PUBLIC HEALTH REFORM OVERSIGHT BOARD (Paper 5.1)

PUBLIC HEALTH SCOTLAND: ENABLING THE NEW BODY

Purpose

1. Now that we have published public health priorities for Scotland and the commissioning process is underway to design and identify the new functions needed by Public Health Scotland (PHS), the programme team would value the Oversight Board's views on whether to progress the delivery of PHS as a Special Health Board or as a non-NHS organisation.

2. To support the discussion, this paper seeks the views of the Oversight Board on:

   2.1 the purpose of the new body;
   2.2 key functions or activities of the body; and on the potential legal basis for the organisation.

3. The Oversight Board's reflections and comments will allow the SROs to recommend an approach to political leaders and will allow the programme team to formally start the legislative and recruitment process for the Board and Chief Executive of the new body.

Purpose of Public Health Scotland

4. At the outset, the purpose of Public Health Scotland needs to reflect the desired relationship we would like PHS to have with Scottish Ministers and Local Government leaders i.e. how the new body is to be governed and funded, how it will be accountable to Scottish Government and COSLA, and the extent to which Scottish Ministers and COSLA should provide direction and guidance and control day-to-day operations. **Annex A** sets out the broad design principles which were agreed by Scottish Government and COSLA at the very outset of the programme, which reflect this. Key aspects of this are, for example, that the body must support a whole-system approach; that it must be seen as being upstream of and distinct from the NHS; that it must support local-decision making; and that it must have a role in ensuring the best use of public sector data.

5. These design principles have been further refined over the course of the last year. As we move into shaping the new body it is important that we test our current description of these guiding principles for Public Health Scotland. This can be summarised as follows:

   5.1 PHS should be jointly accountable to Scottish Ministers and Local Government for the delivery of its strategic objectives as far as possible. However, national and local government also recognise that there may be some key current or future functions (for example, around health protection and contingency planning at the national level) where accountability will need to continue to rest with Scottish Ministers alone. Scottish Ministers are inherently accountable for the performance of the statutory public bodies and health bodies that they fund, so some of this

accountability may need to be achieved administratively via cooperation, consultation and agreements, rather than defined in legislation.

5.2 A general principle should exist of seeking opportunities to undertake processes jointly between national and local government. This should be the preferred approach at all times. Examples might include the selection of the Chief Executive and Chair roles and final agreement of PHS's strategic objectives. Where processes, such as appointments, are attached to a Ministerial power and so sit with Scottish Ministers in a legal sense, this should not preclude making joint decisions with local government around how those powers are exercised.

5.3 Partnership working must sit at the very heart of PHS, recognising their role in supporting the multi-dimensional system of public health. In other words, it is crucial that PHS's primary focus is on enabling the whole system to deliver better public health outcomes and that it is able to work with partners to coalesce around the new public health priorities as they relate to community planning across Scotland.

5.4 PHS should co-design its strategic objectives with relevant partners across the whole system that influences the public's health. This principle conceives of the public health system in its widest sense, and so is multi-dimensional and underpinned by transparency and collaboration.

5.5 Performance reporting should link with existing frameworks and serve to improve transparency and strengthen relationships with communities. This will require some re-orientating of performance reporting to ensure it is more local-facing.

5.6 PHS must have a clear identity, distinct from the NHS and not be perceived as another NHS Board. This will include stand-alone branding and an overt focus on establishing a unique culture and identity as a vehicle for public sector partnership in the widest sense, as part of a multi-dimensional system of public health.

5.7 With the above point in mind, PHS should have the capability to employ non-NHS staff, in addition to NHS staff, and cater for the employment requirements of non-NHS staff (for example, providing continuous service to local government employees with related pension entitlements).

5.8 PHS staff should be located and deployed in a way that helps re-orient the public health system to be more local-facing and support collaboration across the wider system. Over the medium-term, this could include at least a partial move from NHS premises and the identification of co-location collaborative spaces at community, local and national levels, comprised of PHS staff and relevant partners from other parts of the wider public health system.

5.9 PHS must be able to share services with both NHS and non-NHS public bodies and this needs to be done in a way that embraces the whole of the public sector and beyond i.e. the third sector.

Q1. Do you agree that these points are sound guiding principles for Public Health Scotland?

Functions of Public Health Scotland

6. The Board will be aware that work has been undertaken at a high level to describe the functions for Public Health Scotland. This has informed the decisions that were taken in the last year about which existing organisations would be brought together as part of the creation of the new body. However, in developing Public Health Scotland, our starting point should not be limited solely to existing activities – we should consider all the activities and functions that we would wish Public Health Scotland to have.

7. In this regard, our work to begin designing the organisation has separated the functions of PHS into five broad categories, as follows:

   Category 1: *Services/functions that we are already clear PHS will provide, and which are already provided to a large extent by NSS and HS.*

8. There are three existing functions that fall into this category, where it has already been agreed the functions will transfer to PHS:

   - Health protection services (currently provided by HPS)
   - Health improvement services (currently provided by HS)
   - Data, intelligence and evidence services (currently provided by ISD, HPS and HS)

9. These functions already exist within NSS and HS. While these services may develop and change and, in particular, be delivered increasingly in support of local systems, we do not anticipate that the actual services will differ fundamentally from those currently described in existing legislation.

