Health Committee

3rd Report 2004 (Session 2)

Stage 1 National Health Service Reform (Scotland) Bill
Health Committee

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Ayrshire and Arran NHS Board
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UNISON

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- Sense Scotland
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- NHS Borders
- Chartered Society of Physiotherapy Scotland
- British Association of Dermatologists
Health Committee

Remit and membership

Remit:

To consider and report on matters relating to health policy and the National Health Service in Scotland and such other matters as fall within the responsibility of the Minister for Health and Community Care.

Membership:

Christine Grahame (Convener)
Mr David Davidson
Helen Eadie
Janis Hughes (Deputy Convener)
Kate Maclean
Duncan McNeil
Shona Robison
Mr Mike Rumbles
Dr Jean Turner

Committee Clerking Team:

Clerk to the Committee
Jennifer Smart

Senior Assistant Clerk
Graeme Elliott

Assistant Clerk
Hannah Reeve
The Committee reports to the Parliament as follows—

INTRODUCTION

1. The National Health Service Reform (Scotland) Bill (SP Bill 6) was introduced in the Parliament on 26 June 2003. The Parliamentary Bureau agreed that the Health Committee ("the Committee") would be the lead Committee on the Bill.

2. The provisions of the Bill conferring power to make subordinate legislation were referred to the Subordinate Legislation Committee under Rule 9.6.2. Under Rule 9.6.3, the Finance Committee took evidence on the Financial Memorandum to the Bill. Both these reports are attached at Annex A to this Report.

Background


4. The Bill sets out to abolish NHS Trusts and seeks to ensure that patients’ interests are put first and that services are planned and provided in an efficient and integrated way, through collaboration within and among NHS bodies. The Bill also seeks to establish Community Health Partnerships (CHPs), develop managed clinical networks, impose a duty on Health Boards to encourage public involvement, remove local health councils and place a duty on Ministers and Health Boards to promote health improvement. In addition it gives Ministers greater powers to intervene in service failure.

5. The Bill was introduced to Parliament on 26 June 2003, and the Explanatory Notes, (http://www.scottish.parliament.uk/bills/index.htm#6) which accompany the Bill, detail the Scottish Executive’s main policy objectives. The Scottish Parliament Information Centre (SPICe) prepared a research briefing on the Bill, published on 18 November 2003 (http://www.scottish.parliament.uk/research/sb-number.htm), and is available separately.
Evidence taken on the Bill

6. The Committee took evidence in public on the general principles of the Bill, on 2, 9 and 16 December 2003 and 6 January 2004. These meetings took place in Edinburgh, and the Committee heard from the following witnesses—

- Elaine Tait, Chief Executive Officer and Dr Mike Watson, Dean, Royal College of Physicians of Edinburgh
- Dr John Garner, Chairman, Scottish Council and Dr Bill O’Neill, Scottish Secretary, British Medical Association
- Pat Dawson, Head of Policy, and Christine Brown, RCN Board Member Ayrshire and Arran, Royal College of Nursing Scotland
- Christine Lenihan, Chairman and Hilary Robertson, Director, Scottish NHS Confederation
- Alexis Jay, Director of Social Work Services and Housing, West Dunbartonshire and Councillor Kingsley Thomas, City of Edinburgh Council, CoSLA
- George Irving, Chairman and Wai-Yin Hatton, Chief Executive, Ayrshire and Arran NHS Board
- Malcolm Wright, Chief Executive and John Ross CBE, Chairman, Dumfries and Galloway NHS Board
- Jim Devine, Scottish Organiser, Health and Danny Crawford, Chief Officer, Greater Glasgow Health Council, UNISON
- Martyn Evans, Director and Liz MacDonald, Policy Manager, Scottish Consumer Council
- John Wright, Director, and Dr Kate Adamson, Convener, Scottish Association of Health Councils
- Warwick Shaw, Chairman, Association of Local Health Care Cooperatives
- Steve Conway, Director of Operations, Jenny Dewar, Chair, Kathleen Bree, Director Allied Health Professions and Nursing and Stephanie Lawton, Head of Human Resources, NHS Orkney
- David A M Thomson, Chairman, Royal Pharmaceutical Society Scottish Department and Asgher Mohammed, Community Pharmacist, Paisley, Royal Pharmaceutical Society
- Judith Catherwood, Convener and Kenryck Lloyd Jones, Secretary, Allied Health Professions Forum Scotland
- Malcolm Chisholm MSP, Minister for Health and Community Care
7. We are grateful to all our witness for taking the time to give evidence and for submitting written evidence for the Committee’s consideration. Their written evidence is set out in Annex C to this report, together with Minutes and extracts from the Official Reports of the Committee meetings.

8. As well as inviting the witnesses listed above to address the Committee, the Committee issued a general call for evidence, inviting anyone with an interest in the Bill to submit written evidence on its general principles. A number of organisations responded and the Committee would like to thank them. These additional submissions can also be found in Annex D to this report.

Provisions of the Bill

**Organisation and operation of NHS**

9. ‘Partnership for Care’ set out the Executive’s intention to abolish NHS Trusts. NHS Trusts can be dissolved via subordinate legislation, as has recently happened in the Borders and Dumfries and Galloway. The remaining trusts in Scotland are also expected to be dissolved in this way. However, primary legislation is required to remove the statutory powers of NHS Trusts. The Bill in section 1 proposes to do this by repealing section 12A and schedule 7A of the National Health Service (Scotland) Act 1978 (‘the 1978 Act’). The functions, staff and assets of the Trusts will transfer to operating divisions of NHS Boards.

10. The abolition of NHS Trusts has been welcomed as a means of reducing NHS bureaucracy. In evidence presented to the Committee the majority of witnesses thought there would be advantages in abolishing the Trusts but more than legislation would be required in order for the changes to be a success. Martyn Evans of the Scottish Consumer Council stated—

   We support the proposed structural changes and believe that they will improve service delivery. However, although the changes are necessary, they are not sufficient. A cultural change is also required in order to effect the structural changes that the bill proposes. (Col 455)

11. Concerns were raised by Unison and the Association of Health Councils regarding barriers to joint working with the major barrier being the different terms and conditions of service that exist between local authority and NHS staff in similar posts doing similar work. Unison indicated that it would prefer to get back to standardised terms and conditions and had had a certain degree of success with regard to some areas of staff within the NHS who had different terms and conditions of service—

   To be fair, we have sat down with the Scottish Executive and negotiated the low-pay deal, which has meant a standardisation of terms and conditions for ancillary staff, administrative and clerical staff and many nursing staff. As part of that agreement, we have a commitment to standardisation of terms and conditions by, I think, October 2004. (Col 444)
12. The Minister has indicated to the Committee that it is his intention to amend the Bill at Stage 2 to include staff governance (Annex C). This was welcomed by those who submitted evidence including the BMA. In addition, Ayrshire and Arran NHS Board and Dumfries and Galloway NHS Board both considered it to be a component that needs to feature more prominently and explicitly in the Bill (Col 441 and 442).

13. The Committee welcomes the inclusion of this issue within the Bill but would have preferred that these provisions had been included in the Bill as introduced to allow for full scrutiny of the proposals.

14. The Committee recognises that delivery of the cultural and structural changes required to implement joint working will not be a simple process. We are aware that the attempts to harmonise terms and conditions as a result of local government reorganisation has not been without its difficulties. The Committee does not wish to see these problems perpetuated in relation to the structural and cultural changes that will be required as a result of this Bill. The Committee still has some concerns in particular in relation to attitudinal changes. We believe that these require to evolve in order to successfully deliver the cultural and organisational changes upon the transfer of responsibility to Health Boards.

Establishment of Community Health Partnerships

15. Section 2(1) of the Bill proposes to insert, into section 4 of the 1978 Act, a requirement for Health Boards to produce a scheme to establish Community Health Partnerships (CHPs) for their area. CHPs are expected to evolve from the current Local Health Care Co-operative (LHCC) structure, but unlike LHCCs, they will be created by statute as opposed to being voluntary groupings.

16. The Committee received evidence that the creation of these bodies is widely welcomed. In particular, local authorities and non-clinician led organisations have welcomed the establishment of CHPs. COSLA in evidence to the Committee stated that they felt that the Bill would improve patient care and the quality of service by devolving power to local communities and increasing the role that local authorities can play in the health improvement agenda. (Col 406)

17. The Committee is aware of concerns that exist regarding how these changes are to be funded. The funding implications in relation to the creation of CHPs are discussed later in this report at paragraph 58.

18. However, from the evidence submitted to the Committee we are aware that there are some concerns which exist around the general operation of CHPs. These can be summarised as follows—

- Governance arrangements should be clear. Organisations should be clear about the services for which they are responsible. There is a need for the Executive to issue clear guidance on how it envisages CHPs will operate. (Scottish Association of Health Councils - Col 459 and COSLA – Col 410)
• CHPs should be as wide as possible and should encompass, as far as possible, all the health groupings that exist in the health service. Organisations would not like to see the good work that has been started with the creation of LHCCs be written off and lost when the CHPs are introduced, this could have a hugely detrimental effect on local structure. The introduction of CHPs should attempt to retain expertise and commitment gained during the operation of LHCCs. (The Royal Pharmaceutical Society of Great Britain, Scottish Department Col 521, the BMA Col 362 and Orkney NHS Board, Col 500)

• CHPs should not be dominated by clinicians and general practitioners. (Ayrshire and Arran NHS Board Col 432)

• Coterminosity with local government boundaries plays an important role in the successful operation of CHPs. (Dumfries and Galloway NHS Board)

• Lack of complaints handling functions once the LHC’s are abolished (Scottish Consumer Council Col 461)

19. The Minister, in his evidence, sought to address the points which had been raised by witnesses.

• There will be both statutory guidance and regulations provided for the operation of CHPs. (Col 528)

• It is the Executive’s intention that CHPs evolve from LHCCs and build on their strengths. (Col 527)

• Who is represented on the committee of the CHP will be laid down in regulations. It will be a vehicle for the integration of social care and specialist services. (Col 527)

• The Executive does not expect CHPs to straddle local authority areas and seeks coterminosity. However, in the larger areas there will be several CHPs for a particular local authority area. (Col 528)

• The model proposed for the handling of complaints is similar to that provided for advocacy services, these services will be independently commissioned by the Boards. (Col 538)

20. Given the Minister’s comments the Committee is satisfied that many of the concerns raised by witnesses have been, or will be, addressed. However, the Committee requests that the Executive submits all statutory guidance and regulations in relation to the operation of CHPs to the Committee for scrutiny prior to their introduction.

Duty of Health Boards to co-operate

21. Section 3 of the Bill proposes to place a duty on NHS Boards to co-operate with other Health Boards, Special Health Boards and the Common Services Agency in planning and providing services. This would allow Health Boards to
enter into arrangements that would advance the health of anyone in Scotland, not just those who reside within a Board area.

22. Some groups who submitted evidence to the Committee welcomed the duty as they considered that it would contribute to the efficiency of patient care. (Written evidence from the Scottish Society for Rheumatology and the Royal College of Anaesthetists – Annex C). Orkney NHS Board stated—

It will make it legal for us to work for our populations but across boundaries. The bill is about making better use of the resources that are available. We already do a lot of regional work, in that many of our clinical services are provided off Orkney by Grampian NHS Board and other health boards. The bill formalises that type of relationship, so it makes best use of scarce resources. (Col 499)

23. Other groups who submitted evidence raised questions as to what types of services would be considered on a cross-regional basis and sought guidance from the Minister on which services are most appropriate and most likely to benefit from being organised on a cross-Board co-operative basis. (Scottish NHS Confederation – Annex C)

24. The Royal College of Physicians of Edinburgh in their evidence felt that a clear formula for resource transfer will be essential because specialist services will be provided in other health board areas (Col 361). The BMA did not advocate a system in which money specifically follows the patient although they did advocate collaboration in the provision of services (Col 361).

25. With regard to the duty of Health Boards to co-operate we support the development of managed clinical networks and other regional and national initiatives. We also seek clarification from the Executive on whether guidance will be available on which services are most likely to benefit from being organised on a regional basis and how resources will be transferred between boards or from central funds.

Powers of intervention

26. Section 4 of the Bill proposes to give Ministers a clear power to intervene, with or without the approval or co-operation of the NHS Board. This would occur when a body charged by the 1978 Act with providing a service, has been deemed by Scottish Ministers as failing, having failed, or likely to fail, in either; providing the service, or providing the service to a standard they regard as acceptable. Section 4(2) gives Ministers the powers to transfer the responsibility and management of a service to another body. The bodies are outlined in section 4(4) of the Bill.

27. The first area of section 4 that concerns us is the lack of detail available on when the powers of intervention would be used. This was expressed by Orkney NHS Board (Col 504). The Minister, in his evidence to the Committee, agreed to look further into the issue of guidance to ensure that Boards are fully aware of the stages that are likely to precede the power of intervention being invoked, (Col 550).
28. The second point we wish to raise with regard to the extent of the Ministers powers to intervene in the case of service delivery. In section 4 “78A” it states that—

(2) The Scottish Ministers may, where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable, direct that specified functions of the body or person under or by virtue of this Act be performed

29. The Minister in his evidence stated that the powers would be used as a last resort. However as the wording stands at the moment, the Committee has some concerns about the possible interpretation of the word ‘necessary’.

30. In a letter to the Committee dated January 2004 (Annex C) the Minister went on to say that the new power of intervention is intended as a last resort, to be used only when other means of remedying service failure have failed or are clearly not going to work, and where the relationship between Scottish Ministers and the Health Board in question have broken down to the extent that the Board’s co-operation cannot be relied upon. In addition, he added that Health Boards are familiar with the range of administrative interventions open to Scottish Ministers and that the ‘escalating intervention protocol’ was most recently sent to Health Boards as part of the consultation of the Performance Incentive Framework on 18 July 2003. The existing formal intervention mechanisms are set out in legislation.

31. Notwithstanding the terms of the Minister’s letter we still have concerns regarding how section 4 “78A (2)” might be interpreted.

32. In addition to the concerns raised about when the powers of intervention will be invoked the Committee considered evidence regarding the financial implications which may arise. The Finance Committee in its report to the Committee at paragraphs 29 and 30 states that it remains unconvinced that the Executive’s estimated average cost of £85,000 associated with the power of intervention is reasonable.

33. The Health Committee shares the concerns of the Finance Committee insofar as we believe the cost of intervention has been considerably underestimated, particularly given the calibre of staff required (and their availability) in any task force and secondment expenses. The Committee is also aware there may be additional costs arising from recommendations brought about by intervention.

34. Finally, the Committee received evidence which indicated that there is still confusion on who would absorb the costs of intervention should a Health Board experience financial problems. The BMA stated—

Our only concern about ministerial intervention is over whether it is reasonable to pass costs on to health boards. That has already been investigated by the Finance Committee, which has, I believe, referred to this committee in its report. (Col 375)

35. The Finance Committee received conflicting written submissions from NHS Argyll and Clyde who considered that the Health Board would absorb the cost and
from NHS Highland Board who considered that the Scottish Executive would pay for intervention.

36. In his evidence to the Committee, the Minister was asked to clarify the position in respect of the costs of intervention. He stated—

My understanding—this may need to be spelled out if it is not clear—is that boards will have to bear that cost. That does not mean that there should not be flexibility. If a board is in financial difficulties and there are particular circumstances that need to be taken into account, there is nothing to prevent the Executive from deciding to fund intervention either fully or in part. However, it would cause considerable concern in all the other boards in Scotland if one board that had been failing were seen to get extra money. At the end of the day, extra money from the Executive is top-sliced from the budgets of all other health providers. The sums involved may be small, but it would cause considerable difficulties for other boards if a board that was perceived to be failing received extra money. (Col 548)

37. He went on to add—

There will have to be an amendment to make that clear. We cannot have that kind of doubt about the issue, so we will probably have to say that the cost will be borne by boards. However, putting it that way does not rule out the possibility of the Executive contributing at its discretion. That is what we intend to do. (Col 549)

38. The Committee is still concerned that the Minister has not fully clarified the matter of which party will be liable for the costs of intervention and welcomes the commitment of the Minister to amend the Bill to ensure Health Boards have a clear understanding of where the financial burden lies in relation to these costs.

Public involvement and the dissolution of Local Health Councils

39. Section 5 of the Bill proposes to place a duty on Health Boards and Special Health Boards to secure the involvement of the public in the planning and development of health services. Section 6(1) proposes to dissolve local health councils. The Executive’s intention is to make public involvement an integral responsibility of the Health Boards, as opposed to that of an external body.

40. In relation to section 5, the Committee welcomes the duty to encourage public involvement. COSLA highlighted the need for more effective consultation mechanisms but also more effective feedback mechanisms. (Col 417). The Scottish NHS Confederation indicated that the challenge was to ensure that communication was thoughtful, realistic and meaningful with the people who were involved in the process (Col 420).

41. The Royal College of Nursing stated that they would prefer to see a more explicit reference to consulting communities (Col 363). This was developed by the Scottish Consumer Council—
I will distinguish between service-user involvement and public involvement, because they get mixed up. Public involvement is often about service planning. It is about the whole range of people who may not currently use a service, but who have an interest in how that service is developed. That public involvement is basically a citizenship issue. It is about engaging with citizens who have the interests of young people and others at heart. Engaging the public as citizens in service planning is a complex matter. We see that when hospitals have to be closed or reorganised.

Service-user involvement is about current service users having their say about how things are. Our interest is in making that more sophisticated, because in some services we also want to bring to the table the non-users of services—those who could use them or who are excluded from them.

However, we understand the public-policy issues around public involvement, because we believe that better decisions are made about huge allocations of money and time. Involving citizens in big strategic decisions is a modern way of working, and it is a better way of working in a democracy. (Col 478)

42. After considering the evidence we are of the view that legislation alone cannot bring about meaningful consultation with the public. We are aware of the different needs of service users and the desire for communities to be involved in service planning. We consider that innovative and sophisticated methods of consultation need to be utilised in order to facilitate a significant exchange of ideas and views. Members of the Committee are aware that, at present, many of the consultation exercises carried out by Health Boards appear to be superficial. Clinicians do not seem responsive to the expectations that service users and the public hold. We want the process to be honest, meaningful and rigorous. Feedback should be easily accessible to ensure that decision making is transparent and responsive to the comments received from the public. Due to the level of public interest in the consultation process, the Committee welcomes further guidance on consultation which the Minister has confirmed he is preparing (Col 534). We seek a commitment from the Minister to improve the current situation and would expect the Committee to be fully consulted and to play an important scrutiny role in relation to the draft guidance.

43. The question of how public involvement will be funded is dealt with later in this report at paragraph 63.

44. The Executive plans to replace the 15 local health councils with one national council, the ‘Scottish Health Council’ which will be independent of NHS Boards. It is envisaged that there will be a local presence in the shape of local advisory councils which will feed local issues into the national body. The role of the national body covers three areas; assessment of how well consultation has been carried out with the public in each board area, development of good practice, and feedback for patients and carers to express their views.

45. The new national council will not have a statutory basis but will be incorporated into NHS Quality Improvement Scotland (NHS QIS), a non-departmental public body.
46. The majority of the evidence submitted to the Committee both in written and oral form would appear to welcome the creation of a national organisation (the Scottish Health Council) but concerns have been strongly expressed to the Committee regarding the independence of such an organisation. Dr Adamson of the Scottish Association of Health Councils—

We view the dissolution of the local health councils as necessary, because it will be extremely helpful to have a national organisation with national standards to be applied on a local basis. At the moment, those standards do not really exist across the health councils. We therefore view a national organisation as extremely important. (Col 460).

47. She went on to add—

I have a problem over the independence issue, which I believe to be extremely important. (Col 406)

48. The view expressed above was a recurring, although not unanimous, theme throughout the evidence. Some witnesses considered that the main problem would be public perception rather than the operation of the Scottish Health Council under the umbrella of NHS QIS. Martyn Evans of the Scottish Consumer Council stated—

It would not change our view that it is of crucial importance that the health council is independent in any objective terms. We say that the present proposed location would make the health council independent in any objective terms. However, we are saying that there is a perception that, because of its proposed location, it might not be independent. In objective terms, we have no worry about its independence as part of NHS QIS, but we have significant concerns about how that would be perceived. (Col 468)

49. The Minister, in his evidence, explained the thinking behind placing the Scottish Health Council within NHS QIS—

We want the Scottish Health Council to have as much clout and leverage as possible, and we think that that will be enhanced by its being part of NHS Quality Improvement Scotland, but it will have special status and safeguards to ensure that it will not in any sense be under NHS Quality Improvement Scotland’s thumb; it will have its own existence within that body. It is important that the Scottish Health Council be tied into the quality agenda because, as I have said on more than one occasion, the starting point for improving quality is the experience of every patient who passes through the health care system. Therefore, if the Scottish Health Council is part of NHS Quality Improvement Scotland, that adds to the leverage and influence of patient and public involvement. (Col 530)

…we must ensure that the Scottish Health Council has a special status within NHS QIS and that there are safeguards for its independence within that body. We are working up the details of that with the Scottish Association of Health Councils; it is one of the key issues that the implementation group is considering. (Col 541)
50. The Committee asked witnesses what other options they could suggest to retain the independence of Scottish Health Council. The following have been suggested—

- retain the Local Health Councils (RCN Col 365)
- have the Scottish Health Council defined in regulations in addition to the following safeguards: a memorandum of understanding between the board of NHS QIS and the Scottish Health Council; a council for the Scottish Health Council; a directorate answerable to the council; a budget; and a research capacity. (Scottish Consumer Council Col 463)
- create the Scottish Health Council as a statutory independent body in its own right and with its own board of governance. (Scottish Association of Health Councils written evidence, Unison Col 448 and Ayrshire and Arran NHS Board Col 437.)
- ensure that the statutory rights and responsibilities which reside with the local health councils, which include the right to visit facilities, are not lost. (Unison Col 451)

51. The Committee is not convinced that the Scottish Health Council should necessarily be part of NHS QIS. The Committee therefore invites the Minister to report to the Committee on progress regarding his work in conjunction with the Scottish Association of Health Councils to guarantee the independence of the actions of the Scottish Health Council. We seek confirmation that the Minister in his discussions with the Scottish Association of Health Councils will address in particular two issues: the question of shared management and, as a consequence of this, the safeguarding of independence of action.

52. In addition to the above, the Committee is aware of the intention to remove the role of patient advocacy when it abolishes the Local Health Councils. The Minister explained that the role of the SHC will be to monitor such services and to ensure their availability. He went on to add that Local Health Advisory Councils can speak for patients where that is appropriate – for example if no other group can do so (Col 531). The Committee would welcome further clarification on the role of Local Health Councils in patient advocacy.

Promotion of health improvement

53. Section 7 of the Bill proposes to give Ministers and Health Boards a duty to promote improvement to the physical and mental health of the Scottish public. The duty can be discharged through any means including providing funding to any person, or by entering into other arrangements, co-operating with, facilitating or co-ordinating the activities of any person.

54. The proposed duty has been well received. Support is shown in the written evidence submitted by Unison, the Chartered Society of Physiotherapy and the Scottish NHS Confederation, amongst others. The Committee is pleased to see this measure included in the Bill. The Committee has explored in depth the
question of how public involvement will be funded, this is dealt with at paragraph 63 below.

Financial consequences

55. The Executive has outlined the cost of implementing the Bill in paragraphs 30 to 42 of the Explanatory Notes (http://www.scottish.parliament.uk/bills/index.htm#6) that accompany the Bill. The Financial Memorandum states that as many of these proposals involve formalising or reforming existing obligations, there is no net additional expenditure arising from the Bill. It goes on to say that as the reforms occur at the same time as increased funding in the NHS, no additional expenditure will be required. In evidence submitted to the Committee a number of areas of the Bill have been identified as having a possible financial consequence.

Dissolution of local health councils and the establishment of the national health council

56. A number of organisations who gave evidence to the Committee were of the view that due to the structure changes proposed, the estimated cost of £2.1 million would not be sufficient, certainly in the initial stages, to fund the establishment of the Scottish Health Council. The Scottish Association for Health Councils commented that—

The £2.1 million, as I understand it, is the money that currently goes from the Executive to support the 15 local health councils and the Scottish Association of Health Councils. It is important to note, however, that many local health councils also receive additional funding in kind from their local board, to cover such things as the cost of premises, IT support and clerical services. It is important that that additional funding is not ignored, and we have asked the Executive to take steps to ensure that it is quantified. Our estimate is that it could be as high as another £600,000. That is money that the existing health councils need. (Col 467)

57. The Committee questioned the Minister in relation to this matter. In his response to the Committee he stated—

I am quite happy with the figure of £2.1 million at the moment. We have adopted an inclusive approach and, given that the Scottish Association of Health Councils is central to the implementation group, I would be happy to listen to its views and those of others who think that that sum will not be adequate. I do not see any reason to believe that that is the case at the moment, but my mind is not absolutely closed on the subject. (Col 544)

Abolition of Trusts and the establishment of CHPs

58. The BMA in its evidence to the Finance Committee raised the point that as role, remit and membership of CHPs had not yet been agreed, it was difficult to ascertain if the Executive’s financial assumptions were correct.
59. Others who concurred with this view include the Royal College of Pathologists, the Royal College of Physicians of Edinburgh (both written evidence). COSLA also stated—

We provided evidence to the Finance Committee on that, and our concern was that financing the community health partnerships cannot be cost neutral if it is done properly, because we need to invest in front-line staff so that they understand such new concepts and can take them forward. We know that fact from the joint future agenda, on which much has been achieved, but only because we invested time and resources in training staff and introducing them to new ideas. (Col 408)

60. Dumfries and Galloway NHS Board in their evidence presented a different view on the abolition of Trusts—

We have made local and recurring savings in excess of £500,000. However, I make it clear that that was not the reason for going down the road of integration and that those savings might not be directly comparable with savings that could be made in other NHS boards around the country.

We had a good lead-in time of 14 months and were clear about where we were trying to go. We also took the view that we did not need three chief executives or three directors of finance and so on. We started with a blank sheet of paper and redesigned everything. (Col 426)

61. NHS Borders in written evidence (Annex C) stated that management cost savings have been reinvested in patient care but did not give a figure.

62. The Committee would not wish to see the initial phase of change compromised in any way due to a lack of funding. The Committee has concerns that it has not been given a breakdown of costs for the creation of the new bodies and therefore cannot make a fully informed comment. Due to the lack of detail in the Financial Memorandum we are seeking more information from the Minister on the expenditure that may arise from this Bill. We would wish to review this issue once the Bill has been enacted. The Committee seeks further reassurance from the Minister that additional funding will be made available where it has been clearly demonstrated by Health Boards that the obligations imposed by this legislation have resulted in additional expenditure which could only be met by cuts in front line services.

Duty to encourage public involvement

63. The financial estimate in relation to the duty to involve the public has been questioned in submissions received by the Health Committee. Written evidence in this regard has been submitted by the Royal College of Physicians and the Scottish NHS Confederation (Annex C). Furthermore the Scottish Consumer Council stated—
The proposed sum is a very modest amount of money for bringing the patient interest up to the same level of understanding and influence that the professional and funding interests have... (Col 467)

64. The Finance Committee although welcoming the additional funding of £14m a year as part of the patient focus and public involvement programme was not satisfied that the findings contained in the Financial Memorandum which indicate that there will be no additional funding required.

65. The Health Committee endorses the view of the Finance Committee. We are not convinced that no additional funding will be required to increase public involvement.

Duty to promote health improvement
66. Written evidence from the Royal College of Physicians and COSLA (Annex C) highlighted concerns about the financial implications arising from the duty on Ministers and Health Boards to promote health improvement. The Executive’s Explanatory Notes outline that overall expenditure is not expected to increase but that the pattern of expenditure is expected to change.

67. As it is still not clear how this duty would be undertaken the Committee finds it difficult to fully scrutinise the Executive’s assumption that these costs could be met by savings elsewhere.

Other issues
Adequacy of consultation
68. The Committee has received no adverse comment on the consultation process for the Bill itself.

Equal opportunities
69. The Minister indicated in his letter of 14 November that he also intends to lodge amendments to create a new section to encourage equal opportunities throughout the NHS. This should allow for the NHS to comply with the Parliament’s mainstreaming agenda. The Committee and the witnesses it took evidence from on this matter welcome this step by the Executive and is satisfied that the Bill’s provisions are not discriminatory on the basis of gender, race, disability, marital status, religion, age or sexual orientation.

Financial Memorandum
70. The Finance Committee’s report is noted by the Health Committee, and is annexed to this Report. Regarding specific recommendations, these have been covered earlier in this report.

Subordinate legislation
71. The Subordinate Legislation Committee’s report is noted and its recommendations adopted by the Health Committee.
POLICY MEMORANDUM

72. Rule 9.6.3 requires the Committee to report on the Scottish Executive’s Policy Memorandum. The Committee is generally content with the explanation of policy within the document.

RECOMMENDATION

73. The Committee endorses the views of the Finance Committee regarding the Executive’s assertion that there will be no additional expenditure associated with this Bill. The Committee considers that there has not been adequate work carried out by the Executive to cost the provisions contained within this Bill and there remains doubt in the mind of the Committee that the Bill will indeed be cost neutral.

74. Overall, the Committee is satisfied that this Bill should improve health service delivery. However, we have identified above a list of concerns which will need to be addressed. The Committee particularly welcomes the provisions covering public involvement and the promotion of health improvement.

75. Subject to the reservations expressed earlier in this report, the Committee recommends that the Parliament approves the general principles of the Bill.
1. The Subordinate Legislation Committee considered the delegated powers provisions in the National Health Service Reform (Scotland) Bill at its meetings on 28th October and 4th November 2003. The Committee submits this report to the Health Committee, as the lead committee for the Bill, under Rule 9.6.2 of Standing Orders.

Committee remit
2. Under the terms of its remit, the Committee considers and reports on proposed powers to make subordinate legislation in particular Bills or other proposed legislation and on whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation.

3. The term “subordinate legislation” carries the same definition in the Standing Orders as in the Interpretation Act 1978. Section 21(1) of that Act defines subordinate legislation as meaning “Orders in Council, orders, rules, regulations, schemes, warrants, bye-laws and other instruments made or to be made under any Act”. “Act” for this purpose includes an Act of the Scottish Parliament. The Committee therefore considers not only powers to make statutory instruments as such contained in a Bill but also all other proposed provisions conferring delegated powers of a legislative nature.

Background
4. The Bill forms part of the package of legislation introduced by the Executive with the purpose of reforming the NHS in Scotland. It amends the organisation and operation of the NHS by, amongst other things, providing for the dissolution of NHS Trusts and establishing Community Health Partnerships. Ministerial powers to intervene to secure the quality of healthcare services are extended and duties are imposed on Ministers and health Boards to promote health improvement.

5. As with the Primary Medical Services Bill recently considered by the Committee, the Bill adopts the drafting approach of repealing, amending and inserting new sections into the National Health Service (Scotland) Act 1978 (“the 1978 Act”).

Subordinate legislation powers

General
6. There are four sections in the Bill that confer powers to make orders or regulations, namely sections 2, 6(1), 8(1) and 10. The Executive has supplied the customary Memorandum for the assistance of the Committee which describes each power and the justification for the delegation. The Memorandum is reproduced at Appendix 1.
7. In addition to these powers, several provisions of the Bill confer direction-making powers on the Scottish Ministers, namely section 2 introducing new section 4A into the 1978 Act which provides for the making of schemes by Health Boards for the establishment of Community Health partnerships and section 4, introducing new section 78A into the 1978 Act conferring default powers on the Scottish Ministers in the event of service failures. However, these powers seem to be of an executive rather than legislative nature and therefore not of further concern to the Committee.

Section 2 inserted subsection 4A(6)  Community Health Partnerships

8. Section 2 of the Bill inserts a new section 4A into the 1978 Act. Section 4A provides for the establishment of Community Health Partnerships ("CHPs").

9. Section 4A(5) enables regulations to be made by the Scottish Ministers to make general provision in relation to CHPs including the number of CHPs to be established in the area of a Health Board and the status, membership, procedures, staffing and expenses of a CHP and the functions to be exercised by a CHP.

10. Section 4A(6) provides that regulations made under subsection (5)(d), in relation to a CHP’s functions, may in particular include provision specifying the functions of a Health Board which are to be exercised on their behalf by a CHP and other matters which are laid down in subsection (6)(b) to (e).

11. The Committee observed that this draft provision included in the regulation-making power an illustrative list of the type of provision that might be included in the regulations.

12. The Committee recalled that during its recent consideration of the delegated powers in the Primary Medical Services (Scotland) Bill at Stage 1 it had remarked on the skeletal nature of the delegated powers in that Bill and on the absence from the draft powers of illustrative lists.

13. As there seemed to be an inconsistency in the approach of the Executive to the inclusion of illustrative lists in Bills the Committee asked for explanation.

Answer 1
14. The Executive replied reiterating the evidence that it gave to the Committee on the Primary Medical Services (Scotland) Bill. Its stated concern is that, in its view, an illustrative list quickly becomes a prescriptive list and therefore restricts what might be included in regulations. In the case of the Primary Medical Services (Scotland) Bill, it was important to have the flexibility necessary to respond to changes in the General Medical Services contract negotiated between the British Medical Association and the NHS Confederation. This has the potential to cause difficulties if the nature of that change is not prescribed in an illustrative list.

15. Where possible, the Executive aims to put as much detail as is possible in regulation-making powers. In the case of the NHS Reform (Scotland) Bill, it was considered appropriate to illustrate in subsection (6) what regulations were likely to be made under subsection (5)(d). The Executive’s reply is reproduced at Appendix 2.
16. Whilst the Committee considered that it might happen that an illustrative list came to be regarded as prescriptive it nevertheless agreed that the Executive had not made it clear why an illustrative list is acceptable in one instance and not in another. As the point seemed more a matter of policy for the lead committee and the Parliament, the Committee draws it to the attention of the lead committee to pursue as it sees fit.

17. The Committee, however, supported the Executive’s stated aim to put as much detail in regulation-making powers as possible. In the case of the present Bill, the detail in the regulation-making power is welcome.

Section 2 inserted subsection 4A

18. The Committee asked for an explanation of how the schemes of establishment for CHPs made under subsection (1) would interact with the Regulations that the Ministers may make under subsection (5).

Answer 2

19. The Executive would like to point out that the regulations are directly linked to the schemes. Regulations will prescribe for example the form and content of, and the procedure in relation to, schemes of establishment (subsection (5)(c)). Regulations may also make provision in relation to the expenses of a CHP (subsection 5(b)). They may also in accordance with subsection (5)(d) and (6)(a) of new section 4A specify those functions of a Health Board which CHPs are able to exercise on their behalf.

20. The scheme of establishment which Health Boards are to submit to the Scottish Ministers will then go on to detail what CHPs will be set up in a Health Board area, what particular functions they would carry out on behalf of the Health Board and the resources that they would have to carry out these functions. The schemes of establishment would be drawn up by Health Boards following a full consultation with interested parties and submitted to the Scottish Ministers for approval or rejection.

Report 2

21. The Executive’s reply makes it clear that the Regulations to be made by the Scottish Ministers are quite separate from the establishment of individual CHPs by schemes made by Health Boards under the Bill as described by the Executive in its response. These schemes, which are not statutory instruments, will be made within the scope of the general regime as laid down in the Regulations.

22. The Regulations to be made by the Scottish Ministers are general regulations to be made by statutory instrument that will apply in respect of all CHP’s. The Regulations will set out the basic framework of the CHP regime including the numbers of CHPs for each Health Board area. The alternative would be to set out such details in primary legislation. However, because of the level of detail and the fact that the legislation may need to be fine-tuned from time to time, the Executive considers that it is more appropriate for the details to be dealt with by Regulations made by the Scottish Ministers rather than by primary legislation. The Committee accepts that position.
23. The Bill does not require the Scottish Ministers to carry out any consultation before making these Regulations nor has the Executive given any indication of the consultation, if any, that would be carried out on the Regulations. Given the nature of the Regulations and because they will provide the basis for the establishment and operation of CHPs, the Committee considered whether the Bill should require the Ministers to consult with interested parties such as Health Boards or even with “such persons as they consider appropriate” before making the Regulations.

24. As the regulations can be changed at any time, the Committee draws to the attention of the lead committee that the insertion of a provision for consultation on any changes with the appropriate bodies would allow for any changes to be implemented through local decisions more easily than if there is no provision for consultation.

25. Also, the importance of the regulations for the operation of community health partnerships may argue for the regulations being made subject to affirmative rather than annulment resolution as proposed in the Bill. Given the policy importance of the provision, the lead committee will wish to consider recommending affirmative procedure rather than the annulment procedure proposed.

**Section 8(1) and (2) Ancillary provision**

*Background*

26. This section enables the Scottish Ministers to make by order such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes, or as a consequence, of the Act and includes the power to amend or repeal any enactment, instrument or document.

27. An order made under section 8 is subject to negative resolution procedure except where it makes amendments to primary legislation when it is to be it will be subject to affirmative resolution procedure.

28. While the Committee had no difficulty in principle with a power to make ancillary provision by way of subordinate legislation it had some concerns about the width of the power in this case and in particular the power to make “supplemental” provisions which seemed to it to be capable of very wide interpretation.

29. The Committee also noted the Special Report on “Henry VIII” powers to make incidental, consequential and similar provision by the House of Lords Select Committee on Delegated Powers and Regulatory Reform dated 11 December 2002 and the concerns expressed by that Committee about the increasing frequency with which such powers were being taken in Bills and the width of such powers. The Committee therefore asked the Executive for its comments.
Answer 3

30. The Executive has noted the content of the Special Report mentioned by the Committee and refers in particular to the comment made in the last sentence of paragraph 2 of the Letter from the First Parliamentary Counsel to the Legal Adviser on page 23 which states—

“While at first sight provisions of the kind you mention may seem of very wide scope, they will have to be interpreted with regard to the context of the Act in which they appear.”.

We note also the terms of paragraph 5 of the Report which appears on page 5 and which states—

“But it is common for some form of incidental or supplementary provision (as well as consequential provision) to be covered. This is because the courts are likely to take a strict view of what is meant by “consequential”. The terms “consequential”, “incidental”, “supplementary” and “transitional” are not mutually exclusive: there is a significant degree of overlap. Incidental or supplementary provision might, for example, fill in detail which is consistent with the provisions of the Act but missing from it, or make changes, to other Acts, which represent the exercise of a choice brought about by the enabling Act and which are not necessarily a direct consequence of that Act.”.

31. The Executive disagrees that the provision might be given a wide interpretation. The provision in question is common and is also limited given that any supplemental provision that might be made must, in accordance with section 8(1) of the Bill, be “for the purposes, or in consequence, of this Act”. This power is taken as a common practice in Bills and are taken as a sensible and limited (by virtue of the limiting words in section 8(1)) precaution against the unexpected. Further, even if the power were to be exercised, it will be subject to further parliamentary scrutiny in terms of section 8(3).

Report 3

32. As the Committee indicated, it had no difficulty in principle with ancillary provisions of the type referred to, which it accepts may be a sensible precaution in many Bills. There also seems to be no reason to doubt the advice of First Parliamentary Counsel as to the general effect of such provisions.

33. As recommended by the House of Lords Committee, the relevant provision in this Bill also provides for an instrument under this section that amends primary legislation to be subject to affirmative procedure. The section therefore appears unexceptionable on that basis.

34. Nevertheless, this Committee notes that the House of Lords Committee also expressed disquiet about the frequency with which provisions of this nature were included in Bills. In particular, they should not be used as cover for inadequate preparation in the drafting of legislation. The Lords’ Committee therefore recommended that while it would naturally not be possible to identify every possible eventuality that might give rise to a need to exercise the power, some fuller justification for its inclusion in any case should be given both in the Explanatory
Notes to a Bill and in the Memorandum to the Committee on its delegated powers with, perhaps, examples of the type of situation envisaged as to when it might be used.

35. While the Committee had no objection to the provision in this Bill, it agreed to consider further the general question of the width of provisions such as these in Bills of the Scottish Parliament.

36. There are no further delegated powers provisions in the Bill of concern to the Committee.
MEMORANDUM TO THE SUBORDINATE LEGISLATION COMMITTEE
BY THE SCOTTISH EXECUTIVE

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL

Provisions Conferring Power to Make Subordinate Legislation

Purpose

1. This memorandum has been prepared by the Scottish Executive to assist consideration by the Subordinate Legislation Committee, in accordance with Rule 9.6.2 of the Parliament’s Standing Orders, of provisions in the National Health Service Reform (Scotland) Bill, conferring power to make subordinate legislation. It describes the purpose of each such provision, explains why the matter is to be left to subordinate legislation and the reasons for seeking the proposed powers.

Outline and Scope of the Bill

2. The overarching policy objective of this Bill is to reform the National Health Service ("NHS") to deliver improved health and better integrated services that are more responsive to the needs of patients and communities. It will also seek to strengthen the role of health improvement to ensure that it is a priority for Health Boards. It proposes to do this by introducing provisions in relation to:

- the dissolution of NHS Trusts;
- establishing Community Health Partnerships;
- placing a duty on Health Boards to co-operate with each other, with Special Health Boards and with the Common Services Agency, in the interests of developing more effective regional planning of health services;
- extending Ministerial powers to intervene to secure the quality of healthcare services;
- placing a duty on Health Boards and Special Health Boards to involve the public in the planning, development and operation of health services; and
- placing a duty on the Scottish Ministers and Health Boards to take action to promote health improvement.

3. The Bill primarily impacts upon the National Health Service (Scotland) Act 1978 ("the 1978 Act") by repealing, amending and inserting new sections into that Act.

4. The Bill is in three Parts:

Part 1: Organisation and operation of National Health Service;
Part 2: Promotion of health improvement;

Part 3: Supplementary

Subordinate Legislation Powers

5. There are four sections in the Bill that confer powers to make orders or regulations. This memorandum reviews each of these in turn.

Section 2 Community Health Partnerships

Power conferred on: The Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative resolution procedure (section 105(2) of the National Health Service (Scotland) Act 1978)

6. Section 2 of the Bill inserts section 4A into the 1978 Act. Section 4A provides for the establishment of Community Health Partnerships ("CHPs").

7. Section 4A(5) enables regulations to be made, which may provide for:
   - the number of CHPs to be established in the area of a Health Board;
   - the status, membership, procedures, staffing and expenses of a CHP;
   - the procedures for submitting a scheme under that section and their form and content;
   - the functions which CHPs should have and how these functions should be exercised; and
   - other matters relating to CHPs.

8. Section 4A(6) provides that regulations made under subsection (5)(d), in relation to a CHP’s functions, may in particular include provision specifying the functions of a Health Board which are to be exercised on their behalf by a CHP and other matters which are laid down in subsection (6)(b) to (e).

9. Under section 4A(1), Health Boards will be required to submit to the Scottish Ministers a scheme for the establishment of CHPs. Under subsection (5), regulations can be made on the procedures for submitting a scheme and what the form and content of such a scheme should be.

10. It is considered that the type of matter covered in section 4A(5) is too detailed for primary legislation and would be best made using secondary legislation so that it can be amended more easily to take account of developments and changes in procedure. Furthermore, the Scottish Ministers would like to retain the flexibility to lay down minimum criteria for CHPs in relation to the number that should be established within an area and how these Partnerships should be staffed and
resourced. Scottish Ministers would like to prescribe in more detail the functions of CHPs and how those functions will be exercised.

11. In relation to the functions of CHPs, it is intended that Health Boards will identify areas where they can devolve resources and responsibility for decision making on community based health care services to frontline staff. Although CHPs will vary from Health Board area to Health Board area, depending on the capacity of CHPs to co-ordinate the delivery of services, the Scottish Ministers may wish to make regulations specifying the functions of a Health Board that must be exercised by CHPs. This may change over time and it is considered to be more appropriate for secondary legislation. Details on consultation and reporting requirements are also considered to be too detailed for primary legislation.

12. In terms of section 105(2) of the National Health Service (Scotland) Act 1978, regulations made under section 4A will be subject to negative resolution procedure. This is considered to be appropriate. The Bill sets out the general principles surrounding CHPs and it is considered that the Regulations made under section 4A will contain further detail on the CHP regime. The Regulations will not amend primary legislation nor are they considered of such special importance that they should merit a more stringent form of parliamentary procedure.

Section 6(1)  Dissolution of local health councils

Power conferred: The Scottish Ministers
Power exercisable by: Order made by Statutory Instrument
Parliamentary procedure: Negative resolution procedure (section 6(2) of the Bill)

13. Section 6 provides for the dissolution of local health councils.

14. Section 6(1) enables the Scottish Ministers to specify by order a date on which local health councils are to be dissolved by that section.

15. In order to fulfil the policy objective of dissolving local health councils and setting up a new public involvement structure it is necessary to have the requisite powers to dissolve local health councils once arrangements have been put in place for the new public involvement structure. A power to specify by order a date for dissolution gives the Scottish Ministers maximum flexibility.

16. It is considered that negative resolution procedure is the most appropriate procedure for this order. A more stringent form of parliamentary control is not thought to be appropriate in the circumstances.

Section 8(1) and (2) Ancillary provision

Power conferred on: The Scottish Ministers
Power exercisable by: Order made by Statutory Instrument
Parliamentary procedure: Negative resolution (section 8(3)) unless the Order contains provisions which add, replace or omit any part of the text of an Act in which case the Order is
17. Section 8 deals with ancillary provisions.

18. Section 8(1) enables the Scottish Ministers to make by order such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes, or as a consequence, of the Act.

19. Section 8(2) provides that an order under subsection (1) may amend or repeal any enactment, instrument or document.

20. This order-making power (which is common place in Bills) is included so that, if a need for any further incidental, supplemental, consequential, transitional or saving provision becomes apparent after the Bill is enacted and implemented, it will be possible to make such provision without the need for primary legislation.

21. An order made under section 8(1) is subject to negative resolution procedure in terms of section 8(3) of the Bill, which is normal for this type of order. Where an order makes amendments to primary legislation then it is to be subject to more stringent scrutiny and hence it will be subject to affirmative resolution procedure in terms of section 8(4) of the Bill.

Section 10(1) and (2)  Commencement and short title

Power conferred on: The Scottish Ministers
Power exercisable by: Order made by Statutory Instrument
Parliamentary procedure: No parliamentary procedure

22. Section 10 provides for the short title and commencement arrangements for the Bill.

23. Section 10(1) provides for the Scottish Ministers by order to appoint a day when the provisions of the Bill are to come into force. Section 10(2) provides that different days can be appointed for different purposes.

24. This order making power is required for commencement of the Bill. It is standard procedure for such commencement provisions to be dealt with by subordinate legislation. Whilst the order is not subject to any parliamentary procedure as such, the Subordinate Legislation Committee will have the opportunity to consider the instrument in terms of its remit.
Appendix 2

From Scottish Executive Health Service Bills Team

National Health Service Reform (Scotland) Bill at Stage 1

Thank you for your letter of 28 October seeking an explanation on a number of issues relating to the above Bill. Each of these is addressed in turn below.

Section 2 inserted subsection 4A(6) Illustrative list

You asked for comments on the Executive’s position regarding illustrative lists in the recent Health Bills. As stated in the evidence on the Primary Medical Services (Scotland) Bill (Col 124), the Executive’s concern is that an illustrative list quickly becomes a prescriptive list and therefore restricts what might be included in regulations. In the case of the Primary Medical Services (Scotland) Bill, it is important to have the flexibility necessary to respond to changes in the General Medical Services contract that is negotiated between the British Medical Association and the NHS Confederation. This has the potential to cause difficulties if the nature of that change is not prescribed in an illustrative list.

Where possible, the Executive aims to put as much detail as is possible in regulation making powers. In the case of the NHS Reform (Scotland) Bill, it was considered appropriate to illustrate in subsection (6) what regulations were likely to be made under subsection (5)(d).

Section 2 inserted subsection 4A Community Health Partnerships

The Committee asked for an explanation on how the schemes of establishment for CHPs made under subsection (1) would interact with the Regulations that the Ministers may make under subsection (5). The Executive would like to point out that the regulations are directly linked to the schemes. Regulations will prescribe for example the form and content of, and the procedure in relation to, schemes of establishment (subsection (5)(c)). Regulations may also make provision in relation to the expenses of a CHP (subsection 5(b)). They may also in accordance with subsection (5)(d) and (6)(a) of new section 4A specify those functions of a Health Board which CHPs are able to exercise on their behalf. The scheme of establishment which Health Boards are to submit to the Scottish Ministers will then go on to detail what CHPs will be set up in a Health Board area, what particular functions they would carry out on behalf of the Health Board and the resources that they would have to carry out these functions. The schemes of establishment would be drawn up by Health Boards following a full consultation with interested parties and submitted to the Scottish Ministers for approval or rejection.

Section 8(1) and 8(2) Ancillary provision

We note the content of the Special Report on Henry VIII powers to make incidental, consequential and similar provision by the House of Lords Select Committee on Delegated Powers and Regulatory Reform. In particular, we note the comment
made in the last sentence of paragraph 2 of the Letter from the First Parliamentary Counsel to the Legal Adviser on page 23 which states:-

“While at first sight provisions of the kind you mention may seem of very wide scope, they will have to be interpreted with regard to the context of the Act in which they appear.”.

We note also the terms of paragraph 5 of the Report which appears on page 5 and which states:-

“But it is common for some form of incidental or supplementary provision (as well as consequential provision) to be covered. This is because the courts are likely to take a strict view of what is meant by “consequential”. The terms “consequential”, “incidental”, “supplementary” and “transitional” are not mutually exclusive: there is a significant degree of overlap. Incidental or supplementary provision might, for example, fill in detail which is consistent with the provisions of the Act but missing from it, or make changes, to other Acts, which represent the exercise of a choice brought about by the enabling Act and which are not necessarily a direct consequence of that Act.”.

The Committee asks what provisions the Executive has in mind in terms of supplemental provision. The question is raised because of the Committee’s concerns over the wide interpretation which might be given to “supplemental”. The Executive disagrees that the provision might be given a wide interpretation. The provision in question is common and is also limited given that any supplemental provision that might be made must, in accordance with section 8(1) of the Bill, be “for the purposes, or in consequence, of this Act”. This power is taken as a common practice in Bills and are taken as a sensible and limited (by virtue of the limiting words in section 8(1)) precaution against the unexpected. Further, even if the power were to be exercised, it will be subject to further parliamentary scrutiny in terms of section 8(3).
Finance Committee

Report on the Financial Memorandum of the National Health Service Reform (Scotland) Bill

Stage 1

The Committee reports to the Health Committee as follows—

Background

1. Under Standing Orders, Rule 9.6, the lead committee in relation to a Bill must consider and report on the Bill’s Financial Memorandum at Stage 1. In doing so, it is obliged to take account of any views submitted to it by the Finance Committee.

2. This report sets out the views of the Finance Committee in relation to the Financial Memorandum published to accompany the National Health Service Reform (Scotland) Bill, for which the Health Committee has been designated by the Parliamentary Bureau as the lead Committee at Stage 1.

Introduction

3. The National Health Service Reform (Scotland) Bill was introduced to the Parliament on 26 June 2003 and its accompanying Financial Memorandum states that there will be no net additional expenditure arising from it. The Finance Committee however, agreed to test this assumption and took evidence from a range of witnesses.

4. At its meeting on 30 September 2003, the Finance Committee took evidence on the Financial Memorandum from—

   John Mullin, Chairman, and Neil Campbell, Chief Executive, NHS Argyll and Clyde.

   John Wright, Director, and Dr Kate Adamson, Convener, Scottish Association of Health Councils.

   Alan McKeown, Team Leader, Health and Social Care, and Alexis Jay, Director of Social Work & Housing Services, West Dunbartonshire Council, COSLA.

5. At its meeting on 7 October 2003, the Committee took evidence from the following Scottish Executive Officials—

   Lorna Clark, Bill Team Manager; Dr Hamish Wilson, Head of Primary Care Division and Alistair Brown, Head of Performance Management Division, Health Department, Scottish Executive.

6. In addition to the oral evidence taken at these meetings, the Committee received written evidence from Health Boards, the British Medical Association and
other affected organisations. These submissions are reproduced at the Appendix and the Committee would like to express its gratitude to all who took time to provide evidence in relation to this Financial Memorandum.

**Finance Memorandum**

7. The Financial Memorandum published to accompany the Bill sets out the cost of implementing the Bill as well as those upon whom such costs will fall. Overall, the Scottish Executive assert that there will be no net additional expenditure as a result of implementing the Bill.

8. The Bill introduces changes to both the structure and ethos of the Health Service and its main impacts are detailed below:

   - subsuming of NHS Trusts into Health Boards;
   - abolition of Local Health Care Co-operatives (LHCC) and creation of Community Health Partnerships (CHP);
   - duty of co-operation between Health Boards;
   - new powers of intervention for Ministers;
   - dissolution of Local Health Councils (LHC) and the creation of a new Scottish Health Council;
   - enhanced duty to promote health improvement

9. In each of these key areas the Scottish Executive considers that any additional expenditure that may be required can be resourced either from within existing budgets or reallocated from monies freed up by the dissolution of organisations.

**Summary of Evidence**

**NHS Trusts**

10. The National Health Service Reform (Scotland) Bill proposes to abolish NHS Trusts moving towards a single-system of working with the Financial Memorandum stating that this process would incur no costs for the NHS. In evidence to the Committee, NHS Argyll and Clyde, who have already started this process, stated that it expected that there will be significant efficiency savings in the region of £600,000 - £700,000 as services are rationalised\(^1\). NHS Ayrshire and Arran also did not expect to incur increased costs as a result of this process.\(^2\)

11. However, other evidence to the Committee raised concerns about whether there may be significant management savings given the need for the newly created operating divisions to require experienced management at all levels\(^3\).

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\(^1\) Campbell, Col 300, Official Report, 30 September 2003.
\(^2\) NHS Ayrshire and Arran, written submission
\(^3\) British Medical Association, written submission
12. In its response, the Scottish Executive stressed that Health Boards had been preparing for the abolition of NHS Trusts and the resulting re-unification of Health Boards for some time and that its experience with Borders NHS Board and Dumfries and Galloway NHS Board was that cost was not an issue. The Scottish Executive further confirmed that it had received a general indication from the Boards that they expect to realise efficiency savings from bringing together functions that are currently being repeated in the Health Board and each of the Trusts⁴.

13. The Committee questioned whether the Scottish Executive could have provided a clearer financial assessment of the costs and savings associated with abolishing NHS Trusts, especially in the initial phases, rather than assuming that they would offset each other. The Scottish Executive indicated that this would not be possible at this time as such information would be specific to each Health Board. The Scottish Executive reiterated that it was confident that the costs associated with dissolution are not of any significance.⁵

14. The Committee agreed that it was regrettable that further information could not be provided as this prevented further scrutiny of whether the costs would truly be balanced out by the savings in each Health Board.

Community Health Partnerships (CHPs)

15. The Financial Memorandum asserted that the creation of CHPs following the abolition of Local Health Care Co-operatives (LHCCs) would not result in additional expenditure. In evidence to the Committee, the Scottish Executive indicated that each Health Board area had not yet concluded its consideration of the current configuration of LHCCs and what that may mean for CHPs. The Scottish Executive, however, noted that current information suggested that there could be 50 CHPs compared with the 80 LHCCs which exist at present.⁶

16. In evidence to the Committee, NHS Argyll and Clyde indicated that whilst there may be longer term savings due to the smaller number of CHPs, it is possible that some initial costs may be incurred as CHPs are significantly more complex than LHCCs. Highlands NHS Board and the Association of Local Health Care Co-operatives also raised concerns that given CHPs will encompass a range of primary care and secondary care services as well as working with partnership organisations the overall management and clinical leadership capacity within each CHP will require to be greater than in each LHCC.⁷ This could result in higher staffing costs despite a smaller number of staff.

17. The Committee also received evidence highlighting concerns that until details on the structure, number and scope of CHPs are determined, it is difficult to state whether or not the Financial Memorandum of the Bill is correct⁸.

18. This echoed the Committee’s concerns that the Scottish Executive was unable to identify the amount of additional money that Health Boards may need to

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⁴ Brown, Col 332, Official Report, 7 October 2003
⁵ Brown, Col 324, Official Report, 7 October 2003
⁶ Wilson, Col 324, Official Report, 7 October 2003
⁷ Association of Local Health Care Co-operatives, written submission
⁸ British Medical Association, written submission
reallocate to the process of establishing CHPs given that NHS Boards are still considering how best to configure their services in the future.

19. In evidence, the Scottish Executive stated that in addition to the funding freed up by the abolition of LHCCs, Health Boards could also access additional funding through the change and innovation fund for service re-design but reiterated that the Executive did not see CHPs creating any additional funding pressures\(^9\).

20. Whilst acknowledging the Executive’s reassurances in relation to additional costs, the Committee continues to have concerns about its ability to fully scrutinise the costs of CHPs when their remit, role, membership and number has yet to be decided.

21. This, in turn, raised broader concerns about the Committee’s scope to in scrutinise Financial Memoranda where much of the detail of the Bill has yet to be finalised and hence any additional costs are, at best, estimates.

Co-operation between Health Boards

22. The Bill proposes to introduce a duty of co-operation between Health Boards. In written evidence to the Committee, NHS Argyll and Clyde stated that joint planning should enable more cost effective use of resources although there may be initial costs to establish an appropriate planning infrastructure. Similarly Highland NHS Board, in written evidence to the Committee, noted that there should be no assumption that regional services will automatically be expanded, since this would require an application of development resources.

Intervention by Ministers

23. The Committee received considerable evidence on the financial implications of the power of Ministerial intervention proposed by the Bill. In particular, NHS Argyll and Clyde, who underwent Ministerial intervention at their request last year, cast doubt upon the figure of £85,000 used in the Financial Memorandum as the average cost of intervention. In evidence to the Committee they stated that in their experience this was a substantially expensive option. Including salary and living costs, their experience was that intervention costs were in the region of £300,000\(^10\). This is particularly the case when experienced high level staff are required to be available at the same time for a task force (displacing existing staff) in addition to the costs of removing these skilled staff from their existing posts.

24. NHS Argyll and Clyde also questioned whether it would be appropriate for Boards who may experience intervention as a result of financial problems to then be asked to bear the considerable additional cost burden of intervention. This concern was also echoed by the British Medical Association in written evidence to the Committee.

25. Finally, NHS Argyll and Clyde raised the question of the costs resulting from intervention. It is foreseeable that the recommendations which arise from a Ministerial intervention may be costly such as the removal of staff and concerns

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\(^9\) Clark, Col 322, Official report, 30 September 2003
\(^10\) Campbell, Col 294, Official Report, 30 September 2003
were raised as to whether Health Boards already experiencing financial difficulties would be best placed to pay for these changes.

26. In written evidence to the Committee, NHS Highland Board believed that as intervention would be at the behest of Scottish Ministers, it assumed that any additional costs would fall directly upon the Scottish Executive and not add to local NHS costs.

27. In oral evidence to the Committee, the Scottish Executive stated that they believed their estimate of £85,000 (which was based on Ministerial intervention at Tayside NHS Board) represents an accurate average cost for intervention. Although it was recognised that some interventions may be more costly, others may be more focussed, shorter in duration and, therefore less costly. In addition, the policy intention is clearly that it would be used as a power of last resort and, therefore, it is not expected that it would be used frequently.\(^{11}\)

28. The Scottish Executive then responded that the question of who would bear any additional costs of such an intervention would be for discussions between Ministers and the department on one hand and the Health Board in difficulty on the other. If an NHS Board argued that the costs would damage service provision, Ministers would listen very carefully to that argument although the presumption is that costs would be contained within existing NHS financial allocations.\(^{12}\)

29. The Committee remains unconvinced that the estimated average cost associated with the power on intervention is reasonable based on the evidence it received. The Committee believes that the cost of intervention has been considerably underestimated particularly given the calibre of staff (and their availability) required in any task force, secondment expenses, and the costs of any resulting recommendations such as staff redundancies.

30. It also remains unclear to the Committee who would absorb the costs of intervention should a Health Board be experiencing financial problems. This confusion is further evidenced by the contrasting written submissions from NHS Highland Board (Scottish Executive would pay for intervention) and NHS Argyll and Clyde (Health Board would absorb the costs).

Public Consultation

31. Public consultation is an important aspect of the current workload of Health Boards and was recognised in submissions as a vital role. However the question of what constitutes proper engagement with communities was raised in evidence.\(^{13}\) In particular, if consultation is to be two way then Health Boards must be able to support people’s desire to become involved and the issue become much more about investing in capacity at local level.\(^{14}\) It is this desire to engage in genuine, meaningful, continuous public consultation that some organisations

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\(^{11}\) Brown, Col 327, Official Report, 7 October 2003
\(^{12}\) Brown, Col 327, Official Report, 7 October 2003
\(^{13}\) Campbell, Col 298, Official Report, 30 September 2003
\(^{14}\) Mullin, Col 298, Official Report, 30 September 2003
recognised as being costly and questioned whether it could be achieved within the current funding allocations of Heath Boards\(^\text{15}\).

32. In response, the Scottish Executive stated that Health Boards already involve the public and that this will put this duty on a statutory footing. In addition, the Scottish Executive explained that the extent to which there is public involvement will depend on what sort of service change is being considered, with more focused consultation incurring smaller costs. An additional £4 million a year will also be available as part of the patient focus and public involvement programme to help with capacity planning, and to ensure that patients and the public are able to participate fully in NHS consultations\(^\text{16}\).

33. The Committee, although welcoming this additional funding, expressed concern that whilst the Financial Memorandum intimates that there will be no additional funding required, it appears that there are now additional resources delivered through other programmes that Health Boards may wish to utilise in order to deliver the policy intentions of the Bill.

**Scottish Health Council**

34. The Bill proposes to abolish Local Health Councils and in turn to use this funding to create a Scottish Health Council (SHC). In evidence to the Committee the Scottish Association of Health Councils questioned whether this funding would be adequate given that existing Health Councils also receive funding in kind from Health Boards which covers such expenses as property rental rates and IT expenditure. If the SHC is to be truly independent then this funding should not continue and the revenue required sought from another source\(^\text{17}\).

35. In its opening statement to the Committee, the Scottish Executive stated that the SHC and its Local Advisory Councils will have a different role from the current Local Health Councils and that existing resources will be sufficient for the setting up and running of the SHC\(^\text{18}\).

**Health Improvement**

36. Evidence the Committee received indicated that it is reasonable to assume that the new duty to promote health will not result in any additional funding requirements but instead a review of how resources are allocated and prioritised.\(^\text{19}\) It was recognised in some submissions, however, that more information about what this duty will mean will enable a more accurate assessment of its potential financial impact (if any).\(^\text{20}\)

**Conclusions and Recommendations**

37. Whilst the Committee recognised the difficulties inherent in costing new methods of working and the creation of new organisations, overall it was

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\(^{15}\) Scottish NHS Confederation, written submission

\(^{16}\) Clark, Col 339, Official Report, 30 September 2003

\(^{17}\) Wright, Col 297, Official Report, 30 September 2003

\(^{18}\) Clark, Col 323, Official Report, 30 September 2003

\(^{19}\) NHS Argyll and Clyde, written submission

\(^{20}\) Scottish NHS Confederation, written submission
disappointed with the lack of financial detail in the Financial Memorandum for the National Health Service Reform (Scotland) Bill.

38. The average costing given for the power of Ministerial intervention was widely debated by the Committee and witnesses and the Committee concluded that there is still considerable uncertainty about the accuracy of the figure and which organisations would bear this cost.

39. The Committee would, therefore, strongly recommend that the Health Committee seek further clarification from the Minister on the circumstances when the Scottish Executive would bear the cost of intervention as opposed to the Health Board as proposed by the Bill.

40. The Committee welcomes the additional information it received on interventions from the Scottish Executive and suggests that the Health Committee should assess whether this information provides adequate guidance on the potential costs of intervention.

41. The Committee concluded that as the role, remit and membership of Community Health Partnerships had yet to be agreed, it was difficult to ascertain whether the Executive’s assumption that the costs of establishing and then running CHPs could be contained within the existing funding for LHCCs was accurate. This was reinforced by written evidence from the British Medical Association. The Committee would, therefore, recommend that the Health Committee seek further information from the Minister on the role, remit and membership of CHPs given that this may impact on the costs of establishing these partnerships.

42. In relation to the transfer of NHS Trusts to Health Boards, the Finance Committee would recommend that the Health Committee explore with the Minister in much more detail how any savings may be used to offset the potential costs of transferring NHS Trust staff and resources to Health Boards.

43. One of the key thrusts of this Bill is in relation to public consultation (as detailed in paragraphs 31-33). The Committee would recommend that the Health Committee further pursue whether the funding provided at present is adequate for carrying out public consultation as detailed in the Bill.

44. In considering the Financial Memorandum of this Bill, the Committee agreed that wider issues had been raised about the quality of information on financial expenditure in relation to Bills. More specifically, the Committee was concerned about the lack of financial information that could be given in relation to the creation of new bodies such as CHPs as well as the lack of detail in relation to subsuming Trusts. It appeared in both cases assumptions had been made that these would be budget neutral but the Committee could not effectively test these assumptions as a result of the minimal financial information on costs and savings that could be made.

45. In relation to funding for the SHC, the Committee remains unconvinced that the funding previously directed to Local Health Councils would be adequate to
fund this new organisation. The Committee would recommend that the Health Committee further explore with the Minister the role and remit of the Scottish Health Council in order to test this funding assumption.

46. More widely, the Committee would recommend that the Scottish Executive revisit that way in which it provides information on Financial Memorandum where it asserts there will be no additional funding required and considers giving much more detail on where costs and savings may be made before asserting that these will balance each other out.

47. In addition, the Committee also felt it was restricted in its consideration of the Financial Memorandum as a number of areas still require clarification. In particular there were still unknown areas in relation to the creation of CHPS and their role; how the duty to improve health would be undertaken and the specific remit of the Scottish Health Council. Without such information it was more difficult for the Committee to fully scrutinise the Executive assumption that these costs could be met by savings elsewhere.
Appendix

SUBMISSION FROM SCOTTISH NHS CONFEDERATION

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL - FINANCIAL MEMORANDUM

The Scottish NHS Confederation welcomes the early introduction of the National Health Service Reform (Scotland) Bill to the Scottish Parliament and looks forward to working with MSPs to ensure that the Bill is scrutinised and debated effectively. The Confederation is the representative body for NHS organisations in Scotland. We support the general aims and principles of the Bill, as we supported Partnership for Care, the White Paper that preceded it. Many of the provisions in that paper were strongly advocated by the Confederation – strong national leadership and shared responsibility on health improvement; a clear link between structural change and priorities for reform; a positive re-evaluation of the vital role of effective operational management; and support for the development of clinical leadership and effective working relationships between managers and clinicians. The NHS Reform Bill provides the necessary legislative framework to take forward these and other actions for reform and improvement in NHS Scotland.

This edition of Update examines each section of the Bill, assesses its implications for the NHS, and offers the Confederation’s viewpoint both on the proposals and on the framing of the legislation at this stage.

Dissolution of NHS trusts

The widely anticipated abolition of NHS trusts was confirmed in Partnership for Care and has already begun to take place: Borders, Dumfries and Galloway and Argyll and Clyde NHS Boards have already dissolved their trusts and have moved to single-system working. The dissolution of individual trusts does not in itself require primary legislation, but the NHS Reform Bill will put the finishing touches to the process by removing references to trusts from the statute book.

The Confederation would ordinarily be concerned about a proposal of yet more structural change as a solution for problems in the NHS, however in this instance we are satisfied that the Scottish Ministers clearly understand that structural change should only be used as a tool to help drive reform, not as a substitute for it. We are also reassured that the changes will take place entirely within existing NHS Board boundaries, and should therefore cause minimum disruption to staff and services. The Confederation therefore supports the dissolution of NHS trusts in Scotland as an aid to removing barriers between primary and secondary care and delivering integrated, whole system working across NHS Scotland.

We would stress, however, that Ministers must allow an adequate level of freedom for individual NHS boards to decide which structures should replace trusts in their areas. There is little point in taking the NHS through more structural change if the new structures do not represent an identifiable advance on those they replace. The 15 NHS boards will share a common shape and whole-system approach across Scotland, but within that system boards must be able to determine for themselves, in consultation with their staff and the communities they serve, what kind of organisational set-up will be most appropriate and effective for their local circumstances.

Community Health Partnerships

The Scottish NHS Confederation strongly supports the creation of community health partnerships (CHPs), and believes that these new bodies have the potential to make enormous contributions on a range of crucial areas at the heart of the reform agenda in NHS Scotland: partnership working, both within the NHS and between health and other agencies; devolution of decision-making to frontline staff; the delivery of services in the community and close to the patient, wherever possible; the development of clinical leadership; and patient, public and community involvement. We very much welcome the fact that CHPs will be statutory bodies, with the clarity that this will bring, whilst still being an integral part of their local health systems.

There is considerable enthusiasm for the concept of CHPs within NHS Scotland but, at the time of writing, not yet a clear vision from Ministers or within the service about how CHPs will operate, what they will look like or how they will represent a step forward from the existing LHCCs. NHS boards are about to embark on reviews of their LHCCs, and the Confederation is also about to
launch a major project to help define and shape CHPs, and these and other pieces of work will help to create the vision over the coming months. What is clear, however, is that that vision must be led by those within NHS Scotland who have experience and expertise in service redesign, partnership working, and delivering frontline services. The Confederation has some concern therefore at the wording of clauses 5 and 6 of section 2, which give an extremely broad description of possible regulations and could potentially allow Ministers to determine virtually every aspect of CHPs centrally and impose them upon the service. We would advise that the legislation should state clearly what will be included in regulations, not what “may” as in the present version, and that those regulations should be drawn up in consultation with the service, once there has been adequate opportunity to consider the role that CHPs will play.

We are also sceptical about the estimate in the Financial Memorandum that creating CHPs will cost no more than the current LHCC budget. It should be borne in mind that LHCCs have now been in operation since 1999, whilst CHPs will be brand new organisations. The creation of new bodies almost inevitably has additional costs attached, at least in their early days, and Ministers should be aware of this.

**Duty of co-operation**

Once again, the Confederation welcomes the formalising of co-operation and shared planning between different local health systems, national agencies and Special Health Boards as a significant contribution to service redesign and integrated care in NHS Scotland. We would ask Ministers to ensure that structures and protocols are fully in place to ensure that regional and national planning processes run smoothly, and that it is made clear in guidance which services are most appropriate and most likely to benefit from being organised on a cross-board co-operative basis.

**Ministers’ powers of intervention**

The Confederation fully accepts that Ministers, being ultimately accountable for the performance of the NHS, should have the ability to intervene where serious failures occur and that it is sensible to formalise this power, which has already been used on a number of occasions, as in the recent example in NHS Argyll and Clyde. However, along with the formalisation of this power must come responsibility in the way that it is used. It must be clearly laid out—either in regulations or, preferably, in the legislation itself—exactly what ‘intervention’ means and in what circumstances it will be used. Although we appreciate that the present Minister has made it clear that he regards ministerial intervention as an action of last resort, future ministers must also be clear about this. The legislation should be framed in such a way that the power cannot be used in a ‘gung-ho’ way and that the principle of health services being planned, managed and delivered locally is preserved. Other lesser interventions are available to use when problems arise, and these should be exhausted before the final ministerial sanction is considered.

The performance management and assessment system for NHS Scotland aims to identify areas of concern and potential problems and to provide varying levels of appropriate, targeted support to local NHS systems to address these issues before crises occur. This proportionate, collaborative approach has the support of the service and Ministers should continue to regard it as the primary method of managing performance in NHS Scotland.

NHS reform will not advance unless NHS leaders themselves are freed up to actually lead the way. The formal power of intervention must be balanced by the promotion of a culture that places trust in managers and clinical leaders and provides them with protected space to innovate, experiment and take risks, unhampered by the fear that their local systems may be taken over if it doesn’t come off. Supporting and nurturing those people who have the expertise and the commitment to deliver improvement will always be the most effective way to make it happen.

**Public involvement**

The Confederation welcomes the inclusion of a formal duty for NHS boards to involve and consult with the public on the planning and development of services. The engagement of patients and communities in decision-making processes is a responsibility that NHS boards have taken increasingly seriously in recent years, and a number of boards in Scotland have already developed innovative and meaningful ways to ensure public involvement. For example, NHS Tayside has created three ‘public partnership’ groups of citizens who will work closely with the board to plan
services in their respective communities. NHS Highland has developed a pioneering ethical decision-making framework, which not only guides the board in its deliberations but also provides the public with a tool to monitor and hold to account the quality of the decision-making process within the local health system. The provision in the Bill will formalise the efforts being made in these and other NHS boards across Scotland, and will send an important message to patients and communities that they are valued partners in making decisions about the services that they use. The creation of the Scottish Health Council will underline this message and is fully supported by the Confederation, although we would urge that Ministers ensure that both the Council and its local offices are fully prepared for operation before the existing local health councils are dissolved.

The Confederation does have some concern, however, about the estimate in the Financial Memorandum that the public involvement duty will involve no additional expenditure by NHS boards. Genuine, meaningful, continuous public involvement is not cheap, as NHS organisations have found through experience—it may require the provision of training both for NHS staff and for communities, for example—and whilst the Confederation fully agrees that it is crucial, it should not have to come at the expense of other services. Ministers should be prepared, if necessary, to back up the requirement with the provision of dedicated funds to the NHS to advance the public engagement agenda.

