Function and Form: An Independent Review of The Scottish Health Council

Summary of Findings & Recommendations

By the Scottish Council Foundation and McCormick-McDowell

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Responsibility for the content of this report, including any errors rests with the authors.

Summary of Findings & Recommendations

Scottish Health Council - Background and Current Shape

1. The Scottish Health Council was created in 2005 with a remit to provide leadership in ensuring the quality and extent of patient focus and public involvement (PFPI) occurs within the NHS. It is established as a Committee of NHS Quality Improvement Scotland (QIS) with its own distinct identity.

2. The Scottish Health Council consists of a national office, based in Glasgow, and a structure of three regions, each of which has its own Regional Manager. Within the national office, working to the Director, are a Development Manager and an Assessment and Feedback Manager. In addition, there is a team of staff within national office, and a recently-established Patient Focus Team to support work across all of the regions. Each region consists of a number of local offices, one for each geographical Health Board located within the region. There are therefore 14 local offices, with on average two or three Local Officers. Local Officers are managed by Regional Officers (three per region) who are in turn managed by Regional Managers.

3. The Scottish Health Council has been charged to deliver a variety of tasks by Scottish Ministers:

a) assessment of the ongoing PFPI activities of NHS Boards;
b) verifying PFPI practice with community-based stakeholders as part of Boards' performance reviews;
c) assessment of patient and public engagement processes in cases of Major Service Change proposed by Boards;
d) development of PFPI practice in Boards; and
e) secretariat support to Independent Scrutiny Panels tasked with examining controversial decisions.

Achievements

4. The Annual Review (October 2007) by the Scottish Government Cabinet Secretary for Health & Wellbeing noted the following:

a) The Scottish Health Council is making a difference by supporting the mainstreaming of Patient Focus and Public Involvement (PFPI);
b) The delivery of reports on PFPI assessment and the quality of public engagement in major service change consultations was acknowledged as a significant achievement, especially given the tight timescales involved. The organisation's workrate was described as impressive;
c) The organisation was described as well-placed to tackle important challenges ahead.

5. The first Annual Review (January 2007) by the former Scottish Executive Minister for Health & Community Care identified the following points:

a) Excellent links had been established between the Council's staff and their partners in NHS Boards and in patient and community groups;
b) There was a general welcome for the Council's decision to link its assessment framework into the HEAT targets;

a) The Council's significant achievement in producing 22 assessment reports and 7 major service change reports was acknowledged;
b) All early targets had been achieved by staff, despite the organisation's widely dispersed workforce;
c) The Council made considerable progress in the first year of its existence with the delivery of an impressive programme of work.

6. The Scottish Health Council is meeting the requirements placed upon it by Scottish Ministers, and in some cases doing so very well. However in this current Review, external stakeholders including NHS Boards and the organisation's staff indicate that there is considerable room for improvement in some key areas, notably: delivery of the full range of functions; proportionality; consistency between areas and over time; and adding value to outcomes for patients and the public. Ministerial Reviews have also highlighted the need for further progress in these areas.

Review Findings

7. It is a sound principle that an organisation's form should follow its functions. At its creation, the Scottish Health Council's form reflected its heritage in the structure of Local Health Councils and a pragmatic decision to avoid creation of a new public body, rather than a 'first principles' approach focused on delivery of its new functions. The Scottish Health Council, NHS QIS and the Scottish Government have made the best of those arrangements but senior officials in all three organisations are aware of the potential difficulties that flow from the current position.

8. The views of stakeholders who contributed to this review indicate that the functions the Scottish Health Council is expected to perform are necessary ones. In order for progress to be maintained, these functions need to be defined accurately, located appropriately, and supported by an organisational structure and culture that enables them to be carried out effectively. However, given that the existing structure was based on historical factors, and experience has shown that this structure is impeding the efforts of staff to deliver the functions, we recommend major reform of the Scottish Health Council, rather than tinkering with the current system (or disbanding the organisation, which a small number of NHS Board respondents have called for).

9. A range of methods (including surveys, interviews and focus groups) with key stakeholders informed this Review. Findings and recommendations are organised in key areas which the organisations commissioning the Review should focus their attention on in order to improve the overall performance of the Scottish Health Council:

   - the design and delivery of key functions;
   - the structure of the organisation;
   - the governance of the organisation;
   - the skills and experience of staff.

10. The review team have adopted the 'form follows function' approach and the report is structured accordingly.

FUNCTIONS

Assessment of Board PFPI actions

11. The assessment function carried out by the Scottish Health Council is based on verification of NHS Boards' self-assessment of PFPI activities. Assessment activity covers two broad areas:

    - The quality and extent of ongoing PFPI actions taken by NHS Boards;
    - Adherence to statutory Guidance on engaging patients and the public in cases of major service change.