10. In relation to the data, intelligence and evidence service, we also anticipate that PHS will be the data controller for the datasets currently held by NSS and HS and will have the flexibility to collect and have data control responsibilities for any future datasets.

    Category 2*: Services/functions that we are already clear that PHS will provide, and which are already provided to some extent in NSS and HS.*

11. There is one service area that falls into this category:

    - Support for delivery of effective, efficient and high quality health and social care services – healthcare public health (HCPH)

12. HCPH (which we are describing as 'Improving Services' within the reform programme commissions) is not a specific service currently provided by NSS or

HS, but ISD do deliver a significant amount of intelligence to support related activity.

13. We note that some aspects of HCPH are currently included within the functions of Healthcare Improvement Scotland. Additionally, some aspects of HCPH, currently included within the functions of HIS, may also need to be established within PHS as a complementary function. That said, we do not anticipate transferring any functions out of HIS into PHS.

Category 3: *Services/functions that we are already clear that PHS will provide, and are not currently directly provided by NSS and HS.*

14. These include:

- National leadership for public health research
- National leadership for public health data science and innovation
- National leadership for the broad multidisciplinary public health workforce

15. We anticipate that there will be some existing functions within NSS that relate to these leadership duties and that there may also be the need for new leadership functions. The detail of what these services should involve is being developed by the programme commissions and we expect to reflect these duties in the enabling legislation for the new body as the commissioning process clarifies the additional services and roles PHS will need.

16. We also anticipate that some aspects of leadership for the public health workforce, currently included within the functions of NES, may also need to be established within PHS as a complementary function. That said, we do not anticipate transferring any functions out of NES into PHS.

Q2. Are there any additional leadership roles you would expect the new body to undertake?

Category 4: *Services/functions that we are considering and may or may not be delivered by PHS depending on further work.*

17. There is one area of work that falls into this category:

- Employment of specialist public health workforce (either in part or in whole)

18. NSS and HS already employ some specialist public health staff. The majority of other specialist public health staff are employed by territorial NHS Boards, or by Local Authorities. It may be that we want some or all of these staff to be employed by the new body from the start, or at some point in the future (depending on the outcome of work which will be undertaken through a planned commission), so we would want to design the new arrangements with this in mind.

Category 5 – *Services/functions that PHS may deliver which we are not yet aware of.*

19. The areas discussed above cover the main services/functions that are evident from our blueprint and described in the commissioning documentation. We do not anticipate significant additional services/functions being added in this first phase of public health reform, but it is possible that the commissions may yet identify such opportunities. Additionally, the wider reform work across government and elsewhere – particularly the whole system discussion - could identify the need for other functions/services and organisations to be considered as part of subsequent phases of public health reform. We have concluded that such discussions fall beyond the terms of reference for the current reform programme.

Q3. Does the Board agree that these five categories describe the main categories of functions that we need to ensure our legislative approach delivers to support Public Health Scotland?

20. We are aware that we also need to ensure that Public Health Scotland is able to respond and develop as required in the future. We recognise that the categories described above, and the specific functions discussed, are the functions we need to consider for 'go live'. However we will ensure our approach does not close off the potential to develop other capabilities in the longer term.

Legal Form of Public Health Scotland Advice

21. The Programme Team has undertaken work to consider the various options for the legal form of Public Health Scotland. The following text reflects more detailed considerations in respect of setting up Public Health Scotland as a Special Health Board, or as a Non-Departmental Public Body. The Programme Team is seeking advice and views from the Oversight Board in terms of the strengths and weaknesses of both of these possible options.

22. The Programme Team has also considered other possible options, such as establishing an Executive Agency, or a Non-Ministerial Government Department, but these have been ruled out for various reasons, but particularly because of the importance of ensuring the new body will be operationally independent and legally distinct from Scottish Government.

Option 1: Special Health Board

23. The first approach would be to establish Public Health Scotland as a new Special Health Board. **Annex B** to this note provides a summary of the likely strengths and weaknesses of this approach, but in summary:

23.1 This approach would ensure that PHS could be established in 2019; that there would be a minimum disruption to staff; would present fewer information governance challenges in relation to NHS data; and it would

be possible for the body to be branded, presented and described as being upstream and separate from the NHS.

23.2 However, this approach will require a bespoke approach to ensure that it is genuinely accountable to Local Government as well as Scottish Government – in Annex B we describe a model of a Public Health Collaboration underpinned by an MOU.

24. In terms of the legislative approach, using the vehicle of a Special Health Board will require a two–stage legislative approach. Firstly, transferring or replicating the majority of the Category 1 and 2 functions set out above under existing secondary legislation measures within the NHS (Scotland) Act 1978; and thereafter, enabling any new functions (and some existing functions that can't be moved or replicated easily) through a Super Affirmative Order under the Public Services Reform (Scotland) Act 2010.