Finally, we note that this section in the Bill negates the need for the proposed Members’ Bill by Paul Martin MSP. We would strongly encourage MSPs who wish to clarify or strengthen the duty to involve the public to do so through amendments to this Bill, rather than through separate legislation.

Promoting health improvement

The Confederation is delighted at the inclusion in the Bill of a formal duty for the Scottish Ministers to promote health improvement. We have long argued that improving Scotland’s health record is not and cannot be a job for the NHS alone and that a clear demonstration of strong national leadership from government is vital to ensure that the issue is a priority for all Scottish public bodies. In this instance, the phrase ‘Scottish Ministers’ in the Bill should not be interpreted as a piece of stock legal jargon but should be taken literally to mean that this is a duty for every member of the Scottish cabinet. So many areas of Executive responsibility have an integral role to play in promoting good health and preventing bad—not just health services, but also finance, housing, social justice, education, transport, the environment, community safety and enterprise—that the provision will only be of real effect if it genuinely cuts across every departmental boundary.

We also welcome the corresponding duty for NHS boards to promote health improvement. Once again, this provision merely formalises a responsibility which every NHS board already acts upon, but its inclusion in the Bill sends an important message about the status of health improvement as a priority for the NHS. It means that innovations such as the newly announced Glasgow Centre for Population Health, along with countless other health improvement projects across Scotland, should be regarded as being as much a part of the core business of NHS Scotland as the day-to-day delivery of services in hospitals and the community.

The framing of the legislation does not make it at all clear, however, how this duty will be carried out. Clauses (1)(2) and (2)(2) of section 7 are vague and their purpose is unclear. Why do they refer only to “any person” and not also to organisations or groups of people? To what end should the financial assistance be used? What form would arrangements or agreements take? It would be helpful to have more detail on the face of the legislation about what is meant by these clauses and what actions they will enable Ministers and boards to take.
<table>
<thead>
<tr>
<th>Provision</th>
<th>Financial Implications per Explanatory Notes</th>
<th>NHS Argyll &amp; Clyde Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissolution of NHS Trusts</td>
<td>No direct cost implications. Winding up of Trusts likely to produce modest reductions in administrative costs to be used by Health Boards to improve patient care.</td>
<td>• There is likely to be significant potential for cost savings through dissolution, for example, combining of administrative functions, eg Finance, HR, Telephonists etc, but there may be “one off” redundancy/early retirement costs required to achieve these potential benefits.</td>
</tr>
<tr>
<td>Community health partnerships</td>
<td>No overall additional expenditure. Resources previously used to support local health care cooperatives will be used to fund community health partnerships.</td>
<td>• Again, there may be potential to reduce administrative costs (subject to matters raised above) due to smaller number of Community Health Partnerships. However, in order to reallocate funding, some initial costs may be incurred. CHPs are significantly more complex than LHCCs and therefore additional management capacity may be required.</td>
</tr>
<tr>
<td>Health Boards: duty of co-operation (regional planning)</td>
<td>No overall additional expenditure. Existing resources to be used more effectively.</td>
<td>• Joint Planning should enable more cost effective use of resources. However, there will be set up costs required to develop an appropriate planning infrastructure.</td>
</tr>
<tr>
<td>Powers of intervention</td>
<td>No direct cost implication until used. If the power is used, any expenditure is expected to be modest and will be contained within existing NHS financial allocations.</td>
<td>• The estimated cost of a task force of 6 people for £85,000 is significantly understated. Individuals of appropriate calibre will have salary costs of up to £100,000 each. 6 people for 6 months would cost £200,000 minimum. This funding may not be available within local health systems.</td>
</tr>
<tr>
<td>Public involvement in the NHS and the dissolution of local health councils</td>
<td>No overall additional expenditure but change expected in pattern of expenditure as a result of new priority. The cost of the new Scottish Health Council will be met from the £2.108 million currently allocated to Local Health Councils, which are being dissolved.</td>
<td>• There is potentially a substantial cost associated with Public Involvement although it is difficult to quantify. Many NHS systems are about to undertake significant modernisation projects. This requires the development of appropriate communications staff infrastructures as well as costs for publishing and venue hire.</td>
</tr>
<tr>
<td>Duty to promote health</td>
<td>No overall additional expenditure but change expected in pattern of expenditure as a result of new priority.</td>
<td>• Agreed that this is likely to require a review of how resources are allocated and prioritised.</td>
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<tr>
<td>SUMMARY</td>
<td>Overall additional expenditure as a result of the above provisions will be zero, for the Scottish Administration; local authorities and other bodies, individuals and businesses.</td>
<td>• The provisions of the Bill will provide opportunities to reduce costs in some areas, but additional investment may be required in order to achieve this outcome. However, it is unlikely that these costs will be significant in the context of the overall health budget.</td>
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SUBMISSION FROM CONVENTION OF SCOTTISH LOCAL AUTHORITIES

General

1. COSLA is keen to ensure that Scottish local government plays a full part in the development of structures and services that set out to meet community needs. The Committee will be aware that COSLA and the Executive have recently agreed a joint commitment to five priority areas of work over the next four years. Significantly, one of these areas is health improvement whilst another key area focuses on the Joint Future agenda. COSLA and its member councils are therefore demonstrably fully committed to playing their part in ensuring health improvement is a priority on the local authority agenda.

Spending Review 2004 – Funding for Health Improvement Work

2. As part of the Spending Review 2004 process COSLA is working on the preparation of its submission to the Executive – timetabled for February 2004. That exercise should identify councils’ expenditure projections for health improvement work and quantify what additional funding councils would require to undertake new initiatives as part of a cross-cutting, policy driven agenda.

The submission is likely to address the issue of Scottish Executive funding to allow the long-term continuation of the Health Improvement Posts within councils currently funded jointly by the Executive and the NHS, (funding for which will expire shortly).

In overall terms, the Committee may be interested to note that the COSLA Spending Review will focus on three key funding areas:

- Significant deficits from the last spending review
- Any new initiatives from the Partnership Agreement
- Pay and Price issues

Given the emphasis in Part 2, Section 7 of the memorandum (Promotion of Health Improvement), COSLA will ensure that an evidence based case is made for adequate financial resources for local government to facilitate the continuation of its agreed role as health improvement authorities. Given the need for a joined up approach to Health Improvement between central and local government and NHS Scotland, the financial memorandum represents a missed opportunity in the ongoing campaign to improve our nation’s health.

3. COSLA is happy to place on record the impetus already given through Scottish Executive funding to its own work on health improvement. Resources within COSLA have been mainstreamed across all COSLA’s work areas, as is fitting with its status as a joint priority area. This also reflects the cross-cutting, cross-service nature of health improvement work in member councils. Working closely with Health Improvement officers in councils, it is anticipated that the impact on political agendas will continue to develop in conjunction with the role of our linked work on Joint Future and Community Planning etc.

National Health Service Reform (Scotland) Bill

4. COSLA is generally supportive of the aims of the National Health Service Reform (Scotland) Bill with its emphasis on developing closer working between health and social care, improving community involvement and ultimately providing improved services.

However, it is anticipated that when the Bill begins its Parliamentary progress COSLA will seek to secure a number of amendments to ensure that the local authority role is fully recognised and that the NHS and councils are clearly regarded as equal partners. This will include making the direct, and we believe, obvious links to the Local Government in Scotland Act 2003 and to joint areas of responsibility with the Minister for Finance and Public Services.

This is due to the developing relationship between local government and NHS and the continuing need to ensure that, where appropriate, joint structures and joint services are established to deliver improved social care.
Financial Memorandum

5. The assertion in the Financial Memorandum that there will be no financial impact on local authorities of the Bill is regarded as premature. While the provisions in the Bill itself may prove to be cost neutral, work and initiatives will flow from its provisions that could have significant financial implications.

COSLA’s experience with Joint Future and other areas of joint working have shown that change cannot be effected without associated costs – for example staff training, secondments, joint working groups, joint training etc. Local authorities cannot be expected to take on new work in the health improvement field without full funding. As indicated above (para 2), work is in hand as part of COSLA’s Spending Review exercise, which, it is anticipated, will cost potential health improvement development work.

Community Health Partnerships

6. Committee members will know that the NHS Reform (Scotland) Bill provides the legislative base for the establishment of Community Health Partnerships (CHPs) in place of Local Health Care Co-operatives and that the Scottish Executive’s consultation exercise on CHPs has just concluded. Unless the Executive has prejudged the outcome of that consultation, how can it be assumed there will be no resource implications? The structure and role of CHPs has yet to be defined locally and while it is recognised some savings may be achieved, there are no guarantees that these will in fact materialise.

September 2003
SUBMISSION FROM ROYAL COLLEGE OF GENERAL PRACTITIONERS (RCGP) SCOTLAND TO THE SCOTTISH EXECUTIVE ON THE ESTABLISHMENT OF COMMUNITY HEALTH PARTNERSHIPS.

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL - FINANCIAL MEMORANDUM

Thank you for seeking our views on the establishment of CHPs. Before going on to answer some of the specific questions posed, we would like to reiterate some key points about the future shape of CHPs which RCGP Scotland and SGPC jointly proposed to the Chief Medical Officer earlier this year:

- Autonomy/commissioning powers for CHPs
- Joint funding and joint working with other healthcare professionals and social services. Normally, CHPs should not cover more than one LA
- Stronger public health links (e.g. In Fine Fettle project in the Borders)
- Pump-priming finding for innovative ideas
- Proper monitoring and accountability (in line with PAF to ensure that Health Boards are Accountable for their devolution)
- An educational lead to look at multi-disciplinary needs

Our overall feeling about the development of CHPs is positive, but we feel that there is a huge variation across the country in the effectiveness of LHCCs as they exist at the moment. Some of this is related to budgetary limitation, but other forces need to be looked at. Where LHCCs are working well, why are they working well?

Section 13,14: what will they do?

Q: Do you agree with these overall roles?

The overall roles do seem reasonable, but there is widespread concern within our profession that CHPs might become overburdened by bureaucratic systems and processes. CHP staff manpower and expertise might be wasted in attending multiple meetings with different groups.

In areas where LHCCs have already built up good relationships with local partners, these should be allowed to continue, and to be built upon.

Involvement with public health seems sensible, but will require considerable restructuring, as these departments have traditionally sat within Health Boards.

Section 15,16: Focus on health outcomes - community benefits

Q: How can CHPs best work with community planning partners to support the health improvement agenda?

The approach here needs to be realistic, and backed up by suitable resourcing. The exact nature of ‘community planning partners’ will vary form region to region. Planning will also need to take into account the implementation for the new GMS Contract, Agenda for Change and the Consultants’ Contract.

Section 17,18: Focus on Service Outcomes - Patient and Carer Benefits

Q: Are these the right service outcomes and what indicators would we use to measure these outcomes?

The bullet points listed range from broad to very specific, and many do not seem to be measurable. The new GMS contract will include many quality markers for general practices, and it would be preferable to avoid any conflict with indicators for CHPs. We strongly support the extension of
direct access to some services such as AHPs, but broader access in general is only a good thing if it is appropriate.

**Section 22-25: What culture and style of working should underpin CHPs?**

We strongly support a team-based and integrated culture which is responsive to developments, but not obsessed with new initiatives. Stability should be regarded as a benefit: excessive change within an organisation is both demoralising and economically inefficient.

**Section 26,27: What services will CHPs be responsible for?**

**Q: What should the core services be?**

In order to provide a ‘full range of independent contractor services’ CHPs will clearly require access to and support from secondary care, and maximum integration of primary and secondary care is crucial.

The other core services listed look reasonable, but allowance should be made for existing structures which vary considerably at present.

**Section 30-33: Will all CHPs be the same size**

**Q: What are your views on population size?**

One size will certainly not fit all, given Scotland’s demography. A minimum population size might reasonably be about 50,000.

**Section 38: Workforce planning**

**Q: What role do you envisage for CHPs in relation to workforce planning and development and the new contractual arrangements?**

Workforce issues should primarily be a matter for improved national information gathering and planning, but CHPs will naturally feed into this process.

The new GP contract presents excellent opportunities for CHPs to develop local services which will help practices to meet their quality targets, but there is also a potential conflict if performance criteria are not closely matched. It is possible that with the new contract arrangements some practices will become more rather than less introspective.

**Section 39-41: What are the organisational arrangements for CHPs?**

The recruitment of suitable staff for formal roles should follow normal good employment practice; the Chair should have an executive function, in order to make the appointment accountable to those within the CHP and to the Health Service as a whole.

Joint responsibility for outcomes across primary and secondary care requires the development of close working relationships. This area requires further consideration.

**Section 43-49: Working together**

CHPs would be an ideal place for shared learning between primary and secondary care, including areas of common concern and clinical effectiveness.

Existing areas of good practice should be shared and built upon.
Section 50-52: Public Partnership Forum

We support the creation of a PPF, but it would be important for these groups to build on and support work done by other agencies, rather than duplicating or replicating this work. It would be useful to have more clarity on exactly how the PPFs would link with the existing Local Health Councils.

Will additional funds be released to CHPs to develop the PPFs? These structures can be very resource-intensive, and might be seen by some as expensive tokenism.

Section 53: NHS Boards

Q: What do you see as the relationship between operating divisions and CHPs?

This is a crucial part of the plan to develop CHPs. Clear lines of responsibility and accountability must be developed and these should conform to a national format despite there being local aspects to the way of working. Again, examples of good practice with organisations such as LHCCs should be considered.

Section 55: How will we build CHP capacity and capability?

Q: What do you see as the developmental priorities?

The most important priority for the development of CHPs is that the proposals are clear, focussed and achievable. Front line staff must be involved without making the whole process cumbersome and time-consuming.

The creation of a feeling of involvement and relevance is critical to staff support; one way of achieving this is to look for problems that are of concern to front line staff and to provide solutions quickly and effectively. This will create an energy about the process which will engage front line staff and help more challenging and perhaps contentious issues to progress.

Performance management and review need to be realistic and achievable.

The roles and responsibilities of CHPs, and where they fit in, need to be clear to partners as well as to those within the CHP.

Development plans for CHPs need to take into account local as well as national priorities as well as capacity and workforce issues.

Section 56: What are the financial arrangements?

Q: Are the financial arrangements clear?

Not entirely - existing arrangements for LHCCs are variable. Specific arrangements for CHPs must be clear, and must be agreed by NHS organisations from the outset.

I hope you find the above comments useful.

Dr Jenny Bennison MRCGP
Deputy Chairman (Policy)
12 September 2003
Many thanks for your letter of 19th September 2003 in connection with the above. On behalf of the Association of LHCCs I would offer the following comments in relation to the Financial Memorandum.

Dissolution of NHS Trusts

The Association of LHCCs does not have access to detailed plans from each of the NHS systems on how they propose to dissolve the current NHS Trust structure. It is for local systems to agree their plans with the Scottish Executive. However past experience would suggest that for many of the senior managers – and their support teams there will be protection of employment which will result in individuals being employed in the newly formed Divisions. It is difficult for the Association of LHCCs to comment on the financial implications of this level of the organisational change.

Community Health Partnerships

The Association of LHCCs does have a clearer understanding and appreciation of the issues at this level.

When LHCCs were first introduced it is understood they were resourced from funding previously supporting the management of GP Fundholding. The formula by which the funding was allocated at a local level – ie by each Health Board appeared to be a matter of local negotiation. Furthermore, the mechanism by which each LHCC utilised its “management allowance” to seek engagement from the independent contractors and public representatives varies across the country. This in turn has been one of the factors which has impacted on the level of multiprofessional activity within LHCCs and this is perhaps an issue which would benefit from more specific guidance.

It is envisaged that in most NHS Board areas there will be fewer CHPs than there are LHCCs and this in turn will provide opportunities for greater efficiency. Rather than multiple LHCCs in a local authority area working with partner organisations on Community Planning, Joint Future agenda etc., it is envisaged that, in the main, there will be one CHP per local authority area. There will also be economies of scale in relation to “internal” issues – developing clinical governance agenda; development of health needs assessment etc. However, while the development of CHPs provides an opportunity to utilise resources (finance and manpower) more effectively LHCCs for some time have been almost at crisis trying to manage the wide agenda – capacity has been a matter of concern for some time.

It is envisaged CHPs will encompass a range of primary care and secondary care services – as well as working with partner organisations – therefore the overall management and clinical leadership capacity within each CHP will require to be greater than that in each LHCC. The Association of LHCCs recognises that there are clinical leadership, management and administrative resources currently available within secondary care and we urge that these resources be available to CHPs if the new organisations are to successfully deliver on their new agenda. The new agenda will include the development of CHPs, GMS2 and Agenda for Change.

With the development of CHPs it is also envisaged that a new public involvement forum will be established – Public Partnership Forum. It is understood further guidance on the role of the forum will follow. However, it would appear that there is an expectation the administrative support will be provided by CHPs and the Association is concerned that there is not there may not be the level of financial resource, nor technical expertise available locally to support this.

The Association of LHCCs cannot comment categorically on the financial implications of the evolution of LHCCs into CHPs. However in closing the Association would make the following observations:
the formula and mechanism for reimbursement of expenses to all independent contractors
and public representatives should perhaps be reviewed;

the current management and clinical leadership capacity within LHCCs has been limited –
with success to date relying on goodwill of clinicians and managers this will not be
sustainable. The development of CHPs will provide an opportunity to utilise resources
more effectively but it is envisaged the current level of resources will not be adequate if
CHPs wish to retain the local focus and balance this with the strategic agenda envisaged;

the size/scope of the posts of CHP General Manager and Clinical Lead have not been
identified – therefore it is very difficult to identify the costs for these positions – and whether
they will be attractive to high quality candidates. In the consultation process currently
underway, there is also a proposal for a CHP Chair. The Association supports such a
position, in principle, but again, until the role/ responsibilities and financial remuneration
envisaged are identified it is difficult to comment further that this time;

the NHS historically has had a policy of no compulsory redundancy policy through
organisational change. From a staff governance perspective this is very positive.
However in the event that suitable candidates for new posts cannot be identified from
within the system, current postholders will require to be found alternative employment at a
comparable grade to their current post. The Association of LHCCs would not wish to
encourage a change in current practice; however this is another factor when seeking to
identify the level of financial resources require.

The Association of LHCCs regards the development of CHPs as a very positive way forward for the
NHS in Scotland and trusts that the resources required will be available to secure engagement of
front line clinicians, managers and members of the local community. The role of clinicians in
primary care is envisaged to change significantly over the next few years and while the
developments proposed are welcome – it is important that the organisational infrastructure is
significantly robust to support the clinicians providing the services to patients.

Jackie Britton
Chair
Whilst we are unable to determine whether or not the implementation of the Health Reform Bill in its entirety will be cost neutral, we believe that there could be additional costs associated with the setting up of the proposed new Scottish Health Council.

Our reasons for this assertion are based on feedback requested from member Health Councils and are as follows:

The increased importance being given by the Scottish Executive to public involvement in the planning, delivery and monitoring of health services.

As a consequence, new duties falling on the Scottish Health Council at local and national level to:

quality assure arrangements made by NHS Boards and to feed this into the Performance Assessment Framework (PAF), for Boards. At a national level, this will require expertise, consistency of assessment and the opportunity to exchange good practice

monitor and assess the operation of NHS Boards’ complaints processes and to ensure that an adequate level of service is in place and working effectively

develop extensive networks with local communities, the voluntary sector and other patient organisations.

In his address to the Annual Conference of the Scottish Association of Health Councils’ on 26 September the Minister for Health and Community Care acknowledged that in order to do this, it [The Scottish Health Council], “should have access to the best professional skills in communication, partnership working, involvement and working with patients”.

Whilst the foregoing may require the Scottish Health Council to increase staff numbers it will most certainly require the new organization to invest heavily in the on-going training and development of staff and Local Advisory Council members to undertake evidence-based monitoring, consistently and in accordance with national standards.

Capital investment in ICT and a secure high-speed communications network will be an operational priority for the new organization. There will also be on-going running and support costs associated with this.

Health Councils currently receive funding “in kind” to varying degrees from their local NHS Boards. This typically covers items of expenditure such as the cost of premises, rates, ICT support, telephone services, office cleaning, payroll etc, although this does vary from Health Council to Health Council. In order to carry out its new functions, it will be essential for the Scottish Health Council not only to be, but to be seen to be, independent from health care service providers. To ensure this, we would strongly recommend that the present “in-kind” funding arrangements should cease, with the Scottish Health Council’s budget being increased directly to cover these costs in full. We wish to make it clear however that we are not recommending a consequential reduction in Boards’ budgets.

Support for NHS complaints is currently provided by many local Health Councils. Under the new arrangements this will no longer be a function of the new Scottish Health Council. NHS Boards will instead require to commission an independent support service to undertake this function. We believe that not only is a commissioned service unlikely to be truly independent but it is also likely to be more costly than the present arrangements.
I refer to your letter dated 19th September 2003 asking that the Western Isles NHS Board provide evidence that no additional expenditure from the Introduction of the National Health Service Reform (Scotland) Bill introduced to the Scottish Parliament on 26th June 2003.

The subsuming of Trusts into Health Boards does not apply for the Western Isles, as it has no Trusts operating within its area.

With regard to the enhanced role of Community Health Partnerships (CHP) the Board has only one Local Health Care Co-operative which is currently progressing towards CHP status by reallocation of existing resources within the Board. There will be one CHP within the Board area.

The NHS Board currently has a Public Health Division responsible for health improvement, health protection and public health.

At Executive Level the Director of Nursing Services is taking the lead on public involvement.

The NHS Board feels that the most important change is to delegate decision making as close the front line as possible. This will enable staff working with patients to innovate and improve care without the constant need to ask permission. The Partnership Forum have been asked to take forward this piece of work and to develop proposals to bring back to the Board.

Dick Manson

Interim Chief Executive
I refer to your letter dated 19 September 2003 requesting comments on the costs associated with implementing the above Bill.

NHS Ayrshire and Arran do not expect to incur increased costs overall resulting from the changes envisaged in the Bill. The subsuming of NHS Trusts into Health Boards and the enhanced role of Community Health Partnerships may involve the redistribution of certain resources, however current plans do not envisage any overall cost increase. Enhanced co-operation and planning with other Health Board areas under regional planning arrangements is already in hand and support for certain aspects of this is being funded nationally, e.g. workforce planning. Some non-recurring costs, such as upgrading of financial ledger systems, will be incurred in moving to single system working, however these are necessary to improve services and reporting.

The draft legislation does leave open-ended potential costs associated with Community Health Partnerships, for example in (5)(b) it indicates that regulations by Ministers may make provision for the status, membership, procedures, staffing and expenses for a Community Health Partnership. This could therefore be more expensive dependent upon the regulations which would be issued which are not under the control of NHS Ayrshire and Arran.

The NHS Board role as regards health improvement and public involvement has been established for a number of years and plans for investment in these areas is therefore not as a result of the above Bill, but is rather a core function of the NHS.

I trust the above is what you require.

Derek Lindsay

Director of Finance
I refer to your letter of 19 September 2003, and would comment as follows, using paragraph numbers from the National Health Service Reform (Scotland) Bill – Finance Memorandum.

32  Dissolution of Trusts

I agree that no costs should fall on the NHS, assuming that there are no major structural changes as a result of this dissolution, or other organisational changes such as the mandatory introduction of Shared Services, or other fixed transfer of services within Scotland. If services are moved on a compulsory nature, then normal redundancy conditions could apply, and this would lead to additional unfunded costs.

33  Community Health Partnerships

Agreed that the resources currently committed to service LHCCs, will transfer to Community Health Partnership Management costs provided the eventual Guidance confirms the demise of LHCCs. Although there will be fewer CHPs, they will assume a greater role, and therefore it is not possible at this stage to automatically assume that there will be a reduction in administrative costs. Further increased delegation to CHPs may increase costs if central economies of scale are lost.

34  Regional Planning

Northern Boards have already made a modest investment to create a regional planning infrastructure. Agreed that the continuation of regional planning will continue broadly within existing resource, since the input will be provided by existing staff. However, there should be no assumption that regional services will automatically be expanded, since this would require an application of development resources.

35  Powers of Intervention

The intervention is at the behest of Scottish Ministers, and is therefore a centrally imposed issue. On this basis, it is assumed that any additional costs would fall directly on the Scottish Executive, and would therefore not add to local NHS costs.

35  Public Involvement in the NHS, and the Dissolution of Local Health Councils

This work will continue to be prioritised within NHS Boards, including a full use of Community Health Partnerships, etc. This will initially be undertaken within existing resource, but any significant expansion in this area would require a reduction in current service delivery, or the development of such current services to create the necessary resource.

37  As with para 35, local Health Councils are centrally funded, and any additional costs would be borne by the Scottish Executive, rather than local NHS systems.

38  Duty to Promote Health Improvement

This has been an NHS Board priority for sometime, and is currently included within the Local Health Plan. Any attempt to significantly increase this rate of movement, may lead to a reduction in current service delivery or development of current services to free up the necessary resource.

I trust that the above comments are self-explanatory, but if you have any queries please do not hesitate to contact me.

Roger Gibbins, Chief Executive
The British Medical Association welcomes the proposed legislation to reform the NHS in Scotland and thanks the finance committee for inviting the BMA to provide a written submission on the financial implications of the NHS Reform (Scotland) Bill.

It is perhaps too early to provide detailed evidence on whether there will be financial implications as a result of the implementation of this legislation. At this stage, we are still not sure of the detailed structure and function of Community Health Partnerships, the reorganisation of management structures, the detail of exactly how the National Health Council will be funded and the scope and cost of any interventions necessary for ministers.

This legislation will bring an end to the internal market as all references to Trusts are removed from the statute book. A single system of local health service management will be created as Trusts cease to exist. It would be naïve to expect that there would be any significant management cost savings for hospitals as the newly established ‘operating divisions’ will continue to require experienced management at all levels. There will be an opportunity to merge functions previously duplicated by Trusts under the same NHS Board, such as human resources, into a single operation under the local Board, which is a welcome development. It is also hoped that the emphasis on regional working can also be applied to certain administrative and management functions of Boards. However, while this will reduce duplication, any cost savings will be absorbed by much needed improved effectiveness. The BMA would emphasise that this Bill provides an opportunity to improve the quality of NHS services and should not primarily focus on reducing costs.

The establishment of Community Health Partnerships (CHPs) will effectively extend and strengthen the role of what are currently Local Healthcare Co-operatives (LHCCs). Greater integration between health and social services should create savings through greater efficiencies. In order to achieve more integrated working between health and social care professionals it is essential that they have the opportunity to share perspectives and develop confidence in working together. The creation of these new NHS organisations will require an initial injection of funding in order to meet the costs of setting up the new structures. Additional administrative support and management expertise are just a couple of examples of extra costs that will be incurred. Some CHPs may be formed by the amalgamation of a number of current LHCCs, again creating savings through economies of scale. However, care must be taken when determining the structure of these organisations to ensure they remain responsive to local health needs. While savings could be achieved by amalgamating existing organisations, this cannot be weighted against the cost of losing touch with local communities.

In order for CHPs to best work with community planning partners to support the health improvement agenda, it is essential that during the development of CHPs, the engagement of general practice is nurtured and allowed to flourish. Although by no means exclusively, much of the activity in primary care takes place in general practice. It is therefore essential that it be made clear to general practitioners how they can most effectively and helpfully feed into the development of CHPs and how this involvement will benefit their patients. There will inevitably be a resource implication for this.

Until details on the structure, number and scope of Community Health Partnerships are determined, it is difficult to state whether or not the financial memorandum of the Bill is correct in saying that there will be no additional expenditure associated with these changes.

Public involvement is a vital role that will be taken forward in community planning via CHPs. The work of the National Health Council, in conjunction with CHPs, will be essential and must be funded appropriately. The Scottish Executive strategy for greater and more effective public involvement must be matched with sufficient levels of funding in order to engage the public and encourage them to play a role in community planning.
The BMA welcomes part four of the Bill which empowers ministers to intervene where health services are failing. Ministers should be accountable for the efficient and effective management of the NHS. Where Boards are failing to deliver high quality services to patients or are unable to manage finances, ministers must have the ability to intervene. In these circumstances, public confidence needs to be regained alongside the rebuilding of the failing services. However, intervention is a costly business and the Bill states that if this power is used, then it must be contained within existing NHS financial allocations. This cost will therefore be incurred by the Board, often at a time when they are facing financial difficulties.

In conclusion, we welcome this Bill and the proposals to reform the NHS in Scotland. It is the view of the BMA that while there may be initial costs associated with the implementation of this legislation, these may be balanced out in the long term by the savings associated with integrated working, economies of scale and increased efficiencies.

Dr John Garner

Chairman, Scottish Council
I have been asked to reply to you on behalf of NHS Lothian with regard to your letter dated 19th September and would respond to the specific issues as follows.

Currently in respect of support services within NHS Lothian we already have commenced a project which is reviewing the manner in which support services such as HR, Finance are being delivered. The project has an agreed financial savings target of £2.5m and good progress is being made towards achieving that target. The move to single system working is a natural extension of that and it is anticipated that that will further assist in both achieving and extending that financial target.

It should however be emphasised that public engagement at both as early a stage as possible and throughout the planning process will incur costs if it is both to be meaningful to the public and effective in terms of outcomes realised. Within NHS Lothian we have experience of this in a number of fora including Development of Local Health Plan and agreement of a pan-Lothian Maternity Strategy.

Promotion of Health Improvement we look on as part of our day to day role in terms of engagement with the broadest spectrum of our planning partners.

As a tertiary centre we have good relationships with our partner Health Boards. This is evidenced by the very positive discussions with colleagues in other NHS Boards and the appropriate level of cost recovery. The additional investment of resource in an appropriate level of infrastructure to take forward regional planning both from a service as well as a manpower perspective is a very welcome strengthening of regional planning to assist in ensuring that services are provided in the most cost effective manner.

Community Health Partnerships (CHPs) are a key component in the delivery of ‘Partnership for Care’ and careful consideration needs to be given to the support to the CHPs both directly and indirectly including clarity on identifying the range of services for which they are responsible and more importantly accountable through a clear scheme of delegation.

Should you wish to discuss any of the above points in further detail please do not hesitate to contact me.

Yours sincerely

James Barbour
Chief Executive
NHS Lothian
HEALTH COMMITTEE

EXTRACT FROM MINUTES

2nd Meeting, 2003 (Session 2)

Wednesday 18 June 2003

Present:

Mr David Davidson               Christine Grahame (Convener)
Janis Hughes (Deputy Convener)  Kate Maclean
Mr Duncan McNeil                Shona Robison
Mike Rumbles

Also present: Carolyn Leckie.

Apologies were received from Helen Eadie and Dr Jean Turner.

The meeting opened at 9.30 am

5. **Proposed NHS Reform (Scotland) Bill (in private):** The Committee agreed to invite written evidence on the general principles of the Bill and to take oral evidence from selected witnesses.

The meeting closed at 10.34 am

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

11th Meeting, 2003 (Session 2)

Tuesday 4 November 2003

Present:

Helen Eadie
Janis Hughes (Deputy Convener)
Mr Duncan McNeil
Shona Robison
Dr Jean Turner

Christine Grahame (Convener)
Kate Maclean
Mrs Nanette Milne (Committee Substitute)
Mike Rumbles

Also present: Dr Andrew Walker, Adviser to the Committee on the Budget process 2004-05

Apologies: David Davidson

The meeting opened at 3.00 pm

3. National Health Service Reform (Scotland) Bill (in private): The Committee considered possible witnesses for Stage 1.

The meeting closed at 4.29 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

15th Meeting, 2003 (Session 2)

Tuesday 2 December 2003

Present:
Mr David Davidson  Christine Grahame (Convener)
Helen Eadie  Janis Hughes (Deputy Convener)
Kate Maclean  Mr Duncan McNeil
Shona Robison  Mike Rumbles
Dr Jean Turner
Also present: Carolyn Leckie

The meeting opened at 1.37 pm

1. National Health Service Reform (Scotland) Bill: The Committee heard evidence at Stage 1 from:

   Elaine Tait, Chief Executive Officer and Dr Mike Watson, Dean, Royal College of Physicians of Edinburgh

   Dr John Garner, Chairman, Scottish Council and Dr Bill O’Neill, Scottish Secretary, British Medical Association

   Pat Dawson, Head of Policy, and Christine Brown, RCN Board Member Ayrshire and Arran, Royal College of Nursing Scotland

The meeting closed at 4.13 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

16th Meeting, 2003 (Session 2)

Tuesday 9 December 2003

Present:
Mr David Davidson
Christine Grahame (Convener)
Helen Eadie
Janis Hughes (Deputy Convener)
Kate Maclean
Mr Duncan McNeil
Shona Robison
Mike Rumbles
Dr Jean Turner

The meeting opened at 2.05 pm

2. **National Health Service Reform (Scotland) Bill**: The Committee heard evidence at Stage 1 from—

Christine Lenihan, Chairman and Hilary Robertson, Director, Scottish NHS Confederation;
Alexis Jay, Director of Social Work Services and Housing, West Dunbartonshire and Councillor Kingsley Thomas, City of Edinburgh Council, CoSLA;

George Irving, Chairman and Wai-yin Hatton, Chief Executive, Ayrshire and Arran NHS Board;
Malcolm Wright, Chief Executive and John Ross CBE, Chairman, Dumfries and Galloway NHS Board; and

Jim Devine, Scottish Organiser, Health and Danny Crawford, Chief Officer, Greater Glasgow Health Council, UNISON.

The meeting closed at 4.35 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

17th Meeting, 2003 (Session 2)

Tuesday 16 December 2003

Present:
Mr David Davidson  Christine Grahame (Convener)
Helen Eadie  Janis Hughes (Deputy Convener)
Kate Maclean  Mr Duncan McNeil
Shona Robison  Mike Rumbles
Dr Jean Turner

The meeting opened at 2.00 pm

3. **National Health Service Reform (Scotland) Bill:** The Committee took evidence at Stage 1 from—

   Martyn Evans, Director and Liz MacDonald, Policy Manager, Scottish Consumer Council;
   John Wright, Director, and Dr Kate Adamson, Convener, Scottish Association of Health Councils; and
   Warwick Shaw, Chairman, Association of Local Health Care Cooperatives

The meeting closed at 16.16 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

1st Meeting, 2004 (Session 2)

Tuesday 6th January 2004

Present:
Mr David Davidson  Christine Grahame (Convener)
Helen Eadie  Janis Hughes (Deputy Convener)
Kate Maclean  Mr Duncan McNeil
Shona Robison  Mike Rumbles
Dr Jean Turner

Also present: Mrs Nanette Milne MSP

The meeting opened at 1.59 pm

1. **National Health Service Reform (Scotland) Bill**: The Committee took evidence at Stage 1 from—

   **Panel 1 - Video Evidence**
   Steve Conway, Director of Operations, Jenny Dewar, Chair, Kathleen Bree, Director Allied Health Professions and Nursing and Stephanie Lawton, Head of Human Resources, NHS Orkney;

   **Panel 2**
   David A M Thomson, Chairman, Royal Pharmaceutical Society Scottish Department and Asgher Mohammed, Community Pharmacist, Paisley, Royal Pharmaceutical Society;
   Judith Catherwood, Convener and Kenryck Lloyd Jones, Secretary, Allied Health Professions Forum Scotland; and

   **Panel 3**
   Malcolm Chisholm MSP, Minister for Health and Community Care, Lorna Clark, Bill Team Leader and Iain Dewar, Bill Team Member, Scottish Executive.

The meeting closed at 4.56 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

4th Meeting, 2004 (Session 2)

Tuesday 27 January 2004

Present:

Mr David Davidson
Helen Eadie
Kate Maclean
Shona Robison
Dr Jean Turner

Christine Grahame (Convener)
Janis Hughes (Deputy Convener)
Mr Duncan McNeil
Mike Rumbles

The meeting opened at 2.01 pm

1. **Items in private:** The Committee agreed to take item 2 in private and to take the consideration of the Draft Stage 1 Report on the National Health Service Reform (Scotland) Bill and the discussion of the Workforce Planning Civic Participation in private on 3 February 2004.

2. **National Health Service Reform (Scotland) Bill (in private):** The Committee considered a draft Stage 1 Report and agreed changes.

The meeting closed at 3.22 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

5th Meeting, 2004 (Session 2)

Tuesday 3 February 2004

Present:

Mr David Davidson  Christine Grahame (Convener)
Helen Eadie  Janis Hughes (Deputy Convener)
Kate Maclean  Shona Robison
Mike Rumbles  Dr Jean Turner

Apologies were received from Duncan McNeil.

The meeting opened at 2.01 pm

1. National Health Service Reform (Scotland) Bill (in private): The Committee considered a draft Stage 1 Report and agreed changes.

The meeting closed at 2.27 pm

Jennifer Smart
Clerk to the Committee
2 December 2003 (15th Meeting, Session 2 (2003)), Written Evidence

The Royal College of Physicians of Edinburgh is pleased to respond to the Scottish Parliament’s call for written evidence on the National Health Service Reform (Scotland) Bill. The College promotes the highest standards of practice in internal medicine and related specialties wherever its Fellows, Collegiate Members and Members practise.

The College’s response to the call for written evidence is as follows:

The general principles of the Bill are supported and the College welcomes the opportunity for closer working across all health and social care sectors for the benefit of patients.

The College understands that the duty of co-operation will support implementation of managed clinical networks and ensure clinical resources are applied effectively and appropriately to improve standards of care. The College notes, however, that these organisational and managerial changes are to be cost neutral and questions whether this is feasible without bridging funding for services which are currently at full capacity. The additional responsibility to support health improvement will add to this pressure.

The College recommends that the Bill offers explicit reassurance to the public that the service changes that may result through these new powers will protect and enhance quality of care in line with recommendations of the clinical professions and the evidence base. Medical Royal Colleges are ideally placed to provide such advice to Ministers, and the College believes that the public would welcome confirmation of an informed and independent perspective on the NHS in Scotland. This is particularly important in cases of alleged serious service failure and where the provision of services may be at risk.

The Bill gives Scottish Ministers powers to alter the shape and functions of organisations that employ doctors in Scotland. It is important that Ministers address the training needs of doctors to sustain quality of care in the future through the recruitment and retention of experienced and fully trained staff. The College considers that supporting the training of clinical staff should be added to the functions Community Health Partnerships and Health Boards.

The College has previously expressed reservations to the Scottish Executive Health Department about the breadth of remit of NHS Quality Improvement Scotland, and remains concerned that Ministers should rely on a single Health Board for standard setting, routine assessment, public involvement and the investigation of serious service failures. There is a risk that this body will be acting not only as judge and jury but will have written the “laws” too. The public and health professions may have greater confidence if ministerial investigations of problem areas are delivered through a vehicle independent of NHS Quality Improvement Scotland.
2 December 2003 (15th Meeting, Session 2 (2003)), Written Evidence

Background

The British Medical Association in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 124,000.

The BMA welcomes the opportunity to comment on the National Health Service Reform (Scotland) Bill which will introduce the legislative changes required to reform the NHS in Scotland. The BMA believes that the current NHS structure in Scotland needs to be reformed to improve its effectiveness. In our election manifesto Priorities for Health we stated that “major structural upheaval is unwelcome but there are opportunities for streamlining service provision and reducing bureaucracy.” We believe this Bill provides opportunities to do just that.

Do you support the general principles of the Bill and the key provisions it sets out? The BMA supports the general principles of the Bill. Last year we welcomed the publication of Partnership for Care, the White Paper that preceded this proposed legislation. Our detailed views on the Bill are listed below:

Abolishing trusts

For some time now, the BMA has questioned the need for 28 NHS trusts to service a population of only 5 million. For example, prior to the decision to disband trusts in the Borders, three organizations were responsible for the provision of health care to a population of a little over 100,000. Complex management arrangements cannot be justified in such circumstances. Trusts are now being disbanded across Scotland and we are seeing the development of single system working. We welcome these developments.

We have been concerned at the continual need by past and present administrations to inflict change on the NHS, with no discernible benefits despite major upheaval. We acknowledge that some change is inevitable, and we also believe that the current structure is not the right one for stability in the long term. The NHS Reform (Scotland) Bill provides an opportunity to streamline service provision and reduce bureaucracy. However, this must provide stability in the long term.

In 1999, it was estimated that £18million would be saved over three years by reducing the number of trusts from 46 to 28. Unfortunately there is little detail on the amount of savings actually achieved. In our evidence to the Parliamentary Finance Committee, we suggested that “it would be naïve to expect that there would be any significant management cost savings for hospitals as the newly established ‘operating divisions’ will continue to require experienced management at all levels”. However, there will be an opportunity to merge functions previously duplicated by trusts, for example human resource functions, under the same NHS Board. We also hope that the emphasis on regional working can be applied to certain administrative and management functions.

Imposing a duty for public involvement in the NHS

The BMA welcomes the clarification of public involvement. Devolving public involvement to the community health partnerships will ensure public participation in decisions taken on the planning and design of local services. However we are concerned that proposals under this Bill to bring the newly established Scottish Health Council under the remit of NHS Quality Improvement Scotland will remove the element of independence of the local health council structure, one of the strengths of the current system.
Health improvement

We welcome the requirement to consider health improvement in the community planning process. Bringing health improvement into the structure of community health partnerships will enable public health issues to be tackled at a local level, however it will involve transferring some of the functions which have historically taken a central role at health board level.

The BMA would like to see the health improvement strategy taken a step further where all policy decisions made by the Scottish Executive should be required to take account of potential health implications e.g. agricultural policy, housing policy etc.

Enhancing existing powers of intervention for Scottish ministers

The BMA welcomes part four of the Bill which formalises powers for ministers to intervene where health services are failing. We believe that ministers should be accountable for the efficient and effective management of the NHS. Intervention has been used in recent years in Tayside and Argyll and Clyde. However the requirement and scope of interventions must be clearly defined in line with the Performance Assessment Framework, either as part of the Bill or within regulations to ensure that intervention does not become the ‘one size fits all’ solution.

Creating a new performance review body

The BMA welcomed the establishment of NHS Quality Improvement Scotland as it brought together several quangos under a single umbrella organisation. There is a challenge for a single organisation to take an independent and broader view of issues if they have responsibility for establishing standards, reviewing performance and conducting formal inquiries where NHS bodies are failing. We suggest that a system of internal governance be established to separate out the three functions and prevent any conflict of interest.

Replace Local Health Care Co-operatives (LHCCs) with Community Health Partnerships (CHPs)

The BMA welcomes the requirement for boards to “devolve appropriate resources and responsibility for decision making to frontline staff... for the delivery of local healthcare services.”

LHCCs are voluntary organisations whereas under this proposed legislation CHPs will have a statutory function within health boards, ensuring that they have a greater say in the design and delivery of services.

Since their inception, LHCCs have been perceived not to be achieving their potential in some parts of Scotland. Anecdotal evidence suggests that where GP practices have been enthusiastic and involved in LHCC activities, they have been more successful in developing organisationally and influencing local service provision.

However, a recent study conducted on behalf of the Scottish Executive found that nearly 40% of GPs questioned had a negative attitude towards LHCCs. Only 22% of GPs had a positive attitude towards LHCCs, while 41% held a neutral view. Positive attitudes may be due to LHCCs supporting better co-operation among practices in clinical governance, quality improvement or service development activity. However, GPs also reported that the support offered by LHCCs in improving clinical care was often poor and had no impact on their quality of care.

The establishment of CHPs marks an important change for the NHS and it is vital that careful planning goes into their creation. Much of the activity in primary care takes place in general practice, therefore it is essential that CHPs actively engage with general practice to ensure involvement in the management and operational structure.

The number of CHPs in each locality is to be decided by each health board. In remote and rural areas where a single CHP could cover a large geographical area with wide population dispersal, it is essential that enough CHPs are created to ensure local flexibility to meet local needs.
Financial support for LHCCs has been variable across Scotland and this has quite possibly contributed to their variable effectiveness. There should be transparent and equitable arrangements for the funding of CHPs across Scotland.

Closer working with local authorities in the delivery of social care is a welcome move and the BMA is supportive of moves to align boundaries for CHPs with those of local authorities. Greater clarification on the roles of each organisation, and how CHPs will facilitate closer joint working is required. There will inevitably be problems in establishing funding streams that are jointly managed by health and social services. Management responsibility will cross the traditional boundaries of the two sectors and there will be issues regarding differential pay and conditions between health and social care workers. In order for effective and efficient joint working, there will need to be an element of commonality between the two parties.

Regional working between health boards

Formalising regional co-operation could improve and equalise service delivery across the country with the development of managed clinical networks. However, to date, managed clinical networks have been established in an ad hoc manner mainly as a result of local initiatives. If we are to rely on managed clinical networks to provide services across health board areas then they must be developed in a structured manner to ensure their effectiveness.

Omissions from the Bill

The BMA welcomes the work of the Partnership Support Unit with the Scottish Partnership Forum and Human Resources Forum in seeking an amendment to this legislation that makes provision for staff governance. In particular the use of powers of intervention where services are failing against staff governance standards. We believe that if this were to be included in this Bill, then it would provide a clear commitment to partnership working from the highest level.

One further area for consideration, although not under the remit of primary legislation is an issue of UK employment law. Introducing associate employer status for employees who work for different health boards under the formalised regional planning networks would provide health care workers with greater security.

Consultation

The BMA is satisfied with the level of consultation that has accompanied this Bill. The BMA had input to the working groups established for the Review of Management and Decision Making which helped to draw up the white paper Partnership for Care, the policy document that underpins this Bill.

The BMA responded to the recent consultation on Guidance for Community Health Partnerships and would hope to be involved in any further consultations relating to the function and implementation of all areas of NHS reform.

Conclusion

The BMA welcomes proposals in Partnership for Care to reform the NHS in Scotland and therefore supports the general principles of this Bill.
SUBMISSION BY THE ROYAL COLLEGE OF NURSING (RCN)

2 December 2003 (15th Meeting, Session 2 (2003)), Written Evidence

The Royal College of Nursing (RCN) is the UK’s largest professional association and union for nurses, with over 356,000 members. (over 35,000 in Scotland). Most RCN members work in the NHS, with around a quarter working in the independent sector. The RCN works locally, nationally, and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a major contributor to the development of nursing practice, standards of care and health policy.

RCN Scotland would wish to make the following points regarding the above Bill.

Part 1

Paragraph 1 - Dissolution of NHS Trusts

RCN Scotland is supportive of this. We are however, concerned to ensure the continued presence of nurse directors within the new operational structures being developed ‘under’ NHS Board level. We are emphatic that nursing must be at ‘the top table of decision making’ and that this requirement be mandatory for all local NHS Boards and special health boards providing clinical services. (We attach a copy of the Munich Declaration – Appendix A)

RCN Scotland is mandated to deliver on its member’s vision for nursing. One critical aspect of that vision is nurse leadership at all levels of service delivery, health care, health policy and health promotion. Our response to the consultation on Community Health Partnerships (CHPs) (Appendix B) makes repeated comment of the need for nurse leadership on the boards of CHPs.

RCN Scotland is engaged with the Scottish Executive in delivering a Scotland wide Clinical Leadership Programme in which 70% of the NHS Boards participate. RCN Scotland is also launching from the 15th of October 2003 a campaign “Speaking Up” to promote nurse leadership.

Our manifesto published in March 2003 called for “a period of stability without further major changes to the way NHS Scotland is structured beyond these proposals”. In implementing these proposals we hope that senior nurses throughout the system are not disadvantaged, and that further management restructuring does not disrupt nursing services and front line staff.

RCN Scotland is keen to see and support professional nursing advisory structures, which support nurses and the management and development of clinical services. We see it as especially important that nurses are actively engaged in service redesign committees and in the development of managed clinical networks. (Our preferred title is Managed Care Networks, which we believe better describes an inclusive approach to network development).

Paragraph 2 – Community Health Partnerships

RCN Scotland’s response is attached at Appendix B. We specifically would wish to see the following added after section 4 of the 1978 Act:

Community health partnerships
Explicit reference to patient/public involvement
Explicit reference to consultation with communities (service provision etc.)
Explicit reference to staff governance including staff representation and arrangements for staff consultation
Explicit reference to professional advisory networks
Paragraph 3 – Co-operation

We suggest this section needs to make explicit the need for consultation with staff and committees “in exercising their functions in the relation to the planning and provision of services”. It should be the case that because NHS Boards or special Boards are working together or co-operating across regional boundaries, that there should be an explicit requirement for consultation with staff groups and a demonstration of partnership working. Further, we contend that where services are to be secured across Board boundaries public/patient consultation should also cross these boundaries.

Paragraph 4 – Powers of Intervention in case of service failure

RCN Scotland is supportive of much of this section however, there is one important omission. We believe that failure of staff governance systems should be added at 78A(l)(b) add a new (iii) to provide staff governance to a standard which they regard as acceptable.

We understand that the Scottish Partnership Forum has secured Ministerial agreement that a Scottish Executive sponsored amendment would be put before the Parliament to meet the intentions outlined above.

RCN Scotland believes that the work undertaken to produce PIN Guidelines and the continuing development of the Scottish Partnership Forum and Human Resources Forum build on and demonstrate effective partnership working. The natural progress of that is to see in law that NHS staff are a valued resource, that staff governance standards will be set and monitored and that the Minister will have a duty to intervene to uphold these standards.

RCN Scotland is aware of the inconsistencies across Scotland in the implementation of the PIN Guidelines. Flexibility of working conditions is one area where targeted work has recently helped to raise awareness and give managers tools for change. RCN Scotland believes that the full implementation of PIN Guidelines would significantly enhance progress on the recruitment and retention of nurses (and other staff).

Paragraph 5 – Public Involvement

This is perhaps an area needing assessment of consultation processes and outcomes. The key points we would wish to highlight are:

- Page 9, paragraph 39 – Explanatory notes, 1st sentence
  Giving responsibility for involving people to Health Boards, rather than giving the responsibility for representing the public to an outside body.

This policy position fails to recognise the legitimate interests of other representative bodies to be consulted, have/hold/give opinion or work with Boards to involve people. While it is right that Boards undertake this function, the role of local health councils to independently have such responsibility to represent people will be lost.

There is no analysis given in the explanatory notes, policy memorandum or otherwise on the content of the powers, duties and rights of local health councils which are to be abolished. Neither was this analysis part of the consultation, nor was any mention of the current legislation. RCN Scotland has supported the creation of the Scottish Health Council. However, we are not aware that its position within NHS QIS was part of a consultation process. The paper “A new Public Involvement Structure for NHS Scotland” does not ask the question about what type of organisation SHC should be, it does - and only asks – what it should do. The over riding principle that the public expects is that their views are independently represented. By having all the public involvement structures within the NHS, this principle is not upheld. These new structures make no reference to protecting and promoting patient rights, which is a different function from involving people. (See Appendix C, RCN Scotland Briefing).

The duty specified does not make explicit reference to the quality of services.

There is no specific requirement to secure public consultation where more than one NHS Board is involved or importantly other providers, e.g. the voluntary sector or local authorities. There is no duty to involve existing representative organisations e.g. client and disease specific groups,
independent providers, community care forum. We understand that an analysis of the responses to the consultation on New Public Involvement Structures was commissioned but not (as far as we are aware) published.

Part 2

Promotion of Health Improvement

While welcoming the recognition of the importance of public health and health promotion, we would ask why 7 (1) “1A (1) states, “It is the duty of the Scottish Ministers to promote the improvement of the physical and mental health of the people of Scotland”, i.e. why is there an explicit reference to physical and mental health, and why not just to health? Would naming physical and mental health in legislation restrict action on environmental health, public health, mental wellbeing, psychological and emotional health etc.? Otherwise, we find the provisions sensible.

Part 3

Supplementary

We have no comment to add

In conclusion, RCN Scotland broadly supports the proposals set out in the Bill with the exception of:

- We see it as an omission that failure of staff governance and welfare does not trigger ministerial intervention.
- That the quality of the consultation on new public involvement structures was limited and did not ask about the status of the Scottish Health Council, nor offer alternative solutions.
- That the analysis of the consultation responses although commissioned – has not yet been published and sent to those who contributed.
- That further amendments are needed to the establishing orders for CHPs to ensure a nurse executive on the Board, requirements for consultation with staff and communities, requirements for clinical governance and professional advisory structures, requirements for staff representation arrangements and requirements for NHS Boards to support the development of CHPs.
MUNICH DECLARATION

NURSES AND MIDWIVES: A FORCE FOR HEALTH

17 June 2000

The Second WHO Ministerial Conference on Nursing and Midwifery in Europe addresses the unique roles and contributions of Europe’s six million nurses and midwives in health development and health service delivery. Since the first WHO ministerial conference that took place in Vienna over ten years ago, some steps have been taken in Europe towards strengthening the status and making full use of the potential of nurses and midwives.

As Ministers of Health of Member States in the European Region of WHO, participating in the Munich Conference:

WE BELIEVE that nurses and midwives have key and increasingly important roles to play in society’s efforts to tackle the public health challenges of our time, as well as in ensuring the provision of high-quality, accessible, equitable, efficient and sensitive health services which ensure continuity of care and address people’s rights and changing needs.

WE URGE all relevant authorities in WHO’s European Region to step up their action to strengthen nursing and midwifery, by:

• Ensuring a nursing and midwifery contribution to decision-making at all levels of policy development and implementation;
• Addressing the obstacles, in particular recruitment policies, gender and status issues, and medical dominance;
• Providing financial incentives and opportunities for career advancement;
• Improving initial and continuing education and access to higher nursing and midwifery education;
• Creating opportunities for nurses, midwives and physicians to learn together at undergraduate and postgraduate levels, to ensure more cooperative and interdisciplinary working in the interests of better patient care;
• Supporting research and dissemination of information to develop the knowledge and evidence base for practice in nursing and midwifery;
• Seeking opportunities to establish and support family-focused community nursing and midwifery programmes and services, including, where appropriate, the Family Health Nurse;
• Enhancing the roles of nurses and midwives in public health, health promotion and community development.

WE ACCEPT that commitment and serious efforts towards strengthening nursing and midwifery in our countries should be supported by:

• Developing comprehensive workforce planning strategies to ensure adequate numbers of well educated nurses and midwives;
• Ensuring that the necessary legislative and regulatory frameworks are in place at all levels of the health system;
• Enabling nurses and midwives to work efficiently and effectively and to their full potential, both as independent and as interdependent professionals.

WE PLEDGE to work in partnership with all relevant ministries and bodies, statutory and nongovernmental, nationally, sub nationally and internationally to realize the aspirations of this Declaration.

WE LOOK TO the WHO Regional Office for Europe to provide strategic guidance and to help Member States develop coordination mechanisms for working in partnerships with national and international agencies to strengthen nursing and midwifery, and
WE REQUEST the Regional Director to make regular reports to the Regional Committee for Europe and to organize a first meeting to monitor and evaluate the implementation of this Declaration in 2002.

Appendix B

Community Health Partnerships

The Royal College of Nursing (RCN) is the UK’s largest professional association and union for nurses, with over 360,000 members. (over 35,000 in Scotland). Most RCN members work in the NHS, with around a quarter working in the independent sector. The RCN works locally, nationally, and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a major contributor to the development of nursing practice, standards of care and health policy.

RCN Scotland has circulated details of this document via its e-based consultation list and directly to Scottish Board members and staff. This response has been constructed using their responses. Elements of the RCN Strategic plan detailing the priorities for our membership have also been added to emphasise our position. This is reflected in our commitment to seeing nurse leadership throughout all levels in health organisations. It is also a key priority of the RCN that nurses are represented at all levels of decision and policy making. As Community Health Partnership's will be the foundation of primary and community care provision, nurses must have formal representation in these new structures.

Practice nurses are already voicing concerns about the implementation of Agenda for Change and whether this will be implemented in practices by GPs. Similarly, concern is being voiced about the central role of primary care nurses in meeting the requirements of the GMS contract. It will be important to demonstrate that practice nurses, district, community nurses and health visitors feel involved and respected within this time of considerable change.

Paragraphs 13 & 14 – page 4

Do you agree with these overall roles?

In general terms we support these roles. We would however, note that the last bullet point describes a role that needs to be jointly achieved with the acute sector. It is not solely the responsibility of the CHP to create and strengthen networks and partnerships as it takes two to tango! A sense of reciprocity and direction on other sectors and partners could have been appropriately included.

The other key aspect that we know to be confusing is whether CHPs are health or health and social care organisations. If they are the latter then much more emphasis is needed on joint service delivery rather than only joint planning.

Similarly the second bullet point, “directly influence NHS Board level strategic planning, priority setting and resource allocation” describes a one way action. While an appropriate role to some extent, its achievement or realisation lies in the hands of others. Some local players already describe difficulties in defining “whose priorities”, accountability for spend and lines of decision making.

Perhaps however, we would have expected to see service delivery as the key role. How much more understandable it would have been for nurses to see recognised their role in health service provision, being recognised as the core role of a CHP. We believe the second statement of the first bullet point “and in developing and delivering joint approaches to local health and social care services for all ages” has most relevance for front line staff.
How can CHPs best work with community planning partners to support the health improvement agenda?

This agenda operates at many levels and includes many agencies and professionals. Essentially however, much of the potential for change lies with the people and communities themselves. Voluntary sector agencies can be critical in supporting hard to reach communities and vulnerable client groups.

NHS Health Scotland needs also to make local support and guidance a reality with regards to both public health and health education. Significant progress has, and is, being made. We see the priority given to this area and the ‘modernisation’ of professionals’ contribution positive, building blocks for the future. This is especially true of the recent reviews of public health and school nursing which make clear the positive nursing contributions to the health improvement agenda.

RCN Scotland is very supportive of the ongoing work to examine the role of primary care nursing and especially practice nurses who also make significant contributions to health education.

In all these roles and across all facets of society, nurses engage with local people. This makes nurses well placed to contribute to the community planning process. Therefore there should be opportunities for nurses across the primary and community care environment to share their assessment of people’s needs to influence the wider planning agenda. Nurses play key roles, for example in learning disability services, mental health and homeless people teams, drug and addiction services, working with children and families, providing sexual health advice, in schools and workplaces, e.g. Occupational health nurses. All these professionals are necessary to deliver “Improving Health in Scotland – The Challenge”.

New structures must promote the multi-facetted voice of nurses and nursing. This will, as in the example of occupational health nurses, mean that the NHS reaches out to local businesses and companies. Importantly however, there needs to be an explicit role of the CHP to promote the well being and health of its own staff.

Are these the right service outcome and what indicators would we use to measure these outcomes?

In essence there is nothing new in the aspirations in paragraphs 17 and 18. What would be helpful is detailed guidance about what is meant by “NHS Boards will be expected to support CHP’s to develop”. What that support looks like, and feels like is important – it’s also an important outcome for CHP’s to report on. While it is right to have aspirational vision for continuous improvements, outcomes cannot be separated from inputs. A more balanced description in resulting guidance would be beneficial.

The new GMS contract provisions including opt out arrangements for GP’s may work against some of these aspirations; for example, broader access to services may not be achievable if large numbers of GP’s opt out of out of hour’s services. Similarly, some practices may choose to provide enhanced services but this may be very local and create demand management problems in adjacent practices.

The third bullet point is problematic: - wider access to information and services can be achieved by more ways than public involvement – although critical, this bullet point confuses information provision to support service awareness and appropriate utilisation of services.

Paragraphs 19-21

What is a Scheme of Establishment?
RCN Scottish Board are emphatic that

- The culture must be one of partnership and inclusion.
- Nurses must have a voice at all levels of CHP; managerial, planning and clinical.
- Support and Organisational Development from NHS Boards and the existing LHCCs should encourage the identification of lead nurses.
- NHS Board Nurse Executives should personally ensure that these lead nurses have a seat and a voice at all levels of - and at all - CHPs. This is essential to ensure nursing contributes to the strategic planning and decision making of CHPs and NHS Boards.
- NHS Board Nurse Executives should ensure lead nurses in CHPs are enabled to contribute to the NHS Board nursing agenda, i.e. the voice of nursing in primary care and community care must be nurtured and supported and directed into the executive nurse.
- There must be investment in local professional advisory networks within and across CHPs and Boards.

RCN Scotland is also very supportive of the agenda to devolve decision making to frontline staff. Far too often our members tell us about dictats from on high, which miss the point. Often their local “home grown” solution was cheaper, quicker and better for patients and staff. As nursing is one of the largest areas of expenditure in Primary Care and Community Care, it is absolutely essential that management includes and reflects their central importance to making these agendas work in practice.

We expect the number of CHPs to be for local determination and like many others, see benefit of maximising the co-terminosity of Local Authorities and CHPs. Equally in some rural, remote and island communities, it may be the community or geography which more naturally determines local boundaries.

**Paragraphs 22-25**

*What culture and style of working should underpin CHPs?*

Perhaps much of this ambitious section will depend on the practical outcomes from the implementation of the GMS contract and the future policy direction of Joint Future. Given the range of major changes set to face primary and community care it is timely to ask how long Joint Future remains a separate policy initiative before it moves to mainstream activity. Some rationalisation of the initiatives in this sector would be welcomed.

Not only will the GP contract change the financing of Primary care, so too will the pay and terms and conditions of all NHS staff change with Agenda for Change. Combine this with restructuring, and ongoing Managed Care Networks development and Joint Future integration between NHS and LA, ambitions such as “unlocking potential,” “encouraging networking” may seem overly optimistic.

Frontline nurses who strive in their day to day contact to improve services, share best practice, implement research, work together with colleagues, need practical support, time and training. Only then will they feel valued. The culture of these new organisations must promote this type of “real” solutions so that all the staff feel included and empowered.

RCN Scotland would promote two programmes, which offer this type of training, the RCN Clinical Leadership Programme, and the RCN Primary Care Leadership Programme.

The intention of CHPs to be flexible and innovate would be supported by: -
- Clarity of inspection and monitoring regimes and focus on clinical governance mechanisms.
- Realistic standards, targets and performance assessment frameworks.
- Streamlining and integrating the policy demands from on high.

RCN Scotland is also keen to see CHPs develop as learning organisations with positive promotion of life long learning and research and audit. Practice development and professional networks like those offered by professional bodies like the RCN often support nurses who otherwise are isolated in their practice.
Paragraph 26 & 27

What Services will CHPs be responsible for?

“The full range of independent contractor service” will be defined by the GMS contract. The list needs to include, addiction services and other specialist services e.g. public health nurses. As per our previous comment, we would wish to see explicit reference to occupational health nursing services, addiction services, school nursing. Recognition of the importance of specialist nursing input to chronic disease management, e.g. epilepsy, asthma and respiratory diseases is also needed.

Responses to Paragraphs 28-33 have been included elsewhere

Paragraphs 34-38

What Status will CHPs have?

RCN Scotland would wish to see more clarity about the status of CHPs. We are unclear how on the one hand their role will be more ‘formal and consistent’, and they will be required to take decisions about resources and staff employment, yet they are not independent statutory bodies.

It may be that to ensure accountability for financial and resource decisions there needs to be more formalisation through guidance from the Scottish Executive on the managerial arrangements. RCN Scotland would wish to see local flexibility yet some consistency across Scotland. We recognise that these two aspirations can be at odds with each other. However, the variation in existing LHCCs needs to be ironed out to ensure improving practice across Scotland.

RCN Scotland is very keen that reference to clinician involvement in design and delivery of health services is not only about doctors. If as is suggested, CHPs will have a significant profile, we would wish to see nurses and nursing central to the agenda. Although the paper makes reference to independent contractor services, there is no explicit mention of employer status. Practice Nurses, Practice Managers and receptionists are probably the largest groups of staff currently employed by GPs. Further guidance must recognise this and develop the role of the CHP as an employer.

Like other respondents to this consultation, RCN Scotland would raise the issue of partnership working, RCN Scotland supports the need for further guidance developed in conjunction with the SPF/HRF on the formal arrangements for staff partnership forum members. These steps are essential to ensure staff governance standards are met by all parts of the NHS.

This guidance should also include consideration of professional committees and Area Clinical Forum. We suggest this is an issue where current best practice should prevail. RCN Scotland is also keen to see local redesign committees engaging with nurses at all levels.

Paragraph 39 and 40

What are the organisational arrangements for CHPs?

RCN Scotland welcomes the commitments set out in paragraph 39 and 40 to involve operational staff and the need for high levels of leadership, management and support services. In envisaging membership of CHP management teams, RCN Scotland is mindful of the need for: a multi-professional composition, and, the central role of nurses to the delivery of primary care and community care services.

We would certainly wish to see a move away from GP lead management to structures, which include nurses.

We would also wish to see staff partnership representation on - and feeding into - management structures. Given the delegated powers of CHP in regard to resources, and given that the rationale for medical and nursing executive presence at NHS board level, this equally applies to the CHP
level. RCN Scotland would wish to see the minimum formal committee composition extended to 4, to include a nurse.

CHP management structures must ensure they are fit for their function in the future i.e. to take forward the GMS contract. It is difficult to see how additional and enhanced services will be delivered without the inclusion of nurses. It is difficult to see how “out of hours”/triage will be provided (if GP’s opt out) without involving nurses. It is difficult to envisage meeting quality clinical standards and chronic disease management provision without the involvement of nurses. Further, RCN Scotland is keen to ensure Practice Nurses and the growing number of nurse practitioners are recognised in management structures for the essential and significant contribution they make to an effective practice and hence an effective CHP.

Paragraphs 47-49

How can we ensure that CHPs are an integral part of the delivery of the Joint Future agenda? What further opportunities do CHPs offer for Partnership working?

As stated earlier, there is a real danger that the implementation of the Joint Future agenda develops in parallel with, rather than integral to, establishing CHPs.

Paragraphs 50-52

Do you agree with the role proposed for the Public Partnership Forum? Do you agree with the proposed close link between the Public Partnership Forum and the local office of the Scottish Health Council?

RCN Scotland is not convinced that at national and local level the right structures have evolved to meet the challenge of patient/public involvement in primary and community care.

Paragraphs 53-54

What do you see as the relationship between operating divisions and CHPs?

RCN Scotland suggests that the local performance management need to be:
- Integrated with existing systems, data, processes etc.
- Simple and relevant
- Recognise local conditions and variables

Clearly many respondents will be pointing to the need for Organisational Development and IT capacity building.

RCN Scotland sees leadership and especially Clinical Leadership as essential to the building of effective CHP’s.

Specific - Comments for CHP Establishing Order 1978 Act Section 4

RCN Scotland would wish to see:
- Explicit reference to patient public involvement
- Explicit reference to consultation with communities (service provision etc.)
- Explicit reference to staff governance including staff representation and arrangements for staff consultation
- Explicit reference to professional advisory networks

We suggest that after Section 4A, paragraph (6) d, you add – As to the support which the NHS Health Board will give to the CHP.

RCN Scotland apologises for the delay in submitting this response. We have considered the responses from other organisations and note the similarity of these themes – Capacity, Change and Challenge. Perhaps that’s what the ‘C’ in CHP is for.
Appendix C

Parliamentary Briefing

S2M-154 Patient Focus and Public Involvement in the NHS

The Scottish Executive recently consulted on A New Public Involvement Structure for NHS Scotland - Patient Focus and Public Involvement.

This briefing provides a short overview of RCN Scotland’s position on this issue.

Key International Political Agreements

This consultation unfortunately does not reflect: the Scottish and UK evidence, the international perspective and comparative models nor World Health Organisation and other European ‘Declarations’.

These include the following:

- The Declaration of Alma Ata (WHO) 1978,
- The Ljubljana Charter on Reforming Health Care in Europe (WHO) 1996,
- The Amsterdam Declaration on the Promotion of Patient Rights (WHO) 1994,
- The European Partnership for Patients Rights and Citizens Empowerment 1997 (established to promote the principles of the above 2)
- The Committee of Ministers of the Council of Europe (adopted in February 2000). This statement includes recommendations on citizen and patient participation in the decision making process affecting health care. These recommend that Governments of member states:
  - Ensure that citizens’ participation should apply to all aspects of health care systems
  - Take steps to reflect in law a range of guidelines covering
    - Citizen and patient participation as a democratic process
    - Information provision
    - Supportive policies for active participation
    - Participation mechanisms
- Create legal structures and policies that support the promotion of citizens’ participation and patient’s rights
- Adopt policies that create a supportive environment for the growth in membership and tasks of organisations of health care users.

The Need for Independence

The key aspect that this consultation fails to address is ‘independence’. We have seen how there is a need to change aspects of the NHS complaints procedure to ensure it is more independent. Whether this is as a result of patient/public perception or reality is immaterial the procedure does not work from the patient’s perspective where independence is not demonstrated.

The balance of power and information (within a practitioner/patient relationship) is often seen to lie with the clinician or the organisation. One way to balance this is to ensure that organisations with a role to represent patients and protect their rights are totally independent. That is why - without going into the detail of this consultation - RCN Scotland cannot support the proposals for a new public involvement structure for NHS Scotland.

The Committee of Ministers of the Council of Europe signed up to legal structures which support the promotion of citizen participation and patient rights. RCN Scotland supports these statements.

It is really important that our politicians differentiate between the roles of promoting and monitoring patient and public involvement to improve quality and the need for legitimate independent processes to protect and promote patient rights and public involvement. The envisaged local and national patient/public organisations could support quality improvement and public involvement but it is unclear if they have statutory powers. While improving quality and engaging with the public are
important aspirations they do not reflect the totality of the aspirations of patients and the public. It is also unclear what will happen to the current legal framework and associated funding of approximately £2 million.

MSPs need to be assured today that the ministerial announcements today requiring the NHS to ensure public involvement in Health Service reorganisation take heed of the Ljubljana charter principles for change detailed below:

• Major policy, managerial and technical decision on development of the health care system should be based on evidence where available.
• Reforms must be continuously monitored and evaluated in a way that is transparent to the public.
• The citizens voice should:
  • Make as significant a contribution to shaping health services as the decisions taken at other levels of economic, managerial and professional decision making.
  • Be heard on issues such as the content of health care, quality of services, management of waiting lists and the handling of complaints.

We have also seen recently the Junior Health Minister at the DoH, David Lammy MP, announce that the abolition of CHSs in England will be delayed by 3 months. This was to "enable the government to respond positively to comments around the specific issues of independent monitoring of the NHS during this transition period" i.e. prior to the abolition of the CHCs. It is unacceptable that the Scottish Health Council will be part of NHS QIS and that its role will be limited to supporting public involvement. NHS QIS is not an independent body it is part of the NHS and responsible to the Minister.
Scottish Parliament
Health Committee
Tuesday 2 December 2003
(Afternoon)
[The Convener opened the meeting at 13:37]

National Health Service Reform (Scotland) Bill: Stage 1

The Convener (Christine Grahame): Good afternoon. I welcome committee members and witnesses to the 15th meeting of the Health Committee in the second session of Parliament. I have received no apologies and I remind people to switch off their mobile phones and pagers.

The witnesses who are here to give evidence are sitting in groups of two for ease of reference for the committee. Elaine Tait is chief executive officer and Dr Mike Watson is dean of the Royal College of Physicians of Edinburgh. Dr Bill O’Neill is Scottish secretary and Dr John Garner is chairman of the Scottish council of the British Medical Association. Our witnesses from the Royal College of Nursing Scotland are Pat Dawson, who is head of policy, and Christine Brown, who is board member for Ayrshire and Arran. I thank them for coming today. The committee will ask questions, and it would be helpful if witnesses would indicate when they want to speak; if representatives of other organisations want to add something they should feel free to do so—but that is not obligatory.

I start with an open question. Do witnesses think that the change to the structure of the national health service that is proposed in the bill is necessary or indeed appropriate? How will the change improve service delivery?

Dr John Garner (British Medical Association): Are there buttons that we have to press if we want to speak?

The Convener: No, please just indicate that you want to speak.

Dr Garner: In general, the BMA welcomes the changes and reforms that are proposed in the bill, although we would particularly like there to be greater emphasis on certain areas. The BMA is keen that inter-health board working should be pushed quite hard, as we believe that, although Scotland will continue to have 15 health boards, there is great opportunity in a country of some 5 million people to work across health boards through managed clinical networks to develop services that are appropriate for the populace.

Pat Dawson (Royal College of Nursing): The Royal College of Nursing Scotland supports the reforms in the bill. Some of our concerns are probably operational. We are concerned that nursing, nurse leadership and nurse executives should be in position in the levels underneath the boards, but that is not necessarily a matter for legislation. In general, however, we support the commitments to the integration of services at an NHS board level that will be brought about by the reforms.

Dr Mike Watson (Royal College of Physicians of Edinburgh): We broadly welcome the reforms, which will improve service delivery through better integration. We are slightly concerned that training and education are not given a high profile as they are integral to better service provision. We would like more emphasis to be put on the integrated approach to training and education, and for NHS Education for Scotland to be brought into that equation.

The Convener: I thank you all for your written submissions, which we have before us.

Mr David Davidson (North East Scotland) (Con): What do the three groups of witnesses think of the treatment of service delivery in rural and remote areas? Do they have any views for or against it, or suggestions that we should listen to?

Pat Dawson: Your question is valid, but I hope that the dissolution of trusts and the focus on the health board area, the other reforms such as the establishment of community health partnerships as vehicles for service delivery in remote, rural and island communities, and the linkages between health boards that have been mentioned, will be among the routes to secure improvements and integration of service design and delivery in remote, rural and indeed urban areas throughout Scotland.

Mr Davidson: My question was on the back of the convener’s, in that the bill talks in generalities about health boards as if they were all unique models. We have received indications that there will be problems in some areas. There have been comments about inter-board area working, which has obviously been accepted by the college and the BMA. I wondered whether, at this early stage in our discussions, you had any other comments about the roll-out of services in those areas.

