



T: 0300 244 4000  
E: scottish.ministers@gov.scot

Lewis Macdonald MSP  
Convener  
The Health & Sport Committee

By Email.

11 October 2018

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

I am writing to provide a Scottish Government reply to the further questions from the Health and Sport Committee's set out in its letter of 2 October 2018 in response to its report "*The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland*" which was published on 2 July.

**Staff Governance**

Pressure on staff – paragraphs 44-45

You refer to the statutory role of Integration Authorities in workforce planning. Duties relating to workforce planning remain with Health Boards and Local Authorities under integration, as they are the employers of staff and contractors of services provided by third parties. Each Health Board and Local Authority must set out in their Integration Scheme how they will work together to develop and support the workforce, and the organisational development arrangements that they will provide to the Health Board, Local Authority and Integration Joint Board to support integration. I fully agree with your point about the importance of involving Integration Authorities and third and independent sector providers in the delivery of the recommendations in the second part of the Health and Social Care Workforce plan, and I can confirm that they are represented on key advisory and delivery groups and actively engaged in specific work-strands.

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

## Consultation and staff relations – paragraph 63

You asked about legislation to establish an Independent National Whistleblowing Officer (INWO) for NHS Scotland. The legislation to confer powers required for the INWO to the Scottish Public Services Ombudsman (SPSO) will be introduced via a Public Service Reform Order. The process for bringing forward a Public Services Reform Order is a super-affirmative procedure within the Parliament, which requires a 60 day consultation period for the draft SSI. Scottish Ministers will consider representations made within the consultation period before laying a draft order before Parliament for approval by affirmative resolution.

We anticipate that legislation will be introduced later this year to allow the role of the INWO to go live in September 2019 subject to the approval of the Parliament. We will ensure that the Health and Sport Committee are advised accordingly when the instrument is laid for the statutory consultation period.

## Whistleblowing – paragraph 117

You asked for more detail on the introduction and consultation of the whistleblowing standards. The Whistleblowing Standards (The Standards) are being developed by the SPSO who we intend will carry out the INWO role. The development of the standards is being overseen by a steering group and informed by a working group consisting key stakeholder groups. The Standards consist of an over-arching set of Principles and a model Whistleblowing Procedure. The SPSO intends to consult on The Standards at the same time as the Scottish Government consults on the draft PSR Order so that they may be considered in conjunction. The provisions introduced by the PSR Order will provide the INWO with powers to investigate whether internal handling of whistleblowing concerns have been investigated in accordance with The Standards, and allow the INWO to make recommendations to the relevant bodies for improvements where required and to report publically on its findings. The SPSO intends to lay the Standards before Parliament for approval at stage 2 of the legislative process.

You also sought more insight into the role of the INWO and sanctions should the INWO's findings indicate failings. It is vital that the INWO helps promote continuous learning and improvement to encourage and open and transparent reporting culture in our NHS.

Under our proposals, which will be subject to parliamentary scrutiny through the legislative process the INWO would have powers to make recommendations for appropriate action by the appropriate body or individual, or to give advice to the appropriate scrutiny body/regulator to make a direction to that effect. Where these recommendations are not met the INWO would also have the ability to lay a special report before Parliament.

As outlined in our previous response, the INWO will also have a national leadership role providing support and guidance to the relevant bodies with the focus on learning and improvement, early resolution, recording and reporting. Where it is found that local processes indicate failings we would expect the INWO to support and challenge Boards to ensure that the relevant improvements were made. Our Staff Governance Monitoring exercise, which is currently under review, will allow us to monitor that any improvements identified have been made.

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

The INWO will not impose sanctions on individual employees, however victimisation of a whistleblower is already a disciplinary matter in line with existing Health Board conduct policies.

### Whistleblowing - Paragraph 118

The annual reports which will be provided for the Statutory Duty of Candour will relate to individual organisations and therefore the impact of these will be determined by the nature and complexity of the health, care and/or social work service provided, the nature of the incidents and the approach taken to implementation by each organisation. This will in turn be linked with the wider culture, learning and improvement support infrastructure. Nationally officials will be reviewing the first set of organisational Duty of Candour reports next year in order to establish an initial baseline of the way this has been implemented and identify a plan of analysis to inform further evaluation and monitoring work as part of wider programme in support of quality management systems. We would expect Duty of Candour reports to form part of the intelligence used by Boards to develop their clinical governance processes and to identify patterns and systemic issues and we are currently considering how this information will be used by the INWO.

