the potential to be shared more widely across other boards. These included:

- A study day for HCSWs to involve them in redesigning roles
- New job descriptions for Band 2 Clinical HCSWs and housekeeper roles
- Development of a Skills Passport by the unit's Practice Educators
- Developing Band 3 HCSW roles
- Clarity of what can be delegated to HCSWs by Band 5 and 6 nurses, freeing up capacity for registered nursing staff
- More effective team working
- Role clarity for HCSWs at RACH, leading to a more flexible workforce

This work is building capacity for SCNs to maximise the contribution of HCSWs across a whole service. The learning during the pilot has been very much two-way. We found that this facilitated approach could be successfully replicated across Scotland, recognising that each organisation may have different requirements of their HCSWs.

Outcome 7: Improved and consistent use of technology with measurable benefits for user satisfaction, accessibility and impact.

What the outcome means
This strategic outcome was set as a result of our having surveyed our users for their views on our online products and services. The results of this indicated that, whilst we had some very good products and services, users experienced a great deal of frustration in trying to locate and access these and they were not joined up, with different systems separately holding the same data. At the same time, we were aware that many of our systems were complex to administer and that we were at risk through having small pockets of developer staff spread across the organisation with no common understanding of, or cover for, our different systems.

Where do we want to be by 2019 and how will this be measured
By 2019 we intend that NES will have completed its journey to being truly digital by default, exploiting all opportunities to deliver educational solutions that support excellence in health and social care for the people in Scotland. This will have been achieved when we can demonstrate that we: provide access to education for the entire NHSScotland workforce, whenever and wherever it is needed; create intuitive and personalised services for all our users, with non-digital alternatives wherever needed; provide advice and support on exploiting the latest digital and technical learning innovations; provide access to the right skills, training, suppliers and partners; ensure staff and patient safety, security and privacy are never compromised; collaborate with educational partners, NHSScotland boards and services, social care services, industry and academia; and ensure data, records and content are always up to date and accessible to those with the authority to do so, and not to those without.

Progress so far
NES Digital in now in its fourth successful year and continues to deliver new, digital services based on our strategy of developing a user-centred, Cloud-based, single unified platform, Turas. The use of Cloud ensures that Turas and the applications that run from it are accessible from any device and from any internet connection, regardless of employer or sector. The platform concept enables the development (by us or others) of applications to interact with data that are held separately, allowing data to be held once, but used for many different (appropriate) purposes. It drives both technical and quality standards. The Turas platform has been designed to create and deliver a personalised experience with the ability to ‘push’ content to users dependent on their role, stage of training and learning pathway.

We have delivered a single system for the management of healthcare trainees. Currently, trainee doctors, dentists and pharmacists can access their records with clinical psychologists and healthcare scientists due to follow soon. We have also redeveloped the Scottish Foundation Schools e-Portfolio which went live in August 2016 and is a fully integrated application on the platform. This application is also being used in Wales, Northern Ireland and Malta.

The Turas Learn application went live during 2016/17. This application provided for the first time a single learning record for all staff groups across the whole of the NHS in Scotland. Integrating with our Turas Portfolio applications means that NHS staff

can manage their training and keep structured evidence for revalidation, CPD or performance indicators from anywhere, at any time. We are working towards the ISO27001 information security standard and remain on target to gain full certification in 2018. The implementation of O365 and the move to the Cloud has enhanced our ability to support agile working and opens the potential for direct collaboration with staff in other health boards as well as social care and the wider public sector. NES Digital staff have been working with NSS and eHealth to support the wider adoption programme for Office 365 across NHSScotland.

NES Digital has supported the Care Inspectorate (CI) in their transformation and journey to Agile methodology with training and project support. As a result, the CI has commenced their first development which will be hosted and run from the Turas platform in support of Care Home of the Elderly Inspections with a go live date of April 2019.

Challenges – necessary improvements and mitigating actions
Our main challenges relate to new, additional digital demands placed on us from our increasing national workforce role. These include ensuring that we work with wider sector partners to deliver on our commitments to *Scotland's Digital Health and Social Care Strategy* and our hosting of the Digital Development Entity (DDE). These underline the key role of digital in driving workforce and service development and our responsibilities for providing the national digital platform for health and social care in Scotland.

Case study: Development of Turas Appraisal
In May 2017, Scottish Government identified that the eKSF software in support of the Agenda for Change Knowledge and Skill Framework could not be funded after April 2018. They approached NES Digital and asked if a replacement application could be built by the team. Discovery work commenced immediately with key stakeholders from NES Workforce Directorate acting as Product Owners. Significant stakeholder engagement across boards was undertaken to ensure a properly user-centric product was created with development commencing in Autumn 2017. There was an immovable go live date of April 2018 which meant significant work was necessary to ensure the minimum viable product was both suitable and available at the start of April 2018. The go live happened on Tuesday 3rd April, immediately after the Easter 2018 Bank Holidays. Over 20,000 NHS Scotland, Agenda for Change staff signed up to the application in the first week. This is another significant success example of NES Digital delivering technology with demonstrable benefits and user satisfaction across the wider service.

Case study: Challenges relating to further development and the on-boarding of content into Turas Learn
As more directorates in NES and external organisations see the benefits of moving to Turas Learn, managing further development and population of content presents challenges. Digital teams are increasing their understanding of Agile methodologies which are resulting in improved processes and ways of working to support delivery of high quality applications. Lessons being learned include the need for open and honest communication between all parties and a shared understanding that

developments should be incremental but realistic about what is achievable. An Agile methodology is, at times, at odds with business project management approaches that rely on different workflows and timelines set by other teams and organisations. For example, the requirement to on-board NHS Grampian by the end of August limits the time available to support NES directorates to move their content to Learn. NES Digital needs to work with partners to develop a robust method of prioritising developments and content on-boarding plus a recognition that additional resource may be required to efficiently manage the service while maintaining the quality of the output. It will be important to carefully balance the promotion of Turas Learn and the delivery of this service with stakeholders given our considerable digital demands.

Outcome 8: Consistently well-developed educational support roles and networks to enable education across the workplace.

What the outcome means
This outcome refers to our commitment to provide support and development to those based within NHS Boards and other employers who have a role in supporting training and education in the workplace for those working in and with NHSScotland. The commitment to provide networks and resources to develop these roles extends to those staff who are funded by us, and those who are not.

Where do we want to be by 2019 and how will this be measured
In collaboration with our partners, we aim to deliver the Everyone Matters 2020 workforce vision by improving and widening access to learning opportunities through developing national networks of tutors, education coordinators, programme directors, facilitators and others who themselves also have access to supporting networks and resources.

The achievement of this outcome is measured by feedback mechanisms such as quality assurance reports, completion of Board impact workplans, engagement and uptake of educational resources including online programmes and usage of digital applications such as e-Portfolio.

Progress so far
We have hosted learning workshops, regional roadshows and national events for trainees, pharmacists and pharmacy technicians, tutors, nurses and midwives, the AHP workforce and healthcare support workers to support the development needs of healthcare staff. E-learning resources have also been created to develop clinical skills in practice, to identify CPD needs, promote career development and help prepare applications for leaning.

We continue to strengthen our established education networks and, within nursing and midwifery, a national NMAHP Practice Education Forum has been established to support the transition of practitioners in health and care home settings into practice education roles during their first 12-18 months in post. This provides a safe space to explore and share practice and enhance their confidence and credibility as educators in practice. A literature review is being undertaken by knowledge services to review factors that enable this transition. Additionally, a survey of induction needs has been conducted to identify support and development for practitioners new to practice education.

In medicine, the Training Programme Management team of the Scotland Deanery has worked to improve resources available to training programme directors. These senior educators are important in supporting trainees to flourish at an individual level and overseeing and managing programmes that deliver comprehensive, balanced training opportunities for all trainees within a programme. These directors are also vital in helping the Deanery receive feedback on what is happening on the ground and in implementing policy developed at national level.

To help support this staff group, a Programme Director Handbook has been developed which is available on the Scotland Deanery website. This acts as a

repository of information and is kept up to date by the Training Programme Management team. Feedback is sought from the training programme directors which then informs future updates. At a regional level, these staff are supported in their role by Associate Postgraduate Deans and by attendance at regional programme director sessions, where there is a greater opportunity to have in-depth discussions about difficulties, to share best practice and network with other deanery staff.

During the recent GMC regional visit to the Scotland Deanery, the visit team commented that the training programme director role is well supported and provides an important link between doctors in training and the central Deanery team.

Challenges necessary improvements and mitigating actions
Curricula and technological changes challenge us to continually review and refresh our learning provision in conjunction with partner organisations. The size and diversity of our workforce means that we cannot design a single NES educational approach although more standardisation and a single point of access are being achieved through Turas. Continued attention to feedback mechanisms to assess our educational impact will help us meet the learning needs of all staff who work in health and social care.

Case study: Care Home Train the Trainer Programme
NES developed and delivered a 'train the trainer' workshop programme to support care home education staff with the implementation of the 'Preventing Infection in Care' educational resource and to build local capacity to deliver this education programme. We now have over 100 trainers working in care homes and third sector organisations who have been trained to provide infection prevention education where care is delivered.

The trainers were asked to complete a self-confidence questionnaire before and after the training, rating their confidence on a scale of 1 to 5 of how confident they were to deliver training or training in a specific topic. Following the 'train the trainer' programme there was a significant increase in trainers' confidence to train staff in how to manage outbreaks of infection, to teach staff about how to wash their hands correctly, carrying out the correct procedure when handling urinary catheter bags and how to care and manage clients who may suffer from infectious diarrhoea. However, it is recognised that ongoing support is important to maintain levels of confidence, especially when guidance/procedures are updated.

A celebration event was held where the trainers told their stories, how they changed infection prevention and control practice for the better and what infection prevention and control training looks like in their workplace. The purpose of the event was to look forward and to continue to develop this programme of work so that we meet the needs of the trainers, their organisation and the people they care for.

Case study: Supporting Dementia Workforce Development in Acute Care and Specialist Mental Health Dementia Units
NMAHP continue to work collaboratively to support the growth of Dementia Champions with completion of 147 graduates in March 2018 from cohort 8. We now have 850 staff who have completed the programme from across health and social

services. There were also 38 Dementia Specialist Improvement Leads graduating from cohort 2 bringing total staff numbers to over 60. Both programmes are designed to enable staff, across sectors and disciplines, to develop their knowledge and skills to improve the experiences and outcomes of care for people living with dementia, and their families and carers, receiving care and treatment in hospitals. This includes Acute General Hospitals, Community Hospitals and Specialist Dementia Units in Mental Health Hospitals and Care Homes. Impact evaluation of both programmes indicates educational impact is improving including knowledge and skills; person centred attitudes; and confidence in working with people with dementia and their families and carers. Examples of impact of these programmes on practice have been shared at national events and best practice awards and further information can be found at http://www.knowledge.scot.nhs.uk/dementia.aspx.

Outcome 9: An effective organisation where staff are enabled to give their best and our values are evident in everyday work.

What the outcome means
This outcome refers to continually improving our ways of working to ensure that we are a user-focussed, high performing organisation in which staff at all levels behave in accordance with our values.

Where do we want to be by 2019 and how will this be measured
By 2019, we seek to be an organisation where leadership, management and meaningful appraisal continually improve the performance of our organisation and the experience, performance and development of our workforce. We want to ensure that the work we do is focussed on the user, makes the best use of technology, supports staff wellbeing and resilience and ensures efficient use of resources.

Progress so far
In 2017/18 we made further progress toward our aspirations of supporting staff and making our corporate values real. Key areas of progress include the following:

- The People and Organisational Development Strategy, *Towards 2020: Improving Our orkforce,* has been refreshed. This strategy clearly aligns with *Everyone Matters* and our Strategic Framework and the collective ambitions of the eight National Health Boards.
- To maintain the respect and trust of our colleagues and users of our services and to continue to be effective, it is vital that we conduct ourselves with a high standard of ethics and integrity. The 'Our Way' concept, developed by a sub group of the Senior Operational Leadership Group, sets out the standards of behaviours we expect to see. This approach was introduced and developed at the NES Staff Conference (25th October 2017) at a session for staff attended by 150 participants. The final articulation of 'Our Way' was thus written by staff, for staff. This initiative was suggested as a direct response to our Staff Engagement Report from the 2017 iMatter exercise.
- All directorates participated in the iMatter staff experience survey for a third time in 2017, with an overall response rate of 81%. Our NES Employee Engagement Index remains relatively stable at 80%: one of the highest in NHS Scotland. The majority (86% of participating teams) have developed an action plan, indicating good engagement in follow up discussions and meeting Scottish Government's expectations in terms of implementation.
- As part of our commitment to support NHSScotland in replacing the electronic recording system (e-KSF) to set meaningful appraisals for staff, work between NES Digital and Workforce culminated in the development of Turas Appraisal. Following a successful soft launch of objective setting with 250 executive level and senior managers in March, the first iteration of this staff app was on 3rd April 2018 for those on agenda for change contracts. This system was developed in partnership with the service and had over 200 user testers before its launch.
- An OD Joint Working Group for the eight National Health Boards has developed proposals for a standard approach to line managers development and a joint coaching framework to be implemented during 2018/19. This will complement and further enhance NES' existing resources for line managers,

whilst increasing accessibility of coaching beyond relatively expensive paid-for provision.

- The values-based recruitment tool developed last year by HR & OD is being used widely within the selection process for posts within NES and is complemented by the values-based induction programme delivered by OD, Leadership & Learning and related on-line resources.
- We have completed the work of harmonising job roles to support greater transparency about grading and transferability of skills across NES. Harmonisation has streamlined job evaluation and enhanced opportunities for flexible working. We have worked in partnership to reduce our 732 active job roles to a harmonised suite of about 50. With a more flexible workforce, we now want to enhance career development opportunities for the wider workforce. Harmonisation has standardised and simplified our job roles portfolio and widened the career development landscape to provide better choice opportunities for NES staff. Attending Job Evaluation Panels was previously a regular feature of the work carried out both across the organisation and within HR. Harmonisation has achieved significant efficiency to enable staff to better focus on achieving our objectives.
- We continue to mark success through our Staff Thanks and Recognition Scheme (STARS) Awards. These were presented at the Staff Conference in Perth in 2017 with nominations received from across all NES directorates for the first time to celebrate contributions made by teams and individuals.

Challenges necessary improvements and mitigating actions
To further support efficient and high-quality delivery, teams must continue to take ownership of their objectives and act on improvements they identify. Greater involvement of staff and managers in diagnosing issues and formulating action plans will help us drive progress and encourage innovative ways of working.

The changing landscape of health and care in Scotland, and the increased expectations of Scottish Government and other external stakeholders, will make establishing and maintaining focus on internal improvements challenging. We will continue to focus attention and energy on core elements such as ways of working, shared values, and staff experience which will empower staff groups within NES to take ownership of their own development.

Case study: uality Management Framework the GMC National Review of Training in Scotland
The Quality Management Framework is the blueprint by which the Scottish Deanery delivers the quality management of postgraduate medical education and training benchmarked against GMC standards. It is also the means by which the Deanery improves the quality of training that is provided by 'local education providers' (LEPs). We work increasingly with medical schools to quality manage undergraduate medical education to provide a seamless educational environment for postgraduate training.

Central to the Quality Management Framework is the collation of data (including trainee feedback from surveys such as the GMC's National Training Survey and the Deanery's own Scottish Training Survey), information and intelligence about the training in all specialties and all training programmes across Scotland. This substantial undertaking is managed by 8 quality management groups, each of which

is responsible for a particular grouping of specialties or programmes across Scotland. Each year the quality management groups conduct about 70 quality management visits, of which the majority are triggered by concerns identified through the review of gathered data, information and intelligence. These visits highlight good practice but also identify weaknesses that must be rectified if training environments are to meet GMC standards.

Review of the quality management processes was a key component of the review of the work of the Deanery that was conducted by the GMC during its recent national review of medical training in Scotland. This review was conducted as part of the GMC's 5 yearly cycle of visits designed to assure the quality of training throughout the UK. The GMC's assessment was that the Deanery has a 'consistent approach to quality management' and that is 'aware of what is happening across Scotland' with 'robust systems in place for identifying and managing concerns over safety of quality'.