25. The drafting and negative resolution timescales for delivery of the first stage are reasonably lean (a few months), but the second stage could take closer to a year. Assuming the majority of the existing functions could be transferred quickly at stage 1 and noting that related recruitment of the Board and Chief Executive could be delivered in parallel (as Special Health Boards are already within the remit of the Commissioner for Ethical Standards in Public Life in Scotland), this could allow the shadow Board and Chief Executive to be in place as early as March 2019 and the transfer of all functions (existing functions and additional functions) could be achieved before the end of 2019 to allow Public Health Scotland to be established before the end of the year.

Option 2: Non-Departmental Public Body

26. An alternative route to a Special Health Board would be to establish a new Non-Departmental Public Body. **Annex C** to this note provides a summary of the likely strengths and weaknesses of this approach, but in summary:

26.1 This approach would allow us to build something new, and genuinely separate from the NHS and there would potentially be more flexibility in what we design.

26.2 However, the legislation for this approach is likely to take much longer and may delay the establishment of the body due to Parliamentary scrutiny; we would have to justify to Parliament why we cannot allocate functions to an existing body; this approach will be much more disruptive in terms of staff terms and conditions; and information governance is likely to be particularly complex (NHS data being governed and managed in a non-NHS body) and may risk our ability to deliver an organisation where data and intelligence is our underpinning foundation. This approach would also likely require a similar approach to governance and accountability as the Special Health Board due to limitations on the ability to make an NDPB accountable to any bodies other than Scottish Government or Parliament, and due to the fact that COSLA does not have a statutory basis. Accountability to Local Government would have to be achieved through

an MOU arrangement, potentially along with legislative duties of consultation and cooperation with local authority leads in specified circumstances.

27. In terms of the legislation, to establish a Non-Departmental Public Body, we would require all related policy actions to be taken forward as a Super Affirmative Order under the Public Services Reform (Scotland) Act. This process would take closer to a year to deliver. Additionally, the new body would need to be brought under the remit of the Commissioner for Ethical Standards and this would delay the recruitment process. We anticipate that this would lead to the Board and Chief Executive being appointed in the autumn of 2019 at the earliest, and the new body being established legally probably in early 2020 at the earliest.

Discussion

28. There are clearly strengths and weaknesses with both possible approaches, as set out above. The different legislative approaches will also have implications. For both approaches described above the Super Affirmative procedure comes with related and detailed Parliamentary scrutiny. An advantage of the Special Health Board approach is that most of the functions could be transferred using other means, and only a smaller proportion of functions would need to be transferred or established using this Super Affirmative procedure. This means that even if there are challenges with this, Public Health Scotland could still be established as a Special Health Board with some of its functions, before the Super Affirmative procedure completes. It would also ensure that existing functions are transferred “as is” without the need for a plenary vote in Parliament. For an NDPB approach, we would not be able to establish PHS in anyway until the Super Affirmative procedure completed.

29. Work has now begun to set out in detail the existing Category 1 and 2 functions described above, in preparation for the Parliamentary process (whatever approach is taken). We will shortly combine this material with related policy instructions describing the emerging role, responsibilities, governance and accountability of the new body. We anticipate all new functions will be identified through the commissioning process, but it is likely to be early autumn at the earliest before the commissions really begin to inform the detailed policy instructions that we will produce.

30. We are also keen to start the recruitment process for the leadership of the new organisation as quickly as possible, to ensure this leadership is in place as far ahead of the organisation being established as possible.

31. For all of these reasons, the SROs would now welcome the views of the Oversight Board on the two possible approaches to the legal form of the new body. In addition to Annexes B and C, **Annex D** offers more detailed information on public bodies in Scotland.

Q4. Given the comments above, and the more detailed assessments of strengths and weaknesses in Annexes B and C, the Oversight Board is invited to discuss options for the legal form of Public Health Scotland.

ANNEX A

PUBLIC HEALTH REFORM DESIGN PRINCIPLES

Public Health at the National Level

- The organisational model for the new body will be co-designed by Scottish Government, Local Government and NHS Scotland, working with the third sector and other partners.

- The governance and delivery model for the new body will include meaningful accountability to both Local and National Government.

- The new body will provide strong, visible independent public health leadership to challenge, support and deliver our agreed national priorities.

- The new body will '*declutter'* and simplify the national public health landscape.

- The new body will be, and be seen to be, upstream of and separate from the NHS, while retaining important operational links.

- The new body will have an overall responsibility for ensuring that the best use is made of public sector data, initially starting with health and Local Government data, and will use this in ways to support public health improvement.

- The new body will provide capacity and capability to ensure national and local decisions and interventions are intelligence and evidence led, and that local professionals (in Local Authorities, Community Planning Partnerships, Integration Authorities and NHS Boards) are supported in areas such as service change, efficiencies, economic impact, equality of prosperity and inclusive growth.