You asked which nine Health and Social Care Partnerships are not using iMatter and what is being done to encourage their participation. The 9 HSCPs which chose not to participate in iMatter in 2017 were:

- Western Isles Council (NHS Western Isles)
- Orkney Island Council (NHS Orkney)
- Stirling Council/Clackmannanshire Council and Falkirk Council (NHS Forth Valley)
- Borders Council (NHS Borders)
- East Lothian Council and West Lothian Council (NHS Lothian)
- Perth & Kinross Council (NHS Tayside)
- Dumfries & Galloway Council (NHS Dumfries & Galloway)

We continue to have very productive conversations with those HSCPs outlined above and are encouraged that most of those that did not participate in iMatter previously have indicated their intention to participate in the future.

It should be noted local authorities have their own mechanisms for measuring staff experience in place. There is no obligation for local authority staff working in HSCPs to participate in iMatter, nor for the local authority to provide us with a reason if they choose not to. This is why we are pleased that those HSCPs that chose to participate recognise the benefits of the Team based approach iMatter offers.

We note your comments about the Dignity at Work Survey not running in 2018. We agree that it is important to be able to assess Dignity at Work issues. As outlined in our previous response, continuous low levels of participation over the last few years indicate that staff are not engaging with this approach to assessing their experience of these issues. The results over the last few years have only represented the views of around a third of staff.

That is why we have commissioned an independent review of staff experience measures, including Dignity at Work issues. This will allow us to consider how we can gather more meaningful and proportionate information.

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

For 2018, we will use our Staff Governance Monitoring exercise to obtain relevant information from Boards, including what steps they are taking to support staff to confidently raise any concerns, as well as seeking assurance that all concerns raised are appropriately investigated.

#### Whistleblowing - Paragraph 119

With regard to the introduction of an external reporting/investigative line for NHS whistleblowers, we believe that it is right that Board, as employers, have the responsibility to initially respond to a concern and that this is key in improving local culture. Where a whistleblower remains concerned about a Board's approach they will have the ability to raise the issue with the INWO.

The Scottish Government, Health Boards and the INWO will support continuous improvement in encouraging whistleblowers to speak out. As set out above, the SPSO, under whose jurisdiction the INWO will fall, are developing the Whistleblowing Standards. These have been developed to ensure that whistleblowers are at the centre and that they are encouraged to speak out and supported when they do. The Standards will provide the framework for investigation of any cases raised with the INWO at the final stage.

Whilst we do not support the introduction of an investigative line, we are continuing to develop and evaluate our policies to ensure that all staff feel it is safe to speak up and raise any concerns and that appropriate action is taken.

#### Whistleblowing - Paragraph 120

With regard to the appointment of individuals to the role of Whistleblowing Champion I have considered this further and recently announced that I will personally appoint the Whistleblowing Champions at Scotland's NHS Boards. If any one of these dedicated professionals feels they are not being heard in their Boards, they will be able to come straight to me.

The role will also be focused on ensuring Board compliance with the new Whistleblowing Standards, ensuring organisational support and training for staff and managers and that sound governance arrangements are in place.

#### Whistleblowing - Paragraph 121

You ask about the role of the INWO in considering the treatment of staff and what steps will be taken against those who mistreat whistleblowers. Consideration of disciplinary and other personnel matters would be required in certain cases, for the INWO to investigate and report on whether the individual had been treated reasonably as a result of raising a whistleblowing concern. This would not involve retaking decision making on HR matters, but it is our intention that the INWO could include comment on them as part of her consideration into whether a whistleblower has been treated fairly – when this is relevant.

The *'Implementing & Reviewing Whistleblowing Arrangements in NHSScotland'* PIN Policy, which all local whistleblowing must comply with, is clear that it is a disciplinary matter to victimise a whistleblower.

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

We will shortly be undertaking a programme of work to review all Health Workforce HR Policies to ensure consistent application across the NHS in Scotland and the Committee's comments will be considered as part of this.