Case study: Taskforce to Improve the □uality of Medical Education □ Training
Achieving excellence in medical education requires partnership and collaborative working. At a strategic level, Scotland's Taskforce to Improve the Quality of Medical Education & Training (TIQME) was established in late 2015 to tackle key challenges in the delivery of high quality medical education and training. It is co-led by a NES Deanery quality workstream lead, a NHS Board Medical Director (MD) and a NHS Board Director of Medical Education (DME) bringing together the NES Medical Directorate Executive Team (MDET), the Scottish Deans Medical Education Group's (SDMEG) leads of all 5 Scottish Medical Schools and the MDs and DMEs of all of Scotland's territorial health boards.

TIQME has enabled sharing and dissemination of good practice across Scotland. It meets quarterly and has taken forward work to address the following themes:

- The new GMC standards for medical education & training
- Joint planning for the 2017 GMC National Review of Scotland
- Approaches to board educational governance
- How boards respond to feedback from Deanery quality management visits
- Trainee engagement in improving the quality of medical education & training – showcasing the 'chief resident model'
- Joint undergraduate and postgraduate quality management visits
- Managing bullying and undermining in the training environment
- Enhanced monitoring
- The problem with the term 'SHO' and how to remove it
- Differential attainment in postgraduate medical education and training.

TIQME constitutes one of the most effective drivers of improvements in the quality of medical education and training in Scotland.

NHS Education for Scotland

NES Board Paper Summary

1. Title of Paper

Post Graduate Medical Education Training (PGMET)
2018 Recruitment and factors affecting recruitment and retention of doctors in training

2. Author(s) of Paper

Stewart Irvine, Medical Director and Deputy CEO
Jean Allan, Associate Director, Medicine
Fiona Muchet, Medical Project Manager
Anne Dickson, General Manager, Training Programme Management

3. Purpose of Paper

This paper has been prepared to provide Board members with a brief overview of recruitment to postgraduate medical education and training, to report on the 2018 recruitment cycle and to outline key issues relating to recruitment/retention of doctors in training in Scotland and across the UK.

4. Key Issues

1. Medical Workforce Supply
2. Recruitment arrangements prior to UK Medical and Dental Recruitment and Selection (MDRS)
3. Postgraduate Medical Education Recruitment - MDRS Governance
4. Foundation, Core and Specialty fill rates 2018
5. Factors affecting recruitment/retention of doctors in training- Understanding Gaps in Training Programmes

5. Educational Implications

It is core business for NES and the Medical Directorate to recruit doctors into approved training programmes in Scotland to provide the future trained medical workforce for NHSScotland. It is also the case that the service depends heavily on doctors in training to deliver care – although important to appreciate that (a) the size of the training workforce is determined by the projected need for trained doctors and (b) the distribution of the training workforce is determined primarily by available educational opportunities

However, there are significant supply side challenges in recruiting to training posts, and gaps in programmes and the failure to recruit across the whole geography of Scotland impacts directly on quality of training for those in programmes and on patient care. These effects are both (a) short term (as a consequence of the contribution by doctors in training to patient care, and the heavy (but uneven) service dependence on this, and (b) long term, as a consequence of undersupply of the trained workforce. Both impact on the sustainability of services to patients across Scotland.

1. It can be seen that, overall, we have filled 85.4% of **vacant** posts at this stage in the recruitment cycle. This compares to a fill of 86% of vacant posts at the conclusion of the 2017 cycle – with an overall fill in 2017 of 95% of **established** posts. The final establishment report for 2018 will be available in October.

2. It can also be seen that vacancy fill in the **early** stages of training is good (98% in foundation, 94% in Core, 95% in ST1 run-through secondary care specialties), fill is less good in general practice (81%) and in higher specialty training (77%).

3. There are clear challenges in some **specialty** areas – with mental health being of particular note. There are also very clear **geographical** challenges – while we have filled 95% of vacant posts in South-East and 88% of vacant posts in the West, we have only filled 76% of vacancies in NES East and 70% in NES North. This pattern is not new.

4. Lastly, in comparison to the **UK**, the vacancy fill of Core and early years training in Scotland is the same as or better than the UK figures, but our fill in higher training is slightly lower. This pattern is also not new. Our overall vacancy fill is 85%, compared to a UK figure of 87%.

6. Financial Implications

It is not the purpose of this paper to detail the costs of the training grade medical workforce – Board members will be aware from the accounts approved at the last meeting of the Board that we fund the full basic salary cost of doctors in approved training posts, and that these costs constitute a significant fraction of the overall organisational budget.

7. Which of the 9 Strategic Outcome(s) does this align to

Theme 1 - An Excellent Workforce
Theme 2 - Improved Quality
Theme 3 - New Models of Care
Theme 4 – Enhanced Educational Infrastructure

8. Key Risks and Proposals to Mitigate the Risks

Monitoring of recruitment trends and areas of concern mean that NES can focus efforts to support Scottish Government policy, attempt to identify and address the drivers for uptake and work with partners/stakeholders such as the BMA, Scottish Academy of Medical Royal Colleges and Health Boards to deliver initiatives to improve recruitment and retention of doctors in approved training programmes.

9. Recommendation(s) for Decision

The Board is asked to note the overview of the Governance and recruitment to postgraduate medical education and training in Scotland. In particular, the Board are asked to note and consider the key messages set out in Section 9 (page 6) of the full paper.

NES
July 2018
DSI, JA,FM, AD

Post Graduate Medical Education & Training (PGMET)
2018 Recruitment and factors affecting recruitment and retention of doctors in training

1. Purpose

1.1 This paper has been prepared to provide Board members with a brief overview of recruitment to postgraduate medical education and training, to report on the 2018 recruitment cycle and to outline key issues relating to recruitment/retention of doctors in training in Scotland and across the UK.

2. Background

2.1 Doctors in training account for a significant proportion of the medical workforce in Scotland – according to ISD, in March 2017, there were about 6,500 consultants + SAS doctors (WTE), just over 4,900 general practitioners (HC) and approximately 5,627 doctors in training (WTE) in Scotland.

2.2 Although doctors in training make a very significant contribution to service delivery – particularly in secondary care – the size of the training grade workforce does not reflect the number of doctors in training that the service would wish to have to deliver care.

2.3 Rather, advice to ministers on the size of the training grade workforce has been determined – first under the 'reshaping medical workforce' project, and currently by the 'Scottish Shape of Training Transitions Group' – based on the numbers of doctors in training needed to provide the required output of trained doctors, whether consultants or general practitioners.

2.4 The process of medical education and training is regulated by the General Medical Council, which determines and approves the curricula to be followed by doctors in training, and approves all locations at which training can take place. They also quality assure both undergraduate and postgraduate training. The approval of training posts in individual units depends fundamentally on the extent to which a given unit can (a) meet the GMC standards and (b) deliver all or part of an approved curriculum.

3. Medical Workforce Supply

3.1 The GMC have published data which demonstrates that Scotland has more licensed doctors per head of population on both the GP and specialist registers, and that we also have significantly more medical undergraduates and doctors in training per capita compared to the UK as a whole.

3.2 ISD have published data which suggests that the consultant workforce in NHSS has increased by almost 100% between 1996 and 2015 (from 2626 to 5026), and that over the same timeframe, the trainee workforce has increased by 50% (from 3915 to 5922).

3.3 Applications to study medicine no-longer greatly outnumber available places - in the 2017 application cycle, UCAS data shows that first time applicants from Scotland to study medicine have fallen from 960 in 2013 to 860 in 2017 – a fall of 10% - against a home-fee intake target for Scotland of around 834. In the 2016 application cycle, only 625 applicants from Scotland successfully entered a UK medical School – of which 83% entered a medical school in Scotland.

3.4 Scottish medical schools admitted 1011 undergraduates in 2016/17 – of which 51% were from Scotland, 25% were from rUK, 7% were from the EU and 17% from RoW.

3.5 When we look at the progress graduates from Scottish medical schools, using data from the GMC NTS census, we see that of the 793 graduates from Scottish schools entering UK F1 training in 2012, by 4 years later (2016) 51% are currently in training in NHSS, 22% are in training in rUK, and 26% are not currently in UK training posts – of whom 14% never enter UK training beyond F2.

3.6 Last year (2017), for the first time, there were insufficient graduate applicants to fill the UK foundation programme, and there were some 300 vacant foundation posts across the UK.

3.7 Even if all doctors completing foundation training in the UK were to progress to specialty training (and we know that some do not), there is insufficient supply out of foundation to meet anticipated specialty training demand. For example, in 2016, 7740 doctors completed UK FY2. In the same year, we sought to fill 8588 CT1/ST1 posts across the UK.

3.8 The number of unique applicants to UK specialty training in round 1 (for CT1 and ST1 posts) has fallen by 2.5% between 2014 and 2018. The number of unique applicants to UK specialty training in round 2 (for higher specialty posts) has fallen by 8% between 2014 and 2018.

3.9 In summary – we face a significant shortfall in supply into the medical training grade workforce.

3.10 Of doctors completing a CCT training programme in Scotland in the past 5 years (3473) almost 80% are still working in Scotland, and 14% are working elsewhere in the UK.

4. Prior to UK Medical and Dental Recruitment and Selection (MDRS)

4.1 Each nation/region advertised and recruited to their own vacancies through different processes across the UK.

4.2 There was no limit on the number of applications that an individual could make, no national person specifications which allowed differential selection processes and no controls in place to limit the number of offers that an individual could accept.

4.3 The 4 nations were competing to attract the same applicants. In addition, applicants were able to withdraw from accepted posts once a preferred offer elsewhere was received.

4.4 There was no national timeline - posts were advertised as posts arose, increasing the number of assessment centres and therefore consultant and trainee time to attend these. Each time a post fell vacant, an advert was placed, and an appointment committee, typically including 4-6 senior medical staff, would be convened for one day to conduct unstructured interviews.

4.5 Scotland was operating in a context as above with multiple systems elsewhere in the UK and a lack of UK consensus on specifications, timelines and application protocols. A baseline review and benefit appraisal was undertaken in 2014 to ensure Scottish Government had appropriate information to support participation in MDRS. A review of this benefit appraisal, and the realisation of expected benefits, will take place in 2018.

5. Postgraduate Medical Education Recruitment - MDRS Governance

5.1 Against that background, UK Medical and Dental recruitment and selection (MDRS) was developed as a UK wide process and is governed by the MDRS Programme Board which has representation from the four home nations, BMA, Medical Royal Colleges, Dental Deans and other stakeholders. The MDRS Programme Board reports to the UK Medical Education Reference Group. An overview of the Governance arrangements is set out at Appendix 1.

5.2 Each nation retains the right to deliver specific "requirement activity" to meet specific policy objectives of their respective government outside of agreed national recruitment agreements.

5.3 Each nation is also responsible for determining their workforce numbers for recruitment within each round – in Scotland, this is now managed through the Scottish Shape of Training Transitions Group.

5.4 A number of sub groups report to the MDRS Programme Board including :

- **Oriel Oversight**: The governance and oversight of the UK online application portal for all recruitment for specialty training, Foundation and General Practice recruitment across the UK are carried out via a single portal - Oriel[1].

- **Quality & Standards**: oversee the quality assurance processes, national standards for assessors and evaluation of medical selection processes including assessment tools.

- **Medical and Dental Careers Strategy** : oversees a four nation approach for careers advice and the needs of the future workforce.

5.5 Lead recruiters across the UK, including Deanery offices, Royal Colleges and Health Boards, work together with agreed person specifications, scoring mechanisms and timetables. These agreed UK standards then apply to all applicants for the specialty and where there is more than one assessment centre, question banks and agreed assessment tools mean that applicants are assessed online and at centres to the same standard.

6. Foundation

6.1 Final year medical students apply to Foundation training in the UK before taking final degree exams. At the point of graduation, they gain provisional GMC registration which allows them to enter a UK Foundation programme and work as a doctor with restrictions on what they are able to do. All UK medical school graduates must then complete 2 years of foundation training within 5 years before they can enter specialty training. As a minimum, they must complete the first year of foundation training in order to gain full GMC registration and the ability to work as a doctor.

6.2 The UK Foundation Programme Office (UKFPO)[2] oversees the recruitment of students into Foundation Schools. Scotland is the largest UK Foundation School. Students rank their preferences in Oriel and most are offered their first or second choice. Within Scotland students can further preference the specific Programme they wish to join depending on the region or the

[1] https://www.oriel.nhs.uk/Web/Account/LandingPage
[2] http://www.foundationprogramme.nhs.uk/pages/home

specialties offered by the Programme. **Fill rates for foundation training in 2018 are set out below.**

NES East			NES North			NES SE			NES West		
Posts	Accepts	Fill %	Posts	Accepts	Fill %	Posts	Accepts	Fill %	Posts	Accepts	Fill%
96	94	98%	144	132	92%	197	194	98%	413	410	99%

7. Core and Specialty Training

7.1 NES Medical Directorate works closely with SGHSC Workforce colleagues throughout the training and recruitment year to an agreed timeline on publication of data from a Scottish and rest of UK context. This ensures consistency of approach and enables the Workforce team to provide timely briefings to the Cabinet Secretary and other officials.

7.2 Appendices 2 - 4 contain fill rates from each recruitment round, by specialty and region, together with UK data comparisons. Recruitment takes place over a sequence of 'rounds' of recruitment. Round 1 is for posts at ST1 level in Core and Run-Through programmes, Round 2 is for ST3 or ST4 and above programmes in un-coupled specialties. Any vacant posts are then mopped up in a Round 1 Re-Advert, and finally Round 2 Readvert is for vacant posts with a February start date.

- **Appendix 2** shows the fill rates for all vacant posts in Scotland at the end of the main recruitment cycle (Round 1 + Round 2 + Round 1 Re-Advert). Note that the percentage fill figures provided are expressed as a percentage only of the **vacant** posts entered into recruitment, rather than as a percentage of the total number of established posts in the specialty. Clearly, only posts which have become vacant in a given programme are available for recruitment.

- **Appendix 3** shows the fill rates for all vacant posts in Scotland at the end of the main recruitment cycle (Round 1 + Round 2 + Round 1 Re-Advert), broken down by region. Some programmes with smaller numbers are managed and so reported as 'national' (all-Scotland) and some are 'East Coast' (North + East + South East).

- **Appendix 4** shows the fill rates for all vacant posts in Scotland at the end of the main recruitment cycle (Round 1 + Round 2 + Round 1 Re-Advert), separated by training level, and compared to whole UK data.

- **Appendix 5** shows the fill rate for the full **2017** recruitment cycle, which allows reporting by establishment. This illustrates that while we filled 86% of vacant posts in that cycle, the fill of all established training posts was 95%.

8. Factors affecting recruitment/retention of doctors in training - Understanding Gaps in Training Programmes

8.1 Gaps in training programmes compromise both training and service delivery. In addition, those gaps which result from an inability to recruit to a training programme carry the important longer term risk of an under-supply of trained doctors.

8.2 Some gaps in training programmes arise because of an inability to recruit to training posts during the national recruitment process (failure to fill). These gaps are particularly problematic because they are not evenly distributed – there are some geographical locations, and some specialties which are very unpopular with doctors in training.

8.3 Larger numbers of gaps arise because of changes in trainees' circumstances following recruitment to a training post. These include, but are not limited to:

a. Parental (maternity/paternity) leave
b. Time out of programme for research (OOPR)
c. Time out of programme for additional experience (OOPE)
d. Time out of programme for additional training (OOPT)
e. Resignation from a training programme (for example to change specialty or location)
f. Departure from a training programme to a trained post following completion of training
g. Undertaking training on a less than full time basis
h. Long-term ill health
i. Acting-up into the consultant grade

8.4 The absolute numbers of gaps in programmes, and the relative distribution of the causes of gaps varies greatly across the training year. Thus rates of parental leave and OOPR are relatively stable, while resignations and departures following CCT increase as the training year progresses.

8.5 AS common cause of gaps in training programmes has been parental leave - an average of 186 posts at any one time (just over 3% of the training establishment) between 2012 and 2016.

8.6 Several potential gaps arise because of trainees taking time out of programme for research - an average of 170 trainees at any one time (just less than 3% of the training establishment) between 2012 and 2016. NES has now put in place a policy whereby any OOPR absence of 12 months or more is replaced with a substantive new post.

8.7 Several potential gaps also arise because of less than full time working – currently the equivalent of 141 posts7 (about 2.5% of the training establishment) – although the funding remaining is used to fund additional training posts.