- Where appropriate, and where the new national body provides the best opportunity for doing so, some functions will be delivered nationally on a 'once for Scotland' basis.

- The new national arrangements will support a multi-agency approach to public health both nationally and locally.

- The new body will be staffed by a 21st Century public sector workforce, continuously seeking to improve efficiency across the public sector; encouraging the application of generic skills as well as international expertise; grounded in agreed ethics and values; and fostering leadership at all levels.

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Public Health at the Local Level

- Support for local public health activity in order to contribute to delivery of the public health priorities is strengthened. The offer of support will include the third and independent sectors where that is appropriate.

- Additional or new local structures will not be created on top of the existing complex landscape.

- Our work will be informed by the agreed public health priorities (with form following function).

- Additional local priorities and a flexible approach to local prioritisation will be respected and supported.

- The successful establishment of a credible, effective new public health body which is responsive to local strategic planning needs is key to building momentum and support for stronger local partnerships.

- It may not be possible to define solutions immediately and opportunities may arise naturally for us to try different models of strengthening local partnerships. We will seek to make effective use of such opportunities.

ANNEX B

SPECIAL HEALTH BOARD

Proposal

- Create a new Special Health Board which brings together the health service functions for health improvement, health protection, health intelligence and health service public health. Governance would be as with other health boards and formal accountability would be to Ministers and to Parliament (through Ministers and directly as appropriate).
- Board appointments would be made formally by Scottish Ministers, but in agreement with COSLA. The selection panel can have a jointly agreed, mixed background panel, with a jointly agreed appointment plan/specification for the role.
- Unlimited committees to delegate specific scrutiny functions to.
- Legislative duties to consult and cooperate with defined public health partners, such as third sector organisations or local authority leaders, can be added.
- Establish an MoU between the new body and COSLA/SOLACE to enable collaboration i.e. a Scottish Public Health Collaboration. As such, COSLA would remain accountable to its members rather than to Ministers for its public health collaboration activities, and Public Health Scotland would be accountable through the Collaboration to COSLA/SOLACE.
- The Collaboration would have no budget or staff of its own – it would be entirely supported by the new public health body – but it would bring together some (or all) of the Board members of the new body and its Chief Executive with COSLA and SOLACE representatives, with the aim of fulfilling the MoUs remit.

Strengths

- Special Health Board governance and accountability arrangements are clear and the size and composition of the board is flexible.
- The 1978 Act allows for Special Health Boards to be delegated the function of providing goods and services to local authorities and education authorities.
- The 1978 Act allows for Special Health Boards to be delegated the function of providing assistance to voluntary organisations, including financial assistance and services.
- NHS pay and remuneration is well understood and likely to be supported by most of the current staff. NHS pay is accorded a high level of political protection.
- The 1978 Act allows for the easy transfer of NHS staff, property, and liabilities (ongoing legal cases, complaints, staff hearings etc.).
- Information governance for NHS data sets would be unaffected by the transfer to a Special Health Board.
- MoUs are a well understood and tested way of working between local and national government, allowing two sets of accountability arrangements to co-exist in one structure with conjoined overall control of public health across a wide range of sectors – and all without binding legislation. This would make it easier to include additional parties to the MOU from other bodies (such as HIS, FSS and SEPA) at a later date.

- The MoU represents a statement of intent, mapping relevant parties and their responsibilities; key stakeholders; shared resources; oversight; conflict of interest and resolution arrangements; staff; costs; periodic review arrangements; and key priorities.
- The Scottish Public Health Collaboration would provide a vehicle for accountability to Local Government, bringing together Public Health Scotland and Local Government representatives at national (COSLA/SOLACE) and local (CPP) level.
- Accountability at the National Level would remain with Scottish Ministers through the Board and its relevant committees; and to the local electorate through council leaders.
- This national led Collaboration would help to make this specific partnership working distinct from the work of CPPs and IJBs – which are more structured and entirely local.
- There would be no requirement for the new body to be publicly branded as an NHS body – it could create its own identity distinct from the NHS.

Weaknesses

- The Order to create a Special Health Board can only delegate Scottish Minister functions related to the Health Service, as specified in the NHS (Scotland) 1978 Act. Any functions outwith that scope will require a separate Order under the Public Services Reform Act (Scotland) 2010.
- NSS has an expansive shared service power in the Public Bodies (Joint Working) (Scotland) Act 2014. It can currently provide administrative, technical, legal, other professional and accommodation services to Scottish Government and any other Scottish public body or cross border public body (in addition to local authorities and education authorities). To achieve that additional power for a new Special Health Board would require a PSRA Order.
- For local government employees, pay and other employment matters are delegated to local authorities, so there is more flexibility with regard to pay alterations etc., dependent upon budget. NHS terms and conditions may be seen as less flexible.
- Not clear the extent to which an NHS Board can directly employ non-NHS staff so directly involving non-NHS staff in the work of the body would need bespoke arrangements or deployment rather than employment (i.e. ongoing employment by other organisations but deployment to the body).