12. The assessment process based on a series of templates has been informed by the National Standards for Community Engagement and guidance on *Consultation and Public Involvement in Service Change* (2002).[1]

13. Assessment of ongoing PFPI actions has been carried out by the Scottish Health Council's Local Officers. Local Officers work with one nominated NHS Board and are located in premises provided by Boards. Assessment of Special Health Boards is the responsibility of Regional Officers working with nominated Local Officers.

14. The assessment framework and supporting guidance is set out by the Scottish Health Council taking account of the needs of Ministers, NHS Boards and Annual Review evidence. Over the last three years the NHS Board self-assessment framework has evolved, resulting in changes to the assessment and verification approach by the Scottish Health Council. The clear shift in focus in 2007-08 meant that, unlike previous years, the Scottish Health Council was not required to produce annual reports based on NHS Board self-assessments. Local Officers were expected to place greater emphasis on verifying with Public Partnership Forums (PPFs), service user and community health groups and the wider public that NHS Boards had undertaken PFPI activities included in their self-assessment reports; and to produce a short statement offering a view on whether the content was an accurate reflection of progress. Interviews with Scottish Health Council staff and external stakeholders indicated that, while both believe the assessment process is improving; there is a widespread view that the pace of improvement has been slower than expected.

15. Significant changes each year to the framework have eroded the possibility of measuring progress and allowing bench-marking of Board performance. Changes to the assessment process, and delay in confirming the approach to be used, reflect negotiations between the Scottish Government and the Scottish Health Council. The result has been to increase the difficulties for Scottish Health Council staff in carrying out assessment activity. Many Local Office staff emphasised the damaging effect of frequent and late changes to the assessment framework on the organisation's credibility and working relationships with their counterparts in Boards.

16. In focus groups, Local Office staff highlighted the need for more attention to be given to explaining how guidance should be used in practice. Board PFPI practitioners, meanwhile, felt there was a "lack of connection" between the Scottish Health Council's focus on the detail of PFPI processes, and the Boards' own reported desire to focus on developing meaningful engagement with local patient and public groups. NHS Boards felt the assessment framework had not been applied inconsistently between areas. Many Scottish Health Council staff agreed that, as a national

[1] The National Standards for Community Engagement project was delivered by the Scottish Community Development Centre on behalf of Communities Scotland and published in 2005.

organisation, the Scottish Health Council needs to adopt a more consistent approach.

17. Three times as many Scottish Health Council staff felt that assessment procedures were effective as did Board respondents (around half of staff compared with one in six PFPI practitioners in Boards). Quarterly self-assessment reporting was seen by many Local Office staff as a necessary challenge to Boards, but was nonetheless acknowledged as very labour-intensive for both the Scottish Health Council and Boards. This view was strongly endorsed by Board respondents, some of whom experienced quarterly reporting to the Scottish Health Council as more like a quarterly *assessment*. Both Local Office staff and Board respondents emphasised the need to develop a stronger focus on the quality of public engagement and the results of it, rather than the processes followed by Boards. Both felt that the Scottish Health Council needs to develop greater expertise in quality assurance of PFPI activities, rather than acting as observers and reporters.

18. The need for the assessment process to respond to the differences between Territorial and Special Health Boards was raised both in survey responses and in focus groups with NHS Board PFPI practitioners. Some Board respondents thought it would be valuable to differentiate approaches by customer type. For example, Special Boards with patients and a specific location (State Hospital at Carstairs and Golden Jubilee National Waiting Times Centre[2]) could align themselves more closely with the approach taken with Territorial Boards, whereas Special Boards without patients (whose main customers are the other Boards) may need to have a distinct self-assessment/verification framework in place.

19. Recommendations:

    a) The Scottish Health Council should continue to undertake assessment of NHS Board PFPI activities in three ways: assessment of ongoing PFPI actions; validation with community-based stakeholders; and assessment of how Boards engage with patients and the public in cases of major service change (there is more discussion of this point below). However, these functions need to be re-defined and located appropriately.

    b) We propose separation of the assessment and development functions, locating separate teams to deliver each from within the national office, with assessment of key PFPI actions becoming, largely, a shared function with NHS QIS. This would create an integrated PFPI assessment model.

    c) We recommend a longer assessment cycle for NHS Board PFPI activities – every three years – with annual self-assessment reports by Boards on interim milestones and an in-depth focus on a smaller number of service areas. This should be seen as complementary to NHS Boards' self-assessment processes. However, quarterly reporting by Boards to the Scottish Health Council, with quarterly feedback, should be discontinued on the grounds of lacking proportionality and adding limited value.

    d) The Scottish Health Council and NHS QIS should explore how far their different approaches to assessment could be harmonised, in order to cut duplication of reporting effort for Boards and to improve consistency both between Boards and over time. We appreciate there are practicalities of marrying assessment cycles, joint planning/delivery of assessment and creating integrated teams, but believe there would be clear value in exploring the scope for joint action.