8.8 Failure to fill training posts also accounts for significant numbers of gaps. In the 2015 recruitment round, 185 posts were unfilled (about 3% of the training establishment). During the 2016 recruitment round, the position was complicated by the addition of 100 additional GP posts once the recruitment process was nearing completion, resulting in 283 unfilled posts. In the full 2017 recruitment cycle, we failed to fill about 4.8% of the training establishment. At this point in the 2018 cycle, we have about 164 unfilled posts.

8.9 The overall establishment of training posts in Scotland is approximately 5,700. Funding for the base salary of most of these posts (approximately 5,500) sits with NES, the remainder being residual board funded posts. Currently, some 1,690 are in foundation training, 540 in core training, and 3,430 in run-through and higher specialist training.

8.10 Gaps in training programmes are not new phenomenon – the circumstances (listed above) which give rise to gaps in training programmes have always been with us, although some of the causes of gaps have increased in recent years. What has changed is the availability of doctors able and willing to undertake shorter fixed term training posts and locum posts to fill these gaps.

8.11 In the past, much of this work was undertaken by international medical graduates working in the UK. Changes in immigration policy – in particular the abolition of 'permit free training' in 2006 - has led to a dramatic fall in overseas doctors entering UK training. As an example, GP NRO data suggests that applicants from India and Pakistan to GP training fell from 4309 in 2006 to 414 in 2015.

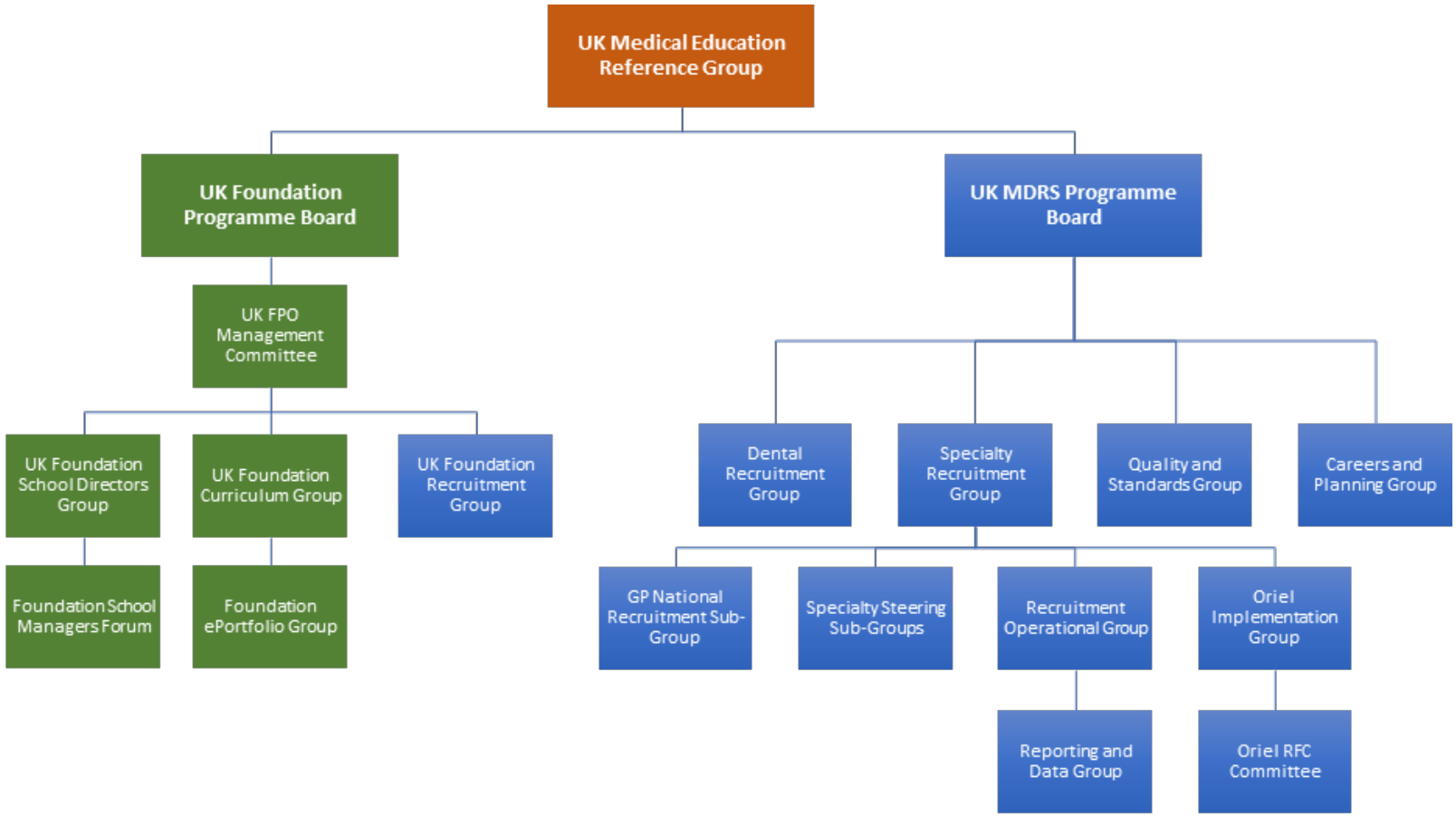
8.12 It is uncertain now what impact the changing relationship between the UK and the EU will have, or the extent to which very recent changes in UK visa policy will improve matters.

9 Key Messages

- There are significant supply-side problems into specialty training across the UK.
- There are not sufficient medical graduates from UK schools to fill foundation programmes.
- There are not sufficient foundation completers to fill an expanding pool of UK (or Scottish) ST1 places - even if all graduates enter foundation, and all F2 completers eventually enter specialty training.
- 50% of graduates from Scottish medical schools are in training in NHSS 4 years later.
- There is a mis-match between service need and graduate ambitions - 19% of graduates from Scottish schools are in GP training in Scotland 4 years on.
- Overseas qualified doctors are a diminishing part of the training population.
- The recent increases in medical graduate intake (some 25% in England and 22% in Scotland) will be crucial to addressing these concerns, going forward.

Stewart Irvine
Jean Allan
Fiona Muchet
Anne Dickson
NHS Education for Scotland
July 2018

Appendix 1 : UK MDRS Governance



Appendix 2 : Scotland Vacant Posts Fill Rates as at 13 June 2018

Specialty	Level	Post Type	2018		
			Posts	Accepts	Fill Rate
Broad Based Training	1	CT	12	11	92
General Practice	1	ST	308	250	81
Public Health Medicine	1	ST	4	4	100
Intensive Care Medicine	3	ST	12	12	100
Occupational Medicine	3	ST	4	2	50
MEDICINE					
ACCS Acute Medicine/Core Medical Training	1	CT	124	124	100
Acute Internal Medicine	3	ST	17	8	47
Cardiology	3	ST	7	7	100
Clinical Genetics	3	ST	1	0	0
Clinical Neurophysiology	3	ST	2	0	0
Clinical Pharmacology and Therapeutics	3	ST	2	2	100
Combined Infection Training	3	ST	16	11	69
Dermatology	3	ST	4	4	100
Endocrinology and Diabetes Mellitus	3	ST	9	8	89
Gastroenterology	3	ST	6	6	100
Genito-urinary Medicine	3	ST	2	0	0
Geriatric Medicine	3	ST	18	14	78
Haematology	3	ST	5	4	80
Medical Oncology	3	ST	6	6	100
Medical Ophthalmology	3	ST	1	0	0
Metabolic Medicine	3	ST	2	1	50
Neurology	3	ST	3	3	100
Palliative Medicine	3	ST	3	3	100
Rehabilitation Medicine	3	ST	3	0	0
Renal Medicine	3	ST	7	5	71
Respiratory Medicine	3	ST	7	7	100
Rheumatology	3	ST	5	5	100
ST3 Medicine Totals			**126**	**94**	**75**
SURGERY					
Core Surgical Training	1	CT	47	47	100
Neurosurgery	1	ST	3	3	100
Trauma and Orthopaedic Surgery	1	ST	15	15	100
ST1 Run Through Surgery Totals			18	18	**100**
Cardio-thoracic surgery	3	ST	1	1	100
General and Vascular Surgery	3	ST	46	22	48
Trauma and Orthopaedic Surgery	3	ST	5	5	100
Neurosurgery	3	ST	1	0	0
Otolaryngology	3	ST	8	8	100
Paediatric Surgery	3	ST	3	3	100
Plastic Surgery	3	ST	4	4	100
Urology	3	ST	5	5	100
ST3 Surgery Totals			73	48	**66**
ST1 & ST3 Surgery Totals			**91**	**66**	**73**

Ophthalmology					
Ophthalmology	1	ST	9	9	100
Ophthalmology	3	ST	2	1	50
Ophthalmology Totals			**11**	**10**	**91**
MENTAL HEALTH					
Core Psychiatry Training	1	CT	60	40	67
Child and Adolescent Psychiatry	4	ST	14	9	64
Forensic Psychiatry	4	ST	4	4	100
General Psychiatry	4	ST	18	15	83
General Psychiatry and Old Age Psychiatry	4	ST	1	0	0
Medical Psychotherapy	4	ST	3	0	0
Old Age Psychiatry	4	ST	7	7	100
Psychiatry of Learning Disability	4	ST	7	2	29
ST4 Mental Health Totals			**54**	**37**	**69**
DIAGNOSTICS					
Chemical Pathology	1	ST	4	2	50
Clinical Oncology	3	ST	8	8	100
Clinical Radiology	1	ST	35	35	100
Histopathology	1	ST	13	9	69
Diagnostic neuropathology	3	ST	1	1	100
Diagnostics Totals			61	55	**90**
PAEDIATRICS					
Paediatrics	1	ST	17	17	100
Paediatrics	2	ST	5	5	100
Paediatrics	3	ST	6	5	83
Paediatrics	4	ST	2	2	100
Paediatrics totals			30	29	**97**
OBSTERICS & GYNAECOLOGY					
Community Sexual and Reproductive Health	1	ST	1	1	100
Obstetrics and Gynaecology	1	ST	20	20	100
Obstetrics and Gynaecology	3	ST	7	7	100
ANAESTHETICS					
ACCS Anaesthetics/Core Anaesthetics	1	CT	64	64	100
Anaesthetics	3	ST	43	43	100
EMERGENCY MEDICINE					
Acute Care Common Stem - Emergency Medicine	1	CT	25	25	100
Emergency Medicine	4	ST	9	8	89
TOTALS			1113	949	85.4

Appendix 3 : Scotland Vacant Posts Regional Fill Rates as at 13 June 2018

Specialty	Level	PostType	Scotland			East Coast			East Region			North Region			South East Region			West Region		
			Posts	Accepts	Fill Rate %	Posts	Accepts	Fill Rate %	Posts	Accepts	Fill Rate %	Posts	Accepts	Fill Rate %	Posts	Accepts	Fill Rate %	Posts	Accepts	Fill Rate %
ACCS Acute Medicine/Core Medical Training	1	CT							12	12	100.00	13	13	100.00	30	30	100.00	69	69	100.00
ACCS Anaesthetics/Core Anaesthetics	1	CT							10	10	100.00	9	9	100.00	13	13	100.00	32	32	100.00
Acute Care Common Stem - Emergency Medicine	1	CT							3	3	100.00	4	4	100.00	5	5	100.00	13	13	100.00
Broad Based Training	1	CT							3	2	66.67	3	3	100.00				6	6	100.00
Core Psychiatry Training	1	CT							4	4	100.00	17	4	23.53	12	11	91.67	27	21	77.78
Core Surgical Training	1	CT				20	20	100.00										27	27	100.00
CORE TOTALS						**20**	**20**	**100.00**	**32**	**31**	**96.88**	**46**	**33**	**71.74**	**12**	**11**	**91.67**	**174**	**168**	**96.55**
Chemical Pathology	1	ST							1	1	100.00	2	1	50.00	1	0	0.00			
Clinical Radiology	1	ST							3	3	100.00	6	6	100.00	7	7	100.00	19	19	100.00
Community Sexual and Reproductive Health	1	ST																1	1	100.00
General Practice	1	ST							37	22	59.46	68	46	67.65	66	63	95.45	137	119	86.86
Histopathology	1	ST							3	2	66.67	3	1	33.33	2	2	100.00	5	4	80.00
Neurosurgery	1	ST	3	3	100.00															
Obstetrics and Gynaecology	1	ST							1	1	100.00	4	4	100.00	6	6	100.00	9	9	100.00
Ophthalmology	1	ST							2	2	100.00	2	2	100.00	1	1	100.00	4	4	100.00
Paediatrics	1	ST							2	2	100.00	4	4	100.00	5	5	100.00	6	6	100.00
Paediatrics	2	ST										1	1	100.00	3	3	100.00	1	1	100.00
Public Health Medicine	1	ST							1	1	100.00	2	2	100.00				1	1	100.00
Trauma and Orthopaedic Surgery	1	ST							3	3	100.00	2	2	100.00	5	5	100.00	5	5	100.00

ST1/ST2 TOTALS			3	3	100.00				53	37	69.81	94	69	73.40	96	92	95.83	188	169	89.89
Acute Internal Medicine	3	ST							2	0	0.00	5	3	60.00	3	3	100.00	7	2	28.57
Anaesthetics	3	ST							7	7	100.00	8	8	100.00	11	11	100.00	17	17	100.00
Cardiology	3	ST										1	1	100.00	1	1	100.00	5	5	100.00
Cardio-thoracic surgery	3	ST										1	1	100.00						
Clinical Genetics	3	ST										1	0	0.00						
Clinical Neurophysiology	3	ST																2	0	0.00
Clinical Oncology	3	ST							2	2	100.00	2	2	100.00	2	2	100.00	2	2	100.00
Clinical Pharmacology and Therapeutics	3	ST																2	2	100.00
Combined Infection Training	3	ST							2	2	100.00	2	0	0.00	7	7	100.00	5	2	40.00
Dermatology	3	ST							1	1	100.00	2	2	100.00				1	1	100.00
Diagnostic neuropathology	3	ST	1	1	100.00															
Endocrinology and Diabetes Mellitus	3	ST							1	0	0.00	1	1	100.00	3	3	100.00	4	4	100.00
Gastroenterology	3	ST							1	1	100.00	1	1	100.00	3	3	100.00	1	1	100.00
General and Vascular Surgery	3	ST							9	3	33.33	7	0	0.00	6	6	100.00	24	13	54.17
Genito-urinary Medicine	3	ST													1	0	0.00	1	0	0.00
Geriatric Medicine	3	ST							3	3	100.00	6	2	33.33	3	3	100.00	6	6	100.00
Haematology	3	ST										1	0	0.00				4	4	100.00
Intensive Care Medicine	3	ST							1	1	100.00	1	1	100.00	4	4	100.00	6	6	100.00
Medical Oncology	3	ST										2	2	100.00	2	2	100.00	2	2	100.00
Medical Ophthalmology	3	ST										1	0	0.00						
Metabolic Medicine	3	ST													1	1	100.00	1	0	0.00
Neurology	3	ST										1	1	100.00	1	1	100.00	1	1	100.00
Neurosurgery	3	ST	1	0	0.00															
Obstetrics and Gynaecology	3	ST							1	1	100.00	2	2	100.00	3	3	100.00	1	1	100.00
Occupational Medicine	3	ST										2	0	0.00	1	1	100.00	1	1	100.00
Ophthalmology	3	ST							1	0	0.00	1	1	100.00						
Otolaryngology	3	ST				5	4	80.00										3	3	100.00