Opportunities

- The use of a negative resolution Order under the 1978 Act would allow the new body and its core functions to be established quickly, with less risk of challenge from MSPs and Parliamentary Committees.
- Quickly establishing the body will enable earlier appointment of new leadership.
- To help them discharge their functions, Boards also have the ability to establish committees with membership drawn from board members and the broader professional landscape for public health. A specific Public Health Partnership Committee could be created encompassing local government and third sector

membership, with specific responsibilities to embed and monitor partnership working at all levels in the organisation.

- Health Boards already have a duty to cooperate with Local Authorities, but further duties could be added via legislation to cooperate and consult with defined 'public health partners' such as the third sector and local government leads, on issues such as the preparation of the national strategic plan, corporate plan, improvement plans or annual reports.

Threats

- A new Special Health Board may be perceived as a simple rebrand and consolidation of existing NHS bodies, rather than a fundamental change in approach.
- There may be barriers between the predecessor organisations that need to be broken down, in order to engender a real change in approach and to mitigate against silo working.
- The MOU and Public Health Collaboration approach may be seen as complex and unhelpful.

Conclusion

In short, the Special Health Board option offers the opportunity to establish the new public health body within agreed timescales, and in a way that enables the transfer of staff, property, liabilities and information with the minimum of complexity. It also offers resilience in terms of access to the pool of NHS Scotland staff and will be attractive to NHS staff in terms of maintaining their existing pay, terms and conditions and career/promotion opportunities.

There are some drawbacks – particularly in terms of the extent to which the new body will be seen as meaningfully different and whether or not the MOU and collaboration approach will be seen as robust (but a similar approach would be needed for an NDPB as well).

ANNEX C

NON-DEPARTMENTAL PUBLIC BODY (NDPB)

Proposal

- The creation of a new Executive NDPB would require primary legislation or an Order under the Public Services Reform Act (Scotland) 2010 to establish. There are a limited number of slots for Bills in each annual legislative programme and bids are prioritised. A PSRA Order generally has a parliamentary process of at least 7 months, assuming no significant challenges from Parliament.
- Governance and accountability would be prescribed in legislation. Accountability would be to Scottish Ministers who ultimately are accountable to Parliament for the functions and performance of the body.
- Board appointments by Scottish Ministers in agreement with COSLA. The selection panel can have a jointly agreed, mixed background selection panel, with a jointly agreed appointment plan/specification for the role.
- Unlimited committees to delegate specific scrutiny functions to.
- Legislative duties to consult defined public health partners and cooperate can be added.
- Establish an MoU (as with Special Health Board) to establish Public Health Collaboration to provide accountability to Local Government.

Strengths

- The new body would have a unique identity and brand, separate and fully upstream from the NHS.
- The new body would have the flexibility to negotiate its own pay deal with Scottish Ministers, albeit within the constraints of SG Public Sector Pay Policy.
- The new body would have greater autonomy in the use of its allocated budget, the number of staff required and the most appropriate organisational structure to deliver its remit economically, efficiently and effectively within the resources available to it.

Weaknesses

- Statutory bodies cannot hold corporate legal existence until Royal Assent for the enabling legislation has been obtained. Consequently, expenditure on the new body, including the costs associated with the recruitment and appointment of Board members and the chair would normally be delayed until after Royal Assent. This could take up to a year.
- To justify creating a new body, the body would need a distinct role to play and functions to perform which cannot be carried out at least as effectively by any other existing organisation. In other words, allocating the function(s) to an existing public body must be considered before any action is taken to establish a new public body.
- Given that there is no precedent in legislation, any functions proposed are likely to attract a high level of parliamentary scrutiny, particularly in relation to shared

services. Any functions taken will have to be proportionate and justified in terms of efficiency, effectiveness, and economy.

- Data sharing agreements will be required – this will be more complex for a non NHS body without well-established legislative compliance and information governance. New public bodies are required to establish formal governance arrangements and policies for the proper management and controlled access to personal data, public information and public records.
- Public bodies are normally given powers in the enabling legislation to employ their own staff, mainly achieved through recruitment and staff transferred permanently from other organisations. In this case, the majority of staff will be NHS, who may be reluctant to transfer.
- There may be issues around the transfer of NHS staff, property, and liabilities (ongoing legal cases, complaints, staff hearings etc).
- Staff may perceive NHS pay and terms and conditions as more favourable and/or politically protected, leading to staff attrition and high likelihood of concern from the trade unions.
- There would be a loss of resilience in terms of ease of NHS staff movement, promotion pathways and career opportunities. The NHS pay system has harmonised conditions of service for all professions and staff can be reassured that the skills they develop throughout their career will be recognised and appropriately rewarded.
- If the role of the organisation alters in future, pay deals may have to be renegotiated.
- An appropriate overarching legislative power would have to be in place to enable broad data sharing. This would attract a high level of parliamentary scrutiny.