[2] NHS24 is a Special Health Board with patients but not based in a single location like those suggested.

e) Under any option, the Scottish Health Council should retain the function of assessing Board performance on a ‘special theme’ basis. For example, assessment of Board provision of advocacy services and sign-posting to complaints information (Independent Advice and Support Services) seems an important role for the organisation to take forward.
f) The development and introduction of a Participation Standard, as announced in the *Better Health Better Care Action Plan*, should help to reinforce the Scottish Health Council’s contribution to the assessment process and help assure NHS Boards of the validity and consistency of the process. Once established, these standards should be maintained for a period of at least three years before any amendment is considered.
g) To improve communication with NHS Boards, we recommend that as part of the creation of a nationally-based assessment team, each NHS Board has access to a named contact within the team to ensure clear working relationships develop. This should promote the creation of a culture of assessment as part of a shared approach to making progress with PFPI, building on the shift to self-assessment by NHS Boards.
h) The assessment cycle would identify priority PFPI development actions for Boards to take forward over the course of the next cycle. These are defined as ‘supply-led’ development actions, on which Boards would be expected to account for progress, as distinct from ongoing ‘demand-led’ actions which would be largely self-identified (see ‘Development’ below).

The range of options explored in the Review are shown in the Annex

<u>From verification to validation</u>

20. The focus of the Local Officer role has changed over time, from mainly ‘Board-facing’ assessment activity to a more recent focus on community engagement with a range of groups engaged in PFPI activity (including PPFs) to gather feedback on how Boards are performing. Survey results showed that Scottish Health Council staff had mixed views about this process of verification: 40% thought it had been ‘fairly effective’ while the same number thought it had been ‘not very’ or ‘not at all effective’. One in ten (11%) of NHS Board PFPI practitioners felt verification had been ‘effective’, while almost seven in ten respondents thought it had been ‘not very’ or ‘not at all effective’. A significant number of Board respondents felt that the verification process to date was not yet robust, led by subjective Local Officer opinions with undue weight given to a small number of stakeholders, rather than emerging from a clear analysis of verification evidence. This suggests there should be a further shift in emphasis from verification of activity to a more outcome-focused validation of the quality and impact of that activity.

21. Mainly because of the late introduction of self-assessment guidance NHS Board PFPI staff and PPF respondents felt that this year verification has been largely an ‘end-year’ exercise rather than an ongoing process to support Board self-assessment,. Scottish Health Council Local Officers reported a switch in emphasis from being ‘Board-facing’ to being ‘public facing’ but felt they required clearer guidance and training to help them conduct that role effectively. Specifically, some reported being unsure as to how to manage conflicting evidence and views from different groups. There appeared to be a lack of confidence in carrying out this broader role, an impression supported by evidence from Board respondents of a degree of detachment from Local Officers when they attended public engagement events organised by the Boards.

22. Of those who responded to the survey, 100% of Scottish Health Council staff, and 84% of Board PFPI practitioners, felt that finding better ways to engage disadvantaged, minority and 'seldom heard' groups is an important role for the Scottish Health Council.

23. Recommendations:

a) The validation function (currently termed 'verification') should become the primary focus of those currently working as Local Officers. They would also play a capacity-building role focused on building close working relations with a cluster of PPFs and other patient/service user and community/voluntary health groups. The goal should be to build local capacity to feedback to NHS Boards around agreed PFPI actions over a longer period (matching the proposed assessment cycle).
b) The priority should be to develop a clear and robust validation framework in partnership with staff throughout the organisation. This should link to the Participation Standard and be applied consistently across the country. The framework should be co-produced at a national level with NHS Boards, PPFs and community stakeholders. Further consideration needs to be given as to how appropriate weight is given to different views.
c) The Scottish Government should identify clearly its preferred role for PPFs, LACs and other patient/community health groups in the validation process, and the Scottish Health Council should actively provide feedback to local groups on how their input is being used. Particular attention should be paid to developing and encouraging the involvement of 'seldom heard' groups.
d) The Scottish Health Council, with the guidance of the Scottish Government, should develop appropriate and distinct ways to support validation in Territorial Boards, Special Boards with patients and other Special Boards, to ensure that appropriate and relevant standards are being applied.
e) The validation process should map onto the proposed PFPI assessment cycle, to focus on consistent themes over a three-year period. This will allow staff to build closer working relationships with community stakeholders.
f) A short validation report would be produced each year by the Scottish Health Council's local staff for each territorial Board (and two Special Health Boards with a territorial location), while the national office would lead on validation of the other Special Boards.
g) The Scottish Health Council should periodically draw together a national overview of its validation findings to identify examples of good practice and areas where improvement may be possible.
h) These recommendations are considered as the best way to develop the Scottish Health Council's local functions.