#### Regulation of Managers – paragraph 132

You ask for further detail on the work on professional accountability for NHS management. The UK Government's Minister of State for Health has asked Tom Kark QC, the former Lead Counsel for the Mid-Staffordshire public inquiry, to lead a review of the regulations applicable in England and overseen by the Care Quality Commission. This review is expected to report later this year. Given the mobility of the management workforce across the UK, a consistent approach to regulation is desirable in order to prevent managers in difficulty simply moving elsewhere. In developing options for the meaningful and proportionate regulation of healthcare managers we are therefore taking into account learning from the recent review of mandatory induction standards for Healthcare Support Workers, devolved powers of Scottish Ministers and the unique structure of the service in Scotland, as well as the outcome of the Kark Review referred to above.

#### Integration Authorities – paragraph 137

I note that you have written to COSLA raising a number of important points, including how they can effectively contribute their views to support the work of the Health and Sport Committee. I understand that they will be responding to you directly on the matters you have raised.

#### Staff Survey and iMatter – paragraphs 143-166

You ask what response rate the Scottish Government hopes to achieve in the next annual report of iMatter. It is always our aim to improve on past response rates to national staff experience measures. The Health and Social Care Staff Experience Report 2017 was the first time that the national response rate information for iMatter was available, and this achieved a response rate of 63%. We want all staff to share their views, but recognise not all staff may wish to do this. We do not feel that it would be appropriate to set a specific target response rate at this time but this will be considered as part of the Strathclyde evaluation.

You also ask for an explanation in the variation of response rates and completion of action plans in Boards and how this would be tackled. As indicated in our previous response, there are a number of reasons why response rates may vary, including potential for survey fatigue (when combined with other local or national surveys), local approaches to disseminating and promoting surveys and also, most importantly, staff perceptions on how feedback on earlier surveys have been taken account of, and acted on.

The variation of response rates between Boards will be further considered by Strathclyde University as part of the independent evaluation.

Individual Board discussions have taken place highlighting the importance of senior teams supporting for time to be provided to allow teams to develop their action plans. This is so that staff may focus more on this element of the iMatter model rather than response rates. Longer term we believe that this will in turn improve response rates.

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

We look for consistently high levels of action plan completions, but do not intend to set a national target at this time. Through the Strathclyde review we will be giving consideration to how this can be best monitored and improved.

With regard to extending the external analysis to look at trends across staff groups and clinical specialisms we are currently working with Boards to look at the use of staff groupings within the iMatter questionnaire. This analysis is already available in the Dignity at Work section of the Health and Social Care staff experience report. As part of their review Strathclyde will have additional conversations during their one to one meetings and focus groups and will be asked to draw conclusions on the relevance of the information and make recommendations on whether and how this could be provided in the future.

## **Clinical Governance**

### Standards and Guidelines of Care – paragraph 214

You ask for my views on whether inspections under the new Health and Social Care Standards should identify the reasons for poor performance and assess whether there are systematic issues faced across NHS Boards to be addressed. It may be helpful if I explain that there is not 'an inspection regime' for the new Health and Social Care standards' as stated in the Committee's recommendations in paragraph 214 of the report. The standards are not designed to be inspected against in a tick box approach but rather, they articulate what people should expect to experience when they use health and social care services. Any inspection/review by any organisation such as Healthcare Improvement Scotland (HIS) or the Care Inspectorate should look at how these Standards influence the ways services are delivered. The HIS Quality Framework is mapped to these.

It is important to note that standards in general have a number of purposes (not always to underpin inspection) e.g. to establish what should be provided when a new service is being established; as the basis of clinical networks self-evaluation etc.

### The Role of HIS – paragraph 216

The Committee stated that it had concerns about the 'lack of coherence in scrutiny by HIS, with the rationale for what is inspected and monitored and what is not [being] unclear.'

The Quality of Care approach and the Quality Framework underpin the design of HIS inspection and review frameworks and inform how it provides external assurance of the quality of healthcare provided in Scotland. The Framework will continue to be refined following feedback from NHS Board level reviews.

It is also worth noting that all HIS inspections take a proportionate approach which is informed by intelligence and robust self-evaluation. Under the Quality of Care approach and using the Quality Framework, NHS boards will be actively engaged in ongoing self-evaluation which informs their own improvement journey.