Paediatric Surgery	3	ST	3	3	100.00															
Paediatrics	3	ST										4	3	75.00				2	2	100.00
Palliative Medicine	3	ST																3	3	100.00
Plastic Surgery	3	ST	4	4	100.00															
Rehabilitation Medicine	3	ST										1	0	0.00	2	0	0.00			
Renal Medicine	3	ST							1	1	100.00				1	1	100.00	5	3	60.00
Respiratory Medicine	3	ST										1	1	100.00	1	1	100.00	5	5	100.00
Rheumatology	3	ST													1	1	100.00	4	4	100.00
Trauma and Orthopaedic Surgery	3	ST																5	5	100.00
Urology	3	ST				4	4	100.00										1	1	100.00
Child and Adolescent Psychiatry	4	ST							1	0	0.00	3	3	100.00	3	2	66.67	7	4	57.14
Emergency Medicine	4	ST										3	2	66.67	4	4	100.00	2	2	100.00
Forensic Psychiatry	4	ST										1	1	100.00	1	1	100.00	2	2	100.00
General Psychiatry	4	ST							4	2	50.00	1	1	100.00	3	3	100.00	10	9	90.00
General Psychiatry and Old Age Psychiatry	4	ST										1	0	0.00						
Medical Psychotherapy	4	ST													1	0	0.00	2	0	0.00
Old Age Psychiatry	4	ST							1	1	100.00	3	3	100.00				3	3	100.00
Paediatrics	4	ST										1	1	100.00				1	1	100.00
Psychiatry of Learning Disability	4	ST							1	1	100.00				2	1	50.00	4	0	0.00
ST3/ST4 TOTALS			**9**	**8**	**88.89**	**9**	**8**	**88.89**	**39**	**26**	**66.67**	**67**	**43**	**64.18**	**71**	**65**	**91.55**	**152**	**117**	**76.97**
TOTAL			12	11	91.67	29	28	96.55	124	94	75.81	207	145	70.05	227	216	95.15	514	454	88.33

Appendix 4 : Scotland Vacant Posts Fill Rates Compared to Whole UK data

Scotland and UK Fill Rates After 3 of the 4 Recruitment Rounds								
Specialty	Level	Post Type	SCOTLAND 2018			UK 2018		
			Posts	Accepts	FillRate	Posts	Accepts	FillRate
ACCS Acute Medicine/Core Medical Training	1	CT	124	124	100	1729	1655	96
ACCS Anaesthetics/Core Anaesthetics	1	CT	64	64	100	581	580	100
Acute Care Common Stem - Emergency Medicine	1	CT	25	25	100	362	362	100
Broad Based Training	1	CT	12	11	92	12	11	92
Core Psychiatry Training	1	CT	60	40	67	555	418	75
Core Surgical Training	1	CT	47	47	100	601	601	100
CORE			**332**	**311**	**94**	**3840**	**3627**	**94**
Chemical Pathology	1	ST	4	2	50	4	2	50
Clinical Radiology	1	ST	35	35	100	283	283	100
Community Sexual and Reproductive Health	1	ST	1	1	100	10	9	90
Histopathology	1	ST	13	9	69	101	75	74
Neurosurgery	1	ST	3	3	100	33	33	100
Obstetrics and Gynaecology	1	ST	20	20	100	277	269	97
Ophthalmology	1	ST	9	9	100	92	92	100
Paediatrics	1	ST	17	17	100	473	390	82
Paediatrics	2	ST	5	5	100	28	20	71
Public Health Medicine	1	ST	4	4	100	77	77	100
Trauma and Orthopaedic Surgery	1	ST	15	15	100	15	15	100
SPECIALTY ST1/ST2			**126**	**120**	**95**	**1393**	**1265**	**91**
General Practice	1	ST	308	250	**81**	4027	3383	**84**
CORE, ST1/ST2 & GP			**766**	**681**	**89**	**9260**	**8275**	**89**
Acute Internal Medicine	3	ST	17	8	47	130	84	65
Anaesthetics	3	ST	43	43	100	392	374	95
Cardiology	3	ST	7	7	100	135	135	100
Cardio-thoracic surgery	3	ST	1	1	100	9	8	89
Child and Adolescent Psychiatry	4	ST	14	9	64	80	38	48
Clinical Genetics	3	ST	1	0	0	13	12	92
Clinical Neurophysiology	3	ST	2	0	0	13	11	85
Clinical Oncology	3	ST	8	8	100	52	52	100
Clinical Pharmacology and Therapeutics	3	ST	2	2	100	13	5	38
Combined Infection Training	3	ST	16	11	69	70	59	84
Dermatology	3	ST	4	4	100	51	51	100
Diagnostic neuropathology	3	ST	1	1	100	6	5	83
Emergency Medicine	4	ST	9	8	89	79	32	41
Endocrinology and Diabetes Mellitus	3	ST	9	8	89	100	60	60
Forensic Psychiatry	4	ST	4	4	100	33	24	73
Gastroenterology	3	ST	6	6	100	85	85	100
General and Vascular Surgery	3	ST	46	22	48	241	208	86
General Psychiatry	4	ST	18	15	83	182	103	57

General Psychiatry and Old Age Psychiatry	4	ST	1	0	0		46	20	43
Genito-urinary Medicine	3	ST	2	0	0		37	13	35
Geriatric Medicine	3	ST	18	14	78		169	110	65
Haematology	3	ST	5	4	80		76	70	92
Intensive Care Medicine	3	ST	12	12	100		169	147	87
Medical Oncology	3	ST	6	6	100		53	52	98
Medical Ophthalmology	3	ST	1	0	0		3	1	33
Medical Psychotherapy	4	ST	3	0	0		4	1	25
Metabolic Medicine	3	ST	2	1	50		22	3	14
Neurology	3	ST	3	3	100		46	46	100
Neurosurgery	3	ST	1	0	0		2	0	0
Obstetrics and Gynaecology	3	ST	7	7	100		92	91	99
Occupational Medicine	3	ST	4	2	50		10	7	70
Old Age Psychiatry	4	ST	7	7	100		64	28	44
Ophthalmology	3	ST	2	1	50		16	10	62.50
Otolaryngology	3	ST	8	8	100		50	50	100
Paediatric Surgery	3	ST	3	3	100		7	7	100
Paediatrics	3	ST	6	5	83		50	38	76
Paediatrics	4	ST	2	2	100		83	78	94
Palliative Medicine	3	ST	3	3	100		37	37	100
Plastic Surgery	3	ST	4	4	100		29	29	100
Psychiatry of Learning Disability	4	ST	7	2	29		41	7	17
Rehabilitation Medicine	3	ST	3	0	0		33	13	39
Renal Medicine	3	ST	7	5	71		69	51	74
Respiratory Medicine	3	ST	7	7	100		88	88	100
Rheumatology	3	ST	5	5	100		49	44	90
Trauma and Orthopaedic Surgery	3	ST	5	5	100		134	128	96
Urology	3	ST	5	5	100		42	42	100
ST3/ST4 TOTALS			**347**	**268**	**77**		**3205**	**2557**	**80**
CORE & ST1/ST2 & ST3/4			1113	949	85		12465	10832	87

Appendix 5 : Scotland : Establishment Fill – End of 2017 Recruitment

2017 Scotland Establishment										
Specialty	Scotland vacancies				UK vacancies				Establishment Overall Fill	
	Vacancies	Filled	FillRate		Vacancies	Filled	FillRate		Establishment	FillRate
Foundation	852	816	95.77		7537	7219	95.78		1698	97.88
ACCS Acute Medicine/Core Medical Training	115	113	98.26		1717	1511	88		247	99.19
ACCS Anaesthetics/Core Anaesthetics	65	65	100.00		679	656	96.61		151	100.00
Acute Care Common Stem - Emergency Medicine	24	24	100.00		344	315	91.57		8	100.00
Acute Internal Medicine	20	8	40.00		150	89	59.33		52	76.92
Anaesthetics	52	47	90.38		565	488	86.37		262	98.09
Cardiology	12	12	100.00		128	124	96.88		51	100.00
Cardio-thoracic surgery	1	1	100.00		20	17	85		12	100.00
Chemical Pathology	2	1	50.00		3	1	33.33		11	90.91
Child and Adolescent Psychiatry	10	5	50.00		86	49	56.98		28	82.14
Clinical Genetics	1	0	0.00		12	11	91.67		6	83.33
Clinical Neurophysiology	2	1	50.00		10	6	60		3	66.67
Clinical Oncology	20	8	40.00		101	79	78.22		40	70.00
Clinical Pharmacology and Therapeutics	0	0			13	2	15.38		7	100.00
Clinical Radiology	28	28	100.00		267	267	100		129	100.00
Combined Infection Training	13	5	38.46		64	54	84.38		42	80.95
Core Psychiatry Training	57	47	82.46		572	382	66.78		163	93.87
Core Surgical Training	47	47	100.00		629	621	98.73		94	100.00
Dermatology	8	8	100.00		44	46	104.5		26	100.00
Diagnostic neuropathology	1	1	100.00		5	4	80		2	100.00
Emergency Medicine	11	8	72.73		95	60	63.16		148	97.97
Endocrinology and Diabetes Mellitus	9	7	77.78		88	74	84.09		36	94.44
Forensic Psychiatry	4	3	75.00		52	38	73.08		15	93.33
Gastroenterology	11	11	100.00		94	94	100		41	100.00
General and Vascular Surgery	33	18	54.55		216	187	86.57		149	89.93
General Practice	430	318	73.95		4279	3599	84.11		1082	89.65
General Psychiatry	20	13	65.00		204	141	69.12		59	88.14
General Psychiatry and Medical Psychotherapy	0	0			11	8	72.73			
General Psychiatry and Old Age Psychiatry	1	1	100.00		63	34	53.97			
Genito-urinary Medicine	3	1	33.33		42	21	50		7	71.43
Geriatric Medicine	13	8	61.54		165	106	64.24		81	93.83
Haematology	9	6	66.67		103	89	86.41		46	93.48
Histopathology	15	12	80.00		104	75	72.12		55	94.55
Intensive Care Medicine	10	9	90.00		163	134	82.21		19	94.74
Medical Oncology	7	2	28.57		54	39	72.22		21	76.19
Medical Ophthalmology	1	0	0.00		4	1	25		2	50.00
Medical Psychotherapy	3	1	33.33		4	2	50		8	75.00
Metabolic Medicine	4	2	50.00		23	6	26.09			
Neurology	2	2	100.00		59	59	100		25	100.00
Neurosurgery	3	2	66.67		38	31	81.58		17	94.12
Nuclear Medicine	1	1	100.00		2	2	100		1	100.00
Obstetrics and Gynaecology	24	24	100.00		271	270	99.63		175	100.00
Occupational Medicine	4	0	0.00		10	6	60		11	63.64
Old Age Psychiatry	15	7	46.67		85	34	40		25	68.00
Ophthalmology	11	11	100.00		78	78	100		69	100.00
Oral and Maxillo-facial Surgery	1	1	100.00		44	33	75		9	100.00
Otolaryngology	8	6	75.00		69	67	97.1		38	94.74
Paediatric Cardiology	1	1	100.00		13	13	100		2	100.00
Paediatric Surgery	1	1	100.00		12	12	100		14	100.00
Paediatrics	32	31	96.88		546	469	85.9		241	99.59
Palliative Medicine	2	2	100.00		38	37	97.37		13	100.00
Plastic Surgery	0	0			33	33	100		32	100.00
Psychiatry of Learning Disability	3	1	33.33		40	13	32.5		13	84.62
Public Health Medicine	5	5	100.00		77	76	98.7		35	100.00
Rehabilitation Medicine	2	1	50.00		26	6	23.08		7	85.71
Renal Medicine	11	9	81.82		81	55	67.9		40	95.00
Respiratory Medicine	10	10	100.00		139	135	97.12		45	100.00
Rheumatology	8	6	75.00		52	48	92.31		21	90.48
Trauma and Orthopaedic Surgery	14	14	100.00		186	186	100		129	100.00
Urology	6	6	100.00		62	62	100		28	100.00
	2078	1798			20671	18374			5791	95.16

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

The role of Health & Social Care Partnerships in reducing Health Inequalities

2. Author(s) of Paper

Caroline Lamb, Chief Executive

3. Purpose of Paper

NHS Health Scotland, in consultation with partners in Health and Social Care and the voluntary sector, recently published a report setting out the role of Health and Social Care Partnerships (HSCPs) and the steps they can take in delivering services in ways which address inequalities in health outcomes and reduce the gap in health and wellbeing across Scotland.

Paul Gray (Director-General Health & Social Care and Chief Executive, NHSScotland) has asked that all NHSS Boards, in consultation with their delivery partners, agree how best to implement the practical actions identified in the report in order to reduce health inequalities across Scotland.

This paper comprises a letter from Paul Gray introducing the report and the associated NHSS Board actions and the report itself.

4. Key Issues

All NHSS Boards have a duty to contribute to reducing health inequalities as one of the National Health and Wellbeing outcomes. The establishment of the new national Public Health body in 2019, as part of the outputs of the Health and Social Care Delivery Plan, will also ensure that Public Health continues to remain a key strategic priority going forward. The Health Scotland report highlights the importance of a human rights approach to reinforce health and social integration and ensure that people are put at the centre of planning, service design and delivery decisions.

5. Educational Implications

NES has a key role in supporting the Public Health workforce in Scotland via the development of educational resources and interventions and the facilitation of leadership and management programmes.

6. Financial Implications

None identified at present. Additional resources would be needed to support any requirements for additional educational resources and interventions.

7. Which NES Strategic Objective(s) does this align to

The actions identified in this report apply to a number of our strategic objectives including a 'demonstrable impact of our work on healthcare services' (outcome 1), 'leadership and management development that enables positive change, values and behaviours' (outcome 4).

The implementation and delivery of public health priorities is one of the key outputs of the Health and Social Care Delivery Plan.

8. Recommendation(s) for Decision

The Board are asked to note the attached letter and report, and to share their views in relation to how NES can support HSCPs to reduce health inequalities; in advance of receiving a fuller report on this issue at a future Board meeting.

NES
July 2018
CL

Director-General Health & Social Care and
Chief Executive NHSScotland
Paul Gray

T: 0131-244 2790
E: dghsc@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

NHS Board Chief Executives

Copy: NHS Board Chairs

Our reference: A21018639

24 May 2018

Dear Colleague

The role of Health and Social Care Partnerships in reducing health inequalities

In my letter dated 19 June 2017 I said that NHS Health Scotland would be bringing out further guidance for Health and Social Care Partnerships.

I am delighted to welcome the publication of *The role of Health and Social Care Partnerships in reducing health inequalities*. It sets out clearly and effectively the role of Health and Social Care Partnerships (HSCPs) and the steps they can take in delivering services in ways which address inequalities in health outcomes and reduce the gap in health and wellbeing across Scotland.

I would therefore be very grateful if you and your delivery partners would agree how best to implement the practical actions identified in ways which will be effective for the people we serve. I am sure that some of this will build on actions already in hand.

You have a duty to contribute to reducing health inequalities as one of the National Health and Wellbeing outcomes. This will require the sort of leadership and momentum which is challenging to create and sustain, but is nevertheless at the heart of what we seek to achieve in addressing Scotland's health inequalities.

NHS Health Scotland, who produced this resource with partners in Health and Social Care and the voluntary sector, are happy to provide further support and guidance on the implementation of the actions.

Yours sincerely

Paul Gray

Paul Gray

NHS Health Scotland

The role of Health and Social Care Partnerships in **reducing health inequalities**

We would like to thank the following Health and Social Care Partnerships and organisations who we consulted with in the development of this resource.

Argyll & Bute Health & Social Care Partnership

Midlothian Health & Social Care Partnership

We would also like to thank Scottish Government, Scotland Excel, COSLA and the Care Inspectorate for their steer and input.

Contents

Foreword

People are living longer in Scotland. This is a success story and to be celebrated. But it also brings challenges for health and social care services as many of us are living longer in ill health. Changing needs of health and social care service users and our workforce, as outlined in the Health and Social Care Delivery Plan, mean that we all need to be clear about the standards and principles we work and adhere to. Maintaining consistently high standards through a period of substantial change is a challenge for all of us, but to the people who rely on health and social care services it is vitally important that we achieve this.

Inequalities in health outcomes across our population remain a key challenge and have a significant impact on the demands on health care and social care services. Many of the root causes of these inequalities are societal. Health and Social Care Partnerships (HSCPs) have roles in planning and empowering communities to take actions to reduce inequalities, not just through health care, but across a range of sectors.

The design of health and social care services also influences the enjoyment and protection of people's human rights, as well as the opportunity to actively participate in decision making that affects their lives. Using a human rights approach reinforces our integration aim of putting people at the centre of our decisions on planning, service design and delivery.

As HSCPs are required to produce and deliver strategic plans, they are continuously in a cycle of planning, implementing and reviewing their work. These planning, implementation and review processes provide the ideal opportunity to consider the actions to address inequalities and develop relevant measures.

This statement provides a framework of actions that HSCPs should consider when developing their strategic plans, and also aims at employees of local authorities and NHS Boards when delivering frontline services. There is signposting to tools and guidance throughout the resource which may help with some of the actions.