<u>Major service change: Assessing patient and public engagement</u>

24. 'Major service change' processes in the NHS are often complex, lengthy and, in the view of some respondents, in need of clearer definition. NHS Board PFPI practitioners expressed frustration at the absence of information on how the Scottish Health Council undertakes its assessment of patient and public engagement processes in such cases. Survey responses from both the Scottish Health Council and NHS Board PFPI practitioners agreed that Scottish Health Council staff need to be better equipped to perform this role. By a margin of 43% to 40%, staff felt the organisation was not well equipped to undertake this form of assessment, reflecting at least in part the uneven exposure to major service change across Local Offices. A majority of Board respondents (57%) did not feel their Scottish Health Council contacts were well equipped to assess major service change. One key element of concern for Scottish Health Council staff in focus groups was that major service

change assessments in particular should focus on the links between engagement processes and decision-making. However, this area has always been problematic as the Scottish Health Council role is to assess the process followed by Boards meets guidance. The Scottish Health Council has no role in commenting on the decisions Boards reach.

25. Recommendations:

a) An expert team covering major service change should be created at the national level, drawing upon the experience in this function held in different locations across the organisation.
b) Each Board undertaking major service change would then be offered a named contact within the team to support their work. An Area Office manager (see below) would have delivery responsibility for assessment of the consultation process by Boards, but would draw on the support of the national major service change team. Where appropriate, Area Offices should be able to draw upon additional staff capacity for the duration of the process recognising the significant draw upon resources at an area level and to avoid local capacity being stretched as far as it has previously.
c) When defining 'major' service change, some Boards call for greater clarity from the Scottish Health Council, as well as a clearer sense of the criteria that might prompt the Scottish Government to use the independent scrutiny process. It has not been possible to provide this and, arguably, no such guidance could be developed to offer clear-cut answers. Major service change is part of a spectrum of possible service change options: it is not always possible to anticipate which proposals will be regarded as major at the outset. One option is that an independent panel could meet under the auspices of the Scottish Health Council to offer guidance on the status of cases which are unclear and referred to it by Boards.
d) However, the primary role for the Scottish Health Council remains assessment of the patient and public engagement process planned and undertaken by Boards in cases of major service change. There is a clear need for external assurance that high standards of patient and public involvement are being planned and achieved.
e) Increasingly, the Scottish Health Council may come to focus on engagement activity across the spectrum of health service change rather than being limited to major changes. This would require staff to engage with Boards on an ongoing basis, offering guidance and assurance that engagement proposals/actions are appropriate and in proportion to the changes involved.
f) In parallel with, and drawing upon the development of national assessment and validation standards, the Scottish Health Council should develop a fully-fledged *quality assurance* role – that is, assessing how well Boards have engaged with patients and the public, not only whether they have taken reasonable steps to do so. In addition, the assessment process should consider how feedback from patients and the public has been taken into account by Boards, assessing what difference the process has made. This is not about assessing the decisions reached by Boards, but rather Boards being expected to demonstrate how they have responded to key concerns of patients and the public.
g) The complexity of the task should not be underestimated, but a more rigorous set of measures is both achievable and important for ensuring public and NHS Board confidence in the process.

The range of options explored in the Review are shown in the Annex.

Demand-led development

26. In this context development has an external focus linking to the quality and extent of PFPI activities and is not about internal organisational development within the Scottish Health Council. Development is perceived by many Review participants, both Scottish Health Council staff and external stakeholders, to have received less attention and been defined less clearly than the Assessment function. This is in line with the Scottish Health Council's own assessment that not enough focus has been given to development and the view of the Cabinet Secretary for Health & Wellbeing in the 2007 Annual Review.

27. Staff respondents felt that capacity to take the development agenda forward have been limited for a range of reasons. These include the pull to deliver assessment activity, especially in cases of major service change in the West Region, and clarity around what the development role involved. Three-quarters of staff (73%) felt that the development role had not been communicated effectively to them by the National Office while a similar proportion (75%) felt it was not well understood by Board PFPI staff. This was consistent with the high proportion (74%) of Board PFPI practitioners who felt that they did not understand the Scottish Health Council's development role. Moreover, 77% of Board respondents felt that current development activity did not offer much practical value, as did half of Scottish Health Council Staff. Four in five (79%) of the Scottish Health Council's staff and a higher proportion (89%) of Board respondents felt further clarification of the development role was necessary.

28. Local Office staff, in particular, felt there was a tension between their assessment and development roles, with monitoring and in some cases the perceived role of 'policing' the Boards tending to undermine their relationship when it came to promoting development. More than half (56%) of Scottish Health Council survey respondents agreed the dual roles sometimes placed a strain on working relationships. One quarter of staff (26%) disagreed. By a margin of 70%-13%, NHS Board survey respondents agreed that the dual roles cause strain. Many NHS Board PFPI focus group participants felt the roles should be performed by different bodies, while Scottish Health Council staff believed the roles should continue to be taken forward by the organisation though perhaps by distinct teams.