Opportunities

- TUPE / COSOP can apply to the transfers of a function from one part of the public sector to another where there is a change of employer. This includes transfers between local government and the NHS or the NHS to an NDPB.
- If appropriate communications are opened and maintained with staff and unions, an acceptable pay deal could be negotiated, and terms and conditions may even be more attractive to some.
- The new body could potentially deliver a better balance of local government and NHS staff, skills and experience, recognising that the social determinants of health might be better tackled in a local authority setting than within the NHS ‘family’.

Threats

- There would need to be appropriate arrangements to protect occupational pensions, redundancy and severance terms of staff in these types of public sector transfer.
- New policies and procedures for dealing with recruitment and/or transfer of staff would need to be established – including impact of TUPE and COSOP and the development of new terms and conditions. This could involve complex and difficult negotiations.

- Staff remuneration would still be in line with public sector pay policy (including efficiency savings) and may receive less prioritisation from Ministers than NHS remuneration.

Conclusion

The key difference between an NDPB and Special Health Board is one of identity and perception. The legislative route to establish an NDPB will be lengthier with more risk of challenge and it will likely mean we cannot appoint new leadership as quickly.

The transfer of staff, property and liabilities will involve additional complexity and information governance in particular will be a particular challenge and might be a risk to our aspiration for the new public health body to have responsibility for data and intelligence. Staff transfer is also likely to be particularly problematic, with most staff expected to prefer to remain within the NHS and/or to preserve NHS terms and conditions.

An NDPB does not offer any advantages in terms of governance and accountability due to limitations on the ability to make an NDPB legally accountable to a body other than Government or Parliament.

ANNEX D

PUBLIC BODIES – ADDITIONAL INFORMATION

General

Public Bodies have an important role in the process of Government, but operate to a greater or lesser extent at arm's-length from Scottish Ministers. They play an important role in advising Government and delivering public services in Scotland. Arm's-length bodies add particular value to Government when they focus on a specific set of issues and stakeholders. Through their specialist skills base and relationships, they provide authenticity for Government in its engagement in that specialist area; and through their sustained focus and authenticity, enable Government to reach areas and interest groups with whom it would otherwise struggle to engage effectively.

Governance and Accountability Framework

In practical terms, operating at arm's-length means a degree of operational autonomy in the discharge of related functions (some or which will be statutory), within an established framework of controls set by Scottish Ministers. Each framework is based on a set of key principles underpinned by core corporate documentation. These frameworks provide suitable flexibility to allow proportionate and appropriate application across the range of types of public bodies. The chosen framework of controls must be proportionate to the role and functions of the body or office-holder and must consider the required level of proximity to Scottish Ministers.

Public Bodies Landscape and Structures

Public bodies have generally been established by successive Governments in response to particular issues and pressures and this has resulted in enormous diversity in the nature and character of public bodies. Most fall within a number of broad categories, such as NHS bodies, Non Departmental Public Bodies (NDPBs), Executive Agencies, public corporations, tribunals and Commissioners/ Ombudsmen. These broad categories also reflect the diversity of functions vested in each type of body.

NDPBs and Executive Agencies

One key distinction however, is between Executive Agencies (which are part of Government and directly accountable to Ministers) and NDPBs (which are not). Although Scottish Ministers set the framework within which NDPBs operate, NDPBs by definition are further removed from Government than Agencies and their Chief Executives are usually appointed by and accountable to a Board rather than Scottish Ministers. Another key distinction is that NDPBs are usually statutory bodies and have defined statutory powers, duties and responsibilities; whereas Agencies operate under the terms of a Framework Document drawn up by Scottish Ministers.

Public Health Scotland – Possible Categories

Executive NDPBs - operate within a strategic framework set by Scottish Ministers; accountable to Scottish Ministers who ultimately are accountable to Parliament for functions and performance of the body; funded by Grant-in-Aid or sectoral levy; carry out administrative, commercial, executive or regulatory functions on behalf of but at arm's-length from the Government; normally established by statute, as companies limited by guarantee or by Royal Charter and they are employers in their own right; headed by a Board appointed by Ministers; Boards hold their Chief Executive to account; vary considerably in terms of size and budget. Chief Executive is the Accountable Officer and the body is subject to guidance such as Scottish Public Finance Manual; prepares and lays own reports and accounts; are subject to a general or specific Ministerial power of direction (with appropriate safeguards in certain circumstances); relationship set out in relevant legislation and a Management Statement/Financial Memorandum. Examples include Scottish Enterprise and SEPA.

Health bodies - operate within a framework of controls determined by DG Health/Chief Executive of NHS Scotland (legally, controls are made by Ministers); accountable to Scottish Ministers who ultimately are accountable to Parliament for functions and performance of the bodies; established by statute; Scottish Ministers provide funding; 14 regional Health Boards and 9 Special Health Bodies deliver healthcare services or provide management, technical or advisory services within NHS Scotland; Boards appointed by Ministers (piloting directly elected members); Chief Executive is the Accountable Officer, held to account by a Board; Ministerial power of direction; employers in their own right; relationship set out in relevant legislation and a Management Statement/Financial Memorandum.