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

St Andrew's House, Regent Road, Edinburgh EH1 3DG  
[www.gov.scot](http://www.gov.scot)



HIS will provide external validation of that self-evaluation at various levels within organisations through Board level reviews, hospital inspections and other quality assurance activity. HIS will analyse existing data and intelligence about an organisation alongside its self-evaluation. This will provide additional context about what is working well locally and where there are challenges. This will form the basis of professional dialogue with the organisation concerned to both validate the self-evaluation and identify opportunities for supportive follow-up work.

Key to this is integration with the work of the Sharing Intelligence for Health and Care Group (SIHCG). The group reviews and discusses the existing data and intelligence from a number of sources, such as HIS itself, the Care Inspectorate, Audit Scotland, the Mental Welfare Commission for Scotland, NHS Education for Scotland, NHS National Services Scotland and the SPSO.

SIHCG feeds back the key issues to the organisation concerned along with what the group sees as successes and priorities in order to inform local internal improvement activities. HIS will use this intelligence, alongside the material set out in the preceding paragraphs, to inform a proportionate and risk-based response about additional intervention that might be required with an NHS board, which, if necessary, will help to diagnose reasons for poor performance.

A report of the Board level review will be published, which will detail the findings of the review. It will include evaluations of performance at a board level, particularly in respect of leadership, outcomes for patients and the capacity for improvement. In addition, the report will contain details of the work to be taken forward by both HIS and the board as a result of the review.

HIS is currently exploring the development of an Emerging Concerns Protocol – initially an internal process (but with the possibility of extending across agencies) to consider concerns based on intelligence which may be from, the SIHCG, an inspection or review, complaint or data return. In addition to this, HIS is considering the potential introduction of improvement notices where recommendations following an inspection have not been successfully implemented. This will be linked to the development, by HIS, of an organisation-wide, consistent and transparent process for escalation of issues to Scottish Government, and potentially Ministers, where identified improvements have not been made by the board involved.

In terms of systematic issues, as part of the Quality of Care approach HIS will initiate national thematic reviews as and when required. The decision making for initiating a thematic review will be informed by its existing inspection and review activities, outputs from the SIHCG, reviews of national data, publicly available information, outputs from organisational self-evaluation and associated discussions with NHS boards and stakeholders. The focus of these reviews will be on helping the system as a whole learn from best practice and to highlight to Government the recurring and consistent themes that require to be addressed if improvement is to be made.

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

St Andrew's House, Regent Road, Edinburgh EH1 3DG  
[www.gov.scot](http://www.gov.scot)



In my initial response to the Committee I set out my plans to work with HIS to strengthen their role. The Committee asked a further question on additional powers for HIS in dealing with patients' concerns. HIS already receives complaints from the public in respect of independent healthcare. However, it would not be appropriate for HIS to receive NHS complaints as a legislative framework is already in place - last updated in 2016. NHS complaints should be dealt with through local resolution by NHS Boards. When this does not prove possible and the complainant remains unhappy, their case may be referred to the SPSO, which is an independent body. When the SPSO upholds an NHS complaint it can make recommendations for remedial steps to be taken by the relevant NHS Board or Boards, and has legal powers to ensure that Boards take appropriate action.

However, trends and patterns in complaints would be picked up through the Sharing Intelligence for Health and Care Group referred to above (of which SPSO are members) and potentially also through the new Emerging Concerns protocol that HIS is developing, also referred to above.

In addition, HIS does have a role where we receive concerns under the Public Interest Disclosure Act and via the National Confidential Alert Line. More detail on this can be found at:

[http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/responding\\_to\\_concerns.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/responding_to_concerns.aspx)

#### Learning and Improving when Things go wrong – paragraph 238

With regard to the ongoing work to deliver a vision of a culture of openness and learning, an Openness and Learning Unit was set up within Scottish Government in June 2017, specifically to take forward this work with stakeholders. A number of meetings have already been held to develop a shared vision and to agree the main drivers and areas of focus to deliver that vision.

The vision as currently set out is that 'Everyone feels able to share what has gone well, what could be better and suggest what could be improved. This helps us all to learn and to improve services, experiences and outcomes.'

The Scottish Government recognises that changing culture cannot be delivered within a fixed timescale, but is of necessity a gradual and iterative process. Nonetheless, it is clear that there is a commitment within the NHS in Scotland to move forward with this. We would be happy to provide you with more details on this as the work develops further.

#### NHS Complaints - Paragraph 241

The Committee asked for elaboration of the reasons why I consider that Clinical Governance Committees rather than an individual in the complaints department should lead on driving improvement on learning from complaints.