To build on this strategic resource, NHS Health Scotland is developing a suite of resources which will help to think about new and innovative ways of working to reduce health inequalities.

We would like to thank the HSCPs, national and local partners who helped in the development of this resource and gave us feedback, and we hope to continue building strong relationships with the HSCPs to work towards reducing health inequalities in Scotland.

We hope that this resource helps HSCPs to recognise the challenge presented by health inequalities and to take the actions necessary to address them.

Gerry McLaughlin
Chief Executive
NHS Health Scotland

Introduction

Health inequalities are the **unfair** and **avoidable** differences in people's health across social groups and between different population groups. They represent thousands of unnecessary premature deaths every year in Scotland. The gaps between those with the best and worst health and wellbeing still persist, and some are widening.[1]

Health and Social Care Partnerships (HSCPs) **have a duty to contribute to reducing heath inequalities as one of the National Health and Wellbeing outcomes**[2], and the actions in this resource help to address this outcome.

This resource strengthens the case that HSCPs, and the people working in them, have a **vital role in providing leadership and governance around reducing inequalities**.

The purpose of this resource is to **offer practical actions** of good practice as a way of considering health inequalities right from the start of developing plans and priorities.

Many of the actions suggested should be familiar and some may already be in place. These actions will be more relevant for some HSCPs than others depending on their scope and structure. The role of the Community Planning Partnership in reducing inequalities and their contribution in delivery of some of these actions is also key.

This resource is **targeted at people working within HSCPs – planners and managers** who are **well placed** to act on the practical actions while making crucial decisions about services and all employees working within HSCPs delivering frontline services.

This resource **can be used as a framework to inform strategic and local governance**. It may also help **identify gaps and actions** not considered in priorities and plans.

[1] See www.healthscotland.scot/media/1086/health-inequalities-what-are-they-how-do-we-reduce-them-mar16.pdf
[2] See www.gov.scot/Resource/0047/00470219.pdf

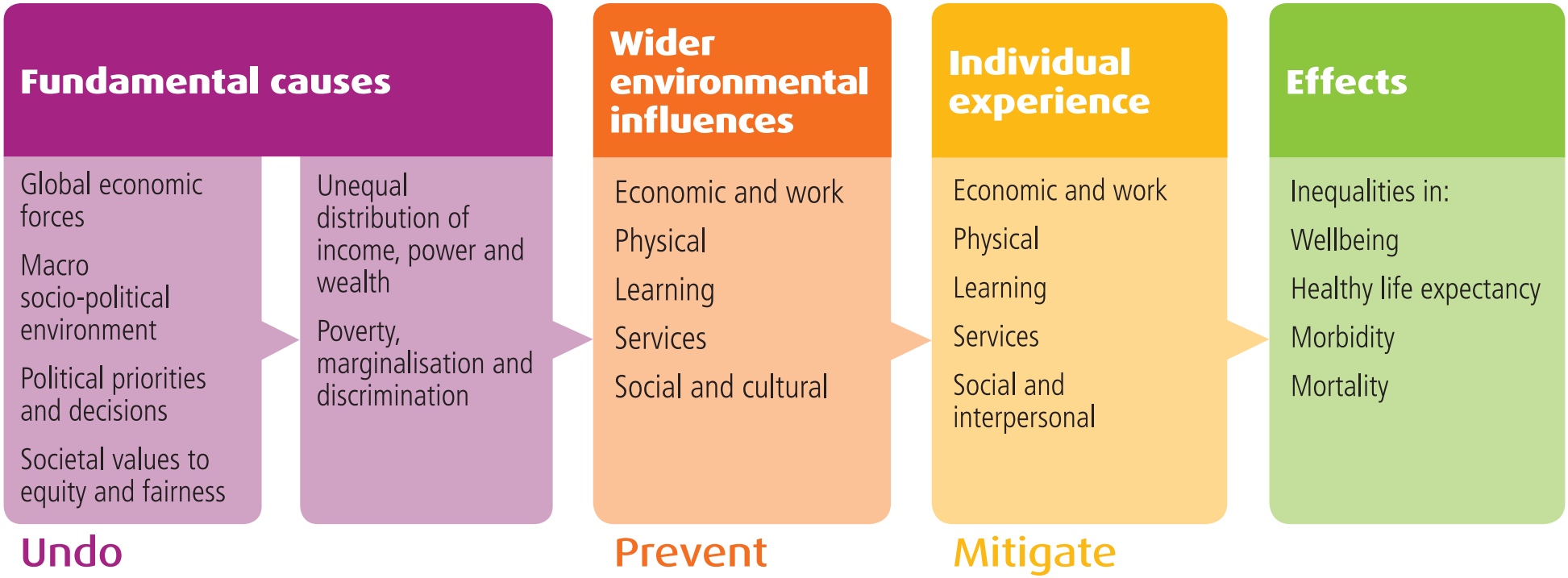
What are health inequalities?

Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. Fundamental causes of health inequalities are an unequal distribution of income, power and wealth. This can lead to poverty and marginalisation of people in society. These fundamental causes also affect the distribution of wider environmental influences on health, such as the availability of work, education and good quality housing. They can also influence access to services and social and cultural opportunities in an area. The wider environment where people live and work then shapes their individual experiences of low income, poor housing, discrimination and access to health services[3].

There is ample opportunity to lead, advocate and influence on reducing health inequalities, albeit some of these fundamental causes may be driven by agencies outwith the control of the Health and Social Care Partnerships. This resource highlights some of the practical actions that could help to reduce health inequalities.

The diagram below illustrates the fundamental causes leading to the influences and experiences they can cause.

Figure 1: Health inequalities: theory of causation



[3] See www.healthscotland.scot/media/1086/health-inequalities-what-are-they-how-do-we-reduce-them-mar16.pdf

Tackling health inequalities requires a blend of action to **undo** the fundamental causes, **prevent** the harmful wider environmental influences and **mitigate** (make less harmful) the negative impact on individuals. Action must be based on evidence of need, understanding of barriers to social opportunities and what is most likely to work.[4]

To prevent environmental factors causing health inequalities, action is needed to ensure equity in the distribution of, for example, good work, high quality and accessible education and public services. People with high levels of need benefit most from preventative services, highlighting the need to invest in community development and community capacity building, as this has long-term impacts on individuals' skills, health and resilience.

[4] Macintyre S. *Inequalities in health in Scotland: What are they and what can we do about them?* Glasgow: MRC Social & Public Health Sciences Unit; 2007.

Acknowledging the challenges and embracing opportunities for prevention

There is a challenge for integration in balancing the increasing demand from demographic changes, the pressure on the existing system and the provision of care and treatment. This is set against the immediate need to find new and improved ways of delivering services as well as increasing opportunities for cost saving.

Health and Social Care Partnerships often find themselves responding to their financial pressures by concentrating services on people assessed as critical or at substantial risk, at the expense of upstream, preventative action. However, a lack of prevention can lead to increased demand on those frontline services under pressure.

Through effective collaboration, Health and Social Care Partnerships have the opportunity to make services universally available and accessible to all people, in proportion to their need, which will help to address the inequalities gap and improve the health of the whole population.

At strategic level, proportionate universalism might involve provision of higher numbers of community addictions support workers, or health visitors in areas of higher deprivation. At the operational level the approach might involve staff undertaking a more targeted promotion and follow-up of vulnerable patients for immunisation, screening or primary/secondary prevention. **Community Planning Partnerships** also have a key role in prevention.

Planning for and investing in preventative action can have a positive impact on improving health and reducing health inequalities, while managing the increasing demand for services and a reduction in spend. This investment in prevention does require resources, but can reduce public spending pressures by:

- reducing the length of time people spend in ill health
- preventing ill health and high rates of crisis management
- reducing the demands for public services
- freeing up resources for other uses.

Practical actions to help reduce health inequalities

This section focuses on six themes which can help strengthen the contribution to reducing health inequalities, founded on international evidence[5] and drawn from local practice. The actions included in the following tables will apply and interface between Health and Social Care Partnerships (HSCPs), NHS Boards and Local Authorities (LAs).

1 Quality services with allocation of resources proportionate to need

2 Training the workforce to understand their role in reducing inequalities

3 Effective partnership across sectors to help reduce health inequalities

4 Mitigation of inequalities through employment processes

5 Mitigation of inequalities through procurement and commissioning process

6 Leadership and advocating to reduce health inequalities

[5] See www.local.gov.uk/marmot-review-report-fair-society-healthy-lives

1. Quality services with allocation of resources proportionate to need

Allocating services in proportion to need and understanding the nature of need within the communities is crucial for Health and Social Care Partnerships (HSCPs) and vital for reducing health inequalities. Better value means more than just living within our means; it means improving outcomes by delivering value from all our resources. It is not just about increasing the efficiency of what we currently do, but also innovating and redesigning services to deliver outcomes in different and more effective ways.

HSCPs could consider using data and service user experience and outcomes to inform decisions about the allocation of funding to tackle health inequalities. This includes making decisions about spending money on prevention to reap benefits at a later date.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Quality services with allocation of resources proportionate to need. • Health and social care services are planned and delivered in proportion to need. • Inequities in access, outcomes and the experience of care are accounted for and addressed.	• Undertake **health inequalities/equalities/human rights impact assessment** with new policies, plans and investment decisions. • **Understand the health of your population** and the factors that shape it. • **Understand the impact** of inequalities on service users and demand on services through the use of available data and feedback and comments from service users, their families and local community. • Ensure **meaningful and effective engagement with community**, individuals and individual service users to understand community needs and to inform the development and implementation of strategic plans. Influencing and having conversations with the wider community about inequalities. • Consider that access to goods and services can depend on where service users live, and the impact on inequalities has to be considered – for example the impact on those who live in the islands or remote areas, or access needs of people who are homeless. • Use the **Place Standard Tool** which helps find those aspects of a place that need to be targeted to improve people's health, wellbeing and quality of life	Integration chief officers Chief social work officers Heads of services and planning Public health and inequalities leads Health intelligence Service and clinical managers Third sector Communities

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
	• Set up a risk assessment process to identify service users at risk of vulnerability – for example routine questions at initial discussions with service users. • Have governance arrangements in place to check progress and actions to address inequalities. • Provide and refer to welfare and money, employability and home energy advice, through working in partnership with relevant agencies such as Citizens Advice Bureau. • Provide appropriate and relevant support, including the use of technology, for people to engage meaningfully in planning services. • If in the scope of the partnership, link the planning with the planning duties under the Children's and Young People (Scotland) Act, which requires partners to focus on early intervention.	

2. Training the workforce to understand their role in reducing inequalities

Evolving health and social care services must also be rooted in a widespread culture of improvement. It is vital to support the people working within Health and Social Care Partnerships (HSCPs) to consider building upon their existing knowledge and skill sets to deliver services that help reduce health inequalities, enabling them to respond to the social and economic circumstances affecting an individual's health, recovery and circumstance. Local Authorities (LAs) and NHS Boards have a major role to play in considering social issues and looking at the wider determinants in order to improve health.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Training people working within HSCPs to understand and help reduce health inequalities. • People working in HSCPs have the knowledge and skills to design and deliver services that are sensitive to inequalities.	• Support all people working within the HSCPs, including independent and voluntary sector, to increase knowledge and skills in: - reducing health inequalities, including cultural competence, human rights, equality and diversity such as **NHS Health Scotland's VLE** and **Public Health Intelligence Training Course**. - building knowledge, understanding, skills and confidence in service users to use health information, to be active partners in their care, and to navigate health and social care systems. This is known as **health literacy**. - embedding inequalities sensitive practice and risk assessment, for example, taking into account issues such as broader social history, financial inclusion, gender-based violence, homelessness support, carer responsibilities, and fuel poverty. • Use innovative ways to get messages across to employees about inequalities, for example via the **power animation developed by NHS Health Scotland**. • Support employees to join networks to increase knowledge in health inequalities. • Support employee development and confidence in contributing to the reduction of health inequalities via existing personal development performance (PDP) and appraisal systems. • **Support people** working in HSCPs to have increased knowledge in public health, and help demonstrate where their skills align with the **Public Health Knowledge and Skills Framework**.	Organisational development Human resources and workforce Equality and diversity leads Public health and health inequalities leads Quality improvement leads Volunteer services managers

More suggestions for information/tools and training for the workforce are at the end of this resource.

3. Effective partnership across sectors to help reduce health inequalities

Health and Social Care Partnerships (HSCPs) cannot tackle health inequalities by working on their own. It is often the health services, local government and/or HSCPs who fund the third sector to deliver local services, and are often best placed to respond to frontline service users. Many third sector organisations have specialist knowledge and skills that could help reduce inequalities much more efficiently. In addition, strong relationships with Community Planning Partnerships are a prime opportunity for ensuring that reducing health inequalities is a shared objective.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Effective partnership with different sectors to help reduce health inequalities. • Strategic plans could support action to address the fundamental and environmental causes of health inequalities by working in partnership with the third sector, and strengthening community engagement and empowerment.	• Ensure there are aims to reduce inequalities in strategic plans, and ensure these are not only aspirational but deliverable through integrated structures. • Mainstream inequalities in development plans, as well as in separate equality and diversity plans, with specific actions, leadership and accountability for particular population groups. • Make clear links from evidence on inequalities with aims and actions in priorities and plans. • Ensure plans reflect effective partnerships with a range of community and third sector organisations for their implementation, such as local housing and welfare rights associations to help those most vulnerable in the community. • Ensure **meaningful and effective engagement** with community individuals and individual service users to understand that community needs to inform the development and implementation of strategic plans. • **Measure and report on the impact** of reducing inequalities for local people and communities as required for the **National Health and Wellbeing Outcomes**.	Integration chief officers Chief social work officers Heads of planning and service Health intelligence Community Planning Partnerships Local improvement support team analysts allocated to each HSCP Third sector Communities

4. Mitigation of inequalities through employment processes

Everyone Matters: 2020 Workforce Vision sets out the health and social care workforce policy for Scotland. The Health and Social Care Partnerships (HSCPs) are not employers themselves, and so the following 'employment' actions are aimed at the Local Authorities (LAs) and NHS Boards working within the partnerships.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Mitigation of inequalities through employment processes. • Mitigating and preventing the impact of inequality is integrated within employment policy and practice.	• Ensure effective governance and monitoring is in place to support the right of an individual employee to the best attainable health by implementing a workforce and **health (including mental health) and wellbeing** strategy. • Ensure the dimensions of the **Fair Work Framework** are embedded into organisation policies, practices and procedures. • Commit to paying, and build on existing commitments to, the **Scottish Living Wage**. • Ensure fair recruitment policy embeds practice to reduce health inequalities. • Support a diverse composition of workforce that reflects the communities they serve, and regularly monitor the workforce composition. • Enhance opportunities within the workforce for young people and vulnerable individuals to progress within the health and social care workforce structures. • Monitor employment processes and ensure that practices, such as flexibility and access to workforce development, are fair and equitable. • Ensure a sustainable workforce planning process that supports progression of existing staff, and creates opportunities to enter the health and social care workforce. • Ensure employees have opportunities to enhance qualifications, skill sets and competence. Provide targeted employment opportunities for vulnerable citizens within the community such as young carers and those with additional needs.	Integration chief officer Heads of service Human resources Workforce leads Trade unions Partnership bodies

5. Mitigation of inequalities through procurement and commissioning processes

Health and Social Care Partnerships (HSCPs) should ensure the strategic commissioning process is equitable and transparent, and is undertaken in partnership with stakeholders via an ongoing collaboration with people who use services, their unpaid carers and providers. This principle needs to be applied when services are delivered on behalf of the HSCP by a partner organisation.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Mitigation of inequalities through procurement and commissioning processes. • Mitigating and preventing the impact of inequality is integrated within procurement policy and practice.	• Embed **community benefit clauses** in procurement activity to strengthen community cohesion, health and wellbeing. • Encourage payment of the Scottish living wage through innovative procurement practice and transparent assessment of the cost of care provision. • Commissioning and procurement processes, undertaken directly or on behalf of HSCP, incorporate good work principles, ensuring the workforce across HSCP commissioned services, and supply chain, benefits from the same employment standards at work as the HSCP partner organisations. • Ensure commissioning and procurement processes undertaken directly or on behalf of the HSCP measure and score impact on inequalities and have monitoring systems in place to ensure the contribution to addressing health inequalities is realised. • Embed good procurement practice through adherence to the guidance on the procurement of care and support services. Ensure support for local SMEs, third sector, supported businesses and the independent sector to compete in public commissioning and procurement processes to enhance local economic benefits. • Ensure capital investment decisions and procurement undertaken on behalf of the HSCP both consider the impact on communities and contribute to reducing inequalities.	Integration chief officer Heads of planning and commissioning Procurement leads Commissioning leads