Role of Scottish Government

Policy and direction
Provide guidance on the policy framework and the body's role in pursuing and delivering Ministerial policies and priorities.

Promotion and awareness
Ensure a high level of awareness across relevant parts of the Scottish Government regarding the body's role, remit and priorities. Promote and facilitate links between the public body and other stakeholders as appropriate.

Outcomes Based Approach
Support and encourage the body's alignment to the National Performance Framework and help bodies to work together across traditional boundaries, in clusters and with external partners.

Performance management
Provide guidance on the outcomes, outputs and targets the body is expected to achieve and how they fit with Ministerial priorities. Ensure the body has an effective

performance management framework in place and monitor progress and performance as necessary.

Governance
Prepare the Framework Document or Management Statement/Financial Memorandum - which sets out the nature of the relationship between the Government and the body - for approval by the appropriate Minister, following consultation with the body; and ensure that these documents are periodically reviewed and updated. Ensure that the body has in place an appropriate management, planning and financial framework and effective processes for internal control. Ensure the timely preparation, approval and publication of the annual report and accounts.

Ensure that an appropriate code of conduct is in place for board members and that the body has a procedure in place for registering and declaring members' interests. Provide advice and support to the body on issues of conduct as required.

Appointment, remuneration and appraisal
In liaison with the body, manage the appointments process for the Chair, Deputy Chair and board members and determine the level of remuneration to be paid, subject to Ministerial approval as appropriate.

Finance
Determine the appropriate level of grant or grant-in-aid to be provided to the body. Ensure that project appraisals, pay remits and any other financial bids or queries (including pensions, severance and other HR issues) are dealt with efficiently.

Staffing
Ensure that the body is kept informed of any guidance on any changes or additions to public sector employment standards. Approve pay and grading systems and significant changes in the terms and conditions offered to staff. Consider and approve the body's pay remit.

Information and guidance
Ensure the timely distribution of information to the body, in particular providing guidance on relevant public sector requirements (e.g. ethics, complaints, FOI, openness and access) and monitor compliance with these requirements.

PUBLIC HEALTH REFORM OVERSIGHT BOARD (Paper 5.1)

Role of the board

For boards of public bodies to operate well they must:

- provide leadership to their organisations;
- set the organisation's strategic direction within the context of Scottish Ministers' policies and priorities;
- scrutinise and monitor the organisation's performance;
- display integrity in how they behave and how they make decisions;
- be open and transparent;
- regularly review how they operate;
- not become involved in the daily running and operation of the organisation.

Role of committees

All boards use committees to manage their workloads. However, the number of committees varies significantly, ranging from one to 24. All public bodies have an audit committee, which is chaired by a non-executive. NHS boards generally have higher numbers of committees - this is partly because some committees are required by legislation and others are required by the Scottish Government.

The make-up of boards varies across and within sectors

The size of the boards of public bodies in Scotland ranges from four to 32.

The number of board members (executive and non-executive) varies significantly across the public sector, but around two-thirds of boards have between 10 and 17 members.

On average, boards that are responsible for the performance of their organisation (NHS bodies, colleges and NDPBs) have more members than advisory boards, with NHS boards tending to be the largest. The size of boards varies by type of body ranging from:

- 11 to 32 in NHS bodies, with an average of 18
- 12 to 17 in colleges, with an average of 15
- 6 to 32 in NDPBs, with an average of 12
- 4 to 14 in executive agencies, with an average of nine
- 8 and 9 in the two non-ministerial departments which have boards.

It is difficult to specify the ideal number of board members. There has to be a balance between having sufficient skills and expertise and not having so many members that decision-making and collective responsibility becomes difficult. Other than the historic context in which boards were established, there is no rationale for the difference in size of boards.

NHS Scotland Boards

NHS National Services Scotland (NSS) currently has a Board of 11, with the Chair, 7 Non-Executive Directors, the Chief Executive and 2 Executive Directors. Health

Scotland currently has a Board of 13, with the Chair, 8 Non-Executive Directors, the Chief Executive and 3 Executive Directors.

Under the NHS (Scotland) Act 1978, a Health Board consists of a chairman, and other members, appointed by the Scottish Ministers.

For the majority of health boards, the size and make-up of the health board is not prescribed explicitly, but can be prescribed in regulations under the NHS (Scotland) Act 1978. An Order made under the Public Services Reform Act (Scotland) 2010 can also amend the constitution of a public body, including a health board.

Non-executives make up the majority of boards except in executive agencies

Nearly all boards have a majority of non-executives which is important in enabling them to hold the management of their organisations to account. The exceptions are the boards of executive agencies and the Registers of Scotland, which have a higher proportion of executive board members reflecting the purely advisory nature of these boards.

The make-up of most boards is usually prescribed in legislation. Some non-executives have a representative role, such as local authority, employee and patient representatives for NHS bodies, and student representatives on college boards. They serve an important function in ensuring that the board is aware of the views of its key stakeholders. However, there is potential for conflict in the role as these non-executives seek to represent their stakeholders but are also members of the board.