Every NHS Board has an Executive Director who has corporate responsibility for the Boards' operation of the NHS complaints procedure. In addition, the Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012 requires that every Board must appoint a feedback and complaints officer to ensure compliance with the arrangements and in particular to ensure feedback etc is monitored with a view to improving performance. The functions of the feedback and complaints officer must be performed by

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



the Chief Executive of the NHS body personally or by a person authorised by the relevant responsible body to act on the Chief Executive's behalf. The measurement framework underpinning the complaints procedure in legislation also includes quality indicators relating to outlining changes or improvements to services or procedures as a result of consideration of complaints which should be reported quarterly to board senior management.

### Serious Adverse Events – paragraphs 278-282

You ask about the consistency between Boards in defining adverse events, the Adverse Event National Framework, which was refreshed in July 2018, defines an adverse event as:

- An event that could have caused (a near miss), or did result in, harm to people or groups of people. Harm is defined as an outcome with a negative effect. Harm to a person or groups of people may result from unexpected worsening of a medical condition, the inherent risk of an investigation or treatment, violence and aggression, system failure, provider performance issues, service disruption, financial loss or adverse publicity.

The Framework recognises that all harm is not avoidable, for example the worsening of a medical condition or the inherent risk of treatment. However, it is often not possible to determine if the harm caused was avoidable until a review is carried out and often areas for improvement are identified even when harm is not avoidable. NHS Boards throughout Scotland should be applying this definition in reporting adverse events. However, the Scottish Government has asked HIS to develop and bring forward a new approach that addresses unacceptable variations in the way the Framework is applied by different NHS Boards.

We are in initial discussions with HIS about the development of a national reporting process covering a small number of specific harms in key clinical areas. I will ensure that the Committee is updated once the position becomes clearer.

HIS is in the process of developing a reporting baseline to establish the status, gaps and inconsistencies in adverse event management processes in NHS boards as set out in the *Learning from adverse events through reporting and review: A national framework for Scotland*, revised in July 2018. This document includes the definition of an adverse event as well as guidance on how to manage adverse events through a six stage process. The findings from this baseline will allow HIS in conjunction with key organisations, to further develop a methodology to deliver an external assurance (HIS) component to adverse event management across NHS Scotland. This will be in line with the HIS Quality of Care approach and duty of candour reporting requirements.

### **Corporate Governance**

#### Accountability – paragraphs 330 and 427

With regard to the remit and timescales for the review of integration, which is being jointly led by the Scottish Government and COSLA, the findings of the review will be reported to the Ministerial Strategic Group for Health and Community Care at its meeting at the end of January 2019. Its remit is to consider progress, including any barriers to change and opportunities for improvement, across integration including budgetary and financial arrangements, governance and commissioning practice, and improving delivery and outcomes.

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

We need to plan our health and social care provision at whichever level - local, regional or national - achieves the best outcomes for people and delivers modern and sustainable services. Strengthening collaborative working at regional level is an important means of achieving some of these objectives. In terms of accountability arrangements, the Committee will wish to note that the regions are not formal boards but collaborative groups of individual Health Boards and other partners including Integration Authorities. The individual Health Boards have a specific role in providing accountability for the work of the regions. For example, the Regional Delivery Plans that are currently being developed will be provided to the Health Boards within each of the regions for formal endorsement.

### Targets and Indicators – paragraph 333

You have asked for an update on the actions being taken following Sir Harry Burns' review of targets and indicators. The Scottish Government has been working with Integration Authorities over the last 18 months to develop a framework of indicators around reducing demand on unscheduled care and avoid unplanned admissions to hospital by developing local services. Since the publication of Sir Harry Burns' review, work has continued to develop and we wrote jointly with COSLA to all Integration Authorities and asked them to share their updated 2018/19 objectives and a brief summary of specific programme of activity which are planned to help delivery against six identified priorities. These priorities include A&E performance, unplanned admissions, occupied bed days for unscheduled care; delayed discharges; end of life care and balance of care spend.