29. On the question of effectiveness, there was a spread of responses from both groups. Fewer than one in three employees (29%) said the organisation was effective in taking forward the development role, with a majority (51%) saying it was not. Almost three-quarters (72%) of NHS Board respondents rated the organisation as 'not very effective' or 'not at all effective' on this function. In focus groups, many Board PFPI participants reported that they would not currently regard the Scottish Health Council as a source of support for development of PFPI.

30. Survey findings point to a very high degree of consensus between Scottish Health Council employees and Board respondents on the importance of three development roles for the Scottish Health Council to take forward:

    - Identifying good practice in PFPI to share with Boards;
    - Supporting the development of Public Partnership Forums; and
    - Linking with the voluntary sector to find better ways to engage with disadvantaged, minority groups or seldom heard voices.

31. Recommendations:

a) The Development function should be split into two distinct roles: demand-led and supply-led.
b) Demand-led development is distinct from the supply-led development actions which would arise from the formal assessment cycle (see 'Assessment').
c) As noted above, the demand-led development function should be driven by a small dedicated team located at the national level.
d) A new framework for PFPI development, based on the concept of a knowledge hub, should be created by this team in partnership with staff across the organisation, Boards, PPFs and other stakeholders. The establishment of an expert Advisory Panel, drawing upon NHS practitioners, health service academics and other public and community involvement experts, would signal a new approach to engaging with stakeholders on development matters.
e) The Scottish Health Council should take the lead in preparing a 'menu' of development processes for NHS Boards, PPFs and other service user and community health groups. The Scottish Health Council has an opportunity to establish itself as a primary source of knowledge on the development of PFPI practice. A 'gateway service' would seek to match stakeholder development needs with advice on suitable options. This should focus mainly on spotting good practice and offering practical advice and guidance. Identification of development priorities and how to address them should increasingly be located within NHS Boards as a corollary to self-assessment.
f) Ongoing development should thus become differential and demand-led. The success of the Scottish Health Council's brokering role would depend on the credibility and reputation of its knowledge hub/gateway resources.
g) These recommendations are considered as the best way to develop the Scottish Health Council's demand-led development function.

FORM

32. The structure of a reformed organisation should flow from its revised functions. The guiding principles for reform should be: rigour; clarity; consistency; proportionality; and involvement of staff and Local Advisory Council members (lay volunteers) as well as external stakeholders.

Structure

33. In focus groups and interviews, Scottish Health Council staff reported consistently that the 'chain of communication' between Local Offices, Regional Managers and National Office did not function well, introducing delays and some contradictions in decision-making. Some interview respondents, both within and outside the Scottish Health Council, felt that it was unfortunate that the *Agenda for Change* grading exercise had resulted in Regional Managers being on a higher grade than National Office managers, as this had cemented in place a structural divide between functional managers (national) and operational managers (regional).

34. As a result, many staff regarded the Scottish Health Council as being four organisations rather than one: three regions and the national office. Staff reported the lack of a common understanding between national and regional levels, and many focus group respondents made a plea for stronger national office guidance and direction. The current structure was considered by many focus group participants to be based more upon former Local Health Council practices rather than the organisation's current needs.

35. Due to its Local Office network and Regional-level staffing, territorial issues have tended to have a more prominent bearing on how the organisation works than a desire to improve functional expertise. While the rationale for having a presence in every Board area may have been clear in the previous Local Health Council model, spreading staff across small Local Offices with various management layers above them has impeded good communication and effective management within the Scottish Health Council.

36. Recommendations:

a) A small number of Area Offices – around 6 or 7 - should replace the 14 Local Offices and 3 Regions. This would provide a critical mass of staff capacity to undertake validation and development/capacity-building roles with PPFs and service user groups. A two-tier National/Area structure is more likely to deliver better communication and consistency in implementing improved frameworks, especially if there is a commitment to a higher level of partnership working than has been evident to date.
b) A network of fewer, but larger, area teams would increase staff capacity and skills mix at a local level, which are currently spread too thinly. This should offer opportunities for staff progression. However, this does not necessarily mean staff having to re-locate. A flexible approach to outreach and home-working should be adopted. In parts of Scotland where commuting to an Area Office is difficult or impossible, support could be provided by a Board or PPF to allow staff to work locally at least part of the time.
c) All posts should reflect functions rather than geographical locations (e.g. 'validation officers' rather than 'local officers'). This is more than a semantic difference. It has been difficult for Scottish Health Council staff to clearly establish and communicate their mandate in their relationships with NHS Boards in particular, and clarity over roles will assist greatly in this. The establishment of clearer functional roles should also allow for progression opportunities within the Scottish Health Council, NHS QIS and elsewhere within the NHS.
d) We support the swift implementation of the National Council's decision (April 2008) to create a new post to support the Director and oversee operational performance. We recommend the creation of an Operations Director post. This would usefully boost senior capacity with a remit to take forward key aspects of internal communications and delivery, for example co-ordinating the work of the proposed Area Offices, enabling the Director to focus on strategy and policy matters. The Operations Director would deputise for the Director as appropriate.
e) The Scottish Health Council National Office, with the support of its own National Council and NHS QIS, will be required to lead a process of cultural change reflecting changes put in place following this Review. The organisation needs to be prepared to be agile to adapt to changing needs and circumstances.