Not all chief executives are board members

The chief executives of all NHS bodies and executive agencies sit on their boards in their own right. However, the picture is mixed in NDPBs and non-ministerial departments. Some NDPB chief executives are not board members, although they do attend board meetings to answer questions and provide advice and information.

This inconsistency is a result of different legislation establishing the role of individual NDPBs. However, excluding the chief executive from board membership appears to be at odds with his or her formal accountable officer role and accountability to the Scottish Parliament for the proper use of public money.

Framework Document

Every public body must prepare a Framework Document based on the model contained in the Scottish Public Finance Manual (SPFM). The framework document should normally be agreed with Scottish Ministers within **3 months** of the body coming into existence.

The purpose of the framework document is to describe the key roles and responsibilities of Ministers, the portfolio accountable officer, the sponsor team, chair, board and chief executive, together with agreed performance and financial management arrangements and details of financial delegations and controls.

Memorandum of Understanding

It may be desirable to enter into a Memorandum of Understanding (MoU) with other public bodies to set out how certain functions and activities will be jointly managed and controlled. An MoU will generally outline the arrangements for co-operation and communication between the respective parties and typically includes:

- Definition of parties
- Common purpose of parties
- Legal status
- In scope – out of scope
- Governance arrangements

Information, Data and Records Management

New public bodies are also required to establish formal governance arrangements and policies for the proper management and controlled access to personal data, public information and public records.

It is essential that a new public body has suitable governance arrangements in place from day one of its operations to ensure compliance with any statutory obligations under the Data Protection Act 1998, the Freedom of Information (Scotland) Act 2002, the Environmental Information (Scotland) Regulations 2004, the Public Records (Scotland) Act 2011 and The Re-Use of Public Sector Information Regulations 2005.

Collaboration and Shared Services

All public bodies require operational, corporate and support services, for example, procurement, payroll, HR, IT, finance, estates, legal and communications. Public bodies must ensure that they achieve value for money in the development and delivery of these functions. There is a strong presumption against new public bodies developing free-standing operational, corporate and support functions and services.

Shared services, in its simplest form, is a ‘service or function that is shared between different organisations or departments’. Fundamentally, shared services provide an opportunity to use collaboration as an enabler for improving the quality and delivery of a service and in securing cost efficiencies.

Public Sector Pay Policy

The 2018-19 Public Sector Pay Policy is a single year policy. It sets out the parameters for pay increases for staff pay remits and senior appointments and applies to public bodies with settlement dates in the year between 1 April 2018 and 31 March 2019 (inclusive).

Our Public Sector Pay Policy applies directly to 44 Public Bodies.

This policy also acts as a benchmark for all major public sector workforce groups across Scotland including NHS Scotland, fire-fighters and police officers, teachers and further education workers. For local government employees, pay and other employment matters are delegated to local authorities.

Scottish Ministers are committed to firm and fair restraint of pay across the public sector in Scotland and they make the decisions on pay for most public sector staff in Scotland. Specifically, this is done through public sector pay policies.

The Public Sector Pay Policy for Staff Pay Remits covers the pay of the Scottish Government's core directorates and its associated departments, agencies, non-departmental public bodies (NDPBs), public corporations and NHS Scotland Senior Managers (Grades A-C only).

The Public Sector Pay Policy for Senior Appointments covers remuneration proposals for Chief Executives (of NDPBs and public corporations); NHS Executives and Senior Managers (Grades D to I only); and the daily fees paid to chairs and members appointed by Scottish Ministers to public bodies.

Agenda for Change is the NHS pay system for all staff directly employed by NHS Health Boards, with the exception of some very Senior Managers and staff within the remit of the Doctors' and Dentists' Review Body.

Legislative process and appointments

The need for legislation to establish the new public body complicates the process of appointing leaders at the right time. This can constrain when the appointments process begins as, properly, new public bodies cannot incur expenditure prior to the legislation establishing them receives Royal Assent. In many recent mergers, the appointments process did not begin until after any necessary legislation was passed. If legislation is needed, 6 to 21 months may be required between the decision to proceed and the start date of the new body, dependent on the type and complexity of legislation (primary or secondary).

Public Appointments

Scotland's public bodies need board members who reflect Scottish society with experience and understanding from every walk of life. Appointments are made on the basis of the skills, knowledge and qualities necessary to fill the role - and nothing else. The final decision about who to appoint is made by the Scottish Minister responsible for the public body, based on the selection panel's assessments.

The Commissioner for Ethical Standards in Public Life in Scotland regulates appointments to the boards of many of Scotland's public bodies. The Commissioner and their team regulate the appointment of people to non-executive positions. Whilst they regulate the process used to make appointments, it is run by civil servants on behalf of the Scottish Government. The responsibility for making these appointments fairly, openly and based on merit lies with the Scottish Government.

In consultation with key partners, they must decide how best to attract the people they need to serve on a board. They may choose whatever method of application best suits the post and the potential applicants and is most likely to encourage people with the right skills and experience to apply. Applicants may be assessed using whatever method is most appropriate.