Dr Watson: It is important that the need for local flexibility in service delivery is recognised. The arrangements for service delivery in the remote communities have to be significantly different. Although we want to maintain standards of care that can be delivered locally, there are issues to do with the availability of staff that mean that local solutions are required and there has to be flexibility. One hopes that the new health boards will take that into account.
Shona Robison (Dundee East) (SNP): On the abolition of the trusts, first, do you think that the proposed operating divisions in the NHS boards are the right structure? Secondly, do you think that the aim of reducing bureaucracy will be achieved as much as it should be with the removal of the trusts or should the opportunity have been taken to reduce bureaucracy further and ensure that there is a more streamlined management structure?

Dr Bill O’Neill (British Medical Association): If you are asking us whether the BMA would have favoured having fewer health boards, we have probably said in the past that we would. However, that has to be balanced against the risk of introducing major upheaval throughout the service in Scotland. There is clearly no appetite for that.

With the abolition of trusts, there is an opportunity to streamline management. Clearly, the bill is enabling, in the sense that that can happen following enactment. It will be down to the operating divisions and health boards to ensure that it does. We will examine closely what happens to ensure that there is improvement with regard to bureaucratic barriers and the lack of expertise in some areas. For example, we have publicly cited human resources as an example of where there is an opportunity—at health board level, quite apart from collaboration between health boards—to pool expertise to improve arrangements in what will be operating divisions across Scotland.

13:45

Elaine Tait (Royal College of Physicians of Edinburgh): It is important that there is clarity of responsibility within the new health boards. In the old trust structure it was clear who had responsibility for quality of care. It should be made explicit in the bill who has direct responsibility within the health board structure. So long as there is clarity of responsibility and accountability, the operating divisions should be able to function correctly.

We are not just talking about clarity of responsibility for quality of care. As my colleague said, we are also talking about ensuring that health boards, which have the health of their population at their heart, recognise their responsibility to maintain the education and training of all health care professionals, even though conflict sometimes arises between the pressures of service and training. Some clarity of responsibility in the bill might be helpful later, when the operational rules, regulations and structures are determined.

Pat Dawson: We make clear it in paragraph 5 of our submission that our members have said that they are seeking “a period of stability without further major changes to the way NHS Scotland is structured beyond these proposals”.

We are keen that nursing, quality and patients are at the centre of the changes, and that whatever structures of divisions or integrated units are put in place, they recognise the pivotal role of patients, quality and nursing.

Dr Watson: I reiterate that, at ground level, there is concern about the impact of another change in management structure. It is important that that is done relatively seamlessly. In the longer term, there may be a saving on bureaucracy, but it has perhaps not been recognised that there will be a transitional cost.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): You mentioned the obvious opportunities to tackle the bureaucracy in the management system by bringing people together and so on. Below the managerial level, in front-line services, what opportunities will the new structures open up for greater flexibility for clinical staff to deliver services? How will the bill improve the cross-board working that has increasingly become necessary to deliver services?

Dr Garner: By introducing a duty on health boards to work across their boundaries. That will ensure that when they are moving and developing services, they will look at what is happening in the boards around them. There will—hopefully—a more seamless development of services that takes into account the needs of patients outwith the board area.

When you talk about what happens below the level of management units, you may be moving into the area of community health partnerships, which is another major part of the bill.

The Convener: We are going to move on to that in due course.

Mr McNeil: I am happy to come back to that. Is there not a requirement on boards at the moment to work together for the benefit of patients? If there is, why has that not worked effectively? What will be the effect of the bill making that an imperative? We see boards protecting their budgets. Are you confident that you will receive a realistic and positive outcome as a result of what seems like an increased duty?

Dr Garner: My understanding is that boards have not been under any statutory duty to cooperate. They have obviously been under a moral duty to find out what is happening around them, but stipulating in the bill that boards must work together means that when developing a service they will have to think about, for example, the area to the west or east of them as well as their own patients. They will have to consider the commonality of area instead of concentrating on
their own silo. I hope that such an approach will avoid a situation in which services that are developed in different areas are in competition because they are responsible only for the patients within a particular boundary.

**Mr McNeil:** Will that in turn encourage a culture within the present trusts and among clinicians in which they can work effectively together? After all, although we can give some good examples of networking and of clinical networks that have been established, we know of bad examples within hospitals where people do not co-operate with those in other disciplines.

**Dr O'Neill:** Before the document “Partnership for Care” and the draft bill were published, much of the discussion on this matter centred on the issue of removing competition. In Scotland, we seem to be heading towards the removal of competition. I realise that we are including other aspects of performance assessment, but down south they are moving towards a system of competition that we certainly do not favour. It is not in patients’ interests to have a system that does not have to take account of patients in other parts of the country or other health board areas, or that allows two trusts to compete with each other even in the same patch over the provision of services to patients. In that sense, the bill’s direction of travel has got to be a good one.

**The Convener:** Pat Dawson has been very patient. I know that she wants to comment on this matter.

**Pat Dawson:** The acute services review report best described aspirations with regard to working together across health boards. Indeed, one of its first sentences refers to considering the NHS in Scotland without any boundaries. Such a statement recognises that there are critical masses of service provision in small, medium-sized and large areas and indeed in areas beyond Scotland’s borders—that is, south of the border. I agree with colleagues who have suggested that, in its requirement to have cross-border working, the bill represents the final aspiration. Whereas the issue previously centred on cross-border finance flows, we will now have a very helpful requirement to carry out cross-border planning.

In response to the second part of Mr McNeil’s question, on whether abolishing trusts would help with integration, some of our members who work in integrated child health teams in Glasgow might belong to the acute trust and others might belong to the community trust. Although there might be differences in service models and service delivery, bringing the two aspects together will simplify integration. Things merge more naturally where there is one organisation that has good and meaningful relationships with the areas that it borders or the people to whom it provides service.

**Shona Robison:** Dr Watson, it is important to return to a comment that you made in response to an earlier question. I think that you said that a transitional cost might be associated with the dissolution of trusts. However, there could be problems in that respect, because the Executive has said that the bill is cost-neutral and that it will have no cost implications. Indeed, it has said that any savings from the reduction in costs will have to be used to improve patient care. Presumably—[Interruption.]

**The Convener:** Shona, I have to interrupt you, because your microphone is pointed away from you. The people in the recording room are semaphoring at me.

**Shona Robison:** Sorry.

Is one of the bill’s major stumbling blocks the fact that it is cost-neutral and the prospect that the savings that the Executive thinks will fund some of its elements might not materialise or that costs might arise that would undermine them?

**Dr Watson:** The answer depends on what time scale you are talking about. There are potential cost savings in the medium term, but if they are to be achieved, investment will be required in the initial phase of change. Over a longer spread, money should be saved but, unless we prime the management change properly, it will be increasingly difficult to implement the bill effectively, which will mean that savings will not be made. In the past, the tendency has been to underinvest in change, which has meant that the outcome of the change has delivered less than was expected.

**Shona Robison:** Are you saying that the Executive is wrong to claim that the bill will be cost-neutral?

**Dr Watson:** No. The issue depends on the time scale over which the Executive is saying that the bill will be cost-neutral. Over a five-year time spread, the bill may well be cost-neutral and money might be ploughed back into patient care, but it will be difficult to implement the bill at zero cost in the first year.

**Shona Robison:** The Executive says that that will happen, but you think that it may be difficult to achieve. Are you worried that the resources that are required may have to come from within existing budgets?

**Dr Watson:** There is a risk that the rate of change will be limited by resources and therefore that longer-term savings and reinvestment will be more difficult to achieve.

**Mr Davidson:** I want to return to the issue of relationships between boards, such as managed clinical networks. The idea implies that money will follow the patient, but boards that are under
pressure, in part through the Arbuthnot formula, might have difficulty in providing care for patients in other areas. Within the new structures—if you accept them—do you want a system in which money follows the patient and in which boards are under a duty of uptake if another board has the capacity to provide a service that they do not provide?

The Convener: Who will answer first? Just go for it—he who dares, wins.

Dr O'Neill: We do not advocate a system in which money specifically follows the patient, although we advocate collaboration in the provision of services. If a health board can potentially provide a specialist service to three health board areas, it would be ridiculous if that board were constrained because of a lack of collaboration between the boards. We do not envisage that collaboration will be on an item-of-service, named-patient basis, although collaborative planning between health boards will be required. It will have to be recognised that, particularly with specialised services, health boards can provide services for populations of patients that are larger than the populations in their areas.

Mr Davidson: I asked the question on the back of your comment that you do not want the NHS board boundaries to change. If we focus on the opportunity for service delivery, more out-of-area payment systems will have to be set up, which will be a paper chase. I ask you to go beyond that stage and say whether money should go from one board to another. Boards may be under a duty to set up services for other boards, but it appears that they will not be under a duty to send patients to other areas, as long as they meet the Government of the day's waiting-time targets.

Dr O'Neill: I do not think that the two are mutually exclusive. A board may provide services for patients with diabetes in a wide area. The planning of that service will require collaboration and perhaps rationalisation of funding. However, the situation may be totally different for another service. That is the system that we advocate, rather than a system that is focused on individual patients travelling in buses in one direction or another.

Dr Watson: My answer is partly in response to Mr McNeil's question. The impact of the working time directive and the consequent need for service rationalisation will result in a lot of intra-health authority reorganisation and in movements across board areas. A formula for resource transfer will be essential because, particularly for rural and remote communities, specialist services will inevitably be provided in other health board areas. For certain services, there might be a single unit for Scotland. A smooth system of transfer of resources will be essential in that situation.

Janis Hughes (Glasgow Rutherglen) (Lab): You have already mentioned community health partnerships, which are obviously an important part of the bill. The specific details of those proposals are still quite sketchy. Are you assured that community health partnerships will lead to an improvement in service delivery?

14:00

Dr Garner: I will start off. I declare my interest—I have a day job as a general practitioner.

The Convener: Yes, your name-plate says “Dr John Garner”, although I have difficulty reading it, because of the angle that it is at.

Dr Garner: I am sorry—I will give it a wee twist.

The Convener: My eyesight is also at fault.

Dr Garner: We welcome the principle of community health partnerships, but we must recall that local health care co-operatives—the organisations from which they will evolve—are relatively young; they have been around for only four or five years. A lot of work has been done in LHCCs and the BMA is concerned that the developments that have taken place and the networking, the inter-practice working and the community working that have been achieved should not be lost as a result of the development of CHPs.

For example, we are told that there will be fewer CHPs than LHCCs, so the boundaries may change automatically. That will obviously disrupt current relationships and systems. We are told that CHPs may follow social work boundaries more closely. There is a lot of sense to such coterminosity but, from the point of view of my practice, I would probably have to work in two CHPs, so there are all sorts of areas in which we need to get down to the detail.

We are keen for there to be an evolution from LHCCs to CHPs, to ensure that the gains that we have made—I think that LHCCs have made real gains—are not lost as we go down the road of CHPs. However, we welcome CHPs, because they will mean more public involvement. It is absolutely right that we will be much more inclusive because, at the moment, LHCCs are focused more on doctors than on the broader community of health care professionals and the public.

Janis Hughes: I agree with most of what you have said. Some local GPs have raised with me the fear that, because the community planning process within which it is envisaged that CHPs will work involves a large number of agencies working together but is in effect driven by local authorities, the work of CHPs—from an ex-LHCC point of view—might be subsumed by the community planning process. Do you have any views on that?
Dr Garner: That is very much up to the GPs. We do not want the creation of CHPs to result in GPs disengaging from the process. That fear exists, because GPs will no longer be at the core of things. The BMA obviously wants to encourage GPs to get involved in, and to work with, CHPs, but there is a hurdle to overcome. That is why I am not keen on a revolution from LHCCs to CHPs, but would prefer more of an evolution that builds on the strengths of LHCCs.

Janis Hughes: Would you like any specific measures to be included in the bill that could go towards ensuring that people on the health side—not just GPs but other health professionals who are involved in LHCCs and who will be involved in CHPs—will benefit?

Dr Garner: What is in the bill has a very thin structure—or rather, it does not contain a lot of detail. The detail that emerges from the consultation process that has gone on will need careful examination to determine how matters can be progressed.

The Convener: Do any other members of the panel wish to come in on that?

Christine Brown (Royal College of Nursing): We would like more explicit reference to be made to consulting communities under sections 5 and 6. We would also like explicit reference to be made to staff governance, including staff representation and arrangements for staff consultation. We would like the wording to be a bit stronger and we want reference to be made to professional advisory networks.

Janis Hughes: That is helpful. Thank you.

The Convener: I want to ask a supplementary. Paragraph 2.7.7 of the BMA’s submission states:

“Financial support for LHCCs has been variable across Scotland.”

You might like to put on the record how they are funded. You proceed to say:

“There should be transparent and equitable arrangements for the funding of CHPs across Scotland.”

Do you have anything to say about changes in funding? Those comments seem to be quite significant.

Dr Garner: From our point of view, LHCCs are financially supported by the primary care trusts—the money is devolved down. The extent of devolution from primary care trusts has varied throughout Scotland. That has given some LHCCs opportunities to develop, but others have felt that they have been constrained by the lack of resource that has been devolved to them.

In future, the health board will be the funding body and we would like there to be some guidance to ensure that money flows to the CHPs. Obviously, the CHPs will have to be accountable for how they spend that money. However, it would be nice to have some guidance on how CHPs should be funded and what duties are expected of them—although that will depend on whether they are urban or rural—so that there is no disparity in what the CHPs achieve throughout Scotland.

The Convener: Would that be better done through the regulations or guidance?

Dr John Garner: I think so, yes.

The Convener: The minister will hear what you are saying.

Pat Dawson: We have to think long and hard about the capacity of primary care at the moment. As the committee well knows, there are major changes happening with the implementation of the general medical services contract. We also have ambitions to implement “Agenda for Change” in primary care, especially for our practice nurses. There is also the reform of the structures that support primary care.

Let us not be under any illusions. I cannot see how on earth this is going to be cost-neutral—it will cost money. We know that there has been investment, but the costs will be about more than just pound signs; it is about people. Nurses, doctors and other health professionals are already working day in, day out in primary care, and going the extra mile for patients. Major changes are coming along that will need a huge amount of capacity in human resources, in development, in support for service delivery that starts where GPs stop under their new contracts, and in the packages and the services that nurses will have to deliver to make up the shortfall under that contract. The agenda is so huge that it is simplistic for the RCN to say that there should not be any change other than what is in the bill. The bill is significant.

The Convener: It is the pebble in the pool.

Pat Dawson: Absolutely.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I will deal with public involvement, which is covered in sections 5 and 6. Section 5 will insert a new section 2B(1) into the National Health Service (Scotland) Act 1978, which makes it clear that

“It is the duty of every Health Board and Special Health Board to take action ... that persons to whom those services are being or may be provided are involved in, and consulted on—

(a) the planning and development, and

(b) decisions of the Health Board”.

Section 6 is about the dissolution of local health councils. Is the abolition of local health councils and their replacement by local advisory councils
coupled to the health boards’ duty of public involvement and improvement to the system of public involvement?

**Pat Dawson:** The RCN in Scotland believes that the committee must ask and decide whether it believes that the new structures will provide and promote independence.

The consultation process for the new public involvement structure had limited research evidence in an area in which we seek to promote evidence-based policy. The current powers and statutory responsibilities of LHCs were not explicitly demonstrated in the consultation, and were only mentioned in the policy memorandum and explanatory notes.

The committee must ask whether the strengths and weaknesses of the current LHC structures will be improved by the new relationships. Each of our organisations has come separately to the conclusion that independence within NHS Quality Improvement Scotland requires a long stretch of the imagination, not for those of us who know the systems and structures, but for the public, and the issue is about the public and their services.

A second question is whether the plethora of systems, advisory structures and so on will deliver a one-stop service for patients and members of the public who seek to be represented or to have their voice heard. I could go on, but I am happy to take questions.

**Mike Rumbles:** I understand that independence is the key, certainly to local advisory councils fitting into the local and national system, but I am more interested in the duty of public involvement being given to the boards, as I have not heard about that. Surely, any organisation—I include your organisations—must have responsibility for public involvement and that responsibility should not be hived off to somebody else. Surely that is the key element of the bill. I would like you to comment on that matter, as I have not yet heard comments about it.

**Pat Dawson:** How much better might things be if there was a duty on boards and a duty to have an independent voice to represent the public? Why should the baby be thrown out with the bath water? If everything is to be done internally and there is to be a duty on the NHS to consult, we should consider the consultation processes of 20-odd years ago. In 1976, the health councils had rights and responsibilities vis-à-vis consultation processes. Indeed, the evidence that the local health council collated gave people a voice to speak directly to the secretary of state, who made decisions about whether service closure or redesign would be promoted. In essence, that structure has been changed, but what I have said indicates that, hitherto, our systems have promoted an independent patient voice at the highest level. In the bill, there is no route other than for the NHS itself to say that it has consulted and followed good practice and it either agrees or does not agree with the public. It is difficult to see how an independent external body will be able to challenge the board or be a vehicle for the voice of patients or the public.

**Mike Rumbles:** I have another question, as the issue is important. Correct me if I am wrong, but I believe that, under the current system, local health councils are appointed by the health boards, so where does independence come in?

**Pat Dawson:** For many years, the health council movement has sought to reform that situation—I say that as a past director of the Scottish Association of Health Councils. It seems that we have gone for a complete overhaul and have not kept the key components of health councils’ success. By virtue of there being one or two areas in which health councils recognised that it was not clever for statute to have the board appoint them, we will no longer have them—the board will be it. The duty will be on the board to do such work, with advice from an independent panel.

**Shona Robison:** I share your views, but want to progress matters a bit. Obviously, independence is a crucial element, but there are also basic roles and functions that a patient expects at a local level. I am not clear about something and wonder whether you are clear about it. Who will provide the local point of contact for a patient who wants to be guided through the complaints system, for example, or who wants to bring to the attention of the local council—as they currently would—a concern at a local hospital that might lead to a walking-the-ward situation, which has happened unannounced on a number of occasions? Can you think of an alternative organisation that could provide that point of contact or a way of providing it? That element seems to be totally missing from the bill.

**Pat Dawson:** In the past, one of the shortcomings of local health councils was that they did not have a statutory duty to support complainants, although many did—local health councils in Lothian, Glasgow and elsewhere had high standards of complaint support. In the past five to ten years, several other agencies have sought to support individuals in making a complaint. Those agencies are primarily advocacy and other mental health, learning disability and support services. Their involvement is to be much welcomed. Another crucial organisation that has supported complainants is Citizens Advice Scotland.

However, some of the key experts on managing, manoeuvring and negotiating with the health service are health council support, information,
advice and complaints officers. As I understand the new requirements, the NHS board will have to commission someone to provide that service, and the local advisory structures will have a role in monitoring its quality. They will move from being providers to being quality advisers. I suggest to the committee that that is not seamless service provision or a one-stop shop for patients who want to make complaints. There are other reviews of the complaints procedure that had a poor evidence base.

14:15

Mr Davidson: There has been quite a lot of discussion about the role of NHS Quality Improvement Scotland and about which departments and functions it will take over. I recall that that was a hot topic at the General Medical Council conference.

Will the witnesses talk about whether NHS QIS should be seen as a standards-developing body and whether there is a need, as Pat Dawson described, for another patient-focused or user-focused body? Such a body would be an independent organisation and not part of the standards organisation. If I may, I will quote from the Royal College of Physicians of Edinburgh’s submission, which says that NHS QIS “will be acting not only as judge and jury but will have written the ‘laws’ too”.

Is there a need for clarity between standards systems and the representation of individual patients, users and carers?

Dr Watson: I think that there is. We are concerned about NHS QIS’s numerous functions. Standard setting is crucial, as is the inspection and monitoring of those standards. To add to those roles identifying and dealing with service failure and dealing with patients involves a blurring of responsibilities. On service failure, identification is important, but there should be a better, separate mechanism for dealing with it. The public perception is that NHS QIS is a single body and the independence that the public would welcome is not there.

Dr O’Neill: We welcomed the fact that several organisations were brought together under the NHS QIS umbrella, because too many organisations were doing too many things and there was overlap. However, as we said in our evidence, the challenge is for a single organisation to fulfil all those functions. There needs to be considerable discussion about how that will be delivered at the end of the day. There is nothing in the bill to prevent us from proceeding in that way, although there are issues about the abolition of local health councils and the creation of a Scottish health council.

We welcome the provision that Mr Rumbles drew attention to. We must instil a culture of public involvement and standards of acceptable performance, and we must make it easier for people to complain when service falls short of an acceptable standard. We must do that right across the service. If we rely simply on existing structures or new structures to do that, we will fail. We must create a health service in which an accepted part of the culture throughout the system is everyone’s responsibility to ensure that there is appropriate public involvement. The organisations that exist to deliver particular services must demonstrate to patients, the public and those who deliver the service that they are fulfilling the different functions that they have been given.

Mr Davidson: I think that you are looking at three different issues: first, the duty on service deliverers to involve patients in planning and everything else; secondly, a clear and distinct duty on NHS QIS to evolve standards; and thirdly—a factor that has not yet appeared in the bill—the question of who will deal with the complaints procedures and so on. Is that a fair summary of your remarks?

Dr O’Neill: There are separate consultations, and Pat Dawson has already drawn attention to concerns that we all share about the separate arrangements at present for reviewing the complaints procedure. The Executive has responded and we are concerned about its response, but that is separate from the bill. Whether it would be appropriate to bring that under the remit of the bill is a different question.

Mr Davidson: In simple terms, do you see the bill as encompassing three different functions?

Dr O’Neill: Yes, but I do not see them as being so distinctly different as you have put it. For instance, I would argue that there is a responsibility on practitioners and on organisations to demonstrate to the public that they are delivering care of an acceptable standard. I do not think that we should be waiting for an examination body of some sort to descend on organisations or on individual practitioners. We should not wait until then to demonstrate that service may be falling short of an acceptable standard.

Pat Dawson: I suspect that there is no member of the committee who has not had a postbag full of letters about NHS dentistry. Will anything in the bill support the promotion of patient rights with regard to access to NHS dentistry? Will it promote some of the European charters and declarations, to which our Government is a signatory, on promoting and protecting patients’ rights?

The Convener: Duncan McNeil, are you prepared to answer that or do you want to ask a question?
Mr McNeil: I shall comment on that. The present situation is not working and the health boards are not speaking for the communities that they represent and are unknown to many people in their communities. We have identified an issue. I do not believe that the current system of health councils is operating to people’s satisfaction. Why else would all the various groups that are concerned with service change and the health service in Scotland be complaining? I am talking about community interests as opposed to specialist interests, which are well represented in the national health service and well represented here today.

Can the responsibility in section 5 on national health service boards to involve the public improve consultation processes? There is also a harder question: how can it bring about more regular involvement by the public and what actions or ideas would improve the current situation and meet the objectives of the bill? What ideas do the witnesses’ organisations have for building in individual patient involvement and community involvement to match the involvement of specialist interests, which clearly have an influence and dominate the thinking of the national health service?

Elaine Tait: That is not a question that can be answered fully in the time we have today. The bill gives health boards a responsibility to co-operate across boundaries on a raft of issues. If one also gives them responsibility for consulting the public on service delivery and service planning, the combination of those two responsibilities, if used creatively with an accountability mechanism through the NHS and the Scottish Executive Health Department, should at least provide a platform for people to share good practice, to learn from one another and to be held accountable. I am not sure that, at this stage of specificity in the bill, it is possible to add anything that will take things much further than that.

We all know that it is an extremely difficult task to engender a culture that will allow patient involvement and encourage patient views to be expressed, and to facilitate that in a structure that itself is involved in organisational change and at a time when we have removed representatives from the local offices that were the predecessors of the Scottish health council. However, the bill at least gives statutory responsibility to the health boards to do that, and it also gives them a statutory responsibility to co-operate across organisational boundaries. That may help. I am not sure whether it is feasible for the bill to do anything more than that at this stage, but I would be happy to be contradicted by my colleagues.

Dr O’Neill: Some things can be achieved by their being enshrined in legislation and some are better achieved by other means. If we look back over the past 10 or 20 years, we see that significant patient involvement and responsiveness to patients’ needs have come not from legislation but from patients’ groups and the voluntary sector. We will have much more public and patient involvement if we give appropriate support to voluntary organisations and other groups that represent patients.

Let us consider the changes that have come about in the treatment of breast cancer over the past 20 years. A group of patients with breast cancer—predominantly pre-menopausal women—said, “Hang on a minute. We want to have a say in the treatment that we are offered and we want to be involved in the decisions that are taken about our care. We want doctors to consult us about the treatment that is available, not just mete it out to us.” That attitude, rather than pieces of legislation, brought about changes in patient and public involvement. We welcome section 5, but it will not deliver public involvement and nor will any other aspect of the proposed legislation. We must have other means of doing so.

Mr McNeil: Mike Rumbles issued a challenge to your organisations, whose influence in the health service is secure. Is there a culture in the various organisations that you represent of promoting the community interest—apart from with warm words—so that the community’s influence can be anything like as strong as the influence that you have as professionals? How do we bring that about? What ideas have your organisations brought to the process that we might use to encourage further community involvement?

Dr Garner: What has happened—and what the BMA has strongly encouraged—is involvement at the level of the individual. As a profession, doctors and nurses have moved towards involving patients in consultation about their individual care. That is the prime building block from which the process must evolve. Previously, we have tried to encourage people in general practice to get involved in patient participation groups, but such groups were difficult to organise. We hope that, as the culture changes—and it is changing at the front line, as doctors discuss with patients the options for their treatment—we will be able to move forward.

The first step will be to move the process into the community health partnerships, which will have public involvement. On a broader scale, we will be able to consider the services that are being offered in an area and to consult those who are in the CHP and their constituents in the community about how best to deliver those services. I envisage movement from the individual to the local level, then building up from that, in an evolutionary process. That is the way we have to go.
Mr McNeil: Are we talking about the C-word—I mean consultation—which people misunderstand? The people whom I and other members represent come to us and say, “This is not consultation; they are not taking account of our views.” Perhaps consultation is the wrong word to use for the type of engagement that we mean. The word gives people an expectation that they have some influence, which, until now, has not been the reality of consultations, which have mainly been about hot issues such as clinical or maternity services reviews. Can we really aspire to true consultation and a partnership in which the community interest can match the specialists’ interests, and sometimes might even win the day? Is that too much to hope for?

Dr Watson: Public involvement is crucial, but there is a danger that, in situations such as those that Mr McNeil describes, people might feel patronised and think that they have not been consulted. The difficulty is for the public to have a sufficient knowledge base, so that they can contribute in the way that they would like. Our organisations consider that it is crucial to contribute to public access to the knowledge base. A major concern is how the public can fully understand the issues, so that they have a basis on which to develop their views.

The Convener: We moved on to that topic, but I want to return to local health councils, which will also involve consultation. The submission from the Royal College of Nursing makes strong representations on local health councils. It says:

“There is no analysis given in the explanatory notes, policy memorandum or otherwise on the content of the powers, duties and rights of local health councils … Neither was this analysis part of the consultation, nor was any mention of the current legislation.”

You also make a distinction between “involving people” and

“protecting and promoting patient rights”.

It is a strong argument. Should we keep local health councils, or whatever we wish to call them? If we do, should they be directly elected and, if the answer to that question is yes, how do we do that? I want to add your views on that to those that have been expressed on consultation generally.

14:30

Pat Dawson: The RCN board and members are not clear that there has been a full exploration of all the potential policy and other outcomes. The consultation did not involve or describe the roles of health councils. Indeed, it used the managerial objectives and not statute to describe what health councils do, although health councils have a statutory duty to represent the interests of the public of the area in which they are established.

If we take the view that the policy and the consultation were inconclusive, we might be drawn to the conclusion that the abolition is pre-emptive. However, there is no doubt that it is entirely appropriate to have a duty on NHS boards to consult.

On consultation, one of the legal views that was given in the case of R v West Sussex health authority states:

“Consultation is the communication of a genuine invitation to give advice and a genuine receipt of the advice … to achieve consultation sufficient information must be supplied by the consulting to the consulted party.”

The committee might find that useful in understanding what consultation is about and determining whether consultation deserves a legal definition.

The Convener: I ask you to answer the other two parts of my question. If we keep local health councils for the purposes of consultation or representation, should they be directly elected?

Pat Dawson: The RCN does not have a policy position on that, but if the implication of your question is that independence of membership should be delivered, processes that deliver it are appropriate.

The Convener: Do you have any views on how direct election would be done? My local health council put the proposal to me, and I asked it how we would go about electing local health council members. The argument against their being nominated by the board is a fair point.

Pat Dawson: It is an absolutely valid point. Over many years, the health council movement has sought ways to distance itself from the NHS boards. Indeed, until a few years ago—I do not know about current practice—most health councils managed the process themselves. The selection process and the guidelines that were developed post the Eckford review were all in place, so that, although the board had a formal role, the health councils delivered the nomination and appointment processes.

Shona Robison: Before we leave public involvement, I would be interested to know whether the witnesses think that a good way of instilling or restoring public confidence would be to introduce directly elected seats on the health boards themselves.

Dr Garner: I am not sure whether the BMA has a policy on that. My concern is that the board is too remote for the person who sits in my surgery or who is in Dr Mike Watson’s outpatient clinic, even if they have elected someone to it. We need much more local involvement in consultation, rather than involvement at the board level. The people in my practice, the local clinic and the user
groups for the diabetic clinic are those who need to contribute their thoughts about how the service is developed and delivered.

**Shona Robison:** What do you think about directly elected places on community health partnerships?

**Dr Garner:** We need to consider how we could achieve that. As we said, the trouble is that we do not know completely how those bodies will function. I have no personal problem with that, but the BMA does not have a policy on the matter.

**Dr Watson:** I back what John Garner says. Local delivery is important. That returns to the point that what is put in place must work. There is no point in having elected individuals who pay lip service to the consultation process. The process will be effective only if people feel that they or their relatives are directly involved locally.

**Mike Rumbles:** The purpose of our asking you questions is to obtain further detail about the comments in your written submissions. After hearing Pat Dawson’s response to the convener’s questions, I admit that I am more confused about the Royal College of Nursing’s position. In its submission, the RCN says that it is right to give health boards the responsibility for involving people, but Pat Dawson’s response to the convener’s questions seemed to undermine the RCN’s support. She has not mentioned something else in the RCN written submission, which criticises the policy by saying:

“This policy position fails to recognise the legitimate interests of other representative bodies to be consulted, have/hold/give opinion or work with Boards to involve people.”

**The Convener:** I am sorry to interrupt, but will you tell us where that is in the submission?

**Mike Rumbles:** That sentence is at the bottom of page 4.

I am confused about the RCN’s position.

**Pat Dawson:** It is not contradictory to agree that any public service should have a duty to consult. The bill creates such a duty. Any statutory organisation that provides a service to the public and involves taxpayers’ money should have a duty to consult in line with the requirements in the bill.

**Mike Rumbles:** Do you confirm your support for the provision that places a duty on health boards to encourage public involvement?

**Pat Dawson:** The contrary part is whether dissolving health councils is also a requirement. As I said, I see no difficulty with all public bodies that provide services having a duty to consult.

**Mike Rumbles:** Point III on page 5 of your submission says:

“RCN Scotland has supported the creation of the Scottish Health Council”, yet what you say is contrary to that. Do I misinterpret you?

**Pat Dawson:** Support for a national organisation is not contradictory. A Scottish health council or whatever it is to be called is needed—we have no difficulty with that. The issue is whether that organisation should be within NHS QIS. Each submission to the committee has referred to that.

In the formal consultation, the question was not asked whether the functions that had been grouped to be performed by the Scottish health council should be part of NHS QIS. That was a statement in the consultation document and not a question for consultation.

**Mike Rumbles:** Forgive me, but I want to ensure that we get this right, because it is important that the RCN’s views are stated clearly and that there are no problems. You say that it is right to have section 5, in as much as it gives the responsibility to health boards. You also say that it is right for the Scottish health council to be established. Is that right?

**Pat Dawson:** Yes.

**Mike Rumbles:** What about the abolition of local health councils?

**Pat Dawson:** We question whether the new structures will provide the same safeguards as local health councils do in statute.

**Dr Jean Turner (Strathkelvin and Bearsden) (Ind):** The BMA witnesses suggested that they would like more detail on when the power of intervention would be or should be used. I think that the public would like to know your opinion on that. When the public know about folk lying on trolleys in accident and emergency departments, or not being able to have hip replacements because there are not enough surgeons, or having to wait an inordinate time for cataract surgery because Gartnavel is short by one and a half full-time equivalent staff, they will think that someone should have intervened in some health boards a long time ago.

**Dr O’Neill:** What do you enshrine in legislation, and what do you deliver by other means? We have a performance assessment framework, we have NHS QIS and we have the power for ministers to intervene. Those three issues should be seen as separate. I may have misinterpreted the question, but Dr Turner seems to suggest that ministers should have powers to intervene much earlier. I am not sure that we would agree with that. We support the idea of the performance assessment framework, we believe in the accountability of health boards and we support the functions of NHS QIS. However, we have
reservations about whether one organisation can deliver all of those functions. It will be up to that organisation to demonstrate to us that it can.

Our only concern about ministerial intervention is over whether it is reasonable to pass costs on to health boards. That has already been investigated by the Finance Committee, which has, I believe, referred to this committee in its report. However, as I say, the three issues that I mentioned should be seen as distinct from one another.

Dr Turner: So, you agree that there should be some intervention but feel that you would not intervene if you found that the staff and patients were dissatisfied. They have been dissatisfied for a considerable time and I am not sure that what we are discussing today will bring about any magical improvement unless structures and management change.

Dr O'Neill: I agree that the provision in the bill for ministerial intervention will not solve the problem of patients waiting on trolleys. However, I do not think that the bill ever could do that. We will have to have a different system for that sort of intervention—a system that is much more responsive to the needs of individual patients when they are waiting in an accident and emergency department, on a ward or wherever. The culture will have to change across the system. We are achieving that to an extent, but we have a long way to go.

Dr Turner: We certainly have. I do not think that the money or the personnel exist. It may be that the Executive could intervene by asking how money is being spent if all the checks are balances are not doing their job. Otherwise we would be saying that the Executive cannot change anything. Do I misunderstand you, or do you think that the Executive cannot do much?

Dr O'Neill: It is not up to me to defend the Executive.

Dr Turner: No, but you said that you had ideas on how the Executive might intervene.

Dr O'Neill: To give a direct answer to the question, I would say that all three organisations agree that we could certainly do with more nurses, more doctors, more staff and more resources in the health service. That is separate from the discussion about the bill, but we would not disagree with Dr Turner on that.

The Convener: For the committee’s information, paragraph 39 of the Finance Committee’s report on the financial memorandum of the bill states:

“The Committee would, therefore, strongly recommend that the Health Committee seek further clarification from the Minister on the circumstances when the Scottish Executive would bear the cost of intervention as opposed to the Health Board as proposed by the Bill.”

It is useful to have that on the record for when the minister comes before us.

Mr Davidson: My question is specifically for the RCN, although it has implications for all professional groups that deliver health care. The RCN’s submission recommends that there should be more detail on how staff groups will be consulted when services are being planned in different parts of the health service.

You talk about supporting professional nursing advisory structures in paragraph 6 of your submission. That is a start, but are you talking about that on the basis of bringing something to the table in clinical care that you think only you are in a position to offer? Are you looking for directors of nursing to be involved at board level and so on?

14:45

Pat Dawson: Yes and yes. The issue of the nurse executives on NHS boards was made clear by the minister, who required all NHS boards to include such a post. We are currently seeking clarification about two NHS boards that do not have nurse executives. There seems to be a strong evidence base that supports the view that clinical leadership in services—from nurses, doctors and others—can promote patient quality of care.

Our concern in paragraph 6, which comes under the heading “Dissolution of NHS Trusts”, was that an unintended consequence of the legislation would be our having NHS boards with a nurse executive and no other senior nursing or clinical input into the operational divisional structures that supported that. We have also been emphatic that we would like to see nurse leadership recognised on those new CHP boards, as my board member Christine Brown said.

Mr Davidson: Does that apply to other clinical areas as well?

Pat Dawson: We are developing partnership throughout the NHS in a supportive and positive way; for example, through development of the partnership information network guidelines. The RCN in Scotland is pleased that the minister has recommended amendment of staff governance in the form of one of the powers to intervene. We know that that is being consulted on at the moment and we wait to see how that consultation unfolds.

All of us here today have vested interests in ensuring that partnership working across all of our professional groups works as positively and effectively as possible.

Mr Davidson: Is it fair to say that you are happy that there will be nursing input at board level, but that you have concerns about the operational divisional level?
Pat Dawson: Yes.

Mr Davidson: I have not come across that before. Non-executive directors of trusts seem to be vanishing, but I was not aware that there would not be some form of management group that included all the potential professional input that exists. Do you suggest that that does not appear in the bill as you would like it to appear?

Pat Dawson: It might be that we are hearing emerging soundings from our members in senior positions to the effect that they are concerned about whether there will be sufficient and robust nursing leadership at the level below the board. We are keen to see whether that is the position of legislation, although I feel that that is another matter; limiting ourselves to the bill was mentioned earlier. We will certainly consider the matter because we have to promote and protect clinical leadership at all levels in the health service.

Mr Davidson: Can I widen that to the other two groups? I think that they might also have input to make.

Dr Garner: From the BMA point of view, along with our colleagues in nursing, we want to ensure that there is medical leadership in the operational divisions—it is essential. I do not know whether that leadership would take exactly the same form, whether it would come from a unit medical director or a divisional medical director, but there would have to be someone there who has the administrative and strategic responsibility to implement the medical advice on how a particular division, hospital or unit is run. I agree entirely with Pat Dawson.

Dr Watson: We are concerned that there were structures in place in the trusts as they stood before that have not been duplicated in the established health boards. I agree that it is early days and that the matter should not be enshrined in legislation, but we are concerned that clinical leadership will not be fully represented, as we feel it should be. The medical director sits on the board, but there are concerns that the full value of professional leadership will not be felt.

Janis Hughes: I have a question on the minister’s proposals on clinical governance. Following an earlier committee meeting, the minister pledged to lodge an amendment at stage 2 that will place a duty on health boards and special health boards to ensure that they have systems in place for monitoring and improving the governance of NHS employees. Do you have any comments on the suitability of the proposed amendment? Will it go far enough?

Dr O’Neill: A separate consultation on the proposed amendment on staff governance is under way and will finish, I think, on 4 February 2004. We are supportive of the principle that will be enshrined, which was suggested by the human resources forum of the Scottish partnership forum.

Janis Hughes: So you think that the proposed amendment goes far enough.

Dr O’Neill: We are still consulting our members on that. Superficially, we are happy with the proposal, although some minor changes may be required. We are happy that the minister has accepted the principle and is prepared to include it in the bill.

Helen Eadie (Dunfermline East) (Lab): The minister has also pledged to lodge an amendment that will encourage health boards to promote equal opportunities when carrying out their statutory functions. What do you feel about that and how do you envisage that the duty might be undertaken?

The Convener: I do not know why I keep turning to you, Miss Dawson.

Pat Dawson: I am the fount of all knowledge.

Dr O’Neill: Doctors have always deferred to nurses.

Pat Dawson: They get their best advice from us.

The Convener: That statement will be used in evidence against you, Dr O’Neill.

Dr O’Neill: We are not aware of the proposed amendment to which Helen Eadie referred.

Helen Eadie: The minister has stated that he will lodge such an amendment. In fact, Parliament has pledged that, in producing legislation, we will be mindful of its implications for equality of opportunity. The Health Committee is anxious to understand how you envisage health boards’ being able to encourage health professionals to deliver on equal opportunities.

Dr O’Neill: Perhaps on the back of the proposed amendment on staff governance, there will be a requirement on health boards to meet the staff governance standard on equal opportunities, which was published in 2002. We expect all employers in the NHS in Scotland to accept the range of partnership information network guidelines that are being produced by the human resources forum.

Dr Watson: Will the proposed amendment be about equal opportunities for staff development?

Helen Eadie: It will apply across the range of services and to employees within the health service.

Dr Watson: Equal opportunities issues have a key role in staff development. As I said, education and training are not highlighted as specific responsibilities, but it is well recognised that the opportunities for staff development are
significantly different among different staff groups. We are in favour of a multi-professional approach to staff development that applies across the board and that gives people opportunities, although that will require resourcing. Overall in the NHS, staff development is under-resourced. I hope that NHS Education for Scotland will be able to help, but the boards also have a function.

The Convener: Time is pressing, so if the witnesses have nothing to add, I thank them for their evidence, which was most helpful.
9 December 2003 (16th Meeting, Session 2 (2003)), Written Evidence

Introduction

The Scottish NHS Confederation represents NHS boards and trusts in Scotland. The Confederation supports the general principles of the Bill and the key provisions it sets out. Many of the provisions that will be enacted by this Bill were originally outlined in the White Paper Partnership for Care, which was supported by the Confederation. The publication of Partnership for Care was the result of a wide-ranging consultation between the Scottish Executive and NHS organisations and thus many of its, and the Bill’s, proposals were widely anticipated.

Dissolution of NHS Trusts

The Confederation supports the dissolution of NHS trusts in Scotland as an aid to removing barriers between primary and secondary care and delivering integrated, whole-system working across NHS Scotland.

The Confederation would ordinarily be concerned about a proposal for more structural change in the NHS. However, in this instance, the proposed change reflects the direction of travel on which the NHS in Scotland has already embarked, characterised by close working relationships between the constituent parts of local NHS systems. As the changes will take place entirely within existing NHS board boundaries, they should cause minimum disruption to staff and services.

Community Health Partnerships (CHPs)

The Confederation supports the thinking behind the creation of Community Health Partnerships, believes that they have the potential to make a significant contribution both to improving the health of communities and to delivering integrated services that meet local needs, and welcomes the fact that they will be created by statute. The Confederation is currently undertaking a major project to help define and shape Community Health Partnerships.

We have some concerns about the wording of clauses five and six of section two of the Bill, which give an extremely broad description of possible regulations and could potentially allow almost every aspect of Community Health Partnerships to be prescribed centrally. While a shared vision and underlying principles for CHPs are vital, the flexibility to adapt the model to local circumstances is also necessary. The Confederation’s view is that the legislation should state clearly what will be included in the regulations, rather than what may be included, and that regulations should be drawn up in consultation with the service once there has been an adequate opportunity to consider the roles that CHPs will play and the shape they will take.

We question the estimate in the Financial Memorandum that creating Community Health Partnerships will cost no more than the current LHCC budget. LHCCs have been in operation since 1999 and are not statutory bodies, whilst Community Health Partnerships will be brand new organisations with statutory responsibilities to discharge. Clearly there will be opportunities to redeploy costs from LHCCs but it seems inevitable that the creation of new bodies will involve additional costs, at least initially.

Duty of co-operation

The Confederation fully concurs that co-operation and shared planning between different local health systems, national agencies and Special Health Boards makes a significant contribution to service redesign and integrated care in NHS Scotland. Co-operation of this type is already happening at various levels within NHSScotland, and so the formalisation of this requirement will not cause any significant implementation difficulties for the NHS.
Ministers’ Powers of Intervention

The Confederation fully accepts that Ministers, being ultimately accountable for the performance of the NHS, should have the ability to intervene where serious failures occur and that it is sensible to formalise this power, which has already been used on a number of occasions (as in the recent example in NHS Argyll and Clyde). However, the Bill is unclear about exactly what ‘intervention’ means and it is important that this is defined, either in regulations or, preferably, in the legislation itself, along with the circumstances in which it will be used. NHS organisations are entitled to know exactly what to expect from legislation that allows direct intervention in their work, and in what way Ministers will interpret and implement it. At present, ministerial intervention is very much an action of last resort and should remain so. The legislation should be framed in such a way that the principle of health services being planned, managed and delivered locally is reserved.

Public Involvement

The Confederation welcomes the inclusion of a formal duty for NHS boards to involve and consult with the public on the planning and development of services. The engagement of patients and communities in decision-making processes is a responsibility that NHS Scotland takes very seriously, and boards across Scotland are developing innovative and meaningful ways to ensure public involvement.

The Confederation does have some concern, however, about the estimate in the Financial Memorandum that the public involvement duty will involve no additional expenditure by NHS boards. Genuine, meaningful, continuous public involvement is not cheap, as NHS organisations have found through experience—it may require the provision of training both for NHS staff and for communities, for example—and whilst the Confederation fully agrees that it is crucial, it should not have to come at the expense of other services. This may mean that the requirement in the legislation is backed by the provision of dedicated funds to advance the public engagement agenda.

Promoting Health Improvement

The Confederation is delighted at the inclusion in the Bill of a formal duty for Scottish Ministers to promote health improvement. We have long called for a strong national lead from government on this issue, and for health improvement to be ‘mainstreamed’ across every Executive department and every Scottish Ministerial portfolio.

We also welcome the corresponding duty for NHS boards to promote health improvement. One again, this provision simply formalises a responsibility which every NHS board already acts upon, but its inclusion in the Bill sends an important message about the status of health improvement as a priority for the NHS. We feel however that parts of this section of the Bill, specifically clauses (1)(2) and (2)(2) of section 7, are rather vague and their purpose unclear. We would welcome more clarity about what is meant by these clauses and what actions they will enable or require Ministers and boards to take.
COSLA, as the organisation representing 31 of Scotland’s councils, is pleased to have this opportunity to submit evidence on the National Health Service Reform (Scotland) Bill to the Scottish Parliament’s Health Committee.

General Comments and Summary

The Bill is recognised as a significant piece of legislation coming at an important time in the development of the Health Service in Scotland, a time when co-operation with key partners and organisations is evolving in tandem with the enactment of the Local Government in Scotland Act 2003 with its new power of wellbeing, the implementation of community planning legislation and the continuing development of partnership working with the Scottish Executive following the elections in May this year and the announcement of its new work programme in the Partnership Agreement. COSLA is committed to helping make a difference to the health of Scotland’s communities and trusts that the framework being put in place by the Executive will assist with that process in encouraging multi-agency co-operation.

Detailed comments follow below and in the annexes. Essentially what COSLA feels must be achieved are:-

<table>
<thead>
<tr>
<th>COSLA Concerns</th>
<th>Proposed Solutions</th>
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<tr>
<td>No reference to the local authority role included in the Bill</td>
<td>Bill to include direct reference to Part 2 (s 16)</td>
</tr>
<tr>
<td>No reference in CHP guidance to role for Minister for Finance and Public Services</td>
<td>Local Government Scotland Act 2003 Schemes of Establishment for CHPs to be agreed jointly by Minister for Health and Minister for Finance and Public Services</td>
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<tr>
<td>Recognition given to the primacy of the community planning process and the links with Joint Future Possible duplication of public consultation processes</td>
<td>Guidance to be re-drafted to avoid duplication of existing structures and ensure links to ongoing initiatives Re-draft CHP guidance to permit use of existing Community Planning consultation mechanisms where appropriate rather than establish separate Public Partnership Forums (PPFs)</td>
</tr>
<tr>
<td>Acknowledgement that, if the Bill is to achieve its potential, additional health improvement work will flow from the Bill</td>
<td>Financial Memorandum, Bill and guidance to be re-drafted to reflect the Partnership needs for Health Improvement rather than a narrower NHS only recognition</td>
</tr>
<tr>
<td>An acknowledgement that the Bill could have financial implications</td>
<td>More detailed analysis of potential financial implication is needed. Focus should be on short-term change management needs</td>
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The Bill – COSLA concerns

The overall aims of the Bill – improving both patient care and the quality of service, the devolution of power to local communities, the strengthening of public involvement and the promotion of health improvement are all fully supported by COSLA. COSLA does, however, have a number of key concerns which have already been raised with the Executive and on which their response is awaited. These concerns mainly relate to the lack of a co-ordinated approach in each stage of the Bill’s preparation and presentation (something replicated in the Executive’s consultation exercise on the associated guidance for Community Health Partnerships (CHPs) for which the Bill provides the legislative base) and are: -
Recognition of the local authority role

Against the background of partnership working that has evolved in recent years, COSLA is disappointed at the lack of recognition of the local authority role on the face of the Bill. It is clear that the development of the NHS-local authority relationship will be essential as a foundation for the success of the legislation. There must be confidence that the partnership is genuine and on an equal basis. The current CHP sections make no reference to local authorities – incongruous given their intention to promote greater integration between health and local government and inexplicable in light of community planning legislation. The Executive’s consultation paper on guidance to accompany the establishment of CHPs did, it is acknowledged, make reference to the local authority role and contribution, but, it was felt, in a less than adequate way. COSLA’s response to that consultation document is at appendix 1 for the Committee’s information.

This point has already been raised informally with the Executive and the explanation offered that as the legislation is in the name of the Health Minister it is outwith his competence to legislate for local authorities. There is a view that lack of parity on the face of the Bill could lead to the assumption that the NHS has a ‘lead’ role despite the stated aim of equal partnership. Local authorities and the NHS have made significant progress in developing effective partnership working in recent years, a process it was envisaged would be continued with the establishment of CHPs, as the Joint Futures agenda is rolled out. It would be unfortunate if the apparent lack of partnership implied in the Bill had a retrograde effect on the moves towards greater co-operation.

All agencies need to continue to develop their partnership working arrangements if the legislation is to be effective. There are concerns that in some areas partnerships are not operating as they should. Failure to include a reference to local authorities in the Bill will neither help eradicate bad practice nor promote continuous improvement in co-operative working.

Acknowledgement of the links with Community Planning and Joint Future

As currently drafted, the Bill does not recognise what already exists in terms of community planning processes to engage with communities and involve them in consultation. Duplication of any kind does not represent the best use of scarce resources and COSLA would argue that where existing community planning mechanisms already exist, these should be used as a mechanism for communication of information, consultation etc rather than creating a new structure. Involving communities can be difficult – and the geographical problems of rural areas and the particular problems of engaging with ‘hard to reach’ groups are well documented - duplication would only exacerbate these difficulties.

Reflection of local democracy

Good practice does exist under the current Local Health Care Co-operative arrangements. The Bill and the introduction of the replacement CHPs should be implemented in a flexible way to ensure that good practice can be built upon and locally determined priorities addressed within the national CHP guidance framework.

Financial implications

The Bill’s Financial Memorandum makes reference to the Executive’s commitment to increase investment in health over the lifetime of the Parliament and the link between this investment and continued reform of services. It concludes, “as many of these proposals involve formalising or reforming existing obligations, there is no net additional expenditure arising from the Bill”. With regard to local authorities and other organisations with an interest in the legislation, the conclusion is the same “The Executive is of the view that there will be no impact on other aspects of public expenditure, including local authorities, or on the costs of the voluntary or private sectors or individuals, as a result of the provisions in the Bill”.

COSLA has given evidence to the Finance Committee on the Financial Memorandum – a copy of the written submission made is at appendix 2. Essentially the thrust of our evidence is that change cannot be effected without costs; that elements of the Bill – notably the establishment of Community Health Partnerships – have yet to be finally agreed, which begs the question as to how
the financially neutral conclusion has been reached; and advises that work on the Spending Review 2004 exercise has been initiated which should provide, by February next year, a robust indication of potential spending on health improvement work by councils during the life of the current Parliament.

Conclusion

COSLA views the Bill as an opportunity for the NHS, local government, the voluntary sector and other partner organisations to move forward. Its requirements formally signal a step change in the way the Health Service will operate, underscoring Ministers’ intentions to devolve power and responsibility to communities. For this to be successful, local authority involvement - as the democratically elected tier of government closest to communities – is essential. COSLA is in discussion with the Executive regarding its concerns relating to the Bill, the associated consultation on the guidance for CHPs and the Spending Review 2004 exercise. It is hoped that these discussions will lead to a refinement of the Bill and the CHP proposals which will be to the ultimate benefit of Scotland’s communities.
Appendix 1

COMMUNITY HEALTH PARTNERSHIPS

COSLA Response to Scottish Executive Consultation

General

COSLA welcomes the opportunity to respond to the Executive’s Community Health Partnership (CHP) consultation paper and is grateful for the extension to the closing date for responses to allow the issues to be considered fully at our Leaders’ September meeting.

As the organisation representing 31 of Scotland’s councils, we have had sight of a number of individual members’ responses. The comments which follow do not attempt to summarise these views – many of which, naturally, make reference to issues of local interest to an individual council area – but rather they draw out issues of national importance relating to the local authority role in that context. These can be grouped under a number of headings.

CHPs – The Principle

The establishment of CHPs must be progressed in the context of other ongoing work, notably Community Planning and the Joint Future agenda, otherwise their effect will be detrimental rather than helpful in achieving the aims of the legislation.

The Local Authority role

Prior to the publication of the CHP consultation paper, COSLA had signalled the need for the local authority role and the primacy of community planning legislation to be recognised fully to reflect the new and developing partnership with the NHS. There was therefore considerable disappointment and concern about the absence of any reference to the role and contribution of local authorities in the Bill, although there are many such references in the CHP document. If the legislation is to be effective, there must be confidence that the NHS-local authority partnership is genuine and on an equal basis, particularly given the view that the CHP paper has an NHS bias (CHPs are described primarily as health organisations). Much progress has been and is being made jointly by the NHS and local authorities in the development of effective partnership working. COSLA is aware of the explanation offered by the Executive that as the legislation is in the name of the Health Minister this precludes the inclusion of a reference to local authorities as that would be outwith his competence. An assurance is required that a means will be found to overcome this administrative protocol to ensure that the goodwill and trust built up is not jeopardised by the Bill’s wording.

Links with the Community Planning Process and the Joint Future Agenda

The similarities between the aims of community planning processes and arrangements put in place/under development as part of the Joint Future agenda and the CHP proposals are clear – improved co-ordination of services, increased community involvement, greater devolution of decision making to local communities, improved access to services etc. The potential for confusion and duplication is considerable, therefore COSLA proposes that where Community Planning of Joint Future structures already exist, these should be sustained as the basis for CHPs. It should be made absolutely clear that the prime role rests with the Community Planning process.

There are in addition other legislative drivers – such as the power to advance well-being, the new duties to be placed on Ministers and Health Boards to promote health improvement and the proposals for integrated children’s services. Their implications and associated links should also be clarified in the final guidance.

Local flexibility

Local flexibility within the national CHP framework is regarded as an essential principle if individual local authorities are to be able to respond to local priorities. Where Local Health Care Cooperatives have worked well, councils are anxious to build on what has been achieved and
question the added value to health service delivery of the introduction of CHPs. The final arrangements for CHPs must ensure that any negative impact on current good practice is avoided and should allow flexibility for future service integration, improvement and development.

**Accountability**

For CHPs to be accountable only to NHS Boards would be unacceptable and be regarded as indicative of an NHS led organisation. There should be arrangements for joint accountability with local authorities in order to reflect the local authority role.

Clarification is required on the extent to which CHPs will have control over their financial resources.

**Boundaries**

There is a general view that CHP boundaries should relate to local authority areas, or their administrative sub-divisions. This will clearly not be possible everywhere which emphasises the need for a consistent approach in the development of a basic framework for CHPs across Scotland.

**Organisational Arrangements**

Whilst a multi agency approach is acceptable in principle, there needs to be a greater emphasis on the local authority contribution and recognition of their working arrangements. Under LHCC arrangements councils were represented but not as equal partners. Given that the CHP remit will be wider than that of LHCCs, this is an issue which requires clarification.

**Scheme of establishment**

The proposals for the scheme of establishment do not reflect adequately the need for a local authority input. To be submitted by NHS Boards for the approval of the Minister for Health and Community Care, there is insufficient recognition of the local authority role. All NHS Boards are required to do is to ‘demonstrate that the views of all stakeholders have been taken into consideration’. It is suggested that the schemes should be jointly agreed by NHS Boards and the local authority/authorities. In addition, the Minister for Finance and Public Services should have joint responsibility for approval of the schemes.

**Public Partnership Forums (PPF)**

The need to avoid duplication, make the necessary connections with Community Planning processes etc has been a theme of this commentary and the response to the proposed establishment of Public Partnership Forums (PPF) through which CHPs will be responsible to communities once again lead to a reiteration of these comments. Where Community Planning groupings already exist, rather than create an additional layer, these should be used.

At a time of unprecedented public consultation, there is a responsibility to avoid making over many demands on people’s time. Voluntary organisations and individuals clearly can have particular problems in becoming involved in multiple meetings. Councils have already identified the need to make contact with ‘hard to reach’ groups to ensure their consultations are genuinely representative and not confined to a vocal minority – a process which will not be aided by an over-proliferation of consultative groups. In addition there are the practical implications for those resident in rural areas where participation in a one-hour meeting can involve considerable travel time – and associated expense.

**Health Improvement**

A recurring theme in councils’ comments on the paper has been links to the Health Improvement element of service provision. CHPs would provide an opportunity to involve staff with a health improvement remit, including public health and health promotions staff and those in health development posts, with a co-ordination and integration role for a community.
Resource implications

The potential resource implications of the guidance will require to be assessed when finalised. If there are additional new financial demands on local authorities, COSLA would expect these to be appropriately funded.

Monitoring the Legislation

The success or otherwise of the legislation will be judged by local communities and individuals basically in ease of access to services, reductions in waiting list times etc. Performance and outcome measures are being developed as part of the Joint Future agenda and appropriate links need to be made and also with single shared assessments. The NHS and local authorities use different performance management tools – best value and performance assessment framework respectively and this is regarded as a barrier to transparency and a hurdle in joint working processes. A single system would be preferable and would assist in demonstrating achievement. COSLA would propose the adoption of the best value regime.

Conclusion

The CHP proposals have been prepared without the co-ordination and joined up thinking advocated throughout the paper and with inadequate reference to what already exists on the ground. Whilst the basic principle of the establishment of CHPs is generally welcomed subject to their setting in the Community Planning context, much requires to be done in finalising the guidance to ensure that appropriate links are made with other work – notably Community Planning and Joint Future – if the result is not to be confusing duplication, a blurring of responsibilities, frustration amongst elected members, staff and the general public plus a decline in the goodwill that is being build up by current work by the NHS and local authorities. COSLA would be happy to work with the Executive in revising the guidance.
Appendix 2

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL – FINANCIAL MEMORANDUM

General

COSLA is keen to ensure that Scottish local government plays a full part in the development of structures and services that set out to meet community needs. The Committee will be aware that COSLA and the Executive have recently agreed a joint commitment to five priority areas of work over the next four years. Significantly, one of these areas is health improvement whilst another key area focuses on the Joint Future agenda. COSLA and its member councils are therefore demonstrably fully committed to playing their part in ensuring health improvement is a priority on the local authority agenda.

Spending Review 2004 – Funding for Health Improvement Work

As part of the Spending Review 2004 process COSLA is working on the preparation of its submission to the Executive – timetabled for February 2004. That exercise should identify councils' expenditure projections for health improvement work and quantify what additional funding councils would require to undertake new initiatives as part of a cross-cutting, policy driven agenda. The submission is likely to address the issue of Scottish Executive funding to allow the long-term continuation of the Health Improvement Posts within councils currently funded jointly by the Executive and the NHS, (funding for which will expire shortly) In overall terms, the Committee may be interested to note that the COSLA Spending Review will focus on three key funding areas:

- Significant deficits from the last spending review
- Any new initiatives from the Partnership Agreement
- Pay and Price issues

Given the emphasis in Part 2, Section 7 of the memorandum (Promotion of Health Improvement), COSLA will ensure that an evidence based case is made for adequate financial resources for local government to facilitate the continuation of its agreed role as health improvement authorities. Given the need for a joined up approach to Health Improvement between central and local government and NHS Scotland, the financial memorandum represents a missed opportunity in the ongoing campaign to improve our nation’s health.

COSLA is happy to place on record the impetus already given through Scottish Executive funding to its own work on health improvement. Resources within COSLA have been mainstreamed across all COSLA’s work areas, as is fitting with its status as a joint priority area. This also reflects the cross-cutting, cross-service nature of health improvement work in member councils. Working closely with Health Improvement officers in councils, it is anticipated that the impact on political agendas will continue to develop in conjunction with the role of our linked work on Joint Future and Community Planning etc.

National Health Service Reform (Scotland) Bill

COSLA is generally supportive of the aims of the National Health Service Reform (Scotland) Bill with its emphasis on developing closer working between health and social care, improving community involvement and ultimately providing improved services. However, It is anticipated, that when the Bill begins its Parliamentary progress COSLA will seek to secure a number of amendments to ensure that the local authority role is fully recognised and that the NHS and councils are clearly regarded as equal partners. This will include making the direct, and we believe, obvious links to the Local Government in Scotland Act 2003 and to joint areas of responsibility with the Minister for Finance and Public Services.

This is due to the developing relationship between local government and NHS and the continuing need to ensure that, where appropriate, joint structures and joint services are established to deliver improved social care.
Financial Memorandum

The assertion in the Financial Memorandum that there will be no financial impact on local authorities of the Bill is regarded as premature. While the provisions in the Bill itself may prove to be cost neutral, work and initiatives will flow from its provisions that could have significant financial implications. COSLA’s experience with Joint Future and other areas of joint working have shown that change cannot be effected without associated costs – for example staff training, secondments, joint working groups, joint training etc. Local authorities cannot be expected to take on new work in the health improvement field without full funding. As indicated above (para 2), work is in hand as part of COSLA’s Spending Review exercise, which, it is anticipated, will cost potential health improvement development work.

Community Health Partnerships

Committee members will know that the NHS Reform (Scotland) Bill provides the legislative base for the establishment of Community Health Partnerships (CHPs) in place of Local Health Care Cooperatives and that the Scottish Executive’s consultation exercise on CHPs has just concluded. Unless the Executive has prejudged the outcome of that consultation, how can it be assumed there will be no resource implications? The structure and role of CHPs has yet to be defined locally and while it is recognised some savings may be achieved, there are no guarantees that these will in fact materialise.
9 December 2003 (16th Meeting, Session 2 (2003)), Written Evidence

I refer to your letter of 26 September 2003 regarding the National Health Service Reform (Scotland) Bill and forward comments from NHS Ayrshire & Arran as follows:

The general principles of the Bill are to be supported, however, further clarity around which services must be provided directly by the NHS and where we have options to commission from elsewhere would be of assistance.

Quality on consultation with the service has been good but some of the supporting papers which help take a longer term view to planning for service provision could have been clearer e.g. the draft guidance on the development of CHPs. The Bill cannot be viewed in isolation of the rest of the White Paper Partnerships for Care if we wish to ensure a long term and strategic approach.

Implications are further down the line and could lead to fragmentation of services unless steps are put in place to prevent this. There is also a need to ensure equity of service provision. The roles of heads of operating division and where they have parity with other senior members of staff requires further thought.

It was noted that Staff Governance was not included in the original Health Bill. To effectively show a balance across the three areas of accountability and governance this was an omission. If this is now to be reconsidered and included then employers will require to understand the implications of this in terms of employer liability.
SUBMISSION BY DUMFRIES AND GALLOWAY NHS BOARD

9 December 2003 (16th Meeting, Session 2 (2003)), Written Evidence

Thank you for giving us (Dumfries and Galloway NHS Board) the opportunity to comment on the above (as requested in your letter of 26 September)

In answer to the three bullet points we would comment as follows:-

This Board supports the general principles of the Bill and the provisions as set out and have no suggestions for addition.

We feel that the consultation has been extensive and have no comment to make on the implementation of key concerns

This Health Board has already implemented some of the Bill's provisions (in particular integrating the Health Board and the two local trusts into a single health organisation) during 2002/3) and would only comment that it is important that local health organisations will find it helpful to have some degree of flexibility in applying the provisions of the Bill.
9 December 2003 (16th Meeting, Session 2 (2003)), Written Evidence

Introduction

UNISON Scotland welcomes the opportunity to respond to the call for written evidence from the Scottish Parliament’s Health Committee regarding the above Bill. Although UNISON Scotland is in favour of some of the proposals, such as the abolition of NHS Trusts, there are some key issues that we would like to raise with the Committee. These fall into three main categories; Community Health Partnerships, health improvement and public involvement.

Community Health Partnerships

UNISON Scotland has already submitted a response to the Scottish Executive’s consultation on Community Health Partnerships (CHP’s) but it may be worth re-iterating some of the key issues to the Health Committee.

As already mentioned, UNISON Scotland welcomes the abolition of NHS Trusts as well as the commitment that the devolution of powers does not stop at CHP level but should include all frontline staff. However UNISON Scotland is disappointed that there is no reference within the CHP consultation on trade unions as a key partner within both the NHS and the proposed CHP’s.

In supporting the concept of a ‘shared NHS culture’ UNISON Scotland’s response to the CHP consultation is based on the assumption that this consultation does not directly impinge on local authority employees. UNISON Scotland believes that a ‘shared NHS culture’ would most easily be achieved by ensuring that the particular NHS Health Board under which each CHP operates directly employs all relevant staff (such as GP practice staff).

We would also support the concept of a Scotland-wide human resources strategy to provide common conditions of service across all NHS Health Boards. One issue that UNISON Scotland would wish to see developed would be the concept of associated NHS employees. This would allow NHS employees to retain their accumulated service conditions if they were to transfer their employment to other parts of the NHS in Scotland. UNISON Scotland believes that this would aid the retention and recruitment of experienced staff as well as providing opportunities for career development. For this issue to be implemented a formally constituted negotiating body, including trade unions, would need to be established at the Scottish bargaining level. Such a move would also lessen the pressures within Agenda for Change regarding the implementation of any new pay and conditions scheme.

UNISON Scotland also has some concern over the issue raised in the CHP consultation document regarding ‘local standards of treatment, access and referral’ as this could lead to a variation in care across NHS Health Board areas resulting in a ‘postcode lottery’ of care.

Health Improvement

Although health improvement is one of the key proposals, there is little detail in either the Bill or even the CHP consultation. UNISON Scotland believes that not enough emphasis has been paid to the role of maintaining and promoting the health of individuals and communities.

UNISON Scotland believes we need to move the debate on health away from hospitals and illness and onto prevention and healthy living. This includes the banning of smoking in public places, a ban on the sale of junk food in NHS hospitals and other buildings as well as the promotion of healthy eating for patients.

The Scottish Executive should look at standardising the food purchasing policy, including the introduction of UNISON’s Food for Good Charter).
UNISON Scotland believes it is absurd for the Scottish Executive to promote healthy living on the one hand and then allow private contractors to install vending machines which sell mainly junk food in NHS hospitals on the other.

In its healthy lifestyle campaign the Executive is encouraging people to eat five portions of vegetables a day. This principle should apply to NHS patients too, ensuring good practice is promoted, not only in the public arena but in the NHS as well.

Also UNISON Scotland believes that the Scottish Executive should look at introducing free school meals for all children to ensure that they all have at least one healthy and nutritional meal each day.

UNISON Scotland also supports the introduction of free eye and dental checks for all.

Public Involvement

UNISON Scotland welcomes the Scottish Executive’s commitment to securing greater public involvement in the NHS in Scotland. We believe that good practice in public involvement needs to be promoted to ensure that quality improvement is driven by the needs of patients and service users.

UNISON Scotland welcomes the Scottish Executives pledge to involve staff and trade unions in all the stages of the planning process for establishing the new Scottish Health Council. We are pleased that the Scottish Executive has shown a strong commitment to partnership working and to applying the key principles of openness, fairness and equity in handling organisational change.

However UNISON Scotland shares the concerns of those organisations that support people in their interactions with the NHS that the move to a national body might prejudice the grassroots structure and introduce more bureaucracy. We believe that it is important that any new structure should be rooted in local concerns.

UNISON Scotland welcomes the proposal that the refocused Scottish Health Council be responsible for delivering the three main functions of assessment, development and feedback. However, we share the concerns of many within the present Health Council structure about the loss of some existing roles. In particular, we would welcome local offices of the new Scottish Health Council retaining the ability to monitor local NHS services.

While UNISON Scotland is broadly supportive of the arrangements to support patient focus and public involvement at the local level, we also consider it important that local offices be allowed greater autonomy to speak on, and deal with, local issues without undue interference from the central body.

UNISON Scotland firmly believes that all public service organisations (including the NHS in Scotland) should be open, transparent and democratically accountable and should encourage active participation from users, the community and staff and their trade unions and would therefore be supportive of direct elections to Health Boards. By having such elections the representatives would be accountable to the public, there would be a better cross section of opinion and it would mean representation from right across the spectrum taking in the public, clinicians and experienced business managers.
Scottish Parliament
Health Committee

Tuesday 9 December 2003

(Afternoon)

[The Convener opened the meeting at 14:05]

National Health Service Reform (Scotland) Bill: Stage 1

14:06

The Convener: We move to item 2 on the agenda. I welcome the witnesses to the Health Committee. Our first witnesses are Christine Lenihan, who is the chairman of the Scottish NHS Confederation, and Hilary Robertson, who is the director of the confederation. We also have Alexis Jay, who is the director of social work services and housing with West Dunbartonshire Council, and Councillor Kingsley Thomas from the City of Edinburgh Council, both of whom are representing the Convention of Scottish Local Authorities.

We will move immediately to questions. Are the structural changes that lie before us necessary to improve health service delivery? How will the changes affect the divides between acute and primary care and between health and social care?

Hilary Robertson (Scottish NHS Confederation): The proposals will be helpful in bringing together primary and secondary care. The joining together—or the removal of the separation between—acute and primary care trusts and the creation of operating divisions, which will be part and parcel of the new unified boards, should allow much greater consistency and better joint working between those two sectors than is the case under the trusts.

The Convener: Do you have reservations or issues to raise or do you think that the new system will run smoothly?

Hilary Robertson: We support the principle of the unified boards.

Councillor Kingsley Thomas (Convention of Scottish Local Authorities): We also support the principle. I am not sure whether I need to declare an interest as a member of a health board and, I presume, as a member of one of the forthcoming unified boards.

COSLA sees the aims of the bill as improving patient care and the quality of service, devolving power to local communities, and strengthening public involvement in the health improvement agenda. Those are important aspects, but our submission is based on the fact that more consideration needs to be given to the role that local authorities can play in the health improvement agenda. More recognition needs to be given to a lot of the work that is going on to convert local health care co-operatives into community health partnerships as the first stage, and into community health and social care partnerships as the second stage. The work that is being done on the joint future agenda should also
be acknowledged. The bill affords a good opportunity to pull together those various strands.

**The Convener:** Thank you both for your written submissions. I noted that you said that although the bill is about partnership, councils are not referred to in the bill. Do you accept, though, that the minister would have difficulty making legislation for local authorities in a health bill? It would be difficult in terms of statute.

**Councillor Thomas:** That is the big issue when we seek to put in place any structures where services cross the divide between the local and the central. We are clear about our democratic responsibilities to our local areas and constituents, and about our responsibilities to deliver council services. Although there may be issues to do with the high-level wording of the bill, the partnership nature of the health agenda needs to be reflected more. Health improvement is no longer just a matter for the health service, because it relies heavily on local authorities too.

**Hilary Robertson:** Our preference is not to specify partners, because the danger is that if local authorities or other partners are specified, that might neglect or exclude other potential partners by implication. We would like the bill to be as all-encompassing as possible, so that health boards can work with as many partners as possible, without it being prescribed that they should only be local authorities.

**The Convener:** Might the relationships be dealt with in regulations?

**Alexis Jay (Convention of Scottish Local Authorities):** Councils see themselves as the key partners in health and social care. Many other partners and stakeholders will be involved in the delivery of services, but councils are the purchasers and deliverers of social care services, so if there is to be a partnership involving social care, we see ourselves as central to it.

**Mr David Davidson (North East Scotland) (Con):** The minister is looking for more flexibility and joint working, which is along the lines of Hilary Robertson’s evidence. Does COSLA envisage local authorities operating outwith their own boundaries, in partnership with other local authorities—given the flexible model that the health service wants to employ—and managed clinical networks operating outwith normal health board areas? Does COSLA have any difficulties with that?

**Councillor Thomas:** Certainly not. There is a role for local elected members in having more influence over how traditional health services are delivered. With the joint future work in Edinburgh and Lothian, we are discussing members’ involvement in community health partnerships and social care partnerships, so that they can bring a local democratic element to the services. It is about extending the boundaries on both sides to co-ordinate the services and reflect local communities’ needs.

**Mr Davidson:** Is that not dealt with by the virtually automatic appointment of councillors to health boards at the moment? Do you want that to continue?

**Councillor Thomas:** That is an element, but it is only the top-level element. For the whole agenda to work, we need to have structures in place at local neighbourhood level, at the level of the LHCCs or the community health partnerships. In Lothian we have eight areas, with one health board giving the strategic overview, but there still needs to be democratic input to the local structures that we are looking to put in place.

**Alexis Jay:** So far, we have seen interesting developments in managed clinical networks. The focus has mainly been on chronic disease management, but there is a lot of scope for councils to work flexibly and perhaps even take the lead in managed care and clinical networks—rather than managed clinical networks—on, for example, services for adults with learning disabilities and services for older people. Managed clinical networks have been health focused so far, but the concept is attractive, and we are interested in considering how it might work across boundaries.

14:15

**Janis Hughes (Glasgow Rutherglen) (Lab):** You have already mentioned community health partnerships, and I want to talk a wee bit more about them. COSLA submitted a fairly lengthy response to the consultation on community health partnerships. At the moment, as we all know, the details are sketchy and we are trying to elicit some of the concerns that people have. I note that one of your concerns is how the joint planning for the financing of community health partnerships would work across two ministerial portfolios. What is the thinking behind that concern?