Governance

37. The Scottish Health Council is currently neither fully integrated into NHS QIS nor fully autonomous. The legislation which created the Scottish Health Council required NHS QIS to establish the Scottish Health Council as a Committee of its main Board. The Chair of the Scottish Health Council is a Ministerial appointment. The then Scottish Executive referred subsequently to the Scottish Health Council being "established within NHS QIS with its own distinct identity." The Council's staff are employed by NHS QIS and subject to NHS QIS operational procedures.

38. Scottish Health Council H.R., Finance, IT and Communications operations are provided by NHS QIS. However, the policy and work programme of the Scottish

Health Council are agreed by its National Council and sponsor division in the Scottish Government Health Directorates. The Scottish Health Council is accountable for its performance to the Cabinet Secretary through the Annual Review process, but the Chief Executive of NHS QIS is, ultimately, the Accountable Officer for the Scottish Health Council. NHS QIS auditors have indicated that this could create a business risk which at present is managed by good inter-personal relationships rather than a robust accountability framework.

39. The relationship between the two organisations was described variously by interviewees as ‘anomalous’ and ‘uncomfortable’, although the relationship was still seen to be working thanks to the efforts of senior staff in the Scottish Health Council and NHS QIS. However, a great deal of emphasis was put on the personal nature of that relationship and interviewees acknowledged that if different personalities were involved the position could change. Scottish Health Council staff had mixed opinions on the organisation’s status: a small number of staff would prefer complete independence while others thought there would be practical benefits from a closer relationship with NHS QIS.

40. Although reflecting the situation at the time of the Scottish Health Council’s creation, we believe this dual identity has subsequently led to complications in the presentation of the organisation’s role and raises questions about lines of accountability. The status quo is a feasible option for the future, since the organisations have worked with it for more than three years without serious risks to either. The model need not be particularly comfortable or neat to be regarded as workable. We recognise that a focus on issues of governance could cause a hiatus period in terms of improving operational performance at a crucial time. However, maintaining the status quo seems to be conditional on there being a consensus between the organisations that this is the right option at this stage. It is not clear that such a consensus exists.

41. Recommendations:

a) The Scottish Health Council could become a Directorate of NHS QIS, with the statutorily independent National Council continuing to oversee its work. Scottish Health Council staff could become ‘mainstream’ employees of NHS QIS while still working with a significant degree of autonomy. Accountability could be streamlined by reporting to Ministers through the NHS QIS Board rather than separately. The Scottish Health Council could report as a more substantive part of the NHS QIS Annual Review process than currently, but there would be a need for NHS QIS to report the activities of the Scottish Health Council in terms distinct from its own activity. Ultimately, it is for the Scottish Government to decide whether, when and how this issue should be addressed.
b) Under any option, we recommend that the Scottish Health Council’s status within the NHS QIS ‘umbrella’ should be reasserted. NHS QIS has been able to maintain its intellectual and operational independence in holding NHS Boards to account for their performance while remaining an NHS Board and the same can extend to the Scottish Health Council. This would also be in line with the shifts in assessment and inspection processes recommended by Crerar.
c) The National Council would benefit from developing a deeper working knowledge of how the various functions are carried out to inform their strategic overview and capacity to engage in resource planning. The National Council as a whole should play a more strongly-emphasised oversight role on behalf of the Board of NHS QIS.
d) In the early development of the Scottish Health Council, it was clearly important that both the Director and the Chairman played an active role in ensuring that the organisation was moving forward in order to deliver its functions to the satisfaction of

Scottish Ministers. As the Scottish Health Council moves from its ‘establishment’ phase to a period of ‘capacity building’, we believe that the appointment of an Operations Director with day to day responsibility for delivery should free up time for the Director to focus more on matters of strategy and policy, and for the Chairman to focus on ensuring the National Council works effectively as a strategic oversight body for the Scottish Health Council.