These six priorities will form a quarterly reporting framework that has been developed for the Ministerial Strategic Group for Health and Community Care (MSG) which covers agreed priorities that support the ambitions set out in the Scottish Government's Health and Social Care Delivery Plan. The framework was developed by the SG and COSLA in partnership with a small working group comprising of lead officers for strategic commissioning and performance in Integration Authorities (IAs), Chief Finance Officers, and data analysts. The framework comprises of:

- a) Quarterly data on the six indicators but in time building on these indicators for example to reflect the contribution of primary and social care.
- b) Overarching narrative summary, drawing out emerging themes from across Integration Authorities to better understand local variation
- c) Local illustrations, inviting individual Integration Authorities to contextualise their progress with a presentation to the group and opportunity for discussion.

We acknowledge that these six priorities, are focused on hospital services, and we continue to work with the MSG data group to develop the framework further. However, we believe that this current framework provides good signals about what is happening across the system and helps facilitate a more holistic look at the whole pathway of care rather than focus on particular areas, such as delayed discharge. It also supports Integration Authorities to look at current performance across the system and establish positive planned trajectories for improvement that fit within the actions described in the National Health and Social Care Delivery Plan and the overall national aim of reducing inappropriate hospital use, shifting resources to the community and supporting the capacity of community care.

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

Finally, it may be helpful to note the following which are other aspects of the ongoing work subsequent to Sir Harry's Review:

- The LDP standards continue to exist and NHS Boards will continue to report how they are performing against them. Scottish Government continues to update the information about NHS Scotland performance against the LDP Standards on the Scotland Performs website. A link is attached, for reference:  
<http://www.gov.scot/About/Performance/scotPerforms/NHSScotlandperformance>
- Scotland's Digital Health and Care Strategy was published in April 2018 and states :-  
'We will begin work now to deliver a Scottish health and care 'national digital platform' The platform will allow for more appropriate use of information – putting in place the infrastructure and supporting improved processes for appropriate use of information for wider purposes, to ensure that health and care systems in Scotland are continuously learning.
- the publication in June 2018 of the revised National Performance Framework reflects a renewed focus on the Scottish Government approach and outcomes based working, and prompts us to boost to our efforts to foster stronger relationships between organisations, people and communities in order to achieve the NPF's Vision including the National Outcome 'We are Healthy and Active.'

#### The Scottish Health Council – paragraph 396

You ask for details on the ongoing work to build capacity in the Scottish Health Council (SHC) and strengthen leadership and staffing to engage at a more strategic level and how these will address concerns about the perception of its independence. The SHC will be a fully integrated part of HIS. As outlined in our previous response to the Committee, and as already referred to above, a number of actions are being taken to increase the understanding and clarity of HIS' operational independence, and therefore by extension the independence of the SHC, including development of a formal statement of the principles by which HIS should operate, underpinned by a revised operating framework, and a new, transparent escalation procedure for HIS.

HIS is in the process of developing new governance arrangements for the SHC to address some of the key points raised through this feedback. This includes reconsidering the membership, remit and operation of the committee, which is a legally required committee of HIS Board, as well as recognising the need for clearer arrangements for engaging with stakeholders and ensuring that there is transparency in demonstrating how their views informs the work programme. It is anticipated that these new arrangements will be implemented during 2019-20.

You also ask whether or not there are any plans to use the Ministerial power of direction to implement oversight of decisions by IJBs with regard to service change as already exists for NHS boards. The Public Bodies (Joint Working) (Scotland) Act 2014 places specific duties on Integration Authorities to ensure the rigour of local engagement and consultation in service planning, which some Integration Authorities are already carrying out very well. It is important that every area achieves a similarly high standard of engagement using approaches that are appropriate to local circumstances.

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

Adopting an approach that is localised and builds confidence and understanding in proposed changes should enable people to see the benefits and opportunities that changes can provide. We therefore do not feel that it is necessary to use a Ministerial power of direction to extend the processes around major service change set out in CEL 4 to cover Integration Authorities. We are nonetheless pleased to note that, following the conclusion of its review of the SHC, HIS has set out a stronger role for the SHC in developing a systematic approach to identifying, sharing and promoting good practice in community engagement. Chief Officers of Integration Authorities also recognise the important role that effective public engagement and participation contributes to the integration agenda. They have agreed to look at this issue in greater depth as a group and Scottish Government officials are providing support.

I hope that this information is helpful in supporting the Committee's consideration of this important area of work.

*Zero autism*



**JEANE FREEMAN**

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

St Andrew's House, Regent Road, Edinburgh EH1 3DG  
[www.gov.scot](http://www.gov.scot)