**Alexis Jay:** We provided evidence to the Finance Committee on that, and our concern was that financing the community health partnerships cannot be cost neutral if it is done properly, because we need to invest in front-line staff so that they understand such new concepts and can take them forward. We know that fact from the joint future agenda, on which much has been achieved, but only because we invested time and resources in training staff and introducing them to new ideas.

Our other concern was that patient involvement cannot be done at no cost. If we are serious about empowering people to participate in new
structures and take up the role that is proposed for them, we must invest in ensuring that they are properly resourced to engage in participation.

**Janis Hughes:** How do you envisage joint working taking place? There are concerns on both sides. In the health service, there are concerns about being subsumed in the community planning process, in which, although the health service has been a partner, it has not had as big a part to play as is envisaged under community health partnerships. You said that you considered local authorities to be key stakeholders in community health partnerships, but our health professionals would argue that they are also key stakeholders. Will you clarify how you envisage that partnership evolving?

**Councillor Thomas:** We certainly do not think of community health partnerships as one organisation taking over the other’s responsibilities—whether that is the health service taking over the local authority’s responsibilities or vice versa. The key word is partnership, and the responsibilities that local authorities now have for developing community planning is an aspect of the community health partnerships. I can talk with two hats on—a health board hat and a local authority one—and can say from my experience that it is a question not of one organisation taking over the other, but of ensuring that they are equal partners in the important work.

**Hilary Robertson:** The Scottish NHS Confederation’s view of community health partnerships—on which we have been working with our members to try to elicit a bit more detail about how they would work, what they would look like and what they would do—is that they are about more than community and social care or primary and community care: they should also include secondary care. From the health point of view, it is important that the partnerships aid joint working and the integration of secondary and primary care.

**The Convener:** Should anything on community health partnerships be added to the bill? Also, COSLA’s submission talks about guidance being “re-drafted to avoid duplication of existing structures” and suggests that we “Re-draft CHP guidance.”

What is happening with that? I do not know what that guidance is, and we are talking about operational duplication.

**Alexis Jay:** We are concerned about the draft guidance that the Scottish Executive issued on community health partnerships. It was put out for consultation and I believe that there was a vast number of responses. We did not feel that the draft guidance was specific enough about the Executive’s vision and what its intention was for community health partnerships. There was concern that there was potential overlap with the joint future agenda that was not clarified by the guidance. We hope that the final guidance will fuse together the different strands that are currently running in parallel.

**The Convener:** I understand that the final guidance is coming out early next year. Is that correct?

**Alexis Jay:** Perhaps. I am afraid that I would not know.

**The Convener:** I am being advised about that.

**Hilary Robertson:** I will make a point about public partnership forums, which will be part of community health partnerships. We envisage there being two distinct elements to the system. The public partnership forums will be about the continuing involvement of patients and the public, whereas community planning is more about consultation. We see those as two slightly different elements of the system.

**The Convener:** I do not think that you commented on whether anything about community health partnerships should be added to the face of the bill. We are talking about guidance and regulations, but should the matter be included in the primary legislation?

**Councillor Thomas:** I am not sure exactly what you mean when you use the term “the face of the bill”.

**The Convener:** I mean in the primary legislation.

**Councillor Thomas:** As I see it, the community health partnership—and beyond that the community health and social care partnership—is the one key vehicle for ensuring that all the principles that everybody signed up to in respect of the joint future agenda can be delivered at all the various levels within the health sector and local authorities. If adding a clear reference to that in the primary legislation would give a high-level commitment to that work, it would be useful.

**Mr Duncan McNeil (Greenock and Inverclyde) (Lab):** The Scottish NHS Confederation’s submission accepts that the minister should be able to intervene where serious failures occur, but calls for more clarity on what intervention will mean. Should the definition of intervention and the circumstances in which the powers of intervention would be used be included in the bill or in regulations?

**Hilary Robertson:** It would be helpful to say in the bill what intervention means and, if possible, what the circumstances are in which it would occur. It is difficult to know from the provisions in
the bill how such intervention might work—some
clarity about that would be helpful.

Christine Lenihan (Scottish NHS Confederation): Scottish NHS Confederation members understand that, rightly, responsibility lies with health boards. There should be strong local management, particularly through the performance assessment framework, which is the accountability mechanism, and the powers of intervention should be a last resort. At the same time, there needs to be a link to the indicators on the performance assessment framework to determine when use of the powers of intervention might be required in a supportive way rather than as a last resort.

Mr McNeil: Would regulations remove the flexibility for there to be ministerial intervention in a variety of circumstances?

Christine Lenihan: No, not necessarily. However, it is important to retain flexibility where the responsibility and accountability is located, which is in the local health system and through the very comprehensive assessment framework that is in place. The detail that our members might like to see is about what circumstances might trigger an intervention, who might trigger the intervention and where responsibility for the costs of the intervention might lie.

Mr McNeil: So regulations would suffice.

Christine Lenihan: We are not of that view. Our members are of the view that the definition of the powers of intervention should be enshrined in the bill.

Kate Maclean (Dundee West) (Lab): Do you not think that enshrining a statement of when and how powers of intervention are to be used in the bill would be very prescriptive and would lead to a lack of flexibility? If the detail in the bill is too prescriptive, the primary legislation might have to be changed in the future to allow intervention in circumstances that none of us can imagine now. We can consult on regulations and change them much more easily than we can change primary legislation—that can be a reason for including a matter in primary legislation, but in this case it might be better to retain some flexibility to deal with situations that might arise in the future.

Hilary Robertson: We concede that point, but it is important that there should be clear understanding of what is meant by intervention. That will depend on the wording in the bill; it would be helpful if there were a clearer definition of intervention in the bill, although perhaps the detail about how such intervention would be triggered and who would intervene should be in the regulations.

The Convener: That could be done without listing the circumstances.

Mr Davidson: I think that the witnesses from the Scottish NHS Confederation are making the point that if accountability is the factor that is behind this section of the bill, it must be defined. I presume that if such a definition were to be included in the bill, you would also welcome a provision to allow a health board to call on the minister to intervene at an early stage, rather than wait until the end of another accountancy period—if there was a problem with financial flow, for example. Is that the kind of flexibility—on the back of a definition—that you would like there to be?

Hilary Robertson: We agree that it is important that boards should be able to ask for support; that should be clearly recognised.

Intervention should be a last resort, but it must be timely. If there are indications that intervention is required, that intervention should be supportive and take place before the stage is reached at which the system is in complete crisis and probably beyond being able to make a speedy recovery. That is the key point. It would be better to put the explanations in regulations, which could be consulted on.

Mr Davidson: In the first session of Parliament, the Scottish NHS Confederation gave evidence to the Audit Committee, of which I was a member. It was clear that the confederation was looking to future legislation to tidy up the two-way process around difficulties that arise in the health service. I think that your main point today is that you would like accountability—and how people would step into that accountability process—to be defined in the bill.

Christine Lenihan: Yes, that is right. We do not take issue with the fact that there is already a comprehensive accountability framework in place and we agree that ministers should have powers of intervention. However, there needs to be clarity about the triggers for and timing of intervention and about whether intervention—albeit a last resort—would be a late last resort. There should always be flexibility to allow those who are accountable for local delivery to be responsible for that, but at the same time, our members would like to explore the possibility of there being a series of triggers for intervention and much clearer understanding about when and why powers of intervention would be used. Invariably, the use of those powers would have to be linked to the information that is in the performance assessment framework.

Mr Davidson: Perhaps it would be appropriate for the confederation to send the committee a short document that explains exactly what clarification is required.

Christine Lenihan: We would be happy to do that.
The Convener: That would be helpful.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I would like to pursue the point, because I am now a little more confused than I was. We are talking about the requirement for flexibility, but surely to put triggers in the bill would have the opposite effect. Section 4 amends the National Health Service (Scotland) Act 1978 to include a new section 78A, on powers of intervention in case of service failure. The new section 78A(1)(b) states that the powers apply where

“the Scottish Ministers consider that the body or person has failed, is failing or is likely to fail—

(i) to provide the service, or

(ii) to provide it to a standard which they”—

that is, the Scottish ministers—

“regard as acceptable.”

It strikes me that the Parliament would be giving a tremendous amount of flexibility and power to the Scottish ministers where there was or was likely to be, in their opinion, service failure or failure in the standard to which service is provided. You seem to advocate that we should include triggers in the bill, but would that not narrow it down in certain circumstances?

Christine Lenihan: I think that we are talking about regulations rather than about the bill.

Hilary Robertson: Our plea for clarity is simply around what intervention means. Having read through the bill, we do not think that it is entirely clear what intervention would consist of. It might be helpful to define it, to say that intervention would happen in certain circumstances and to say what those circumstances are. We have already accepted the point that was made earlier, that it would be more appropriate to do that in regulations rather than in the bill.

Mike Rumbles: It seems to me that the ministers’ powers in the bill are clear and specific. Proposed new section 78A(2) states:

“The Scottish Ministers may, where they consider it necessary”—

to me, that is ultimately flexible—

“for the purpose of ensuring the provision of the service … to a standard which they regard as acceptable”—

again, that is incredibly flexible—

“direct that specified functions of the body”—

that is, the boards or whatever—

“or person … by virtue of this Act be performed, for a specified period and to a specified extent”.

So the ministers can instruct any health board or part of a health board to do whatever they want, to the standard that they specify. If the ministers are not happy, they can bring in, as stated in new section 78A(5),

“(a) an employee of a Health Board, a Special Health Board or the Agency,

or

(b) a member of the staff of the Scottish Administration.”

It seems to me that we are giving the ministers a tremendous amount of flexibility to take the decision to intervene, even before the service has failed, so I do not quite follow your argument.

Hilary Robertson: We are not disagreeing with the flexibility that the ministers will have. We are saying simply that, from the boards’ perspective, it would be helpful to understand better what the intervention might consist of. The bill mentions the ministers’ power where they consider intervention necessary or likely to be necessary. It would be helpful to the boards, who would be the recipients of that intervention, if there was more clarity about what it would actually involve.

Mr McNeil: A preference was stated in the written evidence from the Scottish NHS Confederation that intervention should be defined in the bill. That is not what you are saying now. You are saying that, on consideration, it should probably be done through regulations.

Hilary Robertson: Our written submission states that we would like a definition of intervention to be included either in the bill or in the regulations.

Mr McNeil: Your submission says that intervention should be defined “either in regulations or, preferably, in the legislation itself”.

Hilary Robertson: Yes. We accept the point.

The Convener: On a point of information, it would be useful for the clerks to provide a note; these are amendments to existing statute, and it would be interesting to see where they slot into the National Health Service (Scotland) Act 1978, because that act might contain things that expand on the issue. The bill is not a stand-alone bill and should not be considered in a vacuum, so I ask the clerks to make that information available.

Are members content to move on?

Shona Robison (Dundee East) (SNP): I will move on to the issue of health councils. I do not think that either organisation referred specifically to health councils, although you referred to public involvement. Will the national health council that is proposed by the Executive be more or less independent than the current local health councils?
Christine Lenihan: The confederation supports a strong and effective independent voice for patients. It might not be appropriate for us to comment, as NHS boards are the organisations against which complaints would be made. NHS Quality Improvement Scotland has shown its capacity for independence in principle, but patient representation will be demonstrated as the process evolves. We strongly support the principle that an independent organisation should represent patients’ voices effectively.

Shona Robison: Do local health councils provide an effective patient voice?

Hilary Robertson: I am sure that individual boards would be better able to answer for their areas, but local health councils seem to perform a useful and valued function. Our concern is about patients’ and the public’s perceptions of the new arrangements. As professionals, we and our members have confidence that the new arrangements will provide the required degree of independence, but the public and patients might not have the same perception. We would like that to be kept under review.

We would be confident that NHS Quality Improvement Scotland would be the appropriate place to locate the Scottish health council, and Quality Improvement Scotland has shown its independence, but it would be helpful to test the water and gather opinions from the public and patients to find out whether they share our view.

Shona Robison: It is a bit unclear who will provide hands-on assistance locally. Local advisory councils are proposed, but there is talk about commissioning services to provide the advice and practical hands-on assistance that patients and the public receive at the moment. Do you have a view on whether that will work, and from whom services should be commissioned?

Hilary Robertson: No.

Shona Robison: That is fair enough. You do not have to have a view.

Christine Lenihan: I am not sure whether I can answer the question directly, but I can offer the information that is emerging that many of our members are, with the philosophy of consultation, exploring new ways to engage and communicate with the public—whether or not they are patients—as individuals rather than on a representative or group basis, as has often happened in the past. The NHS has a tremendous commitment to such engagement. The philosophy behind representing patients’ views through Quality Improvement Scotland or any other mechanism is the same; everyone is committed to finding ways to involve patients and members of the public as individuals in current and future care.

Shona Robison: Does COSLA have a view on health councils and the changes?

Councillor Thomas: Since October 2001, local authorities and health boards have had closer working arrangements. Health boards are benefiting from local authorities’ experience of tried and tested methods of consulting service users and carers in social work, and from the various consultative structures that we have long had for developing measures such as community care plans and children’s services plans. That expertise is being used in planning health service matters and consulting patients on them.

We value the local health council structures. Local authorities’ experience can help those bodies to consult more widely, whether on an individual or representative basis. All the local structures that councils have, and are developing, can be used to reach citizens and to discuss not only council services, but health service issues. We are doing that in Edinburgh.

Shona Robison: Obviously, we all welcome the duty to involve the public’s being placed on health boards, but how do we avoid that effort’s becoming tokenistic? There is huge public cynicism, and for good reason: some consultation has been very poor. What needs to be done to make the duty to involve the public mean something? How do we convince the public that the involvement is genuine and not merely a nice idea?

Hilary Robertson: There are quite a number of examples around Scotland of NHS boards’ finding new ways of involving people—ways that go well beyond what would be considered to be traditional consultation exercises—boards are learning from experience. In a number of parts of the country, before they actually need them, people are being asked how they would like services to be configured or provided. While they are well—that is, before they become patients—people are being asked what they want from the health service, how the service might be provided, and what would be particularly important to them. That is a relatively new approach. Examples from around the country are being shared, but it is fair to say that there is a lot of learning to be done about how to involve members of the public meaningfully, rather than tokenistically.

A challenge is to involve people in ways that do not focus on the usual suspects—if I may use that term—or on people who have a particular interest or represent a particular group. The challenge is to speak directly to the members of that group and to the people who use the services. NHS boards have been addressing that challenge willingly and enthusiastically. A lot of good practice has been shared and there is still much to be done—it is not an easy job—but I emphasise that health boards
are tackling the challenge and that they are enthusiastic about doing so.

**Christine Lenihan:** A view is emerging from our members that traditional consultation, which is necessarily issue-specific, may not be the only way forward. Hilary Robertson describes a continuous, meaningful and thoughtful engagement with individual members of the public; that is how members of the public will have a much more fruitful and effective influence on health boards’ plans.

**Councillor Thomas:** We need more effective consultation mechanisms, but we also need more effective feedback mechanisms. From their constituency case work, committee members will know the highly personal issues that can be raised in consultations. Quite often we cannot do everything; we cannot shape our services exactly as every individual would want us to. However, we need to be better at going back to people to explain why we have made certain decisions. We may need a better balance between trying to shape services to meet local community needs and trying to make services as universal as possible.

**Mr Davidson:** There is a view that NHS QIS looks at the delivery of patient care from a technical perspective. The health councils have said that they do not wish to be part of another organisation; they wish to stand alone as a new national body in a national framework. Do the health councils have a point when they say that they consider scrutiny differently from NHS QIS? The approach of NHS QIS is very technical and has the patients’ perspective. Is that approach reasonable? I put that question to COSLA first and then to the Scottish NHS Confederation.

14:45

**Alexis Jay:** I am not sure that we are entirely qualified to answer that question from the patients’ perspective. However, we would certainly promote such an approach and hope that councils would take it with their own services. What the consumer, customer or client—whatever you want to call them—thinks of the service is entirely valid and should form part of any process for developing services. We must hear that voice.

**Christine Lenihan:** I pointed out earlier that NHS QIS has already demonstrated its ability to be independent in setting standards—we might be able to link such an approach to the establishment of standards for quality in patient care. Indeed, those standards are rapidly being established. The confederation sees no reason why, in that respect, the independence of patient representation could not be replicated along the same lines, although perhaps not using exactly the same mechanism.

**Mr Davidson:** In other words, you would not object if the proposed new health council operated outwith NHS QIS.

**Christine Lenihan:** Our membership has no issue with Quality Improvement Scotland’s early demonstration of its capacity to be independent. Of course, we did not refer to that in our brief written submission because the Scottish NHS Confederation represents the bodies against which complaints would be made. As a result, we did not feel that it was appropriate to elaborate on that matter.

**The Convener:** Do you agree that, quite apart from the substantive question whether there would be a conflict of interest in that respect, there might be the perception of such a conflict?

**Christine Lenihan:** Possibly.

**Dr Jean Turner (Strathkelvin and Bearsden)**

(Ind): I want you to confirm your views on the importance of contact within all the services as well as the importance of an independent voice outwith them. It would be good if everyone who worked in the system had the time to feed back problems that were highlighted by any one person and to marry that information with what might be happening outwith the system in the local health council. After all, I get the impression that an awful lot of patients have to contact outside bodies because they have problems with feeding into a system that should exist—indeed, does exist—in the best services. I am beginning to think that when a patient complains to a nurse or doctor, the nurse or doctor is too busy to feed it up into the system. As I said, perhaps many problems could be defused if people within our services had more time to listen to and act on them. Do you feel that your systems are robust enough to comply with that?

**Hilary Robertson:** If I have understood your question correctly, I think that the situation that you described should be covered by the health boards’ complaints procedures, which have been consulted on recently. Of course people want sufficient time to listen to patients’ views; I have no doubt that staff within all our member organisations strive to do so. I expect that, where a problem has been identified and a complaint has been made, the complaints procedure that has been reviewed recently would kick in.

Forgive me if I misunderstood your question.

**Dr Turner:** I would have thought that, in a good organisation, very few general complaints would require to be dealt with under the full complaints procedure. However, improving the situation within the system would probably even be of help to the independent voice outwith it. We should be listening to people and correcting things as we go along. I find that, whatever the system, people feel
that they are not listened to, especially when they are in hospital or are dealing with a particular department. The problem should be sorted out there and then, before it becomes a complaint.

Hilary Robertson: That comment brings us back to the continuing involvement of the public and patients in the system. I am sure that everyone would agree that, however well we listen to people, our ability to listen could always be improved.

Dr Turner: The problem is that we very much need support from outwith the system because such support is currently lacking within organisations. Perhaps you do not agree with that.

Christine Lenihan: The principle of emphasising public and patient involvement as a continuing process rather than as a response to particular decision-making processes is part of that. As Hilary Robertson said, the complaints procedures, which have recently been reviewed and which operate in all NHS boards, are another part. Underlying Dr Turner’s question is a question about the point of the commitment to listen to individuals. NHS bodies are committed to doing that and Hilary Robertson mentioned some existing examples, such as NHS Shetland 100.

The Convener: Rather than list good examples of public involvement now, perhaps you would write to the committee on that issue. It would be useful for the committee to have those examples in written form.

Christine Lenihan: We would be pleased to do that.

Mr McNeil: The Scottish NHS Confederation welcomes the inclusion of formal duties on NHS boards to involve and consult the public on the development of services and to engage with patients. Who would not welcome that? We may be sent a list of good examples, but all too often, we read about poor examples. I accept that public involvement goes across the board and does not focus only on clinical or maternity services reviews. You mentioned additional finances. For the fun of it, will you say whether we get good value for the money we spend on consultation? I will not go through all my experience—

The Convener: You are on a springboard.

Mr McNeil: Consultation gives communities the expectation that they will be part of the planning process and not simply part of the education process. Reams of guidance have been brought forth, which is bureaucratic and time consuming. As it turns out, the process is confrontational and accusations have been made that it is less than honest, which leaves everybody cynical about it. Of course consultation is a good idea and we are all for it, but—until now—it has not helped the service to move and change. Instead, the process has made politicians and communities try to prevent changes. God forbid that politicians should influence the health service, which needs to change, renew itself and move on.

I almost question whether we should proceed through consultation, especially on specific issues. The bill builds on the myth that it is a good idea to consult, even though people are disengaged from the process. Do we get good value for the money that we spend on consultation? Do we need to cut through the bureaucracy and be more honest with people by telling them what the real situation is, rather than pretend for years that they are involved, thus slowing down the process of change?

The Convener: I am listening for a question. That may have been cathartic for you, but it was a speech.

Mr McNeil: There were a lot of questions in it.

Christine Lenihan: I will pick one of them to answer. The confederation does not underestimate the challenge of finding new, different and more meaningful ways in which to involve people. Part of the context in which we live is that people expect to be involved and informed. That does not mean that consultation should be only on change. Change is inevitable, not only in the delivery of health services and health care, but in the way in which we live. The challenge is to ensure that we communicate thoughtfully, realistically and meaningfully with the people who are involved in the process.

The Convener: You said that you are moving away from consultation on specific issues. We will return to that point.

Mr McNeil: The guidelines require us to consult on time scales in a specific way that can draw the process out for four or five years. Is that right? Do we need to look at that and shorten those time scales? Are we moving things forward or holding them back?

The Convener: Do the COSLA witnesses want to come in on that point? I am getting answers from the committee members, but they can speak for themselves.

Councillor Thomas: Health boards need to engage in general continuing consultation, and I genuinely believe that that has greatly improved in recent years with local authority members being on health boards. One of the reasons why that worked was that councillors, rather than senior officers, were put on the health boards. Not only did they knock heads together, but they brought to the boards the skill that politicians have for getting out and speaking to people about things. In
general, health boards are benefiting from the experience of local authority members, which aids the process. However, if what is in question is a set of proposals to open a facility, or even to close a facility—

**The Convener:** We are all aware of which one.

**Councillor Thomas:** Exactly. I am not aware of the full details, but I would be concerned if we were to get too tied down in the bureaucracy of how we consult. If that could extend the process to four or five years, I would be extremely concerned.

**The Convener:** I would like to move on, as I am conscious of the time.

**Mike Rumbles:** How do you feel that the new duty on health boards to promote health improvement complements local authorities’ duty to promote well-being? Does it complement it effectively?

**Alexis Jay:** The short answer is that the health boards’ new duty complements the local authorities’ duty very well. If you look at the range of activities that councils are engaged in and their contribution to health improvement over the years, environmental issues have been significant, as have leisure, sports, healthy eating, education and schools initiatives. We have a huge range of networks and are therefore extremely well placed to pursue health improvement. That is the position that we are in at the moment, as the situation has developed a bit more. We would certainly welcome strengthening of councils’ role in health improvement. We might be concerned about how that is to be funded and developed, but we believe that we have a significant role to play in that area, not just in conventional social care services but in the wider remit of councils across a wide range of functions.

**Mike Rumbles:** My question was really about whether you feel that there is any conflict between what the councils are doing and the authority that the bill gives to health boards.

**Alexis Jay:** That will depend on what the guidance eventually says about the role of councils. It appears to be absolutely appropriate that health improvement is located within community health partnerships. Of course, it will depend on how the structural arrangements work out, but I am confident that we could find ways through that. I know that health improvement staff across the board have some concerns. For example, one or two have said that they might not particularly like being managed by GPs and would prefer a wider scope in which to operate themselves. That is the kind of detail that needs to be worked out, but the development of health improvement through the proposals in the bill and its location in CHPs absolutely complements the relationship with councils. I am sure that we could work closely and co-operatively in ensuring that that is carried through.

**Hilary Robertson:** The Scottish NHS Confederation also sees the two duties as being complementary. It is clearly not just for the health service to try to improve health; it is important that the functions of other bodies are also taken into account and that the health improvement focus straddles all the appropriate departments, functions and bodies.

**Mr Davidson:** I would like to broaden the scope of the question to include money, which is the root of all evil, as we know. You have both made pretty strong remarks about the lack of money for consultation, but what about money for health promotion itself? Do you feel that there is enough clarity in the bill about funding and mixed funding? For example, there might be funding from the education department in a council to promote life-improvement education, while the health board might already have allocated money to that, although it might not be listed under the same budget heading.

15:00

We have to look at cross-boundary working on mixed budgets. We have already had disputes over care, in which a health board has a patient whose care needs are being assessed, and a council has a patient or resident whose care needs are being assessed, so there are two sets of appraisals. Does the bill need to look more closely at health improvement and at how budget definitions are organised, especially given that you both said there is no extra money for consultation?

**Alexis Jay:** Quite honestly, I do not know the direct answer to that question. We hear about the negative examples, but we have lots of good examples of aligned budgets. Many partnerships work closely and have aligned budgets. My council has funded health promotion activities in partnership with two health boards with which we have boundaries. Lots of good things are going on, and organisations are working together, but health promotion and health improvement are not well funded on the ground. We tend to scratch around a bit, looking for funding to back up new initiatives and for areas that we wish to promote. However, I could not be specific about how that should be presented in the bill.

**Mr Davidson:** Would you like to write to us with COSLA’s view?

**Alexis Jay:** Yes.

**Hilary Robertson:** I have one small point. There is plenty of scope for joint working. Perhaps it would be helpful to apply the joint future model to health improvement. We note that the bill places a
duty on health boards to promote health improvement, which includes giving them powers to provide financial assistance to any person. We interpret that to mean any body or organisation. That will encourage joint working between the health service and other partners, such as local authorities and any other relevant partner. We support that. More money is always welcome, of course.

Mr Davidson: Your understanding is, however, that such measures will come out of current funding.

Hilary Robertson: Yes.

Mr Davidson: We are talking about reprioritisation.

Hilary Robertson: Yes.

Mr Davidson: Are you appealing for more money?

Hilary Robertson: No. We are simply recognising—

Mr Davidson: We have the evidence, convener. She said, “No.”

The Convener: In summary, the financial memorandum states that “Overall additional expenditure as a result of the above provisions”—

which is all the provisions in the bill—

“will be zero”.

It also states:

“As many of these proposals involve formalising or reforming existing obligations, there is no net additional expenditure”.

That is not the case, is it?

Christine Lenihan: If we are talking about the summary, we know that some of the structural changes—which is where we started our discussion—are not incurring the costs that might have been thought necessary before they were started. There are examples of single systems that are very advanced in their planning, which have management structures in place, and which are actually releasing efficiency savings that are being deployed within various health systems for other priorities. It is too early to say what will be required in terms of CHPs, but it seems unlikely that in the early days of their development there will be no need for resources from elsewhere in the system. However, on an on-going basis, that has yet to be determined.

The Convener: I am trying to work out whether that was a yes or a no.

Christine Lenihan: It is work in progress. Our evidence is that single-system working is releasing funds back into the system to be spent on other priorities. That is as much as the Scottish NHS Confederation can say at this stage.

The Convener: I recall evidence from last week that conflicts with that, which was that savings of £19 million would be made at some point following restructuring, but the money just disappeared and was never accounted for. I will have to look back at last week’s Official Report to see what it was. Does COSLA feel the same? Financial memoranda are important in all bills.

Councillor Thomas: We have already given evidence to the Finance Committee on that point. We have been clear that it is difficult for us to see how the measures can be cost neutral. The changes that we are seeking to engage and involve local communities, patients and service users will add to the cost, but it will be money well spent.

The Convener: That concludes our questions. Thank you all very much. If, on reflection, you feel that we have missed something, we would be content for you to write to the committee.

I will press on and welcome the next set of witnesses. While they are taking their chairs, I inform the committee that the videoconference with witnesses from Orkney will be on 6 January next year.

I will wait until you are all sitting comfortably. Some people will understand that reference from “Music with Mother” or “Listen with Mother”—I am rambling—it was “Listen with Mother”.

From Ayrshire and Arran NHS Board, I welcome George Irving, chairman, and Wai-yin Hatton, chief executive. I also welcome, from Dumfries and Galloway NHS Board, Malcolm Wright, chief executive, and John Ross CBE, chairman.

I ask the witnesses from Dumfries and Galloway to outline for the committee their experience of working within a national health service system that, like my area in the Borders, no longer has NHS trusts. Is that structural change necessary to improve services, and should it be rolled out throughout Scotland?

John Ross CBE (Dumfries and Galloway NHS Board): When the unified board was set up in October 2001, the chief executive and I had a long discussion about where the major challenges for Dumfries and Galloway would be, not in the next week or month, but 10 or 15 years ahead. We quickly identified for the board that the big challenge would be the demographic change in the population of Dumfries and Galloway: a 26 per cent increase in over-65s, a 26 per cent decrease in those aged 19 and below and an 11 per cent decrease in the working-age population. We realised at that stage that the status quo—a health
board and two trusts—was not an option and that we needed to think radically about how we would start to modernise services in Dumfries and Galloway if we were to cope with the challenges of the next 10 to 15 years. That was the basis of the decision, to which we came quickly, to have an integrated health care system in Dumfries and Galloway that would result in the dissolution of the two trusts.

The Convener: That is a practical example.

Malcolm Wright (Dumfries and Galloway NHS Board): After the discussion that the chairman and I had, we had a process of engagement and consultation. It took 14 months from our taking the initial idea to the NHS board and the minister giving us approval to explore different models to put in place a completely integrated structure.

When we undertook consultation with the public, the local authority and our staff, it was interesting to note that nobody was of the view that having three statutory organisations to run health services in a place the size of Dumfries and Galloway was sensible. We have a population of 147,000 and a staff of 4,200, and everyone was of the view that we could organise services better.

When we examined how patient care was managed, we came to the view that we should design our structures and processes to support the flow of patients through the NHS system. Therefore, we have set up a number of groupings that span primary care, secondary care and, in a number of instances, tertiary care, on a specialty-by-specialty basis. There are about eight or nine local groups for cancer, learning disabilities, mental health or children’s services in which primary-care practitioners and secondary-care clinicians come together with the public and staff to plan services on a regional basis and to determine how they will be run.

In a number of those services, close working with the local authority has been very helpful. Coterminality with the local authority has been a huge advantage. We have been able to do things jointly with the local authority, such as joint appointments for planning and commissioning services as well as for the delivery of services.

One of the consequences of working in a single system is that we have been able to make financial savings, although that was not the reason for doing it. We have managed to reinvest those savings in front-line patient services.

It has been helpful to remove some of the duplication that arose in the three NHS organisations. We have a single finance system, a single finance director, absolute transparency as to where the money is throughout the system, a single personnel system, and a single operational service for estates and capital planning. The fact that all those systems have come together has been helpful.

The key is the bringing together of clinicians from the primary and secondary sectors, examining how they can work in different ways, redesigning services and finding better ways of engaging the public. It has not all been plain sailing but we were glad to have gone there first. It is starting to produce benefits.

The Convener: Coterminality seems to be the key, as does getting rid of duplication. Integration could work in rural areas. It works in the Borders, probably for the same reasons as it works in Dumfries and Galloway. There are problems if people do not know one another. If the system is rolled out throughout Scotland, will it work in urban areas in the way in which you have described? There will be different local authorities involved in such areas and professionals will not know one another in the same way as they tend to in rural areas.

John Ross: That might be possible but it will take greater effort. That said, it took an enormous amount of work for us to achieve what we did. It did not just happen; we had to drive very hard to achieve our ends. There is no doubt in my mind that the bringing together of primary and secondary services and, particularly, of clinicians who work in the primary and secondary sectors, is vital to the achievement of better care pathways.

The Convener: The people part must be important. The personnel who know and work with one another have to be prepared to buy into that. That is why I am interested in what you said about urban areas.

Mike Rumbles: I want to follow up what Malcolm Wright said because it is an important issue for the committee. We seem to have a problem knowing whether money will be saved if bodies are amalgamated into one board or authority. You said that savings were definitely made, but can you quantify those financial savings? Would we be able to make some judgment about whether money would be released by the process?

Malcolm Wright: We have made local and recurring savings in excess of £500,000. However, I make it clear that that was not the reason for going down the road of integration and that those savings might not be directly comparable with savings that could be made in other NHS boards around the country.

We had a good lead-in time of 14 months and were clear about where we were trying to go. We also took the view that we did not need three chief executives or three directors of finance and so on. We started with a blank sheet of paper and redesigned everything. People were leaving the
system anyway so we were able to use natural turnover and make the move relatively seamless through considering the individuals that we had and their strengths and capabilities, rather than simply design a structure on a blank sheet of paper. We matched the structure to the people that we had.

Mike Rumbles: The Executive says that substantial savings could be found by integrating, and that the savings could be channelled into the statutory requirement to engage with patients. From your experience, do you believe that such an approach could be replicated throughout Scotland? The Executive is saying one thing but some of our witnesses, such as those from COSLA, are saying that patient engagement will cost a lot more money and will not be cost neutral. That is the committee’s dilemma.

Malcolm Wright: My personal view is that public engagement is resource intensive if it is done well. Public engagement does not necessarily mean spending more money, but it involves staff time. I will give a brief example of a project that we have developed in Dumfries and Galloway around older people’s services in Mid and Upper Nithsdale. We and the local authority jointly agreed a model of care for older people in the region. It was signed off at a full joint meeting of the NHS board and the council.

We examined a particular part of the region that had a community hospital and a range of other services. Rather than go in and say, “This is what the local model will be”, we said, “This is where we think we want to get to.” We engaged with local elected members, community groups and a wide range of stakeholders, and the local health council was involved in helping to design the model. We took a good 18 months to consider different models and to work them up in the community. The community, staff and other stakeholders came back to us to say what the best fit was for their region. The project was resource intensive, but we think that we have a much more sustainable end result, whereas a less resource-intensive approach might have backfired and not met the objectives.

15:15

The Convener: Before we move on to questions from other members, would the witnesses from Ayrshire and Arran NHS Board like to comment? Please feel free to do so, even though my question was directed to the witnesses from Dumfries and Galloway.

George Irving (Ayrshire and Arran NHS Board): We have benefited from being a near neighbour of Dumfries and Galloway and we have been involved with the progress that has been made there. In Ayrshire and Arran, we welcome the move to single-system working, which we see as a natural progression from the unified system that we have now. It is a major step from integration to a single system, and one of our concerns is to ensure that our single system is based clearly on a model involving devolved decision making and control of resources. There is a concern that we might return to the old central command-and-control model that applied to single-system health boards in the past. We must be alert to that danger, and I hope that the bill, the regulations or the policy memorandum will reinforce that expectation of devolution, not centralisation.

As far as savings are concerned, it is an evolving situation for us. Certain conditions of service have to be observed. One would not design a single system in the way in which we are having to implement it. Therefore, although savings are evolving from the process, we do not foresee major savings immediately.

Mr Davidson: With the change to divisions as opposed to trusts, you have lost out on non-executive input at that level. Has that been a major loss? You now have a much smaller amount of non-executive input to discussion at the divisional level, albeit that you have strategic input at board level. How are you compensating for that, or is it not a loss for you?

Mr Ross: In Dumfries and Galloway, we do not envisage a division. We have a truly unified system, and the minister gave us permission to increase the number of non-executives from four to six, plus me. We think that we have sufficient non-executive input and involvement in the board. Also, the board is larger because we have a local authority member, a staff-side member and a clinical member on the board. The board is therefore much more inclusive than it was when it was a health board. Our non-executive involvement is sufficient to carry out the strategic thinking and, indeed, the governance duties that non-executives have to undertake.

Mr Davidson: There was certainly an important input on the governance side in the larger health boards, which had large machinery. Have you managed to change the model sufficiently to compensate for that, and to mix strategic staff and management?

Mr Ross: We have done so in Dumfries and Galloway, but I would not say that the model could be followed in larger areas, where there would have to be divisions. Our model is particular to Dumfries and Galloway, and I would not necessarily advocate its use elsewhere.

George Irving: We welcome the increase in non-executive input to the board, but we do not
Mr Davidson: Do you base your thinking on a geographic model of representation at non-executive level, or is it based simply on skills?

George Irving: It is based on skills.

Dr Turner: I was interested in the comment that primary and secondary care people talk more to one another, as that is essential if the system is to become more efficient. It might be too soon to find out whether patient waiting times have been reduced or whether patients are more satisfied in the long run, but have you noticed whether patients are treated better in the unified system and go through it more quickly? I imagine that that might well be the case.

John Ross: I will give an outline answer and ask the chief executive to be more specific.

It is too early to say, because we have had a change of culture as well as a change in our way of working. In the past, the culture was that clinicians in primary and secondary care worked in their own fields. The chief executive can give one or two examples of issues on which we are beginning to see improvements in the patient pathway, which is the most important improvement for patients.

Malcolm Wright: One of the advantages has been the development of integrated strategies across primary and secondary care. I mentioned the groups for mental health, learning disabilities and cancer—the improvements on those issues are not directly down to integration, but they are all part of the process. We have Scotland's first managed clinical network for coronary heart disease, which is a good example. Patient representatives, who are supported by the local Hale and Hearty Club of patients with experience of using coronary heart disease services, sit round a table with primary care and secondary care clinicians. The network involves good dialogue on matters such as pre-hospital thrombolysis, door-to-needle times in the hospital and resuscitation issues such as resuscitation training in the hospital. I am not saying that we have gained huge improvements yet, but plans are in place that will allow us to make major advances in the future.

We are pressing down hard on overall waiting times in the system. We have met the Scottish Executive targets on waiting times in the past and we intend to do that this year. We are carrying out significant cross-system work that we have never done before to examine out-patient journeys. We have just approved a study of how we manage bed capacity throughout the region. The study will examine capacity in community hospitals, Garrick hospital in Stranraer and Dumfries and Galloway royal infirmary and will consider how to manage the beds as a single system. In the winter in particular, the infirmary comes under a lot of pressure and we might not use capacity in the community hospitals to maximum effect. The discussions are on-going, but we have the required mechanisms to drive the proposals forward.

Because we have a single board, management team and clinical integration group, and single groups for primary and secondary care for different disease groupings, many opportunities arise for dialogue and for planning throughout the system. We are starting to make improvements, but we have a long way to go.

The Convener: Kate Maclean has a question.

Kate Maclean: I want to return—

The Convener: Sorry, Wai-yin Hatton wants to speak. I have done it again—just because I used to be a Gallovidian, that does not mean that I am biased.

Wai-yin Hatton (Ayrshire and Arran NHS Board): I want to offer two pieces of evidence from Ayrshire and Arran. Although we have not yet gone down the route of formal integration, through the change in culture by which GPs and consultants work more closely we have reduced significantly the dreaded plastic surgery waiting list. The GP who is the chair of the area clinical forum spent a week reviewing the list, as a result of which some patients were rightly re-directed and treated more immediately.

The other example is similar to one of the examples from Dumfries and Galloway. Because clinicians now work together, they have found different ways of working. For example, there is a lot of pressure on our accident and emergency capacity, but GPs now naturally volunteer to do various locum sessions to help to ease the pressure. Such automatic and systematic volunteering was not so obvious before, because people saw themselves as being from two different legal bodies.

Kate Maclean: I have a couple of questions that go back to previous answers. Malcolm Wright said that an ancillary effect of restructuring was a £500,000 saving. The figure does not really mean anything on its own; what percentage of your budget does it represent? Will there be recurring savings of £500,000 year on year? Where is the money going? Is it committed to your health authority area and has it gone into improving services?
Malcolm Wright: It is £500,000 out of a total turnover of more than £170 million, plus the capital allocation to the board. The figure is significant but not massive. On 1 April, when we signed off our health and community care plan, we were able to put £1 million of investment into new clinical services. We were very proud to be able to do so. We were able to increase nursing staffing levels in Dumfries and Galloway royal infirmary, and to invest in a consulting gastroenterologist and in our infection control capacity. A list of things was on the stocks and prioritised and we were able to use some of our development money plus some of our savings.

We face huge challenges with the development of community health partnerships. We will have to consider the capacity of CHPs—in terms of management and clinicians—and how we will build critical mass within CHPs.

The Convener: We will come on to that topic shortly.

Malcolm Wright: Yes, but when we invest resources in future, community health partnerships will be up on the list.

Kate Maclean: You said that you had cotemporary boundaries with your local authority. Does that make things easier than they are, for example, in my health authority area of Tayside, which has three main local authorities and a significant involvement with another two? Is such a set-up much more complicated?

Malcolm Wright: Having cotemporary boundaries makes things hugely more straightforward. We are not talking just about health and the local authority; the police force and Scottish Enterprise Dumfries and Galloway also share the same cotemporary boundary. We are able to design community planning on that basis—and not only at regional level. While we were going through our restructuring process, the local authority was going through a parallel restructuring process. We have tried to design our local health care co-operatives along the lines of the local community planning boundaries. We have local council ward boundaries that are cotemporary with local health care co-operative boundaries. That may be the way forward for CHPs. We have a lot of coternosity right the way through, which makes it much easier to plan for the future.

Kate Maclean: So, taking evidence from you is probably giving us the best-case scenario.

John Ross: I would say so.

Helen Eadie (Dunfermline East) (Lab): The best-practice group report has acknowledged that the development of local health care co-operatives has been patchy across Scotland. Community health partnerships are expected to evolve from the LHCCs. Will practice improve substantially by giving CHPs a statutory basis? Much of the detail of how they will work will be subject to guidance.

The Convener: Let us start with Ayrshire and Arran for a change. You go for it—Dumfries and Galloway is always pushy.

George Irving: But we are always very interested to hear what is going on in Dumfries and Galloway.

We certainly welcome the evolution of LHCCs into CHPs. The CHPs are a different animal altogether. The LHCCs are very much in the NHS family, but the CHPs, which involve health and social care, are quite different.

We are fortunate in that our NHS board area encompasses three local authorities and our current LHCCs—we have three—are cotemporary with them. Structurally, we are well geared up for the CHP route. However, we have some concerns. I heard the COSLA representatives talking about the Local Government in Scotland Act 2003. Local government is rightly sensitive about the introduction of CHPs. In an addendum to the National Health Service Reform (Scotland) Bill, or in some form of regulation, it would be advisable at least to refer to the local government legislation. That would be a tactical move, because we are heavily dependent on our local authority partners.

The issue of the involvement of general practitioners was always going to be difficult. We are fortunate that all our GPs have opted in, but they could equally well opt out. Health service personnel have a statutory duty, but GPs do not. That was also a weakness of the LHCCs.

The concern has been expressed that we should not let CHPs become dominated by clinicians or general practitioners. We welcome CHPs very much and we are geared up for them—I think that we will implement them quickly—but we make some cautionary comments.

15:30

John Ross: I concur with George Irving. In Dumfries and Galloway, we were a bit concerned that minimum population figures were initially assigned to community health partnerships. We have four LHCCs, and as our population is 150,000, those LHCCs are small. However, as my chief executive said, those LHCCs' boundaries are cotemporary with the boundaries of the local authority area committees.

I am slightly concerned that if one community health partnership covered the 147,000 people in our area, it might negate the gains that we have made from close integration of primary and secondary care. I hope that the bill will allow flexibility for different health board areas to decide
becoming paranoid about that.

Case I cut short some witnesses again. I am

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Arran NHS Board again.

I have not taken a response from Ayrshire and

for moving forward. That is fine.

We could easily lose sight of that if the new bodies

a big advantage. Having a statute behind that will help.

Helen Eadie: You all support the statutory basis for moving forward. That is fine.

The Convener: I call Janis Hughes—I am sorry; I have not taken a response from Ayrshire and Arran NHS Board again.

George Irving: I will respond to Mrs Eadie's point about the statutory basis. We have concerns about the proposal to make CHPs sub-committees of NHS boards and our major reservation is about locking CHPs firmly into the committee structures of NHS boards. We expect CHPs to have a wider role than that. We consider the CHP to be the vehicle for the joint future agenda and a local vehicle for community planning. CHPs have huge potential and need statutory underpinning, but they should not be too locked into the health system.

Helen Eadie: That concerns the equality issue and the importance of involving the community in planning, which relates to earlier discussion.

The Convener: I am loth to call Janis Hughes in case I cut short some witnesses again. I am becoming paranoid about that.

Janis Hughes: My question is about Ayrshire and Arran NHS Board's submission, which says:

"Implications are further down the line and could lead to fragmentation of services unless steps are put in place to prevent this."

Will you be specific about that? The bill is supposed to lead to better partnership working, so I am interested in your comments on fragmentation.

Wai-yin Hatton: We support fully the devolution agenda, which can be readily achieved through good delegation schemes, so that people who are on the front line know exactly the parameters and who has authority without having to keep returning to the health board.

We flag up two matters about which we are cautious. In an area that is as big as Ayrshire and Arran and which has a wide range of social problems and deprivation, we must ensure that we do not lose sight of the need to reduce inequalities in health when devolving powers to the front line. We could easily lose sight of that if the new bodies become autonomous infrastructures. Strategic clarity about the health issues that need to be addressed must be tied in.

The Dumfries and Galloway model probably highlighted some benefits of the economies of scale that can be gained from coming together. In a way, that is the opposite side of devolution. In supporting devolution, we must be cautious to avoid fragmenting potential teams. Ayrshire has three teams of different professionals but, in some areas, a team of professionals who are difficult to recruit might be lost. It is a question of ensuring that there is a good balance between a devolved structure, economy of scale and the maintenance of good professional standards for the whole county.

Janis Hughes: What steps could be taken to address the concerns that you have raised?

Wai-yin Hatton: Even though we have not yet come together as one legal body, we have been working together in that direction. All the decisions about changes and redeployment are taken jointly through a corporate team, which consists of chief executives and directors from the board and the two trusts. For the past year, we have been examining and assessing situations and problems together, to ensure that we consider all the different aspects before we come to a decision. That way, no one party or locality can take a decision in isolation, without taking account of the potential impact on other key colleagues.

George Irving: A further point is that, from next Wednesday, we will start operating as a shadow board for the new single system, while the current board works itself out of existence. The shadow board is now empowered to set up the new system—that is virtually what it is there for. Between now and next April, such issues will be on the agenda. We are fortunate that, this week, we received ministerial approval for the non-executive appointments. We can kick off fully as a shadow board next Wednesday. That will be important for us.

Janis Hughes: You think that that kind of proactive working will lead to a situation in which fragmentation will not occur.

George Irving: We are very committed to devolution and to equality throughout the area, but we do not want devolution to lead to dissolution and fragmentation. We want to ensure that there is a strategic centre for a highly devolved operational system.

The Convener: Does Dumfries and Galloway NHS Board wish to comment?

Malcolm Wright: No.

Helen Eadie: I overlooked a question. I meant to ask whether anything more on community health partnerships should be added to the bill.
George Irving: We are reluctant to propose changes on community health partnerships because that might remove flexibility. The policy memorandum and subsequent regulations are much more important than what is included in the bill.

However, I think that the bill should include a reference to the Local Government in Scotland Act 2003, given local authorities’ powers in relation to well-being and community planning. In Ayrshire and Arran, we are comfortable with the clear lead that local authorities must give on community planning. We firmly believe that that is where that responsibility should lie. The health authorities’ role in contributing to the community plan has major implications for the local health plan. At the moment, there is duplication in those plans, time scales are not being synchronised and worthless work is being done. That vehicle is also within the community planning partnership and it could be referred to in the main body of the bill.

Mr Davidson: I have a brief follow-up to Helen Eadie’s question. In my health board area, there are three local authorities—which, coincidentally, is the same situation as in Ayrshire and Arran—and there are three different joint future documents. It is not just the different geography that accounts for the fact that the documents are not identical. I want to tease that out. I understand why both boards seem to be keen on working closely with local government. Does Ayrshire and Arran NHS Board see a need for agreement on a single document throughout the three local authority areas or are you happy to have different documents?

George Irving: There is certainly a wide variation in needs and equalities—or inequalities—in the Ayrshire authorities. We think that local authorities should reserve their right to have community plans for their areas. As a board, we contribute to those plans. We do not send teams of people to the relevant meetings; a small number of the board’s senior officers take a common view and consultation is not included in the bill.

Mr Davidson: I have a question for both boards. You have heard us talking about the proposed new national Scottish health council. Will you give us your views on that? Do you feel that it will be more independent than the local health councils and do you have any concerns about the loss of local representation? Do you think that the new local advisory committees and the new consultation duties will make up for what you have now?

Malcolm Wright: I will start to answer that. The proposed new system will offer a number of advantages, particularly in relation to consistency and scrutiny of public involvement processes within NHS boards. In our area, we have positive experience of working with our local health council—it has a continuing involvement with us in the management and development of strategy and it works with us to design how we go about public consultation.

There is some advantage to linking the new Scottish health council with NHS Quality Improvement Scotland. I agree with previous witnesses that NHS QIS has developed a track record of impartiality, so having the national health council linked with NHS QIS could be helpful. However, the key will be whether boards such as ourselves can develop a good working relationship with whatever structure is put in place at a local level. How things play out at the local level is the key, together with national consistency.

John Ross: I will provide a point of clarification. I agree with our chief executive that we have a good, strong local health council in Dumfries and Galloway; it is a useful sounding board and is able to question the decisions that we take. However, it is not entirely independent because Dumfries and Galloway NHS Board pays the chief executive’s salary and the board’s chief executive line manages the local health council’s chief executive. The local health council does not have total independence. Under the new arrangements, it might be even more independent than it is now.

Mr Davidson: Point taken.

Wai-yin Hatton: Ayrshire and Arran NHS Board has a slightly different view. Even though we have a very good working relationship with our current local health council—the chair of the health council sits as an adviser at the board table—we feel that the health councils should be much more independent. If they are not, their actions may be compromised even though they are doing the right thing.

We are going through a raft of challenging service changes and the health council has been positive; it has provided constructive criticism and support. If health councils are genuinely independent of the NHS system in its widest sense—even independent from NHS QIS—they will be a genuine independent patient advocacy and consultation group. They would not be compromised and people could not accuse them of having potential conflicts of interest. We have a slightly different view from that of other board areas.

Mr Davidson: I ask the representatives of both health boards what your public think of the local health councils and the changes that will take
place. Will they understand the differences that the changes to the system will make?

John Ross: To be honest, I do not believe that they will understand the differences. In some cases there is confusion in the public mind between the health council and the health board. I do not believe that the public would have strong views one way or the other.

George Irving: It depends on the profile of the health council locally. We have been fortunate that, due to circumstances, the health council has recently been involved in, for example, a major transport survey. The health council was involved in that survey independently of the board and it fed into the board. The health council has taken a lead in recent consultations on specific issues; that has elevated its profile and increased public interest in it.

I do not think that the public would see a huge difference, but I verify our chief executive's comments that we believe that we should avoid institutionalising the proposed Scottish health council. We are not in favour of attaching it to NHS QIS, which has a clinical focus. The Scottish health council will have an independent lay focus. We would prefer those two bodies to be separate.

Shona Robison: Both health boards have said that the public may not notice a difference between the existing and proposed arrangements, but members of the public will notice a difference if they go along to get help with the complaints procedure or want to make a complaint. Currently, the local health council can walk the ward unannounced, but in the new set-up that will not be allowed, as the new Scottish health council will not have that advocacy role. It is explicitly stated that all that it will have is the role of monitoring the public involvement duty that the health board will have. Who will undertake the local health councils' current tasks, such as face-to-face contact with the patient who is guided through the system when they want to make a complaint?

George Irving: I did not read the policy memorandum as making as clear a statement as that.

I understand that the Scottish health council’s advisory and local role—its link with local voluntary organisations and so on—and its monitoring function inevitably mean that it will raise issues, and rightly so, with the health service.

15:45

Shona Robison: The Minister for Health and Community Care’s view seems to be very much that the new Scottish health council will not have an advocacy role. Advocacy services will have to be commissioned at local level. That is my understanding of what has been proposed and is probably what is causing so much concern. For me, that very clear advocacy role will be lost. Although we are all in favour of making public involvement a duty, such an approach is not exclusive of the role that is played by local health councils. As it stands, the proposal does not follow the advocacy route. Instead, it seeks to ensure that public involvement will be monitored and, presumably, that advocacy services will be provided in some way, although not directly by local health councils. Are you concerned about that?

George Irving: Yes.

Shona Robison: If the proposal goes ahead, are there any obvious organisations in your area that would provide the advocacy service that is currently provided by the local health council or are you concerned that there are no such organisations?

George Irving: Although there are specific advocacy groups, needs groups and patient groups, there is no general service as such. I would be concerned if the local health councils lost that role completely. That said, my reading of the proposal was slightly different. I thought that flexibility would still be available if the health councils chose to avail themselves of it. I would expect that if they are to link with local organisations, monitor their performance and advise them accordingly, they would raise such issues—or arrange for them to be raised—with the health service.

Shona Robison: So you want the replacement local advisory councils to have the direct advocacy role that local health councils currently have. Indeed, you would be concerned if they did not have such a role.

George Irving: That is right.

Malcolm Wright: I am also concerned about where the proposal might lead. Our experience locally shows that the council and the NHS jointly commission advocacy services, which means that a single advocacy service plays into both the local authority and the health service. At the moment, that service happens to be provided by the local health council as a sort of arm’s-length organisation. I am concerned about where that will go in future and about whether those functions will be carried out by the local grouping or some other body.

Shona Robison: As it stands at the moment, it appears that no significant additional resources will be allocated in this respect other than what can be freed up through the reorganisation of services. Will public involvement cost money and, if so, where will the money come from?
John Ross: We will not necessarily have to shell out a lot of money to meet public involvement obligations. However, it will be costly in the sense that it will take NHS personnel-time to consult adequately and properly. As my chief executive Malcolm Wright has indicated, we have just found that to be the case. However, I see it as part and parcel of something that we will have to do in Dumfries and Galloway if we are going to modernise services. We have to dedicate the management resources that are required to consult meaningfully with communities where it is important to modernise services. That said, I do not want to put a figure on the percentage of our spend that will specifically be allocated to public consultation and involvement.

Wai-yin Hatton: Our campaigns cost additional staff time because we have to hire public places that are accessible and organise campaign material and leaflet drops to every household. However, one recent example highlighted the fact that, although such an approach resulted in additional costs, the proposal was enhanced before the health board considered it. The weighting of the criteria was changed in our appraisal exercise and public engagement led to two further options being offered. I hope that in such circumstances the public will understand the reasons why a preferred option is ultimately chosen because of the information that they receive and because they know that we genuinely take their views on board.

We have also initiated a partnership discussion with a range of public sector partners to find out how we can take advantage of each other's transport networks and improve people's access to hospitals and primary care locations. As a result, although a cost is involved, there is also a tremendous payback. We are simply investing in the improvement of future health services.

George Irving: As far as cost is concerned, there is also a duty on us rigorously to review how we currently undertake public consultation and how focused that consultation is. There are different forms of consultation; explanations in some cases and engagements or full consultations in others.

Sometimes we blindly rush into consultations because they are expected of us, and we do not effectively key into local authority systems, some of which are well established. In our area, for example, there are citizens' juries—whether we think that those are positive or negative—and we could key into such bodies to avoid consulting people over and over again. Consultation and feedback can be sought on general or specific NHS services, but sometimes consultation is simply an over-elaborated explanation cloaked in the guise of consultation.

We must be more sophisticated about how we undertake consultations. For example, we have recent experience of meetings that were very counter-productive, both for the public and for the NHS. We must be clear about what we mean by consultation and how we do it. Savings can be made if consultation is done properly, but effective consultation can be costly.

Shona Robison: I think that we would all concur with that.

Malcolm Wright: I highlight two other matters. First, although the health service is changing, there are still training costs for educating staff about involving the public in the design and running of services.

Secondly, in Dumfries and Galloway, one of the actions in the community plan is to streamline the consultation processes that take place across public sector agencies. We have learned how to use existing local mechanisms, such as the seven local area committees.

In a rural area, the GP out-of-hours service presents a big challenge. We have engaged with the elected members on the local area committees and with members of the public to discuss the challenge and try to devise the models of care that will be available in the future. It can be advantageous to link in with the local authority.

Dr Turner: NHS boards will have a duty to promote health improvement. Will that be beneficial and, if so, in what way?

Wai-yin Hatton: We very much welcome the increased emphasis on and clarity about health improvement. At the end of the day, I am a patient as well as a member of the health authority.

I listened to witnesses who spoke earlier and the role of local authorities in community planning and community health partnerships demonstrates that the health service alone cannot deliver health improvement; there is inter-dependency. The bill gives us a greater chance of ensuring that we systematically work with our key partners. In a number of areas there are signs that funds are being pooled, rather than just aligned, and decisions about how we deploy resources—be those money, facilities, accommodation or people—can mean that we tackle health improvement more effectively.

A question was asked earlier about managed clinical networks. We are looking at integrating the health promotion functions of the board, the trusts and the local authorities, to see how we can take advantage of the managed health promotion network concept to continue to work with our external partners to improve health.

Malcolm Wright: We also strongly support the inclusion in the bill of the duty to promote health.
improvement and the alignment with local authorities to consider money that is provided by the Scottish Executive. For example, the better neighbourhood services funding that the Scottish Executive provided to Dumfries and Galloway Council was discussed with community planning partners and then used to put in place a range of new facilities, such as youth clinics and youth services, which we used directly to focus on, for example, teenage pregnancy rates in the region.

We have made a commitment to endeavour, year on year, to increase the moneys that go from the general NHS allocation into ring-fenced health improvement programmes. On 1 April we were able to allocate £100,000 towards building more capacity for health improvement, for example, by taking forward smoking cessation programmes across the region. The bill reinforces a direction of travel to which we are already committed.

The Convener: Presumably, if the promotion of health improvement becomes a statutory duty, health boards will be entitled to more funding when they negotiate with the Executive.

Malcolm Wright: We get the money from the Executive anyway—

The Convener: That is not on the record; you will have to say something more—

George Irving: More optimistic.

Malcolm Wright: It reinforces our local work if money is put into such initiatives.

The Convener: I was being helpful. I will move on.

Mike Rumbles: My question is directed at Ayrshire and Arran NHS Board. In your written submission you referred to an omission from the bill, in that staff governance was not included. How would you like staff governance to be represented in the bill? Would you like the Executive to produce an amendment to ensure that health boards have a system in place to monitor and improve the governance of NHS staff?

Wai-yin Hatton: Something was put out for consultation, which we were pleased to see. In addition to setting up governance committees within each NHS board, staff governance needs to be elevated to the same level as clinical governance, because our biggest investment and asset is our staff. If we do not properly look after their health, well-being and conditions—and I do not mean pay conditions—potentially we will have a depleted group of staff to tackle the winter pressures. They might end up being patients themselves because of stress. If we are to compete with other industries so that good staff remain within the public sector, we need to give them genuine evidence of commitment, as well as evidence that we value them. That is why we feel strongly that the staff governance component needs to feature more prominently and explicitly in the bill, so that all bodies are required to deliver on that.

Mike Rumbles: I would be interested in any other comments.

John Ross: I support that.

The Convener: Thank you for your evidence. That concludes this evidence session. I will suspend for a few minutes. People have been peeling off, which is a warning to me. You are welcome to have a coffee. The same goes for the Unison representatives, who are about to give evidence and who have sat here patiently.

15:56
Meeting suspended.

16:04
On resuming—

The Convener: I welcome the very patient Unison representatives, who are, they tell me, in need of the health service because they are both suffering from the cold; I am glad that they are both sitting some distance away from me. Jim Devine is the Scottish organiser for health, and Danny Crawford is the chief officer of Greater Glasgow Health Council; both are from Unison. I know that they listened to the earlier evidence, which is helpful.

Janis Hughes: Your written evidence welcomes the abolition of trusts, but you make a number of points regarding community health partnerships, about which, as you will have heard from previous evidence, we are asking a lot of questions. As you know, following consultation much of the detail will be set out in regulations. Is there anything on community health partnerships that you would like to see in the bill, rather than in guidance?

Jim Devine (Unison): I will make a wider point. I was a member of the Bates committee that examined human resources and the joint future agenda, and I had genuine concerns. We have heard a lot about coterminosity. If we started with a blank sheet of paper, we would be talking about coterminous local authorities and health care bodies. Single-status agreements are coming to local authorities and agenda for change is coming to the health service.

Some of the advanced initiatives on the joint future agenda and LHCCs are falling down when it comes to bringing together workers from different partnership organisations that have different terms and conditions and different grievance and disciplinary procedures. There are major issues—for example, nurses have issues about
professional accountability. We even face the basic problem that some local authorities take a holiday on a particular Monday while the health professionals’ holiday is the following Monday. The locality manager is employed by the health service and the local authority, but the situation may mean that services are shut.

We have to learn lessons. As a trade union, our concern is that although the initiative is good, we need to have more meat on the bones. I do not want to be prescriptive, but guidance needs to be produced on issues such as similar terms and conditions, grievance and disciplinary procedures, and accountability. Prior to becoming a full-time officer, I worked on the first primary psychiatric team to be based in a general practitioner practice. People began with enthusiasm, but they quickly learned that the colleague beside them from social work, who did exactly the same job, was on £3,000 or £4,000 more than they were, which created major difficulties. Guidance should be produced on the HR agenda. Staff who are employed by GPs should come back into the national health service. It has to be clear who the employer is and what the procedures are.

Janis Hughes: That is an important point, which you made strongly in your consultation submission. You say that you would like guidance. In your written submission, you mention local standards of treatment, access and referral, which you say could lead to a postcode lottery. Could that issue be dealt with in guidance, or would you prefer it to be included in the bill?

Jim Devine: This afternoon’s debate has been partly about involving patients and staff. That could include having a Scottish strategy to examine what we are trying to do and the difficulties that we face; it should also include minimum standards. I am not convinced that we should have the current targets, because they give the health service a terrible kicking, which has a demoralising effect on staff. We can talk about national minimum standards, and targets that are agreed locally with community involvement. It is not about saying that if Danny Crawford is in Glasgow and I am in Edinburgh, he will get a better service. There is a need for a minimum level of service. That is part of the earlier debate that you had about involvement.

The Convener: Does Danny Crawford wish to add to that?

Danny Crawford (Unison): No.

Mr Davidson: On the front page of your submission, you comment that you seek “common conditions of service across all NHS Health Boards.”

but you have not qualified that in relation to qualifications or responsibility. Does that mean that Unison is against anything other than a uniformly applied core arrangement? Are you in favour of flexibility to allow health boards in which there is a key shortage to attract staff to an expensive housing area or to somewhere that does not have the normal facilities that we might expect in the central belt?

Jim Devine: One of the problems that trusts created was that they had the right to determine local pay bargaining, the consequence of which is that we have staff working alongside one another on different terms and conditions. The differences are often minor, but they exist. For example, if you were on a trust contract, your annual leave entitlement would be less than mine would be if I had worked for the past 20 years in the national health service.

In the comment that you quoted, we are saying that, before we introduce agenda for change and get back to standardising the care that we want throughout Scotland, we need to get back to standardised terms and conditions. We need to have the baseline; if we do not have the baseline, we cannot introduce agenda for change, because, if terms and conditions are not standardised, we cannot introduce a pay modernisation system. It is frustrating enough to work on a joint future project or in an LHCC beside somebody who is on different terms and conditions, but I am sure that you can appreciate how much more frustrating it is to work in Stobhill hospital in north Glasgow alongside a colleague who is on different terms and conditions.

To be fair, we have sat down with the Scottish Executive and negotiated the low-pay deal, which has meant a standardisation of terms and conditions for ancillary staff, administrative and clerical staff and many nursing staff. As part of that agreement, we have a commitment to standardisation of terms and conditions by, I think, October 2004.

In the paragraph of our submission that you quoted, we make a point about associated employee status. That is very important, because we will not get the flexibility that we want in the delivery of care throughout Scotland if we have a Scottish strategy but do not introduce associated employee status. If Janis Hughes worked for Greater Glasgow NHS Board and left to go to, for example, Lothian NHS Board, she could lose a lot of her conditions of service. Doctors, on the other hand, have associated employee status, so they can move throughout Scotland and carry their conditions of service with them. That is not the case for nurses, porters, domestic staff or administrative and clerical staff. Although it might be argued that, because associated employee status concerns employment legislation, it is not a devolved matter, the advice that we have from our
lawyers is that there is something in the National Health Service and Community Care Act 1990 that would allow the Scottish Parliament to introduce associated employee status.

Mr Davidson: It would be helpful if Unison could draw up a note to clarify its reference to that act.

The Convener: It would be. I was not aware of what happens when staff move about.

Kate Maclean: There have been problems with staff moving to the care commission from local authorities and health boards and having different conditions and pay—that has caused some bad feeling. Do you want the bill to be delayed until the situation can be clarified and something can be firmed up on common conditions? From a previous life, I remember harmonisation, which came before single status, which the employer and employee sides have failed to implement. Single status has been around and agreed for years, and I do not think that we have reached the stage at which it will finally be implemented. If we had to delay the bill—which, in other aspects, would be an improvement—we would probably have to delay it for a long time to get agreement on conditions.

Jim Devine: Unison would not want the bill to be delayed, because it sends out a lot of positive messages. When I worked in the Scottish health service, staff were employed by the Scottish health service. I hope that we go back to that system, because that would send out a powerful message.

When the number of trusts went from 47 to 27, there was a 25 per cent reduction in the number of senior managers who worked in the Scottish health service. That money was diverted somewhere; I am sure that it went into patient care services. In the earlier evidence, you heard the arguments from the NHS boards in favour of a single system, but there are many other arguments. For example, purchasing policies among the four trusts in Glasgow are all over the place—one trust buys beds here and the other buys beds there. When the trusts come together, the purchasing policy will be improved. Simple matters such as that are one of the advantages of the system and would provide savings.

Mike Rumbles: I appreciate that you support a Scotland-wide human resources strategy for terms and conditions, but how relaxed are you about having different terms and conditions north and south of the border?

16:15

Jim Devine: The union supports national pay bargaining and, to be frank, we would be daft to throw that system away. We have recruitment and retention problems in Scotland, but there are greater problems elsewhere. For example, the vacancy level for nurses in Scotland is about 1.8 per cent, whereas London hospitals have a vacancy level of 30 to 35 per cent. That situation allows us to tap into the benefits of national bargaining. However, the other side is that we should have the right to tweak the machine in Scotland, which we have done. For example, through the low-pay deal, ancillary staff members now earn £5.35 an hour; that rate is not great, but it is different from the rate south of the border of £4.62 an hour. If you were to say that I want to have my cake and eat it, you would be quite right.

Mike Rumbles: I want to pursue the issue because it is of interest to me. In your job as a negotiator you want to get the best terms for your members, but if the Scottish Executive could give enhanced terms and conditions to your members in Scotland, would it be a difficulty that those conditions would not apply south of the border?

Jim Devine: No. We have already negotiated different conditions. That has caused me personal difficulties with my national officers, but it is not a difficulty for our members. If the Health Committee wants to give us a 10 per cent pay increase, we will happily accept that.

The Convener: Now I know why you are a negotiator.

Mr McNeil: My question is a little less exciting, but it is about a major issue. Unison's evidence states:

"we need to move the debate on health away from hospitals and illness and onto prevention and healthy living."

I am sure that everyone would agree that that is taken as read. Do you accept that the proposed duty on ministers and health boards to promote health improvement at least starts us on that journey?

Jim Devine: Yes. The important role of local authorities in promoting health improvement, which was mentioned in earlier evidence, must be considered. There have been great initiatives, such as the free entry into swimming baths in Glasgow. Health care must be considered in its broadest sense. When I worked in primary care psychiatry, I saw no one who had already been seen by a psychiatrist, but I was involved in taking people off medication. We held surgeries in a local leisure centre, which made people feel comfortable about access to the service. A few weeks ago, Greater Glasgow NHS Board had nurses in bookies' shops. Such initiatives are to be welcomed because we must get the message out.

A few weeks ago, I made a speech about an ethical health policy, although as I am Robin Cook's election agent, it is probably dangerous to
talk about that. We need to consider broader partnerships with local authorities and other bodies. We advocate banning smoking in public places. Our trade union believes that it is not acceptable for people, in effect, to kill other people while they are going about their work. That is a major health and safety issue. It is absolutely daft that people can walk into an NHS hospital, where health is supposed to be promoted, and see at the front door a vending machine that sells junk food. Simple strategies that can be implemented are to be welcomed.

**The Convener:** Do hospitals make money from those vending machines?

**Jim Devine:** I suspect that they do.

**The Convener:** That is why hospitals have them.

**Mr McNeil:** That is a simple point, but the problem is that a shop outside the hospital could sell the same items in abundance. Do you agree that although such initiatives can be debated and considered, they are complementary to overall health provision and would not necessarily reduce demand for health services or the need to provide acute services?

**Jim Devine:** I know where Duncan McNeil is trying to take me. It is interesting to read reports about the situation in Finland 15 years ago, when it had a greater problem with coronary heart disease in particular, and the situation there now. A community-based Government-driven campaign has been undertaken in Finland on healthy living, healthy lifestyles and healthy eating, and now it is being said that the demand on acute services is less. It would be wrong to pretend that implementing the strategy now would produce gains within five years. Healthy living will affect the next generation.

**Mr McNeil:** Jim Devine will be aware that such campaigns started in Finland not to improve health, but to address famine and hunger, and they have been undertaken for some time.

**The Convener:** I am conscious of the time, and the piper playing outside the building is annoying me enormously. As a Scot nat, I should not say that, but he is. We will move on.

**Helen Eadie:** Earlier, we discussed public involvement. Your submission says that Unison “welcomes the Scottish Executive’s pledge to involve staff and trade unions in all the stages of the planning process for establishing the new Scottish Health Council.”

Does Unison share the concerns of other organisations about the independence of a national health council that will be part of NHS Quality Improvement Scotland?

**Jim Devine:** Convener, may I hand over to my colleague? We are a double act today.

**The Convener:** Certainly—just leap in. I do not think that your man needs to be told that.

**Danny Crawford:** The short answer is yes. Unison has concerns about that matter. Unison welcomes the establishment of a Scottish health council and welcomes patient focus and public involvement in the NHS, but it feels that the changes that will be introduced with the Scottish health council mean that the body should be independent.

I realise that no organisation is completely independent and that obtaining independence might be difficult. We understand that the Scottish Executive considered several options. One was a non-departmental public body, another was a special health board and another was a link with NHS QIS. The white paper said that the Scottish health council should be linked to Quality Improvement Scotland. When the NHS’s chief executive launched the white paper, he said that the health council should be an arm’s-length organisation. Most recently, the minister said that the organisation should not be under the thumb of Quality Improvement Scotland.

What has yet to be worked out is how the Scottish health council will sit with Quality Improvement Scotland, if it is to do so. Unison’s position is that it would be better if the health council were as independent as possible, to represent patients’ interests in the NHS.

**Helen Eadie:** Shona Robison said that local health councils provide the complaints route into the health service. Will you comment on that?

**Danny Crawford:** Unison has concerns about that issue. We understand that the proposal is that the Scottish health council’s local offices would not provide the support that local health councils have provided to individuals who want assistance to make complaints through the complaints procedure or who want to know their rights.

We understand that NHS boards are to commission so-called independent bodies to provide such assistance. That might work well, but all the feedback that we have had—and we heard this view today as well—is that the system whereby the local offices of health councils provide support and advice works well. There may be one or two places where things are not done in quite the same way. In Dumfries and Galloway, for example, an advocacy service is provided for users of local government services as well. Historically, by and large, health councils have helped with complaints. They have done reasonably well; we are certainly not aware of any complaints about the way in which they have performed that function.

In England, the complaints procedure has been reorganised and concerns have been raised that...
the new system is more bureaucratic and more costly. We would not want that to happen here. The system seems to work well and we are not sure why it would need to be changed.

**Dr Turner:** There is a duty to involve the public and it has been said that that will not involve significant additional resources. Will public involvement be improved in health service planning?

**Jim Devine:** It would be wrong to say that consulting will not cost. One practical example of that was the introduction of the patients charter. Any member of staff who works in an accident and emergency department will tell you that everybody who walks in the door knows all about their rights as a patient. We are not against the charter. However, when it was launched, there were videos, television adverts and letters, and people were told, on their appointment cards, about their rights as patients. It would be wrong to pretend that all that had no cost. If we want to communicate, to involve people and to make a mark, that will cost money.

**Danny Crawford:** Consultation will have an associated cost. That said, Unison's position is that the NHS should be open, transparent and accountable. Making NHS boards the primary body responsible for public involvement is logical and appropriate. It will be the NHS boards that are hauled before this committee or the Public Petitions Committee to justify how they went about a consultation exercise.

In Glasgow, an issue arose to do with a secure care unit. The reporter who came back—an MSP at the time—said that the board had consulted beyond what it had to do. However, the point was that the amount of consultation that it had to do was not an amount that the public felt was appropriate. I do not think that the Scottish Parliament felt that it was appropriate either.

A step change is required to improve the way in which the health service engages with and consults the public. It is right and proper that the NHS board has that responsibility. That said, it does not have to be the only body with that responsibility. There should be a local independent body that comments not only on the appropriateness of how consultation is done, but on the particular issue.

**Mike Rumbles:** I asked the witnesses from Ayrshire and Arran NHS Board about improving the governance of NHS employees. Should the Executive introduce amendments to the bill to place a duty on health boards to ensure that they have systems in place for monitoring and improving the governance of NHS employees?

**Jim Devine:** I totally agree with the comments that those witnesses made. In the Scottish health service, we have a unique form of industrial relations. We work in partnership, and we sit down with management, to get away from the confrontation that went on for many years. We work on the practicalities of the development of services and the provision of care. The most valuable resource in the provision of care is the staff. They want to feel part of the team and to feel valued. As the witnesses from Ayrshire and Arran said, if you are to have clinical governance—if the chief executive was making an assessment—staff governance should be there as well. That has been pushed by all the trade unions and professional bodies in Scotland.