Enabling Factors

42. The Scottish Health Council needs the opportunity to develop as a national organisation, with a much clearer structure aligned to functional responsibilities. The National Office should have lead responsibility for creating improved frameworks and procedures to ensure consistent delivery of the organisation’s functions across the country, and ensure that it makes full use of staff skills and experience. Currently, only one in four staff believe that the organisation’s work (e.g. taking forward the development role) is informed by a wide range of expertise including that of staff, and clearly there is room to improve in this area. More than four in ten (43%) staff felt that there are enough staff with appropriate skills and experience throughout the organisation, while a similar proportion (41%) did not. Almost half (47%) did not believe there were sufficient training opportunities available for staff to acquire additional skills.

43. In focus groups, it emerged that many Local Office staff do not appear confident in their ability to perform the tasks expected of them, and Board PFPI practitioners reported that they did not always regard Local Office staff as sufficiently expert or senior enough to be regarded as experts in PFPI. The Scottish Health Council should, therefore develop appropriate training, guidance and personal development tools in collaboration with staff.

44. Recommendations:

a) The National Office should develop and disseminate a national overview of Scottish progress with the PFPI agenda based on evidence emerging from assessment, validation and development activities. This will allow it to identify common themes emerging across NHS Boards; significant gaps and weaknesses; and to focus on how well staff are performing.
b) While the interaction between Local Officers and PFPI leads in the NHS Boards is often mis-matched in terms of status/expertise, some Local Officers appear to be working significantly below their level of competence. The overall skill set of the Scottish Health Council needs to gravitate upwards, with the organisation making a conscious commitment to its entire staff becoming expert advisers and assessors within the terms of their functional roles, be they expert at working with local organisations to validate NHS Board activities, or in the development of new PFPI techniques within NHS Boards.
c) A programme of ongoing training and development should flow from a formal and structured induction (with the Knowledge and Skills Framework to be used where appropriate). Personal Development Plans should be developed consistently and actions put into practice to ensure that skills development flows from roles and responsibilities.
d) A dedicated organisational development and learning post might provide valuable capacity to enable the organisation to make progress on this front.
e) A more strategic engagement is needed between Scottish Health Council’s senior managers and NHS Boards to set the context for ongoing relationships between the Scottish Health Council and NHS Board staff on a day-to-day basis.

f) The Scottish Health Council would benefit from reviewing and improving its own internal communications, to ensure a consistent, shared understanding amongst its staff of the organisation's priorities, and therefore the roles and responsibilities for staff. This will in turn be the next step towards enhancing the Scottish Health Council's credibility with external organisations, as its staff act as ambassadors for the organisation with external stakeholders.
g) In reforming each of its functions, it is essential that the National Office draws upon the experience of staff across the organisation, and continues to look outwards to engage with key stakeholders, in developing new frameworks, tools and training opportunities.
h) Better communication about roles, expectations and timescales is needed between the Scottish Government and the Scottish Health Council to ensure a programme of reform succeeds.
i) Evidence from the Review supports the conclusion that the Project Team establishing the Scottish Health Council created a three-tier structure which has proved complex and unwieldy in terms of communication and management. Overall, staff have done their best to make a flawed structure work, but only structural reform to fit with its revised set of functions is likely to improve matters. A two-tier structure formed around a clearer set of functions, being taken forward by staff better equipped and more confident, is significantly more likely to succeed in these terms.

ANNEX 1

The range of options explored are as shown for the following themes:

Assessment of key PFPI actions by Boards	
Option 1: Recommendation	**Integrated PFPI assessments based on a 3 year cycle. Focus on a smaller number of service areas in more depth. Combined Scottish Health Council/QIS team. Addition of peer reviewers from other Boards and some lay reviewers.** Boards continue to produce annual self-assessment reports as 'milestones' towards eventual SHC/QIS assessment. 21 Boards suggests c.7 assessed per year, with framework tailored to needs of territorial Boards and types of Special Health Boards. Requires progress towards the Participation Standard.
Pros	Assessment model draws upon QIS expertise. Offers national consistency in assessment. Separated out from other functions. Eases discomfort in Local Officer/Board relations. Movement from quarterly to annual reporting by Boards and feedback by the Scottish Health Council is more proportionate.
Cons	Different cultures, approaches to measurement and relationships with Boards between Scottish Health Council and QIS. Unclear how well these can be combined for purpose of integrated PFPI assessment. This would be a partial approach: it is likely to leave some areas still requiring separate assessment activity (i.e. area of overlap may be significant but not complete).
Option 2	**Transfer PFPI assessment function wholly into QIS.**
Pros	As for Option 1, drawing more fully upon QIS expertise and enhances credibility with Boards.
Cons	Although there are areas of overlap with SHC, QIS primary focus is not patient and public involvement. Risk of losing a dedicated focus on the quality of PFPI activity by Boards.
Option 3	**Stick with Board annual self-assessment and validation by the Scottish Health Council, but no other external assessment of PFPI actions.**
Pros	A 'lighter touch' option which would see SHC staff become mainly community-facing and building up validation evidence with PPFs, service users and others.
Cons	Unclear that self-assessment reporting by Boards has demonstrated sufficient progress to assure Ministers and the public of the commitment and quality of engagement led by Boards. Unclear when the evidence base underpinning validation activity will be sufficiently robust or consistent to serve as the only check upon progress within Boards.