6. Leadership and advocating to reduce health inequalities

Health and Social Care Partnerships (HSCPs) have an important role in advocating for action at national and local level to address health inequalities. This means advocating for fairer policy and fairer planning when engaging with chief officers, elected members, non-executives, heads of planning as well as policymakers at community planning levels. This sort of leadership and momentum is challenging to create and sustain, but it is at the heart of the Christie recommendations.[6]

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Advocating to reduce health inequalities. • Integration authorities, elected members and other senior managers actively advocate for action on inequalities in partnership with local authorities, Community Planning Partnerships, the third sector and others in their community.	• Discuss what role and steps could be taken for HSCPs to contribute to reducing health inequalities, and agree how this can be monitored. • Advocate at partnership and policy level for fair and equitable access to services. • Advocate for and highlight the key opportunities that address inequalities in health, such as routine payment of at least Scottish living wage, and Fair Work Framework principles. • Advocate for planning policies that deliver positive place making, particularly for communities with high levels of need. • Advocate for economic policies that are most likely to support fair, high quality employment. • Support partners to use socioeconomic impact assessments and other approaches to ensure their plans and policies support people with highest levels of need. • Chief officers and elected members constructively advocate for policy change at a national level on inequalities.	Integration chief officers Chief social work officers Elected members Non-executives Councillors[7] Heads of services Commissioning Planning Heads of strategy Third sector partners

[6] See www.gov.scot/Publications/2011/06/27154527/0
[7] See www.improvementservice.org.uk/documents/em_briefing_notes/em-briefing-health-inequalities.pdf

Key policies and drivers strengthening the role of Health and Social Care Partnerships in reducing health inequalities

- Public Bodies (Joint Working) (Scotland) Act 2014 provided the legislative framework for the integration of health and social care service in Scotland.
- The Equality Act (2010) underpins all of the work that HSCPs and Health Boards and councils do. In its simplest form the general duty is about taking a person-centred preventative approach to the delivery and planning of our services.
- The 2020 Vision for Health and Social Care describes actions on how health and social care can strengthen its role in preventing and reducing health inequalities through its opportunity of an integrated system.
- The Health and Social Care Delivery Plan (2016) recognises the vital contribution health and social care integration plays to reduce health inequalities.
- HSCPs' strategic plans are an opportunity to embed actions and governance which help to reduce inequalities.
- National Health and Wellbeing Outcomes are strategic statements which HSCPs aim to achieve. Strategic commissioning plans are based on these outcomes and Outcome 5 asks HSCPs to demonstrate how their services can contribute to the reduction of health inequalities.
- Socioeconomic duty will be introduced by Scottish Government, where public bodies like local councils and NHS Boards will have to think carefully about how to reduce poverty and inequality whenever they make big decisions that are important to all of us.
- The Community Empowerment (Scotland) Act 2015 aims to raise the level of ambition for community planning, which has ample opportunity to embed actions to help reduce health inequalities. Community planning has strong connections with HSCPs and will often involve people working across the two planning structures.
- Children and Young People Scotland Act (2014) (part 9) places responsibilities on local authorities and their partners to improve outcomes for looked after children. A focus on health outcomes is explicit.
- Scotland's Mental Health Strategy (2017–27) is a 10-year vision describing the link between social inequalities and poor mental health.
- National Health and Social Care Workforce Plan (due end of 2017) aims to ensure health and social care staff are resourced to be better targeted, aligning demand and supply to ensure people get the right support at the right time, which has the opportunity to look at inequalities and services proportionate to need.

- National health and social care standards (2017) take a human-rights based approach to ensure everyone in Scotland receives the same high quality care no matter where they live. One of the principles is ‘equality and diversity’.

- Social Care (Self-directed Support) (Scotland) Act (2014) places a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their support.

Support

Below is a list of where to go for support to help with the practical actions outlined in this resource.

Organisations

- **NHS Health Scotland's tools and resources**
- **Scottish Human Rights Commission**
- **Health and Social Care ALLIANCE (Scotland)**
- **I Hub – Supporting health and social care**
- **Community Planning in Scotland Portal**
- **The national improvement service for local government in Scotland**
- **Glasgow Centre for Population Health**
- **Information Services Division**
- **The King's Fund**

Workforce training and networks

- NHS Health Scotland's **Virtual Learning Environment**: e-modules on 'health inequalities aimed at health and social care staff'
- NHS Health Scotland: **Scottish Health and Inequalities Impact Assessment Network**
- University of Dundee: **Tackling inequalities through health and social care design**
- Royal College of Physicians: **Introduction to the Social Determinants of health**
- ScotPHO: **Public Health Information Network**

- Glasgow University: **Health Economics and Health Technology Assessment**
- Scottish Health Council: **Participation Tooklit**
- Scottish Community Development Centre: **Communities Matter**

Staff health and wellbeing

- **Healthy Working Lives** Adviceline: 0800 019 2211

Measuring data on health inequalities

- NHS Health Scotland: **Public Health Data**
- Each Health and Social Care Partnership will have a Local Improvement Support Team who can help with data and measuring performance

Additional papers to read

- Public Health England: **Reducing health inequalities: system, scale and sustainability**
- UCL Institute of Health Equity, Department of Epidemiology and Public Health, University College London: **Working for Health Equity: The Role of Health Professionals**
- Audit Scotland: **Health and Social Care Integration**
- Scottish Parliament: **Integration Authorities' Engagement with Stakeholders**
- Scottish Health Council: **Evaluation Participation: A guide and toolkit for health and social care practitioners**
- NHS Health Scotland: **Maximising the role of NHS Scotland in reducing health inequalities**

Further information

We hope you find this publication useful and use it to further develop your understanding of the role of Health and Social Care Partnerships in contributing to reducing health inequalities. If you would like any advice or further information please contact:

Lorna Renwick
Organisational Lead – NHS team, NHS Health Scotland
lornarenwick@nhs.net

Arma Sayed-Rafiq
Senior Health Improvement Officer – NHS team, NHS Health Scotland
arma.sayed-rafiq@nhs.net

This publication is aimed at people working in Health and Social Care Partnerships (HSCPs). It describes practical actions as a way of considering health inequalities at the beginning when developing plans and priorities.

This resource may also be made available on request in the following formats:

0131 314 5300

nhs.healthscotland-alternativeformats@nhs.net

Corporate member of Plain English Campaign
Committed to clearer communication
489

EFQM
Recognised for excellence
3 star - 2016

We are a Living Wage Employer

Published by NHS Health Scotland

1 South Gyle Crescent
Edinburgh EH12 9EB

www.healthscotland.scot @NHS_HS nhshealthscotland

6218 4/2018

NHS Education for Scotland

FEEDBACK, COMMENTS, CONCERNS AND COMPLAINTS

ANNUAL REPORT 2017-18

CLICK ANYWHERE TO CONTINUE

We are a national special NHS Board responsible for education, training and workforce development for those who work in and with NHSScotland.

The summary table below precedes the full report and provides brief details of the complaints we received between 1 April 2017 and 31 March 2018, plus other feedback, comments and concerns.

The full report provides more detailed information on feedback, comments, concerns and complaints we received during 2017-18.

SUMMARY OF COMPLAINTS RECEIVED AND OUTCOME 2017-18

Subject of complaint	Outcome of complaint
Complaint (1) about online pharmacy guidance	All online media not intentionally linked to NES webpages have been removed. ***Upheld***
Complaint (2) about graphics on course materials.	Incorrect graphic replaced with geographically correct graphic. ***Upheld***
Complaint (3) about experience as a dental trainer.	Dental to review their guidance on external longitudinal evaluation of practice (LEPs) and how that guidance is communicated to trainers. ***Upheld***
Complaint (4) about access to training.	No recommendations made. ***Outwith period for investigation***
Complaint (5) about access to training.	Training delivered by NES (or NES staff) should clearly state eligibility criteria. ***Not upheld***

Subject of complaint	Outcome of complaint
Complaint (6) dental trainer unhappy about their experience.	Apology given and improvements to communication and processes made. ***Partially upheld***
Complaint (7) dental practitioner unhappy about the organisation of a study day.	Apology given and learning hours clarified. ***Resolved at frontline, upheld***
Complaint (8) NHS staff member unable to print certificate and unhappy with response.	Apology given and problem resolved. ***Resolved at frontline, upheld***
Complaint (9) NHS staff member unhappy about automated email mistake and lack of apology.	Apology given and mistake rectified. No further action needed. ***Resolved at frontline, upheld***
Feedback (1) about medical trainer unhappy about their experience.	Not applicable – feedback only

CONTENTS

INTRODUCTION

Welcome to our annual report on feedback, comments, concerns and complaints for 2016-17. By gathering feedback and comments, listening to concerns and dealing with complaints we routinely capture the views of staff, trainees, stakeholders and partner organisations.

This is important because it helps us to establish what matters to our stakeholders and how we can improve our educational products and services for staff and trainees across health and social care.

1 OUR PROCESSES FOR ENCOURAGING AND GATHERING FEEDBACK

We plan and deliver our activities and targets in partnership with a wide range of stakeholders and gather feedback from trainees and learners through our various educational governance processes. This approach focuses on getting it right, making it better, sharing good practice and providing assurance that our education and training is of high quality, makes a difference and is well managed.

We use a *Contact Us* page on our website to provide an online form for feedback (positive or negative) about any aspect of our work. Further information, including examples of these processes and how we use feedback is provided below.

1.1 OUR APPROACH TO GATHERING AND IMPLEMENTING FEEDBACK

We work in partnership with a wide range of organisations and individuals throughout the lifecycle of our education initiatives. This begins with engagement with the Scottish Government, employers, learners, professional bodies, third sector organisations and others to identify the most important educational priorities. This engagement is essential in enabling us to identify required learning content, understand preferred learning styles and identify potential barriers to access or knowledge and skills acquisition.

Our stakeholders play an important part in the review and improvement of education initiatives by providing informed feedback and expert advice. The development, commissioning or quality management of education and training is informed by stakeholder participation in consultation exercises, focus groups, reference groups, steering groups, programme boards, and the valuable feedback we elicit from learners, Health Boards and others. There are several examples where service users or learners participate in the ongoing review and enhancement of our programmes such as the Family Nurse Partnership.

CASE STUDY

SHAPING THE FAMILY NURSE PARTNERSHIP

The Family Nurse Partnership (FNP) is a preventive, licenced, early-intervention programme offered to young, first-time mothers. It is based on the principles of developing self-efficacy, promoting human ecology and attachment. The Programme begins in early pregnancy and is oriented to the future health and well-being of the child. The Family Nurses who facilitate the Programme receive specialist training from NES to equip them for the new role.

During the year we updated the FNP documentation used in home visits where Family Nurse Practitioners are accompanied by a supervisor to support programme implementation. Feedback is requested from the client about the impact of the programme on their life course. The updated documentation makes it easier for the nurse and supervisor to use client feedback in tailoring the support provided, and shaping the educational agenda.

1.2 OUR EDUCATIONAL GOVERNANCE PROCESSES

Our Educational Governance arrangements, a characteristic feature of the organisation, are designed to ensure that the quality of our education activities is managed effectively and continuously improved. This involves the application of quality assurance and quality control processes and the sharing of information at local, directorate and corporate levels. Our Educational and Research Governance Committee (E&RGC) is responsible to the NES Board for scrutiny of our processes and how they are applied.

A key focus for our Educational Governance monitoring processes is the engagement of programme teams with partner organisations, health and care staff, trainees, service users and third sector organisations. In reviewing these relationships, our executive management and Board seeks assurance that our activities are aligned with service needs (including those of patients) and learner preferences. We also consider the methods used to elicit feedback from trainees and other learners, and the responsiveness of teams to comment and concerns.

1.3 INVOLVING OUR STAKEHOLDERS IN OUR EDUCATIONAL ACTIVITIES

We have a range of mechanisms in place to ensure we actively involve stakeholders in the development of our educational and training activities. The following are a selection of examples illustrating our work in this area.

CASE STUDY 1 LAY MEMBER INVOLVEMENT IN CORE AND SPECIALTY DENTAL TRAINING

NES controls the number of training places available for dentists in Scotland, co-ordinates this training and funds the salaries of the trainees. Following the successful completion of undergraduate education and Foundation training, NES recruits aspiring dentists to Core and Specialty programmes, which we quality manage on behalf of the Scottish Government.

One of our key roles in Core and Specialty Dental training is to support the Annual Review of Competence Progression (ARCP) for Dentists. We have recruited lay people as full members of our ARCP panels following nominations from patient groups, or through previous involvement in our work or that of other healthcare organisations (e.g. Healthcare Improvement Scotland). These lay people will conduct interviews with trainees not deemed to be engaging with their programme, or who raise other concerns. The lay interviewer will produce an Interim Review of Core Progression report, leading to action points, which are monitored by the trainee's Education Supervisor and the NES Training Adviser.

This process, based on published Guidelines and Standards for Dentistry, is valued as an independent, external check.

CASE STUDY 2

COLLABORATIVE LEADERSHIP IN PRACTICE

The Collaborative Leadership in Practice (CLiP) initiative offers tailored support to teams of health and social care professionals who are working together, (or who are planning collaboration) in localities, clusters or Health and Social Care Partnerships to integrate services. We work with each team over a period of about eight months using action inquiry (learning by doing), which means that the programme becomes a part of the locality work the team is immersed in, not separate from it. With coaching and facilitation support, teams explore and test new ways of thinking and acting that improve both the quality of the relationships, and the outcomes through the transformation of services.

A key feature of the programme has been the locality teams' meetings with their local community to identify issues, needs, priorities and preferences. The consultative meetings were designed to identify the most urgent priorities for service improvement/reconfiguration. Meetings take the form of large-scale open-space events based on a key question; for example, one open-space event looked at improving the life experience of house-bound patients.

Although the CLiP project is currently being evaluated, a number of positive outcomes have already been reported including the following:

- Changes to prescribing practices, efficiencies in pharmacy and home care and enhanced patient safety.

- Commitment to multi-disciplinary assessments with better outcomes for service users and carers.
- Greater confidence amongst GPs and other practitioners in talking to patients and referring them to other services, including non-clinical services.
- Greater knowledge of local services and resources amongst professionals, clarity of referral routes, greater sharing of practical information and consistency of approach in a locality.
- Better information about services for patients and carers.
- Better support for housebound patients with long-term conditions in the community who are socially isolated.
- Quicker response times for patients.
- Better deployment of community resources rather than acute admission.

CASE STUDY 3

PALLIATIVE AND END OF LIFE CARE FRAMEWORK

NES NMAHP, in partnership with the Scottish Social Services Council co-produced a Palliative and End of Life Care (PELC) Framework[1], promoting a consistent, inclusive and flexible approach to learning and development in this area for the health and social service workforce. During the development of the Framework we consulted with various stakeholders from different sectors, including members of our Education Advisory Group, this included representatives from the Marie Curie Voices Group, and the Coalition of Carers.

The development of the Framework, associated learning resources and wider implementation has been informed by analysis of Care Opinion[2] data on real life experiences of palliative and end of life care.

[1] https://learn.nes.nhs.scot/2450/palliative-and-end-of-life-care-enriching-and-improving-experience

[2] The website used by patients to provide feedback on their health and care experiences www.careopinion.org.uk

1.4 EQUALITY AND DIVERSITY

We actively collect feedback on equality, diversity and inclusion, at directorate level through a variety of mechanisms, including engagement with stakeholder groups, educational delivery and participation in project steering groups. The findings are reviewed by the *Participation, Equality and Diversity Lead Network* (PEDLN), which comprises senior representatives from each of our directorates, as part of an annual review of performance. Findings are used to identify priorities for action, including operational planning targets and longer-term equality strategy.

The case studies throughout this report illustrate how we engage with diverse stakeholders when developing our educational programmes and resources. The extent and impact of the diversity of this engagement is a focus of the PEDLN meetings and reviews, which seek to share intelligence and learning from programme and directorate-level feedback and engagement.