16:30

**Mr Davidson:** I want to pursue the issue of the governance of NHS employees. What are Unison's views on access to continuing professional development?

**Jim Devine:** We are very supportive of that, but it comes with a price. Over the past 15 years, the work load for health service workers has more than doubled, because of an increase in the throughput of patients. The difficulties that we all have are in getting people off wards and departments so that they can have a clear career structure. The new pay mechanism, agenda for change, makes development and the knowledge and skills framework a crucial part of people’s grading. Increasingly, people will want training and development and a clear strategy for that will be needed.

Under agenda for change, one hour's work on processing a form will be the equivalent of 14 years in capacity for the Scottish health service. Managers will have to sit down with people and conduct an assessment of their situation. They will have to conduct a development review and consider people's development and training needs. That work will have to be funded. Every hour of the process is the equivalent of 14 or 15 years of work, so there are major implications for health service capacity next year.

**Mr Davidson:** Do you agree that if staff have a higher skill base they will be able to take on more care, as well as more technical care?

**Jim Devine:** We are very supportive of the developing role of nurses and other staff. Tragically, my mum died during the summer, so I spent time in a hospital ward for about six weeks. Increasingly, all grades and disciplines of staff are taking on developing roles, compared with those that they had when I worked in the NHS. Nursing assistants take blood, while senior staff nurses run wards and departments. In Glasgow, there is talk of some nursing staff performing minor operations. We are supportive of such initiatives, but people...
must be given the necessary training. Members will not be surprised to hear a trade union official say that not only do people need to be given training, but they need to be paid the going rate.

Mr Davidson: That will add to the difficulties that you have with the financial memorandum.

Jim Devine: I have a practical suggestion for the committee. Whenever the Scottish Executive makes an announcement on health, it should put a price tag on that. There are serious difficulties with morale, especially among senior managers, who on a daily basis confront members of the public who point out that, according to Gordon Brown and Jack McConnell, record amounts of money are being spent on health. If a manager cannot deliver the service when that is being said, who is lying? Is it the manager or, dare I say it, is it you, the politicians? Whenever an announcement is made, the Executive should indicate clearly the cost of the service.

Mr Davidson: I agree.

The Convener: As part of the package, should there be direct elections to NHS boards, on the basis that those would provide democratic accountability and transparency?

Jim Devine: That is an interesting question and I am not trying to duck it. Until six months ago, I would have said that there should not be direct elections to boards.

The Convener: You cannot now say no—in your submission you say that you are for direct elections.

Jim Devine: I know. I have attended the past three meetings of Greater Glasgow NHS Board, at which the closure of Yorkhill hospital was discussed. It is very interesting that the elected councillors were the people who were most nervous about making a hard decision. There may be a lesson there.

The Convener: I do not know what the lesson is, but you have hedged your bets cleverly. That concludes this evidence-taking session.

Danny Crawford: I do not want to prolong the discussion, but I would like to make a point about the statutory rights and responsibilities that currently lie with local health councils. My understanding of the position is the same as Shona Robison’s. The changes that will take place will mean that those rights and responsibilities will no longer lie with anyone. That is a very important point. The rights include the right to visit facilities and the right to get information from and make comment to NHS boards. Health councils also represent people. People representing patients’ interests and the public interest attend and have speaking rights at meetings of NHS boards. Hopefully, those rights will not be lost when the changes take place. We do not want the baby to be thrown out with the bath water. There ought to be change, but certain good aspects of the current system should be retained.

The Convener: If you have any other thoughts about issues that we have not asked about, please write to let us know after the meeting.

Meeting closed at 16:35.
9 December 2003 (16th Meeting, Session 2 (2003)), Supplementary Written Evidence

During the Scottish NHS Confederation’s oral evidence on the NHS Reform Bill evidence, the committee requested further information on two topics: the Confederation’s view of the power of intervention contained in the Bill; and examples of good practice in patient and public involvement in NHS Scotland. I am very pleased to enclose two short papers setting out this information, which I hope the committee will find useful.

The NHS Reform Bill: Powers of intervention - Clarification of the Scottish NHS Confederation’s position

In our written submission to the Health Committee on the NHS Reform Bill, on the matter of the ministerial power of intervention, the Scottish NHS Confederation stated that we would like to see further clarification of how the power of intervention would be used, either in regulation or on the face of the Bill. During our oral evidence to the committee, we accepted that this clarification could be achieved through regulations and we were invited to submit further information about our view of what is required.

The Confederation believes that it is vital that the principle of health services being planned and delivered by the individual local health systems themselves is preserved and that it would be helpful for the regulations to state this clearly.

We believe that part 4, section 1 of the Bill

\[
\text{it is a function of a body or person under or by virtue of this Act to provide, or secure the provision of, a service, and the Scottish Ministers consider that the body or person has failed, is failing or is likely to fail—}
\]

\[
\text{to provide the service, or}
\]

\[
\text{to provide it to a standard which they regard as acceptable}
\]

sets out very broad circumstances in which intervention could take place.

We would like to see the inclusion of a benchmark by which the failure or likely failure of a service would be judged. The Ministers’ evaluation of failure must be based on a consistent standard that is accepted, fully understood by and implemented across the service. This would ensure that NHS Boards were entirely clear about the circumstances in which the power of intervention may be used.

We would suggest that the current NHS Scotland Performance and Accountability Framework would be an appropriate benchmark and that it could be specifically named as such. The Framework itself is regularly re-evaluated, monitored and updated as necessary, so there should be no risk of either the primary legislation or the regulations being overtaken by new developments in the standards for organisational, financial, clinical or staff governance.

We do not in any way oppose a power of intervention being created – indeed, we believe that timely, supportive intervention can be extremely effective and that the formalisation of the power will give local health systems an assurance that, should a crisis or potential crisis occur, support from the centre will be available.

In summary:
we agree that the regulations are the appropriate place for the details of when intervention will be triggered
the regulations should be agreed following consultation with the service and should use the Performance and Accountability Framework as a benchmark we do not oppose the power of intervention but see it as part of the central support mechanism for the service
we believe the circumstances required for intervention must be clearly understood so that the power will be used appropriately.

**Public Involvement in NHS Scotland**

This paper outlines a range of examples of patient and public involvement in NHS Scotland. These examples are a small sample of the innovative work being carried out in different settings and with different patient and community groups. However, they give an indication of the different approaches to continuing and in-depth patient and public engagement across NHS Scotland.

**NHS Tayside – ‘Healthy Tayside’ strategy**

NHS Tayside has developed a framework for sustainable and meaningful patient and public involvement for the long-term. A public partnership group has been created in each of the Perth, Angus and Dundee areas. These permanent small groups of 15-20 citizens will work closely with the NHS locally to help plan services to meet the needs of their communities. However, Tayside has also moved into previously uncharted territory in order to lay the foundations for a sustainable partnership of genuine engagement between the public and the NHS, not only in the planning and delivery of health services but also in improving the health of people in the area. A ‘Healthy Tayside’ think-tank, chaired by Canon Kenyon Wright, is addressing the development of a new health culture. The aim is to examine how the responsibility for health can be shared between the NHS, citizens and communities, with the involvement of educationalists, industry, housing and other stakeholders.

**Highland NHS Board – The Possible Highlander: 20/20 vision**

This public involvement project aimed to engage people who were not necessarily already patients or service users, in discussion about the kind of NHS they wanted to see and use over the next 10, 15 and 20 years. Three distinct groups of citizens – young people in 5th and 6th year, young mothers, and people in their mid-50s – many of whom lived in the most remote parts of the region, were asked, in a series of exercises, to talk about what they would need from the NHS at various stages in the future and what they thought its priorities should be. The exercise helped the Board to develop methods of engaging members of the public who are usually difficult to reach, and the results contributed to its overall health strategy for the region.

**NHS Shetland – The Shetland NHS 100**

The Shetland NHS 100 is a diverse panel of individual citizens, recruited through leaflets in the local press, who take part in regular meetings with senior NHS representatives. The meetings are a two-way process, with members of the panel able to generate their own topics for the agenda as well as being used as a sounding board and consultation forum by the NHS board. The Shetland 100 panel is also involved in designing and commenting on wider public consultations at their earliest stages. Panel members are able to register their particular interests, such as older people, on a database, and are then notified when, for example, an internal board strategic planning meeting will be discussing that issue. The panel member is then able to attend and contribute to that meeting if they wish.

Seventy six people are currently on the panel with around half of these taking a regular active role. The project will shortly be re-advertised to recruit a further 24 participants to bring the total to the full 100.

**Ayr, Prestwick and Troon Local Health Care Cooperative – Public Involvement Committee for Healthcare**

This LHCC recruited 22 individuals to a Public Involvement Committee for Healthcare by contacting people at random through the GPs’ lists. Committee members take part in discussions about the planning and delivery of new services and also raise issues of concern to the local population with all health care providers in the area. Communication is a two way process, with the chairman of the Committee and the LHCC Office Manager responsible for ensuring communication links within primary and secondary care providers. The benefits have included Committee members gaining an
insight into clinical priorities from a patient perspective, and opportunities for health care providers to have open discussions with a diverse group of people.

**NHS Ayrshire and Arran – Dalmellington Area Centre**

The award winning Dalmellington Area Centre in Doon Valley is well known for locating on a single site all council services, a GP surgery, dental surgery, police and other government agencies such as the Benefits Agency. High quality ICT support and training are also available to local businesses and individuals. Local people were involved from the outset in the design of the centre and planning the delivery of services and a permanent centre users’ group continues to be involved in operational issues.

**NHS Greater Glasgow – Multicultural Health Development Programme**

The Multicultural Health Development Programme has developed community forums which consist of patients, carers and religious representatives from the diverse communities across Glasgow. These forums give patients and carers an opportunity to voice health concerns and ensure that their needs are addressed by policy planners and commissioners. Smaller local forums have also been set up to support LHCCs with high minority ethnic populations.
9 December 2003 (16th Meeting, Session 2 (2003)), Supplementary Written Evidence

Mr Davidson posed two questions to COSLA representatives during the Health Committee’s evidence session on 9 December 2003 which required further consideration -

Is there enough clarity in the Bill about funding and mixed funding? Does the Bill need to look more closely at health improvement and how budget definitions are organised?

Definitions

Before commenting on these issues, however, it is felt that it would be helpful to clarify certain definitions

It is important to recognise the distinction between health promotion, public health and health improvement as there is a tendency to use these terms interchangeably. Health promotion is only one means of delivering health improvement. The following is taken from a paper prepared by the Community Health Partnership Development Group.

When the terms ‘health improvement’ or ‘improving health’ are used in the current context, population health improvement is generally implied, rather than improving the health of a given individual. Health improvement is not the same as public health or health promotion. It is a goal, not a field of activity. It is a goal pursued through promoting good health, preventing ill health and maximising the population health impact of treatment and care services. It is the goal of public health and, within the public health function, of health promotion (which concentrates on promoting good health and preventing ill-health). It should be seen as the main goal of health care services as a whole. And it is the one single goal that unites the NHS, Local Authorities and other partners such as the voluntary sector.

There is not a simple response to Mr Davidson’s questions. In both cases, there are associated issues and the following comments address these.

Is there enough clarity in the Bill about funding and mixed funding?

The Bill is unclear in relation to funding issues which are explored in more detail in its accompanying policy and financial memoranda. In COSLA’s written evidence to the Parliament we have stated our belief that the contention that the implementation of the Bill will be financially neutral is inaccurate and does not, in particular, reflect the needs of the wider health improvement agenda. In this respect we believe that the Bill misses the opportunity to put in place a framework for a more co-ordinated approach to the planning, funding and execution of health improvement strategies which fits with other legislation – notable that relating to community planning.

COSLA is concerned about the initial narrow focus of the Bill in relation to health improvement. As currently drafted, the focus for responsibility for health improvement lies with the NHS. The reality is that the NHS is only one body working on the prevention of ill health. Local authorities and their voluntary sector partners also play a key role in this vital area of work - it is not an issue addressed exclusively by any one organisation and the Bill should reflect this.

COSLA is not calling for a prescriptive solution within the Bill but is rather looking for a mechanism that ensures both the NHS and Local Government work together to make best use of scarce public resources, promoting healthy lifestyles and working towards health improvement for all. At present Scottish Local Government is under a statutory obligation through the Local Government (Scotland) Act to work with NHS partners (and others) in the community planning processes. There is no reciprocal arrangement in the NHS Reform (Scotland) Bill. COSLA strongly believes that this is inequitable and is a fundamental weakness, open to misinterpretation, which is easily rectified.
Does the Bill need to look more closely at health improvement and how budget definitions are organised?

The lack of specific health improvement funding streams is acknowledged, as is the fact that many of the actions taken by councils to contribute to improved health and the reduction of ill health do not necessarily come under a specific health improvement budgetary heading. Within COSLA itself, health improvement is being mainstreamed across the range of the organisation’s work. Too often in the past the focus has been on the generation of specific outputs with the drive being to deliver a target only rather than the generation of long-term change. COSLA believes that the long-term goal of improving Scotland’s health cannot be attained unless there is a switch to an outcome centered approach.

COSLA also believes that the mainstreaming of health improvement funding within overall budgets, will facilitate the development of local solutions to local priorities, but within an agreed national framework. One example would be the recent announcement of £24 million to employ 600 physical activity co-ordinators in schools. In this announcement attention has focussed on the figures of £24 million and 600 posts rather than the outcome to be delivered by the initiative. COSLA would ask, would it have been better to develop the desired outcome and then charge the community planning partnership (which includes local NHS partners) with developing tasks to achieve that outcome? For COSLA this example reinforces the need for a statutory link between planning for the proposed Community Health Partnerships and Community Planning.

The annex to this paper summarises work being done in one particular local authority in and across a number of departments. This activity will obviously not be replicated exactly in all council areas but is indicative of the type of approach being adopted and illustrates the range of activities undertaken. Work listed relates to the council’s own initiatives, Scottish Executive initiatives, e.g. ‘Hungry for Success’, ongoing work that can cut across a number of council departments such as anti social behaviour and traditional core local authority business such as food safety and dog & pest control – areas of work which do not tend to attract headlines but which are nevertheless important elements in work to secure health improvement. Some of the activity is directly related to lifestyle issues and much to life circumstance issues. It illustrates the complexity of capturing spend on Health Improvement work and thus the advantages of the adoption of an outcome centred approach.

To cost the financial input to health improvement work in our sample council would require the costing of:

- full time secondment of quality development adviser to Health
- part of integration manager role in health improvement
- council contribution to role of health improvement officer
- environmental health officer role in improving health for children and older people
- social work strategy officer contribution to health improvement in relation to the national Choose Life Strategy
- corporate services officer contribution to staff health improvement
- staff counselling officer
- staff stress reduction programmes
- staff physical activity programmes
- staff contributions to drug and alcohol forum health improvement related work
- fitness instructors
- sports development advisers
- contributions to Welfare Advice

Conclusion

COSLA believes that the health improvement balance within the Bill is unhelpful and does not reflect the realities on the ground. The partnership between local authorities and local NHS Boards is improving through the development of Joint Health Improvement Plans, the statutory inclusion of NHS in the Community Planning agenda and the progress of the Joint Future Agenda.
There is a momentum on the ground that neither the Bill nor its the financial memorandum capture. Given that situation, here must be an acceptance that this Bill will have wider impacts than on the NHS and that the legislation should reflect this position. It is in this context that COSLA believes that the getting the correct emphasis, at the correct level, on strategy and financial planning for the targeting of health improvement activities is crucial. In this respect, the approach adopted for Joint Future for care and service delivery is regarded as a helpful model.

COSLA would be happy to work with the Health Committee and the Scottish Executive on this matter if that would be helpful.
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**Notes:**
- SHAW: Service for Health, Ageing, and Wellbeing
- Young Enterprise: A social enterprise that provides work opportunities for young people.
SUBMISSION BY AYRSHIRE AND ARRAN NHS BOARD

9 December 2003 (16th Meeting, Session 2 (2003)), Supplementary Written Evidence

The following are my observations as an NHS Board Chairman as distinct from the views of an NHS Board as a collective entity.

Primary

Abolishing NHS Trusts


These developments have resulted in a cultural change within the NHS in terms of integrated working and removal of service boundaries, paving the way for the now timeous abolition of NHS Trusts – the progression from integration to single system working, with the focus on devolution of decision making and control of resources and on the unimpeded patient’s journey.

Suggestion – that the Bill and/or Regulations should emphasise the requirement for single system NHS Boards to devolve as far as possible and appropriate decision making and control of resources to operational units and divisions. We must avoid replacing the Trust system with a central command and control arrangement.

Public Involvement

The duty imposed on Health Boards is welcomed and should translate what should be good practice into a statutory requirement. This should enhance good practice. The difficulty of the task in securing appropriate public involvement in planning and redesign of health services should, however, be acknowledged. It is also acknowledged that some local authorities have longer and wider experience of public involvement in planning, etc. and Health Boards should be encouraged or required to link with local authority partners as appropriate in such exercises.

Boards should be aware of the differences between explanation; engagement; consultation and be clear about which is appropriate and in what circumstances.

Suggestion – that this element of the Reform Bill be reviewed in terms of the requirements proposed for local authorities under the ‘Local Government (Scotland) Bill’, particularly in relation to community planning. Most health services are provided within the community. Duplication must be avoided particularly in relation to engagement or consultation.

The establishment of the Scottish Health Council is welcomed in terms of providing advice and leadership in promoting greater public involvement in NHS Scotland, by disseminating and distributing examples of good practice and by ensuring oversight of NHS Board activities via local Advisory Councils. The Scottish Health Council should be a “stand alone” body not subsumed within the NHS Quality Improvement Scotland. The third role envisaged for Advisory Councils in developing effective links with local voluntary organisations and patient groups is also welcomed. Local groups should, however, retain an advocacy function.

Health Improvement

The emphasis on health improvement is welcomed. NHS Boards should have a duty to participate in their local Community Planning process, which should be led by the appropriate local authority as, I believe, is re- emphasised in the Local Government (Scotland) Bill 2003. The same Bill, I understand, proposes a duty on local authorities to be responsible for the “well being of the local population”. A co-ordinated approach to community planning is, therefore, essential.
This has implications for NHS Boards in relation to the production of Local Health Plans, which currently are not synchronised in terms of timescale or content with local authority Community Plans.

Suggestion – that it be acknowledged in the Reform Bill or Regulations that local authorities have the lead role for community planning, to which NHS Boards have a duty to contribute and to which their respective Local Health Plans should relate. The Local Health Plan could and should become a more focused, operational document for NHS service delivery purposes.

I would, however, question the proposed Ministerial power to direct funds for health improvement, bypassing on occasions NHS Boards. Currently many health improvement initiatives undertaken by local authorities, voluntary organisations, local community groups and the NHS are fragmented and unco-ordinated – there is a wide range of activity. We should also acknowledge the current requirement to produce Joint Health Improvement Plans with local authority colleagues – an endeavour to integrate such provision. Direct funding from the Scottish Executive could, I suggest, exacerbate such fragmentation and lead to conflicts and uncertainties in terms of sources of funding.

Suggestion – that NHS funds for health improvement be channelled through NHS Boards and therefrom to, for example, Community Health Partnerships, which will have a major integrating and local service delivery, i.e. health improvement, role. Community Health Partnerships will be integral elements of the new single system NHS.

There is further concern that direct funding from the Centre could favour larger, national organisations and disfavour local initiative.

Powers of Intervention for Scottish Ministers.

The powers as proposed and as more fully conveyed in the Policy Memorandum to the Bill are valid and acknowledged.

Performance Review Body

The formal establishment of NHS Quality Improvement Scotland is welcomed, including powers of intervention. This should give consistency to the format of any regretfully required investigations or inquiries and ensure that lessons learned are appropriately conveyed.

Replacing Local Health Care Co-operatives with Community Health Partnerships

Welcomed. The establishment of CHPs is a natural progression from the introduction of LHCCs in 1997. Evolution but also major change and development. LHCCs were largely “within the NHS family” in terms of services and attitudes. CHPs should embrace health and well being in its widest sense – health improvement – health provision, social and voluntary care.

CHPs must not, however, merely replace Primary Care Trusts and the emphasis should be on devolution of decision making and control of resources to a local community level. I have concerns about recent proposals that CHPs could become committees of NHS Boards – this, I suggest, would over-formalise and constrain their activities and locate them too specifically within the NHS.

We should be aware of understandable sensitivities within local government to what could be viewed as an NHS dominated approach to promoting and providing local and community based health and well being. CHPs should be built on equal partnerships and not be viewed as a takeover of social care services by the NHS.

Suggestion – that the role of local government be recognised in the Reform Bill and cross-referred to the Local Government Bill in relation to local authority duties for community planning and the well being of local populations. The Bills should be viewed in partnership.

In relation to the NHS, again devolution of decision making and resources is imperative. We should avoid creating over-managed and over-bureaucratic local CHPs and provide appropriate
support services to them, so that their focus is on operational service delivery and responding to local need. The role of General Manager is of critical importance and will, I suggest, require major investment in design and training. Whereas promotion of and involvement in CHPs is a statutory, compulsory requirement for NHS staff, the involvement of general practitioners is still viewed as voluntary. This, I would suggest, has been a weakness in the current LHCC arrangement and could be a continued weakness into the CHP system.

Suggestion – that the voluntary nature of GP involvement be reviewed although it is anticipated that few, if any, will opt out, especially given the new GMS contract. Equally, it is important that CHPs be not re-arranged around GP practices in terms of true partnership working and avoidance of domination by one particular professional group. Again, the role of the General Manager assumes significant importance.

The introduction of CHPs is unreservedly welcomed in terms of developing responsive, devolved, integrated and comprehensive service provision, irrespective of service provider and professional background.

Suggestion – that CHPs are viewed as a new and much needed vehicle to promote and progress the Joint Future Agenda. This has major implications for local authorities and their community planning processes.

Statutory co-operation on Health Boards across regional boundaries.

Such requirements are welcomed if, on occasions, regrettably necessary. We should not require to be instructed to co-operate. We should wish and be committed to do so. Ayrshire and Arran has, for example, arranged for the Scottish Ambulance Service to be represented formally at Board meetings. This is merely a small example.

There can be considerable benefits from regional initiatives, for example in terms of specific support services, and the establishment of Managed Clinical Networks requires further promotion and invigoration. The duties of co-operation should enhance this.

Secondary


These are supported and no major omissions have been identified.

Consultation

This appears to be appropriate and responsive. I understand that duties of staff governance to NHS Boards have already been added to the Bill as a result of such initial consultations.

Practical Implications

These have been largely dealt with in terms of the seven primary points above.
The Scottish Consumer Council (SCC) is pleased to submit evidence to the Health Committee of the Scottish Parliament on this important piece of legislation. We have been involved in much of the discussion and debate about public involvement in the NHS, in relation to how NHS boards consult their communities, and in relation to the future of health councils in Scotland.

Do you support the general principles of the Bill and the key provisions it sets out? Are there any omissions from the Bill that you would like to see added?

Principles

The SCC considers that the principles underlying the Bill are as follows:

- integration of services across primary and secondary care, and between health and social care
- delegation of power and resource from boards to communities
- promotion of public involvement
- promotion of health improvement
- services which are planned and delivered at the most appropriate level, i.e. community level, board level, on a regional basis, or at national level
- promotion of patient safety.

The SCC supports these principles.

Key provisions

The key provisions of the Bill are

- the abolition of trusts
- the creation of Community Health Partnerships
- new duties on NHS boards to
  - promote health improvement
  - to involve the public and
  - to co-operate with other health boards
- the abolition of local health councils to allow for the creation of a Scottish Health Council
- the creation of a power to intervene in case of service failure
- duty on Scottish Ministers to promote health improvement

The SCC broadly supports these provisions but we would like to make the following comments on them.

Structural change

The structural changes proposed in the Bill, i.e. the abolition of trusts and the creation of CHPs, will not necessarily, in themselves, achieve the policy objectives which the Scottish Executive Health Department seeks to achieve through this Bill. Changes to structures do not necessarily create the changes in culture which are needed to effect real change. While the removal of separate primary and secondary care trusts may be seen as a necessary step towards greater integration between primary and secondary care, there are dangers that boards might recreate this division by establishing separate operating divisions for primary and secondary care.

Similarly, the devolution of resources and planning from board level to Community Health Partnership level will depend on the willingness of the board to do this.
Although CHPs are new bodies, and the intention is that there will be a greater degree of consistency than has been the case with Local Healthcare Co-operatives (LHCCs), they will, in most areas of Scotland, evolve from LHCCs, and so will take both the strengths and weakness of existing LHCCs with them. In parts of the country where the development of LHCCs has led to new energy and direction in primary care services, this is likely to carry forward effectively on the slightly larger canvas of the CHP. However, in other areas the new CHP may have to overcome the history of an LHCC which may not have been an effective vehicle for promoting interagency working or for planning services at local level.

**Partnership working**

The SCC understands, from the consultation which has taken place about Community Health Partnerships, that CHPs will be NHS bodies but will be expected to work in partnership with the other key agencies, particularly local authorities, and with their local communities. The SCC wholeheartedly supports inter-agency working between the NHS and local authority services, but creating a structure called a community health partnership does not in itself guarantee that partnership working will be any easier or more effective than it is at present. There is a danger that the new terminology may create confusion. There is an important distinction between an organisation which has a partnership structure, and one which is committed to partnership working.

**Duties**

The SCC agrees with the clear statutory requirement that NHS boards should promote health improvement, public involvement and working at regional level with other boards. It is, however, important to recognise that NHS boards cannot do this alone. In relation to both health improvement and public involvement they can only achieve significant improvement through working with other bodies. In relation to health improvement this will involve voluntary sector organisations, community health projects, and national initiatives such as the national demonstration projects.

In relation to public involvement there is a need to support the capacity of communities and individuals to be involved, and to create effective partnerships. The nature of public involvement is that it is a two (or more)-sided process, which requires both sides to be engaged. It is a way of working and a process which it is not entirely within the competence of the NHS to “deliver” on its own.

The SCC welcomes the duty on Scottish ministers to promote health improvement, which recognises that in any policy development or initiative the impact on public health should be a key consideration.

**Health councils**

Health councils in Scotland have acted as the voice of the patient for almost 30 years, and the SCC accepts that it is timely to review what their role should be in the changing world of the NHS. We agree that alongside many strengths, there are weaknesses in the current system. These include the perceived lack of independence of local health councils, whose members are appointed by NHS boards, and the variable pattern of activity across Scotland.

The SCC supports the creation of a Scottish Health Council at national level, with significant powers in relation to the monitoring and development of public involvement in the NHS. We have expressed our reservations about locating this new body within NHS Quality Improvement Scotland, and believe that there will need to be effective safeguards to allow the Scottish Health Council to develop an independent agenda and voice, in order to meet the needs of patients in Scotland.

**Powers of intervention**

The SCC welcomes the attention currently being given to patient safety, and believes that the power for Scottish ministers to intervene to secure the quality of healthcare services is an important part of this.
What are your views on the quality of consultation and the implementation of key concerns?

Consultation

The Scottish Executive developed many of the ideas contained in the legislation through various working groups, for example the LHCC Best Practice Group, the Primary Care Modernisation Group and through the Review of Management and Decision Making in the NHS. In parallel with the Review, there was a series of NHS Forum meetings which brought together a wide range of people working in different sectors, and patients and their representative groups, including the SCC. This provided an opportunity for those involved to take the issues to their wider networks and forums, although there was no formal widespread consultation process.

In relation to the proposals for the abolition of local health councils and the duty on NHS boards to encourage public involvement, there has been an extensive process of consultation. This involved a pre-consultation which was carried out by the SCC, and a report on this was published in May 2002. A formal consultation on the proposals then took place between March and June 2003. The consultation process leading up to the publication of the NHS Reform Bill has if anything been too long, with staff working in health councils experiencing a prolonged period of uncertainty about what would be happening to their jobs, and about their role and function.

The Scottish Executive Health Department has also recently consulted on Community Health Partnerships. Although this consultation document was not distributed widely outside the NHS, the SCC believes that most of those with an interest in responding to it will have come into contact with it through existing networks, for instance in the voluntary sector, or community health networks.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

Scottish Health Council

We believe that the Scottish Health Council should have the ability to speak authoritatively on behalf of patients to the NHS and to the Scottish Executive, and for this reason the SHC needs to be clearly independent of the NHS and of the Scottish Executive. Indeed, the independence and the perception of independence will be vital to the success of the SHC. It might therefore have been expected that the SHC would be an independent non-departmental public body (NDPB). However, policy makers do not favour the creation of new NDPBs, and the consultation proposes the establishment of the SHC within another organisation, in this case, NHS Quality Improvement Scotland.

While it is intended that NHS QIS should be seen to be “entirely independent of government and NHSScotland”, there may be a problem in the public perception of a body which has NHS clearly in its title, and which works closely with the NHS.

If the SHC is to be located within NHS QIS, or indeed any other body, it is vital that there are safeguards to ensure its independence, and to maintain a distinct identity for the council. The kind of conditions or safeguards which the SCC would like to see in place would include the following:

- a memorandum of agreement between the SHC and the host organisation, setting out the nature of their relationship to one another, covering the management of staff, and the relationship of the NHS QIS board to the SHC council
- a council to oversee the work of the SHC, and to approve its workplan, appointed through the public appointment process
- director of SHC to be answerable to the SHC council rather than to the NHS QIS board
- a separate budget under the control of its council
- its own research capacity.

In the changeover from local health councils to the local arms of the Scottish Health Council it will be important to try to retain the skills and knowledge which health council staff have developed, and the contacts they have within their local communities which will be useful in beginning to develop local networks of public and patient groups.
Community Health Partnerships

There is still a lack of clarity about the kind of bodies which CHPs will be. There is nothing in any guidance that we have seen to date which explains what the governance and management arrangements will be.

Public partnership forums

There is a great deal of uncertainty about the nature of the Public Partnership Forums which are discussed briefly in the recent consultation on Community Health Partnerships. There is nothing in the Bill about these forums, but they are likely to be one of the main ways in which CHPs will be made accountable to their local communities and so will be very important in practice.
16 December 2003 (17th Meeting, Session 2 (2003)), Written Evidence

Dissolution Of Health Councils And Establishment Of Scottish Health Council As Part Of NHSQIS

Health Councils generally welcome the proposal to establish a new Scottish Health Council as a national organisation with local offices, carrying out the same core functions in accordance with nationally agreed standards and procedures. Health Councils also recognise and support the need for strong links with NHS Quality Improvement Scotland. This will be particularly important in terms of standards development and in monitoring the performance of NHS Boards as part of the Performance Assessment Framework (PAF).

We consider that the independence of the new Scottish Health Council, to act and speak in the best interests of patients to be of paramount importance and believe that this can best be achieved by establishing the Scottish Health Council as a statutory independent body in its own right with its own board of governance, whilst maintaining close working relationships with NHS Quality Improvement Scotland. If however, the Scottish Health Council is to be established as part of NHSQIS, additional safeguards will be required to ensure that the Scottish Health Council is free to pursue its own agenda in the best interests of patients and is not “under the thumb” of NHSQIS. We believe therefore that the Scottish Health Council should not simply be established as another operating division of NHSQIS, but that its establishment together with its role, remit and powers must be underpinned by statute.

In terms of the proposed remit for the Scottish Health Council, this is more narrow and restrictive than that of existing Health Councils. We are therefore concerned that many of the existing functions carried out by Health Councils could simply disappear, unless alternative delivery mechanisms are identified, agreed and implemented, before existing Health Councils are abolished. The right of access to monitor NHS facilities from a patient and public perspective, which currently lies with the local Health Councils, should also transfer to the new Scottish Health Council and be a function of Local Advisory Councils. We also consider it to be important for the new Scottish Health Council to retain the same rights of representation on NHS Boards and additionally at strategic planning and organisational management levels within the proposed Community Health Partnerships. Another concern relates to the independent complaints system which is currently provided by many local Health Councils, but which in future, will be commissioned by NHS Boards themselves.

An area of particular concern is the lack of detail about the proposed role of lay members who will make up the Local Advisory Councils. Lay members in Health Councils currently play an important role in making public involvement a reality and we believe that they have an important role to play in the new organisation. Their active involvement will be particularly important in ensuring that the Scottish Health Council is not only independent from NHS bureaucracy, but is clearly seen to be so.

The question remains “Who is going to speak up for patients and the public”? We believe that an organisation that is championing public involvement must also be able to ensure that people’s voices are not only heard, but acted upon. There are many who are still unable or unwilling to speak for themselves and who need a strong organisation to speak for them. There are also many areas of NHS service provision, which are not covered by patients’ organisations and where we believe the new Scottish Health Council has a key role to play. As the proposals currently stand, there is a real danger that for some sections of the population, the patients’ voice will not be heard.

Funding The Scottish Health Council

We believe that if the new Scottish Health Council is to succeed, it must be properly resourced. The increased importance being given by the Scottish Executive to developing public involvement and the role proposed for the new organisation, requiring evidence based assessments to be undertaken in accordance with nationally agreed standards and procedures, will require leadership
and management of the highest quality. The organisation will require highly skilled, trained and motivated staff. A comprehensive training and development programme will also be required for members of the Local Advisory Councils.

Funding is currently provided to many Health Councils by NHS Boards on an in-kind basis, and it will be essential to ensure that this is not lost to the new Scottish Health Council. We are not however suggesting that this funding should be taken away from NHS Boards at the expense of front-line services. This will therefore require additional funding for the new Scottish Health Council, over and above the existing provision.

**Community Health Partnerships (CHPs)**

Whilst we welcome the opportunity for patients and the public to participate in the planning of local health services through the establishment of Public Partnership Forums (PPFs), we note that these will not be independent bodies. Their precise role and remit remains unclear as does their relationship with the Local Advisory Councils of the Scottish Health Council. We consider it vitally important for the new Scottish Health Council to not only work closely with PPFs, but to also be actively involved in the development and assessment of the public involvement processes undertaken by CHPs and in monitoring outcomes.

**Dissolution Of Trusts**

Health Councils generally welcome the decision to abolish NHS Trusts and the opportunities that this presents to streamline administration and provide greater service integration across Board areas. We would however be concerned if this were to lead to greater centralisation and less openness.

**Power Of Intervention In The Case Of Serious Service Failure**

Whilst the powers conferred upon NHSQIS to intervene in the case of serious service failure are generally welcomed by Health Councils, we would caution that these should be used sparingly and only as an option of last resort.

**Public Involvement – Duty On Health Boards**

As the Scottish Health Council is to have the role of developing best practice and assessing how effectively NHS Boards carry out their Public Involvement duties, it will be essential for the new Scottish Health Council to be appropriately resourced to enable it to carry out these functions independently and in the best interests of patients and the public.
Introduction

The Association of LHCCs is pleased to add to the consideration of the National Health Service Reform (Scotland) Bill. As can be imagined the main focus of our evidence concerns the very welcome advent of Community Health Partnerships. We would wish to emphasise what we consider to be the key point emerging from the Primary Care Modernisation work and stated in the White Paper, CHPs should evolve from LHCCs. This is not explicitly stated in the Bill, although the idea is certainly included within the phrasing of the Bill.

LHCCs, though varying very widely in scope, character, composition, size and establishment are all characterised as slim management structures, operating with and in support of a group of clinicians focused on providing services for a (relatively) small and local population. They have done things differently, and they have made a difference. LHCCs have been very focussed on action and perhaps rather less on management process. Many NHS bodies are required by legislative, governance and statutory responsibilities to be accountability focussed. There is no doubt that at the outset the voluntary and co-operative nature of LHCCs was very important and helpful in arriving at shared, multi-disciplinary objectives, structures and styles of working.

Size has been an issue for LHCCs, so too has delegation of responsibility and flexibility by local NHS systems. LHCCs that are very local have resulted in local acute sectors, Local Authority partners and voluntary agencies having trouble identifying how and who to establish links with to discuss and develop interface arrangements. Some NHS systems, for a variety of reasons, have not been able and or willing to delegate budgets and responsibilities to LHCCs and by so doing give LHCCs the flexibility to develop services in their own way.

Attached to this evidence is the entire Association comment on the CHP consultation exercise. The specific areas on which we would wish to focus in our evidence are:

- The need for clarity but also flexibility about what the core elements of a CHP will be.
- Stay true to the benefits of LHCC and reinforce that CHPs evolve from LHCCs, low beaurocracy, short decision making paths, multi-disciplinary groups of clinicians making decisions and supported by senior management.
- Sufficient delegated resources of manpower, talent, influence and budget.
- Development and training of CHP Boards.
- Clarify how governance and accountability will flow CHP/NHS/LA.
- We welcome the proposal to provide funding for public involvement; this will enable us to do this in a very meaningful way.
- What is the PCO, will its functions be separate from CHP or integrated with, will depend on each area and number of CHPs
- Bottom up development in a sensible timescale.
- Recognition of other drivers and change, eg Pay Modernisation.

Core Elements Of A CHP

CHPs will undoubtedly develop over time. The roles and responsibilities will not necessarily be the same at the outset as they will be one year in. It is however important to be clear about the core functions. Notwithstanding this there must be flexibility about even the basic list of core elements and responsibilities as local circumstances may well make different approaches essential.

A key feature of CHPs will be the relationship with Local Authority partners. The initiative has been very much lead by Health from the outset and not taken account of some of the drivers and constraints of Local Authorities. The development of links between potential CHP systems and Local Authorities must be a key part of the schemes of establishment to be required of NHS Boards. Despite the best efforts within Joint Future work there remain some obstacles to joint
working, and one that is often mentioned are the differing terms and conditions of service between the systems for similar work.

There are 3 components to consider under “Core Elements”, roles, responsibilities and services.

Roles.
CHPs must have a key role in:
- Community planning, which needs to be integrated with Health Planning process.
- Networks and interfacing with hospital services, voluntary sector and other statutory sectors in order to deliver integrated care and services for all.
- Identify and take account of available resources and employ them to maximum effect.
- Planning and delivering the health improvement agenda.
- Be involved with and influence NHS and SW strategic planning and resource allocation.
- Plan and deliver primary and community based services.
- Involving the public in all of their planning and governance arrangements.
- The quality and value agendas. This must include decisions about which guidelines and initiatives are implemented within available resources.

Responsibilities.
CHPs must have delegated authority and flexibility in order to deliver the roles outlined in 8 above. This must include appropriate budgets; this has not been the case universally for LHCCs.

Services.
The list of services in the SEHD Summary of Consultation is an excellent start, but must not be taken as absolute, essential or exhaustive as local circumstances may suggest variation. The list is:
- Independent contractor services
- Community related health services including community nursing: allied health professionals; and any community based integrated teams (e.g. rapid response teams, hospital at home)
- Community based midwifery services
- Relevant aspects of health promotion/education
- Community mental health services
- Community access to a range of outpatient and diagnostic services
- Community resource centres/hospitals
- Community assessment and rehabilitation
- Drug and alcohol services
- Voluntary services

Benefits Of LHCCs

LHCCs brought together an extremely powerful coalition of clinicians and management. The synthesis of GPs with nursing and AHPs aligned many agendas, budgets and talents in a way that had not previously been the case. They exhibited enthusiasm and a “can do” approach to life.

Within the constraints of budgets and delegated authority LHCCs showed imagination in developing services and resources. LHCCs have not posed a threat to financial stability in NHS Boards, although the pressures on the prescribing budgets cannot be ignored. It is however LHCCs in many areas that have led the work to reduce waste in prescribing budgets.

A balance will have to be achieved in order to maintain the involvement of clinicians, the energy and enthusiasm of LHCC managers and systems whilst establishing sufficient infrastructure to handle the increased responsibilities without causing the new CHPs to become unwieldy organisations focussed more on process than action.

Infrastructure

LHCCs have been established on a relative shoestring. As Primary Care Trusts dissolve this will be more exposed. It is important that CHP establishments are sufficient to handle the workload. If one contrasts (English) PCTs and LHCCs they do exist at opposite ends of the infrastructure scale.
As NHS systems re-organise the opportunity to redeploy high quality staff within emerging CHPs should not be ignored or lost. Equally the role of LHCC General Managers should not be ignored; they have been highly influential in the successes of LHCCs along with Chairmen and other LHCC Board members.

**Development And Training Of CHP Boards**

We have not commented further on the composition of CHP Boards. Many of the members though will not have a background in management or leadership or may lack some important skills. Leadership and development training must be made available and funded (including backfill) not just for initial members but for succession planning too.

**Governance And Accountability**

CHPs are new; they will occupy a new place in the accountability and governance arrangements, in both the NHS and LA systems. These will need local development but guidance should ensure that these are neither unnecessarily onerous nor complex.

Given the size, importance and budgets involved the senior management should be appointed at Director level in order to ensure appropriate involvement.

**Public Involvement**

LHCCs have all involved the public, but to varying degrees. A specific responsibility and appropriate funding will enable this to be taken forward in a very meaningful way.

**Responsibilities Of Primary Care Organisation**

The new GMS contract places significant responsibilities (and workload) on the Primary Care Organisation (PCO). As CHPs are not to be statutory bodies they cannot hold these responsibilities. It is however very likely that many of the responsibilities will indeed be delegated to CHPs. This must be clear in the schemes of establishment and appropriate staff transferred to handle the work.

**Development Timescale**

We have referred to training and development and change over time. We would not wish to slow down the move to CHPs, and the likely timing of legislation is not worrying. It has to be recognised however that in order to deliver a sensible and coherent plan, and the necessary consultation to be complete, that too demanding a timescale will put too much focus on re-organisation rather than service delivery which should be our focus.

The co-operative element of the title LHCC was very important. It led to a bottom up scheme of development and a greater coherence within LHCCs. It would be important to involve staff, public and existing LHCCs fully in the development of local plans. The responsibility lies with NHS Boards, this must not mean that it becomes a directive process of NHS Boards setting up something which they describe as a CHP but has none of the characteristics of an LHCC.

**The Change Agenda**

The change agenda facing the whole public sector is huge. This is certainly true in the NHS and CHP development but is one item. The capacity to inspire and lead all of this change is finite, as is the enthusiasm of our workforce. Whilst change is a vital opportunity for all systems and often produces step change in services it can also be something of a challenge. LHCCs were a successful opportunity and challenge. The Association of LHCCs sees the establishment of CHPs as a change with similar potential.
The National Health Service Reform (Scotland) Bill: Stage 1

14:02

The Convener: Item 3 on the agenda is on the National Health Service Reform (Scotland) Bill. I direct members to papers HC/S2/03/17/2, HC/S2/03/17/3 and HC/S2/03/17/4, which are the written submissions from our witnesses. I thank the witnesses for their submissions; it is helpful to have them before we take oral evidence.

I welcome Martyn Evans, director of the Scottish Consumer Council, and Liz Macdonald, the council’s policy manager. I also welcome John Wright, director of the Scottish Association of Health Councils, and Dr Kate Adamson, the convener of the association. If you want to speak in answer to a question, you should indicate or gesture in some manner. If anyone else wants to make a point, they should just come in, because I might not think to ask directly.

Mike Rumbles: The first question to our witnesses is straightforward and basic. Do you think that the changes to the structure of the national health service that are proposed in the bill will improve service delivery? Will the bill succeed in that aim?

Martyn Evans (Scottish Consumer Council): We support the proposed structural changes and believe that they will improve service delivery. However, although the changes are necessary, they are not sufficient. A cultural change is also required in order to effect the structural changes that the bill proposes.

The Convener: As I say, other witnesses should just feel free to comment.

Dr Kate Adamson (Scottish Association of Health Councils): Provided that the transfer between primary and secondary care is genuine and seamless, there will be huge advantages for the public and patients, from community care up to specialist services. The bill will be extremely beneficial if its provisions and the important cultural change that it envisions are implemented.

Mr Davidson: In your written evidence, you support many of the principles of the bill. You say that one of the challenges is the nature and culture of the NHS. However, we are concerned that that might happen.

Mr Davidson: Is that because primary care and acute services will be subsumed into one board and will not be dealt with separately, as they are now?

John Wright: Yes.

Mr Davidson: How could that be remedied in the bill?

John Wright: I do not have any suggestions on how that could be remedied in the bill. That will depend on the way in which boards conduct their business and meetings—how those meetings are structured, how the public are made aware of the meetings and what the agenda items are.

Dr Adamson: It will also depend on the individual structures in the 15 areas. In some areas, the specialist acute services will be in association with the community health partnerships, whereas in other areas there is talk about operating divisions. It is critical that the proposed systems are studied so that they are effective.

Liz Macdonald (Scottish Consumer Council): It is also worth noting that the package is balanced. Although one could say that things will be more centralised at board level, there should—if the proposals work as I understand they are intended to work—be greater devolution of influence to a local level in the community health partnerships, which will be able to plan services for local communities based on local needs. There is a balance between the two developments.

Mr Davidson: Is that well enough covered in the bill?

Martyn Evans: There is a tension, but we cannot say how we would improve the bill in that respect, because that is not the issue. The policy intention is clear. It is about trying to balance the twin tracks of national standards and local control, which, although difficult to do, is the right approach to take. The more local control over service delivery there is, the more responsive the service will be in urban and rural Scotland. However, local control should be taken alongside an ambition to have national standards to end postcode prescribing and to end the situation where, if one is lucky enough to live in a particular area, one will get more and, if one is unlucky enough to live in another area, one will get less. There is a tension, but we could not amend the bill to deal with it.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): In your written evidence, you support many of the principles of the bill. You say that one of the challenges is the nature and culture of the NHS.
Can you identify some of the barriers that will prevent us from applying the principles of the bill?

Martyn Evans: There are barriers, but we do not believe that they will prevent the principles of the bill from being applied. From our point of view, the clearest principle is the duty on health boards to involve and engage the public in a whole range of areas. That is a different way of working from the old managerial and professional way. From a consumer point of view, we do not say that the interest of service users should dominate; we just say that that interest should be balanced with and brought to the table alongside professional, managerial and financial interests.

The great challenge is in making that a reality within all the complex arrangements of service delivery and service planning within the NHS. We see those tensions played out most weeks in the press with regard to service change. The NHS is up to the challenges, but we do not think that the structure alone will deliver the improvements that we were asked about. However, that is one of the areas that require more work and more support, which the bill will bring.

Mr McNeil: Have you any ideas that you can bring to the table about how engagement and public involvement can be improved?

Martyn Evans: There are two mechanisms by which to do that. The first is the Scottish Executive’s current structure whereby a team helps NHS boards to deliver their required involvement with the public. The second is that the new Scottish health council will be able to develop the capacity of patients to find their own voice and to promote their own interests, although we are doubtful about whether the investment that is going into the health council will be sufficient to support its ambitious community development programme. I think that an amount of roughly £2 million is going into that area.

The Convener: I do not want to stray into the issue of the health councils, as we will come to them later. I ask members to stick to the generality.

Mr McNeil: Okay.

The Convener: I wonder whether our witnesses would comment on evidence that we received last week. My recollection is that the view was taken that integration might be easier in rural areas than in large conurbations, especially in respect of culture change and personnel. In practice, the process can already be seen in the Borders. I got the impression that the changes will be hard enough to achieve in rural areas and that they will be a bigger challenge in urban areas.

Dr Adamson: In rural areas, there tends to be more coterminosity with the local authority area. That is an important issue. In urban areas, a local authority might have to deal with two health boards, which can create tensions.

Martyn Evans: We agree that boundary issues are key. I understand that your previous witnesses talked about the fact that boundaries are different in different delivery areas. The big challenge for the whole public sector is to try to deliver coherent services where there are different boundaries. Indeed, where boundaries are different, different structures will have to be developed. We cannot plan for coterminous boundaries; we simply have to address the issue. However, those difficulties will be less in some of our rural communities. We do not doubt that, within the structure, rural services will be able to respond well to the challenges that they face.

Helen Eadie (Dunfermline East) (Lab): My question, which I invite any panel member to answer, is about the establishment of the community health partnerships. Given that the community health partnerships are expected to evolve from the local health care co-operatives, will practice be improved by giving them a statutory basis when much of the detail of how they will work will be subject to guidance, regulations and local variations?

The Convener: Dr Adamson has taken a very deep breath. I do not know what is coming next.

Dr Adamson: As I am on the community health partnership development group, I definitely took a deep breath. The LHCCs are comparatively new and have developed at different rates across Scotland. The fact that both the good and the bad from the LHCCs could be taken through to the community health partnerships, instead of only the good, is a problem. It really is a brave new world.

Liz Macdonald: As some of the committee’s previous discussions have shown, there seems to be continuing confusion about the nature of the community health partnerships. The bill might not be clear enough in that respect. Our understanding is that the community health partnerships will be bodies within the NHS that are expected to work in partnership with other agencies. However, the term “community health partnership” creates the impression that the CHP is in itself a partnership body. There is a need for more clarity in the bill, guidance or regulations about the governance and management structures of the CHPs.

Helen Eadie: You have pre-empted my other question, which was to ask whether anything should be added to the bill in respect of CHPs.

14:15

Martyn Evans: Because of the way in which language is used, “community” and “partnership”
can mean a lot of different things to different people. When CHPs are described, sometimes they clearly come across as NHS organisations and sometimes they come across as partnership organisations with other bodies that are outside the NHS. We think that the governance arrangements should be crystal clear, although we have not decided whether they should be set out in the bill. We certainly think that the committee should consider whether the bill would be improved if it contained clear governance arrangements for those organisations that are not clear about the services for which they are responsible.

Dr Adamson: There is definitely a governance issue. We must remember that local authorities, which will be part of the CHPs, have by definition different governance arrangements from health boards. That issue really needs to be considered.

Helen Eadie: If the witnesses form a view on the matter at some stage, it would be helpful if they could let us have it in writing.

The Convener: I am a little confused, as I thought that CHPs went across different disciplines. Paragraph 19 of the policy memorandum says:

“The evolution into CHPs, which will have a key role in the overall planning of services in an area and co-ordinating the delivery of enhanced community based services, requires a more formal arrangement underpinned by legislation.”

Perhaps a definition is needed in the bill.

At our meeting last week, a witness from Ayrshire and Arran NHS Board said:

“The CHPs are a different animal altogether. The LHCCs are very much in the NHS family, but the CHPs, which involve health and social care, are quite different.”—[Official Report, Health Committee, 9 December 2003; c 432.]

I have got it into my head that social work, housing and health would be part of the CHPs. Is that not correct?

Martyn Evans: We understood that CHPs would be NHS organisations that engage in partnership work with organisations that are outside the NHS. If we are confused about the matter—and we are saying that some of that confusion is caused by the language that the consultation paper uses—perhaps the governance arrangements would make the structure much clearer. We would have to press the Executive on what the policy intention is.

Liz Macdonald: Our view on what a CHP is is based on the recent consultation document, on the basis of which guidance for CHPs will be developed. In the document, the CHP is described as a “key NHS partner”.

The Convener: So it is an NHS animal.

Dr Adamson: It is an NHS animal. We hope that the guidance will be available at the beginning of February, after the next meeting of the development group. That will be an important time, when we will be interested in commenting on the guidance that comes out.

The Convener: It is interesting that the submission from the Scottish Consumer Council says:

“the new terminology may create confusion”. It has done that for me.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The terminology creates confusion for me, too. I was speaking to some general practitioners, who will be heavily involved in community health partnerships, and they do not understand the system either. The definition must be clear. I have not been able to speak to anybody who has a clear idea of what is ahead.

The Convener: We can put that question to the minister.

Dr Adamson: There is some ambivalence on the matter. Although the development group will provide guidance, some areas have already considered local governance and establishment criteria. In my area—Highland—for example, that information exists in draft form and is waiting to run, but some areas have not yet reached the same level of development.

The Convener: We will seek clarification from the minister.

Shona Robison (Dundee East) (SNP): What are the witnesses’ general views of the proposals to dissolve the health council structure as we know it?

Dr Adamson: We view the dissolution of the local health councils as necessary, because it will be extremely helpful to have a national organisation with national standards to be applied on a local basis. At the moment, those standards do not really exist across the health councils. We therefore view a national organisation as extremely important.

Martyn Evans: We welcome the national body. We welcome its independence from service providers, as the current health councils are not independent, in our view. We welcome the threefold function of the body, which comprises assessment, development and feedback, as is described in the papers accompanying the bill.

Dr Adamson: I have a problem over the independence issue, which I believe to be extremely important.

Shona Robison: We will obviously explore that issue a bit more shortly.
In its evidence, the Royal College of Nursing Scotland said that it was not necessary to get rid of health councils altogether and that the structure of the councils could be reformed, particularly with regard to their independence. The RCN said that getting rid of the health councils was a bit like throwing the baby out with the bath water. We could have a national body, but we could also maintain the current functions of local health councils. What do you think about that view?

Martyn Evans: I will deal with the matter of independence first and come back to the other issues. I was talking about independence from service providers. It is important to stress that, as the current health councils are not independent of the service providers—they are appointed and paid for by the service providers and their staff are on secondment from the service providers. We welcome the proposed Scottish health council, for which those things will not be true. As a consumer organisation, we do not think that the current state of affairs is satisfactory. However, there is a further question, which you will no doubt press us on, about the independence of the Scottish health council.

Liz Macdonald: On the abolition of the local health councils, I would say that, despite the fact that the Scottish health council is clearly to be a national body, there will still be local offices with local advisory groups. In that sense there will be a continuing presence of a form of local health council. We will have to wait and see how the local offices and local advisory councils develop their roles.

Shona Robison: There seems to be a lack of clarity around the various functions involved.

Liz Macdonald: Yes, although I think that that is a separate issue.

Martyn Evans: One of the functions that the local bodies may lose is complaints handling, which is done by some but not all of them. We are also concerned about how voice will be given to patient groups—how the visits are concerned. As for how we ensure that the visits function is maintained, my view is that more investment should be put into the Scottish health council for that purpose.

Shona Robison: How do we ensure that that happens?

Martyn Evans: As I said before, we are worried about the financial capacity of the Scottish health council to deliver that aspect of its work and to build on it. The committee has received evidence about how the voluntary sector can respond as far as visits are concerned. As for how we ensure that the visits function is maintained, my view is that more investment should be put into the Scottish health council for that purpose.

Shona Robison: If those questions are not answered, is there a danger that, in doing away with bodies that already carry out that function, we will be taking a leap in the dark and just hoping that things will be okay and that public and patient involvement will happen? We need to ensure that that function is a little more definite.

Martyn Evans: That definiteness will come from the assessment role of NHS Quality Improvement Scotland and the Scottish health council, which will assess local service delivery to see whether patient involvement and visits are being encouraged. Our view is that the uncertainty can be resolved through that mechanism. If there is uncertainty, it is up to NHS QIS and the Scottish health council, through their assessment functions, to ask why visits are not being allowed, why patient groups are not being encouraged to come in and why long-term patients organisations are not getting support to engage in that way. There is potential for a step change so that that important assessment role—which we agree the local health councils are carrying out well at present—is undertaken more extensively and effectively. Change and improvement will be better assessed through the NHS QIS and Scottish health council route.

Shona Robison: One of my colleagues will return to the finances later.

The Convener: We will move on to David Davidson’s question.

Mr Davidson: I have no wish to be accused of leading witnesses, but both organisations mention the following issue in their evidence. Do you think that if the national health council is part of NHS QIS, there is a risk that it will be unable to act independently? If so, do you think that the bill should say something about that, in the form of a
definition or whatever? Should the council be set up as an independent body and, if so, what kind of body should it be?

Dr Adamson: We think that independence is important. We are involved in a lot of discussion and negotiation with the Scottish Executive and NHS QIS and we are running a project to consider the future of the Scottish health council. If it is within NHS QIS, we will need many safeguards because the health council must have an independent voice. I must stress that that independent voice should always be evidence based—that is an important point, which must be covered in the organisation. We must have definite safeguards in governance rules and so on, so that the situation is maintained if the minister and the chairperson and chief executive of NHS QIS all change.

Mr Davidson: You are saying that you want that to be defined in statute.

Dr Adamson: It is essential that the existence of the Scottish health council be included in statute. Our understanding is that it is probably not legally possible to put it in primary legislation, but it could be in a statutory instrument. There is a question about whether it could be a statutory organisation if it were part of another organisation, such as NHS QIS, and we are seeking advice on that.

Martyn Evans: This is one of the most challenging issues. It is about objective and subjective independence. Objectively, NHS QIS is clearly an independent organisation. We have seen how it operates and how it has built up credibility as an independent organisation; it has involved patients and members of the public in its service standards. However, the public perception of NHS QIS is different; it is perceived to be part of the NHS because it has NHS in its title.

We believe that there should be additional safeguards, not about the objective side of it, as we believe that QIS is an independent organisation and that the minister is committed to the independence of the Scottish health council. The safeguards that we would like are: a memorandum of understanding between the QIS board and the Scottish health council; a council for the Scottish health council; a directorate answerable to the council; a budget; and research capacity.

To answer Mr Davidson’s question directly, the one bit that we think should be in the bill is the requirement to have a memorandum of understanding between the board of QIS and the entity called the Scottish health council. The bill does not have to define that memorandum, but the requirement must be there to ensure that something is put down on paper that sets out the rather complex relationship that is envisaged.
the proposals, as the council may not be considered to be independent. We also have written evidence from the Scottish Association of Health Councils that states:

“We consider the independence of the new Scottish Health Council, to act and speak in the best interests of patients to be of paramount importance”—

I do not see how its independence could be more important than that—

“and believe that this can best be achieved by establishing the Scottish Health Council as a statutory independent body in its own right with its own board of governance”.

There seems to be a clear option of recommending to the Executive that it should go down that route, away from what it has suggested. However, I do not think that the committee would want to do that unless there was very strong evidence from everybody who had come before us that that would be best. We are getting that strong evidence from the health councils, but you are hedging your bets. Are you saying that it is not necessary for the committee to recommend a change to the bill as regards independence?

Martyn Evans: No, we are not saying that. I hope that we are not hedging our bets on this. The subjective view of independence would not be addressed if another special health board were created, because that also would be perceived to be part of the NHS. How could we get over that problem? In addition, if it were to be an independent organisation, its budget, at £2 million, is very modest. A lot of money would have to be spent on internal processes, so it would not be as efficient.

Also, the Scottish health council would have to build its independence and credibility. QIS has, in my experience, built that credibility of being independent within the NHS itself and in a wider policy field. I do not know whether it has had much impact in the public field, but it has had an impact in the wider policy field.

We would say that building on the safeguards within the structure of QIS is the best way forward, because putting the Scottish health council into a larger organisation gives you economies of scale, and the benefits of hitting the ground running and of the real independence that we believe is there.

Mike Rumbles: I would like to press you on one point. You asked, “Why create another health board?” That is what the proposal would mean, as far as you are concerned, but it would not have to be a health board. In fact, it would not necessarily have to be part of the NHS. If we think outside the box, we could think about health councils not actually being part of the National Health Service in Scotland. Do you see what I am getting at?

Martyn Evans: I do see that, but I was just responding to the proposal.

If the national health council were a wider body, perceived as part of the NHS, that part of our concern might not be there, but our other concerns would be. With only £2 million, a very small organisation would have to build its credibility. There is therefore a more pragmatic question to answer, and I would say, based on my experience of running small organisations, that such organisations can be efficient and effective. However, they can be more efficient and more effective by being part of a larger organisation, as the Scottish Consumer Council is.

The Convener: Before I bring in Shona Robison, I would just like to pick up on what you said about money. Martyn Evans referred to the £2 million mentioned in the explanatory notes, which state that the funding for the Scottish health council would be

“The £2,108,000 currently allocated to local health councils”.

Martyn Evans raised that figure, but the evidence from the Scottish Association of Health Councils states:

“This will therefore require additional funding for the new Scottish Health Council, over and above the existing provision.”

Does the Scottish Association of Health Councils think that we will need more than £2 million for the Scottish health council, and does the Scottish Consumer Council think that we need more than £2 million? The financial memorandum says that there will be

“no net additional expenditure arising from the Bill”,

and that is considered an accurate assessment. Could we clear up that point about the funding?

John Wright: The £2.1 million, as I understand it, is the money that currently goes from the Executive to support the 15 local health councils and the Scottish Association of Health Councils. It is important to note, however, that many local health councils also receive additional funding in kind from their local board, to cover such things as the cost of premises, IT support and clerical services. It is important that that additional funding is not ignored, and we have asked the Executive to take steps to ensure that it is quantified. Our estimate is that it could be as high as another £600,000. That is money that the existing health councils need.

We are talking about a fundamentally different type of organisation—a national organisation with local offices working on the same core functions to national standards. In such an organisation, there needs to be considerable investment in the training and development of staff and local members, and that is something that the existing
health council structure has not been funded to do. Establishing the new Scottish health council, as currently proposed, will involve significant additional costs over and above the £2.1 million, if we are to have an organisation that can hit the ground running and, most important, be effective for patients.

**The Convener:** Are you saying that more than £600,000 will be needed?

**John Wright:** I am saying that the £600,000 is basically—

**The Convener:** I understand that. I am asking how much more you are talking about.

**John Wright:** I cannot say how much more would be needed, but there would need to be training and development for staff so that there could be competent managers in the organisation. As a different type of organisation, the Scottish health council will need to invest in development and training for both staff and members.

**Martyn Evans:** We agree with John Wright that in-kind contribution must be recognised and specified clearly, because the health boards make an important in-kind contribution.

On the financial memorandum saying that there will be no change in the £2.1 million that is available, if we were to go into the system without making any change, we would be asking the Scottish health council to achieve a significant step change in the culture of service delivery with the same level of resources that has been available in the past. We do not think that that level of resources is sufficient to meet the challenge. In our view, that challenge is about bringing the patient interest to the table alongside the well-organised professional interest that previous witnesses have mentioned and the well-organised financial and managerial interests within the NHS. The proposed sum is a very modest amount of money for bringing the patient interest to the table alongside the professional and funding interests have.

We do not believe that the Scottish health council will necessarily cost any more money than the amount that is proposed, but we do not think that it will be able to do the job unless more money is put into it—that is slightly different from what John Wright is saying. It is not inevitable that the health council will cost more money, but it will not succeed unless there is an investment of more than £2 million.

**The Convener:** It will be useful to put that point to the minister.

**Shona Robison:** I want to respond to two of the points that have been made. I want to pick up Martyn Evans on what he said about independence. You seemed to imply that the fact that the health council would not be big enough or well enough resourced to stand alone was driving your thinking on where it should be located. Should not the question of where the health council should be located in order for it to be as independent as possible be a matter of principle? Should resourcing not be left aside when considering that principle? If resources were not an issue, would that change your view on where the health council should be located?

**Martyn Evans:** It would not change our view that it is of crucial importance that the health council is independent in any objective terms. We say that the present proposed location would make the health council independent in any objective terms. However, we are saying that there is a perception that, because of its proposed location, it might not be independent. In objective terms, we have no worry about its independence as part of NHS QIS, but we have significant concerns about how that would be perceived.

All that I can do is respond to the alternative proposal of which I am aware, which is that there could be an NHS special health board. We say that there is no doubt that such a board would also be objectively independent, but the perception would remain the same—because the board would be an NHS board—and, in addition, there would be practical issues, although I accept that they would not be matters of principle.

We share the view of our colleagues—we think that it is absolutely vital that the health council is an independent organisation.

**Shona Robison:** My second question is for the Scottish Association of Health Councils. You have heard what the Scottish Consumer Council has said about safeguards. In your evidence, you said that, if you do not get the structure that you want, “additional safeguards will be required” as a fallback. Are the safeguards that the Consumer Council was outlining the same kind of safeguards that you are in favour of or do you have other safeguards in mind? If so, can you let us know what those other safeguards are, either today, or subsequently in writing?

**John Wright:** As I recall, the points that Martyn Evans made about safeguards are similar to those that we would make. We have been trying to work up proposals in a bit more detail, by considering issues such as the relationship between the health council and the board of NHS QIS and how accountability would work within that organisation. We have tried to work out the issue in a bit more detail and I would be happy to share our information on what we think that the safeguards for the health council’s independence within NHS QIS would be.
Janis Hughes (Glasgow Rutherglen) (Lab): I refer to the written submission from the Association of Health Councils. You say that you are concerned that many of the existing functions carried out by Health Councils could simply disappear, unless alternative delivery mechanisms are identified.

Will you tell us what functions you are concerned might be lost under the proposal? What mechanisms could address those omissions?

Dr Adamson: We feel that it is extremely important to ensure that the public and patient voice is heard, although we are not suggesting that the Scottish health council necessarily has to be that voice.

The health boards have a duty to involve the public. However, there is a definite problem relating to the three to four-year interim development period, in which the health boards will have to develop new systems. We are currently considering various transition arrangements. We are also concerned about the arrangement whereby the public goes to a health board for information and the health board replies to their concerns. We have to ensure that the public’s voice is heard and that the health boards do not give them the information as a way of avoiding problems. The public must get independent information as well as information from the boards.

Janis Hughes: Do you think that the bill goes far enough in relation to public involvement and the duty that will be on boards to involve the public? Might there, therefore, be a role for health councils to play that might not be in the new proposals?

Dr Adamson: There is definitely a role in ensuring that this process is adequate. The role of the Scottish health council will be to assess whether it is adequate. However, there has to be a robust mechanism by which any problems can be flagged up.

Janis Hughes: What would you suggest as a robust mechanism? What should there be in the bill to address the elements that you think might be lost?

Dr Adamson: We are considering that at the moment. We are not experts in legislation so we have to take advice from people as regards the mechanisms that can be used.

Janis Hughes: I want to add something about functions being lost or not carried over. We have given our view about complaints and complaint handling and about the right of access in order to monitor services and I now want to agree with what Kate Adamson said about patient voice.

We agree with the policy direction that states that the Scottish health council will allow patients to find their own voice and to represent their own interests in all their diversity. Our concern is for those patients who are unable to do that for themselves: perhaps the very young; teenagers in particular; or perhaps homeless people seeking dental appointments, or whatever. We are talking about people at the margins who are disadvantaged. The Scottish health council must have a clear equalities strategy and it must be able to give a voice to some of those people. It is our experience that such people cannot easily be helped to find their voice because of the nature of their circumstances and how they engage with the NHS.

Although we broadly approve of building a capacity to enable people to say how they find the
services, there are key groups in our society who will not be able to have a voice. We do not suggest that that should be covered by the bill; equalities statements are part of safeguarding a voice for the voiceless. That voice is not necessarily a national one, but a voice that says to the local service provider, “In your area, this is a failure,” or, “This is a concern that we have about our local office of the Scottish health council.”

I agree strongly with what Kate Adamson said about voice.

Mr McNeil: It is natural at a time of change that one focuses on what one might lose and on what one is losing. We have heard from the Scottish Consumer Council that it believes that it was time for a review of the health councils, that all was not perfect, that there were weaknesses in the system and that this is an opportunity for progress. Will you take the opportunity to identify some of the weaknesses that you perceive in the system? Can you tell us what we can improve through the review, rather than dwelling on what we might lose?

John Wright: I make it clear that we agree with and are supportive of the need for health councils to reform, as Dr Adamson said earlier. The basic principle is that we are talking about fundamental and structural reform of the health service, of which the health councils are part. With the changes that are taking place in the NHS, we recognise that health councils need to reform and respond to that change. We agree with the principle that the board should be responsible for public involvement. We are positive from that point of view.

We see this as an opportunity to improve what health councils do because it is not about what is good or bad for health councils; it is about being able to deliver outcomes for patients. That will be determined by the powers, the remit, the role and the responsibilities that are given to health councils. The separation from service providers, which you have already talked about, is a positive step.

I do not want to be totally negative and say that everything about being involved in NHS QIS is bad because that organisation has, as we have said, demonstrated its ability to act independently. It has powers to intervene and it has powers to bring about change in the NHS. Having those powers vested in the Scottish health council and giving it teeth to deliver will give significant advantages over the current set-up. Currently, health councils can go along to boards and point out issues, and the boards can simply pat them on the head and say, “Thanks very much, but we’re not going to do anything about it.” From the powers and responsibilities that will be given to the Scottish health council will flow the opportunity to deliver change for patients and to ensure that the patients are involved in the planning and delivery of the NHS and that they will be able to communicate their voice. There are many positive points there. Our concern is that the organisation is created in the right environment, with the appropriate powers and remit to be able to deliver, and that it not only has independence but is perceived to be independent.

The Convener: We see a slight difference in views between the two groups.

I ask Duncan McNeil whether he wants to proceed with a question on the complaints procedure before we move on to questions from David Davidson.

Mr McNeil: Yes, that might be helpful. I return to the concerns about the complaints system, which was mentioned both in your written evidence and earlier this morning, when we heard evidence of concerns over the lack of investment and focus. Will you say more about your concerns about the complaints service and whether you believe that giving the boards responsibility to establish such a service will be an improvement on the current set-up? Did you say earlier that not every board has a complaints system in place?

Martyn Evans: One of the weaknesses of the current system is that not every health council has a mechanism for dealing with complaints, so the pattern of service delivery throughout Scotland is variable. The extent of support depends on the individual board, so the system is not coherent. The new NHS complaints procedure that is coming through will cut out the middle level: it is about local service provision and resolution at the local level. The evidence that we took in our preconsultation work showed that few people knew about the role of local health councils. Other organisations that provide advice and assistance are well known; name recognition of some of them is around 90 per cent.

To be consistent, we must invest in a complaints support service throughout Scotland. The Scottish health council should have a role in defining who should take up the services locally and in monitoring how well they are provided. We welcome the greater focus on consistency throughout Scotland and we hope that there will be proper funding of support services for people who make complaints about the NHS. The evidence that we took showed that a significant number of people just want to be dealt with locally and reasonably quickly, rather than go through the existing escalating procedure, which takes a significant amount of time.

Mr McNeil: Does Kate Adamson want to say anything about that? There was quite a challenge there in relation to your perception of the number
of MSPs and other people who use the procedure. I do not use it; many of us use a direct route. The challenge from the Scottish Consumer Council was that it should not necessarily be the health councils that provide the support and that citizens advice bureaux or local advice groups with name recognition and accreditation should do that work.

**Dr Adamson:** Work is being done on the mechanisms under which complaints are dealt with and on whether health boards will have to deal with complaints or whether they will commission services. The extremely important point that Martyn Evans made is that adequate training and capacity must be built into the handling of complaints; health boards cannot take on that work without making considerable investment.

**Martyn Evans:** I do not want my criticisms of the system to be taken as criticisms of health council members or staff. The councils’ impact has been dramatic over the past 30 years; our criticism is of the structure and the method of service delivery. We have talked about the improvement that the proposals might bring. I say that in case I overstepped the mark in making my criticisms.

**Mr Davidson:** I go back to something that Liz Macdonald said about NHS QIS and its image, which rang a bell. It really comes down to what NHS QIS does. Many people see it as an organisation that audits and can intervene in professional delivery as opposed to one that deals with patient involvement. John Wright said clearly that the health councils welcome the ability of NHS QIS to step in to intervene. Does that mean that health boards have a separate role in putting a case to NHS QIS as an independent body to intervene from a patient perspective in something that might not be to do with professional standards but which might be to do with outcomes and accessibility? I challenge you both on that question again. John Wright made himself very clear, but where does the Scottish Consumer Council believe that the difference lies?

15:00

**Liz Macdonald:** I am not sure that I understand your point.

**Mr Davidson:** John Wright said that the health councils welcome the fact that NHS QIS has the power to intervene on delivery, and that NHS QIS is perceived as being more professional. Is there a role for the health councils to act as an independent body on behalf of patients and to take a case to NHS QIS?

**Liz Macdonald:** If there is an established system for setting standards and monitoring them, there would be no need for ad hoc approaches, which seems to be what you are suggesting.

**Mr Davidson:** That is how the system operates at the moment.

**Martyn Evans:** The system does not operate that effectively at the moment. NHS QIS has a system of doing routine and regular reviews and writing those up in the expectation that there will be improvement. It has powers to intervene in service failure and it is grappling with how it undertakes those powers. There is no reason why the Scottish health council could not support a voluntary organisation that wanted NHS QIS to take action on a perceived service failure in a particular location. If the memorandum of agreement that we have suggested is drawn up, there is no reason why the Scottish health council should not use internal mechanisms to ask the QIS board to intervene in a perceived service failure. There is also no reason why the current structure would preclude your suggestion.

Liz Macdonald was saying that the current quality assurance system is a routine system—it is not a system for exceptional circumstances—and it is understood that service failure will be exceptional. There is a mechanism for dealing with service failures and if we suggested that the memorandum of agreement might be put into statute, we would be looking for that memorandum to have a route to service failure intervention. That would be a strong indicator of independence from the QIS board. NHS QIS would still have to decide whether to intervene on service failure but the Scottish health council could make such a proposal. In an open and transparent organisation, it would be known that such a proposal had been made and what the evidence for it was.

**Dr Adamson:** A close relationship with QIS is viewed as being extremely valuable; it will be the important relationship. There will be an advantage in that the Scottish health council will not necessarily have to go back to the boss organisation, as it has to have a voice in areas where problems are perceived to exist. The council will benefit from QIS’s experience in setting standards and considering outcomes, but it must be able to comment on those in its own right, especially where public involvement is concerned.

**Dr Turner:** Public involvement is very important. Given that the duty to involve the public will not be accompanied by significant additional resources, will it improve public involvement in health service planning?