Assessment of Major Service Change informing, engaging and consulting options and process	
Option 1: Recommendation	**Major Service Change team established to develop expertise in quality assurance of informing, engaging and consulting options/actions with patients and the public, working alongside Boards from early stage of process.** Revised framework co-ordinated by team at National Office in partnership with local/regional staff experienced in this area. Joint delivery with key Area Office staff. Boards have named contact(s) within Major Service Change team.
Pros	Establishes a functional centre of expertise, offering consistent guidance to Boards. Develops a national overview of findings from cases of Major Service Change.
Cons	Unknown if sufficient cases of major service change to justify a permanent core team. Option likely to be more sustainable if team also advises Boards on appropriate engaging options for other (non-major) forms of service change.
Option 2	**As Option 1, but established as a project team to develop revised framework, and thus with a finite life. Delivery then taken forward at Area Office level as cases occur, drawing upon National Office expertise (Major Service Change Manager) as required.**
Pros	As above, with potentially more flexible use of National/Area Office staff expertise.
Cons	Unclear if sufficient National Office expertise is maintained. Risk of unreasonable burden upon some Area Offices, with knock-on effects for other tasks (validation and local capacity-building).
Option 3	**Establish a *service change team* with a remit to offer best practice guidance to NHS Boards across the spectrum of service changes, including but not limited to major service change.**
Pros	Team serves as a 'critical friend' to NHS Boards when service changes are planned. If changes are then identified as 'major', initial engagement will have been covered during the early stages of the process; could help to raise the quality of engagement for any proposed service change by NHS Boards; Scottish Health Council staff involved from the start and should mean 'no surprises' for either side as the process moves forward. Proportionality should be the core principle applied.
Cons	NHS Boards would only value team's input if competence and experience demonstrated; risk of the team being perceived as extending the *assessment* role across the spectrum of service change cases, rather than offering advice and guidance.
Option 4	Combine secretariat support for Independent Scrutiny Panels (ISPs) with Major Service Change Manager/team role. These are separate functions, with the Scottish Health Council's role to provide quality assurance of PFPI engaging activity by Boards, and ISP role to consider the quality of Board options for service change.
Pros	Over time, this is more likely to add up to a significant role within the National Office.
Cons	A conflict of interests might be perceived outside the organisation, and the distinction between the two roles lost.
Option 5	Independent expert panel convenes under the auspices of the Scottish Health Council to assess what is 'major' - and thus requires

	the full engagement process - in cases referred by Boards. This is not, strictly, about the Scottish Health Council's functions but a possible other secretariat role which might require Ministerial assent to be established.
Pros	Provides an independent assessment of cases that are likely to be contested/controversial. Offers a process for treating difficult issues consistently.
Cons	Charge of lacking accountability and making decisions without sufficient local knowledge. Boards may be unlikely to accept decisions without right of appeal.

Governance: Relationship with QIS	
Option 1: Recommendation	**Closer integration: The Scottish Health Council becomes a Directorate of QIS.**
Pros	The Scottish Health Council's distinct status within NHS QIS is maintained. It reports through NHS QIS but is accountable to Ministers for ensuring its roles are performed effectively. Lines of accountability would be reduced. Operational issues related to common service may be resolved more readily.
Cons	The option requires greater scrutiny. The risks are probably small, but the risk of distracting the Scottish Health Council from the task of reform may be greater.
Option 2	**Status quo: existing governance relationship continues.**
Pros	The Scottish Health Council and QIS have lived with an anomalous situation for more than three years without obvious risk to either. The governance model need not be particularly comfortable or neat to be workable.
Cons	Relies on skilful management of the interface between the two organisations. Potentially vulnerable to a change of leadership in either. Consensus in favour of the status quo is unclear since one partner (QIS Board) has expressed concern about potential risks.
Option 3	**Independence: The Scottish Health Council becomes a separate organisation.**
Pros	Likely to increase profile of the Scottish Health Council's objectives and emphasise its independence from Boards.
Cons	Unrealistic in a policy environment moving towards fewer public bodies rather than more, and efficiency savings through shared services. Risk of creating PFPI activity as a separate endeavour, cut off from the NHS.
Option 4	**Merger: QIS takes on the full remit for ensuring progress in PFPI.**
Pros	Could mainstream PFPI into other quality improvement frameworks.
Cons	High risk of losing a dedicated focus on how the NHS is faring in non-clinical aspects of PFPI. The Scottish Health Council and NHS QIS bring different approaches to an agenda with important areas of overlap. Merging the functions into one organisation is not necessary to achieve greater synergy.