Our complaints log enables us to code complaints and concerns thematically as being relevant to equality and diversity at both directorate and corporate level. Complaints and concerns are reviewed annually by PEDLN within the context of our equalities review, providing another source of data which can be triangulated to inform policy and strategy development and to measure our progress delivering our equality outcomes and equality mainstreaming priorities.

The PEDLN meetings also provide a forum to share the outcomes of feedback on equality, diversity and inclusion undertaken at directorate level, to discuss the implications for other professional groups, share good practice and to inform specific projects.

Examples include:

- Sharing learning from a pilot programme to reduce differential attainment for International Medical Graduates and Black and Minority trainees in postgraduate medical training, which has been informed by engagement with educational supervisors and trainees;

- A review of barriers and enablers to inclusion for disabled trainees, which has informed ongoing work to establish a reasonable adjustments passport;

- Discussion of feedback on accessibility issues with digital platforms, ways to improve accessibility and learning points.

We have an Inclusive Education and Learning Policy which sets out the expectations for embedding equality and diversity in educational work and encourages the use of feedback for improvement, particularly feedback on accessibility. The policy covers all aspects of learning. Implementation of the policy is monitored through the Educational Governance process, which includes a focus on educational inclusion and feedback from learners.

2 ENCOURAGING AND HANDLING COMPLAINTS

We encourage and handle complaints directly through our Educational Governance processes and training programme feedback channels. Our Contact Us digital form is available for those wishing to express a concern or make a formal complaint.

During 2017-18 we enhanced our arrangements for complaints handling to ensure compliance with the *NHSScotland Complaints Handling Procedure* that came into force on 1 April 2017. This included putting in place a method for capturing feedback from complainants on their satisfaction with our processes and how we can make further improvements. The Scottish Public Services Ombudsman subsequently conducted a compliance assessment of NES's Complaints Handling Policy. This confirmed that our arrangements met their requirements, subject to minor amendment of information about our processes on the NES website.

Through our Educational Governance processes, we have in-built local appeals or complaints processes e.g. in foundation and speciality training in medicine and dentistry. In line with our educational support role as a Special Health Board we do not normally receive a high number of complaints and a detailed breakdown for 2017-18 is provided in the *Feedback, Comments, Concerns and Complaints Register* below. A total of nine complaints were handled through our formal complaints process in 2017-18, with one further item of critical feedback also being investigated. There were 10 complaints formally investigated in 2016-17.

In line with the requirements of the NHSScotland Complaints Handling Procedure, we have learned from the complaints received during the year to enhance our work.

This is reflected in the table at 2.1 below, which details some of the specific improvements resulting from the complaints we have investigated.

2.1 FEEDBACK, COMMENTS, CONCERNS AND COMPLAINTS REGISTER - YEAR TO 31 MARCH 2018

Source (1)	Summary (2)	File Ref (3)	Is complaint suitable for frontline resolution?	Receipt Date	Acknowledged (A) and Response (R) Dates	Outcome (4)	Was complainant satisfied with frontline resolution?	Lessons learned/ Improvements (5)
Member of public	***Complaint (1)*** about online pharmacy guidance	Pharmacy April 2017	**yes**	01/04/17	A - 05/04/17 R - 07/04/17	Upheld	**yes**	All online media not intentionally linked to NES webpages have been removed.
Staff (other NHS)	***Complaint (2)*** about graphics on course materials.	NES course materials April 2017	**yes**	15/04/17	A - 21/04/17 R - 24/04/17	Upheld	**yes**	Incorrect graphic replaced with geographically correct graphic.
Staff (other NHS)	***Complaint (3)*** about experience as a dental trainer.	May 2017 Dental	**no**	21/04/17	A - 02/05/17 R – 11/05/17	Upheld	**n/a**	Dental to review their guidance on external longitudinal evaluation of practice (LEPs) and how that guidance is communicated to trainers.

Source (1)	Summary (2)	File Ref (3)	Is complaint suitable for frontline resolution?	Receipt Date	Acknowledged (A) and Response (R) Dates	Outcome (4)	Was complainant satisfied with frontline resolution?	Lessons learned/ Improvements (5)
Member of public	***Complaint (4)*** about access to training.	November 2017 historic medical	**no**	07/11/17	A - 07/11/17 R – 07/11/17	Well outwith complaint timescale of 12 months.	**n/a**	n/a
Staff (other NHS)	***Complaint (5)*** about access to training.	November 2017 medical training event	**yes**	21/11/17	A - 21/11/17 R - 27/11/17	Not Upheld	**no**	Training delivered by NES (or NES staff) should clearly state eligibility criteria.
Staff (other NHS)	***Complaint (6)*** dental trainer unhappy about their experience.	Dental February 2018	**yes**	31/01/18	A - 01/02/18 R – 29/03/18	Partially upheld	**yes**	Apology given and improvements made to communication and processes.
Staff (other NHS)	***Complaint (7)*** dental practitioner unhappy about the organisation of a study day	March 2018 Dental training	**yes**	13/03/18	A – 13/03/18 R – 14/03/18	Resolved at front line and upheld	**yes**	Apology given and learning hours clarified.

Source (1)	Summary (2)	File Ref (3)	Is complaint suitable for frontline resolution?	Receipt Date	Acknowledged (A) and Response (R) Dates	Outcome (4)	Was complainant satisfied with frontline resolution?	Lessons learned/ Improvements (5)
Staff (other NHS)	***Complaint (8)*** pharmacist having difficulty obtaining/ printing evidence of certification	Pharmacy/ Digital 2018	**yes**	10/01/18	A – 10/01/18 R – 15/01/18	Resolved at front line and upheld	**yes**	Apology given and issue resolved
Staff (other NHS)	***Complaints (9)*** NHS staff member unhappy about automated email mistake and lack of apology	March 2018 Human Factors Course	**yes**	21/03/18	A – 21/03/18 R – 21/03/18	Resolved at front line and upheld	**yes**	Apology given and mistake rectified
Staff (other NHS)	***Feedback (1)*** about medical trainer unhappy about their experience.	Medical west February 2018	**yes**	25/02/18	A - 26/02/18 R – 06/04/18	Resolved at front line	**unknown**	Individual thanked for their feedback and a full response to the points raised was given.

NHS NATIONAL SERVICES SCOTLAND (NSS) GUIDANCE NOTES:

(1) Source:	**Indicate the status of the person e.g. "FYI Trainee", "External Contractors", "Educational Institution", "and Professional Organisation". For the purposes of logging, returns should be anonymous with the proviso that further information may be sought as necessary.**
(2) Summary:	**Provide a brief outline covering the core substance of the feedback indicating whether it is a comment, a concern or a complaint.**
(3) File Reference:	**Use your local identifier such that each case can be found as necessary.**
(4) Outcome:	**Indicate current status if the issue has not been resolved, or indicate, in the case of complaints, whether it has been upheld, partially upheld or rejected and the grounds for that outcome.**
(5) Improvements:	**Outline learning opportunities or improvements identified as a result of issue raised, either locally or corporately.**

3 THE CULTURE, INCLUDING STAFF TRAINING AND DEVELOPMENT

One of our key workforce priorities is creating and sustaining a healthy organisational culture which values openness, honesty and responsibility. Through our ways of working we encourage our staff to be open, to listen and learn and to take responsibility and lead by example. This applies to how we respond to feedback, comments concerns and complaints and as outlined in Section 2, during 2017-18 the corporate complaints team and each directorate's complaints lead have worked to ensure that we are compliant with the *NHSScotland Complaints Handling Procedure* that came into effect 1 April 2017. This included encouraging ongoing training across all staff involved in handling complaints throughout the organisation, particularly around the new *Complaints Handling Procedure.* The corporate Complaints Handling Team has participated in complaints investigation training, with all members achieving the BTEC Complaints Handling and Investigation award.

During 2017-18 we have supported NHS Boards with the implementation of the new model Complaints Handling Procedure. We have worked with Healthcare Improvement Scotland, Scottish Social Services Council, Care Inspectorate, Scottish Public Services Ombudsman and Scottish Government to provide a comprehensive range of training and education which enabled staff from across health, social care and social work to share learning and good practice in complaints handling at four national events. The events enabled participants to understand the new model Complaints Handling Procedure and work together on case studies to identify common shared learning across sectors.

The events were oversubscribed and were attended by over 850 staff with over 2200 applicants for places. As well as the events, we continued to promote e-learning modules across NHSScotland.

In addition to the partnership working outlined above, the e-learning modules have been used by Defence Medical Services (DMS) to support implementation of a new approach to complaints handling across their service. We have provided strategic and operational support to DMS to enable them to implement a more person-centred approach to complaints handling in line with the approach taken by NHSScotland. A workshop was provided for DMS attended by 63 multi-disciplinary staff including civilian and military personnel. We continue to provide this support to DMS as they embark on this new challenge with further workshops planned for 2018/19.

4 IMPROVEMENTS TO SERVICES

We gather feedback through educational surveys, evaluation and impact assessment (as documented above). This data is held by our directorates in a variety of formats and systems. The section below provides examples of improvements made as a result of our feedback and educational governance processes in addition to improvements resulting from feedback, comments, concerns and complaints reported to our directorates or received directly by our corporate complaints team.

4.1 EDUCATION AND TRAINING PROGRAMMES

CASE STUDY 1

LAY REPRESENTATIVE INVOLVEMENT IN THE QUALITY MANAGEMENT OF POSTGRADUATE MEDICAL EDUCATION

We have a well-established group of lay representatives to assist us with various quality management activities relating to postgraduate medical education and training. They are impartial individuals without a medical background who have a fundamental role of ensuring transparency and adherence to due process.

The lay representatives bring an additional level of independent scrutiny to our quality management processes. This helps us meet requirements stipulated by both the Conference of Postgraduate Medical Deans (COPMeD) and the General Medical Council (GMC). Lay representatives are part of Medical Directorate panels/committees at various local and national events relating to the management of postgraduate medical education. They also participate in Quality Management visits to Local Education Providers, and are involved in other Deanery activities such as recruitment and Annual Review of Competence Progression (ARCP) assessments. In its recent visit to the Scotland Deanery, the GMC concluded that the involvement of lay representatives in quality management processes was an area which was ‘working well’.

Their report states that:

'The [lay] representatives we met with explained that they had been through a rigorous recruitment process, and gave details of their induction which includes generic induction to the role, ongoing additional training such as equality and diversity or recruitment, and attendance at an annual conference. The representatives spoke highly of the induction process, especially the opportunity to meet other lay representatives'.

CASE STUDY 2

DENTAL CARE QUALIFICATION FOR NURSERY NURSES

NES's Oral Health Improvement Team (OHIT) provides educational support for the delivery of national initiatives aimed at improving Scotland's oral health as set out in the Scottish Government's Oral Health Improvement Strategy for Priority Groups. A key workstream for OHIT is the Childsmile initiative, which focuses on child oral health improvement, through the training of Dental Nurses) and Dental Health Support Workers (DHSWs) to provide preventative services in schools, nurseries and dental practices. The initiative has been successful, with a significant proportion of dental practices delivering Childsmile services since 2006. 1,026 Dental Nurses and DHCSWs completed the training between 2011 and the end of 2015.

During the year we developed an accredited nursery nurse qualification to support toothbrushing in nurseries and the delivery of the Childsmile programme. This was in response to an approach from South Lanarkshire College and Lanarkshire Health Board. They had been working together informally to provide some input on oral health to the nursery nurse students

(HNC in Childcare Practice) and wondered if something more structured could be produced which would result in a qualification. The Oral Health Improvement Team worked together with the Scottish Qualifications Authority, NHS Lanarkshire and South Lanarkshire College to produce an SCQF level 6 oral health qualification. The aim is to establish good oral health habits for every child and contribute to a reduction in oral health inequalities, teach children an important life skill and contribute to the health and wellbeing element of the Curriculum for Excellence. Staff in nurseries have expressed how helpful it will be to have staff with these extra skills and knowledge working within the nursery.

CASE STUDY 3

USING LEARNER PERCEPTIONS OF FLYING START NHS TO SHAPE NATIONAL AND LOCAL ENGAGEMENT

Flying Start NHS is the national development programme that the Scottish Government requires all newly qualified NMAHP practitioners (NQPs) to complete. It is designed to help them make the step from student to confident and capable, registered health professional in their first year of practice, in all sectors and settings across Scotland.

In 2017, NHS Education for Scotland (NES) completely revised the programme to reflect the ever-changing environments in which NQPs work. The changes were also driven by feedback from NQPs and others with experience of Flying Start NHS, as well as managers and service leads. The new programme focuses on what is most practical and beneficial to learn in the workplace and is designed to fit in with other learning e.g. mandatory training. To date over 1,300 NQPs have registered on the new programme.

The NMAHP Flying Start NHS team have developed a plan to measure the impact of the programme based on the Kirkpatrick Model. Data is being collected in the form of a survey on views of NQPs on commencement of the programme. Since the launch in October 2017 over 300 NQPs have responded to the survey, including providing qualitative feedback. This information has provided valuable insight into how they view the programme and is helping to shape national and local engagement strategies, in collaboration with the Flying Start NHS leads group which includes representation from sectors outwith the NHS.

CASE STUDY 4

SERVICE USER INVOLVEMENT IN MULTIDISCIPLINARY PSYCHOLOGY EDUCATION AND TRAINING

Our Psychology Directorate's multidisciplinary workstreams continue to involve service users in educational methods such as role play, actors, and narratives from people with lived experience deliver specific examples or messages enhance add significant value to learning. Protocols and guidelines have been developed to ensure service user contributors have the necessary information and protection. Examples from across our work streams include:

- Active involvement of the autism community in Scotland in both the commissioning and development of the 'NHS Education for Scotland Autism Training Framework Optimising Outcomes: A framework for all staff working with people with Autism Spectrum Disorders, their families and carers' that has received international acclaim.

- Active participation from two survivors of complex trauma in the national reference group that developed the framework, *'NHS Education for Scotland Transforming Psychological Trauma: A Skills and Knowledge Framework for The Scottish Workforce'.* As part of this work survivors of complex trauma have provided feedback on the helpful and unhelpful skills that they have experienced from staff within their contact with services.

- Psycho-social Interventions for Psychosis' training materials for Mental Health Nurses and Allied Health Professionals have been co-produced with Experts by Experience, the Psychological Intervention Team (PIT), the University of Glasgow and clinical experts in the field of psychological therapies for psychosis.

- Active involvement of parents in the Incredible Years® and Triple P® within the Psychology of Parenting Project (PoPP). Service user involvement is carried out in joint partnership with PoPP and staff in Community Planning Partnerships at the earliest possible stage and continues all through the parents' journey in the programme.

- Carer representatives contribute to the Dementia Programme board, and 'Responding to Distress in Dementia: A Staff Supported Guide for Carers' which has been piloted in the Western Isles.

4.2 FEEDBACK - EDUCATIONAL GOVERNANCE

As described in section 1.2 above, we value feedback from learners as an important source of information on educational quality. This information provides us with assurance on the efficacy of our work and helps us to identify opportunities to improve (or remediate) educational programmes. We have continued to evolve the ways in which we gather feedback from learners about specific aspects of their learning experience (educational supervision, quality of facilitation, materials provided) to enable us to make focused enhancements.

In addition to collecting and using our own feedback to enhance education and training we also share this intelligence with key partners to improve health and care services. In Medicine, Scotland's Taskforce to Improve the Quality of Medical Education & Training (TIQME) has approached educational quality at a strategic level. This Taskforce is co-led by a NES Deanery quality workstream lead, by a NHS Board Medical Director (MD) and a NHS Board Director of Medical Education (DME). It brings together the NES Medical Directorate Executive Team (MDET), the Scottish Deans Medical Education Group's (SDMEG) leads of all five Scottish Medical Schools and the MDs and DMEs of all of Scotland's territorial Health Boards to engage in tackling some of the greatest challenges we face in delivering high quality medical education and training. TIQME has also enabled sharing and dissemination of good practice across Scotland. TIQME meets quarterly to tackle challenging themes such as:

- New GMC standards for medical education & training
- Trainee engagement in improving the quality of medical education & training – showcasing the 'chief resident model'

- Joint undergraduate and postgraduate quality management visits
- Managing bullying and undermining in the training environment
- Differential attainment in postgraduate medical education and training.