**Martyn Evans:** We think that it will. As we said at the beginning, we are talking about a culture change. That might involve some investment in training but the major impact will be on service provision in public services for patients, in that their feedback will be respected and encouraged and their interests will be taken care of when service delivery and future services are planned.
I hope that we are not being naive when we say that we hope that the duty will improve NHS services in Scotland. It will make a major difference. The structures proposed in the bill, such as the capacity-building support that the Scottish health council will give, will be of major importance, and the statutory duty to involve the public and patients will also be of great importance. We are very optimistic about the changes that could take place in the NHS as a result of the bill.

The Convener: Do I detect dissent among the panel?

Dr Adamson: We are extremely concerned about the fact that public involvement by health boards is to be cost neutral. Unless that money is ring fenced, the problem that we have already of public involvement being considered not that important will definitely continue, and front-line services will be considered important as far as funding is concerned. There will be a conflict, unless the boards' duty of public involvement is covered in another way.

Dr Turner: That is an important issue. The Scottish NHS Confederation said that the proposal would cost quite a lot of money because, to use its phrase,

“Genuine, meaningful, continuous public involvement is not cheap”.

I agree with that. The feedback from patients is that public involvement is fine but people already want to be involved and there is nobody to listen to them. That is the main thing. There are not enough nurses on the wards and there is not enough time in surgeries, and when people try to relate to people in the NHS, they find that the people in the NHS do not seem to have the time to listen. Even if there were more staff to answer questions, a cost would be involved. Enormous costs could be involved in public involvement.

Dr Adamson: We support that attitude.

Martyn Evans: Our experience is that it does not cost public services huge amounts of money to focus on their service recipients. After all, that should be the nature of what their business is about. There is a difference between getting the views of the public service user and providing the time, to which Dr Turner referred, for a general practitioner to spend with a particular patient. The issues are different. It can be argued quite legitimately that, for clinical and medical reasons, GPs and others need more time to see their patients. However, our evidence is that a large organisation such as the NHS—it is the largest organisation in Scotland—does not need significant extra funding to focus on its service users. It needs a culture change to reassess how it spends its money but we do not think that it needs large amounts of extra money over and above what it currently receives.

Mike Rumbles: On that point, I think that the issue is one of perception. I note that Dr Kate Adamson said that more money would not be provided for the bill. However, my understanding from the evidence that we have received from previous witnesses is that the Executive has said not that there will be no more money but that the bill will not add any further costs. For instance, Dumfries and Galloway NHS Board—which is a small health board in comparison with others—said in evidence that it saved £500,000 through service reorganisation. That is quite a substantial sum of money. The bill will make changes from the top and if those savings were replicated elsewhere, that could make moneys available. As far as I understand it, the Executive is saying that people will be able to redirect such moneys to public involvement among other things. Do you not share that perception of the situation?

Dr Adamson: We have read the evidence that Dumfries and Galloway NHS Board gave, but £500,000 on the board's turnover is not quite as good as it might sound at first hearing. We are talking about savings that will be made over quite some time but money will be required immediately to fund public involvement. Although the proposals may be cost neutral over time, there is definitely an issue over the initial cost.

Mike Rumbles: I want to pursue that point. You said, fairly, that the £500,000 is insignificant compared to the board's turnover. However, the funding of health councils is £2 million Scotland-wide, is it not? If the 15 health boards each saved £500,000, that would amount to a total of £7.5 million. Surely that is a substantial sum to save. I am sure that the actual savings would be a lot more, would they not?

Dr Adamson: The health councils will continue with assessments and other functions, so the £2 million will not go to the boards for public involvement. Public involvement is a new process.

Mike Rumbles: You seem to misunderstand my point. You said in response to my question that £500,000 is not a particularly large sum in proportion to the turnover of Dumfries and Galloway NHS Board. I then used another comparative example: the £2 million for health councils Scotland-wide. I am not saying that that sum would go to public involvement—I understand that it will not. However, the point that I am trying to make is that we do not know how much money will be freed up through the savings process; it could be several million pounds. It seems to me that if Dumfries and Galloway NHS Board can make savings of £500,000, there will be generally a substantial sum of money that should be directed to public involvement. I was questioning your point that more money should be allocated.
Dr Adamson: I am talking about allocating more money during the set-up period rather than in five years' time. I believe that that is an extremely important point. Dumfries and Galloway NHS Board said in its evidence that it could not guarantee that its saving would be mirrored in other areas.

The Convener: Three members want to ask supplementary questions. I ask them to be brief, so that we can move on. I am mindful that another witness is waiting.

Mr McNeill: I will be very brief. We have had a lot of evidence, including that from Dumfries and Galloway NHS Board, but I do not think that in any of that evidence anyone has described the cost of public involvement as being enormous amounts of money. We need to clarify that no one has given us such information; in fact, it is contrary to all the evidence that we have taken. What is your definition of enormous amounts of money?

Dr Adamson: It was not my intention to imply that enormous amounts of money would be involved. I want to ensure that the process of and the mechanisms for public involvement are covered. The Scottish Association of Health Councils has been considering the developing frameworks for public involvement that the boards are producing and the development of performance assessment. Our perception is that health boards are producing those things at different speeds. The frameworks are in operation, because the boards must produce them, but we do not have total confidence in the processes that they are undertaking.

Mr McNeill: That could be more to do with the culture than with the financial constraints.

Dr Adamson: It could be.

Dr Turner: My understanding—I wonder whether it is yours—is that public involvement is to take place throughout the whole health service and not just in the public's interaction with health councils. Time is money in every other form of employment and business. Therefore, if the culture has to change and people have to find more time to interact with patients and relatives to feed back to health councils and consumer councils, an amount of money will be involved that has not yet been prescribed. We have no idea yet what that amount will be.

Dr Adamson: A lot of the public involvement has been on the part of lay people giving their time voluntarily. If employees of health boards are required to be involved, by definition there will be a cost.

Liz Macdonald: A lot of the talk has been along the lines that public involvement is something new that has not happened before, but it would be a mistake to think that. We have been working on public involvement in the health service for many years. Public involvement is going on, and there are lots of examples of good practice. We are not talking about a step change in funding; we are talking about the introduction of a statutory duty as another driver to push people down a road that a lot of people are already on.

Helen Eadie: When I first came to the Scottish Parliament the guidelines on public involvement had not been changed since 1947. That was a contentious issue in my area in Fife. I ask each witness to define public involvement for me, because I am aware that there are many examples of best practice.

The Convener: I ask the witnesses to be brief.

Martyn Evans: I will distinguish between service-user involvement and public involvement, because they get mixed up. Public involvement is often about service planning. It is about the whole range of people who may not currently use a service, but who have an interest in how that service is developed. That public involvement is basically a citizenship issue. It is about engaging with citizens who have the interests of young people and others at heart. Engaging the public as citizens in service planning is a complex matter. We see that when hospitals have to be closed or reorganised.

Service-user involvement is about current service users having their say about how things are. Our interest is in making that more sophisticated, because in some services we also want to bring to the table the non-users of services—those who could use them or who are excluded from them.

We make that distinction, but we are much more interested in service-user involvement, only because we are the Scottish Consumer Council, and that is our locus. However, we understand the public-policy issues around public involvement, because we believe that better decisions are made about huge allocations of money and time. Involving citizens in big strategic decisions is a modern way of working, and it is a better way of working in a democracy.

The Convener: I will take one definition only from each organisation.

Dr Adamson: I support Martyn Evans's comments: there are the service users and there are the public. The service user often has their own interests; the public have a broader perception, but perhaps they do not understand the issues. It is essential that both groups are involved, and disadvantaged people must be enabled.
The Convener: I thank the witnesses. We will have a five-minute adjournment until 25 past 3.

15:18

Meeting suspended.

15:26

On resuming—

The Convener: I welcome Mr Warwick Shaw, chair of the Association of Local Health Care Cooperatives, a gentleman whom I met before in his work in the Scottish Borders. I will start off with a general question. Do you think that the change to the structure of the NHS as proposed in the bill is necessary or appropriate? That is quite a soft ball for you. Do you think that it will improve service delivery? That is a more difficult question.

Mr Warwick Shaw (Association of Local Health Care Cooperatives): I am speaking both as the chair of the association and as someone with a background in the NHS in the Borders. I think that the move to a single structure in the NHS in the Borders has been very valuable. It has enabled many improvements to begin, although I would not necessarily say that they have all been realised.

The Convener: I ask you to move the microphone a little closer to you.

Mr Shaw: Certainly, and I will move a bit closer to it as well.

The Convener: Thank you.

Mr Shaw: The reorganisation is an important one, and it offers many opportunities to improve services and the way in which they are delivered. That applies both to the public, who are the users of the service, and to the professionals, who deliver it.

Dr Turner: Do you think that the bill should explicitly state that community health partnerships should evolve from LHCCs? If so, why do you think that that would be beneficial?

Mr Shaw: I will answer the second part of the question first. When LHCCs evolved, as a result of a couple of phrases in the 1997 white paper, “Designed to Care”, the guidance was broad and was very much an outline. It enabled front-line clinicians to feel far more involved than they had been in decisions on investment and on how services were shaped, and in how their lives were affected. The various reviews of LHCCs, the best-practice group and the primary care modernisation group have all identified that. There is a tremendous range of LHCCs, some of which have made a significant difference to the way in which services are provided. I am not suggesting that either big LHCCs or small LHCCs are the answer. It is not purely a question of size, although I think that we used that phrase in our evidence. It is much more an issue of attitude—I am perhaps phrasing that in a slightly different way than was done previously.

The Convener: If things have evolved in the way that you describe, what in fact is a community health partnership, or CHP—as one might work in the Borders, for example? I know that you are not here to give evidence on that, but if you have one in the Borders, you might as well tell us about it.

15:30

Mr Shaw: We do not actually have a community health partnership in the Borders; there is a unified NHS board. Many of the characteristics of a community health partnership are displayed in one of the LHCCs, but it has been set up as an LHCC, not a community health partnership, and therefore has fewer responsibilities and a slim infrastructure, as do most LHCCs.

What is a community health partnership? The association was invited to become part of the drafting process with the Scottish Executive Health Department, and we spent quite some time batting around what a community health partnership is. The summary of the consultation process contains quite a good description of what would be in a community health partnership, but that is rather different from what a community health partnership might do. Not only would there be services and staff within a community health partnership, the community health partnership would exercise influence over other areas, both within health services and within the local authority. I agree that community health partnership is not necessarily a tremendously helpful name to describe what is probably fundamentally an NHS body, albeit one with necessarily extremely strong links with the local authority partners.

Dr Turner: Can you give an example of something that is working well at LHCC level that would probably work well in a community health partnership with the local authority?

Mr Shaw: An example of that is the integration of the primary health care team at a level above the primary health care team—not just the general practitioners who work in a practice, who always work in close partnership, but the district nursing staff, the health visiting staff, community midwives, the local social worker and the local community practice nurse. All those people who work within a defined geographic area have always been able to work closely if there was the will for that locally. LHCCs have made that far more likely to be the case by allowing such joint working to take place.
at the planning level for those local primary care teams.

Dr Turner: That certainly happened in some areas before the creation of community health partnerships. All those people worked together in a geographical area. In connection with the local authority, would there be more involvement with social work and housing services?

Mr Shaw: Certainly.

Dr Turner: That is what I was wondering. Do you have any examples of that happening at the moment?

Mr Shaw: There are examples around Scotland, but things have evolved differently in different areas. In your constituency, there is a well-developed discharge team, which involves good co-operation between the local authority and the LHCC.

Dr Turner: Yes, that is right.

Mr Shaw: That is also the case elsewhere.

Mr McNeil: It is important to examine the relationships between local authorities and LHCCs. Some of the more developed LHCCs take an integrated approach, but that is not uniform throughout the country. What are the strengths and weaknesses of LHCCs? What are the best examples? Where are the weaknesses? Can the formation of community health partnerships be expected to improve those relationships or does the committee need to do something to ensure that that happens?

Mr Shaw: In most cases, the areas where LHCCs have worked better are those where there is already an element of coterminosity and one LHCC does not have to try to deal with two local authorities—or vice versa—or something more complex. The community health partnership is specified as being coterminous with a local authority or some obvious part thereof. If coterminosity is one of the key elements in the success of integrating local authorities and LHCC services, we can assume that CHPs will be better able to develop services jointly if coterminosity is rolled out across the CHP model.

Janis Hughes: I have a follow-on question. How much emphasis do you place on the importance of coterminosity? Particularly given the way in which things stand in the central belt at the moment, coterminosity will be quite difficult to achieve. I know that the issue has been raised with the Executive and that it is looking at it in the context of the consultation on CHPs. How important is it to keep the CHPs coterminous with the areas that they are to serve?

Mr Shaw: It would be useful, but it is not vital. Coterminosity makes things simpler and, if one can make things simpler, they are probably more likely to succeed.

Janis Hughes: Would it be better to have a smaller CHP and keep it coterminous than to go for a bigger group with no coterminosity?

Mr Shaw: There are advantages to both. If a community health partnership is too small, it will not be possible to achieve an economy of scale in infrastructure. If it is too large and it covers too big an area, the complexity of the infrastructure means that it will have to work far harder in order to engage with all the appropriate partners.

Janis Hughes: You alluded to the fact that one of the benefits of LHCCs is that they can react to local needs. LHCCs are composed of groups of health professionals who work together in their local area. Will the statutory basis that is proposed for the community health partnerships mean that they will be more bureaucratic? If so, will they lose some of their ability to react to local needs?

Mr Shaw: Most of the members of the Association of Local Health Care Cooperatives steering committee would be concerned if CHPs were to become what we would characterise as traditional NHS organisations—by that I mean if CHPs became relatively bureaucratic and procedure and governance driven, as opposed to how we characterise ourselves, which is as slim organisations that concentrate on trying to do something. We rely on the NHS infrastructure around us to provide the governance framework within which we operate.

Janis Hughes: Is there anything that could be added to the bill that would help the CHPs to avoid that bureaucratic quagmire?

Mr Shaw: Community health partnerships need to exist as part of an NHS body and not as statutory, independent bodies in their own right. As we move away from the trust model, there is a danger that we could almost recreate them.

The Convener: From reading proposed new section 4A of the National Health Service (Scotland) Act 1978, as inserted by section 2 of the bill, I think that there can be more than one community health partnership in a board area. Is that correct?

Mr Shaw: Yes.

The Convener: I think that I was getting the wrong idea that there would be one community health partnership in a board area. I can see that, if the health board covers a big area, it might have two or three CHPs in its area. If CHPs were set up on an area basis, could that deal with the difficulties of coterminosity?

Mr Shaw: There will be one community health partnership in only a very few health board areas.
If that were to happen, it would almost be as if we had one structure sitting on top of another structure, which would not be terribly helpful. In many areas, the coterminality of a community health partnership in a health board area will be with the sub-divisions of a local authority and not the entire local authority. One example is Ayrshire and Arran NHS Board, which is considering having three community health partnerships. I think that Argyll and Clyde NHS Board is considering having four.

The Convener: Is that because not all the local authority area is in the NHS board area?

Mr Shaw: That is right. However, there is a need to try to retain a more local focus. We do not want to have a community health partnership with a million patients in it.

The Convener: I was thinking that way, but I have just realised that I was thinking wrongly, which is a bad sign.

Mr Davidson: I turn to the practice outcomes, because the delivery of health care is what the bill is supposed to be about. As CHPs are supposed to evolve from LHCCs, do you think that practice will improve? CHPs will be given a statutory basis, but much will be laid down by regulation, by guidance and by local variations.

Mr Shaw: By defining what a community health partnership's responsibilities are, one gives a level of legitimacy if there is a different view at the health board level in each area. One of the reasons why LHCCs are at different stages of development around Scotland is the level of the support that they were given by local health boards and the level of freedom that those boards were prepared to delegate.

Mr Davidson: In other words, the new sense of freedom comes with responsibility.

Mr Shaw: Yes. Where the freedom was given, the responsibility was returned.

Mr Davidson: On CHPs, do you think that an addition should be made to the bill to enshrine flexibility in devolved management? The minister talks about that principle, but are you content that there is enough in the bill to demonstrate it?

Mr Shaw: There is the opportunity in the bill for that to take place, but if it were defined, that would probably be rather welcomed by the steering committee of the Association of Local Health Care Cooperatives.

Shona Robison: The financial memorandum to the bill states that the community health partnerships will not require any "overall additional expenditure". Do you agree?

Mr Shaw: Given that the bill is in the context of a significant reorganisation of every local NHS system, there will certainly be possibilities to redeploy staff and transfer resources that might be freed up from the unified system into community health partnerships. You should also bear it in mind that most CHPs will be an amalgamation of several LHCCs, so some management and administrative effort will be available. Whether that is at the right level and with the right skills is a different question. I am almost falling into the civil service trap of weasel words—

The Convener: Heaven forfend.

Mr Shaw: I think that it is possible that additional expenditure will not be required, but goodwill, imagination and a willingness to transfer good staff, rather than spare staff, will be needed.

Shona Robison: Let us see whether we can get you out of the civil service trap. Under infrastructure, your evidence says:

"LHCCs have been established on a relative shoestring ... It is important that CHP establishments are sufficient to handle the workload."

Given that CHPs will involve several LHCCs, as you mentioned, CHPs will presumably involve several shoestrings. To me, that reflects a concern that community health partnerships might not be adequately resourced—that comes from your written evidence, but also from what you said about ensuring that CHPs have the right personnel. Your evidence goes on to say:

"As NHS systems re-organise the opportunity to redeploy high quality staff within emerging CHPs should not be ignored or lost."

Of course, staff cost money; they are not free. Do you think that we need to ensure that there are adequate resources for CHPs? If so, how do we do that?

Mr Shaw: My association's steering committee would certainly agree with you, but it would also agree that one has to be realistic. NHS financial systems are already under some strain, and it would not be helpful to suggest that sums should be ring fenced for yet another style of organisation. It may well be helpful to the development of community health partnerships, but not to the overall NHS systems. I really think that we need to avoid trying to fave one group over another. Our evidence reflects the fact that there are two sides to the argument. There will be additional demands for an appropriate infrastructure for community health partnerships evolving from LHCCs, but that does not necessarily require investment from outside the existing envelope.

15:45

Shona Robison: So we run them on a shoestring as well.
Mr Shaw: As you yourself suggested, several shoestrings coming together can be plaited into a relatively substantial rope.

The Convener: A man of metaphors.

Mr Shaw: Hopefully not one who will hang himself. [Laughter.]

The Convener: He has thrown that rope to you. Clutch it, Shona.

Shona Robison: That is an interesting response. I am interested in what you are saying about balancing. We know that there are significant pressures on the NHS, and the Audit Scotland report makes interesting reading. However, we are also told—and we all agree—that what can be done in primary care should be done, so there will be an expectation that CHPs will deliver an awful lot more than LHCCs delivered. As we know, the success of LHCCs was very patchy across Scotland. I agree that it is a balancing act, but we also have huge expectations. Is there a danger that expectations of what can be delivered will be high and that, if we do not put in the necessary resources, those expectations could be dashed?

Mr Shaw: There is a difference between making resources available to a community health partnership and investing those resources in the management capacity and infrastructure of a community health partnership. Not an awful lot of managers actually treat people or provide services to individuals—some do, because they are also clinicians—but that is what we should be about. Rather than design our own empire, we should design something that is sufficient to meet the financial, organisational, planning and governance requirements. We should not just build an empire because we can.

Shona Robison: So we should keep bureaucracy to a minimum.

Mr Shaw: Yes. When LHCCs began, they were funded on a transfer of the old fund-holding manager allowance of £3 a head. I do not know whether that is well known to committee members, but that is pretty much what most LHCCs run on. Many of the larger ones manage to invest quite a lot of that in services and front-line staff rather than in their own organisation and infrastructure. Maybe we are our own worst enemies, as we have not provided ourselves with the infrastructure that there might have been money to provide, because we took a decision that it should be invested in services.

Shona Robison: That is interesting.

The Convener: In your written evidence you say:

“"A key feature of CHPs will be the relationship with Local Authority partners."" You go on to say:

“Despite the best efforts within Joint Future work there remain some obstacles to joint working, and one that is often mentioned are the differing terms and conditions of service between the systems for similar work.”

I do not know whether “some obstacles” is civil service speak, but I would like you to develop that point, because it has been raised before. If you are asking people to co-operate, they may be pretty hostile to one another if they are getting a lot less pay and their conditions are not so good.

Mr Shaw: One can be magnanimous if one is earning a lot more pay, but I do take your point.

The Convener: It is a serious point.

Mr Shaw: One of the oft-quoted examples is occupational therapy, where people with exactly the same professional qualification work on either side of the local authority-NHS boundary and are paid entirely differently.

The Convener: How much of a difference is there between people at the same level doing the same job? Thousands?

Mr Shaw: Not many thousands but a couple of thousands. It obviously depends on the grade as well. There are also differences between the terms and conditions of some care assistants in local authorities and those of health care assistants in NHS systems. Those differences generally favour those on the NHS side, not necessarily in hourly pay but in the continuity of employment.

The Convener: I do not want to spend too much time on this, but I want to flag it up because I think that what counts is the relationship between people at the coalface. We can have all the structures in the world in place, but the system will not work if there is hostility between people who are doing the same job because one of them is being paid a few thousand pounds less than the other.

Mr Shaw: Yes, and that is not something that can be resolved at a local level.

The Convener: You are right. We should bear that in mind.

Mr Davidson: Paragraph 9 of your submission says:

“"CHPs must have delegated authority and flexibility in order to deliver the roles outlined ... above. This must include appropriate budgets"." Given that you have to come to some arrangement with the local authorities, which have their own budgets, do you think that there has to be better definition of how you use combined budgets on the basis that, in many cases, patients are assessed twice, by two different set-ups?
Mr Shaw: Yes, I do. That falls under what we term “governance and accountability” in our submission.

There are various drivers, performance assessment frameworks and so on and QIS and the social work inspectorate use entirely different systems. There will be entirely different deliverables for the NHS and the social work elements of community health partnerships. That will definitely present us with a challenge.

Mr Davidson: Does your association have any particular thoughts to share with us in relation to that problem, if you see it as a problem?

Mr Shaw: We have at least 15 or 20 different thoughts. It depends on the area from which the representative comes. Each area has specific issues and some work well while others do not. As a rule, we feel slightly at variance with the joint future drive that aligned budgets are safer than pooled budgets.

Mr Davidson: Convener, could we ask Mr Shaw to send us something from his committee on that area? The area is complex and I know that some of the local authorities are already concerned about who will drive the process because, obviously, the CHPs will be health organisations.

The Convener: Are you happy to do that after taking advice from the representatives?

Mr Shaw: We will have a go.

Mr McNeil: On public involvement, your submission says:

“LHCCs have all involved the public, but to varying degrees. A specific responsibility and appropriate funding will enable this to be taken forward in a very meaningful way.”

When there is a specific responsibility to involve the public, how will you do it better?

Mr Shaw: The level of public involvement has been immensely varied. Some LHCCs have an occasional chat with a member of the public, others have members of the public sitting on their boards and others embark on quite elaborate public involvement exercises. The more elaborate the exercise to involve the public, the greater the commitment and the expense. Most LHCCs will have tended to invest the money in services, as I said before, rather than in public involvement, which has not been a specific LHCC responsibility but has tended to reside at trust or health board level. As trusts disappear, public partnership forums are formed and the responsibility is given to LHCCs, there will be a structure in which public involvement must take place. There is an enthusiasm in LHCCs to do that work and involve the public more closely in the planning of the service. At this point I should say that I am grateful to the Scottish Consumer Council for drawing such a clear distinction between public and service user.

The Convener: That was helpful.

Mr McNeil: Your submission says that appropriate funding will enable the public to be involved in a meaningful way. However, the Scottish Consumer Council suggested that the problem was more cultural than financial.

Mr Shaw: That is a fair point. At the moment, however, LHCCs have no responsibility for public involvement and therefore not all of them dedicate any money to public involvement. In the future, LHCCs will have that responsibility and they will need to identify funds so that they can involve the public in a more meaningful way.

Mr McNeil: Have you done any work on how you would respond to that?

Mr Shaw: To be honest, we have not. We are waiting to see what the shape of public partnership fora might be. Many of us have made use of the local health council structures, but they are going to move on.

The Convener: That is tactful—we will also move on. Thank you for giving evidence, Mr Shaw. I hope that you found the experience as interesting as the committee has done.
6 January 2004 (1st Meeting, Session 2 (2004)), Written Evidence

Evidence and Feedback from NHS Orkney on the National Health Service Reform (Scotland) Bill.

NHS Orkney is the smallest health board in Scotland. It serves a population of just under 20,000 people who live on 17 inhabited islands that form part of the Orkney archipelago. Delivering a sustainable primary care led health and social care service to the islands means that remote and rural issues are high on NHS Orkney's agenda.

These 3 questions were emailed to NHS Orkney's Board members and representatives of the advisory committees to the Board. These are the anonymised replies received.

Do you support the general principles of the Bill and the key provisions it sets out? Are there any omissions from the Bill that you would like to see added?

One board member supports the principles of the Bill but is disappointed that, although Boards will have new statutory duties of public involvement and co-operation with other bodies, Staff Governance is not included as a statutory duty of Boards.

The absence of staff governance in the Bill is of concern to another board member. NHS Orkney is committed to staff partnership.

We don't have a LHCC in Orkney and I do not know what kind of animal a CHP will be. I do not know where it sits in relation to Joint Future Agenda. Is there duplication or conflict here? There is the potential for tension between regional planning and local needs and decision-making. I hope that there will a correct balance of channelling resources and that individual Boards do not suffer and local decision-making is not unduly constrained.

What are your views on the quality of consultation, and the implementation of key concerns?

5 weeks is not long enough consultation process. In particular we would have thought Local Health Councils would want to consult their communities, given the proposal to abolish them and 5 weeks would not be long enough.

In remote and rural areas, Local Health Councils are very active & highly thought of by the communities they represent as being their voice within the NHS. Centralising LHCs would disadvantage these areas. We would have liked the consultation to have included this.

I welcome Health Boards participation in community planning and am glad of the emphases in Health Improvement. I would prefer that we have power to choose the way we spend the funds, as Scottish Executive directives don't always fit Orkney's situation.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

No comments were received on this point.
6 January 2004 (1st Meeting, Session 2 (2004)), Written Evidence

Key points

The Royal Pharmaceutical Society supports the general principles of the Bill.

The Society supports the evolutionary development of CHPs from LHCCs, building on the best elements of the existing structure.

Since the inception, pharmacists have strived to become more actively involved in the day to day running of LHCC’s.

However, pharmacists experienced difficulties in attending day time meetings of LHCCs as a result of the lack of necessary financial support.

Participants should be welcomed to the CHP table because of the contribution they can make and not because of an anticipated professional dominance.

The trend towards an inclusive approach in LHCCs should be continued and encouraged in CHPs.

Witnesses

David A M Thomson – Chairman, Royal Pharmaceutical Society Scottish Department
David Thomson has been a member of the Scottish Executive of the Society since 1996. He is Director of Pharmacy for Greater Glasgow Primary Care Trust and Vice Chair of the Association Scottish Trust Chief Pharmacists Primary Care Group. David Thomson is a member of the National Pharmacy Forum, the Greater Glasgow Area Pharmaceutical Committee and the Vaccine Strategy Group for Scotland. He is a past National Tutor for the Scottish Centre for Post Qualification Pharmaceutical Education.

Asgher Mohammed – Community Pharmacist, Paisley
Asgher Mohammed has been a practising independent community pharmacist for nearly 20 years. He was a pharmacy representative of and latterly chairman of Paisley Local Health Care Cooperative (LHCC). Currently he is a member of the College of Pharmacy Practice and the LHCC Professional Advisory Committee of NHS Argyll & Clyde. Recently Asgher won the first Scottish ‘Independent’ pharmacy practice of the year award. He has a passion for the pharmaceutical input towards improving patient care.

The Royal Pharmaceutical Society of Great Britain is the independent professional body of all pharmacists in Great Britain. The title of pharmacist is reserved for members of the Society. The Scottish Department of the Society represents those members that practice in Scotland. The Society in Scotland represents 4,000 pharmacists working in the community, hospitals, education, research and industry. In the community, pharmacists and their staff see nearly 600,000 people on a typical day across Scotland, more than any other health profession.

General Principles of the Bill

The Society supports the general principles of the Bill (as introduced). In particular, the Society supports the establishment of Community Health Partnerships (CHPs). CHPs are intended to evolve from LHCCs and must build on the best elements of the previous structure.

The introduction of Local Health Care Co-operatives (LHCCs) in 1999 was an attempt to develop health services relevant to that community. In general LHCCs were afforded a degree of licence in forming their own geographical boundaries around voluntary groups of primary care healthcare professionals. The principle was sound and encouraged innovative methods to identify and tackle issues of concern to that locality. At the outset, the structure of local management committees, required to return a GP majority, became GP dominated with other healthcare professionals...
reluctant to become involved. Attempts to become more actively involved met with resistance and certainly pharmacists reported difficulty in attracting the necessary financial support required to attend daytime meetings.

Since the inception, pharmacists have strived to become more actively involved in the day to day running of LHCCs. Many pharmacists are members of the LHCC Executive committee and other key areas of influence within their organisation. One pharmacist, until recently, chaired an LHCC.

The trend towards a more inclusive approach must continue with participants welcomed to the table because of the contribution they can make and not because of an anticipated professional dominance traditionally accommodated in previous health service reforms.

**Quality of Consultation and implementation of key concerns**

The Society wishes to ensure that is properly involved in the consultation process. Pharmacy, as a key stakeholder in the delivery on healthcare on behalf NHSScotland should be automatically invited to submit its views.

Practical implications of putting these provisions in place and consideration of alternative approaches

The change in emphasis at Ministerial and Health Board level with the explicit statement of the duty to promote the improvement of the physical and mental health of the people of Scotland is welcome. The Society highlights the developing discipline of Pharmaceutical Public Health in Scotland and seeks to ensure that there is adequate access at Health Board and CHP level to advice and support from specialists in this discipline across the country.
Allied Health Professions Forum Scotland

AHPF Scotland presents a strategic alliance representing diverse and independent health and social care professions in the UK. AHPF Scotland exists for the 13,000 professional members in Scotland, to encourage collaboration and liaison between members and professional bodies north of the Border.

AHPF Scotland Submission to the Health Committee of the Scottish Parliament on the National Health Service Reform (Scotland) Bill.

Introduction

The Allied Health Professions Forum Scotland (AHPF Scotland) should like to thank the Health Committee for the opportunity to give oral evidence on the National Health Services Scotland Reform (Scotland) Bill. The reform of services is of primary interest to all the member associations and their membership.

AHPF Scotland

The Allied Health Professions Forum Scotland exists to foster collaboration and encourage liaison between the allied health professional bodies. AHPF Scotland presents a strategic alliance representing diverse and independent health and social care professions in the UK. AHPF Scotland has recently been set up for the 13,000 professional members in Scotland, to encourage collaboration and liaison between members and professional bodies north of the Border.

Membership is open to any professional association representing Scottish health professionals, who are registrants (or prospective registrants) with the Health Professions Council, or who are state registered.

The following bodies are in membership of AHPF Scotland:
• Ambulance Service Association
• Art Therapies Advisory Group
• The British Association of Art Therapists
• The British Dramatherapy Association
• The Association of Professional Music Therapists
• The British Dietetic Association
• British Association of Prosthetists and Orthotists
• British Orthoptic Society
• British Association/College of Occupational Therapists
• Chartered Society of Physiotherapy
• Institute of Biomedical Science
• Registration Council of Scientists in Health Care
• Royal College of Speech and Language Therapists
• Society of Chiropodists and Podiatrists
• Society of Radiographers

The majority of staff represented by the above bodies work in the NHS in Scotland.

Overview of the NHS Reform Bill

Allied Health Professionals work in a very large variety of locations, delivering services to patients in acute and primary settings and promoting Scotland’s health. The Allied Health Professions have welcomed the direction outlined in the Scottish Executive white paper (Partnership for Care), and
broadly support the aims of the legislation to reduce bureaucracy and improve strategic planning and delivery in community health. What will be crucial is how the policy aims are interpreted in practised across the Health Board areas in Scotland.

The Allied Health Professions are crucial at every stage and every level in the planning and delivery of improved services and their inclusion in the decision making process is vital. The place of AHPs in the chain of services, and the role of AHP staff in reducing waiting times and improving services cannot be under stated. Whether with reference to the role of Radiography and waiting times in cancer care and acute services, or physiotherapy and rehabilitation in the community, the AHPs must be included in the design and delivery of services. Patient care can be severely adversely affected in circumstances where allied health professionals are not consulted, and this is increasingly recognised across the NHS in Scotland.

The place of the Allied Health Professions in the NHS

The inclusion of allied health professions in the planning decision making is not straightforward. As can be appreciated from the scope and diversity of the professional bodies, the allied health professions are organised in smaller units and do not have the ‘critical mass’ to organise themselves collectively to have a strong voice within health boards. Historically, the NHS has had a tendency to be dominated by the medical and nursing staff, and this simply reflects the collective numbers of such staff. The much smaller numbers and stratified nature of allied health professions has meant that their influence and ability to contribute to the planning and decision making process has been limited. AHPF Scotland has been established to ensure a stronger national voice for the AHPs in Scotland, but this level of organisation cannot be beneficial to patient care unless it is reflected by an improved voice for AHPs at a local, Health Board and hospital level.

In community settings also, Allied Health Professions report difficulties in being heard. In many parts of Scotland, AHPs have found themselves under represented at the management boards of LHCCs. It is not only the development of multi-professional services but development

In line with the Scottish Executive white paper that must considered in this context. Improvements to services can only come from an inclusive environment, and the creation of Community Health Partnerships can deliver improvements if an inclusive approach is taken from the outset.

Recent efforts have been made by the Scottish Executive to redress the balance and the establishment of the AHP officer at the SEHD and specific AHP Posts on special Health Boards reflect this welcome shift in emphasis. This must now be reflected at a local level where health services are designed and delivered.

AHPF Representation

AHPF Scotland recognises that there are already a significant numbers of members the allied health professions on the Health Boards and LHCCs across Scotland. However, this has often resulted by default rather than by design. AHPF Scotland seeks the creation of reserved places for the Allied Health Professions on the new Health Boards, Management Committees and Community Health Partnerships to guarantee a voice for the Allied Health Professions. Whether a Dietician or an Occupational Therapist, an AHP Representative on decision-making structures would have a responsibility to consider the concerns of all the professions.

As a specific voice for the AHPs, the role of such members would act as a focus for the concerns of all allied health professionals, and reinforce the need for consultation and collaboration among all AHPs. This measure should not prevent professionals becoming members in another way, but should ensure adequate inclusion of professions to contribute to the process of designing and improving services.

Conclusion

AHPF Scotland welcomes the reforms of the Health service outlined in the legislation and believes the proposed changes present an opportunity to improve and modernise the health service in Scotland.
Crucial to this process must be the development of team working among all the staff of the NHS, and the role of the allied health professionals must be seen in equal partnership alongside the role of medical and nursing staff. To this end, AHPF Scotland seeks a reserved place for the Allied Health Professions on each of the Health Boards and Community Health Partnerships. This would create a focus for the inclusion of Allied Health Professions in decision making which otherwise proves very difficult, and would reflect the changes already taking place at a local and national level.

**The Allied Health Professions**

**Art Therapists**
Help patients to understand their problems and come up with solutions through the use of arts such as painting, drawing and sculpture.

**Chiropodists/ Podiatrists**
Diagnose and treat foot problems, carry out nail surgery and give advice on proper care of the foot especially for those with conditions such as diabetes.

**Dieticians**
Work with people to promote wellbeing, prevent food-related problems and treat ill health through diet.

**Drama Therapists**
Encourage patients to express the whole range of their emotions and to increase their understanding of themselves and others through drama.

**Music Therapists**
Help people to understand their behaviour and emotional difficulties through music.

**Occupational Therapists**
Use a variety of activities, and/or equipment and adaptations, to enable recovery after illness or injury and to support independent living and health.

**Orthoptists**
Diagnose and treat a range of eye disorders and defects of vision.

**Orthotists**
Design and fit pieces of equipment known as orthoses to patients who need support for a weak arm, leg or spine.

**Prosthetists**
Provide care and advice for patients who have lost or were born without a limb, fitting the best possible artificial replacement.

**Physiotherapists**
Assess and treat people with physical problems caused by injury, ageing, disease or disability promoting recovery and relief from pain.

**Radiographers**
Diagnostic radiographers produce high quality images using all kinds of radiation, such as X-rays, and other tests to diagnose illness. Therapeutic Radiographers treat mainly cancer patients using radiation therapy, and occasionally drugs, and support their care through all phases of the illness.

**Speech and Language Therapists**
Assess, diagnose and treat people who have communication and/or swallowing difficulties.
Amendments To NHS Reform (Scotland) Bill

I am writing to inform you about two new sections that I am intending introducing to the NHS Reform (Scotland) Bill at Stage 2. These will cover staff governance and equal opportunities.

Staff Governance

After the introduction of the Bill, a number of groups, including the Scottish Partnership Forum, expressed disappointment that the Bill had not included provisions to put staff governance on an equal footing with clinical and financial governance in the NHS. Staff governance is a system of corporate accountability for the fair and effective management of staff. A staff governance policy has been in place in NHSScotland since January 2002, however, it has not been a legal requirement to have such arrangements in place. I had originally intended to reserve this for inclusion in a future health Bill, but I have listened to the concerns and have decided to bring this forward and to include it in to the NHS Reform (Scotland) Bill.

The staff governance provision will place a duty on Health Boards and Special Health Boards to ensure that they have systems in place for monitoring and improving the governance of NHS employees.

Equal Opportunities

Similarly, NHSScotland has been working hard to encourage equal opportunities throughout the National Health Service. Partnership for Care details the commitment of NHSScotland to extend the principles set out in Fair for All across the NHS to ensure that the health service recognises and responds sensitively to the individual needs, background and circumstances of people’s lives. Work is ongoing to implement Fair for All and the requirements of the Race Relations (Amendment) Act, with support from the National Resource Centre for Ethnic Minority Health and the Commission for Racial Equality. Preparatory work has been undertaken with the Disability Rights Commission to ensure NHS compliance with the Disability Discrimination Act. An LGBT Health Needs Assessment project has been developed with support from Stonewall Scotland and work has been done to implement an “all faiths and none” approach to Spiritual Care with support from the Scottish faith groups and a Chaplaincy and Spiritual Care Unit.

The development of an Equality and Diversity Strategy for NHSScotland will also allow the NHS to comply with the Scottish Parliament’s mainstreaming agenda. The strategy will ensure that NHSScotland respects and values each individual patient, carer, member of the public and member of staff for who they are. It will make sure that NHS Scotland is provided with the support it needs to meet their needs and the needs of staff from minority groups or communities. The three existing equality commissions in Scotland have indicated that they believe this is the correct approach for NHSScotland and have agreed to work with us in the development of the strategy.

However, I recognise the importance of putting the requirement to encourage equal opportunities on a statutory basis where appropriate and that is why I am proposing to amend the NHS Reform Bill to require health service bodies to encourage equal opportunities when carrying out their statutory functions.

I hope that the Committee agrees that these are important issues, which are worthy of inclusion to the NHS Reform (Scotland) Bill. Further information on the detail of the amendments will be available in due course but I wanted to alert the Committee to my intentions now so that you are able to include the issues in your oral evidence taking at Stage One.
6 January 2004 (1st Meeting, Session 2 (2004)), Written Evidence

National Health Service Reform (Scotland) Bill

I refer to your letter of the 9 December in which you asked for further information on our proposals to amend the Bill to include staff governance and equal opportunities. You also asked for further information on the role of advocacy.

Staff Governance

On the 17 November, the Scottish Executive issued a consultation paper on its proposal to amend the Bill to include staff governance. This consultation paper provides further information on the amendment and also includes a draft section for consideration. I have enclosed a copy of the consultation paper with this letter. It can also be found on the internet at the following website:

http://www.show.scot.nhs.uk/sehd/publications/DC20031125StaffGov.pdf

If your committee members have more detailed questions about staff governance once they have looked at the consultation paper, we will, of course, be happy to address them.

Equal Opportunities

NHSScotland is required to act in accordance with current legislation on sex, race and disability discrimination and has specific duties under the Human Rights Act to act compatibly with the European Convention on Human Rights. An impending European Directive will also make discrimination illegal in employment on grounds of sexuality, religion and belief, and age. In addition these statutory obligations under UK and European law, the Scottish Executive is working to mainstream equal opportunities throughout NHSScotland to impact on the culture and attitude of those working in the organisation. To date, much of this mainstreaming work has been done in an administrative capacity.

Whilst equal opportunity rights are a reserved matter, it is within the competence of the Scottish Parliament to require public organisations to encourage equal opportunities. Such provision for equal opportunities is becoming more common in Scottish Bills and recent examples of this include the:

- Local Government in Scotland Act 2003 (s59);
- Mental Health (Care and Treatment) (Scotland) Act 2003 (s3); and
- Housing (Scotland) Act 2001 (s106).

We have instructed solicitors to draft an amendment that will require Health Boards, Special Health Boards and the Common Services Agency to encourage equal opportunities when discharging the functions given to them under the National Health Service (Scotland) Act 1978. They will also be required to observe all laws relating to equal opportunities. We envisage that the wording of the amendment will be similar to the sections listed above.

As I mentioned above, NHSScotland has been working to encourage equal opportunities and to mainstream it throughout the service so that it impacts on the culture and attitude of those working in the organisation. Therefore, it is not expected that this will have a significant impact on NHSScotland. Nevertheless, the Scottish Executive considers it important to put the requirement to encourage equal opportunities on a statutory basis where appropriate, which is why we are proposing this amendment.

Examples of the work NHSScotland is undertaking to encourage equal opportunities include the ongoing work to implement Fair for All and the requirements of the Race Relations (Amendment) Act, with support from the National Resource Centre for Ethnic Minority Health and the Commission for Racial Equality. Preparatory work has been undertaken with the Disability Rights...
Commission to ensure NHSScotland compliance with the Disability Discrimination Act. An LGBT Health Needs Assessment project has been developed with support from Stonewall Scotland and work has been done to implement an “all faiths and none” approach to Spiritual Care with support from the Scottish faith groups and a Chaplaincy and Spiritual Care Unit.

The development of an Equality and Diversity Strategy for NHSScotland will allow it to comply with the Scottish Parliament’s mainstreaming agenda. The strategy will ensure that NHSScotland respects and values each individual patient, carer, member of the public and member of staff for who they are. It will make sure that NHSScotland is provided with the support it needs to meet their needs and the needs of staff from minority groups or communities. The three existing equality Commissions in Scotland have indicated that they believe this is the correct approach for NHSScotland and have agreed to work with us in the development of the strategy.

Advocacy

Advocacy is an important way of enabling people to make informed choices about, and remain in control of their own health care. Traditionally this has been mainly available to vulnerable groups, such as people with mental health problems, learning difficulties or physical disabilities, and older people. However, it should also be available more widely to all health service users where this is needed.

Independent advocacy in Scotland is supported through the Advocacy Safeguards Agency, which promotes and develops independent advocacy, and supports statutory agencies to develop these services. Independent advocacy in Scotland is also supported by the Scottish Independent Advocacy Alliance which provides advocacy projects with a network support structure. There is also a requirement on Health Boards to work with their local authority partners to ensure integrated advocacy is available to all who need it, and all Health Boards have developed an advocacy plan. The Mental Health Act also gives new rights to mental health service users to have their interests represented by independent advocates.

In terms of expressing views about health services, and ensuring that individual patients and carers have the opportunity and where necessary the support to be heard, we intend that the new Scottish Health Council will have the function of ensuring arrangements are in place to support individual patient and carer feedback. It is the responsibility of NHS providers in the first place to make sure that the views of people who use their services are actively sought, and that it is as easy as possible for people to give them. The Scottish Health Council will also need to ensure there is an independent body which can pass on the patient’s or carer’s views, and support him or her through the process. The role of the Scottish Health Council will be to monitor and quality assure these arrangements.

I hope that this letter provides the Committee with the additional information that they require. Please do not hesitate to contact me if they would like any more information on the points raised in this letter.
Scottish Parliament
Health Committee
Tuesday 6 January 2004
(Afternoon)

[THE CONVENER opened the meeting at 13:59]

National Health Service Reform
(Scotland) Bill: Stage 1

The Convener (Christine Grahame): I welcome everyone to the first meeting in 2004 of the Health Committee. I have received no apologies. I remind members to switch off pagers and mobile phones. I welcome Nanette Milne, who is sitting in on the meeting to get acclimatised to the Health Committee.

I welcome also the panel of witnesses in Orkney from Orkney NHS Board. We are a bit apprehensive about doing the videoconference with them. Some of us have done one before, but it was a long time ago. I welcome, from Orkney NHS Board: Steve Conway, the director of operations; Jenny Dewar, the chair; Kathleen Bree, the director of allied health professions and nursing; and Stephanie Lawton, the head of human resources.

My first question is a simple one. Do you believe that the bill's proposed change to the structure of the national health service is necessary or appropriate? If you believe that it is, how will the change improve service delivery, which is what it is all about?

I ask one of the witnesses to act as chair of the panel and to direct questions to other members of the panel, if appropriate.

Steve Conway (Orkney NHS Board): If I may, I will answer the questions and ask the others on the panel to contribute as we go along.

In general, we believe that the bill's principle are entirely appropriate and that they will enhance how we provide the services that the bill addresses. In many cases, the bill will merely formalise and impose a statutory duty in relation to service provision that we already undertake.

The Convener: What you are saying is that the bill will just make the provision of services that are already being provided a statutory duty. Is that correct?

Steve Conway: Yes.

Jenny Dewar (Orkney NHS Board): We ought to point out that we do not have NHS trusts in Orkney, so the big restructuring due to the move to single-system working will not affect us. Therefore, we have concentrated on other aspects of the bill.

The Convener: Are members finding the sound a bit difficult?

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Yes.

The Convener: I am sorry, but I am informed that nothing can be done about it. We will just have to strain a little. Can the panel in Orkney hear us clearly?

Kathleen Bree (Orkney NHS Board): Yes.

The Convener: We will move on then.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): In their written submission, the witnesses claim that there is potential for tension between regional planning and local needs and local decision making. Will they elaborate on that possibility and on the potential consequences?

Steve Conway: Yes. The first issue is about governance and non-executive directors' involvement in decision making at a regional level as opposed to their current role at board level. The second issue is how we will be able to engage patients and the public actively in the processes at a local level when we are dealing with a regional issue.

Can you still hear me?

Mr McNeil: Yes—with difficulty.

Steve Conway: It went very quiet this end for a minute.

The next conflict that we are a little anxious about is the risks for boards, particularly island boards, if we have to move from the Arbuthnott funding formula to a regional funding formula. The same applies to the voting mechanism within a regional structure. We serve a population of 20,000. If regional planning is activated on a population basis, we do not believe that we will have the fair say that we would like to have.

The other aspect that is particularly relevant to us as an island board is that in the regional context we will have to ensure that everyone appreciates the significant differences in being an island. Those differences are not just about remoteness; there are many other issues.

The Convener: Would you like to develop that? What are the other issues? Perhaps it would help if you elaborated.

Steve Conway: We have 17 inhabited islands, some of which can be reached by plane and some
of which can be reached only by boat. All the islands can be reached only in certain weather conditions. That is not something with which Highland NHS Board, for example, will be overly familiar, although it has regional complexities that we do not share, such as the mileage between locations. Not all our islands have general practitioners. We are also different from other regions in that we have only six surgeons on the mainland, and we have only one hospital.

Jenny Dewar: Another issue that we face is a problem with the recruitment and retention of staff, because we have such a small population. We see regional planning as a way to help us to alleviate those problems by working across boundaries. We welcome the statutory underpinning of that function in the bill. It will make it legal for us to work for our populations but across boundaries.

Mr McNeil: Can you identify any benefits? You have a list of concerns, but you say in your evidence that you generally support the bill. What benefits do you envisage for areas such as yours, apart from the one that you have just described?

Steve Conway: The bill is about making better use of the resources that are available. We already do a lot of regional work, in that many of our clinical services are provided off Orkney by Grampian NHS Board and other health boards. The bill formalises that type of relationship, so it makes best use of scarce resources.

Janis Hughes (Glasgow Rutherglen) (Lab): Your written submission mentions that you do not know much about community health partnerships because you do not have a local health care co-operative in Orkney. Notwithstanding the fact that you are not particularly experienced, you will have read the proposals in the bill on community health partnerships and will be aware of the consultation process that is under way. Will community health partnerships help you to improve service delivery?

Kathleen Bree: We are signed up to the principle of community health partnerships and we see them as a positive move. Although we in Orkney do not have an LHCC as it is known elsewhere, I suppose that the board operates in a pseudo-LHCC way. We certainly envisage the community health partnership developing the involvement of the community and clinical staff in decision making on the development of services, which will be good for the local authority and other organisations. The community health partnership is a much-needed development and, from our perspective on the island, it is also the way forward for sustained services.

Janis Hughes: Could anything be added to the bill to help with community health partnerships, particularly given the issues that you face?

Steve Conway: I do not think that we have identified anything to date. Perhaps other witnesses can think of something.

Jenny Dewar: Given that all health boards are currently developing community health partnerships, we are concerned that we have not seen the detail of the regulations. We would not want to see anything in the regulations that cuts across the development work that we are already doing. We would like them both to be aligned.

Shona Robison (Dundee East) (SNP): You argued in your evidence that the five-week consultation process was not long enough and went on to state that local health councils are highly thought of in the community. Will you say a little more about that? In particular, you have said: “Centralising LHCs would disadvantage these areas.”

Will you comment further on that?

Jenny Dewar: There are two things to say about that. On the consultation period, our evidence demonstrates that we did not have much time to put it together. As I said, I do not think that the local health council had the opportunity to consult the community, so what is in the evidence from us are the views of individual board members. We welcome the chance to put all that together today and to give a more cohesive board view.

I turn now to what the local health councils do and the issues that we think might arise in Orkney. At the moment, the local health council is drawn from a population of less than 20,000, and the same people generally do the same sort of community work across Orkney. If a local advisory council is put in place, as it will be, many of the current local health council members will be the people who put their names forward. Because of their health involvement, they are also the people whom the health board, with its new duty to consult the public, would look to consult. We do that anyway, but the new proposals formalise the process.

Given that the local advisory council’s role is to feed its concerns into the Scottish health council, I wonder whether there might be a conflict because the same people will be doing the same things. Where consultation has taken place but not everyone is satisfied with the outcome, people might feel that an issue ought to be raised with the board about the conduct of the consultation.

The point that I really want to make about our local health council—I am sure that it is the same in other areas—is that it has a wealth of experience and a deep understanding of health issues in our community. I would be sorry to see that dissipate with the introduction of a new structure, so I hope that any such introduction will...
be managed so as to retain that expertise and commitment.

**Shona Robison:** Do you see a way of achieving that within the bill, or do you feel that the bill needs to be amended to reflect that and to ensure that that important role is maintained?

**Jenny Dewar:** I do not think that that will necessarily be achieved in the bill. In fact, I would be reluctant to see too tight a provision made in the bill, because I recognise that different health councils work in different ways in different areas. If anything, I would like there to be flexibility in the regulations and the set-up to allow boards to work with the local advisory councils and, at national level, with the Scottish health council to produce something that will achieve what we are looking for. Basically, we want to get people involved in our planning and service delivery and we want to get their views on how we provide services.

**Mr McNeil:** In your written evidence, you said:

"Local Health Councils are very active & highly thought of by the communities they represent as being their voice within the NHS."

Were no health council members available to give us evidence today? Were they invited along? Did you attempt to involve health council members in giving evidence to the committee?

**Jenny Dewar:** No, because we felt that it was your role to invite council members if you wanted their views.

**The Convener:** I was about to come in with a pre-emptive strike before you answered. That is a matter that we should have considered. Having made that omission, we could now ask for written evidence. You are exonerated and we are not.

**Mr David Davidson (North East Scotland) (Con):** Are the witnesses satisfied that the new national health council, which the minister proposes in the bill, will be more independent than the local health councils?

**Jenny Dewar:** Yes, because at present health council members are appointed by health boards. I have reservations about the council coming under the umbrella of NHS Quality Improvement Scotland, as it is clear that there will not be quite as much independence as there could have been, although I see that the proposal reflects the need to focus on quality issues around health care services and on having an outside view of assessing those services.

14:15

**Mr Davidson:** We have received evidence from other groups and bodies that are worried about the new health council being perceived as being a part of NHS Quality Improvement Scotland. Is that a concern in the Orkney NHS Board area? Do you have any evidence for that concern?

**Jenny Dewar:** It is a concern among people who discuss the issues, but I would not say that it is an issue for the community as a whole—it would be daft to say that. People worry mostly about health care issues when such issues affect them directly.

**Mr Davidson:** Do I take it from what you say that the local health council acting as a representative of the community, if you like, and working locally does a job that you think is different from that which a new national body that sits within NHS QIS would do?

**Jenny Dewar:** Very much so. If we wanted to continue in the same way, taking on board our statutory role in public involvement, I would poach people from the health council and use them to facilitate community involvement in what we are doing, but that is not the role of the new advisory council.

**Mr Davidson:** Do you want to add anything about the independence of the national health council?

**Jenny Dewar:** No. I think that the proposals are misleading. There will be more independence than there is at present, but I would not regard the council as being totally independent.

**The Convener:** If any member of the panel wishes to say something, they should indicate that.

**Kate Maclean (Dundee West) (Lab):** I want to ask Jenny Dewar to expand on her response to Shona Robison’s question about local health councils. Many of the written submissions that we have received express concerns about the loss of local representation in the shape of health councils. I understand from your response to Shona Robison’s question that you expect local advisory councils to be made up of the same local people who are interested in health issues in the area. Is that the case? If it is, would that compensate for the dissolution of local health councils?

**Jenny Dewar:** That would happen in Orkney because of its small population and the fact that the same people take on community involvement wherever they are located and in whatever field. However, I can see that the picture could be quite different in the Highlands or greater Glasgow, for example, where there are much bigger pools of people to take on involvement.

**Kate Maclean:** I presume that if the health board has a duty of public involvement, technically every person who lives in the health board area could be involved in discussions and decisions about services. Are you confident that that will
happen? Would that also compensate for the loss of local health councils?

**Jenny Dewar:** At the moment, we support pulling people into whatever planning processes we undertake, whether they are health council members or come from other voluntary organisations. Perhaps Steve Conway will say a few words about the healthfit day that we had in that context. Essentially, there is a culture that we are proud of. We clearly reach out. I am absolutely convinced that there is room for improvement, but if we start from the basis that we want to involve people, we are halfway there. The issue is about getting the structures and processes right so that everybody is involved and not just those who put their names forward.

**Steve Conway:** I will give an example of that process. In December, we had a healthfit event. We invited interest groups, commissions, members of the public and patients to a core service review. The event was split over two days, when we considered all the aspects of service provision in Orkney. That demonstrates clearly that we involve the community in the processes, and that we acknowledge the benefit in doing so.

**Dr Turner:** On public involvement, we could learn a lot from Orkney because all the difficulties that you have up there make Orkney a microcosm of Scotland. It sounds as though people communicate well with each other. How will public involvement improve the consultation process in the NHS?

**Kathleen Bree:** I am sorry; we were debating who would answer. Public involvement can advise us on where we are not consulting effectively. The process is cyclical. By engaging the public, we can learn where the gaps are and about the places that we are not managing to reach. Even if only the usual suspects are willing to get involved, public involvement can inform us how we can expand our consultation process and advise us how we can engage with other people who might be reticent or who have not wanted to be involved in the past. The process is on-going. Members of the public can be our advisers as well as being consulted.

**Jenny Dewar:** Involvement rather than consultation is key.

**Dr Turner:** Have you thought of any new ways of involving the public other than what you have done already?

**Kathleen Bree:** I am sorry; we did not hear your question.

**Dr Turner:** Have you thought of any new ways of involving the people who do not normally get involved? You seem to do the job so well because of the nature of your geography. In fact, you have answered the question in your answers to other questions.

**The Convener:** I just want to clarify whether making it a duty to consult will make any real difference. If you are consulting the public to find out what is wrong with their NHS, does making such consultation a duty make any difference?

**Steve Conway:** I do not believe that it will in Orkney. As we keep emphasising, the community is very small. Kirkwall has a population of 12,000 to 14,000. Everybody that we deal with or meet has some influence on our thinking. I do not believe that making consultation a statutory responsibility will affect the way in which we undertake that responsibility.

**The Convener:** No, and you would not like to speculate about the effect on other health boards. That is not your job.

**Steve Conway:** We do appreciate the difficulties that much larger boards will face. I do not imagine for one minute that the Health Department is using the proposal as a stick to encourage larger health boards to involve the public, but it will help to focus their attention.

**The Convener:** Thank you.

**Helen Eadie (Dunfermline East) (Lab):** The evidence that the Health Committee has received, including a submission from the British Medical Association, suggests that there should be more detail about when the power of intervention should be used. What are your views on that?

**Steve Conway:** The intervention by ministers is the one area that we are concerned about. We in the NHS have clear structures and procedures in relation to performance, whether corporate or individual. Although we acknowledge that the bill's proposals are to be used only as a last resort, it is hard for us to imagine a situation in which ministerial involvement against an individual could occur without its affecting the whole board structure.

**Stephanie Lawton (Orkney NHS Board):** Building on the principles of staff governance and best practice, we would support the full exhaustion of all available internal procedures before resorting to ministerial involvement.

**The Convener:** Will you develop the notion of staff governance, please? What is meant by that term? You state in your written evidence:

“Staff Governance is not included as a statutory duty of Boards.”

Will you please develop the point, linking it to the power of intervention?

**Stephanie Lawton:** NHS Orkney fully embraces the principle of staff governance and supports its
implementation locally. We fully implement the partnership information network guidelines—the PIN guidelines—which allow for individual performance and, if necessary, corporate performance to be identified and measured. We view the intervention of ministerial powers very much as a last resort. We assume that other policies would be exhausted first.

The Convener: I think that the next question is a colleague’s. Take over please, David.

Mr Davidson: That is very kind of you, convener. We do play a team game down here now and again.

The point about staff governance’s not being a duty has been laboured—it is mentioned twice in the submission to the committee. What provisions would the witnesses have liked there to be in that regard, bearing in mind the fact that the minister proposes to lodge an amendment at stage 2 to place a duty on health boards and special health boards to ensure that they have in place systems to monitor and improve the governance of NHS employees? Are there any particular things that the committee should take from your ideas on staff governance?

Jenny Dewar: Before the bill’s publication, the board had three governance duties, only two of which were statutory and which were to do with clinical governance and financial governance. Retaining staff governance as a non-statutory duty would have given the wrong message to our staff about the importance that we attach to it, so I thoroughly welcome the news that an amendment is likely to appear at stage 2.

Mr Davidson: I repeat the final part of my question: what views should the committee take on board when we come to discuss the minister’s proposal at stage 2?

Jenny Dewar: I did not quite catch that, but I would be looking for the duty to be present and for it to be statutory. We would need the same flexibility as exists in relation to other issues in how boards implement the duty, bearing in mind the fact that boards must provide a system of governance.

Mr Davidson: Convener, perhaps we might ask Orkney NHS Board to send us something in writing about staff governance.

The Convener: Is the panel content to provide that?

Jenny Dewar: Yes, absolutely.

The Convener: Thank you very much.

Helen Eadie: I have a question about equal opportunities, which is a very important issue for the Scottish Parliament. What do the witnesses feel about the proposed measures for giving health bodies a duty to encourage equal opportunities when they carry out their statutory functions? How do you envisage the measures’ being put into effect?

Stephanie Lawton: NHS Orkney fully supports the implementation of equal opportunities and has in place the necessary policies and procedures. A local race equality scheme is in operation and we monitor our requirements regularly in accordance with the Race Relations (Amendment) Act 2000. Race equality in Orkney is not a major concern, but we recognise that we have a responsibility and a requirement to monitor race equality matters and to promote equal opportunities, so we do that.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I would like to ask a supplementary question, after Helen Eadie has responded.

Helen Eadie: The points that I wanted to raise have largely been covered in the answers to my questions, but I would like the witnesses to give examples of disability issues that they encounter in relation to public involvement and equal opportunities, because I imagine that the engagement of people with disabilities in public participation is a matter of concern in Orkney, as it is everywhere.

14:30

Jenny Dewar: It is possible that issues around consultation are different in Orkney because they are centred on access. It is difficult for a person with a disability who lives on an island to come to Kirkwall for a meeting, although we make good use of electronic whiteboards and videoconferencing links.

It is also difficult—although I do not think that we do too badly at this—to ensure that people on the remote islands know what is going on. There are certainly channels of communication between staff. On the islands that have small populations, the general practitioner or the family health nurse provides a key focus and a means of disseminating information and receiving people’s views.

The real problems relate to access; they include transport and, for carers, the difficulty of finding someone to look after the person for whom they care—he or she might have to come from another island. The problems are practical, but they are not without solutions.

Mike Rumbles: I want to clarify a point about public involvement and to follow up Duncan McNeil’s question, when the suggestion that we should have invited the local health council to attend today’s meeting seemed to be put to one side. As I understand it, the invitation to attend today was made to NHS Orkney.
In your submission you said that local health councils are "highly thought of" in the community. That goes to the heart of one of the matters that the committee has been concerned with in its work on the bill and, indeed, in its work on the Primary Medical Services (Scotland) Bill, which we considered recently. In the National Health Service Reform (Scotland) Bill that we are now considering, the intention of section 5 is to underpin public involvement legally in order to ensure that patients—the people to whom services are delivered—

"are involved in …

(a) the planning and development, and
(b) decisions of the Health Board".

I think that Duncan McNeil was making the point—I do not want to put words in his mouth—that if Orkney has a good local health council, which provides an effective voice for the community, it might have been useful to have brought that council along today so that we could hear that voice.

Do you believe that Orkney NHS Board currently involves the public effectively in its decision-making process?

Steve Conway: Yes. I accept that you regard it as an oversight that we did not bring someone from the local health council to today's meeting. That was not a consideration, however—

Mike Rumbles: May I interrupt? I am not saying that there was an oversight on your part. I was not expecting someone from the local health council necessarily to attend, but I am interested in the background to your current thinking about public involvement.

Steve Conway: I accept that. Perhaps it would be helpful if I returned to the core service review, which is the best example that I can give of our commitment to public and patient involvement. That review represented probably the most fundamental and significant review of health care provision that our board has undertaken in recent history. It will inform the way in which we will work for at least the next 5 years. We are very sure that we involved all the interest groups, the local health council, patients and the public in that consultation. We will continue to involve them as we develop the review's findings.

In addition to that, two representatives of the local health council attend all board meetings. They are sent the papers a week in advance of meetings so that they can consult other members of the health council.

Kathleen Bree: We also have representatives from the local health council on our corporate management team and our joint management team. In addition, a local health council representative is present at many of our clinical effectiveness steering group meetings. We have quite a list of committees and groups that are part and parcel of our decision-making process and on which the local health council is represented.

Jenny Dewar: I mentioned culture earlier. When a working group or committee is set up, a representative of the local health council or someone from the public is included when membership is being considered. It is usually easier to go through the local health council, because a member of the public is probably involved in the local health council anyway. We acknowledge that we need to work hard at widening that representation further but, for the moment, that is the way the process works, although we will develop it further.

Mr Davidson: I will take Mr Conway back to something that he said earlier. He said that he would be concerned about equality of funding if there was a move towards regional finance planning. That is obviously a crucial issue for Orkney; I am sure that it will be a crucial issue in other parts of Scotland, as well. Will you expand on why you are so concerned about equality of funding, given that there will be powers to treat patients outwith the board, and that money may flow a bit more easily with the patient? What would you like to see in the bill?

Steve Conway: I would like the bill to include more rounded recognition of the funding formulae that are used and an acknowledgement that there is a perception—in many cases, it is the reality—that the funding formulae that exist today can disadvantage island NHS boards. That might be compounded by any regional impositions that are placed on us, unless they are based fairly on the services that we provide and where we provide them.

Mr Davidson: You also said in your written submission that you were looking for the

"power to choose the way we spend the funds, as Scottish Executive directives don't always fit Orkney's situation."

Do you have anything to add to that comment?

Steve Conway: I confess that I was not in the organisation when that submission was produced for the committee, but I think that the basis of that comment was the fact that we spend 10 per cent of our annual allocation on treating patients off the islands. We therefore have to be careful about how the funding arrangements balance, compared to other boards that fund only provision within their own boundaries, other than the national services.

Kathleen Bree: I think that that comment was made about health improvement rather than about service delivery. Although I was not privy to that
comment, I think that the board was trying to emphasize that we sometimes have national directives that are relevant for health improvement, but do not necessarily address the priorities that we have in Orkney. For instance, the emphasis in Orkney would be more on alcohol than on drugs. I am not saying that we do not have some sort of drugs problem, but it is not our main problem; if we consider drugs, alcohol and substance misuse, alcohol is our top problem area. Therefore, when a national initiative on drugs comes out, we need more flexibility so that, rather than focus mainly on drugs problems, we can focus our resources on alcohol problems.

Mr Davidson: That is very helpful for clarity's sake. Thank you.

The Convener: I thank the witnesses very much. We have finished our questions, but is there anything about which we ought to have asked but have not and on which you want to say something?

Steve Conway: No. Thank you very much for the opportunity to be here.

The Convener: I suspend the meeting for five minutes to allow the videoconferencing equipment to be taken out.

14:39
Meeting suspended.

14:45
On resuming—

The Convener: For our next panel of witnesses, I welcome David Thomson, who is the chairman of the Royal Pharmaceutical Society of Great Britain’s Scottish department and Asgher Mohammed—have I said that properly?

Asgher Mohammed (Royal Pharmaceutical Society of Great Britain, Scottish Department): Yes.

The Convener: Thank you. Asgher Mohammed is a community pharmacist in Paisley and a member of the Royal Pharmaceutical Society. From the Allied Health Professions Forum Scotland, I welcome Judith Catherwood, who is the convener, and Kenryck Lloyd Jones, who is the secretary. I refer members to papers HC/S2/04/1/2 and HC/S2/04/1/3, which are the written submissions from our witnesses.

Mr McNeil: In today's written evidence and in previous submissions, many organisations have expressed broad support for the development of community health partnerships. Are the structural changes necessary to improve service delivery? How will the changes affect the divide between acute and primary care, and that between health and social care?

The Convener: I think that the witnesses heard the previous panel of witnesses. As with them, this panel does not have a chair because different organisations are giving evidence, so I ask people just to pitch in.

Asgher Mohammed: My experience of local health care co-operatives in the past five or six years is that where the finance that comes to the health board should go in primary and secondary care has always been debated. It is essential that we bring down the barriers between primary and secondary care; the bill’s provisions on that are to be welcomed. Changes to structures will also mean more change at grass-roots level. When practitioners work at the coalface, they need to address the changes that make a difference to people. The ethos of the bill is excellent because it is patient centred.

As for the effect on health and social care, it is obvious that different models of LHCCs operate throughout Scotland, but we in Paisley have always had good relationships with our local authority colleagues. That has been essential in allowing us to do all the good work that we have done. We could not have done that without our colleagues. The bill will cement such partnerships and we welcome it.

Judith Catherwood (Allied Health Professions Forum Scotland): For the allied health professions, the dissolution of trusts and the creation of unified health boards and community health partnerships bring many benefits. We support the changes very much, because our services have by nature been small and the creation of trusts generated operational difficulties in delivery of our services. The bringing together of services and the ability to deliver AHP services throughout a board area and across health and social care partnerships will be of great advantage to us. It will affect occupational therapy in particular, because occupational therapists who work in local authorities and those who work in health will have added advantages from working more closely together.

Kenryck Lloyd Jones (Allied Health Professions Forum Scotland): As the allied health professions think more of themselves as having a specific role, increasingly some are concentrated in acute settings and some are concentrated in primary settings. The professions are also increasingly aware of the differences between the two settings and of the need for joined-up thinking on service delivery and planning.
David A M Thomson (Royal Pharmaceutical Society of Great Britain, Scottish Department):
The bill can build on the current structure's strengths and allow more multidisciplinary working across the perceived barrier between primary and secondary care, which is a relatively artificial barrier that should be removed. That involves schemes such as medicine management projects—which handle patients' transfer between primary and secondary care—and a drug misuse project under which partnership working with social services supports patients using health care intervention and social care intervention at the same time. The bill offers the potential to build on such projects and to enhance dramatically the quality of patient care.

Mr McNeil: In evidence from the trade unions, we heard about problems and barriers to people working together; for instance, when occupational therapy is delivered for a local authority through the health service. Such problems arise because of different wages and conditions, for example. Have you come across such problems?

Judith Catherwood: Yes. I work in Elgin in Moray, where the OT service is moving towards integration. One difficulty is the differences in terms and conditions, particularly in pay and career structure. I cannot comment more, but there is a difficulty.

Asgher Mohammed: Duncan McNeil asked earlier whether the new structures are necessary to make a difference. If they are to make a difference, all the players must be involved at the level at which they can make a difference. We need the AHPs and pharmacists at the helm, along with our colleagues in the nursing and medical professions. Sometimes, we are not up there and we cannot make decisions for patients. The new structures will be good, but only if we are involved. It is important for the AHPs and pharmacists to be part of the structures, but the bill does not say explicitly that we should be there. We feel that we are sometimes marginalised. Both groups of professions should be involved in every structure in CHPs and above.

Mr McNeil: You argue the case for that strongly in your written evidence.

Dr Turner: What do you hope that the role of your respective organisations will be within the ambit of the new developments? How do you see your role developing?

Kenryck Lloyd Jones: We must remember that the AHPF is an organisation that has existed for only the past couple of years and that it still has no direct funding. To bring together the allied health professions, even at a national Scottish level, means bringing together a diverse range of professions. The challenge is how to do that locally. We must ensure that inclusion of allied health professions means that all the professions that make up the AHPs contribute to the decision-making structures. That is the challenge and it is what the AHPF has set out to achieve throughout Scotland.

Dr Turner: Will there be difficulties in doing that? Until now, the organisation has been very much medical and nurse led.

Kenryck Lloyd Jones: We accept fully that there will be difficulties, but that is not a reason not to do the work, which is necessary. If the Scottish Executive's targets on everything from service standards to waiting lists are to be met, the allied health professions will have a crucial role. Therefore, the work must be done.

David A M Thomson: We must develop to accommodate expectations through the national strategy for pharmaceutical care. Much service development comes through the community pharmacy network—which enhances patients' access to direct supply for minor ailments—and through the delivery of model schemes for pharmaceutical care. The network will need to be supported by individuals who are positioned within the structure and who can help to develop local systems.

Asgher Mohammed: We would expect pharmaceutical advice at board level on the health improvement strategy, which is one of the bill's main focuses. Below that, we need pharmaceutical advice at community health partnership level and below that we have pharmacy locality groups, which are where the hard work will be done. We need good leadership at every level and we need to work with other professions.

It is essential that all the professions have their say. The experience in Paisley was that the LHCC’s not being general practitioner led made a huge difference to how it developed: it developed in a more multidisciplinary way. Much of the success of the Have A Heart Paisley national demonstration project was due to people working together at grass-roots level.

Dr Turner: Those are excellent answers. It is important that the bill work for the patient. If pharmacists are to do more for patients, do you envisage difficulties with how patient information will be communicated backwards and forwards? I take it that that is a big worry in being involved at different levels with patients.

David A M Thomson: Absolutely. The developments under “The Right Medicine: A Pharmaceutical Strategy for Scotland” will introduce computer and information technology links between community pharmacies and other prescribers so that community pharmacists will be
able to access NHSnet. There is a trend towards communication being exchanged electronically. Such links are probably 18 months to two years away so, until then, communication will need to be paper based. The arrangements will be in line with developments as they happen at the coalface. Communication is important but I think that it will be resolved by the introduction of IT.

The Convener: David Davidson also has a question.

Mr Davidson: As usual, I must declare that I was once secretary to the royal Scottish pharmaceutical society or, rather, the Scottish department of the Royal Pharmaceutical Society.

Mike Rumbles: Get it right, David.

The Convener: Can you remember what it was?

Mr Davidson: It was a long time ago, in another life.

Will you explain to the committee the important difference between the Royal Pharmaceutical Society and the Scottish Pharmaceutical General Council, which are the two organisations that interface with the Executive? In many cases, the people who will be most affected by the bill will be the contractors—such as community pharmacists—although I appreciate that Mr Thomson comes from a hospital background. The committee needs a fair understanding of the differences and the effects that they will have. The context is that the new pharmacy contract is still under negotiation, but it will be a critical part of how the CHPs will roll out. Will you give us some background information on that?

David A M Thomson: The Royal Pharmaceutical Society represents all pharmacists in Scotland and is the professional body for pharmacists. The Scottish Pharmaceutical General Council represents the interests of contractors, which are the high street pharmacies. We work extremely closely together. By virtue of its size, Scotland affords positive close and collaborative working.

The on-going discussions on development of the new contract are, I guess, entering a stage that will see the introduction of the more local services, so that it will be possible to handle minor ailments through community pharmacies. Those who are least able to afford medication will not be required to access the GP network in order to avoid paying directly for medication.

A medication review is being undertaken within the pharmacy setting in order to improve the quality of current care. Model schemes will be introduced to target patients who have specific disease states; for example, people with severe and enduring mental illness, the frail elderly and people with more chronic diseases such as asthma and epilepsy. The review also deals with the management of repeat supply, which accounts for about 80 per cent of prescription volume. That element will be transferred to the community pharmacy network and will be handled by the community pharmacist, who will have the important communication links back to the initial prescriber.

On the back of that, elements such as supplementary prescribing—which is being introduced just now—will radically change how health services will be delivered through pharmacies in the future. The services will be very patient focused, which will be to patients’ advantage.

Mr Davidson: The pharmacy contract is not yet in place, yet it will be a major part of CHP delivery in communities. Would the Royal Pharmaceutical Society and the SPGC care to submit further evidence on the role of the pharmacy contract within the development of CHPs, given that the Minister for Health and Community Care has not really defined where this is going to come from and how it is going to run?

David A M Thomson: We would welcome that opportunity.

The Convener: I must mention our time scale: we would need that evidence as soon as possible before we move on to the next stage of the bill.

Mr McNeil: I want to return to the idea that, as everyone has agreed, the process must be a “development of team working”, to use the words of the AHPF Scotland submission. Can such team working be achieved only by having X representatives on the health board and X representatives on the community health partnerships? In practical terms, can your organisations and networks sustain that level of activity? You are coming from a position in which you claim exclusion, to the opposite end of the spectrum, where you are represented at every level. Can you get agreement within your organisations about an appropriate level of involvement? Is that the only way in which you can achieve the influence that you seek in relation to the improvement of service delivery?

15:00

Asgher Mohammed: Both our organisations are relatively small. Experience of LHCCs throughout Scotland has been patchy. Some LHCCs have delivered an awful lot and team working has been great in each organisation. The problem is that LHCCs have not worked well in some areas because people have been excluded. That is because people have been given a choice and, although choice is sometimes very good and
I welcome it, sometimes it means that some professions become less able to promote their input to patient care. Both our organisations would have to be on the CHPs for us to have a voice by right. That is what we seek.

Kenryck Lloyd Jones: We are not necessarily talking about moving from a position of exclusion to one of inclusion. That is a rather extreme statement; as has been said, experience has been patchy. However, we seek a more systematic way of involving the allied health professionals, who, as has been stated, are a very diverse community. At the moment, those who fulfil an AHP role are at least minded to consult and include other members. For example, a dietitian will know that, to represent the allied health professions, they should consult physiotherapists, occupational therapists or radiographers. If that were to be taken away and if we were to have a representative who was a member of one of the allied health professions simply by coincidence or lucky chance, that person could consider themselves to be there to put forward what they happened to think and not necessarily to consult other colleagues in the same way that they would have done if they had had a specific representative role. That is why we have been quite strong in asking for diverse representation in the first place, instead of representation of a small interest group.

David A M Thomson: There are two aspects to that—the competence and the level of input relevant to their competence that the individual concerned can provide, whether they are a pharmacist, an AHP or whatever. At the moment, there is no requirement for a pharmacist to have a position at board level in the new structure, even though the drugs bill represents a massive input to patient care. Both our organisations would be happy to come to a compromise within our grouping, provided that there is a systematic way to include us.

Judith Catherwood: So you want representation, but it should be left to you to decide who the representatives are.

Mike Rumbles: To be a little parochial about the matter, in my constituency there are three or four LHCCs. Let us say that there will be three community health partnerships and that your organisation will be represented on all of them. I could go to one meeting and your organisation would be represented by a dietitian, but it might also be represented by a dietitian at the other two meetings. You are arguing against the ad hoc approach in the current system, but will the new system not also have an ad hoc approach?

Kenryck Lloyd Jones: It might be a little over-deterministic to say that you want pro rata representation of every profession.
Mike Rumbles: I am only probing.

Kennyck Lloyd Jones: We must recognise that the allied health professions are regulated by a single body, the Health Professions Council. That body regulates a range of diverse professions and when it sends representatives to other bodies, or indeed to the Scottish Parliament, it does not necessarily think that it has to send one representative from each profession. The allied professions are mature; they know that physiotherapy is different from radiography, but they ensure that their approach reflects the natural evolution of the health professions. That is recognised in the developments at the Scottish Executive, which now has an allied health professions officer, and in the AHP positions at NHS Education for Scotland.

The professions remain distinct and they have their own professional bodies, but there is an increasing coming together and a recognition of team working is evolving. How does that work in practice at the local level? Perhaps dietitians will be good in one area and physiotherapists will be good in another area, but people might be happy with that. What should be measured is whether people feel sufficiently represented—if they do not, perhaps they can tackle the problem in their groupings. That is what is likely to happen.

The Convener: I follow your point.

Mike Rumbles: That is a good response.

Janis Hughes: Your organisations have made strong cases, both today and in your written submissions, for inclusion in community health partnerships. I do not think that the committee disagrees that representation on CHPs should be as wide as possible and should encompass, as far as possible, all the health groupings that exist in the health service.

How will community health partnerships improve service delivery in respect of working with agencies other than health agencies, such as local authorities and other outside organisations? At the moment, LHCCs focus pretty much on staff in health-related services, but how will things evolve?

David A M Thomson: There will be evolution. Most of my experience in this area is with joint addiction teams, which support individuals through rehabilitation programmes. Health aspects are catered for—probably through a methadone support facility—but the social problems that may have led people towards a habit in the first place are also catered for. There is partnership, which is helped when there is coterminosity between the health board and the local authority. For example, Glasgow City Council and the Greater Glasgow NHS Board have good working relationships in joint addiction teams. Addiction is the area in which I have seen joint working at its best.

Judith Catherwood: Another example, from my profession, would be work that has taken place in schools. In Moray, we have what is called a collective—which I think is the precursor to a community health partnership—and we have worked closely with our local authority, with which we are coterminous. Dietitians have had the opportunity of going into schools to educate pupils about healthy eating and health improvement. We have also been able to work with teachers and other agencies within schools to develop initiatives that encourage children to eat in a different way. We have worked with the catering service and have helped with the implementation of “Hungry for Success”. Joint working has opened doors for us that would not be open were we just closeted within the NHS.

Helen Eadie: I want to move on and ask about the powers of intervention. Should the definition of intervention, and of the circumstances under which the power of intervention will be used, be included in primary legislation or in regulations?

Asgher Mohammed: In Argyll and Clyde NHS Board, for the first time in Scottish history—I think—four chief executives lost their jobs overnight. I do not think that that has happened before and it happened because of the intervention of the Scottish Executive. There are two sides to this: sometimes you need a carrot and sometimes you need a stick. When all else has failed, it can be absolutely necessary for the stick to come out.

Helen Eadie: Should that power be included in the legislation or in regulations?

Asgher Mohammed: Yes, I think it should. Very occasionally, the power will be required as absolutely the last resort. However, that would happen only when all else has failed.

The Convener: I am sorry, did you say that the power should be in regulations, or in the primary legislation?

Asgher Mohammed: It would be better to have the power in regulations. In the unusual circumstances of its being necessary, the power should be there. We would hope that people would be mature and that things would not get to that stage; but, if it was absolutely necessary and in the interests of patient care, the power should be used as a last resort. That is my personal view.

The Convener: Would anyone else like to comment? This is an interesting seam.

David A M Thomson: The power would be used at the final stage. Governance issues that are covered in legislation for our professional bodies would, I hope, limit the requirement for intervention. Furthermore, the local performance programme would highlight issues before that final
That we have received.

That is the idea that is emerging from the evidence. Intervention will not take place at the whim of any minister— I will not blame the current one. They want there to be a clearly defined procedure so that health professionals can get on with their job. People want to see what the rules are so that they understand that there is more flexibility if the definitions are in regulations, because if the definitions are in the bill it is difficult to add something, as legislation would have to be changed to do so. Is that why you think that it is better for the definitions to be in regulations rather than in the bill?

David A M Thomson: So that it would be embedded within the NHS regulations.

Mike Rumbles: Convener, is there not confusion between—

The Convener: Yes. I am looking at section 4, which lays out “the powers of intervention in case of service failure”. If members look at that section of the bill they will see that the provision to intervene is in the primary legislation.

15:15

Kate Maclean: The powers of intervention are stated in the bill, but what Helen Eadie asked about and what I am asking about is whether the definitions should be in the bill or in regulations. I understand that there is more flexibility if the definitions are in regulations, because if the definitions are in the bill it is difficult to add something, as legislation would have to be changed to do so. Is that why you think that it is better for the definitions to be in regulations rather than in the bill?

David A M Thomson: It may be appropriate for us to submit a written statement after the meeting.

Mr Davidson: It would be nice to have the Royal Pharmaceutical Society’s view on how to deal with the matter because—as many members have said—we have received evidence that people want to see what the rules are so that health professionals can get on with their job. They want there to be a clearly defined procedure before the minister steps in so that they know that intervention will not take place at the whim of any future minister—I will not blame the current one. That is the idea that is emerging from the evidence that we have received.

It would be helpful if you could clarify why you favour the regulation system, which gives the ministers total flexibility unless the whole of the Parliament is united against it; that flies in the face of what the bill is intended to do.

Mike Rumbles: The bill gives a tremendous power to Scottish ministers. The proposed new section 78A(2) states:

“The Scottish Ministers may, where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable”.

The point that we are making is that Scottish ministers will have a very open-ended power. Should that power be narrowed down? Is that wide power suitable or should it be narrowed?

David A M Thomson: As I said, it would probably be more appropriate to submit the answer in writing.

The Convener: I presume that there have been cases when such powers have been tested, when chief executives have been dismissed or whatever and there has been a test of what has been defined as a failure. That would give us guidance. It would be interesting to receive a written response. Rather than try to amend the bill on the hoof, we will now move on.

Mr Davidson: I will move on to the proposal to dissolve local health councils and set up a new national health council. Is your organisation satisfied that a new national health council, such as the one proposed by the Executive, will be more independent than the current local health councils? I ask you to comment on the fact that the minister has suggested that the new national health council should be placed within NHS QIS. Does that create an identity problem about the individuality and independence of the new national health council?

Kenryck Lloyd Jones: There is always concern when a body is to be set up about whether it will be reflective of the communities that it is supposed to represent. It is a question of how things will be done. The Allied Health Professions Forum has not had detailed discussions on the matter, so it would be wrong of me to say that anything that I will say is reflective of its policy. However, there are general concerns that public involvement should be seen to be working. That means that the public must know who their representatives are and how they are represented rather than discover after the fact that they were represented.

Mr Davidson: Do you have any comments on the perceived independence—or not—of the new health council?

Kenryck Lloyd Jones: NHS QIS is a relatively young body. All the bodies that we are discussing have a quasi-independent role. Whether the health council is perceived as being independent depends very much on one’s initial view of quangos as a whole, rather than the situation in this particular case.
Asgher Mohammed: At LHCC level, we have always found local health councils to be very useful. They give added value to our discussions. I tend to favour the view that was expressed from Orkney and believe that the new health council should be independent. If it comes under NHS QIS, that will be like having the person who checks and the person who punishes in the same department, which is not very fair. It would seem more logical and objective for the health council to be independent.

Mr Davidson: Are you suggesting that the role of the health council should be to address patients’ requirements, whereas NHS QIS should be responsible for regulation of standards?

Asgher Mohammed: Yes. The health council should examine NHS QIS. If not, who will police the police?

The Convener: What an interesting answer. I am not saying that the others are not interesting, but that answer was quite challenging.

Shona Robison: We have heard concerns expressed that the loss of health councils will mean a loss of local representation. Do you think that the duty on health boards to ensure public involvement will in some way compensate for that loss? How do you think it will improve public consultation in practice?

Judith Catherwood: The Allied Health Professions Forum Scotland has not discussed that issue in detail, but we welcome the fact that there will be an onus on boards and organisations to include the public in discussion and to have genuine consultation. In fact, there will be more than consultation—the public will be involved in key decision making. We are not opposed to that.

I am not hugely familiar with the different systems that are proposed, but at the local level health councils bring a great deal of expertise and provide a focal point where one can usually find the right person to serve on a group. They offer the support that is necessary for people to be involved, which is important. The new organisation should give the public a voice and the necessary training. I use the word “training” in a strange sense, but people need considerable support if they are to be members of a formal organisation such as an NHS board or a working group. I hope that whatever structure is put in place gives the public that opportunity.

David A M Thomson: We must also build on the strengths of the previous structure. The benefits gained from engagement with local health councils are embedded in the new structure. Pharmacies have used the local health councils often and well and their contribution is valued extremely highly. I do not want that to be lost.

Shona Robison: One of the roles that local health councils have now will not have in the future is advocacy. They act as advocates on behalf of patients and members of the public. Are you concerned that they will no longer have that role?

David A M Thomson: That does not give me too much direct cause for concern. The community pharmacy network in Scotland is visited by 600,000 patients on a daily basis. The network was established mostly by private money, so if we do not look after our patients, we will not have a business. There is a commercial aspect to the issue, although it relates to the health service. In a way, pharmacists act as their patients’ advocates—they look after their local patients. There is huge loyalty to pharmacies—80 per cent of people use the same pharmacy on an on-going basis.

Shona Robison: I was thinking more about the role of health councils in helping people to find their way through the health service system—whether it be to make a complaint or to find out some information. The local health councils have played a very important role with regard to advocacy in its widest sense; however, that key role will be removed from them. Would you prefer them to retain that function?

David A M Thomson: Although that is certainly a strength of the local health councils, the likes of Epilepsy Scotland also have patient support groups. Such members’ interest groups might take on some of that role instead.

Asgher Mohammed: Having public involvement at board level is an excellent step, because health care professionals sometimes forget that they serve patients. Such public involvement is a great asset that we would not want to lose. As far as making complaints is concerned, most people should know which mechanisms to use. No matter whether they are in a doctor’s surgery, pharmacy or health centre, they should find it easy to complain and know who to complain to. It does not matter whether the CHP or the health board takes on the issue, as long as patients and the public find the system open, transparent and easy to use.

As I have said, it is good to have public involvement at health board level. Indeed, we need that representation at every level, including in CHPs and health boards. Without those people, we will lose the added value that their involvement brings.

Shona Robison: I have a further question for the allied health professionals. Across your professions, have you had any experience of public involvement in shaping your own services? How could we achieve such an objective in future?
Kenryck Lloyd Jones: As an example, direct access to physiotherapy is very popular. Indeed, in surveys that we have carried out with the general public, eight or nine out of 10 people have said that they would prefer to go directly to a physiotherapist—or, to mention another area, a dietitian—rather than go via a GP. Such an approach might also save a lot of GP time. The idea is to involve the public by providing them with access to the professions.

That said, as far as complaints are concerned, we should perhaps distinguish between public and individual involvement. After all, the public in its abstract form is different from the individual, and we need different systems for those two areas.

We should remember that a patient's involvement in his or her treatment is now very much to the fore as far as education is concerned. Therapy is not merely carried out on people—in other words, someone does not come along and perform it—but happens through consultation with the patient as an agreed procedure. In the same way, the planning and delivery of services should involve the patient community and should not be something that they simply turn up to and receive.

Judith Catherwood: Although most AHP services have tried to involve the public, doing so has been quite a challenge. However, the opportunities presented by the introduction of community health partnerships and of statutory responsibilities with regard to community planning will allow us to have an interface with the public that might not have been as readily available before. As a result, community planning and public consultation will help us in that respect.

The Convener: Section 5 puts a duty on health boards to consult the public on "the planning and development, and ... decisions of the Health Board or Special Health Board affecting the operation ... of ... services."

Such statements are all good and grand. However, there is a difference between anecdotal consultation and rigorous and thorough consultation and I note that the explanatory notes do not mention any extra money being made available for that work. If health boards will have a duty to consult the public, can such consultation be done for nothing or at neutral cost? If not, where will the money come from to enable proper consultation exercises to be conducted? If the money is not available, such statements are simply motherhood and apple pie.

Asgher Mohammed: In Paisley, we have had public representation on the executive group, the clinical governance group and other groups. Those public representatives have been paid for their time. It is not really fair on people to expect them to do something for nothing. People give up their time, energy and effort to help, so I think that we should pay them to come. So long as the payment reflects what people are doing and how much time is involved, that is fair and we ought to fund it.

The Convener: I was thinking not only about paying people to turn up, but about funding a consultation exercise in which people would be paid to run, in a professional manner, whatever consultation procedure was being used, so that the resulting data would have some value.

15:30

Asgher Mohammed: If you want good-quality work, you have to pay for it. It is better to pay to get the quality, so that you know exactly what you are getting. There should be provision for payment to be made, but that is not reflected in the bill. I agree that there should be funding, but it is not there at present.

The Convener: Separate from delivery of frontline services?

Asgher Mohammed: Yes.

The Convener: Do other witnesses want to comment?

Judith Catherwood: I agree. Any enhancement of the current system of formal consultation will take time. It takes time to co-ordinate the process, to collate all the comments and to put them into a document that the board and others can consider. That will certainly account for a bigger part of the resource that the NHS boards will need, so there will have to be a dedicated resource. How that will be funded I have no idea, but it will take money.

Helen Eadie: I would like Judith Catherwood, and anyone else who wants to answer, to amplify the point about the challenge of public consultation. The inference that I took from what you were saying was that that is a developing area of work and that different pilot projects are being undertaken across Scotland. What pilots are you aware of and what costs might have been involved in them? In an urban or semi-rural area, who pays to transport people to such meetings? Have you come across such problems before?

Judith Catherwood: I have quite limited experience, but you will be aware that NHS QIS recently published new standards for food, fluid and nutritional care, and in Grampian, where I work, we are looking to involve the public in a focus group exercise to try to get views from them on how we could improve the service and better implement the standards. That will obviously involve money, including, as you said, money to cover people's time and their expenses for getting to venues. We will need some help to facilitate that and somebody to pull together all the comments.
That is just a small-scale example of what could eventually be a large undertaking.

Mr McNeil: We heard evidence from Borders NHS Board that the new structures that it has put in place have eliminated duplication of jobs and cut out levels of bureaucracy, so that the board can generate funds that can be allocated to the whole area of consultation. Apart from that, are not we talking about an on-going dialogue with patients at that level, rather than just the big consultations that take place on changes in services? Are not we talking about a cultural change?

Recently, pharmacists have been communicating very effectively with their customers. People were coming to me and saying, “My community pharmacy is under threat.” In the right conditions, we can communicate effectively, and at no great expense, on issues that affect individuals and their communities. I wanted to say that on the record, because I do not think that it is the committee’s view that consultation should be let go because it will cost money. Consultation may cost money, but we can generate that money through the new structures that we put in place. Do you agree?

Kenryck Lloyd Jones: Very much so. As you say, the culture is changing and evolving. The emphasis is now very much on inclusivity in all aspects of service provision.

The Convener: I think that the question, however, is whether savings can be made elsewhere in the bill that would pay for any additional costs. The question is quite simple. I think that that is what Duncan McNeil was asking about.

Mr McNeil: No. I think that I have made my point. I would like a response from the panel, convener.

David A M Thomson: Any redesign exercise, which is basically what we are discussing, could be directed at saving costs. As the example relating to pharmacies shows, a communication exercise can be conducted quite effectively without costing huge amounts of public money.

Mr McNeil: That is fine.

Helen Eadie: The minister has pledged an amendment that would require health service bodies to encourage equal opportunities when they perform their statutory functions. What do you think of the proposed amendment to give health bodies a duty to encourage equal opportunities? How do you envisage that proposal’s being put into effect? You might also want to comment on the cost implications of the proposal, as equal opportunities usually do not come without costs.

Kenryck Lloyd Jones: I am sure that every health board would say that equal opportunities are at the forefront of what they do. Nevertheless, making explicit the encouragement of equal opportunities would help to focus the agenda. I think that that was mentioned earlier in another context. Such an approach can be welcomed.

I do not know what you think the additional costs might be, but it is clear that equal opportunities should not be compromised to cut corners in respect of costs. Most professions would agree that equal opportunities are paramount. Just as equal opportunities are paramount for patients, they are paramount in respect of how the health service operates.

Asgher Mohammed: I have a personal view. From what I know about the Stephen Lawrence inquiry and what is happening throughout Britain, it has been mooted that there is institutionalised racism in the NHS, the police and the judiciary. If there is, we must welcome the proposed duty in the bill and matters must then be monitored. Will there be equal opportunities in reality, or will lip service simply be paid to them?

Helen Eadie: That is an important question, but can you think of any particular examples for which the proposed duty will have cost implications? I do not want to lead the witnesses but, to be going on with, I was thinking about issues relating to race relations, languages, disability and access. Do the witnesses want to comment on such issues?

The Convener: It would be useful if the witnesses wrote to the committee about those issues, if they want to, because it is hard to be put on the spot and asked to deal comprehensively with such matters. The committee would be interested in hearing about cost implications for the witnesses’ professions, if there are any. Important points have been raised. Race as well as disability issues could be dealt with—that would be extremely useful.

Asgher Mohammed: I have not experienced such problems myself.

The Convener: We did not presume that you had, but the point was well made.

I thank the witnesses for their evidence. There will be a suspension before the minister arrives. We have a long agenda to get through.

15:38

Meeting suspended.

15:45

On resuming—
The Convener: I welcome Malcolm Chisholm, the Minister for Health and Community Care; Lorna Clark, the bill team leader; and Iain Dewar, a member of the bill team at the Scottish Executive.

Janis Hughes: Much of the detail about community health partnerships will be left to regulations and guidelines; that detail has been consulted on recently. As you may know, we have spoken to a number of witnesses during the course of our discussions on CHPs and one of the issues that have been highlighted is that the local health care co-operative set-up can be patchy in different parts of the country. We would like assurances from you that the CHPs will not replicate the patchiness and the occasional inefficiencies of the LHCC network.

The Minister for Health and Community Care (Malcolm Chisholm): That is the intention. We do not generally want structural upheaval. We want CHPs to evolve from local health care co-operatives and to build on their strength. We want to get rid of what you describe as their “patchy” nature. There are, however, some excellent LHCCs throughout Scotland. I caught bits of the previous session, when the members of the Royal Pharmaceutical Society said that they wanted guaranteed representation. We will ensure that that takes place. When LHCCs were started, that was one of the issues on which there was no guidance; it was all left to local flexibility and freedom. There are strengths in that, which we do not want to lose because the last thing that we want from CHPs is a top-down situation. We have to be careful to get the balance right between local flexibility and certain standards. Who is represented on the committee of the CHP is something that we will want to lay down in regulations.

I regard CHPs as being a key policy and a key part of the bill. When people ask me why we do not have foundation hospitals in Scotland, I tell them that we have CHPs. We have our own reform agenda, of which CHPs are one of the most exciting parts. We want to try to make the planning and delivery of health care more responsive to the needs of local populations and to develop more services in primary care settings. The most important thing is perhaps that we have a vehicle for integration with social care and specialist services. In contrast with England, our attempt to develop single-system, integrated working is the most distinctive feature of our health reform agenda. We want single systems in a decentralised context, which is where CHPs are key.

Janis Hughes: We welcome that response. The witnesses from the Allied Health Professions Forum Scotland were keen that they be represented, and they wanted specific guidelines—or regulations—about membership. You have reassured me that those will be introduced.

One of the other areas that we have touched on in our evidence taking has been coterminosity with regard to CHPs. At the moment, LHCCs by and large expect that their boundaries will change; some may become larger and others may become smaller. That may lead to much more confusion with regard to coterminosity. How are your thoughts developing on that issue?

Malcolm Chisholm: It is a big issue, not least in a constituency such as that of Janis Hughes. Work is being done by local health systems in partnership with local authorities, and there are no proposals for community health partnerships to straddle local authority areas. In certain cases, however, they will cross two health board boundaries. We probably need to make a small amendment to proposed section 4A(1) of the National Health Service (Scotland) Act 1978 to make it clear that in some cases two health boards may be introducing a scheme of establishment. That is as far as it goes. We do not expect CHPs to straddle local authority areas. We will, in principle, have coterminosity with the local authority area. However, in the larger areas, for example Glasgow, there will be several CHPs for a particular local authority area, whereas in areas where the population is smaller, such as the Borders, there may be only one CHP in each local authority area.

The Convener: I have a more technical question. When you referred to the detail of the CHPs, you talked about the pharmacists and you mentioned regulations. However, you have also referred to guidelines. I can see why there has to be flexibility but, given the statutory import of regulations as opposed to guidelines, are you talking about regulations, or are you talking about guidance, which is much looser?

Malcolm Chisholm: That is an important question and I understand why you are interested in it. I believe that we need both statutory guidance and regulations. We want a balance between what must be prescribed and must apply in every CHP, and having a certain amount of local flexibility. The last thing that we want is an inflexible blueprint. Therefore, my present thinking is that we should have a combination of regulations and statutory guidance. However, we want the Health Committee to consider that and comment on it, as it did with the previous bill.

The Convener: That is what I am coming to. Where are the guidance and the regulations in the brewing pot?
Malcolm Chisholm: The guidance is further ahead because we sent out a consultation document that was almost like guidance in its formulation. We have had a lot of feedback on that. We want to take that on board and issue a new document in perhaps a month. It would be good if we could share that with the committee so that it could examine the document and feel part of the process. However, the new document would obviously have to be only draft guidance, because there cannot be any final guidance until the Health Committee and the Parliament have had their say. Therefore, anything that goes out now is only draft guidance. However, members will understand that boards want to get on with the development of their work in that area.

Mr McNeil: We have heard today, again, of Orkney NHS Board’s concerns about the dissolution of local health councils. The board feels strongly that it has a particularly active health council, which is regarded as the voice of the community. The RCN has likened the dissolution of health councils to throwing the baby out with the bathwater. Why have you not thought about reforming health councils rather than abolishing them?

Malcolm Chisholm: In a way, what we are doing is reforming. I noticed that you picked out only one bit of the RCN’s position. Equally, the RCN supports the creation of the Scottish health council. I believe that we will be getting the best of both worlds. We want a national organisation—the Scottish health council. The RCN and most people who responded to the consultation agree with that. However, we also want a strong local base for the health council. The reality is that some local health councils are excellent but that they work in different ways.

One of the fundamental issues about local health councils is that NHS boards appoint them. I believe that it is important to have a body that oversees public involvement and that is independent of health care providers. We do not have, and never have had, that situation. Health care providers appoint local health councils. We want to set up a body that is independent of health care providers. The fundamental principles for me are independence from health care providers and a strong local base.

Obviously, we will have wider discussions today and in the future about how we make public involvement a lot better than it has been. The creation of the Scottish health council is fundamental to public involvement, because one of the council’s key roles will be to monitor and oversee that. The committee often tells me that a particular health board’s involvement with the public has not been good. It will be the Scottish health council’s role to point out such things and to report on every service change in terms of how public consultation has been conducted. The council will give reports to the minister and if a report said that public consultation had been inadequate, it would have to be done again more appropriately. Therefore, the creation of the Scottish health council will carry forward the public consultation agenda.

I understand people’s concerns about the council having a strong local presence and that is why the local advisory councils will be a necessary and key part of the process.

Mr McNeil: Do we not run the risk of demoralising people who have expressed a continuing interest on their community’s behalf? That could particularly be the case in a place such as Orkney, which has an active, involved health council. Does your one-size-fits-all proposal not contradict what that local community wants? Is there not a risk that those people will disengage and that your proposed structures will be second best?

Malcolm Chisholm: No, because those people will have an opportunity to be represented on the local advisory councils, which will be the local presence of the Scottish health council. In many cases, they will be the ideal people to fulfil that role. When I spoke recently at the conference of the Scottish Association of Health Councils, I was positive not only about the work that the health councils had done, but about the importance of their members’ being involved—if they want to be involved—in the new organisation. We have an implementation group, which fully involves the Scottish Association of Health Councils, that is helping to work up the detail of the proposal.

The other issue that the RCN flagged up is the Scottish health council’s place within NHS Quality Improvement Scotland. I do not know whether you will ask about that separately, but I will briefly describe the thinking on that. We want the Scottish health council to have as much clout and leverage as possible, and we think that that will be enhanced by its being part of NHS Quality Improvement Scotland, but it will have special status and safeguards to ensure that it will not in any sense be under NHS Quality Improvement Scotland’s thumb; it will have its own existence within that body. It is important that the Scottish health council be tied into the quality agenda because, as I have said on more than one occasion, the starting point for improving quality is the experience of every patient who passes through the health care system. Therefore, if the Scottish health council is part of NHS Quality Improvement Scotland, that adds to the leverage and influence of patient and public involvement.

Mr McNeil: Nevertheless, in Orkney, there is a group of people who complain that they have not
been able to consult their community about the changes and who wish to continue with the present format. If we are saying that communities should be able to decide, why can we not allow them to do so?

Malcolm Chisholm: I do not know—

Mr McNeil: When you talk to centralised bodies, which is the level at which you deal, what sort of dialogue do you find has taken place with those communities in which there is active consultation? I agree that, from the point of view of consultation, not all the health councils operate at the highest level and serve their communities effectively. In Scotland, all the best goalkeepers are dead goalkeepers, and we might be dealing with some mythology about how effective health councils are, but we have repeatedly had evidence of best-practice examples of health council members serving their communities and wishing to continue on that basis. At what appropriate level have we engaged those people to give them the opportunity to continue that service?

Malcolm Chisholm: They will still be able to do that. An important part of what we are saying is that there should be local advisory councils, but the Scottish Association of Health Councils, the RCN and nearly everybody else who responded to the consultation supported the creation of a Scottish health council. It has to have strong local roots and have local advisory councils, but people recognise that, over the years, the fact that the system applies differently in different areas has weakened, rather than strengthened, the system. The proposal gives a bigger prominence to the health council and flags up the importance of public involvement. We cannot have bodies monitoring such involvement if there are different standards in different parts of Scotland. We must have a clear national organisation with national standards, but it must have local councils as well. We are proposing the combination of a national organisation with local roots. I repeat that that was supported overwhelmingly in the consultation and that it was supported by the Scottish Association of Health Councils and the RCN.

The Convener: I make no comment. Does Shona Robison want to come in on this topic?

Shona Robison: I will come in now; I did not want to cut across the next question.

I have listened to what you have said, minister, and I do not particularly disagree with any of it, although we could perhaps debate how independent NHS QIS is—we will come to that in a few minutes—but I still do not understand why you feel that it is necessary to remove the key role of patient advocacy from the local health councils. Would it not be possible to have the structure that you suggest but still leave that important role at a local level? I have spoken to some of those who heard your speech at the conference, and they consider patient advocacy to be an important element of their work; it is the interface with patients and the public which, if you like, helps them through the system. I do not understand the thinking behind your belief that it is necessary to remove that role.

16:00

Malcolm Chisholm: You have given an interesting example, because some health councils have that role and others do not. Similarly, some health councils help with complaints and others do not. We have invested more in advocacy over the past two years than has ever been invested by anyone and we are building up independent local advocacy services. The role of the health council will be to monitor such services and to ensure that they are available. In a sense, that represents part of the shift in the role of health councils, which will ensure that processes are in place for public involvement, advocacy and complaints, rather than deliver everything themselves.

We can consider the matter in another way. In the past, you might say that the local health council substituted for the public. We are saying that we do not want a small group of people to speak on behalf of the public; we want much wider public involvement and we want there to be a group that ensures that such involvement happens, monitors it and does something about problems—or draws them to the attention of people who can do something about them.

That is not to say that the local health advisory council cannot speak for patients where that is appropriate—for example, if no other group can do so. I can provide you with a copy of a letter that I wrote to the Glasgow health council to clarify that point when it raised it with me and in the newspapers. We are not saying that local health advisory councils cannot have that role, but we do not want a model in which they do everything for the public; we want there to be wider public involvement, which the councils support and monitor, so that the public involvement agenda is much bigger than it has been in the past.

Shona Robison: I understand the logic of your thinking, but the issues that the Glasgow health council raised are interesting. You have begun to soften your position in relation to advocacy, as it appears that you are saying that if a local health advisory council so wishes, it will be able to continue to perform an advocacy role. That is interesting, because I think that, up to now, the assumption has been that that role will not remain with local councils. However, you are saying that there will be flexibility.
Malcolm Chisholm: That was the position in the original consultation document. I cannot read out the whole letter that I wrote to the Glasgow health council, but I will read out the relevant sentence, which basically repeats what was in the consultation document. The letter says:

“Where the Scottish Health Council identifies an area where public concern or viewpoint is not adequately being considered or where there is not an appropriate patient support group, it will be expected to raise this with the NHS Board or to put forward the views expressed by the public.”

So the health council can have that role, although that is not its primary function.

Shona Robison: However, my first response to that is to ask who will define “adequately” and decide whether there has been adequate consultation or an appropriate group to speak for the patient.

Malcolm Chisholm: The Scottish health council will decide, as it says in the letter.

Shona Robison: So the Scottish health council will make that decision, but I can see that there might be problems—

Malcolm Chisholm: It will not be me who makes that decision.

Mike Rumbles: I want to pursue the matter. You have made it clear that the Scottish health council will monitor public involvement. Section 5, on public involvement, says that the health board must ensure that the people who use the services—patients or the people who will become patients—

“are involved in, and consulted on—

(a) the planning and development, and
(b) decisions of the Health Board”.

Consultation is quite separate from involvement and I am still unclear as to how you envisage that the health boards will fulfil their obligations under the bill to involve patients—and not just by consultation—in the decisions that are made by health boards.

Malcolm Chisholm: Involvement and consultation are the key words and perhaps they serve to summarise the big change—from consultation to involvement—that we are in the middle of. We all know that in the past, consultation meant end-stage consultation, whereas now we require involvement at a much earlier stage, including consultation during the process of coming up with options as well as consultation on what in the past might well have been a single option that had already been put forward.

Obviously, people are still dissatisfied with how consultation is carried out in many cases. The new draft guidance that was produced last year is still being revised and we need to have final guidance on how boards consult. Along with the guidance, we have run a programme of support for boards, which is what much of the patient focus and public involvement initiative has concentrated on. Some of the money for that initiative has been spent on working with boards to get them to improve consultation. We all, including the boards, accept that a steep learning curve is involved. The aim is to involve people at an early stage and not simply to consult at the end of the process; it is also to involve people on a wider range of issues than has been the case in the past.

Mike Rumbles: I want to pursue the point, although I understand and agree entirely with what you have said. The bill states that people should be “involved in ... decisions of the Health Board”, which means involvement before decisions are made. However, I am trying to get you to tell us your view of how health boards will actually do that.

Malcolm Chisholm: That would require a detailed answer and, if I gave you a blueprint, you might not be happy. The public involvement team has produced a toolkit—a large document with a range of methods that boards can employ to engage with communities in ways in which they have not engaged in the past. That means not only using methods such as big formal public meetings. The document mentions different kinds of opinion panels and groups and a range of other options. The aim is to reach a wider range of people in new ways. We should not prescribe from the centre that boards should do A, B and C; we must be a wee bit more flexible than that.

The role of the Scottish health council is important. It is better to give boards a bit of flexibility and to have an independent body to consider whether the systems are adequate, rather than to over-prescribe from the centre by telling boards to carry out procedures A, B and C. That is our thinking.

The Convener: I want to clarify one point. You said that the Scottish health council will monitor what is done on the ground locally. That is fine because practices are not standardised at the moment. However, the policy memorandum states:

“The role of the Scottish Health Council will be to provide leadership in securing greater public involvement”.

That is a top-down role rather than simply a monitoring role. My concern is that the flexibility that ought to exist locally, given that standards must be met, will not exist and that systems will be imposed from above. Let us leave aside Quality Improvement Scotland at present. My problem with the language is that monitoring is perfectly laudable, but the top-down role is not.
Malcolm Chisholm: Which section of the policy memorandum was the quote from?

The Convener: Please excuse me, I have a sore throat. I have a legitimate lozenge in my mouth, not a Smartie. I am at paragraph 42 on page 10 of the memorandum.

Malcolm Chisholm: Right. The issue of the balance between national standards and local flexibility comes across in many topics. I do not have a problem with a body that is independent of me, and which has expertise in public involvement, providing leadership in securing greater public involvement. The council will not impose a blueprint, but it will ensure that the kind of failures of which the committee is aware will not happen any more. It is admirable that there should be a body that provides leadership and supports boards and others to carry out consultation better, which monitors the way in which they do so and which ensures that feedback from patients and the public, which is important, is received. I do not have a problem with that kind of leadership.

The Convener: With respect, minister, you used and continue to use the word “monitor”, but the policy memorandum does not say anything about monitoring. I do not have a difficulty with monitoring.

Malcolm Chisholm: Monitoring is part of the role. You flagged up the word “leadership”, which I do not have a problem with. Monitoring is part of a wider role that can be described generally as providing leadership and ensuring that things are done better than they have been done in the past. Monitoring is one way of describing the role, but it is not an exhaustive definition of what the Scottish health council will do; it is the bit that was relevant to what we were talking about a moment ago. A national body that provides leadership is a good thing, as long as it has local presence and flexibility, which are important.

Mr McNeil: I want to pursue the point made by Mike Rumbles. We should welcome the ambition to involve and consult people at health board level. That is really important. However, it will also be a long-term objective. Some of the bad communication and consultation that have taken place have done serious harm to the relationship between health boards and communities. I welcome the attempt to get things back on track.

We have discussed with others who have given evidence the expectation that involvement and consultation give to communities. In the longer-term planning of health boards—their priorities over a five or 10-year period—it is very important to get that right. Is there a case for suspending consultation programmes and ideas when services are facing radical change or are in crisis? My experience—which is shared by many—is that when we say that we will hold a consultation about a radical change to a service we create a false expectation in a community. We are being less than honest with that community. If radical change to a service in an area is necessary, is there not a case for being honest with the community and presenting proposals to it for debate, rather than giving the notion that consultation is taking place on two, three or four options? Honesty is vital in this process.

Malcolm Chisholm: That is an interesting suggestion. If we could produce an example of a situation in which there was genuinely no alternative, we could make a case for the approach that you suggest. However, there is usually more than one option, even when radical change is thought to be necessary. I do not see why the public should not be involved not only in giving a view on the options but in formulating those options in the first place. I understand the point that you are making, if there is genuinely thought to be no alternative to one course of action. However, even in that situation there would be a strong duty on boards to ensure that they explained the issues in a far better way than they have in the past and I would not be driven to the conclusion that public involvement should be suspended.

Mr McNeil: Perhaps I did not communicate my point effectively. I was not saying that the involvement of the public should not be welcomed. However, as the minister knows, in certain health board areas across the country there are situations in which a consultation process can take one, two or three years. During that process, the services on which the health board is consulting are collapsing along the road—irrespective of the consultation. In that situation, the consultation becomes meaningless. That is different from longer-term planning. We have created an expectation in the public. If the objective of involving and consulting communities is to be successful, we need to build up from the current very low point. How can we do that if we allow situations to develop in which, week by week, consultations are seen to become meaningless and people disengage from the process as a result?

Malcolm Chisholm: From your comments, one might draw some conclusions about the length of consultations. If they are taking place over the sort of time scales that you suggest, it would seem to be appropriate for them to be held more quickly. That point can be taken on board. The other conclusion that we can draw is that we should try to deal with issues before the crisis point is reached. Argyll and Clyde NHS Board may be mentioned in other contexts today. One of the problems with the board’s previous management was that it failed for too long to address some of
the issues in the area. That situation is to be avoided. There are many lessons to be learned from the situation that you describe, but I do not think—and you are not suggesting—that that should lead to a suspension of public involvement.

Mike Rumbles: I want to ensure that my understanding of what is before us is the same as yours. You should correct me if I am wrong, as I may be guilty of wishful thinking. The bill says that health boards must ensure that patients are "involved in" and "consulted on" the development of services. Those are two quite separate things, although they are part of the same process. The policy memorandum makes it clear that the Scottish health council will not only provide leadership but "support the development of good practice in public involvement".

That implies that the Scottish health council will have a monitoring role. Obviously, if good practice is to be spread across Scotland, the council will need to monitor what is happening.

I think that there is a second part to that process, which I want to check with you. As well as monitoring whether health boards throughout Scotland show good practice in public involvement, will the Scottish health council have a role in following up that monitoring and identification of good practice? What power will the Scottish health council have to ensure good practice in public involvement? Would the Scottish health council go back to you so that you could use your powers of intervention, or would it go directly to health boards? What process would the Scottish health council use and what power would it have?

Malcolm Chisholm: You are right that monitoring, which I flagged up in a particular context, is not the Scottish health council’s exclusive role. Monitoring is part of its role, but supporting development is another part, which you have emphasised. Ensuring that feedback from patients and the public not only takes place but is taken account of is perhaps the Scottish health council’s other key role.

It depends on the situation, but the Scottish health council will have a role in the most prominent controversial service changes that come into the Scottish Executive and its advice will be taken on board. It will have real teeth. As you know, at the moment consideration of whether the consultation on different service changes has been adequate has to be done by the health minister. Perhaps the most topical example of that is the questions that are being asked about the secure care unit in the west of Scotland.

Once it is set up, the Scottish health council will be the body that gives a view on all the processes that have taken place. If the Scottish health council says that the process has not been adequate, it will then be up to the minister and the Executive to take action to ensure that something is done about that. Such proposals would not be accepted if they did not get a green light from the Scottish health council.

Dr Turner: Will you provide us with clarification on patient advocacy and the complaint-handling role? It is important that it is easy for the person who has a problem to raise it. Will you clarify how the NHS boards will deal with that, given this flexibility? Will boards perhaps commission separately for that advocacy and complaint-handling role, as we have heard it suggested?

Malcolm Chisholm: Boards have already been commissioning independent advocacy services. I think that everyone would agree that there has been a big expansion of such services over the past two years. A lot of money has certainly gone into such services. That is the model that is being proposed for complaints as well.

I know that some concerns have been expressed about boards commissioning those services but the reality is that they have already been doing so for advocacy. We have taken a strong line with boards that they must commission independent advocacy organisations. Sometimes we have got into trouble because we have said that a body could not provide the service because it is not independent enough from the providers of services. If you look at the model for advocacy, you can have confidence that complaints will be handled by independent bodies.

We are saying that boards should ensure that that support is available to people. The role of the Scottish health council and the local health council bodies will be to ensure that those arrangements are working effectively. I repeat that not all health councils currently provide such support for complaints. Some do, but some do not. That is the way that the system works at the moment.

Dr Turner: From the health boards that use that process at present, are there any figures for the cost-effectiveness of that in comparison with the way that things were done before?

Malcolm Chisholm: I am not sure that cost-effectiveness is uppermost in our mind so much as the independence of the organisations and the level of the service that they provide to patients. We have put a considerable amount of money into advocacy, but the key thing is whether those bodies are independent and whether they are delivering a service to patients and service users more generally who need them. That should be the key criterion.
Dr Turner: Have you any evidence on how speedily the services operate? The patient sincerely wishes to have a result quite quickly. Does commissioning mean that cases are dealt with faster?

Malcolm Chisholm: We are in the middle of a process. I am not saying that we have all the services that we need. I am simply stating the fact that there has been a big increase in the number of independent advocacy services in the past two years. We have a lot more to do and we are saying that complaints are a new matter that has to be taken on board.

Mr Davidson: I will press you for more of a definition. You said that the advisory parts of the new Scottish health council may or may not deal with the advocacy role. You have talked a lot about establishing independent advocacy bodies, but you have not told us today or put in writing the definition of advocacy services and how that could be applied.

You suggest that the new health council will monitor those services, so I presume that what it monitors must be defined, or will it be left to develop models for use? You might recommend, or give a health board the right to establish, an advocacy service. For the sake of argument, I will mention a mental health advocacy service in Grampian that is in difficulty because of a lack of funding, of decision making and of patient expectation. I do not pick that out as a particular difficulty, but a difficulty does exist. Will we have clarity from the Health Department about what will be monitored?

Malcolm Chisholm: A range of services is involved. Advocacy is the service that is being picked out, and advocacy services basically support vulnerable people in dealing with health and social services and, in some cases, other bodies. Much work is being undertaken on advocacy. Two years ago, we produced a guide for commissioners in which we covered all the issues. Advocacy is one strand, but it might be different from the complaints procedure, although the matters could overlap. Some people with complaints might need the support of advocacy services, but others might not.

A key aspect of the patient focus and public involvement agenda is the analysis of different strands. I introduced the debate in the chamber in June partly to achieve clarity about that. Other strands are the patient agenda, patient experience, patient involvement and support for patients through advocacy and complaints procedures. The wider public involvement agenda is a citizens’ agenda and does not involve only those who are using health services. Advocacy is an important part of that, but it is by no means the only part.

Mr Davidson: I agree that the complaints procedure is slightly different, although some overlap exists. I do not argue about that. However, the Executive will give to a body that has not yet been created a role that it cannot define. That body will have to operate under some guidance. Will we have that eventually?

Malcolm Chisholm: I did not flag up advocacy services, so I am not sure how they entered the debate. To complicate matters, we have the Advocacy Safeguards Agency, which fulfils the role that has been described. Advocacy is probably the last of the matters that I would have flagged up as involving a central role for the Scottish health council, because we already have a body that monitors advocacy services. The Scottish health council will be concerned with wider public involvement, the complaints procedure and other matters. We already have a body that deals with advocacy services.

Mr Davidson: That is fine, but you suggested—we can check the *Official Report*—that local health councils or the new bodies could be involved in advocacy services. Will that be on a commissioning or agency basis? Who will decide?

Malcolm Chisholm: It will be interesting to check the record. I do not want to labour the point, but in the extract from the letter that I quoted, I did not use the word “advocacy”. The phrase that I used was

“put forward the views expressed by the public.”

When members of the public express concern about a particular service, the local advisory council can put those views to the board. Advocacy is a slightly different concept, which refers to giving support to vulnerable people.

The Convener: We do not have the letter, but I understand that the minister has undertaken to provide the committee with a copy of it.

Mr Davidson: I am happy to wait for that clarification.

Helen Eadie: The evidence that the committee has heard indicates that there is great concern about the independence of the Scottish health council. Although the establishment of the council is welcomed, we are concerned about its inclusion within NHS QIS. Why was it decided to establish the Scottish health council in that way, as opposed to establishing it as a separate statutory body?

Malcolm Chisholm: Well—

The Convener: That was a heavy sigh, minister.

Malcolm Chisholm: That is partly because I have covered some of that question already—I got a bit ahead of myself. I am wondering how much to repeat.
As I said, it is important that the Scottish health council should be independent from health care providers—that is one reason to move away from the system of appointment by health boards. A contrary proposal, which might be the one that you put forward, is that we should set up the Scottish health council as a non-departmental public body that stands on its own. The first point is that, compared to other NDPBs, the health council will be a relatively small unit. There are certain logistical advantages in sharing support services with another body.

The more important reasons, which I have already touched on, are that we want to give the body as much clout and leverage as possible and that we see patient and public involvement as centrally connected to the quality agenda. The starting point for improving quality is the experience of every patient who goes through the health care system, so there is an intrinsic connection. In the consultation, the majority of people, although not all, welcomed that connection in principle.

The corollary of that is that we must ensure that the Scottish health council has a special status within NHS QIS and that there are safeguards for its independence within that body. We are working up the details of that with the Scottish Association of Health Councils; it is one of the key issues that the implementation group is considering.

You present an alternative scenario, in which the health council is set up as a relatively small NDPB, but we think that it is better for it to be connected to NHS QIS. As Martyn Evans said in his evidence, the reality is that NHS QIS operates as an independent body and, in that sense, I do not think that there is a problem with its independence from me. People have concerns—the RCN was concerned about how independent the health council would be within the organisation. We must ensure in the way in which we set up the council that it has its own existence within the umbrella organisation.

**The Convener:** My response to that is, “Why bother?” If you will have to build firewalls or moats around the council, why not just set it up separately?

**Malcolm Chisholm:** I always knew that that would be a major point of debate on the bill. Size is one practical reason why it would be difficult to make the council a separate body but, for me, the intrinsic connection between the patient and public agenda and quality is an important reason for connecting the council to NHS QIS. My perception is that the proposed structure will help to give the body greater clout and leverage, but I accept that there will be an interesting debate on the issue during the next few weeks.

**Helen Eadie:** The question is whether there will be management lines of accountability to NHS QIS; the answer to that will signal whether the body is independent. If the Scottish health council is accountable to the chief executive of NHS QIS, that will raise an issue.

**Malcolm Chisholm:** Most organisations have accountabilities. NHS QIS has accountabilities to the Scottish Executive, but in my view that does not mean that it does not operate independently. The relationship between NHS QIS and me might be the same as that between the Scottish health council and NHS QIS. Such a relationship does not mean that an organisation does not have the same space, as it were, and independence within the arrangements. No doubt if we set up a Scottish health council in the way that you suggest, someone might question its independence because it was accountable to me. The same arguments might well apply in a different form. That does not mean that the council will not be independent; it means that we have to set it up in such a way that it is given its own space.

16:30

**Helen Eadie:** I inferred from what you said—I cannot remember the precise words that you used—that the Scottish health council is to be included in NHS QIS because of its scale and because of accommodation issues, for example. Is that what you were driving at?

**Malcolm Chisholm:** That was the first reason that I gave. I said that that was not the most important reason, but that it was a factor. The Scottish health council will be a relatively small body in comparison to some NDPBs. In other situations we are attacked in the Parliament for having too many NDPBs, so it will be interesting if the Health Committee proposes a new one, but that is your right if that is what you want to do.

**The Convener:** I do not think that threatening us with that gets you out of it.

Perception is also an issue. You have rightly talked about the reality of the management line, but perception is often more important than reality. The perception seems to be that the new Scottish health council will not be independent.

**Malcolm Chisholm:** I am not sure which bit of the perception you are talking about. I have not read all the evidence that the committee has received, but Martyn Evans said that, although that is the perception, it is not the reality.

What are people frightened about? Is it such a bad thing in principle for the Scottish health council to be part of the body that is spearheading all the new work that is being done on the quality agenda, which is one of the most significant
advances in health care in recent times? Is it a problem that the Scottish health council will be part of such an organisation or is it a problem that it will be part of an organisation that has “NHS” in its title? To be honest, I do not know what the problem is.

The Convener: If you read the evidence that the committee has heard, that will give you guidance on that point. Many witnesses have raised the issue with us.

Helen Eadie: The issue has been raised by all the witnesses. People in informed circles have told me that they distinguish between quangos that have a budget to spend on front-line service delivery on behalf of the public, using public money, and other quangos. The issue is the extent to which an organisation should be an independent body. That sets hares running because one encounters issues of accountability—to whom should the independent body be accountable? The debate is bigger than can be covered by the quick response that we have received today.

The Convener: Yes, I think that it is.

I am conscious of time, so we will move on to questions from David Davidson.

Mr Davidson: I will try to be helpful to the minister and ask some fairly simple questions.

This afternoon, minister, you have told us about new roles that the Scottish health council will have. You have talked about communications to the new advisory councils and you have talked about leadership, which has not yet been defined. You have also talked about monitoring and consultation. Those are all serious roles. When the Scottish Association of Health Councils gave evidence, it said that delivery was impossible—the word “impossible” is probably mine, before anybody criticises me—for the currently proposed £2.1 million because of the new roles that are being given to the health council and the need for the council to become a much more cohesive and professional organisation. Do you agree that the Scottish health council can do the job that you want it to do for £2.1 million? If not, what sum of money should it get?

Malcolm Chisholm: The implementation group is discussing many of those issues. I am sure that you agree that £2.1 million is a lot of money. Obviously, over time no wall is drawn around the sum of £2.1 million, but it is more than enough to set up the body and to get the show on the road. We must be mindful of the fact that that figure is not the sum total of the money that goes into the work on patient focus and public involvement—the figure of £14 million has been mentioned before for the work that has gone specifically into that initiative. It may well be that some of that money can supplement the £2.1 million. No one is saying that that is necessarily the end of the road, but I think that the sum is quite sufficient to set up the body.

Mr Davidson: Before the bill goes through the Parliament, could you give us a hint about what you think the budget that the Scottish health council needs to work to should be? It would not necessarily be able to deliver on that in the first year, while it is growing, as there may be front-end costs.

Malcolm Chisholm: I am quite happy with the figure of £2.1 million at the moment. We have adopted an inclusive approach and, given that the Scottish Association of Health Councils is central to the implementation group, I would be happy to listen to its views and those of others who think that that sum will not be adequate. I do not see any reason to believe that that is the case at the moment, but my mind is not absolutely closed on the subject.

Mr Davidson: I want to move to another question on money. Will you outline any work that the Executive has done to reach the conclusion that the bill will not result in any net additional expenditure? Has the Executive made separate calculations of the savings and additional costs that the bill will produce in each of the affected departments?

Malcolm Chisholm: In general terms, we recognise that there will be costs and savings. The fundamental point that the financial memorandum makes is that the bill will not result in any expenditure beyond that which has been announced. For example, there is a new duty to improve health, but of course we have already announced the provision of large sums of money to increase the health improvement budget. The point of that is to spend the existing money more effectively.

There are some methodological difficulties, because it is not possible to be precise about the financial effect of the abolition of trusts, for example. We have used the figure from Dumfries and Galloway NHS Board, which I know has been used in committee, because that process has happened there—that has given the concrete figure of £500,000 over three years. Given that most boards have not been through that process yet, it is difficult to arrive at such concrete figures. However, we can say with confidence that abolishing trusts will certainly not cost more and will save some money, because of the rationalisation of various functions.

The situation is different in each case. On community health partnerships, there will be two main expenditures—those related to the provision of services and those associated with the
management of CHPs. Although most of the management costs already exist within the LHCCs and primary care trusts, the provision of service costs are subject to the much wider budgets relating to boards and service development.

We could go on to consider each of the different areas. I suppose that the power of intervention has been the most controversial in previous evidence-taking sessions. We were asked specifically to give a figure for that, but we did not think that that would be easy to do, as the situation would be different in each case. We used the example of Tayside NHS Board—that is how the figure of £85,000 was arrived at—but, if one were to base the calculation on the intervention in Argyll and Clyde last year, the figure would be higher than that. On the other hand, if one were to imagine what would have happened if the scenario that arose at the Beatson oncology centre two years ago had been dealt with under the power of intervention, the figure would have been less than £85,000. The figure is different in different cases.

As I said, there are some methodological difficulties with estimating the bill's costs and savings, but we can go on doing the work and developing the figures as more information becomes available.

Mr Davidson: Will you share with us the financial assumptions that your department worked on and that resulted in the present state of the financial memorandum?

Malcolm Chisholm: As I have said, the financial memorandum was basically saying that the bill would not result in any expenditure beyond what had already been announced. It said that reprioritisation might be required in certain areas, so it was not ruling out the possibility that more money would be spent on particular areas, but its fundamental point was that the bill would not result in any expenditure beyond what had already been announced.

Mr Davidson: That is a net conclusion. Can we have the assumptions on which you have calculated where the savings and costs will come from?

Malcolm Chisholm: I accept that there is more work to be done on that issue, partly because new information on trusts and other areas becomes available all the time. That is something that we must keep working on. I am not claiming that the financial memorandum was ideal, but I think that some of the difficulties were the result of circumstances rather than of failings in the Health Department.

Shona Robison: You have already touched on the issue of additional resources for public consultation and said that £14 million was available for public involvement measures. Presumably that money is already in the system. However, will additional resources be required to meet the new duty, particularly given the staff time that will be needed to ensure that public involvement is adequate?

Malcolm Chisholm: We are talking about different budgets. The £14 million that you have mentioned is from the patient focus and public involvement initiative and is not included in health boards’ budgets. Instead, that money supports boards’ work, the advocacy work that we have already referred to and the fair for all initiative, which relates to ethnic minority health and is relevant to the equal opportunities provisions that we are proposing to add to the bill. Furthermore, there is the health council budget of £2.1 million that has been mentioned. Of course, as we will no doubt discuss in a moment, most of the money is with the boards—in other words, the money for the boards’ work on public involvement will be taken from their budgets, not from the budgets that I have just described.

The reality is that people are already working on those areas; the key thing is to get them to carry out that work better. Indeed, as I said earlier, much of the patient focus and public involvement initiative is about supporting boards in that respect. In most cases, the initiative is not about employing lots of new people, but about getting the people who are currently doing the work to do it better. As a result, I do not think that a fundamentally big increase in public expenditure will flow from the duty on public involvement.

Shona Robison: Do you accept that doing the work well might involve a wider range of staff than is currently involved? Given that the thrust behind the measure is that public involvement is everyone’s duty—not just the duty of the public involvement officer—such work might require more members of staff to become involved. Surely that will impact on available staff time. Will you monitor that situation? Moreover, given that we have all received feedback from boards about their tight budgets and the fact that they are strapped for cash, will you look at the matter again if it is proving difficult for boards to carry out the work without additional resources to free up staff time?

Malcolm Chisholm: I am always happy to look at things again, if necessary. However, the issue highlights the different strands of the agenda. The aspect of the agenda that will impact more on every member of health care staff is what I would describe as patient focus. Indeed, I spent most of the debate in June outlining that part of the agenda because, with the culture change in the NHS, staff are engaging with patients every day. The requirement to relate differently to patients and to take on board patients’ experiences will impact on every member of the health care team.
However, I do not think that every member of the health care team will routinely engage with the wider public as citizens. That activity will be more discrete.

As I said, patient focus is about people doing their existing jobs differently, whereas public involvement is probably more tied to specific members of staff who engage with the wider public. As those staff already exist, the issue is about ensuring that they do their job more effectively than they have in the past.

**Kate Maclean:** I have a couple of questions about the powers of intervention, the first of which is why such powers are needed and when and how they will be used. My second question centres on who will pay for those powers.

According to the evidence that we have received, everyone accepts that Scottish ministers should have the power to intervene if things go wrong, because they are accountable for the NHS in Scotland. However, people are concerned that the bill does not make it clear what is meant by intervention. Evidence that we have heard has suggested that some organisations would like intervention to be defined more clearly in the bill and we heard evidence today that other organisations would be satisfied with a definition in regulations. Can you clarify for the committee on the record when and how the powers of intervention would be used?

There seems to be no clarity about who would bear the cost of the powers of intervention. Earlier, you referred to previous evidence and to the estimate by the Scottish Executive of £85,000, which was based on ministerial intervention in Tayside NHS Board. However, we also heard that the cost of intervention in Argyll and Clyde NHS Board was £300,000. You said that the cost of intervention at the Beatson was less than £85,000, but if memory serves me correctly the Beatson Board was £300,000. You said that the cost of intervention in Argyll and Clyde NHS Board. However, we also heard that the cost of intervention in Argyll and Clyde by ministerial intervention in Tayside NHS Board was £85,000, whereas other boards are under the impression that they will have to do so. Can you clarify that issue?

16:45

**Malcolm Chisholm:** Intervention is envisaged very much as a last resort. There are many earlier steps that can be taken. Proposed new section 78A(2) states:

“The Scottish Ministers may, where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable, direct that specified functions of the body or person under or by virtue of this Act be performed”.

That is important, as it leaves open the possibility of challenge. A board could challenge a decision to intervene and there could be a judicial review, if intervention were thought not to be necessary. It is thought to be necessary only as a last resort.

On the first question, it would be very difficult in principle for us to describe in some way, either in the bill or in regulations, the situations in which intervention would arise. The bill states that intervention may take place when a body or person is failing to provide a service to a standard that is acceptable. I accept that that appears to be subjective, although any decision to intervene remains subject to challenge. I do not know how we could translate that into a description in the bill or in regulations. It would be interesting to hear suggestions, but I cannot imagine how we would do that.

Proceeding by examples is a good approach. In some ways, it is easier to use the concrete examples that we have. We were able to intervene at the Beatson and in Argyll and Clyde NHS Board because, ultimately, we secured the agreement of the relevant governing bodies to do so. Under the powers that we currently have, we could not have intervened without their agreement. That is why we need the new power. At some point, a board may say that it will not co-operate with us and that it wants to continue to provide a service itself.

I have given the examples of difficulties in the running of a cancer service and more wide-ranging difficulties in Argyll and Clyde. How would we describe those in the bill? That question defeats me. The basic idea is that intervention can take place when a service is judged to be failing. That is the right general description, because it relates to the issue about which the public are concerned. If there is a service failure in an area, under the new political arrangements in Scotland people want the centre—in the first instance, the Scottish Executive, but the Scottish Parliament could also call for intervention—to intervene. The general criterion of service failure is right, but it escapes me how we would write the details of that into the bill.

**Kate Maclean:** The second part of my question was about the cost of intervention.

**Malcolm Chisholm:** My understanding—this may need to be spelled out if it is not clear—is that boards will have to bear that cost. That does not mean that there should not be flexibility. If a board is in financial difficulties and there are particular circumstances that need to be taken into account, there is nothing to prevent the Executive from
deciding to fund intervention either fully or in part. However, it would cause considerable concern in all the other boards in Scotland if one board that had been failing were seen to get extra money. At the end of the day, extra money from the Executive is top-sliced from the budgets of all other health providers. The sums involved may be small, but it would cause considerable difficulties for other boards if a board that was perceived to be failing received extra money.

**Kate Maclean:** I suspect that boards would not be envious of another board in which ministers were intervening, even if the cost of intervention were borne by the Scottish Executive.

Just for clarity, are you saying that the definition of intervention will not be in the bill or in regulations and that the cost of intervention—even if it is necessary because of severe financial problems caused by mismanagement—must still be borne by the health board, even if it amounts to £300,000 or more?

**Malcolm Chisholm:** We may need to clarify that, but that would have to be the formal position. As you know, we made a contribution in the case of Argyll and Clyde and I would not want to rule out that degree of flexibility. In my judgment, if we write into the bill that the cost will be borne by the Scottish Executive, that will cause more of a negative reaction, because although we might not be perceived as rewarding failure we would be seen as helping a board where there is failure. I think that that would create a negative reaction from boards that would ultimately have to bear the cost of such intervention.

**The Convener:** I do not know whether you intend to put that into regulations or guidance, but it would be helpful to have further thoughts from you on the costs of intervention. You seem to be saying that you will need to exercise discretion.

**Malcolm Chisholm:** There will have to be an amendment to make that clear. We cannot have that kind of doubt about the issue, so we will probably have to say that the cost will be borne by boards. However, putting it that way does not rule out the possibility of the Executive contributing at its discretion. That is what we intend to do.

**Kate Maclean:** If a board is to operate without knowing when the Executive is likely to intervene, that seems to create some difficulty. I can accept that there perhaps should not be a definition in the bill, because that would not allow enough flexibility, but I cannot understand why the definition of intervention cannot be in guidance for boards. Without such definitions, how are they to know at what stage and for what reasons there will be an intervention?

**Malcolm Chisholm:** If members can come up with a form of words that would somehow capture what service failure is, I would be interested in hearing from them. The point is that intervention will not come like a bolt from the blue. It will happen very rarely, because a whole ladder of interventions would be used before the sort of intervention that we are now discussing would be made. Boards would know a long time before that happened, because the problems would have been flagged up.

**Kate Maclean:** Will that be in guidance, then? Will the stages that are reached before intervention be set out in guidance?

**Malcolm Chisholm:** The boards already know what the stages are, because when they get into difficulties the Executive intervenes in management support or in other areas. I do not imagine that that is something that boards do not know about already. I shall look further into the issue of guidance. Perhaps, for all I know, there is already some formal guidance. There has been a lot of guidance from the Scottish Executive Health Department over the years and I cannot say that I have read every single piece of it. However, I can certainly be confident in saying that boards know what the procedures are. As to whether those procedures are currently written down in guidance, I will have to get back to you.

**Kate Maclean:** Is that something that we could explore further through correspondence?

**Malcolm Chisholm:** We shall write to the convener.

**The Convener:** The policy memorandum refers to what happens at the end of the road, once you have sacked—to use a rather brutal word—a chair or other board members. The memorandum says:

> These are very much powers of last resort and have rarely, if ever, been used.

It would be quite useful to know in what circumstances they have been used. That would give us some idea of the ultimate sanction in cases where you have had to intervene because the situation has been so bad that people have almost been suspended on the spot. I do not know about the other committee members, but that would certainly be useful for me.

**Malcolm Chisholm:** We can incorporate that information in our letter. It is now 26 years since the National Health Service (Scotland) Act 1978, but I am told that the most draconian power in that act—to hold an inquiry and then sack the board—has not been used.

**The Convener:** So, do you have to have a judicial inquiry?

**Malcolm Chisholm:** Part of the problem may be that the procedure is very cumbersome. That may be why it has never been used.
Mike Rumbles: I would like to pursue that point. My observation is that the definition is quite clear; it is wide and gives the minister a huge amount of power. You have just said that the power would be used as a last resort and that such interventions would happen very rarely. I take that on board and I am sure that that is the case.

However, the bill states that Scottish ministers may intervene

“where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable”.

That can be read in two ways. One way of reading it would be that intervention can take place if the minister—not anybody else—feels that it is necessary. That appears to be the objective test, according to my reading of the bill. Would not it be better to have said that Scottish ministers may intervene “where they consider it essential for the purpose of ensuring the provision of the service in question”, changing “necessary” to “essential” and leaving out

“to a standard which they regard as acceptable”? If intervention is to be a last resort and a rare event, the provision does not need to be so all-encompassing.

Malcolm Chisholm: That is an interesting suggestion and it could give rise to an interesting amendment. I would not like to make a snap reaction to it, but I shall certainly reflect on what you have said.

The Convener: Thank you, minister. We have another short item before we go on to our private budget briefing and I know that you are coming back for that.
6 January (1st Meeting, Session 2 (2004)), Supplementary Written Evidence

National Health Service Reform (Scotland) Bill – Inclusion of Staff Governance

Please find below supplementary evidence from NHS Orkney in relation to the inclusion of Staff Governance in the Reform (Scotland) Bill.

At the time of the submission of written evidence NHS Orkney Board members were concerned that staff governance would not be included in the Bill. However, we welcome the proposal from the Minister to lodge an amendment at Stage 2 to ensure that staff governance is included.

Staff governance forms the third component of governance combining with financial and clinical governance to complete the governance framework within which NHS Boards and Special Health Boards are required to operate. The inclusion will reinforce the parity with the other governance requirements.

NHS Orkney aims to support the creation of a culture where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the Board and is built upon partnership and collaboration. Staff Governance is a system of corporate accountability to ensure the fair and effective management of all staff. It is about monitoring NHS Orkney performance as employers. In particular the Staff Governance Committee is responsible for ensuring that the National Staff Governance Standard is met. NHS Orkney understand that there is a proposal to build on the standard by reflecting changes as NHS Scotland continues to evolve.

Effective people management is a key component in leading and supporting change in the Health Board. Ensuring we are able to recruit to meet the needs of the services, investing in knowledge and skills and providing a climate and organisational culture which promotes and encourages innovation are responsibilities of all managers. The staff governance standard reinforces this requirement and allows transparency throughout the organisation. NHS Orkney feel it is vital that staff understand the key components of the standard and how it relates to their employment within the Scottish HealthCare system and that the key components are not changed but strengthened.
6 January (1st Meeting, Session 2 (2004)), Supplementary Written Evidence

Thank you for your letter of the 9th January regarding our evidence session with the Health Committee on Tuesday 6th January. Please pass on our thanks to the Committee for the opportunity to give evidence on the NHS Reform Bill.

As you say in your letter the Committee requested some additional information from us on the following:

- the role of the pharmacy contract within the development of Community Health Partnerships;
- whether we feel definitions for the powers of intervention, including examples of the possible types of intervention, should be presented in primary or secondary legislation;

I understand that the Scottish Pharmaceutical General Council have already responded regarding the pharmacy contract. As this is their area of expertise and responsibility I feel that no further comment is required on this particular item.

Regarding the powers of intervention, the Society believe the powers should be defined more clearly to ensure that intervention is clearly the last resort irrespective of whether this is detailed in primary or secondary legislation. We also want to make the point that if local governance procedures are to be effective and if local communities and health professionals are to take responsibility for the NHS services in their area it should be clear that central power is seen to be kept to a minimum.

Thank you again for the opportunity to give evidence and do not hesitate to contact me if you require further information on this or any other matter in which you believe the Society could be of assistance.
6 January (1st Meeting, Session 2 (2004)), Supplementary Written Evidence

I am writing following the meeting of the Health Committee held on 6 January 2004 at which there was a request for information on the role of the pharmacy contract within the context of development of Community Health Partnerships.

The Scottish Pharmaceutical General Council represents Scotland’s 1150 community pharmacy contractors. We negotiate on their behalf with the Scottish Executive on the terms of service and remuneration for contractors’ NHS work. Currently SPGC is negotiating with the Scottish Executive on the proposed new contract for community pharmacy.

Negotiations on the new Scottish community pharmacy contract are still at an early stage. The aim of the new contract will be to deliver the Scottish Executive’s policies for the future provision of community pharmacy services as described in the Scottish Executive’s February 2002 publication, ‘The Right Medicine - A Strategy for Pharmaceutical Care in Scotland’.

The contract will be a national agreement, thereby avoiding creation of ‘postcode services’. We anticipate, however, that CHPs will have a responsibility for co-ordinating a small number of local services, such as pharmaceutical advice to nursing homes and out-of-hours provision.

SPGC does not anticipate that the new pharmacy contract will have a significant impact on the development of CHPs. However, in our submission to the Scottish Executive’s consultation on CHPs, SPGC made the following points which may be of interest to the Health Committee:

It will be vital that the CHPs be fully aware of all service developments within primary care. CHPs, in seeking to deliver local healthcare services, must take cognisance of what is already happening within individual professions and work to integrate these services within the overall local provision to ensure that services are provided with no unnecessary duplication of effort and waste of resource.

There will be opportunities for specific local benefits if CHPs give community pharmacy the opportunity to work in partnership with other primary care professionals and local stakeholders to deliver agreed healthcare messages. Such participation we see as an enhancement of the nationally agreed role.

There will be a need for CHPs to keep abreast of any agreements made nationally and in turn to feed back information on the success of such initiatives.

We assume the role of CHPs will lie in co-ordinating pharmacy’s contribution to local service provision overall.

I hope that this information is helpful to the Health Committee in its deliberations on the NHS Reform (Scotland) Bill.
6 January (1st Meeting, Session 2 (2004)), Supplementary Written Evidence

Letter from Malcolm Chisholm MSP to Greater Glasgow Health Council

Many thanks for your letter of 13 October which raises issues around my address to the Scottish Association of Health Councils Annual Conference on 26 September.

The support and guidance from the Health Council movement has been very valuable to the development of the proposals for the new public involvement structure and the considerations of the detail of the new structure and its implementation. As you will be aware, a Steering Group has been established to advise the Implementation Team and many of the issues that you raise will be discussed on 21 November at the first meeting. As a member of the Scottish Association of Health Councils your health council will, of course, be kept up-to-date with developments.

You ask for clarity around 2 specific questions which I am happy to offer as far as possible at present. First, you ask about whether, in some circumstances, the Scottish Health Council may speak on behalf of patients. Our proposals are based on the premise that the NHS Boards will be successfully engaging with the patients and the public. This will be a duty placed upon them by the Reform Bill which will be underpinned by revised guidance on Informing, Engaging, and Consulting with Patients, Carers and the Public. Where the Scottish Health Council identifies an area where public concern or viewpoint is not adequately being considered or where there is not an appropriate patient support group, it will be expected to raise this with the NHS Board or to put forward the views expressed by the public.

Secondly, you ask about the statutory rights and duties currently carried out by the health councils. This is an area that will be considered by the Steering Group and the Implementation Team. However, as you note, the consultation paper commits us to ensuring that all of the functions currently carried out by health councils continue, although not necessarily by the Scottish Health Council. It is important to reiterate that the new structure will not restrict Scottish Health Council access to information or opportunities for them to engage with the public, rather it will establish measures for them to ensure that NHS Boards develop effective and sustainable methods for consulting with and involving the public.

I do appreciate the concerns which exist in the health council movement during this period of relative uncertainty and will ensure that the information on progress from the Implementation Team is made available to all those that are interested. I am confident that the outcomes of the new structure will deliver better patient-focussed care and the increased involvement of the public in the design and implementation of health policies. All health councils will have a crucial role in ensuring the success of this and I hope that you and your colleagues look forward to this challenge.

Thank you again for your comments: they are very welcome.
6 January (1st Meeting, Session 2 (2004)), Supplementary Written Evidence

Many thanks for giving me the opportunity on 6th January to give evidence to the Health Committee on the NHS Reform Bill: a piece of legislation which I believe will help to deliver improved health to the people of Scotland and better integrated health services that are more responsive to the needs of patients and communities.

At the Committee meeting, I undertook to get back to you on a couple of issues.

Public Involvement and the role of the Scottish Health Council

I have already sent to you a copy of the letter I sent to Mrs Patricia Bryson of Greater Glasgow Health Council, which helps to clarify the role of the Scottish Health Council. The Scottish Health Council will have three main functions, as outlined in the consultation paper A New Public Involvement Structure for NHSScotland: Proposals. These are:

- **Assessment**: to play a central role in the annual accountability review process, by ensuring that NHS Boards are discharging their duties in relation to monitoring the patient experience and to patient and public involvement;
- **Development**: to provide a critical mass of expertise and experience available to organisations representing the interests of service users and the public throughout Scotland, and to help develop and spread good practice in public involvement in the NHS;
- **Feedback**: to ensure that arrangements are in place to ensure that patients or carers who have views about their health services that they wish to express have the opportunity and, where necessary, the support to do so.

There are many ways in which individuals and the public can express their views of health services. The Scottish Health Council will support patients and carers in expressing these views and ensure arrangements are in place to support individual patient and carer feedback. NHS providers are mainly responsible for ensuring the views of the public are sought and listened to, and we will also expect them to ensure there is support for patients and carers in expressing views. The key role of the Scottish Health Council, as I explained, will be to monitor and quality assure these arrangements. As the letter states, however, where the Scottish Health Council identifies an area where public concern or viewpoint is not adequately being considered or where there is not an appropriate patient support group, it will be expected to raise this with the NHS Board or to put forward the views expressed by the public.