CASE STUDY

PATIENT ASSESSMENT QUESTIONNAIRE

Our Dental training programmes employ valid and reliable programmes of assessment. Their aim is to assess a range of generic skills and attributes which are important in the delivery of care whilst monitoring the clinical skills and knowledge required of practitioners. Feedback generated from continuous assessment helps drive training as well as providing evidence of progress and achievement. Assessment evidence on performance is collected in an electronic portfolio throughout the training and considered for satisfactory completion at the end of training.

A key source of assessment is through a Patient Assessment Questionnaire (PAQ), which is completed anonymously by patients following consultations with dentists or dental therapists in training. The PAQ is seen as a valuable method of collecting feedback on the quality of care, which is used to check or improve trainees' practice. The feedback is given by patients using a tablet computer and a bespoke application provided by NES. This allows the anonymised data to populate trainee portfolios, which are accessed by trainers and the trainee. Data provided in this way is used to check competence and guide future training. Trainees are assessed in this way in each year of their programme.

4.3 COMPLAINTS AND FEEDBACK

Where we have identified arising from complaints and feedback we have responded with actions to improve services. An outline of specific improvements resulting from the nine complaints and one item of feedback received by our corporate complaints handling team during 2017-18 is given below.

- Review of guidance on external longitudinal evaluation of practice (LEPs) in Dentistry and how that guidance is communicated to trainers
- Improved information about the eligibility criteria for training delivered by NES (or NES staff) in medicine.
- Improvements made to communication and processes in relation to VT Advisor statements.

5 ACCOUNTABILITY AND GOVERNANCE

This annual FCCC report is submitted to our Executive Team, Education and Research Governance Committee and Audit Committee and recommendations arising from complaints are followed up by our corporate complaints team. The annual report is published on our website by the end of June each year at www.nes.scot.nhs.uk/about-us/planning-and-corporate-governance.aspx and sent to the Scottish Government and the Scottish Public Services Ombudsman (SPSO).

Our Educational and Research Governance Committee (E&RGC) meets regularly to monitor and quality assure our educational services and to record recommendations made as a result of feedback. A formal note of E&RGC meetings is reported to our Board as a routine and regular agenda item.

This resource may be made available, in full or summary form, in alternative formats and community languages.

Please contact us on 0131 656 3200 or email altformats@nes.scot.nhs.uk to discuss how we can best meet your requirements.

NHS Education for Scotland
102 Westport
Edinburgh
EH3 9DN

0131 656 3200 | www.nes.scot.nhs.uk

NESD0900 | Designed and typset by the NES Design Service

NES **NES 18 69**
Item 10b
July 2018

NHS Education for Scotland

Board Paper Summary: Partnership Forum Minutes

1. Title of Paper

Minutes of the Partnership Forum meeting held on 17 May 2018

2. Author(s) of Paper

David Ferguson, Board Services Manager

3. Purpose of Paper

To receive the unconfirmed minutes of the Partnership Forum meeting held on 17 May 2018

4. Items for Noting

Item 6 – Regional National Board Collaborative Plans

The Partnership Forum received an update on the progress of these plans.

Item 7 – Workforce Metrics, Reporting and Performance Management

The Partnership Forum noted the development of the People and OD Dashboard.

Item 8 – Turas Appraisal Update

The Partnership Forum noted the progress of the implementation of Turas Appraisal, including work to ensure compliance with the new general data protection regulations (GDPR).

Item 9 – NHSScotland Recruitment Shared Services

The Partnership Forum noted the progress of NHSScotalnd Recruitment Shared Services.

Item 10 – Lead Employer Update

The Partnership Forum noted and was satisfied with the progress of the Lead Employer development.

Item 18 – Our Way Update

The Partnership Forum noted and was satisfied with the progress of the Our Way initiative.

5. Recommendations

None.

NES
July 2018
DJF

NHS Education for Scotland

PARTNERSHIP FORUM

Minutes of the Eighty-first meeting of the Partnership Forum held on Thursday 17 May 2018 at Centre for Health Sciences, Inverness

Present: Liz Ford, Employee Director (Joint Chair)
Dorothy Wright, Director of Workforce
Caroline Lamb, Chief Executive

In attendance: Linda Walker, GMB Representative
Jenn Allison, Admin Officer
Christine McCole, Head of Service, HR (VC, 2CQ)
Ameet Bellad, Senior Specialist Lead, Workforce (VC, Westport)
Lynne Archibald, Senior Officer, HR (VC, Westport)
Jen Calder, Business Partner, OLDD (VC, Westport)

1. Welcomes and Introductions

Caroline Lamb welcomed everyone to the meeting, particularly Christine McCole who was attending to present to item 8, 9 and 12, Ameet Bellad who was attending to present to item 7, Lynn Archibald who was attending to present to item 14 and Jen Calder who was attending to present to item 18.

2. Apologies for Absence

Apologies were received from David Felix, Postgraduate Dental Dean/Management Representative, David Cunningham, BMA Representative, Ros Shaw, RCN Representative and Jackie Mitchell, RCM Representative.

3. Partnership Forum Minutes 22 March 2018 (NES/PF/18/15)

The minutes of this Partnership Forum meeting were approved as a correct record.

Action: JA

4. Partnership Forum Actions 22 March 2018 (NES/PF/18/16)

It was noted that all the action points from the previous meeting had been completed or were in hand.

5. Matters Arising from the Minutes

There were no matters arising from the previous minutes.

6. Regional National Board Collaborative Plan

Caroline Lamb and Dorothy Wright updated the Partnership Forum on the progress of the Regional and National Board Collaborative Plans. The following was noted/discussed:

- Draft Regional and National Plans were submitted to the Scottish Government in April. There are a range of propositions in the plans including the investment support required. The Regional Planners and Directors of Finance are due to meet on 18th May with the aim of reaching a consensus of what will be funded in phase one and to identify areas where more information may be required.

- It is anticipated that NES will continue with plans regarding the development of an eRostering system as well as wider work relating to NHSScotland Business Systems development, including further development of Turas and development of a Once for Scotland job evaluation system (replacement of the CAJE data base). Caroline added that the Digital Health and Social Care Strategy, which was published a couple of weeks ago, highlights the importance of developing Scotland's digital infrastructure in a different way by moving away from large scale contractors and developing in house where possible.

The Partnership Forum noted the progress of the Regional and National Board Collaborative Plans.

7. Workforce Metrics, Reporting and Performance Management

(NES/PF/18/18)

Ameet Bellad updated the Partnership Forum on progress of the People and OD Dashboard. The following was noted/discussed:

- Ameet has been working on developing a dashboard tailored to the requirement of the Board and Committees, which will have live data in it in time for the next Partnership Forum. Ameet will send relevant links to members of the Partnership Forum. **Action: AB**

The Partnership Forum noted the development of the People and OD Dashboard and look forward to the presentation at the Partnership Form in July.

8. Turas Appraisals Update

(NES/PF/18/19)

Christine McCole presented the papers to update the Partnership Forum on the implementation of Turas Appraisal and associated data protection Impact Assessment. The following was noted/discussed:

- Turas Appraisal was successfully launched across all Boards in NHSScotland on the planned launch date of Monday 02nd April 2018. In total 167,059 accounts were set up on Appraisal, almost 40,000 staff have logged in to the application, including 365 NES staff. The Partnership Forum agreed that

additional communication should be produced to increase registration of NES staff. **Action: CMcC**

- The digital team are migrating historical e-ksf data to Turas, including relevant attached documents, which will be available to staff by late May/early June. All required information governance documentation has been completed.

- 220 staff attended 28 'hands on' demonstration sessions, including via Skype. Sessions were provided in the regional offices in Dundee, Aberdeen and Inverness. In addition, a guide for managers and staff on using Turas Appraisal in the PRP process has been developed and is available on the Turas Appraisal page on the intranet.

The Partnership Forum noted the progress of the implementation of Turas Appraisal, including the work to obtain compliance with the new general data protection regulations. They agreed that Turas Appraisal is a vast improvement from eKSF and congratulated colleagues who have been involved in the development and implementation.

9. NHS Scotland Recruitment Shared Services

Christine McCole updated the Partnership Forum on the progress of NHSScotland Recruitment Shared Services. The following was noted/discussed:

- The preferred supplier for the Once for Scotland recruitment system is Jobtrain. Implantation of this system will substantially enable the move to shared services. It is anticipated that funding will be confirmed on the 22nd May.

The Partnership Forum noted the progress of NHSScotland Recruitment Shared Services.

10. Lead Employer Update

Dorothy Wright updated the Partnership Forum on the progress of Lead Employer. The following was noted/discussed:

- The configuration of interfaces between Turas People and eESS has proved in more challenging that anticipated and further development of Turas People is the preferred option for sharing required information cross regional and board boundaries.

- It is anticipated that the Cabinet Secretary will make an announcement regarding Lead Employer model early June.

The Partnership Forum noted and were satisfied with the progress of Lead Employer.

11. Trade Union Deduction of Contributions at Source (DOCAS)

Liz Ford updated the Partnership Forum that the Implementation day regarding the deduction of Union subscriptions from wages in the Public Sector is yet to be announced. The Partnership Forum noted the update.

12. Trade Union Facility Time Reporting

Christine McCole and Liz Ford updated the Partnership Forum that there is a regulatory requirement of the public sector to record and report on Trade Union Facility Time. This is to be agreed Scotland wide and staff-side are awaiting confirmation of details regarding this. The Partnership Forum noted the update.

13. Any other business

There was no other business raised for discussion.

14. Special Leave Policies

a) Special Leave Policy (NES/PF/18/20)

Lynne Archibald presented the policy to advise the Partnership Forum of the result of a scheduled 3-year review of the Special Leave Policy. The following was noted:

- The outcome of the scheduled 3-year review of Special Leave Policy is that no significant amendments to the policy are required, as there have been no changes to PIN guidelines. The only change to the Policy is Section 2– Legal Framework "The Statutory Right to request flexible working practice". This paragraph has been amended to reflect current legislation and link with the Flexible Working Practices Policy.

- The Equality Impact Assessment (EQIA) concluded that there are no significant amendments to the Policy apart from using gender neutral pronouns to replace his/her, this has been actioned.

The Partnership Forum noted and were satisfied with the minor amendments to the policy and ratified the policy. As only minor updates had been made, the Partnership Forum agreed the documents did not need to be submitted to the Staff Governance Committee for ratification. **Action: CMcC**

15. Information Governance Policy (NES/PF/18/21)
16. Data Protection, Confidentiality and Privacy Procedures (NES/PF/18/22)
17. Corporate Information Security Policy (NES/PF/18/23)

Dorothy Wright presented the updated Information Governance policy, Corporate Information Security Policy and corresponding Data Protection, Confidentiality and Privacy Procedures to the Partnership Forum. The following was noted:

- No major changes have been made to the policies, they have been updated to ensure compliance with legislation changes.

- The Partnership Forum agreed that it would be useful to produce further communication to inform staff of their responsibilities regarding the changes, including links to relevant mandatory training. **Action: CMcC**

The Partnership Forum noted and were satisfied with updates to the Information Governance Policy, Corporate Information Security Policy and corresponding Data Protection, Confidentiality and Privacy Procedures and ratified the policies.
Action: CMcC
As only minor updates had been made the Partnership Forum agreed the documents did not need to be submitted to the Staff Governance Committee for ratification.

18. Our Way (NES/PF/18/24)

Jen Calder presented the paper to update the Partnership Forum on the progress of Our Way, as initiated by the Senior Operational Leadership Group (SOLG) and developed by the OD Leadership and Learning and HR teams. The following was noted:

- Our way is intended to influence a culture in NES that supports what we have in our existing Dignity at Work policy. An interactive PDF has been drafted, including scenario videos, which will be forwarded on to member of the Partnership Forum. **Action: JC**

- Jen noted that the next steps are to engage further with colleagues in the Northern offices to ensure Our Way accurately reflects all NES staff, recruit staff side reps from each site to champion Our Way, and produce communications to go out to all staff.

- Future iMatter results will help to measure the impact of Our Way.

The Partnership Forum noted and were satisfied with the progress of Our Way and look forward to reviewing the interactive PDF.

19. Policy Tracker

The Partnership Forum noted the Policy Tracker.

20. Health, Safety, Welfare Committee Minutes

There were no minutes available for submission that have not already been submitted to the Partnership Forum.

21. Change Management Programme Board Minutes 05th Feb

The Partnership Forum noted these minutes.

22. Any Other Business

Dorothy Wright informed the Partnership Forum that the Scottish Government Staff Governance Monitoring Return has been drafted and will be submitted to the Scottish Government in due course, following approval from the Chief Executive, Employee Director and Chair of the Staff Governance Committee. It will be submitted to the next Partnership Forum for information.

23. Date and time of next meeting

The next Partnership Forum meeting will take place on Thursday 26th July in 2CQ at 11:00 with an all staff meeting taking place at 10:00.

NES
May 2018
JA/dw

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Training and Development Opportunities for Board Members

2. Author(s) of Paper

David Ferguson, Board Services Manager

3. Purpose of Paper

To provide details of any upcoming training and development opportunities for Board members

4. Key Issues

- Papers detailing any upcoming training, conferences and seminars that may be of interest to Board members have become standing items for noting on Board agendas.

- We also continue to draw training and development opportunities to Board members' attention as they arise.

- The items below have been notified to Board members previously by e-mail:

(i) 'On Board Scotland' training

11th September 2018 – Edinburgh
10th December 2018 – Stirling
19th March 2019 - Glasgow

(ii) The Effective Audit and Risk Committee training

16th October 2018 – Glasgow
13th December 2018 – Stirling
21st March 2019 - Edinburgh

(iii) NHS Board Members National Masterclass

3rd September 2018 – Edinburgh

(iv) Duty of Candour Masterclasses

18th September 2018
3rd October 2018
11th October 2018
30th October 2018

(N.B. venues to be confirmed)

(v) NES Staff Conference

21st November 2018 - Perth

- A list of confirmed and pending national conferences (provided by the NES Conference Team) is attached to this paper.

- Members may also find it helpful to have this link to the details on the NES website of forthcoming events organised by the NES Conference Team: http://events.nes.scot.nhs.uk/

5. Educational Implications

None.

6. Financial Implications

The events at (i) above cost £395.00 plus VAT per place.

The events at (ii) above cost £225.00 plus VAT per place

There is no charge for the events at (iii), (iv) and (v) above

7. Recommendation(s) for Decision

None. This paper is for information only.

NES
July 2018
DJF

National Conference Dates 2018

Month	Date	Meeting Workshop	Location	NES Contact	Conference Team Confirmed
October	7	Optometry Conference	The Hilton Hotel, Glasgow	Emily McGarva	Y
November	9	Academy for Healthcare Science/NES Event	The Studio, Glasgow	Rob Farley	Y
	21	NES Staff Conference	Perth Concert Hall	Karen Howe	Y

Published 2 July 2018
SP Paper 367
7th report (Session 5)

The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee
Comataidh Slàinte is Spòrs

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

Published in Scotland by the Scottish Parliamentary Corporate Body.

All documents are available on the Scottish Parliament website at:
http://www.parliament.scot/abouttheparliament/91279.aspx

For information on the Scottish Parliament contact Public Information on:
Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

Contents

Health and Sport Committee

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

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/health-committee.aspx

healthandsport@parliament.scot

0131 348 5524

Committee Membership

Convener
Lewis Macdonald
Scottish Labour

Deputy Convener
Ash Denham
Scottish National Party

Miles Briggs
Scottish Conservative and Unionist Party

Alex Cole-Hamilton
Scottish Liberal Democrats

Kate Forbes
Scottish National Party

Emma Harper
Scottish National Party

Alison Johnstone
Scottish Green Party

Ivan McKee
Scottish National Party

David Stewart
Scottish Labour

Sandra White
Scottish National Party

Brian Whittle
Scottish Conservative and Unionist Party

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

---

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]

---

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.

182 Health and Sport Committee. *Official Report 27 February 2018*, Col 25.

183 Health and Sport Committee. *Official Report 27 February 2018*, Col 53.

184 Health and Sport Committee. *Official Report 27 February 2018*, Col 53.

185 The Conveners Group. *18 April 2018.*

186 The Conveners Group. *18 April 2018.*

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

188 Health and Sport Committee. *Official Report 27 February 2018* .

189 Health and Sport Committee. *Official Report 27 February 2018* .

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

191 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