There is also an important role for the public partnership forums that will form part of the development of Community Health Partnerships. It is currently envisaged that places will be reserved on the CHP committee for members of the public partnership forum, who will be responsible for representing the wide range of public opinion. We see the public partnership forums as being able to represent a range of views and groups at local level, and they will have a major task to ensure that health services are responsive and in touch with the needs of the public locally.

As we established at the committee meeting, it is important to differentiate between expressing and advocating the views of the public (which will be done by individual members of the public, interest groups, community groups, community planning mechanisms and public partnership forums) and advocacy services which aim to support people in making informed choices about, and remaining in control of, their own health care. Traditionally advocacy has been mainly available to vulnerable groups, such as people with mental health problems, learning difficulties or physical disabilities, and older people. But it should also be available more widely to all health service users where this is needed.
Power of intervention

The committee also asked about the proposed new power of intervention, the prior steps to be taken before the power would be used, and whether guidance on these prior steps has been provided to the NHS. As I explained, the proposed new power of intervention is intended as a last resort, to be used only when other means of remediating service failure have failed or are clearly not going to work, and where the relationship between Scottish Ministers and the Health Board in question have broken down to the extent that the Board’s co-operation cannot not be relied on.

Other administrative and formal measures that Scottish Ministers can use to intervene in the operation of Health Boards include:

- Asking the Health Board to produce a recovery plan with time bound actions, supported by regular monitoring meetings between the Health Department and the Health Board to check progress against the recovery plan;
- With the agreement of the Board, the Department can arrange for additional senior staff to strengthen the management team of a Health Board if, for example, a recovery plan has been produced, but is not being adhered to;
- Where control over capital or current expenditure has been inadequate, or there are serious doubts about regularity, propriety or value for money, the Department’s Accountable Officer can (in accordance with the terms of appointment) withdraw the appointment of a Board’s Chief Executive as NHS Accountable Officer;
- Terminating appointments to the Board by virtue of Regulation 5(2) of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001;
- Issuing a direction under section 2(5) of the National Health Service (Scotland) Act 1978; and
- Using the default powers under section 77 of the National Health Service (Scotland) Act 1978 and removing the entire Board.

You asked about the circumstances when Ministers had used existing formal powers of intervention. As I mentioned to you at the committee meeting, as far as the Department is aware, the section 77 default powers have never been used. The power to issue Directions to remedy service problems in a particular Board area has not been used since devolution, nor have Scottish Ministers used their formal power to terminate Board appointments. However, Ministers have on two occasions asked Health Board Chairs to consider their positions and in both cases resignations followed. One case followed what Ministers believed were serious problems relating to an important public consultation exercise; the other related to a widening financial deficit.

The proposed new power of intervention is designed to allow a quick, targeted response when a service has failed, is failing or is likely to fail and the relevant Board is unable or unwilling to cooperate with the Minister and the Department in putting the situation right. A decision to intervene would be based on clear evidence that service failure had occurred or was occurring. A range of potential failure would be covered by the proposed power. Clinical service failure could come to light, for example, through complaints from patients over poor treatment; NHS Quality Improvement Scotland reports about clinical standards not being met; whistle-blowing by members of staff; a lack of public confidence in a clinical service; a serious clinical event; or audit results showing comparatively poor or declining performance. Management failure may come to light through, for example sustained failure to meet performance targets such as waiting times; comparatively poor or declining performance demonstrated by key indicators within the performance assessment framework; poor external relationships with partners; failure to tackle strategic long-term issues; and low staff morale. Financial management failure will become apparent through large unexpected deficits and an inability to control these over time despite, for example, recovery plans being agreed and implemented. In all these examples, Scottish Ministers would have to be satisfied that the failure resulted in or was likely to result in inadequacy of a service.

Health Boards are familiar with the range of administrative interventions open to Scottish Ministers and the Health Department on Ministers’ behalf. The “escalating intervention protocol” was most recently sent to Health Boards as part of the consultation on the Performance Incentive Framework on the 18th July 2003. The protocol can be found in paragraphs 8-16 of Appendix A to the Appendix of this letter. The existing formal intervention mechanisms are set out in legislation.
I hope that this addresses all the outstanding issues that the Health Committee has raised. I look forward to reading your Stage 1 report on the Bill.

Appendix

PARTNERSHIP FOR CARE – PERFORMANCE INCENTIVE FRAMEWORK

1. Following from the White Paper “Partnership for Care”, I am writing to you to invite your comments on the development of the new Performance Incentive Framework.

2. In “Partnership for Care” it was stated that we would work with Boards to develop a new Performance Incentive Framework (PIF) in 2003. This would support good and improving performance in the NHS and balance the current escalating intervention protocol that is under review in light of the tabled Health Bill. The attached consultation paper sets out the initial thinking around the PIF and we look forward to working with you now to help shape the final version.

3. During the consultation period, we would be happy to meet and discuss any aspects of the proposed PIF with colleagues in the NHS. If you wish to arrange a meeting, you can contact Robert Kirkwood (0131-244 2556) or Andy Smith (0131-244 6918) who are leading the development. The closing date for comments on the proposals is 17 October 2003.

4. Any comments should be sent to:

Claire Flynn
Performance Management Division
Scottish Executive Health Department
2 E N
St Andrew’s House
Regent Road
EDINBURGH
EH1 3DG

Access to consultation responses

5. We will make all responses available to the public in the Scottish Executive Library 21 days after the closing date of the consultation unless confidentiality is requested.

6. All responses will be acknowledged.

Yours sincerely

JOHN ALDRIDGE
PARTNERSHIP FOR CARE

PERFORMANCE INCENTIVE FRAMEWORK

1. Scotland’s Health White Paper “Partnership for Care” published on 27 February 2003, gave a commitment to a new Performance Incentive Framework (PIF) to be developed in 2003 supporting NHS Boards who display good and/or improving performance.

Role of the Performance Incentive Framework
2. The PIF will seek offer clear and transparent incentives and will balance the escalating intervention protocol that already exists (see Appendix B).

3. This discussion paper is consistent with “Partnership for Care” as well as with “Rebuilding our NHS”, published in May 2001. These documents outlined a commitment to establishing a set of incentives to encourage good performance and act to intervene and support to turn round weak performance across NHS bodies. Also relevant to the development of the PIF is the fact that the Performance Assessment Framework (PAF) is now embedded in NHS Scotland; it provides systematic comparative performance information, which is published annually. It is broadly based, and looks at many indicators besides financial performance so we have a sound basis for assessing performance.

4. The next step is to set out and agree with the NHS appropriate and relevant incentives with which to acknowledge good performance. In doing so, we recognise that one of the most powerful acknowledgements is proper public and peer recognition of a job well done.

Operation of the Performance Incentive Framework
5. In framing proposals for incentives, we have been guided by the following principles:
   • incentives for NHS systems where things are going well or going better, in addition to support where performance is declining or weak;
   • greater clarity and predictability about when acknowledgement of success will be given and when intervention will occur, so that behaviour and performance are influenced over time;
   • acknowledgements which, wherever possible, are specific to meeting agreed targets, eg, on waiting;
   • a range of successes which can be acknowledged; and
   • the approach being open and transparent to the NHS, patients, public and other bodies.

6. It is expected that an effective PIF would have the following characteristics:
   • A balance between incentives and interventions.
   • Acknowledgement for sustained improvement in performance, not just one-year sprints that turn out to be unsustainable.
   • Takes account of where performance of individual Boards is starting from, as well as performance against Scottish averages.
   • System should be flexible enough to simultaneously deliver incentives and intervene in a Board that has areas of both good and declining performance.
   • Existing incentives/interventions are embraced by the new approach.
   • The PIF will not be purely financial.
   • It will have a high level of acceptance within the NHS.
   • It will not “penalise” the public in areas of poor or declining performance (poorly performing services already penalise the public by providing poor service – PIF should not make it worse).
   • The public should notice the difference a PIF system makes.

7. Examples of the incentives being considered are contained within Appendix A. These examples seek to build on current work and perceived good practice and create a framework around this. Over time, additional means of incentivising performance as well as additional interventions could be introduced. In the same way that the PAF changes slightly year on year the PIF could also develop to reflect changes in practice and legislation. The list at Appendix A should not be seen as exhaustive, indeed, there will be a number of areas that you may wish to see included within any final version of the PIF.
8. The actual operation of the PIF would be transparent, with clear triggers for each level of incentive or intervention. The responsibility for the use and targeting of incentives/intervention would rest with the Chief Executive of NHSScotland. While the incentives would be linked to the annual Accountability Review cycle, the intervention system is already in operation and would be invoked as and when required. The aim is to put the incentive aspects of the system into operation after the Accountability Reviews in summer 2004.

Consultation

9. The White Paper sets out that the NHS should be given appropriate incentives to encourage strong performance as well as relevant interventions when necessary. It is right, therefore, that the NHS will play a major role in the development and implementation of the PIF.

10. The closing date for comments on the proposals, as outlined in Appendix A to this paper, is 17 October 2003.

11. Any comments should be sent to:

Claire Flynn
Performance Management Division
Scottish Executive Health Department
2 E N
St Andrew’s House
Regent Road
EDINBURGH
EH1 3DG

Health Department
Performance Management Division
Appendix A

1. **Individual/Group Recognition**

Public recognition and official thanks for a job well done. This would help to balance bad publicity when things go wrong. Incentives could include:

a. Long & Good Service Award Scheme (currently under development) - rewards all staff from porters to consultants;

b. "well done" visits by NHS Chief Executive and/or Health Ministers;

c. plaque and/or "certificates" awarded to relevant staff;

d. celebrate achievements recognised by external award giving bodies;

e. media releases both national and local for the above;

f. timing could be throughout the year but especially after the Accountability Review process in support of the publication of the Chief Executive’s letter to the NHS Board.

2. **Financial**

Break even for current financial year. Incentives could be:

a. reduced detailed justification for capital schemes (already, provisionally, introduced as part of the revision of the capital allocation system);

b. perhaps the flexibility around the use of specific funding allocations (eg, if allocation is made to improve discharge planning but NHS Board already has robust plans in place, then the Board should be allowed to divert these funds to another area of need).

3. **Specific Activity Performance**

Improving performance in specific selected activities (eg, waiting times, clinical outcomes). Incentives could be:

a. reduced frequency of assessment (if annual reduce to every 2/3 years);

b. reduced frequency of visits (if annual reduce to every 2/3 years);

c. specific activities would not be part of Accountability Review process;

d. preferential access to pilot schemes relevant to specific activity;

e. preferential access to additional finance from SEHD for specific activities.

4. **Mutual Support**

A good performing Board in a specific activity helps a Board with poor or declining performance in that activity eg, by secondment and/or Task Force. Incentives could be:

a. Department funds the good performing Boards' costs in relation to secondment/Task Force for agreed period.

5. **Dissemination of Good Practice**

A Board with good or improving performance in a specific activity disseminates the best practice to all other NHS Boards in Scotland. Incentives could be:
a. Department funds the good performing Boards’ costs arising from the dissemination of best practice for one financial year.

b. Sabbaticals for individuals and the funding for back filling posts.

6. **Local Autonomy and Enhancement**

Good performance by a Board on a number of pre-set indicators. Incentives could be:

a. greater freedom to re-invest locally generated capital receipts (up to agreed limit).

7. The policy principle underpinning the success aspects of the system is that one of the most powerful acknowledgements is proper public and peer recognition of a job well done. This acknowledgement could be utilised frequently and regularly and would have an immediate impact. The acknowledgement will also be targeted specifically at the area of activity where sustained good performance has been identified.

8. The escalating intervention protocol detailed here is already in existence. This is targeted at addressing weaknesses in the local NHS system rather than seeking to target individuals. The Health Bill, currently being tabled in the Scottish Parliament, seeks to augment these powers by enabling timely and effective support to be given in areas where the health system is failing.

9. Currently, the escalating intervention protocol is as follows:

10. Meetings between officials from SEHD and NHS Board with SEHD providing help, advice and support with a view to resolving problems within a short, focused timescale.

11. Meetings between officials from SEHD and NHS Board lead to the production of a "recovery plan" (eg, Grampian financial recovery plan). This plan will be closely monitored by the SEHD along with the usual complement of help, advice and support.

12. Where performance continues to be poor SEHD discusses with the NHS Board how management might be strengthened and takes the necessary action (eg, Beatson Unit).

13. If performance continues to be poor the Department can choose to send in a Task Force to assist management (eg, in Tayside and more recently Argyll & Clyde).

14. In addition to support/action above, the Chief Executive, NHSScotland can recommend to the Minister that he should request the Chair and non-executives of an NHS Board to seek the resignation of or dismiss the Chief Executive of the NHS Board.

15. Ministerial action can be taken to remove the Chair and/or members of an NHS Board.

16. The policy principle underpinning the support aspects of the system is that only in exceptional circumstances should action/support need to extend direct intervention by SEHD (such as using a Task Force). SEHD and NHS Boards will make every effort to resolve performance related issues with a strong presumption that early meeting between Board and Department will account for the vast majority of the necessary support/action measures.
ADDENITIONAL WRITTEN EVIDENCE

SUBMISSION BY AUDIT SCOTLAND

We are pleased to offer some comments on the practical implications arising from the Bill. From an audit perspective these include the need for:

- strong governance and controls of the major budgets previously managed by trusts;
- transparency in accounting for the use of resources within the new unified boards; and
- relevant, clear and timely performance reporting.

Transitional arrangements for the dissolution of trusts and the formation of unified health boards and community health partnerships (CHPs)

Reorganisation presents opportunities, but risks are also involved. In the short term there are risks associated with the disruption of current management arrangements, and the transfer of services and functions. In the medium term, there are the risks that arise from new management arrangements and controls which have not been tested over time.

Specifically the following will need to be managed over the transitional phase as trusts are dissolved and unified health boards and CHPs are established:

- Keeping an open dialogue with partners and the public to ensure that their feedback is taken into account in the development of new structures;
- Ensuring that future structures are clear to planning partners and the public;
- Maintaining a proper governance framework within trusts during the transitional phase of restructuring;
- Ensuring the correct transfer of balances and assets to the unified health boards;
- Ensuring that appropriate staff responsibilities are maintained in particular areas where the separation of duties is essential for internal financial controls.

New structures

The unified health boards will be large complex organisations responsible for health strategy and the delivery of healthcare services. The boards will need to give a high priority to creating a sound framework of governance. If this is achieved in the early stages then the likelihood of major problems in future years is significantly reduced.

Specifically, the new bodies should:

- Ensure that board members have the right skills and training to undertake their wide-ranging roles;
- Clarify accountability arrangements and systems for performance management and reporting;
- Establish a robust risk and control framework to prevent a breakdown in core business systems, processes and controls which could lead ultimately to a failure to maintain services;
- Rationalise the key financial and operational systems to achieve efficiency gains;
- Ensure that key staff with the right skills and experience are retained or recruited to lead the new organisations and that these are designed in such a way as to achieve the most efficient management structure;
- Ensure the active involvement of local partners in the development of the new community health partnerships. This will mean that CHPs can participate fully in the development of joint services and community planning in local areas.
- Attempt to dovetail the new health structures with those of their key local partners.
Performance reporting

Best Value places a strong emphasis on continuous improvement in public services and public performance reporting. The health service is responsible for a large part of public expenditure in Scotland, and the public need assurances that this is being managed efficiently and effectively. There will need to be increased transparency in the way in which health resources are allocated and used. Over recent months we have seen a public debate about individual health boards’ priorities and the need to make difficult decisions about the best use of resources.

Health boards report to the Health Department and ultimately to Ministers. Chief Executives of health boards are Accountable Officers and as such are accountable to Parliament for the economic, efficient and effective use of resources.

The new unified health boards will need to put in place reporting mechanisms which allow Parliament and their local communities to know how they are discharging their duties in relation to:

- Matching service provision to the needs and priorities of the local population;
- Ensuring equity and access to care based on need;
- Delivering cost effective health services;
- Demonstrating continuous improvement in the quality of care provided to patients; and
- Contributing to the health improvement of their local population. This will need to be done in partnership with other agencies and has an obvious overlap with community planning under the Local Government Act.

Role of the auditor

Appointed auditors will keep a close eye on governance issues during the dissolution of trusts and in the setting up of the new structures.
The Scottish Society for Rheumatology (SSR) is generally supportive of the overall direction of the National Health Service Reform (Scotland) Bill. However, we would like to respond to your request for comment on the three specific areas highlighted below:

**General Principles and key provisions of the Bill**

The SSR supports the general principles and key provisions of the Bill, however we would like to comment on the following specific provisions:

- The SSR supports moves which will facilitate the equitable delivery of quality services across the country and we have noted the measures to support appropriate quality standards. Both the British Society for Rheumatology (BSR) and SSR have been working closely to develop robust standards within our specialty. These will be based, in part, on evidence based guidelines such as those produced by the Scottish Intercollegiate Guideline Network (e.g. on early Rheumatoid Arthritis and Osteoporosis). We believe that the drive to ensure consistency in service delivery and equity of access to care will work to the advantage of our patients. At present, the failure to fully implement HTBS guidance on anti-TNF therapy in Rheumatoid Arthritis, for example, has led to an undesirable example of “postcode prescribing”.

- The SSR supports recommendations to facilitate cross-boundary co-operation. This is consistent with our vision of how optimum rheumatology services should be delivered. In the recent Public Health Institute for Scotland Needs Assessment Report, “Rheumatoid Arthritis in Adults: Gaining Health From Effective Treatment”, for example, there is a specific recommendation that Health Boards in the North and West and Island Boards should consider planning services jointly. At present, artificial geographical barriers make this difficult to achieve.

- We welcome measures to further involve patients and public in service planning. We also support the role of professional bodies and patient groups such as Arthritis Care and National Osteoporosis Society who have a sophisticated understanding of the needs of those whom they represent. In this regard two current pieces of work being conducted by the Welsh Assembly and the Arthritis and Musculoskeletal Alliance (ARMA) may form a valuable template for service planning, namely the Welsh Assembly’s National Strategy for arthritis in Wales; and ARMA’s user-centred Standards of Care for people with musculoskeletal conditions project. We are concerned, however, as to how the dissolution of Local Health Councils fits with a desire for enhanced public consultation, as with their dissolution, a mechanism to influence the health agenda locally may be lost.

**Practical implications of implementing the Bill**

Our main concern regarding the implementation of the Bill is the continued distorting effect that the emphasis on current health priorities will continue to have on the Health Service in Scotland. 1 in 5 people in the UK live with arthritis, including both the young and the elderly. Musculoskeletal conditions are a major cause of physical disability in the community. Current demographic trends suggest that physical disability associated with osteoarthritis, and the need for joint replacement surgery, will increase by 66% by the year 2020. In spite of this, the absence of defined “priority status” for arthritis and other musculoskeletal conditions has led to a situation where it has become almost impossible to compete for new resource for rheumatology units, regardless of the strength of the evidence or the overall health benefit. We would therefore wish to see reassurance that the Bill’s provisions are applicable across the full range of health issues in Scotland and that where effective delivery of care is supported by the Bill, patients with arthritis and other musculoskeletal conditions do not “lose out” by being in “competition” for resource.

This response from the Scottish Society for Rheumatology relates to a specific area of Health provision. However, the area of musculoskeletal disease is of enormous importance within the overall framework of the NHS and we trust that these comments will receive due consideration.
SUBMISSION BY THE DISABILITY RIGHTS COMMISSION

Introduction

The Disability Rights Commission in Scotland welcomes the opportunity to comment on the general principles of the NHS Reform (Scotland) Bill. Access to appropriate health care, equipped to address the needs of all sections of Scottish society, is a matter of great concern to disabled people in Scotland and the DRC is anxious to ensure that that the Bill addresses these issues.

One in seven of Scotland's population is disabled – 830,000 people. These figures cover a wide range of impairments and corresponding health needs. Disability is not a homogenous issue, nor are the needs of disabled people uniform. It is important to stress that having a disability is not the same as suffering from ill health. Disabled people are not ill, but a disabled person may have particular health priorities or require services to be delivered in a particular way. The Disability Rights Commission works to a social model of disability, which focuses not on individual impairments but on the physical and attitudinal barriers to disabled people's full participation in society as equal citizens.

The DRC recognises that legislation has already been enacted by the Scottish Parliament to address particular aspects of the clinical needs of some disabled people in Scotland, such as the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003. The NHS Reform (Scotland) Bill is however an opportunity to look in a holistic manner at how the National Health Service moves from being an illness management bureaucracy to a national health provision and promotion service which understands and can respond to the needs of an increasingly diverse Scotland, and ensure equality of treatment for all disabled people.

The DRC has been engaged with the Scottish Executive and NHS Scotland in discussions about extending the existing Fair for All provisions for black and ethnic minority (BME) communities to the field of disability. This process was initiated by the health White Paper (Partnership for Care, February 2003) which stated:

'We believe there is also a need for a more coherent approach within NHSScotland to meeting the needs of disabled people. In the European Year of Disabled People we will extend the principles set out in Fair for All across the NHS to ensure that our health services recognise and respond sensitively to the individual needs, backgrounds and circumstances of people’s lives'. (p.20)

A joint DRC/Scottish Executive/NHS Quality Improvement Scotland conference, Improving Disabled People’s Access to Health Provision, was held in Stirling on 28 February 2003, with the Minister for Health and Community Care outlining the Scottish Executive’s vision for the future of the Health Service in Scotland:

‘Developing a patient focus in the delivery of health care involves a recognition of the diversity of patient needs and preferences. Clearly needs are likely to vary according to age, gender, disability, ethnicity, religion, culture and a wide range of other factors. A patient-focused health organisation will be aware of these and responsive to them.’

General Principles and Omissions

‘Why couldn’t they check that I was hearing them properly? Even if I didn’t have a hearing aid, it should have been in my medical notes that I’m hard of hearing, because I’ve been to the doctor and the hearing aid clinic not that long ago. Or does each clinic only bother with the bit of you that they deal with?’

Delegate at Improving Disabled People’s Access to Health Provision

The ongoing work on Fair for All underpins the DRC’s main concern with the Bill. We are puzzled as to why, with work of such importance being undertaken by the Scottish Executive Health Department and NHS Scotland, the Policy Memorandum accompanying the Bill should describe it as equality neutral (paragraph 41, p.8: ‘The Bill’s provisions are not discriminatory on the grounds of gender, race, disability, marital status, religion or sexual orientation’). Fair for All is underpinned
by a broad equality and diversity approach and this should be reflected both in the Bill and in its accompanying documents.

To ensure that the equality and diversity values of Fair for All, which are central to a modern, patient-centred NHS, are at the heart of the new legislation, the Bill should place a statutory duty to encourage and observe equal opportunities on all public authorities covered by its provisions. Schedule 5 of the Scotland Act 1998 confers important powers of encouragement and observance of equal opportunities to the devolved Scottish institutions; such a duty on the face of the bill, far from being a hindrance or additional burden, would serve as an enabling principle, a linkage in statute between the ideals of Fair for All and the aims of the NHS Reform Bill.

Equality requirements have already been written into a number of pieces of devolved legislation, for example the Housing (Scotland) Act 2001 and the Local Government in Scotland Act 2003. There is therefore a clear precedent for such provisions and a template for the NHS Reform Bill to follow. The committee will be aware that the existing Fair for All which addresses the needs of BME communities grew out of the public duty in the Race Relations (Amendment) Act 2000 (RRAA). The Fair for All disability equality scheme should have a similar statutory footing through the NHS Reform Bill.

The argument could be made that the ongoing Fair for All work aims to go significantly beyond such a statutory duty and that such a requirement would therefore add nothing to the Bill. This line of argument could be supported by the fact that the BME Fair for All seeks to go beyond the duties of the RRAA. However, it is important that the commendable work being carried out under Fair for All is underpinned by a statutory duty. The DRC recognises and welcomes the Scottish Executive’s commitment to disability equality and in particular to ensuring that disabled people are not faced with barriers to appropriate health care. This is not however the same as placing a duty in statute on the relevant public authorities. Such a duty helps root the principles behind Fair for All and foster a culture of equality.

The ways in which statute underpins culture and values raises areas such as community care where there is an overlap between health and local authority service provision through the Joint Futures initiative. How in practice would these services work when local government is working to equal opportunities principles enshrined in statute and health is not? A statutory duty would do much to ensure that an equality culture began to permeate all relevant sections of the public sector.

Practical Implications of Putting these Provisions in Place and Consideration of Alternative Approaches

In my area the Health Board helps to fund our group [a disability forum] but they never come and ask us for help. We know most of the places to go for advice; we can point people to specific resources’.

Delegate at Improving People’s Access to Health Provision

The Scottish Health Council (SHC) has the potential to be an important forum for ensuring that the health needs of disabled people are appropriately addressed. However, for the SHC to be effective in this regard disabled people must be properly represented and disability properly addressed. Tokenism must be avoided as well as the tendency to assume that any one disabled person speaks for all disabled people.

The SHC’s ability to act as a watchdog will be affected by how well it in turn is monitored and audited. The DRC would like further information on how this is to be done.

Similarly, the introduction of Community Health Partnerships (CHPs) offers opportunities to enter into greater and more meaningful dialogue with health service users than was previously the case, with the potential for better and more inclusive decisions being taken regarding the provision of frontline services. However, this will again be dependent on the quality and breadth of the consultation.
Conclusion

In summary, the DRC welcomes the general principles of the NHS Reform Bill, but believes that it must reflect the guiding principles of *Fair for All* as set out in the *Partnership for Care* White Paper. This entails a grounding of these principles in a statutory duty to encourage equal opportunities.

A statutory duty would also do much to ensure that the new structures and organisations proposed in the Bill carry with them the potential for more meaningful involvement of and engagement with disabled people in determining their own health and treatment needs.
The overall aim of this bill is to reform the present organisation of the National Health Service in Scotland to produce improved efficiency and patient care. This is a worthy objective which is supported strongly by the Royal College of Anaesthetists. The additional aim of devolving decision making and resources to frontline NHS staff is also a welcome development.

The natural degree of competition which was engendered by the concept of NHS Trusts led in some cases to less efficient use of resources. It is of particular importance to consider how best to use the scarce manpower resources available now that the European Working Time Directive is acknowledged to have a considerable effect on the number of doctor-hours available for patient care. Public involvement is essential to achieve agreement on the best way to use the resources available to the NHS.

An essential requirement of improved care in the NHS is a high level of staff morale. If staff are highly motivated then they will expend considerable efforts in maintaining and improving the system: if not, it becomes progressively more difficult to maintain a high quality of care and also to effect significant change. The pressure on all frontline staff working in the health service has increased over the past years leading to a reduction in motivation. There has been too little recognition of what they have achieved in the past and it is essential to provide innovative support to the frontline staff.

The important point to re-establish is the concept that the frontline NHS staff ‘own’ the system in conjunction with, and on behalf of, the public who are their patients. Then they will be encouraged to make every effort to change for the better. Where they perceive that faceless bureaucrats are the owners, there will be less motivation to make the necessary extra effort to implement change.

Work already undertaken by NHS Quality Improvement has demonstrated the enthusiasm and dedication of NHS staff in setting and achieving the best standards of care for their patients. The proposal to empower NHS QIS to monitor and review quality standards is of major importance.

Requiring a duty of co-operation across regional boundaries is a further useful way to increase the efficiency of patient care in Scotland and is to be welcomed. Many links have developed over past years as a function of geography and the available transport routes. These links should be exploited across regional boundaries for the benefit of the health care of their populations.
The Scottish Regional Council of the Royal College of Pathologists welcomes the opportunity to comment on the NHS Reform Scotland Bill as requested in the call for evidence dated 12th September 2003.

The Scottish Council notes that the bill proposes the following measures:

- Abolishing NHS Trusts and removing statutory powers relating to or referring to NHS Trusts – the aim is to put patients’ interests first.
- Imposing a duty for Public Involvement in the NHS, giving Health Boards the primary responsibility for patient consultation on planning and redesign of services. Establishing Scottish Health Council to monitor performance and effectiveness of Boards in relation to public involvement, assisted by local advisory councils.
- Health Improvement – placing a duty on Health Boards to participate in community planning process, making health improvement a priority. Creating Ministerial power to choose how to direct funds for health improvement, removing obligations to channel funds through Health Boards.
- Enhancing existing powers of intervention for Scottish Ministers, as last resort, to ensure consistent delivery of service across the NHS to agreed clinical standards.
- Creating new performance review body, NHS Quality Improvement Scotland, to monitor and review quality standards, and to investigate serious service failures – potentially invoking new powers of intervention.
- Replacing Local Health Care Co-operatives (LHCCs) with Community Health Partnerships (CHPs), and imposing duties on Health Boards to submit proposals for establishing CHPs to Scottish Ministers, requiring them to ‘devolve appropriate resources and responsibility for decision making to frontline staff…for the delivery of local healthcare services’ (SP Bill 4-PM p3)
- Creating statutory duty of co-operation on Health Board across regional boundaries – regionally and nationally where necessary – through series of managed clinical networks, to undertake regional planning to spend money and allocate resources throughout Scotland rather than individual Health Board Areas.

The Committee invites the views of organisations and individuals in written evidence on the following points—

Do you support the general principles of the Bill and the key provisions it sets out? Are there any omissions from the Bill that you would like to see added?

The Scottish Regional Council welcomes the key provisions in the Bill but is concerned that with the abolition of NHS Trusts there will be another major organisational upheaval in the NHS which will remove resources from the delivery of patient care rather than the stated goal of promoting high quality patient care.

The Scottish Regional Council notes the wish to promote greater public involvement in the running of the NHS and supports this proposal.

The promotion of Health Improvement programmes is to be welcomed. The proposal to create Ministerial powers to choose how to direct funds for health improvement should not normally override the due democratic processes of the Scottish Parliament.

Enhancing Ministerial powers in the area of ensuring consistency of healthcare delivery may be in the public interest as a last resort.

The creation of NHS QIS is welcomed.

The creation of proposal to create CHPs is noted. The resources required to set up these partnerships must not be drawn from existing areas of patient care.
A Scotland-wide perspective on the management of the Health Service through managed clinical networks has the potential to deliver improvements in the consistency and quality of healthcare in Scotland.

What are your views on the quality of consultation, and the implementation of key concerns?

The Scottish Regional Council of the College is concerned about the timescale allowed for consultation (1 month) particularly as the request for comments was not sent directly to the Regional Council but to College Headquarters in London with an inevitable, be it brief delay occasioned by that roundabout consultation route.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

The proposals need to be implemented with as little disruption to the service as possible and with a view to minimising bureaucracy and resource wastage.
Introduction

T&G Scotland welcomes the opportunity to submit comments to the Scottish Parliament’s Health Committee regarding the general principles of the National Health Service Reform (Scotland) Bill.

As a union that represents members in a wide range of NHS occupations, including hospital porters, ambulance personnel, catering and cleaning staff and administration staff, the T&G has a major interest in and commitment to the development and advancement of policy in the area of Health and Community Care in Scotland. We trust that the committee will take our views on the principles and provisions of the Bill into account.

Our union notes that the main purpose of the Bill is to reform the organisation and management of the NHS in Scotland through the dissolution of NHS trusts and the integration of acute and primary care services into NHS Boards and to devolve decision making and resources to frontline staff through the establishment of Community Health partnerships.

Our union has stated on previous occasions that we would welcome legislation with the aim of ensuring the NHS is able to deliver high quality services for the Scottish people, which would, in particular:

- Abolish the internal market in the health service
- Focus health policies on patients needs
- Invest in health services and support carers
- Cut NHS bureaucracy

And

- Bring greater accountability and transparency to decision making, giving a voice to staff, patients and the public.

The need to reduce bureaucracy within the NHS through a shift from appointed bodies such as the Health Boards and NHS Trusts arrangements has, in our view, been evident for many years. The T&G has argued for a number of years that a new system involving the election of a wide range of community and staff representatives to bodies with responsibility for taking strategic local health service decisions would be the best way forward.

In light of this position, our union generally welcomes the principles of the National Health Service Reform (Scotland) Bill and we particularly welcome provisions for the dissolving of NHS Trusts with the aim of putting the patients’ interests first.

We would, however, suggest that further discussion is needed in regard to how the new Boards will be constituted, and who serves on them, to ensure constructive trade union involvement, as the representatives of workers within the NHS.

As previously stated, our union represents members in a wide range of NHS occupations and support roles ranging from porters to ambulance personnel. Despite the fact that these employees perform roles that are crucial to the smooth operation of the NHS and the maintenance of high standards, many of them are at the lower end of the NHS pay scale and their contribution does not often receive the recognition it deserves.

Much is proposed within the Bill with regards to devolving appropriate resources and responsibility for decision making to frontline staff. We therefore feel it will be necessary, in conjunction with reforming the organisation and management of the NHS, to ensure that the Scottish Executive also
commits to the development of a highly skilled and motivated NHS workforce, capable of delivering the highest possible standards of patient care, and in particular that it:

- Supports the contribution made by all members of the health care team
- Ensures fair pay and the best possible terms and conditions for all staff whether contracted to or directly employed by the NHS

And

- Invests in training and education for NHS staff.

T&G Scotland is of the firm belief that valuing NHS staff and supporting the contribution made by all members of the healthcare team should be an integral part of reforming and managing the NHS and achieving a fairer and more equitable approach to the delivery of NHS care in Scotland.

Therefore, whilst our union is generally supportive of the overall principles of the National Health Service Reform (Scotland) Bill, we hope that discussions and consultation will continue between all stakeholders and that the issues we have highlighted will be taken into consideration.
ADSW very much welcome the reforms proposed by the Bill. Whilst the main purpose of the Bill is the integration of primary and acute health care, social work is the key partner in supporting people to live in their communities.

The Joint Futures agenda has meant that social work and health are now better integrated and can secure better outcomes for older people and their carers. Social work and health have pooled resources (budgets, staff, buildings and equipment) and delegated responsibility to meet this objective. Therefore, changes to the management and accountability of health services and any new duties placed upon them will have a direct bearing on social work departments and local authorities as a whole.

Any change must improve the experience of patients and the patient journey. It is at the interface between primary and secondary care that most organisational problems arise. The Association therefore believes that the integration of these two sectors will make a positive impact on those who use health services.

The principles of the Bill

ADSW are supportive of the general principles of the Bill but would like to make comment on the following issues.

*Replacing Local Health Care Co-operatives (LHCCs) with Community Health Partnerships (CHPs)*
ADSW welcome the proposals for CHPs and are positive about the role they can play in improving accountability in the health service. However, CHPs must build upon the Joint Futures agenda and work with us to ensure that duplication and overlap does not occur. We strongly argue that existing partnership agreements should be used to develop the new structures. Diverting money and time into creating new processes should be resisted.

Because CHPs are seen as the successors to LHCCs, it may be worth examining how LHCCs have got on since they were introduced in 1997. It is our experience that their development across Scotland has been patchy. There are huge differences in the ways in which they operate currently and the level of involvement they have in managing services. ADSW appreciates the local flexibility of the model proposed but we must recognise that not everyone will start from the same place and would hope that the Bill can be shaped in such a way as to secure status and more uniformity to CHPs. We are also keen to see CHPs have equivalent standing to other parts of the NHS, such as the proposed operating divisions. Moreover, there must to be a single point of contact for decision-making.

A major stumbling block, as experienced in a number of areas, is the issue of boundaries. Where a population is not aligned there can be significant problems in trying to uniformly implement initiatives. We fully support the Executive’s clearly stated preference for co-terminosity with council boundaries and believe this should be rigorously pursued.

*Creating a statutory duty of co-operation on Health Boards across regional boundaries.*
We would like further clarification on these proposals and examination of what services this statutory duty would extend to.

Again, the issue of boundaries must be considered if we are serious about integration of services.
The Financial Memorandum

With regards to the Financial Memorandum that accompanies the Bill, we do not agree that the proposals are cost neutral. The costs of implementing the Joint Futures agenda – those of staff training, joint working groups, secondments, etc - were absorbed by social work and health. The changes that the Bill seeks to secure will not be effective without investment in front line staff – and this comes at a cost.

Likewise, the Bill’s commitment to public participation can only be achieved by resourcing groups and communities to do this.

The Association strongly supports the changes that the Bill will bring about but would urge that the costs be fully examined and properly funded.
General comments

RCSLT members welcome the opportunity to comment on the NHS Reform (Scotland) Bill. Consultation around the bill has been helped by direct mailing of the Health Committee letter to RCSLT although this was initially to the London HQ. This prompted a response where as the press release did not. Smaller organisations lack the resources to continually monitor the Scottish Parliament website and so particularly welcome appropriately targeted mailings on issues of interest.

RCSLT are not clear about the accessibility of consultation to people with communication disability in Scotland but would wish to see this maximised. RCSLT members would welcome the opportunity to assist the committee with this goal. RCSLT support the general principles underlying the Bill. RCSLT have several comments regarding the provisions it sets out detailed below.

Part 1

Organisation and Operation of the National Health Service.

2 Community Health Partnerships
(5) (b) etc. and 6 (e)

RCSLT welcome the power of Ministers to regulate on matters such as membership of Community Health Partnerships and who they must consult. A key issue for SLTs throughout the health service is effective representation on service planning, implementation and monitoring bodies – such as LHCC bodies to date. SLTs (and other Allied Health Professions) are too often represented by colleagues from other disciplines who have restricted insight in to the potential contribution SLTs do and / or could make to health. This leads to under utilisation of SLT skills, knowledge and experience in the delivery of health service priorities.

RCSLT believe that such regulation could introduce consistent and equitable integration of all members of the “health family” in to decision making across Scotland.

(6) (a)

SLT services are normally managed on a city or Board area wide basis. Although recognising the benefit of regulations around devolution of decision making from Board to CHP level RCSLT would anticipate problems in regulations which devolve management of services (such as SLT) down to CHP level. Fragmentation of services would inevitably affect service quality.

It is unclear if the Minister would be required to consult on regulations with stakeholders.

Co-operation
3.
RCSLT welcome this provision.

Powers of Intervention
4.
RCSLT welcome this provision but in reference to 4. (5) (a) ask how this relates to the Health Professions Council – the regulatory body for SLTs and others.

Public Involvement
5.
RCSLT strongly welcomes the statutory duty to consult with service users.

It would be helpful if the Bill was explicit regarding equitable consultation with the diverse range of service users.
SLTs are particularly interested in the effective inclusion of people with communication disability (e.g. difficulties reading, writing, communicating verbally etc. such as people who have had strokes, people with a learning disability). These service users, by virtue of their communication difficulties, are commonly excluded from consultations. They are also over represented in “hard to reach” communities and frequently suffer poor health as a direct result of their communication difficulties, e.g. mental illness.

**Part 2**

**Promotion of Health Improvement**

7 (1)

*Duty of Scottish Ministers to promote health improvement*

RCSLT welcome the explicit duty of Ministers to promote health improvement. It is assumed that “Ministers” refers to all Scottish Executive Ministers without exclusion.

7 (2)

*Duty of health boards to promote health improvement*

RCSLT also welcome this duty.
Voluntary Health Scotland - Background

Voluntary Health Scotland (VHS) is the national network of voluntary health organisations in Scotland, the first and only of its kind in the UK. VHS was launched in 2000, in response to the expressed needs of voluntary sector agencies for a strategic vision for the sector, the strengthening of voluntary-statutory sector partnerships and support for the voluntary health sector to make these things happen.

The 320 VHS members account for some 32% of the estimated voluntary health sector. Both national organisations, large and small, and locally based groups, some very broad in their scope, are represented in the VHS membership.

Over 1,000 agencies and groups in Scotland are active in working for health improvement, raising awareness of chronic and often neglected conditions, providing specialist advice and information, supporting carers and contributing to policy development. The sector:

- Employs up to 14,000 workers
- Supports 72,000 volunteers
- Has an annual turnover of £200m

The voluntary health sector works to improve health in Scotland by:

- Putting the voice of patients and local people at the centre and involving them in service development
- Promoting health and combating disadvantage
- Working across agency, sectoral and geographical boundaries
- Reaching marginalized groups
- Providing care at local primary and community level in partnership with statutory services
- Contributing to the development of health policy

These ways of addressing Scotland’s health needs place the voluntary health sector in a key position to work in partnership with NHS Boards and local authorities in Scotland.

VHS participated in the Review of Management and Decision-making in the NHS, contributing extensively to the discussions around the proposed changes to NHS Scotland in the context of the deliberations of Sub-Groups C & F. We have also prepared a paper describing the potential role of the voluntary and community sector in the development of CHPs¹ and have submitted a response to the recent consultation on the Guidance on the proposed Community Health Partnerships.

Evidence

Does VHS support the general principles of the NHS Reform (Scotland) Bill and its key provisions? Does VHS discern any omissions?

Voluntary Health Scotland strongly supports the general principles underpinning the Bill. We welcome these in that they accord closely with the vision of health and health care developed as long ago as 1978 in the WHO Declaration of Alma Ata and incorporated into the practice of the voluntary health sector. Central to voluntary health sector belief and way of working are:

- Outcomes from service interventions must directly benefit patients and carers
- Full participation by patients, local people and communities must take place in the development of solutions to meet health needs

¹ Weir B, for VHS - What does a Community Health Partnership mean for the voluntary sector?
Co-operation, integration and partnership between people, services and sectors is necessary for the pursuit of health
Care should be delivered as close to home as possible

In relation to the policy objectives and key provisions of the Bill:

Part 1, Section 1 – Dissolution of NHS Trusts

VHS supports the provisions to abolish NHS Trusts, in that this will remove any remaining elements of competition in health service delivery, replacing it with the collaboration and co-operation that will improve health outcomes for individuals and communities.

Section 2 – Community Health Partnerships

VHS supports the view that Community Health Partnerships (CHPs) offer the best opportunities for the collaboration and local co-ordination of services necessary for the improvement of health outcomes. We affirmed this in our response to the Draft Guidance on CHPs.

We believe that it is important that the voluntary sector is not only a key partner, but an equal partner in planning, developing and delivering joint approaches to local health and social care services. We believe that this can only be achieved where the CHP has a co-ordinating role, supported by statute.

In relation to the new Section 4A, Subsection 5 (b, c, d) therefore, we shall seek an explicit guarantee of voluntary sector membership of CHPs and of a voluntary sector role in the delivery of the designated CHP functions.

In relation to Subsection 6 (e), which refers to regulations made under Subsection 5(d), and in relation to the development of CHP functions, we shall seek robust consultation mechanisms for dialogue between CHPs and their NHS Boards to include patients, local members of the public and voluntary sector service providers.

Section 3 – Health Boards: duty of co-operation

VHS supports the SEHD’s policy objective of regional planning of services to meet the specialist needs of patients whilst maintaining quality of service. We also support the development of Managed Clinical Networks (MCNs). The NHS acknowledged the vital role of specialist voluntary sector agencies in MCNs at the launch conference in November 2002. Specialist voluntary organisations are already spearheading new MCNs for MS and Epilepsy, and we remind the Committee that most of the specialist voluntary health organisations have both a national and a regional presence.

In relation to the new Section 121 Subsections1 and 2(b), VHS will seek explicit inclusion of the voluntary sector under the Duty of Co-operation, and of the sector’s role as specialist service providers under the widened powers of NHS Boards to take any steps necessary to benefit specific health need throughout Scotland.

Section 4 – Powers of intervention in case of service failure

VHS supports the policy objective expressed in Section 4. Too often, constituent members – patients, carers, volunteers and staff – of specialist voluntary organisations report serious system failure at local level – complete lack of, or poor quality specialist service. Competing priorities and lack of resources are usually the only reason given by NHS Boards for such failures.

We believe that stronger ministerial powers are required to ensure a consistent quality of services across Scotland and that the presence of NHS Quality Improvement Scotland (NHSQIS) and the accountability mechanism embodied in the Performance assessment Framework (PAF) will support this.
VHS will continue to advocate for the voice of patients, carers and specialist voluntary organisations in the setting and monitoring of standards.

**Section 5 – Public Involvement**

VHS applauds the efforts made so far by the SEHD and by NHS Boards and Trusts and LHCCs to involve patients, carers and the public meaningfully in the modernised NHS. We note in particular the achievements of the patient Focus Public involvement (PFPI) Initiative.

VHS responded to the consultation on the proposed Scottish Health Council structure. In it, we expressed concern that under the proposed arrangements NHS Boards will now be in the position of both providing the service and acting as the voice of patients. In addition, siting the new Scottish Health Council within NHSQIS compromises its ability to maintain an objective public voice.

We are interested in the proposal for the development of local Public Partnership Fora as a mechanism for engaging with local communities. However, we are unsure as yet how these will evolve, how they will ensure fair representation and how they will link with other local structures for public involvement. The role of the voluntary sector in shaping and influencing the role of PPFs is vital.

Under new Section 2B the primary responsibility for public involvement must reside with NHS Boards, with the new Scottish Health Council (SHC) and Local Advisory Councils (LACs) providing the assessment, development and feedback functions.

Nowhere has it been made clear what the relationship between the PAF 5 (PFPI) Framework and the Scottish Health Council and local offices will be. In addition, we are unsatisfied with the PAF requirement only to monitor input from patients, the public and the voluntary sector at local level – we wish to see evidence of the outcomes of this involvement.

VHS believes that the voluntary sector is essential to public involvement in the NHS and will therefore seek explicit inclusion of the sector in the provisions laid out under new Section 2B (1) (a & b).

**Section 6 – Dissolution of Local Health Councils**

VHS recognises that this provision is required by the revised public involvement measures, but takes the view the new SHC and proposed LACs will only be able to offer more effective public involvement with the support of the voluntary sector.

**Part 2, Section 7 – Duty to promote health improvement**

Voluntary Health Scotland applauds the ongoing commitment of the Scottish Executive to promote health improvement and tackle health inequalities through the first and into the second term of the Scottish Parliament.

Many hundreds of voluntary organisations and community-based groups in Scotland work to a developmental agenda for improvement in health and reduction in health inequalities in local areas. In addition, voluntary and community groups are a significant force in three of the National Demonstration Projects and in Healthy Living Centre initiatives across Scotland. Increasingly, the sector is taking part in joint health improvement and community planning processes.

VHS therefore supports the policy objectives contained in new Sections 1A and 2A under Section 7 (1), giving Ministers and NHS Boards themselves both a duty and broader powers to improve health and to link with the community planning agenda. Ministerial powers to fund directly action to support health improvement would enable the voluntary sector to add even greater value to the agenda.

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2 Scottish Executive Health Department, Proposals for a New Public Involvement Structure for NHSScotland (2003)
Sections 1A (2) (a, b and c) and 2A (2) (a, b and c) include the giving of financial assistance to or entering into agreement with or facilitating the activities of others in the interests of furthering health improvement. In this context, VHS intends to press for greater direct investment in the voluntary health sector’s health improvement activities and fairer access to service delivery options, with costs and benefits assessed on an equitable basis. VHS will seek explicit reference to the sector’s role in community planning for health improvement.

What are the views of VHS on the quality of consultation and the implementation of key concerns?

VHS is satisfied with the quality of consultation on key areas thus far. We await results from the recent consultations on the New Public Involvement Structure for NHS Scotland and on the Guidance to Community Health Partnerships.

Voluntary Health Scotland is keen to take up the opportunity to provide oral evidence on the Bill in due course, making more detailed submission on amendments from the unique voluntary health sector position.

Does VHS have any comments on the practical implications of putting these provisions in place and the consideration of alternative approaches?

In our view, the main implementation issue arising from the Bill at this stage appears to be the hidden costs of implementation. We do not think that the process can be largely cost-neutral. The voluntary sector has most experience in the area of public involvement. The costs of effective consultation and engagement are high, in both time and human resource terms. We shall be urging the Executive to allocate sufficient resources for this.
Thank you for the opportunity to comment on this draft Bill, and for agreeing to this late submission.

As you may be aware, Optometry Scotland (OS) was established earlier this year as the single, unified representative body for the optometric profession in Scotland. OS member organisations are the Association of Optometrists (AOP), the College of Optometrists, the Federation of Ophthalmic and Dispensing Opticians (FODO), the Scottish Committee of Optometrists (SCO), and the Area Optical Committees (AOC) throughout Scotland.

In general, we are pleased to say that we are content with the thrust of the Bill as presently drafted. Our specific comments are:

- **Dissolution of NHS Service Dissolution of Trusts** - We welcome the dissolution of NHS Trusts and the establishment of the NHS Boards as we believe that a seamless, integrated care network is the most appropriate way of delivering a high quality service. Amongst other things, this should allow for better utilisation of the optometric resource in the managed care of people with eye problems.

- **Community Health Partnerships** – We consider the development of Community Health Partnerships to be a progressive step forward for patient care as it clearly allows for the development of integrated care pathways and clinical networks to facilitate the delivery of services in a new and innovative manner. Similarly the introduction of Local Care Partnerships (with local authorities) will provide improved holistic care for the public.

- **Public Involvement** – We are particularly pleased to see the emphasis given to encouraging public involvement in the delivery of health care in Scotland. We would commend you the Glasgow Integrated Eyecare Service, one important aspect of which has been the involvement of patient groups in service design and delivery.

- **Health Improvement** - OS welcomes the opportunity to participate in the planning process within CHPs. We believe that the development of this new culture where all carers work in a collaborative and cohesive manner will help fashion a framework for better integration within the NHS and amongst partner agencies and organisations.

- **NHS Quality Improvement Scotland** - OS welcomes the formation of a single quality body for health in Scotland. Optometrists have worked within some of the founding organisations such as SIGN, the HTBS and CSBS when considering the development of screening services for diabetic eye disease.

We hope these comments will prove helpful. OS would welcome the opportunity for further discussion on these and other associated topics and would be delighted to provide oral evidence to the Committee on any aspect of the profession and the delivery of eye care in Scotland should the opportunity arise.
Introduction

Sense Scotland offers a range of services for children, young people and adults who are deaf blind or who have multi-sensory impairment with additional physical, learning or communication difficulties. Our services are designed to provide continuity across age groups. We have particular experience in working with people who have additional complex health needs and work closely with families and colleagues from health, education and social work. This breadth and depth of approach to service delivery helps us take a wider perspective on the direction and implementation of new policies.

Comments

We support the main aim of the Bill, namely to abolish NHS Trusts and thereby to cut bureaucracy and improve efficiency. We have three main concerns with the proposal to establish single local health systems. These relate to the introduction of Community Health Partnerships and:

- structural change
- public participation
- CHPs and coordination.

CHPs and structural change

Section 2 notes that CHPs will replace local health care cooperatives (LHCCs), devolving management responsibility to frontline staff. We agree that local health services should meet the needs of individuals and communities and that CHPs should be designed so that they improve public involvement and local accountability.

Currently, LHCCs cover ‘natural communities’, with their size varying according to geography and population, in the range 20,000 to 150,000 people per LHCC. For example, GGHB has sixteen LHCCs, managing and delivering integrated services across defined areas. Each LHCC has, since being introduced in 1999, built up structures, staffing, relationships and working practices.

Paragraph 33 in the Financial Memorandum on CHPs notes that no additional expenditure will be incurred because there will be fewer CHPs than LHCCs. Fewer CHPs means that existing staffing structures, built up over the last four years since LHCCs were first introduced, will have to be replaced by new ones. That process will take time and introduce a period of uncertainty.

CHPs and public participation

We are not clear how the proposals will achieve improvements on participation. Fewer CHPs than LHCCs will result in less public participation and involvement, rather than bringing about any increase. The Bill does not give appropriate attention to how public participation will be improved. Section 5 of the Explanatory Notes provides a short statement on public involvement. We would have preferred to see public participation and involvement included within the section covering proposals for CHPs. As it is, neither the Bill nor the accompanying explanatory notes provides any clear understanding of what public participation will actually mean.

CHPs and co-ordination

We wish to make two points on the improvements in coordination that are expected as a result of introducing CHPs. The first is a general point, where we have concerns about what appears to be a fragmentation of initiatives on coordination. The second is a more specific point, relating to the Financial Memorandum in respect of costs on local authorities.

Sense Scotland has, over the past six years, responded to many central and local government initiatives in which proposals for improved coordination have played a major part, for example,
Additional Support for Learning (Scotland) Bill; For Scotland’s Children; The Same as you?; Review of Speech and Language Therapy etc. report.

These and other consultations are giving rise to initiatives such as Joint Futures, Joint Management, Joint Resourcing, Single Shared Assessment, Coordinated Support Plans and so on. We believe that coordination is vital but we are concerned that not enough consideration is being given to the effect of the combination of these initiatives on frontline staff. Fragmentation is being caused by different lead agencies making proposals, on how coordination will be managed and achieved, without considering the overall effect of multiple requests for coordination.

Our more specific point relates to the Financial Memorandum covering ‘costs on local authorities and other bodies, individuals and businesses’. Paragraph 41 states:

_The Executive is of the view that there will be no impact on other aspects of public expenditure, including local authorities, or on the costs of the voluntary or private sectors or individuals, as a result of the provisions in the Bill._

In parallel with the NHS Reform Bill, the Additional Support for Learning (Scotland) Bill is, at the time of writing, about to begin its Parliamentary progress. A major strand of that Bill is that it will introduce Coordinated Support Plans (CSPs). CSPs will have an impact on services such as speech and language therapy, physiotherapy, occupational therapy, GP practices and others. Improved coordination between agencies is a priority but we are concerned that it will not happen if it is to be seen as a ‘nil cost’

The aforementioned Review of Speech and Language Therapy etc. report has confirmed that there are shortages of NHS therapists working with children and unacceptable waiting times for some children. While the funding of NHS therapists may lie out with the NHS Reform Bill proposals, the management structures within which any new staff will work will be within the remit of CHPs.

Taken together, we believe that it is optimistic to believe that there will be no additional costs on local authorities, or local authorities on CHP structures, under the proposed legislation.
Introduction

GMB Scotland welcomes the opportunity to submit comments following the call for written evidence from the Scottish Parliament’s Health Committee regarding the National Health Service Reform (Scotland) Bill.

GMB Scotland represents a broad spectrum of staff employed within the NHS and is committed to major developments and advancements in Health and Community Care Policy which are to the benefit of both Staff and members of the public.

National Health Service Reform (Scotland) Bill.

Dissolution of NHS Trusts

GMB Scotland welcomes any reform which ensures reorganisation of Trusts and changes to the management of the NHS i.e. the main focus of the Bill which ensures the following:

- The abolition of NHS Trusts
- Integration of both Acute & Primary Care Services under the auspices of NHS Boards.
- The devolution of decision making to frontline staff as a result of the establishment of Community Health Partnerships

Community Health Partnerships

GMB Scotland is supportive of legislation which encourages

- Localised service planning and delivery of care involving patients and healthcare staff
- Partnership working with Local Authorities which ensures a seamless package of care for the patient
- The delivery of a health improvement agenda which is focused on local need rather than national priorities.

Regional Planning of Health Services

GMB Scotland is encouraged by the need for co-operation between Health Boards to ensure healthcare based on patient need is delivered as effectively and efficiently as possible. This should, in theory, create an integrated NHS System across Scotland. To that end GMB Scotland would campaign for associated employer status applicable to all NHS Staff and would pursue the aim of all staff working in the NHS to become NHS Employees i.e. any remaining staff working for Private Contractors be returned to the NHS and GP Practice staff become direct employees of the newly constituted Health Boards. Associated employer status for NHS Staff would be advantageous for workforce planning and the recruitment & retention of staff within the NHS.

Public Involvement

GMB Scotland supports the need for greater public involvement to ensure quality services and the drive continuous improvement of health care provision. The emphasis however should be no greater than Trade Union/Professional Organisations involvement at Health Board Level. Both groups have an integral part to play in the development and improvement of services at local level. We believe that the Scottish Executive is committed to strong partnership working at National Level and would wish to see this transmitted to local situations.
Conclusion

The Scottish Executive is to be congratulated on its forward thinking in the modernisation of the NHS in Scotland and GMB Scotland welcome the proposals contained within the National Health Service Reform (Scotland) Bill. GMB Scotland would like to reinforce the following points

- The integration of Acute & Primary Care NHS Trusts alongside the abolition of Trust Status creating NHS Boards and Community Health Partnerships is to be welcomed. GMB Scotland would like some reassurances on the constitution of said NHS Boards and CHPs which will include frontline staff in the decision making process.
- The need for the efficient delivery of effective healthcare at local level supported by meaningful investment based on local priorities.
- That Scotland has a “National” Health Service which has improved recruitment and retention of staff thus making headway towards an exemplar employer both in the remuneration and welfare of all Staff.
- The reduction in NHS bureaucracy resulting in reduction of wasted resources should be redirected back into Training and Development of current NHS Staff and thus investing in the NHS’s greatest asset which has been sadly lacking in recent years.

GMB Scotland is hopeful that these comments can be used in a constructive manner and would welcome any further involvement in the consultation process of the National Health Service Reform (Scotland) Bill.
Comments from NHS Borders Experience in moving to Single System Working

NHS Borders hereby submits evidence to the Scottish Parliament’s Health Committee, in particular on the proposal to dissolve NHS Trusts, thereby integrating the management of acute and primary care services into NHS Boards. The evidence is based on NHS Borders experience of moving to single system working.

In early 2002, the Board was given the opportunity to design future arrangements tailored to local circumstances which fitted with the policy direction set out in the Scottish Health Plan, *Our National Health, a plan for action, a plan for change.*

A key objective of the changes was to improve the coordination of care within the NHS and between the NHS, social care and other partners. A major aspect of achieving this was to remove the artificial organisational barriers which existed with two local NHS Trusts and a Health Board. The move to a single organisation opened up more opportunities to capitalise on the co-terminosity between NHS Borders, Scottish Borders council, Scottish Enterprise Borders and other agencies, especially in the joint action required to improve health and tackle health inequalities.

In addition to the structural change, great emphasis is placed on changing behaviours and relationships within the NHS and with partner organisations and this was evidenced in the consultation process. Successful implementation of an integrated health system depends, critically upon the development of new sets of behaviours, relationships and processes. Behaviours are aligned to the competencies required to deliver a more responsive and integrated service.

The Board managed the transition from the three separate NHS organisations to a single entity within the space of 15 months. Simultaneously NHS Borders remained focussed on the key deliverables for NHS Scotland.

The following are the immediate benefits of the move to a single organisation:

- Integrated planning and delivery of clinical care;
- Improved relationships across the system, with speedier decision making
- More focus for joint action between NHS and other partner organisations
- Management cost savings which have been reinvested in patient care

The involvement of the local authority in the integration project was crucial in ensuring a link with the Joint Future agenda and the wider concerted action to improve health and tackle inequalities in health.

The establishment of a single NHS organisation allowed the creation of a single set of management services supporting a single Board. Significant management cost savings were achieved and these were fully incorporated into the Board’s Local Health Plan
SUBMISSION BY THE CHARTERED SOCIETY OF PHYSIOTHERAPY SCOTLAND

The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body representing physiotherapists, physiotherapy students and assistants. More than 98% of all physiotherapists in Scotland are members of CSP Scotland and physiotherapy is the fourth largest health care profession in the UK, and the largest of the allied health professions.

Physiotherapy involves the skilled use of physical interventions to promote, maintain and restore physical, psychological and social well being. Using problem solving and clinical reasoning, physiotherapists work to restore functional movement or reduce impairment utilising movement, exercise and the application of electro-physical modalities.

CSP Scotland has around 4,000 members in Scotland. Approximately sixty percent of chartered physiotherapists work in the NHS. The remainder are in education (including students), independent practice, the voluntary sector and other employers, such as sports clubs or large businesses. Three Scottish universities offer degrees in physiotherapy, and are among the most over-subscribed university courses in the country. Approximately 150 newly qualified physiotherapists graduate in Scotland each year.

Introduction

CSP Scotland has welcomed the broad direction of health policy outlined in the White paper Partnership for Care. The white paper proposed the removal of bureaucracy, the strengthening of local provision and the emphasis on collaboration, multidisciplinary team working and innovation and modernisation. All these proposals have been broadly welcomed by CSP Scotland, and note the degree of political consensus that has characterised Partnership for Care in Scotland. CSP Scotland continues to promote a genuinely national public health service which is both patient centred and values its staff.

The following submission will make broad comment on the proposed reforms, and then make more specific comment on the reform of community care structures and the establishment of Community Care Partnerships to replace Local Health Care Co-operatives in primary care.

Comment on Legislative Commitments

Abolishing NHS Trusts and removing statutory powers relating to or referring to NHS Trusts – the aim is to put patients’ interests first.

CSP Scotland has supported this measure. The dissolution of NHS Trusts removes the internal market structure that many health bodies, including CSP, has criticised. Ultimately it is the ‘competitive culture’ that deserves to be replaced by collaboration and choice. The abolition of NHS Trusts should also simplify services.

Imposing a duty for Public Involvement in the NHS, giving Health Boards the primary responsibility for patient consultation on planning and redesign of services.

CSP Scotland has welcomed measures to improve patient involvement, and supports the Scottish Executive aim to ensure that decisions take account of public views, and that public participation in decision making about health provision is facilitated. The duty should ensure that public involvement becomes part of the culture as well as of the new structures of NHS Scotland. There is evidence to suggest that public involvement can help drive improvements in services, and public involvement may be essential for initiatives such as health promotion, where information must target the general public and be relevant to them.

Health Improvement – placing a duty on Health Boards to participate in community planning process, making health improvement a priority.

All physiotherapy has a health promotion component and chartered physiotherapists have an important role to play in improving public health and meeting national or local targets such as for
stroke, coronary heart disease and mental health. CSP Scotland strongly supports the duty placed on Health Boards to participate fully in health promotion, and believes that effective collaboration with local authorities, professional bodies and patient groups will also be necessary to improve Scotland’s health.

Creating Ministerial power to choose how to direct funds for health improvement, removing obligations to channel funds through Health Boards.

CSP Scotland is not opposed to this measure, and can see a number of advantages for service provision, provided that service fragmentation does not result.

Enhancing existing powers of intervention for Scottish Ministers, as last resort, to ensure consistent delivery of service across the NHS to agreed clinical standards.

CSP Scotland does not oppose this measure, although this power may not be necessary in view of the evidence and the existing powers of Ministers.

Creating statutory duty of co-operation on Health Board across regional boundaries – regionally and nationally where necessary

CSP Scotland supports the encouragement of co-operation between Health Boards and would go further in pointing to the benefits of collaboration and joint provision in areas where patients may seek services from the Health Board area adjacent to the area in which they live. Co-operation between Health Boards can also encourage further the culture of partnership working, and ensure that the design and delivery of services is seamless across health board areas as well as within them.

Replacing Local Health Care Co-operatives (LHCCs) with Community Health Partnerships (CHPs), and imposing duties on Health Boards to submit proposals for establishing CHPs to Scottish Ministers, requiring them to ‘devolve appropriate resources and responsibility for decision making to frontline staff…for the delivery of local healthcare services.

A significant proportion of physiotherapists work in local communities in a primary care setting and Chartered Physiotherapists are developing innovative services in primary care across Scotland. CSP Scotland members are committed to developing modern patient centred services that are flexible enough to respond to the diverse needs of different patient groups. CSP Scotland therefore has an essential interest in the future development of Community Care Partnerships (CHPs) and the following submission focuses on those aspects of the proposed legislation and guidance relevant to the practice and promotion of physiotherapy services.

NHS Reform and Community Health Partnerships

The following response has been drawn together from consultation with CSP members in Scotland surrounding the Scottish Executive consultation on Community Health Partnerships and the NHS Scotland Reform (Scotland) Bill.

Physiotherapy in the Community – Background

In order to continue to improve and expand services, CHPs must provide a clear role for physiotherapists and other allied health professions, in which their skills, expertise and contribution is recognised. The inclusion of physiotherapists in the decision making process will be vital to the success of CHPs and CSP Scotland recommends that any guidance specifically recognises the various roles played by all those in Community Care.

The role of physiotherapy is often overlooked in consultations or discussions relating to community care, but it plays a crucial role in health promotion, rehabilitation and enabling patients to maintain independence. Physiotherapy is a genuinely cradle-to-grave form of healthcare, ranging from neonatal treatments and paediatric to care of the elderly. Increasing numbers of physiotherapists are working in the community, cutting across traditional health and social care boundaries, as part of multidisciplinary teams that embrace other health professionals, social workers and others.
Community physiotherapists work with patients in their own homes, in their workplaces and in local health centres, sports centres and other community facilities. Physiotherapists have a unique range of skills and knowledge that enables them to respond to problems associated with injury, disability and illness, allowing patients to return to work or independent living, reducing the number of hospital admissions, and relieving pressure on other services.

Community physiotherapists undertake a wide range of generic and specialist treatments, and the following exemplify this work:

- **Cardiac rehabilitation**: Scotland has the second highest mortality rate from coronary heart disease (CHD) in Western Europe. Physiotherapists are key to prevention of CHD through cardiac rehabilitation programmes. This relatively inexpensive form of care has been proven to reduce mortality by at least 25%.

- **Strokes**: people in Scotland are 25% more likely to die from stroke than those in England and Wales. It is the third commonest cause of death. More than 20 research programmes have shown that integrated care involving physiotherapists and other healthcare professionals saves lives and prevents long term disability.

- **Care of older people**: falls are a major risk factor for older people, with hip fractures a common result. Half of those who sustain hip fractures are never able to walk again independently, and a quarter die within 18 months. Physiotherapy is a key tool in preventing the occurrence and recurrence of falls.

- **Musculo-skeletal care**: back pain and other musculo-skeletal conditions are responsible for the majority of working days lost every year through work-related illness. Back pain costs the NHS millions of pounds every year, and lost working days cost industry even more. Evidence shows that immediate access to physiotherapy reduces the costs of both, and speeds return to work.

- **Mental health**: physiotherapists use a number of therapies, such as massage, reflexology and acupuncture, to help people suffering from mental health problems, drug and alcohol dependencies and work-related stress.

- **Combating social exclusion**: physiotherapists work with a range of groups in society who can find it difficult to access health care through traditional means, and whose social exclusion increases their risk of ill-health. Physiotherapists have a vital role in health promotion, which also greatly benefits socially excluded groups.

All the above services must be taken account of during the strategic planning and delivery of health services in the community. If CHPs are to take on a greater strategic role, then the involvement of physiotherapists, along side other health professionals will be vital. CSP Scotland would therefore recommend that the Scottish Executive devotes resources to facilitating the full involvement of health professionals, and that this must be at the planning stage of partnership community objectives.

**The Need for Continuity**

The creation of management systems through CHP development must not lead to a break up of current systems, and must compliment or reinforce effective management.

The strategic role for CHPs must also compliment the responsibilities of Health Boards, which may also increase with the changes to Primary Medical Services. CSP Scotland has also warned against service fragmentation if health professionals were to be employed by GP practices. There can be significant problems that result from health professionals having to work in isolation, as this can substantially reduce opportunities for training and for continuing professional development.

There are also issues relating to a lack of clinical supervision and the absence of peer support where physiotherapists work in isolation. CSP Scotland seeks to encourage and promote professional collaboration and the promotion of best practice, among chartered physiotherapists as
professionals, and in the delivery of physiotherapy services. This is best achieved where health boards continue to have a co-ordinating role as the employer and the body that retains the obligations and duties. CSPs must be in a position to enhance that role and reflect the local service needs, while ensuring a comprehensive strategy remains in place for the health board region.

**Participation in Primary Care Structures**

Physiotherapists are currently key members of Local Health Care Co-operative (LHCC) teams, and can be expected to be working in CHPs, alongside medical and nursing staff, other allied health professionals, and social care services. LHCCs have become increasingly important in the delivery of primary and community care and the extension of their role, and the strengthened role for planning and delivery of services is a logical progression.

However, in many parts of Scotland, physiotherapists have found themselves excluded from the management boards of LHCCs, which are dominated by medical and nursing personnel. LHCC management boards are making vital decisions about delivery of local health services, which affect the working lives of frontline staff, but physiotherapists and other allied health professionals report often struggling to make their voices heard in the decision-making process. It is not only the development of multi-professional services but development in line with the white paper that must be considered in this context.

It should be noted that it is not only multi-professional services that must be developed, but the development of services to patients, that must be the ultimate goal. Services to patients are improved by the inclusive nature of the planning process. Greater awareness of new initiatives can be promoted, and examples include:

- Direct access to physiotherapy without the need for GP or hospital referral, reducing GP waiting times.
- Qualified physiotherapists administering steroid injections, reducing Orthopod waiting times.

Resources can be directed more efficiently and new initiatives and good practice can be spread more effectively where the decision making process involves all those that can contribute.

The whole primary and community care team must play a part in decision-making if genuinely integrated services are to be achieved, therefore it is vital that places are made for physiotherapists and other allied health professionals on all CHPs across Scotland. The development of multi-professional teams makes this progress essential. As a result, CSP Scotland proposes that all CHP Boards have a place reserved for allied health professionals.

**The Role of CHPs**

It will be vital the CHPs have a role in various developments of the evolution of health services. One are is Managed Clinical Networks (MCNs), where CHPs must have a role to play in facilitation and promoting the work of networks. It must be clear where MCNs sit in the new structures and how each will interact.

CSP Scotland welcomes the view that there will be continue to be flexibility in the shape and nature of health structures at a local level to reflect local need and the CHPs will not be developed on a ‘one size fits all approach’. Nevertheless, such flexibility must exist within clear guidance to protect minimum standards and promote good practice.

**Service Standards**

It will be important that equitable service standards are developed and maintained across health board areas. There remains a need to have a baseline for all services and outcomes, and to establish equity of service provision that can reflect and respond to differing local needs. Currently community health planning is variable across health boards and health board areas, and attention must be given to urban / rural distinctions and population pockets with specific needs.
CSP Scotland also welcome that CHPs will be accountable to Health Boards, but note that the distinction between strategic and operational functions may not be helpful in practice.

There appears to be insufficient attention in the proposals to integrated care. Service integration should not be an afterthought or an oversight, and CSP Scotland believes this feature of service design requires a much greater emphasis in the Scottish Executive proposals.

Remaining Areas

CSP Scotland would finally point to remaining questions that arise from the current consultation. The important question remains as to how CHPs will work with the Acute Sector. There must be some point of communication, collaboration and inclusion in decision making if integrated service provision is not to stop at the point of acute service provision.

In addition, the relationship with management levels and the local authority must be meaningful and not merely token gesture, and it is not clear how this will be achieved.

Ultimately CSP Scotland would support ‘bottom-up’ operational units to support strategic planning, but question whether this can or will be incorporated into the current proposals.

Co-operation

CSP Scotland supports the encouragement of co-operation between CHPs in the same area, and between Health Boards. There are clear benefits of collaboration and joint provision in areas where patients may seek services from adjacent areas in which they live.

Co-operation can also encourage further the culture of partnership working, and ensure that the design and delivery of services is seamless across within health board areas and even across them.

Additional Resources

The stated policy intention of the Scottish Executive to provide substantial additional resources for the development of primary care services (to accompany reform proposals) is also welcomed.

Nevertheless, CSP Scotland would seek reassurance that additional resources for primary care services are not found from reductions to other health service budgets.

Self Referral

One of the areas that the Society would identify as an opportunity within the current proposals is the extension of self-referral access to physiotherapy services. Physiotherapists are legally allowed to be the first point of contact for patients in the NHS, but the majority of patients still access physiotherapy via medical referral.

Evidence strongly suggests that direct access to physiotherapy in the NHS would have considerable benefits in terms of appropriate and timely referrals. A pilot study in Dundee showed a dramatic reduction of General Practitioner workload, and decreased absence from work, an increase in patient satisfaction and empowerment which demonstrates the value of direct access to physiotherapy in the NHS.

Direct access to physiotherapy is now being piloted in a number of areas in Scotland in community settings, and current indications are that this can provide genuine benefits for patients, who can seek physiotherapy services without the need for referral from a hospital or GP.

Conclusion

Chartered physiotherapists are committed to developing modern innovative services and CSP Scotland aims to work with all involved to deliver a genuinely national health service that is both patient centred and values its staff.
On behalf of the Scottish Dermatological Society and the Scottish Council of Dermatology, I would like to thank you for the opportunity to provide feedback on the NHS Bill.

We welcome aspects of the proposals, including Managed Clinical Networks, Clinical Leadership and Redesign and, of course, the emphasis on patient involvement (particularly those with common chronic skin ailments, such as psoriasis, dermatitis and leg ulcers).

Our main concern in secondary care provision for those with skin disease is that the new system may encourage selective development of perceived areas of priority, such as cancer and vascular disease, while squeezing future development of others, such as disabling chronic skin disease which, although non life threatening, do seriously impact on an individual’s quality of life.

The dangers of prioritising one area at the expense of another are self evident. It will be important for the Community Health Partnerships to keep in mind a broad picture of specialist services. We see the membership and function of the CHPs to require clarification and underline the need for specialist service involvement within these structures.

Another matter of concern, which follows a similar theme, relates to central initiatives such as Managed Clinical Networks and Redesign, which although initially funded centrally, local Health Board funding will be essential to enable it to be sustainable. It is stated that Health Boards will be put under an obligation to support such structures after central funding has expired. In reality, existing Trusts who may have a different set of priorities, will be tempted to renege. We would like to emphasis the need for binding agreement to ensure that funding made centrally for a specific purpose is not used by the Health Boards as a subsidy for other areas.

In short, I would like to emphasis that in times of rapid change, we need to make sure that careful consideration is given to the broad picture and that systems are in place to ensure the continuity of development for the wide provision of secondary dermatology care.